

**Medicare Part D: 5 Tier Closed Formulary**

Please click here.

**For Medicare Part D: Prior Authorization Criteria**

Please click here.

Formulary ID: 17499 Version: 21

Updated: 11/2017

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## List of Abbreviations

**T1:** Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest cost-sharing tier.

**T2:** Cost-Sharing Tier 2 includes generic drugs.

**T3:** Cost-Sharing Tier 3 includes preferred brand name drugs and may include some single-sourced drugs (those generic drugs made by a single manufacturer).

**T4:** Cost-Sharing Tier 4 includes non-preferred brand name drugs and may include some single-sourced generic drugs (those generic drugs made by a single manufacturer).

**T5:** Cost-Sharing Tier 5 includes specialty drugs. This is the highest cost-sharing tier.

**PA:** Prior authorization required

**PA-BvD:** This drug may be covered under Medicare part B or D depending on the circumstance. Information may need to be submitted describing the use and setting of the drug to make the determination.

**PA-NS:** Prior authorization required for new starts only

**QL:** Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

Below is a list of drug name formatting patterns that may appear in the following pages.

## List of Patterns

**lowercase italics:** Generic drugs

**UPPERCASE BOLD:** Brand name drugs



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>Anti - Infectives</b>		
<i>abacavir oral tablet</i>	T2	
<b>ABACAVIR-LAMIVUDINE</b>	T5	
<i>abacavir-lamivudine-zidovudine</i>	T2	
<b>ABELCET</b>	T5	PA-BvD
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T2	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T2	PA-BvD
<i>adefovir</i>	T2	
<b>ALBENZA</b>	T4	
<b>ALINIA</b>	T4	
<i>amantadine hcl</i>	T2	
<b>AMBISOME</b>	T4	PA-BvD
<i>amikacin injection solution 500 mg/2 ml</i>	T2	
<i>amoxicillin oral capsule</i>	T1	
<i>amoxicillin oral suspension for reconstitution</i>	T1	
<i>amoxicillin oral tablet</i>	T1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate</i>	T2	
<i>amphotericin b</i>	T2	PA-BvD
<i>ampicillin oral capsule</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T2	
<i>ampicillin-sulbactam injection</i>	T2	
<b>APTIVUS</b>	T5	
<i>atovaquone</i>	T5	
<i>atovaquone-proguanil</i>	T2	
<b>ATRIPLA</b>	T5	
<b>AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML</b>	T4	
<b>AVELOX IN NACL (ISO-OSMOTIC)</b>	T3	
<b>AVYCAZ</b>	T5	
<b>AZACTAM IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2 GRAM/50 ML</b>	T3	
<i>azithromycin</i>	T2	
<i>aztreonam injection recon soln 1 gram</i>	T2	
<i>baciiim</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bacitracin intramuscular</i>	T2	
<b>BARACLUDE ORAL SOLUTION</b>	T3	
<b>BARACLUDE ORAL TABLET</b>	T5	
<b>BETHKIS</b>	T4	PA
<b>BICILLIN C-R</b>	T3	
<b>BICILLIN L-A</b>	T3	
<b>BILTRICIDE</b>	T3	
<b>CANCIDAS</b>	T4	
<b>CAPASTAT</b>	T4	
<b>CASPOFUNGIN</b>	T4	
<b>CAYSTON</b>	T5	
<i>cefaclor oral capsule</i>	T2	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	T2	
<i>cefaclor oral tablet extended release 12 hr</i>	T2	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	T2	
<i>cefadroxil oral tablet</i>	T2	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	T2	
<i>cefdinir</i>	T2	
<i>cefepime</i>	T2	
<i>cefixime</i>	T2	
<i>cefotaxime injection recon soln 1 gram, 2 gram, 500 mg</i>	T2	
<i>cefotetan injection</i>	T2	
<i>cefoxitin</i>	T2	
<i>cefpodoxime</i>	T2	
<i>cefprozil</i>	T2	
<i>ceftazidime</i>	T2	
<b>CEFTIN ORAL SUSPENSION FOR RECONSTITUTION</b>	T4	
<i>ceftriaxone injection recon soln 10 gram, 250 mg, 500 mg</i>	T2	
<i>ceftriaxone intravenous</i>	T2	
<i>cefuroxime axetil oral tablet</i>	T2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T2	
<i>cefuroxime sodium intravenous</i>	T2	
<i>cephalexin</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>chloramphenicol sod succinate</i>	T2	
<i>chloroquine phosphate</i>	T2	
<i>cidofovir</i>	T2	
<i>ciprofloxacin</i>	T2	
<i>ciprofloxacin (mixture)</i>	T2	
<i>ciprofloxacin hcl oral</i>	T1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>ciprofloxacin lactate intravenous solution 400 mg/40 ml</i>	T1	
<i>clarithromycin</i>	T2	
<b>CLEOCIN HCL ORAL CAPSULE 75 MG</b>	T3	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T2	
<i>clindamycin pediatric</i>	T2	
<i>clindamycin phosphate injection</i>	T2	
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	T2	
<i>clotrimazole mucous membrane</i>	T2	
<b>COARTEM</b>	T4	
<i>colistin (colistimethate na)</i>	T2	
<b>COMBIVIR</b>	T5	
<b>COMPLERA</b>	T5	
<b>COPEGUS</b>	T4	
<b>CRESEMBA</b>	T5	
<b>CRIXIVAN ORAL CAPSULE 200 MG, 400 MG</b>	T3	
<b>CUBICIN</b>	T5	
<b>CYTOVENE</b>	T4	PA-BvD
<b>DAKLINZA</b>	T5	PA; QL (28 EA per 28 days)
<b>DALVANCE</b>	T5	
<b>DAPSONE ORAL</b>	T3	
<b>DAPTOMYCIN</b>	T5	
<b>DARAPRIM</b>	T3	
<i>demeclocycline</i>	T2	
<b>DESCOVY</b>	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
<i>didanosine</i>	T2	
<b>DIFICID</b>	T5	QL (20 EA per 10 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DORIBAX INTRAVENOUS RECON SOLN 500 MG</b>	T4	
<i>doxy-100</i>	T2	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg</i>	T2	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg, 200 mg, 50 mg</i>	T2	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 150 mg, 75 mg</i>	T1	
<i>doxycycline monohydrate oral capsule</i>	T2	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	T2	
<i>doxycycline monohydrate oral tablet</i>	T2	
<i>e.e.s. 400 oral tablet</i>	T2	
<b>E.E.S. GRANULES</b>	T4	
<b>EDURANT</b>	T4	
<b>EMTRIVA</b>	T3	
<b>EMVERM</b>	T4	
<i>entecavir</i>	T5	
<b>EPCLUSA</b>	T5	PA; QL (28 EA per 28 days)
<b>EPIVIR HBV ORAL SOLUTION</b>	T3	
<b>EPIVIR HBV ORAL TABLET</b>	T4	
<b>EPIVIR ORAL SOLUTION</b>	T3	
<b>EPIVIR ORAL TABLET</b>	T4	
<b>EPZICOM</b>	T5	
<b>ERAXIS(WATER DILUENT)</b>	T4	
<b>ERYPED 200</b>	T4	
<b>ERYPED 400</b>	T4	
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	T2	
<b>ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG</b>	T3	
<i>erythrocin (as stearate) oral tablet 250 mg</i>	T2	
<b>ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG</b>	T3	
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	T2	
<i>erythromycin ethylsuccinate oral tablet</i>	T2	
<i>erythromycin oral capsule, delayed release(dr/ec)</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>erythromycin oral tablet</i>	T2	
<i>ethambutol</i>	T2	
<b>EVOTAZ</b>	T3	
<i>famciclovir</i>	T2	
<i>fluconazole</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	T2	
<i>flucytosine</i>	T2	
<b>FUZEON SUBCUTANEOUS RECON SOLN</b>	T5	
<i>ganciclovir sodium</i>	T2	PA-BvD
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T1	
<b>GENVOYA</b>	T5	
<i>griseofulvin microsize</i>	T2	
<i>griseofulvin ultramicrosize</i>	T2	
<b>HARVONI</b>	T5	PA; QL (28 EA per 28 days)
<b>HEPSERA</b>	T5	
<i>hydroxychloroquine</i>	T2	
<i>imipenem-cilastatin</i>	T2	
<b>INTELENCE ORAL TABLET 100 MG, 200 MG</b>	T5	
<b>INTELENCE ORAL TABLET 25 MG</b>	T4	
<b>INVANZ INJECTION</b>	T4	
<b>INVIRASE ORAL CAPSULE</b>	T4	
<b>INVIRASE ORAL TABLET</b>	T5	
<b>ISENTRESS HD</b>	T5	
<b>ISENTRESS ORAL POWDER IN PACKET</b>	T4	
<b>ISENTRESS ORAL TABLET</b>	T5	
<b>ISENTRESS ORAL TABLET,CHEWABLE 100 MG</b>	T5	
<b>ISENTRESS ORAL TABLET,CHEWABLE 25 MG</b>	T3	
<i>isoniazid injection</i>	T1	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole</i>	T2	
<i>ivermectin</i>	T2	
<b>KALETRA ORAL TABLET 100-25 MG</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>KALETRA ORAL TABLET 200-50 MG</b>	T5	
<i>ketoconazole oral</i>	T2	
<b>LAMISIL ORAL TABLET</b>	T4	QL (90 EA per 180 days)
<i>lamivudine</i>	T2	
<i>lamivudine-zidovudine</i>	T2	
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T2	
<i>levofloxacin intravenous</i>	T2	
<i>levofloxacin oral</i>	T2	
<b>LEXIVA ORAL SUSPENSION</b>	T3	
<b>LEXIVA ORAL TABLET</b>	T5	
<b>LINCOCIN</b>	T4	
<i>lincomycin</i>	T2	
<i>linezolid intravenous</i>	T4	
<i>linezolid oral</i>	T5	
<b>LOPINA VIR-RITONAVIR</b>	T5	
<b>MAVYRET</b>	T5	PA; QL (84 EA per 28 days)
<i>mefloquine</i>	T2	
<b>MEPRON</b>	T5	
<i>meropenem</i>	T2	
<i>methenamine hippurate</i>	T2	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral</i>	T1	
<i>minocycline</i>	T2	
<i>moderiba</i>	T2	
<i>moderiba dose pack oral tablets,dose pack 400 mg (7)- 400 mg (7), 600 mg (7)- 600 mg (7)</i>	T2	
<b>MONUROL</b>	T4	
<i>morgidox oral capsule 50 mg</i>	T3	
<i>moxifloxacin oral</i>	T3	
<b>MOXIFLOXACIN-SOD.ACE,SUL-WATER</b>	T4	
<b>MYCAMINE</b>	T4	
<i>nafcillin injection recon soln 1 gram, 10 gram</i>	T2	
<b>NEBUPENT</b>	T4	PA-BvD
<i>neomycin</i>	T2	
<i>nevirapine</i>	T2	
<i>nitrofurantoin</i>	T2	PA; QL (1800 ML per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	PA; QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	T2	PA; QL (360 EA per 365 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	PA; QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	PA; QL (90 EA per 365 days)
<b>NORVIR</b>	T3	
<b>NOXAFIL ORAL SUSPENSION</b>	T5	
<i>nystatin oral suspension</i>	T2	
<i>nystatin oral tablet</i>	T2	
<b>ODEFSEY</b>	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T2	
<b>OLYSIO</b>	T5	PA; QL (28 EA per 28 days)
<b>ORAVIG</b>	T4	
<b>ORBACTIV</b>	T5	
<i>oseltamivir</i>	T2	
<i>oxacillin in dextrose(iso-osm)</i>	T2	
<i>oxacillin injection recon soln 10 gram</i>	T2	
<i>paromomycin</i>	T2	
<b>PASER</b>	T4	
<b>PCE</b>	T4	
<b>PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML</b>	T4	
<i>penicillin g potassium injection recon soln 5 million unit</i>	T2	
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	T2	
<i>penicillin g sodium</i>	T2	
<i>penicillin v potassium</i>	T1	
<b>PENTAM</b>	T4	
<i>piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram, 40.5 gram</i>	T2	
<i>polymyxin b sulfate</i>	T2	
<b>PREZCOBIX</b>	T3	
<b>PREZISTA ORAL SUSPENSION</b>	T3	
<b>PREZISTA ORAL TABLET 150 MG, 75 MG</b>	T3	
<b>PREZISTA ORAL TABLET 600 MG, 800 MG</b>	T5	
<b>PRIFTIN</b>	T4	
<b>PRIMAQUINE</b>	T3	
<b>PRIMSOL</b>	T4	
<i>pyrazinamide</i>	T2	
<i>quinine sulfate</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>REBETOL ORAL SOLUTION</b>	T4	
<b>RELENZA DISKHALER</b>	T3	
<b>RESCRIPTOR</b>	T3	
<b>RETROVIR INTRAVENOUS</b>	T3	
<b>RETROVIR ORAL CAPSULE</b>	T4	
<b>RETROVIR ORAL SYRUP</b>	T4	
<b>REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG</b>	T3	
<b>REYATAZ ORAL POWDER IN PACKET</b>	T4	
<i>ribasphere oral capsule</i>	T2	
<i>ribasphere oral tablet 200 mg, 400 mg</i>	T2	
<i>ribasphere oral tablet 600 mg</i>	T5	
<i>ribasphere ribapak oral tablets, dose pack 200 mg (7)- 400 mg (7)</i>	T2	
<i>ribasphere ribapak oral tablets, dose pack 400-400 mg (28)-mg (28), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	T5	
<i>ribavirin oral capsule</i>	T2	
<i>ribavirin oral tablet 200 mg</i>	T2	
<i>rifabutin</i>	T2	
<i>rifampin</i>	T2	
<b>RIFATER</b>	T4	
<i>rimantadine</i>	T2	
<b>SELZENTRY ORAL TABLET</b>	T5	
<b>SIRTURO</b>	T5	
<b>SIVEXTRO INTRAVENOUS</b>	T5	
<b>SIVEXTRO ORAL</b>	T5	QL (6 EA per 31 days)
<b>SOVALDI</b>	T5	PA; QL (28 EA per 28 days)
<b>SPORANOX ORAL SOLUTION</b>	T3	
<i>stavudine oral capsule</i>	T2	
<b>STREPTOMYCIN</b>	T3	
<b>STRIBILD</b>	T5	
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole-trimethoprim</i>	T1	
<b>SUPRAX ORAL CAPSULE</b>	T3	
<b>SUPRAX ORAL SUSPENSION FOR RECONSTITUTION</b>	T3	
<b>SUSTIVA</b>	T3	
<b>SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML</b>	T5	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>SYNERCID</b>	T4	
<b>TAMIFLU</b>	T3	
<b>TAZICEF INJECTION</b>	T4	
<b>TECHNIVIE</b>	T5	PA; QL (56 EA per 28 days)
<b>TEFLARO</b>	T4	
<i>terbinafine hcl oral</i>	T1	QL (90 EA per 180 days)
<i>tetracycline</i>	T2	
<b>TIGECYCLINE</b>	T5	
<i>tinidazole</i>	T2	
<b>TIVICAY ORAL TABLET 10 MG</b>	T4	
<b>TIVICAY ORAL TABLET 25 MG, 50 MG</b>	T5	
<b>TOBI</b>	T4	PA
<b>TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE</b>	T3	PA
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T1	
<b>TRECATOR</b>	T4	
<i>trimethoprim</i>	T2	
<b>TRIUMEQ</b>	T5	
<b>TRIZIVIR</b>	T4	
<b>TRUVADA</b>	T5	
<b>TYBOST</b>	T3	
<b>TYGACIL</b>	T5	
<i>valacyclovir</i>	T2	
<b>VALCYTE ORAL RECON SOLN</b>	T4	
<b>VALCYTE ORAL TABLET</b>	T5	
<b>VALGANCICLOVIR ORAL RECON SOLN</b>	T4	
<i>valganciclovir oral tablet</i>	T5	
<b>VANCOCIN</b>	T5	
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg</i>	T2	
<i>vancomycin oral capsule 125 mg</i>	T4	
<i>vancomycin oral capsule 250 mg</i>	T5	
<b>VEMLIDY</b>	T5	QL (31 EA per 31 days)
<b>VFEND</b>	T5	
<b>VIDEX 2 GRAM PEDIATRIC</b>	T3	
<b>VIDEX EC</b>	T4	
<b>VIEKIRA PAK</b>	T5	PA; QL (112 EA per 28 days)
<b>VIEKIRA XR</b>	T5	PA; QL (84 EA per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VIRACEPT ORAL TABLET</b>	T5	
<b>VIRAMUNE ORAL SUSPENSION</b>	T4	
<b>VIRAMUNE XR</b>	T4	
<b>VIREAD</b>	T3	
<i>voriconazole intravenous</i>	T2	
<i>voriconazole oral suspension for reconstitution</i>	T2	
<i>voriconazole oral tablet 200 mg</i>	T5	
<i>voriconazole oral tablet 50 mg</i>	T2	
<b>VOSEVI</b>	T5	PA; QL (28 EA per 28 days)
<b>XIFAXAN ORAL TABLET 200 MG</b>	T4	QL (9 EA per 3 days)
<b>XIFAXAN ORAL TABLET 550 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>ZEPATIER</b>	T5	PA; QL (28 EA per 28 days)
<b>ZERBAXA</b>	T4	
<b>ZERIT</b>	T4	
<b>ZIAGEN ORAL SOLUTION</b>	T3	
<b>ZIAGEN ORAL TABLET</b>	T4	
<i>zidovudine</i>	T2	
<b>ZMAX</b>	T4	
<b>ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML, 3.375 GRAM/50 ML</b>	T3	
<b>ZYVOX INTRAVENOUS PARENTERAL SOLUTION 600 MG/300 ML</b>	T5	
<b>ZYVOX ORAL</b>	T5	
<b>Antineoplastic / Immunosuppressant Drugs</b>		
<b>ABRAXANE</b>	T4	
<b>ADRIAMYCIN INTRAVENOUS SOLUTION 20 MG/10 ML</b>	T4	PA-BvD
<i>adrucil intravenous solution 500 mg/10 ml</i>	T2	PA-BvD
<b>AFINITOR</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>ALECENSA</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>ALIMTA INTRAVENOUS RECON SOLN 500 MG</b>	T3	
<b>ALUNBRIG</b>	T5	PA-NS; QL (186 EA per 31 days)
<i>anastrozole</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ARIMIDEX</b>	T4	
<b>AROMASIN</b>	T4	
<b>ARRANON</b>	T4	
<b>ASTAGRAF XL</b>	T3	PA-BvD
<b>AVASTIN</b>	T5	
<i>azacitidine</i>	T5	
<b>AZASAN</b>	T4	PA-BvD
<i>azathioprine</i>	T2	PA-BvD
<i>azathioprine sodium</i>	T3	PA-BvD
<b>BAVENCIO</b>	T5	PA-NS
<b>BELEODAQ</b>	T5	PA-NS
<i>bexarotene</i>	T5	
<i>bicalutamide</i>	T2	
<b>BICNU</b>	T4	
<i>bleomycin injection recon soln 30 unit</i>	T2	PA-BvD
<b>BOSULIF</b>	T5	PA-NS
<i>busulfan</i>	T4	
<b>BUSULFEX</b>	T4	
<b>CABOMETYX</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>CAPRELSA</b>	T5	PA-NS
<i>carboplatin intravenous solution</i>	T2	
<b>CASODEX</b>	T4	
<b>CELLCEPT INTRAVENOUS</b>	T4	PA-BvD
<b>CELLCEPT ORAL CAPSULE</b>	T4	PA-BvD
<b>CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION</b>	T4	PA-BvD
<b>CELLCEPT ORAL TABLET</b>	T5	PA-BvD
<i>cisplatin</i>	T2	
<i>cladribine</i>	T2	PA-BvD
<b>CLOFARABINE</b>	T4	
<b>COMETRIQ</b>	T5	PA-NS
<b>COTELLIC</b>	T5	PA-NS
<b>CYCLOPHOSPHAMIDE ORAL CAPSULE</b>	T4	PA-BvD
<i>cyclosporine intravenous</i>	T2	PA-BvD
<i>cyclosporine modified</i>	T2	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
<b>CYRAMZA</b>	T5	
<i>cytarabine</i>	T2	PA-BvD



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)</i>	T2	PA-BvD
<i>dacarbazine intravenous recon soln 200 mg</i>	T2	
<b>DACOGEN</b>	T5	
<b>DARZALEX</b>	T5	PA-NS
<i>daunorubicin intravenous solution</i>	T2	
<i>decitabine</i>	T5	
<i>dexrazoxane hcl intravenous recon soln 250 mg</i>	T2	
<i>docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)</i>	T2	
<i>doxorubicin intravenous solution 50 mg/25 ml</i>	T2	PA-BvD
<i>doxorubicin, peg-liposomal</i>	T2	PA-BvD
<b>DROXIA</b>	T4	
<b>ELIGARD</b>	T4	
<b>ELIGARD (3 MONTH)</b>	T4	
<b>ELIGARD (4 MONTH)</b>	T4	
<b>ELIGARD (6 MONTH)</b>	T4	
<b>ELITEK</b>	T5	
<b>ELLENCE INTRAVENOUS SOLUTION 200 MG/100 ML</b>	T4	
<b>EMCYT</b>	T3	
<b>EMPLICITI</b>	T5	PA-BvD
<b>ENVARUS XR</b>	T4	PA-BvD
<b>EPIRUBICIN INTRAVENOUS SOLUTION 200 MG/100 ML</b>	T4	
<b>ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML</b>	T3	
<b>ERIVEDGE</b>	T5	PA-NS
<b>ERWINAZE</b>	T5	
<b>ETOPOPHOS</b>	T4	
<i>etoposide intravenous</i>	T2	
<i>exemestane</i>	T2	
<b>FARESTON</b>	T3	
<b>FARYDAK</b>	T5	PA-NS
<b>FASLODEX</b>	T5	
<b>FEMARA</b>	T4	
<b>FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG</b>	T5	
<b>FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fludarabine intravenous recon soln</i>	T2	
<i>fluorouracil intravenous solution 2.5 gram/50 ml</i>	T2	PA-BvD
<i>flutamide</i>	T2	
<b>FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)</b>	T5	
<b>FUSILEV</b>	T4	
<i>gemcitabine intravenous recon soln 1 gram</i>	T2	
<i>gengraf</i>	T2	PA-BvD
<b>GILOTRIF</b>	T5	PA-NS
<b>GLEEVEC ORAL TABLET 100 MG</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>GLEEVEC ORAL TABLET 400 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>GLEOSTINE</b>	T4	
<b>HALAVEN</b>	T5	
<b>HERCEPTIN INTRAVENOUS RECON SOLN 440 MG</b>	T5	
<b>HEXALEN</b>	T3	
<i>hydroxyurea</i>	T2	
<b>IBRANCE</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>ICLUSIG</b>	T5	PA-NS
<i>idarubicin</i>	T2	
<b>IDHIFA ORAL TABLET 100 MG</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>IDHIFA ORAL TABLET 50 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<i>ifosfamide intravenous recon soln 1 gram</i>	T2	
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<b>IMBRUVICA</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>IMFINZI</b>	T5	PA-NS
<b>IMURAN</b>	T4	PA-BvD
<b>INLYTA</b>	T5	PA-NS
<b>IRESSA</b>	T5	PA-NS
<i>irinotecan intravenous solution 100 mg/5 ml</i>	T2	
<b>ISTODAX</b>	T5	
<b>JAKAFI</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>JEVTANA</b>	T5	
<b>KADCYLA INTRAVENOUS RECON SOLN 100 MG</b>	T5	
<b>KEPIVANCE</b>	T5	
<b>KEYTRUDA</b>	T5	PA-NS

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG</b>	T5	PA-NS; QL (49 EA per 28 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG</b>	T5	PA-NS; QL (70 EA per 28 days)
<b>KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG</b>	T5	PA-NS; QL (91 EA per 28 days)
<b>KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)</b>	T5	PA-NS; QL (42 EA per 28 days)
<b>KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)</b>	T5	PA-NS; QL (63 EA per 28 days)
<b>KYPROLIS</b>	T5	
<b>LARTRUVO</b>	T5	
<b>LENVIMA</b>	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium injection recon soln 100 mg, 350 mg</i>	T2	
<i>leucovorin calcium oral</i>	T2	
<b>LEUKERAN</b>	T3	
<i>leuprolide subcutaneous kit</i>	T2	
<i>levoleucovorin intravenous recon soln 50 mg</i>	T4	
<i>levoleucovorin intravenous solution</i>	T4	
<b>LONSURF</b>	T5	PA-NS
<b>LUPRON DEPOT (3 MONTH)</b>	T5	
<b>LUPRON DEPOT (4 MONTH)</b>	T5	
<b>LUPRON DEPOT (6 MONTH)</b>	T5	
<b>LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG</b>	T3	
<b>LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG</b>	T5	
<b>LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG</b>	T5	
<b>LYNPARZA ORAL CAPSULE</b>	T5	PA-NS
<b>LYNPARZA ORAL TABLET</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>LYSODREN</b>	T3	
<b>MATULANE</b>	T5	
<b>MEGACE ES</b>	T4	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	T2	
<i>megestrol oral tablet</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MEKINIST</b>	T5	PA-NS
<i>melphalan hcl</i>	T5	
<i>mercaptopurine</i>	T2	
<i>mesna</i>	T2	
<b>MESNEX ORAL</b>	T3	
<i>methotrexate sodium (pf)</i>	T2	PA-BvD
<i>methotrexate sodium injection</i>	T2	PA-BvD
<i>methotrexate sodium oral</i>	T1	PA-BvD
<i>mitomycin</i>	T2	
<i>mitoxantrone</i>	T2	
<b>MUSTARGEN</b>	T4	
<i>mycophenolate mofetil</i>	T2	PA-BvD
<i>mycophenolate mofetil hcl</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T2	PA-BvD
<b>MYFORTIC</b>	T4	PA-BvD
<b>NEORAL</b>	T3	PA-BvD
<b>NERLYNX</b>	T5	PA-NS; QL (186 EA per 31 days)
<b>NEXAVAR</b>	T5	PA-NS
<b>NILANDRON</b>	T5	
<i>nilutamide</i>	T5	
<b>NINLARO</b>	T5	PA-NS
<b>NIPENT</b>	T4	
<b>NULOJIX</b>	T5	PA-BvD
<i>octreotide acetate injection solution 1,000 mcg/ml, 200 mcg/ml</i>	T3	
<i>octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml</i>	T2	
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	
<b>ODOMZO</b>	T5	PA-NS
<b>OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML</b>	T5	PA-NS
<i>oxaliplatin intravenous solution 100 mg/20 ml</i>	T4	
<i>paclitaxel</i>	T2	
<b>PERJETA</b>	T5	
<b>POMALYST</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>PROGRAF INTRAVENOUS</b>	T3	PA-BvD
<b>PROGRAF ORAL CAPSULE 0.5 MG, 1 MG</b>	T4	PA-BvD
<b>PROGRAF ORAL CAPSULE 5 MG</b>	T5	PA-BvD
<b>PURIXAN</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>RAPAMUNE ORAL SOLUTION</b>	T3	PA-BvD
<b>RAPAMUNE ORAL TABLET 0.5 MG</b>	T4	PA-BvD
<b>RAPAMUNE ORAL TABLET 1 MG, 2 MG</b>	T5	PA-BvD
<b>REVLIMID</b>	T5	PA-NS; QL (21 EA per 28 days)
<b>RITUXAN</b>	T5	
<b>RUBRACA ORAL TABLET 200 MG, 300 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>RYDAPT</b>	T5	PA-NS; QL (248 EA per 31 days)
<b>SANDIMMUNE</b>	T3	PA-BvD
<b>SANDOSTATIN INJECTION SOLUTION 1,000 MCG/ML, 100 MCG/ML, 200 MCG/ML</b>	T5	
<b>SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON</b>	T5	
<b>SIGNIFOR</b>	T5	PA
<b>SIGNIFOR LAR</b>	T5	
<b>SIMULECT INTRAVENOUS RECON SOLN 20 MG</b>	T4	PA-BvD
<i>sirolimus</i>	T2	PA-BvD
<b>SOLTAMOX</b>	T4	
<b>SOMATULINE DEPOT</b>	T5	
<b>SPRYCEL</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>STIVARGA</b>	T5	PA-NS
<b>SUTENT</b>	T5	PA-NS
<b>SYLVANT INTRAVENOUS RECON SOLN 100 MG</b>	T5	PA-NS
<b>SYNRIBO</b>	T5	
<b>TABLOID</b>	T3	
<i>tacrolimus oral capsule 0.5 mg, 1 mg</i>	T2	PA-BvD
<i>tacrolimus oral capsule 5 mg</i>	T5	PA-BvD
<b>TAFINLAR</b>	T5	PA-NS
<b>TAGRISSO</b>	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
<b>TARCEVA</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>TARGRETIN</b>	T5	
<b>TASIGNA</b>	T5	PA-NS
<b>TECENTRIQ</b>	T5	
<b>THALOMID</b>	T5	PA-NS
<i>thiotepa</i>	T5	
<i>toposar</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>topotecan intravenous recon soln</i>	T2	
<b>TORISEL</b>	T5	
<b>TREANDA INTRAVENOUS RECON SOLN 100 MG</b>	T4	
<b>TRELSTAR INTRAMUSCULAR SYRINGE</b>	T3	
<i>tretinoin (chemotherapy)</i>	T2	
<b>TREXALL</b>	T3	PA-BvD
<b>TRISENOX</b>	T4	
<b>TYKERB</b>	T5	PA-NS
<b>VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)</b>	T4	
<b>VELCADE</b>	T5	
<b>VENCLEXTA ORAL TABLET 10 MG, 50 MG</b>	T4	PA-NS
<b>VENCLEXTA ORAL TABLET 100 MG</b>	T5	PA-NS
<b>VENCLEXTA STARTING PACK</b>	T5	PA-NS
<b>VIDAZA</b>	T5	
<i>vinblastine intravenous solution</i>	T2	PA-BvD
<i>vincasar pfs intravenous solution 1 mg/ml</i>	T2	PA-BvD
<i>vincristine intravenous solution 1 mg/ml</i>	T2	PA-BvD
<i>vinorelbine intravenous solution 50 mg/5 ml</i>	T2	
<b>VOTRIENT</b>	T5	PA-NS
<b>VYXEOS</b>	T5	PA-NS
<b>XALKORI</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>XERMELO</b>	T5	PA; QL (93 EA per 31 days)
<b>XGEVA</b>	T5	
<b>XTANDI</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)</b>	T5	
<b>YONDELIS</b>	T5	
<b>ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)</b>	T5	
<b>ZANOSAR</b>	T4	
<b>ZEJULA</b>	T5	PA-NS; QL (93 EA per 31 days)
<b>ZELBORAF</b>	T5	PA-NS
<b>ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 250 MG</b>	T4	
<b>ZOLINZA</b>	T5	PA-NS
<b>ZORTRESS ORAL TABLET 0.25 MG</b>	T4	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG</b>	T5	PA-BvD
<b>ZYDELIG</b>	T5	PA-NS
<b>ZYKADIA</b>	T5	PA-NS
<b>ZYTIGA ORAL TABLET 250 MG</b>	T5	PA-NS; QL (124 EA per 31 days)
<b>ZYTIGA ORAL TABLET 500 MG</b>	T5	PA-NS; QL (62 EA per 31 days)
<b>Autonomic / Cns Drugs, Neurology / Psych</b>		
<b>ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG</b>	T5	
<b>ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING</b>	T5	
<b>ABILIFY ORAL TABLET 10 MG, 20 MG, 30 MG</b>	T5	PA-NS
<b>ABILIFY ORAL TABLET 15 MG, 2 MG, 5 MG</b>	T4	PA-NS
<b>ABSTRAL SUBLINGUAL TABLET 100 MCG</b>	T4	PA; QL (124 EA per 31 days)
<b>ABSTRAL SUBLINGUAL TABLET 200 MCG, 300 MCG</b>	T5	PA; QL (124 EA per 31 days)
<b>ABSTRAL SUBLINGUAL TABLET 400 MCG</b>	T5	PA; QL (119 EA per 31 days)
<b>ABSTRAL SUBLINGUAL TABLET 600 MCG</b>	T5	PA; QL (79 EA per 31 days)
<b>ABSTRAL SUBLINGUAL TABLET 800 MCG</b>	T5	PA; QL (60 EA per 31 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T1	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
<b>ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG</b>	T5	PA; QL (40 EA per 31 days)
<b>ACTIQ BUCCAL LOZENGE ON A HANDLE 1,600 MCG</b>	T5	PA; QL (30 EA per 31 days)
<b>ACTIQ BUCCAL LOZENGE ON A HANDLE 200 MCG</b>	T5	PA; QL (124 EA per 31 days)
<b>ACTIQ BUCCAL LOZENGE ON A HANDLE 400 MCG</b>	T5	PA; QL (119 EA per 31 days)
<b>ACTIQ BUCCAL LOZENGE ON A HANDLE 600 MCG</b>	T5	PA; QL (79 EA per 31 days)
<b>ACTIQ BUCCAL LOZENGE ON A HANDLE 800 MCG</b>	T5	PA; QL (59 EA per 31 days)
<b>ALLZITAL</b>	T4	QL (372 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>almotriptan malate oral tablet 12.5 mg</i>	T2	QL (8 EA per 31 days)
<i>almotriptan malate oral tablet 6.25 mg</i>	T2	QL (16 EA per 31 days)
<i>alprazolam intensol</i>	T2	PA
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg</i>	T2	PA; QL (31 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 3 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet, disintegrating 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<b>AMERGE ORAL TABLET 1 MG</b>	T4	QL (20 EA per 31 days)
<b>AMERGE ORAL TABLET 2.5 MG</b>	T4	QL (8 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amitriptyline-chlordiazepoxide</i>	T2	PA-NS
<i>amoxapine</i>	T1	
<b>AMPYRA</b>	T5	PA; QL (62 EA per 31 days)
<b>ALENZIN</b>	T4	
<b>APOKYN</b>	T5	
<b>APTENSIO XR</b>	T4	
<b>APTIOM</b>	T4	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg</i>	T3	PA-NS
<i>aripiprazole oral tablet 20 mg, 30 mg</i>	T5	PA-NS
<i>aripiprazole oral tablet, disintegrating</i>	T3	PA-NS
<b>ARISTADA</b>	T4	
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>ascomp with codeine</i>	T2	PA; QL (372 EA per 31 days)
<b>ATOMOXETINE</b>	T4	PA
<b>AUBAGIO</b>	T5	PA; QL (31 EA per 31 days)
<b>AUSTEDO ORAL TABLET 12 MG, 6 MG</b>	T5	PA; QL (124 EA per 31 days)
<b>AUSTEDO ORAL TABLET 9 MG</b>	T5	PA; QL (155 EA per 31 days)
<b>AXERT ORAL TABLET 12.5 MG</b>	T4	QL (8 EA per 31 days)
<b>AXERT ORAL TABLET 6.25 MG</b>	T4	QL (16 EA per 31 days)
<b>AZILECT</b>	T3	
<i>baclofen oral tablet 10 mg</i>	T1	
<i>baclofen oral tablet 20 mg</i>	T2	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>BANZEL ORAL SUSPENSION</b>	T4	
<b>BANZEL ORAL TABLET 200 MG</b>	T4	
<b>BANZEL ORAL TABLET 400 MG</b>	T5	
<b>BELBUCA</b>	T4	PA; QL (62 EA per 31 days)
<i>benztropine</i>	T2	
<b>BRISDELLE</b>	T4	
<b>BRIVIACT</b>	T4	
<i>bromocriptine</i>	T2	
<b>BUNAVAIL BUCCAL FILM 2.1-0.3 MG</b>	T4	QL (31 EA per 31 days)
<b>BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG</b>	T4	QL (62 EA per 31 days)
<b>BUPRENEX</b>	T4	QL (267 ML per 30 days)
<b>BUPRENORPHINE</b>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl injection</i>	T1	QL (267 ML per 30 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T2	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T1	
<i>bupropion hcl oral tablet extended release 12 hr</i>	T3	QL (62 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<i>buspirone oral tablet 10 mg, 15 mg, 5 mg</i>	T1	
<i>buspirone oral tablet 30 mg, 7.5 mg</i>	T2	
<i>butalbital compound w/codeine</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	T2	PA; QL (403 EA per 31 days)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	T2	QL (403 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-aspirin-caffeine oral capsule</i>	T2	
<b>BUTISOL ORAL TABLET 30 MG</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>butorphanol tartrate injection solution 1 mg/ml</i>	T2	QL (720 ML per 30 days)
<i>butorphanol tartrate injection solution 2 mg/ml</i>	T2	QL (360 ML per 30 days)
<i>butorphanol tartrate nasal</i>	T2	QL (5 ML per 28 days)
<b>BUTRANS</b>	T4	PA; QL (4 EA per 28 days)
<b>CAMBIA</b>	T4	
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T1	
<i>carbamazepine oral tablet</i>	T1	
<i>carbamazepine oral tablet extended release 12 hr</i>	T2	
<i>carbamazepine oral tablet, chewable</i>	T1	
<b>CARBATROL</b>	T4	
<i>carbidopa</i>	T2	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T2	
<i>carisoprodol-asa-codeine</i>	T2	PA; QL (2582 EA per 31 days)
<i>celecoxib</i>	T2	
<b>CELONTIN ORAL CAPSULE 300 MG</b>	T3	
<b>CEREBYX INJECTION SOLUTION 500 MG PE/10 ML</b>	T4	
<i>chlordiazepoxide hcl</i>	T2	
<i>chlorpromazine</i>	T2	
<i>citalopram</i>	T1	
<i>clomipramine</i>	T2	PA-NS
<i>clonazepam</i>	T2	
<i>clonidine hcl oral tablet extended release 12 hr</i>	T2	PA
<i>clorazepate dipotassium</i>	T2	
<i>clozapine oral tablet 100 mg, 200 mg</i>	T2	
<i>clozapine oral tablet 25 mg, 50 mg</i>	T1	
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 25 mg</i>	T2	
<b>CLOZAPINE ORAL TABLET, DISINTEGRATING 150 MG, 200 MG</b>	T4	
<b>CLOZARIL</b>	T4	
<i>codeine sulfate oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<b>COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML</b>	T5	QL (31 ML per 31 days)
<b>COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML</b>	T5	QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet</i>	T2	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dantrolene</i>	T2	
<b>DAYTRANA</b>	T4	
<b>DEPACON</b>	T4	
<b>DEPAKENE</b>	T4	
<b>DEPAKOTE</b>	T4	
<b>DEPAKOTE ER</b>	T4	
<b>DEPAKOTE SPRINKLES</b>	T4	
<i>desipramine</i>	T2	
<b>DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR</b>	T4	
<i>desvenlafaxine succinate</i>	T4	
<i>dexmethylphenidate</i>	T2	
<i>dextroamphetamine oral capsule, extended release</i>	T2	
<i>dextroamphetamine oral tablet</i>	T2	
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 30 mg</i>	T2	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 12.5 mg, 15 mg, 5 mg, 7.5 mg</i>	T1	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	QL (93 EA per 31 days)
<b>DIASTAT</b>	T4	
<b>DIASTAT ACUDIAL</b>	T4	
<i>diazepam intensol</i>	T2	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	QL (124 EA per 31 days)
<i>diazepam rectal kit 2.5 mg, 5-7.5-10 mg</i>	T4	
<i>diclofenac potassium</i>	T1	
<i>diclofenac sodium oral</i>	T1	
<i>diclofenac sodium topical drops</i>	T2	
<i>diclofenac sodium topical gel 1 %</i>	T3	
<i>diclofenac-misoprostol</i>	T2	
<i>diflunisal</i>	T2	
<i>dihydroergotamine injection</i>	T2	
<i>dihydroergotamine nasal</i>	T2	QL (8 ML per 31 days)
<b>DILANTIN</b>	T4	
<b>DILANTIN EXTENDED</b>	T4	
<b>DILANTIN INFATABS</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DILANTIN-125</b>	T4	
<i>divalproex oral capsule, delayed rel sprinkle</i>	T2	
<i>divalproex oral tablet extended release 24 hr</i>	T3	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	T2	
<b>DOLOPHINE ORAL TABLET 10 MG</b>	T4	PA; QL (206 EA per 31 days)
<b>DOLOPHINE ORAL TABLET 5 MG</b>	T4	PA; QL (248 EA per 31 days)
<i>donepezil</i>	T2	
<i>doxepin oral</i>	T2	PA-NS
<b>DUEXIS</b>	T4	PA; QL (93 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T3	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg, 40 mg</i>	T3	QL (31 EA per 31 days)
<b>DUOPA</b>	T4	PA-BvD
<b>DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR</b>	T4	PA; QL (10 EA per 30 days)
<b>DURAGESIC TRANSDERMAL PATCH 72 HOUR 12 MCG/HR, 25 MCG/HR</b>	T4	PA; QL (20 EA per 30 days)
<b>DURAGESIC TRANSDERMAL PATCH 72 HOUR 50 MCG/HR</b>	T4	PA; QL (17 EA per 30 days)
<b>DURAGESIC TRANSDERMAL PATCH 72 HOUR 75 MCG/HR</b>	T4	PA; QL (12 EA per 30 days)
<i>duramorph (pf) injection solution 0.5 mg/ml</i>	T2	PA-BvD; QL (4000 ML per 30 days)
<i>duramorph (pf) injection solution 1 mg/ml</i>	T2	PA-BvD; QL (2000 ML per 30 days)
<i>eletriptan hbr oral tablet 20 mg</i>	T2	QL (12 EA per 31 days)
<i>eletriptan hbr oral tablet 40 mg</i>	T2	QL (6 EA per 31 days)
<b>EMBEDA ORAL CAPSULE, ORAL ONLY, EXT. REL PELL</b>	T4	PA; QL (62 EA per 31 days)
<b>EMSAM</b>	T5	
<i>endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T2	
<i>epitol</i>	T1	
<b>EQUETRO</b>	T4	
<i>ergoloid</i>	T2	
<i>ergotamine-caffeine</i>	T2	
<i>escitalopram oxalate</i>	T4	
<i>estazolam</i>	T2	
<i>eszopiclone</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ethosuximide</i>	T2	
<i>etodolac</i>	T2	
<b>EVZIO INJECTION AUTO-INJECTOR 0.4 MG/0.4 ML</b>	T4	
<b>EVZIO INJECTION AUTO-INJECTOR 2 MG/0.4 ML</b>	T5	
<b>EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 16 MG, 8 MG</b>	T4	PA; QL (62 EA per 31 days)
<b>EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 32 MG</b>	T4	PA; QL (48 EA per 31 days)
<b>EXELON TRANSDERMAL</b>	T3	
<b>EXONDYS 51</b>	T5	PA
<b>FANAPT</b>	T4	
<b>FAZACLO ORAL TABLET,DISINTEGRATING 100 MG, 12.5 MG, 25 MG</b>	T4	
<b>FAZACLO ORAL TABLET,DISINTEGRATING 150 MG, 200 MG</b>	T5	
<i>felbamate</i>	T2	
<b>FELBATOL</b>	T4	
<b>FENOPROFEN ORAL CAPSULE 400 MG</b>	T4	
<i>fenoprofen oral tablet</i>	T2	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T2	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T3	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T3	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<b>FENTANYL TRANSDERMAL PATCH 72 HOUR 37.5 MCG/HOUR</b>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>FENTANYL TRANSDERMAL PATCH 72 HOUR 62.5 MCG/HOUR</b>	T4	PA; QL (15 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T3	PA; QL (12 EA per 30 days)
<b>FENTANYL TRANSDERMAL PATCH 72 HOUR 87.5 MCG/HOUR</b>	T4	PA; QL (11 EA per 30 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG</b>	T5	PA; QL (124 EA per 31 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG</b>	T5	PA; QL (119 EA per 31 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG</b>	T5	PA; QL (79 EA per 31 days)
<b>FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG</b>	T5	PA; QL (59 EA per 31 days)
<b>FETZIMA</b>	T4	PA-NS
<b>FLECTOR</b>	T4	PA; QL (62 EA per 31 days)
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	T2	
<i>fluoxetine oral solution</i>	T1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T1	
<b>FLUOXETINE ORAL TABLET 60 MG</b>	T4	
<i>fluphenazine decanoate</i>	T2	
<i>fluphenazine hcl</i>	T1	
<i>flurazepam</i>	T2	
<i>flurbiprofen</i>	T2	
<i>fluvoxamine</i>	T2	
<b>FOCALIN XR ORAL CAPSULE, ER BIPHASIC 50-50 20 MG, 25 MG, 35 MG</b>	T4	
<i>fosphenytoin injection solution 100 mg pe/2 ml</i>	T2	
<b>FROVA</b>	T4	QL (12 EA per 31 days)
<i>frovatriptan</i>	T3	QL (12 EA per 31 days)
<b>FYCOMPA ORAL SUSPENSION</b>	T4	
<b>FYCOMPA ORAL TABLET</b>	T4	
<i>gabapentin oral capsule</i>	T2	
<i>gabapentin oral solution 250 mg/5 ml</i>	T2	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	T2	
<b>GABITRIL ORAL TABLET 12 MG, 16 MG</b>	T3	
<b>GABITRIL ORAL TABLET 2 MG, 4 MG</b>	T4	
<b>GABLOFEN INTRATHECAL SOLUTION 10,000 MCG/20ML (500 MCG/ML), 40,000 MCG/20ML (2,000 MCG/ML)</b>	T4	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GABLOFEN INTRATHECAL SYRINGE 50 MCG/ML (1 ML)</b>	T4	PA-BvD
<i>galantamine</i>	T2	
<b>GEODON INTRAMUSCULAR</b>	T3	
<b>GILENYA</b>	T5	PA; QL (31 EA per 31 days)
<i>glatopa</i>	T5	QL (31 ML per 31 days)
<b>GRALISE</b>	T3	PA-NS
<b>GRALISE 30-DAY STARTER PACK</b>	T3	PA-NS
<i>guanfacine oral tablet extended release 24 hr</i>	T2	PA
<i>guanidine</i>	T2	
<b>HALCION ORAL TABLET 0.25 MG</b>	T4	PA
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate injection</i>	T2	
<i>haloperidol lactate oral</i>	T1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 2 mg, 20 mg, 5 mg</i>	T1	
<i>haloperidol oral tablet 10 mg</i>	T2	
<b>HETLIOZ</b>	T5	PA
<b>HORIZANT</b>	T4	PA-NS
<b>HYCET</b>	T4	PA; QL (5723 ML per 31 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	T2	PA; QL (5723 ML per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	T2	PA; QL (403 EA per 31 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>hydromorphone (pf)</i>	T2	PA; QL (124 ML per 31 days)
<i>hydromorphone injection syringe 2 mg/ml</i>	T2	PA; QL (155 ML per 31 days)
<i>hydromorphone oral liquid</i>	T2	PA; QL (1550 ML per 31 days)
<i>hydromorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>hydromorphone oral tablet extended release 24 hr 32 mg</i>	T2	PA; QL (48 EA per 31 days)
<b>HYSINGLA ER</b>	T4	PA; QL (31 EA per 31 days)
<i>ibuprofen oral suspension</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>ibuprofen-oxycodone</i>	T2	PA; QL (30 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>imipramine hcl</i>	T2	PA-NS
<i>imipramine pamoate</i>	T2	
<b>IMITREX NASAL SPRAY, NON-AEROSOL 20 MG/ACTUATION</b>	T4	QL (8 EA per 31 days)
<b>IMITREX NASAL SPRAY, NON-AEROSOL 5 MG/ACTUATION</b>	T4	QL (32 EA per 31 days)
<b>IMITREX ORAL TABLET 100 MG</b>	T4	QL (9 EA per 31 days)
<b>IMITREX ORAL TABLET 25 MG</b>	T4	QL (36 EA per 31 days)
<b>IMITREX ORAL TABLET 50 MG</b>	T4	QL (18 EA per 31 days)
<b>IMITREX STATDOSE KIT REFILL SUBCUTANEOUS CARTRIDGE 4 MG/0.5 ML</b>	T4	QL (6 ML per 31 days)
<b>IMITREX STATDOSE KIT REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML</b>	T4	QL (4 ML per 31 days)
<b>IMITREX SUBCUTANEOUS</b>	T4	QL (4 ML per 31 days)
<b>INDOCIN ORAL</b>	T4	
<i>indomethacin oral</i>	T1	
<b>INGREZZA ORAL CAPSULE 40 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>INTUNIV ER</b>	T4	PA
<b>INVEGA ORAL TABLET EXTENDED RELEASE 24HR 1.5 MG, 3 MG</b>	T4	
<b>INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG, 9 MG</b>	T5	
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML</b>	T5	
<b>INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML</b>	T4	
<b>INVEGA TRINZA</b>	T5	
<b>KADIAN ORAL CAPSULE, EXTEND. RELEASE PELLETS 10 MG, 100 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG</b>	T4	PA; QL (62 EA per 31 days)
<b>KADIAN ORAL CAPSULE, EXTEND. RELEASE PELLETS 200 MG</b>	T4	PA; QL (31 EA per 31 days)
<b>KAPVAY</b>	T4	PA
<b>KEPPRA ORAL SOLUTION</b>	T5	
<b>KEPPRA ORAL TABLET 1,000 MG</b>	T5	
<b>KEPPRA ORAL TABLET 250 MG, 500 MG, 750 MG</b>	T4	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>KEPPRA XR</b>	T4	
<i>ketoprofen oral capsule</i>	T2	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	T2	
<i>ketorolac injection cartridge 30 mg/ml</i>	T2	
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	T2	
<i>ketorolac oral</i>	T2	
<b>KEVEYIS</b>	T4	PA; QL (124 EA per 31 days)
<b>KHEDEZLA</b>	T4	
<b>LAMICTAL ODT</b>	T3	
<b>LAMICTAL ORAL TABLET</b>	T4	
<b>LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG</b>	T4	
<b>LAMICTAL STARTER (BLUE) KIT</b>	T4	
<b>LAMICTAL STARTER (GREEN) KIT</b>	T4	
<b>LAMICTAL STARTER (ORANGE) KIT</b>	T4	
<b>LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG, 250 MG, 50 MG</b>	T4	
<b>LAMICTAL XR STARTER (BLUE)</b>	T4	
<b>LAMICTAL XR STARTER (GREEN)</b>	T4	
<b>LAMICTAL XR STARTER (ORANGE)</b>	T4	
<i>lamotrigine oral tablet</i>	T2	
<i>lamotrigine oral tablet extended release 24hr</i>	T2	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<i>lamotrigine oral tablet,disintegrating</i>	T2	
<b>LATUDA ORAL TABLET 120 MG, 80 MG</b>	T5	
<b>LATUDA ORAL TABLET 20 MG, 40 MG, 60 MG</b>	T4	
<b>LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY</b>	T5	PA; QL (31 EA per 31 days)
<b>LAZANDA NASAL SPRAY,NON-AEROSOL 300 MCG/SPRAY</b>	T5	PA; QL (16 EA per 31 days)
<b>LAZANDA NASAL SPRAY,NON-AEROSOL 400 MCG/SPRAY</b>	T5	PA; QL (12 EA per 31 days)
<b>LEVETIRACETAM IN NAACL (ISO-OS)</b>	T4	
<i>levetiracetam intravenous</i>	T2	
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
<i>levorphanol tartrate</i>	T1	PA; QL (186 EA per 31 days)
<b>LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML</b>	T4	PA-BvD
<i>lithium carbonate</i>	T1	
<i>lithium citrate oral solution 8 meq/5 ml</i>	T1	
<i>lorazepam intensol</i>	T2	
<i>lorazepam oral tablet</i>	T2	
<i>lorcet (hydrocodone)</i>	T2	PA; QL (372 EA per 31 days)
<i>lorcet hd</i>	T2	PA; QL (372 EA per 31 days)
<i>lorcet plus oral tablet 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>loxapine succinate</i>	T2	
<b>LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG</b>	T4	PA-NS; QL (93 EA per 31 days)
<b>LYRICA ORAL CAPSULE 225 MG, 300 MG</b>	T4	PA-NS; QL (62 EA per 31 days)
<b>LYRICA ORAL SOLUTION</b>	T4	PA-NS; QL (930 ML per 31 days)
<i>maprotiline</i>	T2	
<b>MARPLAN</b>	T3	
<b>MAXALT ORAL TABLET 10 MG</b>	T4	QL (12 EA per 31 days)
<b>MAXALT ORAL TABLET 5 MG</b>	T4	QL (24 EA per 31 days)
<b>MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG</b>	T4	QL (12 EA per 31 days)
<b>MAXALT-MLT ORAL TABLET,DISINTEGRATING 5 MG</b>	T4	QL (24 EA per 31 days)
<i>meclofenamate</i>	T2	
<i>mefenamic acid</i>	T2	
<i>meloxicam oral tablet</i>	T1	
<i>memantine oral solution</i>	T3	
<i>memantine oral tablet</i>	T3	
<b>MEMANTINE ORAL TABLETS,DOSE PACK</b>	T4	
<i>meperidine (pf) injection solution 100 mg/ml</i>	T2	PA-BvD; QL (200 ML per 31 days)
<i>meperidine (pf) injection solution 25 mg/ml</i>	T2	PA-BvD; QL (800 ML per 31 days)
<i>meperidine (pf) injection solution 50 mg/ml</i>	T2	PA-BvD; QL (400 ML per 31 days)
<b>MESTINON ORAL SYRUP</b>	T3	
<b>MESTINON TIMESPAN</b>	T3	
<i>metadate er</i>	T2	QL (93 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>metaxall</i>	T2	
<i>metaxalone</i>	T2	
<i>methadone injection solution</i>	T2	PA-BvD; QL (160 ML per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methamphetamine</i>	T5	PA
<i>methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 30 mg, 50 mg, 60 mg</i>	T2	
<i>methylphenidate hcl oral capsule, er biphasic 30-70 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 40 mg</i>	T2	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 40 mg</i>	T2	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 60 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral solution</i>	T2	
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>migergot</i>	T2	
<b>MIGRANAL</b>	T4	QL (8 ML per 31 days)
<b>MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HR 0.375 MG, 2.25 MG, 3 MG, 3.75 MG, 4.5 MG</b>	T4	
<i>mirtazapine</i>	T2	
<i>modafinil</i>	T2	PA; QL (31 EA per 31 days)
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<b>MORPHINE INTRAVENOUS SYRINGE 10 MG/ML</b>	T4	PA; QL (200 ML per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>morphine intravenous syringe 2 mg/ml</i>	T2	PA; QL (1000 ML per 30 days)
<i>morphine intravenous syringe 4 mg/ml</i>	T2	PA; QL (500 ML per 30 days)
<b>MORPHINE INTRAVENOUS SYRINGE 8 MG/ML</b>	T4	PA; QL (250 ML per 30 days)
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	T2	PA; QL (51 EA per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral capsule, extend. release pellets</i>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	T2	PA; QL (1400 ML per 31 days)
<i>morphine oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>morphine oral tablet extended release 100 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T2	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T2	PA; QL (31 EA per 31 days)
<b>MYSOLINE</b>	T4	
<i>nabumetone</i>	T1	
<i>nalbuphine injection solution 10 mg/ml</i>	T2	QL (200 ML per 30 days)
<i>nalbuphine injection solution 20 mg/ml</i>	T2	QL (100 ML per 30 days)
<i>naloxone injection solution</i>	T2	
<i>naloxone injection syringe 1 mg/ml</i>	T2	
<i>naltrexone</i>	T2	
<b>NAMENDA ORAL TABLET</b>	T4	PA
<b>NAMENDA TITRATION PAK</b>	T4	PA
<b>NAMENDA XR</b>	T4	PA
<b>NAMZARIC</b>	T4	PA
<b>NAPRELAN CR</b>	T4	
<i>naproxen oral suspension</i>	T1	
<i>naproxen oral tablet</i>	T1	
<i>naproxen oral tablet, delayed release (dr/ec)</i>	T2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	T2	
<i>naratriptan oral tablet 1 mg</i>	T2	QL (20 EA per 31 days)
<i>naratriptan oral tablet 2.5 mg</i>	T2	QL (8 EA per 31 days)
<b>NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION</b>	T4	
<i>nefazodone</i>	T2	
<b>NEUPRO</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NEURONTIN</b>	T4	
<b>NORCO</b>	T4	PA; QL (372 EA per 31 days)
<i>nortriptyline</i>	T2	
<b>NUCYNTA ER</b>	T4	QL (62 EA per 31 days)
<b>NUCYNTA ORAL TABLET 100 MG</b>	T4	QL (155 EA per 31 days)
<b>NUCYNTA ORAL TABLET 50 MG, 75 MG</b>	T4	QL (186 EA per 31 days)
<b>NUEDEXTA</b>	T3	
<b>NUPLAZID</b>	T5	PA-NS
<i>olanzapine intramuscular</i>	T2	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 7.5 mg</i>	T2	
<i>olanzapine oral tablet 5 mg</i>	T3	
<i>olanzapine oral tablet, disintegrating</i>	T2	
<i>olanzapine-fluoxetine</i>	T2	
<b>ONFI ORAL SUSPENSION</b>	T4	
<b>ONFI ORAL TABLET 10 MG</b>	T4	
<b>ONFI ORAL TABLET 20 MG</b>	T5	
<b>ONZETRA XSAIL</b>	T4	QL (16 EA per 31 days)
<b>OPANA ER ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 5 MG, 7.5 MG</b>	T4	PA; QL (100 EA per 31 days)
<b>OPANA ER ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 30 MG</b>	T4	PA; QL (69 EA per 31 days)
<b>OPANA ER ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 40 MG</b>	T4	PA; QL (51 EA per 31 days)
<b>OPANA ORAL</b>	T4	PA; QL (186 EA per 31 days)
<b>ORAP ORAL TABLET 1 MG</b>	T3	
<i>oxaprozin</i>	T2	
<i>oxazepam</i>	T2	
<i>oxcarbazepine</i>	T2	
<b>OXTELLAR XR</b>	T4	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T2	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<b>OXYCODONE ORAL TABLET, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG</b>	T4	PA; QL (100 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG</b>	T4	PA; QL (69 EA per 31 days)
<b>OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG</b>	T4	PA; QL (62 EA per 31 days)
<i>oxycodone-acetaminophen oral solution</i>	T2	PA; QL (1860 ML per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	T3	PA; QL (372 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>oxycodone-aspirin</i>	T2	PA; QL (360 EA per 30 days)
<b>OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG</b>	T4	PA; QL (100 EA per 31 days)
<b>OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG</b>	T4	PA; QL (69 EA per 31 days)
<b>OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG</b>	T4	PA; QL (62 EA per 31 days)
<i>oxymorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	T2	PA; QL (100 EA per 31 days)
<i>oxymorphone oral tablet extended release 12 hr 30 mg</i>	T2	PA; QL (69 EA per 31 days)
<i>oxymorphone oral tablet extended release 12 hr 40 mg</i>	T2	PA; QL (51 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg</i>	T3	
<i>paliperidone oral tablet extended release 24hr 6 mg, 9 mg</i>	T4	
<i>paroxetine hcl oral tablet</i>	T1	
<i>paroxetine hcl oral tablet extended release 24 hr 12.5 mg</i>	T1	
<i>paroxetine hcl oral tablet extended release 24 hr 25 mg, 37.5 mg</i>	T2	
<b>PAXIL ORAL SUSPENSION</b>	T4	
<b>PEGANONE</b>	T3	
<i>pentazocine-naloxone</i>	T2	QL (335 EA per 31 days)
<b>PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG</b>	T4	PA; QL (372 EA per 31 days)
<i>perphenazine</i>	T2	
<i>perphenazine-amitriptyline</i>	T2	PA-NS
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	
<b>PHENYTEK</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet, chewable</i>	T2	
<i>phenytoin sodium extended</i>	T2	
<i>phenytoin sodium intravenous solution</i>	T2	
<i>pimozide</i>	T2	
<i>piroxicam oral capsule 10 mg</i>	T1	
<i>piroxicam oral capsule 20 mg</i>	T2	
<i>pramipexole</i>	T2	
<i>primidone</i>	T2	
<b>PRIMLEV</b>	T4	PA; QL (403 EA per 31 days)
<b>PRISTIQ</b>	T4	
<i>procentra</i>	T2	
<i>protriptyline</i>	T2	
<b>PROVIGIL ORAL TABLET 100 MG</b>	T4	PA; QL (31 EA per 31 days)
<b>PROVIGIL ORAL TABLET 200 MG</b>	T5	PA; QL (31 EA per 31 days)
<i>pyridostigmine bromide</i>	T2	
<i>quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	T2	
<i>quetiapine oral tablet 25 mg</i>	T1	
<b>QUILLIVANT XR</b>	T4	
<b>RADICAVA</b>	T5	PA
<i>rasagiline</i>	T3	
<b>RELPAK ORAL TABLET 20 MG</b>	T4	QL (12 EA per 31 days)
<b>RELPAK ORAL TABLET 40 MG</b>	T4	QL (6 EA per 31 days)
<b>REXULTI</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML</b>	T4	
<b>RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 50 MG/2 ML</b>	T5	
<b>RISPERDAL M-TAB</b>	T4	
<b>RISPERDAL ORAL SOLUTION</b>	T5	
<b>RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 4 MG</b>	T4	
<b>RISPERDAL ORAL TABLET 3 MG</b>	T5	
<i>risperidone oral solution</i>	T1	
<i>risperidone oral tablet</i>	T1	
<i>risperidone oral tablet, disintegrating 0.25 mg</i>	T2	
<i>risperidone oral tablet, disintegrating 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG</b>	T4	QL (186 EA per 31 days)
<i>rivastigmine</i>	T2	
<i>rivastigmine tartrate</i>	T2	
<i>rizatriptan oral tablet 10 mg</i>	T2	QL (12 EA per 31 days)
<i>rizatriptan oral tablet 5 mg</i>	T2	QL (24 EA per 31 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T2	QL (12 EA per 31 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 31 days)
<i>ropinirole</i>	T2	
<i>roweepra</i>	T2	
<b>ROXICODONE ORAL TABLET 15 MG, 5 MG</b>	T4	PA; QL (186 EA per 31 days)
<b>ROXICODONE ORAL TABLET 30 MG</b>	T4	PA; QL (138 EA per 31 days)
<b>ROZEREM</b>	T4	
<b>SABRIL</b>	T5	
<b>SAPHRIS (BLACK CHERRY)</b>	T4	
<i>selegiline hcl</i>	T2	
<b>SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR</b>	T3	
<i>sertraline</i>	T1	
<b>SILENOR</b>	T4	PA-NS
<b>SPRITAM</b>	T4	
<b>SUBOXONE SUBLINGUAL FILM 12-3 MG</b>	T3	QL (62 EA per 31 days)
<b>SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG</b>	T3	QL (93 EA per 31 days)
<b>SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY</b>	T5	PA; QL (124 EA per 31 days)
<b>SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 400 MCG/SPRAY</b>	T5	PA; QL (86 EA per 31 days)
<b>SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 600 MCG/SPRAY</b>	T5	PA; QL (57 EA per 31 days)
<b>SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 800 MCG/SPRAY</b>	T5	PA; QL (43 EA per 31 days)
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	T2	QL (8 EA per 31 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	T2	QL (32 EA per 31 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 31 days)
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 31 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 31 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	T2	QL (6 ML per 31 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T2	QL (4 ML per 31 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T2	QL (6 ML per 31 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T2	QL (4 ML per 31 days)
<i>sumatriptan succinate subcutaneous solution</i>	T2	QL (4 ML per 31 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	T2	QL (4 ML per 31 days)
<b>SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 4 MG/0.5 ML</b>	T4	QL (6 ML per 31 days)
<b>SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 6 MG/0.5 ML</b>	T4	QL (4 ML per 31 days)
<b>SURMONTIL</b>	T4	PA-NS
<b>SYNALGOS-DC</b>	T4	PA; QL (300 EA per 30 days)
<b>TASMAR ORAL TABLET 100 MG</b>	T5	
<b>TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)</b>	T5	PA; QL (120 EA per 365 days)
<b>TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG</b>	T5	PA; QL (62 EA per 31 days)
<b>TEGRETOL ORAL SUSPENSION</b>	T4	
<b>TEGRETOL ORAL TABLET</b>	T4	
<b>TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG</b>	T3	
<b>TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 200 MG, 400 MG</b>	T4	
<i>temazepam</i>	T2	
<i>tencon oral tablet 50-325 mg</i>	T2	QL (372 EA per 31 days)
<i>tetrabenazine</i>	T5	PA
<i>thioridazine</i>	T2	
<i>thiothixene</i>	T1	
<i>tiagabine</i>	T2	
<i>tizanidine</i>	T2	
<i>tolcapone</i>	T5	
<i>tolmetin oral capsule</i>	T2	
<i>tolmetin oral tablet 600 mg</i>	T2	
<b>TOPAMAX</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>topiramate oral capsule, sprinkle</i>	T2	
<b>TOPIRAMATE ORAL CAPSULE,SPRINKLE,ER 24HR</b>	T4	
<i>topiramate oral tablet</i>	T2	
<b>TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83</b>	T4	QL (30 EA per 30 days)
<b>TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG</b>	T4	QL (30 EA per 30 days)
<i>tramadol oral tablet</i>	T1	QL (240 EA per 30 days)
<i>tramadol oral tablet extended release 24 hr 100 mg, 200 mg</i>	T2	QL (30 EA per 30 days)
<i>tramadol oral tablet, er multiphase 24 hr 300 mg</i>	T2	QL (30 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	QL (372 EA per 31 days)
<i>tranylcypromine</i>	T2	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trazodone oral tablet 300 mg</i>	T2	
<b>TREXIMET ORAL TABLET 10-60 MG</b>	T4	QL (9 EA per 31 days)
<b>TREXIMET ORAL TABLET 85-500 MG</b>	T4	QL (10 EA per 31 days)
<i>triazolam</i>	T2	PA
<i>trifluoperazine</i>	T2	
<i>trihexyphenidyl</i>	T2	
<b>TRILEPTAL</b>	T4	
<i>trimipramine</i>	T3	PA-NS
<b>TRINTELLIX</b>	T4	PA-NS
<b>TROKENDI XR</b>	T4	
<b>TYLENOL-CODEINE #3</b>	T4	PA; QL (403 EA per 31 days)
<b>TYLENOL-CODEINE #4</b>	T4	PA; QL (403 EA per 31 days)
<b>TYSABRI</b>	T5	QL (15 ML per 28 days)
<i>valproate sodium</i>	T2	
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
<i>venlafaxine oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<i>venlafaxine oral tablet extended release 24hr 150 mg, 37.5 mg, 75 mg</i>	T2	QL (31 EA per 31 days)
<b>VENLAFAXINE ORAL TABLET EXTENDED RELEASE 24HR 225 MG</b>	T4	QL (31 EA per 31 days)
<b>VERSACLOZ</b>	T3	
<i>vicodin</i>	T2	PA; QL (403 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>vicodin es</i>	T2	PA; QL (403 EA per 31 days)
<i>vicodin hp</i>	T2	PA; QL (403 EA per 31 days)
<i>vigabatrin</i>	T5	
<b>VIIBRYD ORAL TABLET</b>	T4	PA-NS
<b>VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)</b>	T4	PA-NS
<b>VIMOVO</b>	T4	PA; QL (62 EA per 31 days)
<b>VIMPAT INTRAVENOUS</b>	T4	
<b>VIMPAT ORAL SOLUTION</b>	T4	
<b>VIMPAT ORAL TABLET</b>	T4	
<b>VIVITROL</b>	T4	
<b>VOLTAREN TOPICAL</b>	T4	PA
<b>VRAYLAR ORAL CAPSULE</b>	T5	PA-NS; QL (31 EA per 31 days)
<b>VRAYLAR ORAL CAPSULE,DOSE PACK</b>	T4	PA-NS; QL (14 EA per 365 days)
<b>VYVANSE ORAL CAPSULE</b>	T4	QL (31 EA per 31 days)
<b>WELLBUTRIN SR</b>	T4	QL (62 EA per 31 days)
<b>WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG</b>	T4	QL (93 EA per 31 days)
<b>WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG</b>	T4	QL (31 EA per 31 days)
<b>XANAX ORAL TABLET 0.25 MG, 0.5 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>XANAX ORAL TABLET 1 MG, 2 MG</b>	T4	PA; QL (155 EA per 31 days)
<b>XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG</b>	T4	PA; QL (31 EA per 31 days)
<b>XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 2 MG</b>	T4	PA; QL (155 EA per 31 days)
<b>XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 3 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>XENAZINE</b>	T5	PA
<b>XODOL 10/300</b>	T4	PA; QL (403 EA per 31 days)
<b>XODOL 5/300</b>	T4	PA; QL (403 EA per 31 days)
<b>XODOL 7.5/300</b>	T4	PA; QL (403 EA per 31 days)
<b>XTAMPZA ER</b>	T4	PA; QL (62 EA per 31 days)
<b>XYREM</b>	T5	PA
<i>zaleplon</i>	T2	
<i>zamicet</i>	T2	PA; QL (5723 ML per 31 days)
<b>ZARONTIN</b>	T4	
<i>zebutal oral capsule 50-325-40 mg</i>	T2	QL (372 EA per 31 days)
<b>ZELAPAR</b>	T5	
<b>ZEMBRACE SYMTOUCH</b>	T4	QL (8 ML per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>zenzedi oral tablet 10 mg, 5 mg</i>	T2	
<b>ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG</b>	T4	
<b>ZINBRYTA</b>	T5	PA; QL (1 ML per 28 days)
<i>ziprasidone hcl</i>	T2	
<b>ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR</b>	T4	PA; QL (100 EA per 31 days)
<i>zolmitriptan oral tablet 2.5 mg</i>	T2	QL (16 EA per 31 days)
<i>zolmitriptan oral tablet 5 mg</i>	T2	QL (8 EA per 31 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T2	QL (16 EA per 31 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T2	QL (8 EA per 31 days)
<i>zolpidem oral</i>	T2	
<i>zolpidem sublingual</i>	T3	
<b>ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG</b>	T4	QL (16 EA per 31 days)
<b>ZOMIG NASAL SPRAY,NON-AEROSOL 5 MG</b>	T4	QL (8 EA per 31 days)
<b>ZOMIG ORAL TABLET 2.5 MG</b>	T4	QL (16 EA per 31 days)
<b>ZOMIG ORAL TABLET 5 MG</b>	T4	QL (8 EA per 31 days)
<b>ZOMIG ZMT ORAL TABLET,DISINTEGRATING 2.5 MG</b>	T4	QL (16 EA per 31 days)
<b>ZOMIG ZMT ORAL TABLET,DISINTEGRATING 5 MG</b>	T4	QL (8 EA per 31 days)
<b>ZONEGRAN ORAL CAPSULE 100 MG, 25 MG</b>	T4	
<i>zonisamide</i>	T2	
<b>ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 2.9-0.71 MG</b>	T4	QL (93 EA per 31 days)
<b>ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 8.6-2.1 MG</b>	T4	QL (62 EA per 31 days)
<b>ZUBSOLV SUBLINGUAL TABLET 5.7-1.4 MG</b>	T4	QL (31 EA per 31 days)
<b>ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG</b>	T4	
<b>Cardiovascular, Hypertension / Lipids</b>		
<i>acebutolol</i>	T1	
<i>afeditab cr</i>	T1	
<b>AGGRENOX</b>	T3	
<b>ALTOPREV</b>	T4	
<i>amiloride</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amiloride-hydrochlorothiazide</i>	T1	
<i>amiodarone intravenous solution</i>	T2	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-atorvastatin</i>	T2	
<i>amlodipine-benazepril</i>	T1	
<b>AMLODIPINE-OLMESARTAN</b>	T3	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>amlodipine-valsartan-hcthiazyd</i>	T2	
<b>ANTARA ORAL CAPSULE 30 MG, 90 MG</b>	T4	
<b>ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML</b>	T5	
<i>aspirin-dipyridamole</i>	T2	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T1	
<i>atorvastatin</i>	T1	
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>betaxolol oral tablet 10 mg</i>	T2	
<i>betaxolol oral tablet 20 mg</i>	T1	
<b>BIDIL</b>	T4	
<i>bisoprolol fumarate</i>	T1	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
<b>BRILINTA</b>	T3	
<i>bumetanide</i>	T1	
<b>BYSTOLIC</b>	T4	
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
<i>captopril-hydrochlorothiazide</i>	T1	
<b>CARDENE IV IN SODIUM CHLORIDE INTRAVENOUS PIGGYBACK 40 MG/200 ML</b>	T4	
<b>CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 120 MG</b>	T4	
<i>cartia xt</i>	T1	
<i>carvedilol</i>	T1	
<i>chlorothiazide</i>	T1	
<i>chlorothiazide sodium</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine light</i>	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T2	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel</i>	T2	
<i>clorpres oral tablet 0.1-15 mg, 0.2-15 mg</i>	T2	
<b>CLOPRES ORAL TABLET 0.3-15 MG</b>	T3	
<i>colestipol oral granules</i>	T2	
<i>colestipol oral tablet</i>	T2	
<b>CORLANOR ORAL TABLET 5 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>CORLANOR ORAL TABLET 7.5 MG</b>	T4	PA; QL (62 EA per 31 days)
<b>COUMADIN ORAL</b>	T4	
<b>DEMSER</b>	T3	
<b>DIBENZYLINE</b>	T5	
<i>digitek oral tablet 125 mcg</i>	T1	PA
<i>digitek oral tablet 250 mcg</i>	T2	PA
<i>digoxin injection solution</i>	T2	PA
<i>digoxin oral solution 50 mcg/ml</i>	T2	PA
<i>digoxin oral tablet 125 mcg</i>	T1	PA
<i>digoxin oral tablet 250 mcg</i>	T2	PA
<i>diltiazem hcl intravenous</i>	T1	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24 hr 180 mg, 360 mg, 420 mg</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl oral tablet</i>	T1	
<i>dilt-xr</i>	T1	
<b>DIURIL</b>	T3	
<i>dofetilide</i>	T3	
<i>doxazosin</i>	T1	
<b>DYRENIUM</b>	T4	
<b>EDARBYCLOR</b>	T4	
<b>EDECRIN</b>	T3	
<b>EFFIENT</b>	T3	
<b>ELIQUIS ORAL TABLET 2.5 MG</b>	T3	QL (62 EA per 31 days)
<b>ELIQUIS ORAL TABLET 5 MG</b>	T3	QL (74 EA per 31 days)
<i>enalapril maleate</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous solution</i>	T2	
<i>enoxaparin subcutaneous syringe 100 mg/ml</i>	T4	
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 150 mg/ml</i>	T5	
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	T2	
<b>ENTRESTO</b>	T3	PA; QL (62 EA per 31 days)
<i>eplerenone</i>	T2	
<i>eprosartan</i>	T1	
<i>ethacrynate sodium</i>	T2	
<i>ethacrynic acid</i>	T2	
<i>ezetimibe</i>	T3	
<i>ezetimibe-simvastatin</i>	T3	
<i>felodipine</i>	T2	
<i>fenofibrate micronized</i>	T2	
<i>fenofibrate nanocrystallized oral tablet 145 mg</i>	T3	
<i>fenofibrate nanocrystallized oral tablet 48 mg</i>	T2	
<b>FENOFIBRATE ORAL TABLET 120 MG, 40 MG</b>	T4	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>fenofibric acid (choline)</i>	T3	
<i>fenofibric acid oral tablet 105 mg</i>	T3	
<i>fenofibric acid oral tablet 35 mg</i>	T2	
<b>FENOGLIDE</b>	T4	
<i>flecainide</i>	T2	
<i>fluvastatin oral capsule</i>	T1	
<i>fluvastatin oral tablet extended release 24 hr</i>	T3	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T2	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
<b>FRAGMIN SUBCUTANEOUS SOLUTION</b>	T5	
<b>FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML</b>	T5	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>FRAGMIN SUBCUTANEOUS SYRINGE 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML</b>	T3	
<i>furosemide injection</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T2	
<b>GONITRO</b>	T4	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	T2	
<i>heparin (porcine) injection solution</i>	T2	
<i>hydralazine</i>	T1	
<i>hydrochlorothiazide</i>	T1	
<i>indapamide</i>	T1	
<b>INNOPRAN XL</b>	T4	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<b>ISORDIL</b>	T4	
<i>isosorbide dinitrate oral</i>	T2	
<i>isosorbide mononitrate</i>	T1	
<i>isradipine</i>	T2	
<i>jantoven</i>	T2	
<b>JUXTAPID</b>	T5	PA
<b>KYNAMRO</b>	T5	PA
<i>labetalol intravenous solution</i>	T1	
<i>labetalol oral</i>	T1	
<b>LANOXIN</b>	T4	PA
<b>LESCOL XL</b>	T4	
<b>LIPOFEN</b>	T4	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
<b>LIVALO</b>	T4	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lovastatin</i>	T1	
<b>LOVENOX SUBCUTANEOUS SYRINGE 150 MG/ML, 60 MG/0.6 ML</b>	T4	
<i>matzim la</i>	T2	
<i>methyclothiazide</i>	T2	
<i>methyldopa-hydrochlorothiazide</i>	T1	
<i>metolazone</i>	T2	
<i>metoprolol succinate</i>	T1	
<i>metoprolol ta-hydrochlorothiaz</i>	T1	
<i>metoprolol tartrate intravenous</i>	T1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	T1	
<i>mexiletine</i>	T2	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
<i>moexipril-hydrochlorothiazide</i>	T1	
<b>MULTAQ</b>	T4	
<i>nadolol</i>	T1	
<i>nadolol-bendroflumethiazide</i>	T1	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T3	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T3	QL (31 EA per 31 days)
<b>NIACOR</b>	T4	
<i>nicardipine intravenous solution</i>	T2	
<i>nicardipine oral</i>	T2	
<i>nifedipine oral tablet extended release</i>	T2	
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine</i>	T2	
<i>nisoldipine</i>	T2	
<i>nitro-bid</i>	T2	
<b>NITRO-DUR</b>	T4	
<i>nitroglycerin intravenous</i>	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual spray,non-aerosol</i>	T2	
<b>NITROSTAT</b>	T4	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T3	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T3	QL (93 EA per 31 days)
<b>OLMESARTAN-AMLODIPIN-HCTHIAZID</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>olmesartan-hydrochlorothiazide</i>	T3	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG</b>	T4	PA; QL (93 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG</b>	T5	PA; QL (186 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG</b>	T5	PA; QL (521 EA per 31 days)
<b>ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG</b>	T5	PA; QL (261 EA per 31 days)
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	T2	
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T1	
<i>phenoxybenzamine</i>	T5	
<i>pindolol</i>	T1	
<b>PRADAXA</b>	T3	QL (62 EA per 31 days)
<b>PRALUENT PEN</b>	T5	PA; QL (2 ML per 28 days)
<i>prasugrel</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T1	
<i>prevalite oral powder</i>	T2	
<i>procainamide injection</i>	T2	
<b>PROMACTA</b>	T5	PA
<i>propafenone</i>	T2	
<i>propranolol intravenous</i>	T1	
<i>propranolol oral capsule, extended release 24 hr</i>	T2	
<i>propranolol oral solution</i>	T1	
<i>propranolol oral tablet</i>	T1	
<i>propranolol-hydrochlorothiazid</i>	T1	
<b>QBRELIS</b>	T4	
<i>quinapril</i>	T1	
<i>quinapril-hydrochlorothiazide</i>	T1	
<i>quinidine gluconate</i>	T2	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<b>RANEXA</b>	T3	
<b>REMODULIN</b>	T5	PA-BvD
<b>REPATHA PUSHTRONEX</b>	T5	PA; QL (3.5 ML per 28 days)
<b>REPATHA SURECLICK</b>	T5	PA; QL (2 ML per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>REPATHA SYRINGE</b>	T5	PA; QL (2 ML per 28 days)
<i>rosuvastatin</i>	T3	
<b>SAVAYSA</b>	T4	QL (31 EA per 31 days)
<i>simvastatin</i>	T1	
<i>sorine</i>	T1	
<i>sotalol af oral tablet 120 mg</i>	T1	
<i>sotalol oral tablet 160 mg, 240 mg, 80 mg</i>	T1	
<b>SOTYLIZE</b>	T4	
<i>spironolactone</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T1	
<i>taztia xt</i>	T2	
<b>TEKTURNA</b>	T4	
<b>TEKTURNA HCT</b>	T4	
<i>telmisartan</i>	T1	
<i>telmisartan-amlodipine</i>	T1	
<i>telmisartan-hydrochlorothiazid</i>	T1	
<i>terazosin</i>	T1	
<b>TIKOSYN</b>	T3	
<i>timolol maleate oral</i>	T1	
<i>torseamide oral</i>	T2	
<i>trandolapril</i>	T1	
<i>trandolapril-verapamil</i>	T2	
<i>tranexamic acid intravenous</i>	T2	
<i>triamterene-hydrochlorothiazid</i>	T1	
<b>UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG</b>	T5	PA; QL (62 EA per 31 days)
<b>UPTRAVI ORAL TABLET 200 MCG</b>	T5	PA; QL (144 EA per 28 days)
<b>UPTRAVI ORAL TABLETS,DOSE PACK</b>	T5	PA; QL (200 EA per 28 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	T2	QL (62 EA per 31 days)
<i>valsartan oral tablet 320 mg</i>	T2	QL (31 EA per 31 days)
<i>valsartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<b>VASCEPA</b>	T4	
<b>VECAMYL</b>	T4	
<i>verapamil intravenous solution</i>	T2	
<i>verapamil oral</i>	T2	
<i>warfarin</i>	T1	
<b>WELCHOL</b>	T3	
<b>XARELTO ORAL TABLET 10 MG, 20 MG</b>	T3	QL (31 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>XARELTO ORAL TABLET 15 MG</b>	T3	QL (52 EA per 31 days)
<b>XARELTO ORAL TABLETS,DOSE PACK</b>	T3	QL (51 EA per 30 days)
<b>YOSPRALA</b>	T4	PA; QL (31 EA per 31 days)
<b>ZETIA</b>	T3	
<b>ZONTIVITY</b>	T4	
<b>Dermatologicals/Topical Therapy</b>		
<b>ACANYA TOPICAL GEL WITH PUMP</b>	T4	
<i>acitretin oral capsule 10 mg, 25 mg</i>	T5	
<i>acitretin oral capsule 17.5 mg</i>	T4	
<i>acyclovir topical</i>	T1	
<b>ACZONE TOPICAL GEL</b>	T4	
<i>adapalene topical cream</i>	T2	
<i>adapalene topical gel</i>	T2	
<i>adapalene-benzoyl peroxide</i>	T4	
<i>ala-cort topical cream 1 %</i>	T1	
<i>ala-cort topical cream 2.5 %</i>	T2	
<i>alclometasone</i>	T1	
<i>amcinonide</i>	T2	
<i>ammonium lactate</i>	T2	
<i>amnesteem</i>	T2	
<i>apexicon e</i>	T2	
<b>ATRALIN</b>	T4	
<i>avita topical cream</i>	T2	
<b>AVITA TOPICAL GEL</b>	T4	
<b>AZELEX</b>	T4	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone, augmented topical cream</i>	T2	
<i>betamethasone, augmented topical gel</i>	T1	
<i>betamethasone, augmented topical lotion</i>	T2	
<i>betamethasone, augmented topical ointment</i>	T2	
<i>calcipotriene</i>	T2	
<i>calcipotriene-betamethasone</i>	T2	
<i>calcitriol topical</i>	T2	
<b>CAPEX</b>	T4	
<b>CARAC</b>	T5	
<i>ciclopirox</i>	T2	
<i>claravis</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CLINDACIN P</b>	T4	
<i>clindamycin phosphate topical</i>	T2	
<i>clindamycin-benzoyl peroxide topical gel</i>	T2	
<i>clindamycin-tretinoin</i>	T2	
<i>clobetasol scalp</i>	T2	
<i>clobetasol topical foam</i>	T2	
<i>clobetasol topical gel</i>	T2	
<i>clobetasol topical lotion</i>	T2	
<i>clobetasol topical ointment</i>	T3	
<i>clobetasol topical shampoo</i>	T2	
<i>clobetasol topical spray,non-aerosol</i>	T2	
<i>clobetasol-emollient topical cream</i>	T3	
<i>clodan</i>	T2	
<b>CLODERM</b>	T4	
<i>clotrimazole topical</i>	T2	
<i>clotrimazole-betamethasone</i>	T2	
<b>CONDYLOX TOPICAL GEL</b>	T3	
<b>CORDRAN TAPE LARGE ROLL</b>	T3	
<i>cormax scalp</i>	T2	
<b>CORTISPORIN TOPICAL</b>	T3	
<b>COSENTYX</b>	T5	PA; QL (2 ML per 28 days)
<b>COSENTYX PEN</b>	T5	PA; QL (2 ML per 28 days)
<b>CUTIVATE TOPICAL LOTION</b>	T4	
<b>DENAVIR</b>	T3	
<b>DESONATE</b>	T4	
<i>desonide</i>	T2	
<i>desoximetasone</i>	T2	
<i>diclofenac sodium topical gel 3 %</i>	T4	
<b>DIFFERIN TOPICAL LOTION</b>	T4	
<i>diflorasone</i>	T2	
<i>doxepin topical</i>	T2	
<b>DUPIXENT</b>	T5	PA; QL (4 ML per 28 days)
<i>econazole</i>	T2	
<b>ELIDEL</b>	T4	
<b>EPIDUO FORTE</b>	T4	
<b>EPIDUO TOPICAL GEL WITH PUMP</b>	T4	
<i>ery pads</i>	T2	
<i>erygel</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>erythromycin with ethanol topical gel</i>	T2	
<i>erythromycin with ethanol topical solution</i>	T2	
<i>erythromycin-benzoyl peroxide</i>	T2	
<b>EURAX TOPICAL CREAM</b>	T3	
<b>EURAX TOPICAL LOTION</b>	T4	
<b>EXELDERM</b>	T4	
<b>FINACEA</b>	T4	
<i>fluocinolone</i>	T2	
<i>fluocinonide topical cream 0.05 %</i>	T2	
<i>fluocinonide topical cream 0.1 %</i>	T4	
<i>fluocinonide topical gel</i>	T2	
<i>fluocinonide topical ointment</i>	T2	
<i>fluocinonide topical solution</i>	T2	
<i>fluocinonide-e</i>	T2	
<b>FLUOROURACIL TOPICAL CREAM 0.5 %</b>	T5	
<i>fluorouracil topical cream 5 %</i>	T2	
<i>fluorouracil topical solution</i>	T2	
<i>flurandrenolide</i>	T3	
<i>fluticasone topical</i>	T2	
<i>gentamicin topical</i>	T1	
<i>halobetasol propionate</i>	T2	
<b>HALOG</b>	T4	
<i>hydrocortisone butyrate topical ointment</i>	T2	
<i>hydrocortisone butyrate topical solution</i>	T2	
<i>hydrocortisone butyr-emollient</i>	T2	
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	T1	
<i>hydrocortisone topical lotion 2.5 %</i>	T1	
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone valerate</i>	T2	
<i>imiquimod</i>	T2	
<b>KENALOG TOPICAL</b>	T3	
<i>ketoconazole topical</i>	T2	
<i>lidocaine (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)</i>	T2	
<i>lidocaine hcl injection solution 20 mg/ml (2 %)</i>	T2	
<i>lidocaine hcl mucous membrane jelly</i>	T2	
<i>lidocaine hcl mucous membrane jelly in applicator</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	
<i>lidocaine hcl urethral</i>	T2	
<i>lidocaine topical adhesive patch,medicated</i>	T2	PA; QL (124 EA per 31 days)
<i>lidocaine topical ointment</i>	T2	
<i>lidocaine viscous</i>	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	
<b>LIDODERM</b>	T4	PA; QL (124 EA per 31 days)
<i>lindane topical shampoo</i>	T2	
<i>malathion</i>	T2	
<b>MENTAX</b>	T4	
<i>methoxsalen</i>	T2	
<i>metronidazole topical cream</i>	T2	
<i>metronidazole topical gel 0.75 %</i>	T2	
<i>metronidazole topical gel 1 %</i>	T1	
<i>metronidazole topical lotion</i>	T2	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<i>mupirocin calcium</i>	T2	
<i>myorisan</i>	T2	
<b>NAFTIFINE TOPICAL CREAM 1 %</b>	T4	
<i>naftifine topical cream 2 %</i>	T3	
<b>NAFTIN TOPICAL CREAM 2 %</b>	T4	
<b>NAFTIN TOPICAL GEL</b>	T4	
<b>NEO-SYNALAR</b>	T4	
<i>neuac</i>	T2	
<i>nolix</i>	T3	
<b>NORITATE</b>	T4	
<i>nyamyc</i>	T2	
<i>nyata</i>	T2	
<i>nystatin topical</i>	T2	
<i>nystatin-triamcinolone</i>	T3	
<i>nystop</i>	T2	
<i>oxiconazole</i>	T2	
<b>OXISTAT</b>	T4	
<b>PANDEL</b>	T4	
<b>PANRETIN</b>	T5	
<i>permethrin topical cream</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PICATO</b>	T3	
<i>podofilox</i>	T2	
<i>prednicarbate</i>	T2	
<i>prudoxin</i>	T2	
<b>REGRANEX</b>	T5	
<b>RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %</b>	T4	
<b>SANTYL</b>	T3	
<i>selenium sulfide topical lotion</i>	T1	
<b>SILIQ</b>	T5	PA; QL (3 ML per 28 days)
<i>silver sulfadiazine</i>	T1	
<b>SORIATANE ORAL CAPSULE 10 MG, 17.5 MG</b>	T5	
<b>SORIATANE ORAL CAPSULE 25 MG</b>	T4	
<i>ssd</i>	T2	
<b>STELARA INTRAVENOUS</b>	T5	PA; QL (104 ML per 180 days)
<b>STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>STELARA SUBCUTANEOUS SYRINGE 90 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<i>sulfacetamide sodium (acne)</i>	T1	
<b>SULFAMYLON TOPICAL CREAM</b>	T3	
<b>TACLONEX TOPICAL SUSPENSION</b>	T5	
<i>tacrolimus topical</i>	T2	
<b>TALTZ AUTOINJECTOR (3 PACK)</b>	T5	PA; QL (1 ML per 28 days)
<b>TALTZ SYRINGE</b>	T5	PA; QL (1 ML per 28 days)
<b>TAZAROTENE</b>	T4	
<b>TAZORAC TOPICAL CREAM 0.05 %</b>	T4	
<b>TAZORAC TOPICAL GEL</b>	T4	
<b>TOLAK</b>	T4	
<i>tretinoin</i>	T2	
<i>tretinoin microspheres topical gel with pump</i>	T2	
<i>triamcinolone acetonide topical aerosol</i>	T2	
<i>triamcinolone acetonide topical cream</i>	T1	
<i>triamcinolone acetonide topical lotion</i>	T1	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>trianex</i>	T2	
<i>triderm topical cream 0.1 %</i>	T1	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VALCHLOR</b>	T4	PA-NS
<b>VEREGEN</b>	T4	
<i>zenatane oral capsule 30 mg</i>	T2	
<b>ZOVIRAX TOPICAL CREAM</b>	T3	
<b>ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 %</b>	T4	
<b>ZYCLARA TOPICAL CREAM IN PACKET</b>	T5	
<b>Diagnostics / Miscellaneous Agents</b>		
<i>acamprostate</i>	T2	
<b>ADAGEN</b>	T5	
<i>alendronate oral tablet 40 mg</i>	T1	
<i>anagrelide</i>	T2	
<b>ARALAST NP INTRAVENOUS RECON SOLN 500 MG</b>	T5	PA
<b>AURYXIA</b>	T4	
<b>BUPHENYL</b>	T5	
<i>bupropion hcl (smoking deter)</i>	T3	QL (62 EA per 31 days)
<b>CARBAGLU</b>	T5	PA
<b>CARNITOR</b>	T4	PA-BvD
<i>cevimeline</i>	T2	
<b>CHANTIX</b>	T4	
<b>CHANTIX CONTINUING MONTH BOX</b>	T4	
<b>CHANTIX STARTING MONTH BOX</b>	T4	
<b>CHEMET</b>	T3	
<b>CLINIMIX 4.25%/D5W SULFIT FREE</b>	T3	PA-BvD
<b>CLINIMIX E 2.75%/D10W SUL FREE</b>	T4	PA-BvD
<b>CLINIMIX E 2.75%/D5W SULF FREE</b>	T4	PA-BvD
<i>d10 %-0.45 % sodium chloride</i>	T2	
<i>d2.5 %-0.45 % sodium chloride</i>	T2	
<i>d5 % and 0.9 % sodium chloride</i>	T2	
<i>d5 %-0.45 % sodium chloride</i>	T2	
<i>dextrose 10 % and 0.2 % nacl</i>	T2	
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	T2	
<i>dextrose 5 %-lactated ringers</i>	T2	
<i>dextrose 5%-0.2 % sod chloride</i>	T2	
<i>dextrose 5%-0.3 % sod.chloride</i>	T2	
<i>dextrose with sodium chloride</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>disulfiram</i>	T2	
<i>etidronate disodium</i>	T2	
<b>EXJADE</b>	T5	
<b>FERRIPROX</b>	T5	
<b>FOSRENOL ORAL POWDER IN PACKET</b>	T4	
<b>FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 750 MG</b>	T4	
<b>FOSRENOL ORAL TABLET,CHEWABLE 500 MG</b>	T5	
<b>GLASSIA</b>	T5	PA
<b>INCRELEX</b>	T5	PA
<i>kionex</i>	T2	
<i>lactated ringers irrigation</i>	T2	
<i>levocarnitine (with sugar)</i>	T2	PA-BvD
<i>levocarnitine oral tablet</i>	T2	PA-BvD
<b>LITHOSTAT</b>	T4	
<i>midodrine</i>	T2	
<i>neomycin-polymyxin b gu</i>	T1	
<b>NICOTROL</b>	T4	
<b>NICOTROL NS</b>	T3	
<b>NORTHERA</b>	T5	PA
<b>NUTRESTORE</b>	T4	
<b>ORFADIN</b>	T5	
<i>pilocarpine hcl oral</i>	T2	
<b>PROLASTIN-C</b>	T5	PA
<b>RAVICTI</b>	T5	PA
<b>RENAGEL</b>	T3	
<b>REVELA ORAL TABLET</b>	T3	
<b>RILUTEK</b>	T5	
<i>riluzole</i>	T5	
<i>ringer's irrigation</i>	T2	
<i>risedronate oral tablet 30 mg</i>	T2	
<i>sevelamer carbonate</i>	T3	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate oral powder</i>	T5	
<i>sodium polystyrene (sorb free)</i>	T2	
<i>sps (with sorbitol) oral</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>SYPRINE</b>	T3	
<b>THIOLA</b>	T4	
<b>VELPHORO</b>	T5	
<b>VELTASSA</b>	T4	PA; QL (30 EA per 30 days)
<i>water for irrigation, sterile</i>	T2	
<b>ZEMAIRA</b>	T5	PA
<i>zoledronic acid-mannitol-water</i>	T2	
<b>Ear, Nose / Throat Medications</b>		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal</i>	T2	
<b>BACTROBAN NASAL</b>	T3	
<i>chlorhexidine gluconate mucous membrane</i>	T1	
<b>CIPRO HC</b>	T4	
<b>CIPRODEX</b>	T3	
<b>COLY-MYCIN S</b>	T4	
<i>floxin otic (ear) drops</i>	T2	
<i>fluocinolone acetonide oil</i>	T2	
<i>hydrocortisone-acetic acid</i>	T2	
<i>ipratropium bromide nasal</i>	T1	
<i>neomycin-polymyxin-hc otic (ear)</i>	T2	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T2	
<b>OTOVEL</b>	T4	
<i>periogard</i>	T2	
<i>triamcinolone acetonide dental</i>	T2	
<b>Endocrine/Diabetes</b>		
<i>acarbose</i>	T1	
<b>ACTHAR H.P.</b>	T5	PA
<b>ACTOPLUS MET XR</b>	T4	
<b>AFREZZA</b>	T4	
<i>alcohol pads</i>	T2	
<b>ALDURAZYME</b>	T5	
<b>ALOGLIPTIN</b>	T4	
<b>ALOGLIPTIN-METFORMIN</b>	T4	
<b>ALOGLIPTIN-PIOGLITAZONE</b>	T4	
<b>ANADROL-50</b>	T4	PA
<b>ANDRODERM</b>	T3	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)</b>	T3	PA
<b>ANDROGEL TRANSDERMAL GEL IN PACKET</b>	T3	PA
<b>APIDRA</b>	T4	
<b>APIDRA SOLOSTAR</b>	T4	
<b>ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"</b>	T4	
<b>AVANDIA ORAL TABLET 2 MG, 4 MG</b>	T3	
<b>AVEED</b>	T4	PA
<b>AXIRON</b>	T4	PA
<b>BASAGLAR KWIKPEN</b>	T3	
<b>BYDUREON</b>	T3	QL (4 EA per 28 days)
<i>cabergoline</i>	T2	
<i>calcitonin (salmon)</i>	T2	
<i>calcitriol intravenous solution 1 mcg/ml</i>	T2	PA-BvD
<i>calcitriol oral</i>	T2	PA-BvD
<b>CERDELGA</b>	T5	PA
<b>CEREZYME INTRAVENOUS RECON SOLN 400 UNIT</b>	T5	
<i>chorionic gonadotropin, human</i>	T2	PA-BvD
<i>cortisone</i>	T2	
<b>CYCLOSET</b>	T4	
<i>danazol</i>	T2	
<b>DDAVP NASAL SOLUTION</b>	T4	
<b>DEPO-MEDROL</b>	T4	
<b>DEPO-TESTOSTERONE</b>	T4	PA
<i>desmopressin injection</i>	T2	
<i>desmopressin nasal solution</i>	T2	
<i>desmopressin nasal spray,non-aerosol</i>	T2	
<i>desmopressin oral</i>	T2	
<i>dexamethasone intensol</i>	T2	
<i>dexamethasone oral elixir</i>	T1	
<i>dexamethasone oral tablet</i>	T1	
<i>dexamethasone sodium phosphate injection solution</i>	T2	
<b>DEXPAK 13 DAY</b>	T4	
<i>doxercalciferol intravenous</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 0.5 mcg, 2.5 mcg</i>	T2	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>doxercalciferol oral capsule 1 mcg</i>	T5	PA-BvD
<b>ELAPRASE</b>	T5	
<b>ELELYSO</b>	T5	
<b>EMFLAZA</b>	T5	PA
<b>FABRAZYME INTRAVENOUS RECON SOLN 35 MG</b>	T5	
<b>FARXIGA</b>	T3	
<i>fludrocortisone</i>	T2	
<b>FORTESTA</b>	T4	PA
<b>GAUZE PAD TOPICAL BANDAGE 2 X 2 "</b>	T3	
<i>glimepiride</i>	T1	
<i>glipizide</i>	T1	
<i>glipizide-metformin</i>	T1	
<b>GLUCAGEN HYPOKIT</b>	T3	
<b>GLUCAGON EMERGENCY KIT (HUMAN)</b>	T3	
<b>GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG</b>	T4	PA
<i>glyburide</i>	T2	PA
<i>glyburide micronized</i>	T2	PA
<i>glyburide-metformin</i>	T2	PA
<b>GLYSET</b>	T3	
<b>HECTOROL INTRAVENOUS SOLUTION 4 MCG/2 ML</b>	T4	PA-BvD
<b>HECTOROL ORAL CAPSULE 0.5 MCG</b>	T4	PA-BvD
<b>HECTOROL ORAL CAPSULE 1 MCG, 2.5 MCG</b>	T5	PA-BvD
<b>HUMALOG</b>	T3	
<b>HUMALOG KWIKPEN</b>	T3	
<b>HUMALOG MIX 50-50</b>	T3	
<b>HUMALOG MIX 50-50 KWIKPEN</b>	T3	
<b>HUMALOG MIX 75-25</b>	T3	
<b>HUMALOG MIX 75-25 KWIKPEN</b>	T3	
<b>HUMULIN 70/30</b>	T3	
<b>HUMULIN 70/30 KWIKPEN</b>	T3	
<b>HUMULIN N</b>	T3	
<b>HUMULIN N KWIKPEN</b>	T3	
<b>HUMULIN R U-100</b>	T3	
<b>HUMULIN R U-500 (CONC) KWIKPEN</b>	T3	
<b>HUMULIN R U-500 (CONCENTRATED)</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydrocortisone oral</i>	T1	
<b>INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE</b>	T3	
<b>INVOKAMET</b>	T3	
<b>INVOKAMET XR</b>	T3	
<b>INVOKANA</b>	T3	
<b>JANUMET</b>	T3	
<b>JANUMET XR</b>	T3	
<b>JANUVIA</b>	T3	
<b>JARDIANCE</b>	T3	
<b>JENTADUETO</b>	T3	
<b>JENTADUETO XR</b>	T3	
<b>KANUMA</b>	T5	PA
<b>KOMBIGLYZE XR</b>	T4	
<b>KORLYM</b>	T5	PA
<b>KUVAN ORAL TABLET,SOLUBLE</b>	T5	
<b>LANTUS</b>	T3	
<b>LANTUS SOLOSTAR</b>	T3	
<b>LEVEMIR</b>	T3	
<b>LEVEMIR FLEXTOUCH</b>	T3	
<i>levothyroxine oral</i>	T1	
<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>	T2	
<i>liothyronine</i>	T2	
<b>LUMIZYME</b>	T5	
<b>MEDROL ORAL TABLET 2 MG</b>	T4	
<i>metformin oral tablet</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	
<i>metformin oral tablet extended release 24hr</i>	T1	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
<b>METHITEST</b>	T4	PA
<i>methylprednisolone</i>	T2	
<i>methylprednisolone acetate</i>	T2	
<i>methylprednisolone sodium succ injection recon soln 40 mg</i>	T2	
<i>methylprednisolone sodium succ intravenous</i>	T2	
<i>methyltestosterone oral capsule</i>	T5	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MIACALCIN INJECTION</b>	T4	PA-BvD
<i>migliol</i>	T2	
<b>MILLIPRED ORAL SOLUTION</b>	T4	
<i>millipred oral tablet</i>	T2	
<b>MYALEPT</b>	T5	PA
<b>NAGLAZYME</b>	T5	
<i>nateglinide</i>	T1	
<b>NATESTO</b>	T4	PA
<b>NATPARA</b>	T5	PA
<b>NESINA</b>	T4	
<i>novarel intramuscular recon soln 10,000 unit</i>	T2	PA-BvD
<b>NOVOLIN 70/30</b>	T3	
<b>NOVOLIN N</b>	T3	
<b>NOVOLIN R</b>	T3	
<b>NOVOLOG</b>	T3	
<b>NOVOLOG FLEXPEN</b>	T3	
<b>NOVOLOG MIX 70-30</b>	T3	
<b>NOVOLOG MIX 70-30 FLEXPEN</b>	T3	
<b>NOVOLOG PENFILL</b>	T3	
<b>ONGLYZA</b>	T4	
<b>OSENI</b>	T4	
<i>oxandrolone oral tablet 10 mg</i>	T5	PA
<i>oxandrolone oral tablet 2.5 mg</i>	T2	PA
<i>pamidronate intravenous solution</i>	T2	PA-BvD
<b>PARICALCITOL INTRAVENOUS</b>	T4	PA-BvD
<i>paricalcitol oral capsule 1 mcg</i>	T2	PA-BvD
<i>paricalcitol oral capsule 2 mcg, 4 mcg</i>	T1	PA-BvD
<b>PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"</b>	T4	
<i>pioglitazone</i>	T1	
<i>pioglitazone-glimepiride</i>	T1	
<i>pioglitazone-metformin</i>	T1	
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 15 mg/5 ml (3 mg/ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
<i>prednisolone sodium phosphate oral tablet, disintegrating</i>	T2	
<i>prednisone intensol</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>prednisone oral solution</i>	T1	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets,dose pack</i>	T2	
<b>PREGNYL</b>	T4	PA-BvD
<b>PROGLYCEM</b>	T3	
<i>propylthiouracil</i>	T2	
<i>repaglinide oral tablet 0.5 mg</i>	T1	
<i>repaglinide oral tablet 1 mg, 2 mg</i>	T2	
<i>repaglinide-metformin</i>	T2	
<b>RIOMET</b>	T4	PA; QL (791 ML per 31 days)
<b>ROCALTROL</b>	T4	PA-BvD
<b>SAMSCA</b>	T5	
<b>SENSIPAR ORAL TABLET 30 MG</b>	T3	
<b>SENSIPAR ORAL TABLET 60 MG, 90 MG</b>	T5	
<b>SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML</b>	T4	
<b>SOLU-MEDROL (PF) INJECTION</b>	T4	
<b>SOLU-MEDROL (PF) INTRAVENOUS RECON SOLN 500 MG/4 ML</b>	T4	
<b>SOLU-MEDROL INTRAVENOUS RECON SOLN 2 GRAM</b>	T4	
<b>SOMAVERT</b>	T5	
<b>STIMATE</b>	T3	
<b>STRENSIQ</b>	T5	PA
<b>STRIANT</b>	T4	PA
<b>SYMLINPEN 120</b>	T3	
<b>SYMLINPEN 60</b>	T3	
<b>SYNAREL</b>	T5	
<b>SYNTHROID</b>	T4	
<b>TESTIM</b>	T4	PA
<i>testosterone cypionate</i>	T2	PA
<i>testosterone enanthate</i>	T2	PA
<b>TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP</b>	T3	PA
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i>	T3	PA
<b>TESTOSTERONE TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)</b>	T3	PA
<b>TESTOSTERONE TRANSDERMAL SOLUTION IN METERED PUMP W/APP</b>	T4	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>THYROLAR-1</b>	T4	
<b>THYROLAR-1/2</b>	T4	
<b>THYROLAR-1/4</b>	T4	
<b>THYROLAR-2</b>	T4	
<b>THYROLAR-3</b>	T4	
<b>TIROSINT</b>	T4	
<i>tolazamide</i>	T1	
<i>tolbutamide</i>	T1	
<b>TOUJEO SOLOSTAR</b>	T3	
<b>TRADJENTA</b>	T3	
<b>TRESIBA FLEXTOUCH U-100</b>	T3	
<b>TRESIBA FLEXTOUCH U-200</b>	T3	
<b>TRULICITY</b>	T3	QL (2 ML per 28 days)
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	T1	
<i>veripred 20</i>	T2	
<b>VICTOZA 3-PAK</b>	T3	QL (9 ML per 30 days)
<b>VOGELXO TRANSDERMAL GEL</b>	T4	PA
<b>VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP</b>	T4	PA
<b>VPRIV</b>	T5	
<b>XIGDUO XR</b>	T3	
<b>ZAVESCA</b>	T5	
<b>ZEMPLAR INTRAVENOUS</b>	T4	PA-BvD
<b>ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG</b>	T4	PA-BvD
<i>zoledronic acid intravenous solution</i>	T2	
<b>ZOMETA</b>	T5	
<b>Gastroenterology</b>		
<b>AKYNZEO</b>	T4	PA-BvD
<i>alosetron oral tablet 0.5 mg</i>	T2	
<i>alosetron oral tablet 1 mg</i>	T5	
<b>ALOXI</b>	T4	
<b>AMITIZA</b>	T3	QL (62 EA per 31 days)
<i>amoxicil-clarithromy-lansopraz</i>	T2	
<b>ANZEMET ORAL</b>	T4	PA-BvD
<b>APREPITANT</b>	T4	PA-BvD
<b>APRISO</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ASACOL HD</b>	T3	
<i>atropine injection syringe 0.05 mg/ml</i>	T2	
<i>balsalazide</i>	T2	
<i>budesonide oral</i>	T4	
<b>CANASA</b>	T3	
<i>carafate oral suspension</i>	T3	
<b>CESAMET</b>	T4	PA-BvD
<b>CHENODAL</b>	T5	PA
<b>CHOLBAM</b>	T5	PA
<i>cimetidine</i>	T2	
<i>cimetidine hcl oral</i>	T2	
<b>CIMZIA</b>	T5	PA; QL (2 EA per 28 days)
<b>CIMZIA POWDER FOR RECONST</b>	T5	PA; QL (6 EA per 28 days)
<i>colocort</i>	T2	
<i>compro</i>	T2	
<i>constulose</i>	T2	
<b>CREON</b>	T3	
<i>cromolyn oral</i>	T2	
<b>CUVPOSA</b>	T4	
<b>CYSTADANE</b>	T3	
<b>DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)</b>	T3	
<i>dicyclomine intramuscular</i>	T2	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
<b>DIPENTUM</b>	T3	
<i>diphenoxylate-atropine</i>	T2	
<i>dronabinol oral capsule 10 mg</i>	T5	PA-BvD
<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	T2	PA-BvD
<b>EMEND INTRAVENOUS</b>	T4	
<b>EMEND ORAL</b>	T4	PA-BvD
<i>enulose</i>	T2	
<i>esomeprazole magnesium</i>	T2	QL (31 EA per 31 days)
<i>esomeprazole sodium</i>	T2	
<i>famotidine (pf)</i>	T1	
<i>famotidine (pf)-nacl (iso-os)</i>	T2	
<i>famotidine oral suspension</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
<b>GATTEX ONE-VIAL</b>	T5	PA
<i>gavilyte-c</i>	T2	
<i>gavilyte-g</i>	T2	
<i>gavilyte-n</i>	T2	
<i>generlac</i>	T2	
<i>glycopyrrolate injection</i>	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
<b>GOLYTELY ORAL POWDER IN PACKET</b>	T4	
<i>granisetron (pf) intravenous solution 100 mcg/ml</i>	T2	
<i>granisetron hcl intravenous</i>	T2	
<i>granisetron hcl oral</i>	T2	PA-BvD
<i>hydrocortisone rectal</i>	T1	
<b>INFLECTRA</b>	T5	PA; QL (8 EA per 28 days)
<i>lactulose oral solution 10 gram/15 ml</i>	T1	
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg</i>	T3	QL (31 EA per 31 days)
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	T3	QL (62 EA per 31 days)
<b>LIALDA</b>	T3	
<b>LINZESS</b>	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	
<b>LOTRONEX ORAL TABLET 0.5 MG</b>	T3	
<b>LOTRONEX ORAL TABLET 1 MG</b>	T5	
<b>MARINOL ORAL CAPSULE 10 MG, 5 MG</b>	T4	PA-BvD
<b>MARINOL ORAL CAPSULE 2.5 MG</b>	T5	PA-BvD
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<b>MESALAMINE ORAL TABLET, DELAYED RELEASE (DR/EC) 800 MG</b>	T4	
<i>mesalamine with cleansing wipe</i>	T2	
<i>methscopolamine</i>	T2	
<i>metoclopramide hcl injection solution</i>	T2	
<i>metoclopramide hcl oral</i>	T2	
<i>misoprostol</i>	T2	
<b>MOVANTI</b>	T3	QL (31 EA per 31 days)
<b>MOVIPREP</b>	T4	
<b>MYTESI</b>	T4	QL (62 EA per 31 days)
<i>nizatidine</i>	T2	
<b>OICALIVA</b>	T5	PA; QL (31 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>omeprazole oral capsule, delayed release(dr/ec)</i>	T1	
<i>omeprazole-sodium bicarbonate</i>	T2	
<i>ondansetron</i>	T2	PA-BvD
<i>ondansetron hcl (pf)</i>	T2	
<i>ondansetron hcl oral</i>	T2	PA-BvD
<b>OSMOPREP</b>	T4	
<b>PANCREAZE ORAL CAPSULE, DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800-56,800- 98,400 UNIT, 2,600-6,200- 10,850 UNIT, 21,000-54,700- 83,900 UNIT, 4,200-14,200- 24,600 UNIT</b>	T3	
<i>pantoprazole</i>	T2	
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	T2	
<i>peg-electrolyte soln</i>	T2	
<b>PENTASA</b>	T3	
<b>PERTZYE</b>	T3	
<i>polyethylene glycol 3350 oral powder</i>	T2	
<b>PREPOPIK</b>	T4	
<i>prochlorperazine</i>	T2	
<i>prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)</i>	T2	
<i>prochlorperazine maleate</i>	T2	
<i>procto-pak</i>	T2	
<i>proctosol hc topical</i>	T2	
<i>proctozone-hc</i>	T2	
<i>propantheline</i>	T2	
<b>PYLERA</b>	T4	
<i>rabeprazole</i>	T2	QL (62 EA per 31 days)
<i>ranitidine hcl injection solution 50 mg/2 ml (25 mg/ml)</i>	T4	
<i>ranitidine hcl oral capsule</i>	T2	
<i>ranitidine hcl oral syrup</i>	T1	
<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	T1	
<b>RECTIV</b>	T4	
<b>RELISTOR ORAL</b>	T5	PA; QL (93 EA per 31 days)
<b>RELISTOR SUBCUTANEOUS SOLUTION</b>	T4	QL (18.6 ML per 31 days)
<b>RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML</b>	T4	QL (18.6 ML per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML</b>	T4	QL (12.4 ML per 31 days)
<b>REMICADE</b>	T5	PA; QL (8 EA per 28 days)
<b>RENFLEXIS</b>	T5	PA; QL (8 EA per 28 days)
<b>SANCUSO</b>	T4	
<b>SUCRAID</b>	T5	
<i>sucralfate oral tablet</i>	T2	
<i>sulfasalazine</i>	T2	
<b>SUPREP BOWEL PREP KIT</b>	T3	
<b>SYNDROS</b>	T5	PA
<b>TRANSDERM-SCOP</b>	T4	
<i>trilyte with flavor packets</i>	T2	
<i>trimethobenzamide oral</i>	T2	PA
<i>ursodiol</i>	T3	
<b>VARUBI</b>	T4	PA-BvD
<b>VIBERZI</b>	T5	PA; QL (62 EA per 31 days)
<b>ZENPEP</b>	T3	
<b>ZOFRAN (AS HYDROCHLORIDE) ORAL</b>	T5	PA-BvD
<b>ZOFRAN ODT ORAL TABLET,DISINTEGRATING 4 MG</b>	T4	PA-BvD
<b>ZOFRAN ODT ORAL TABLET,DISINTEGRATING 8 MG</b>	T5	PA-BvD
<b>ZUPLENZ</b>	T4	PA-BvD
<b>Immunology, Vaccines / Biotechnology</b>		
<b>ACTHIB (PF)</b>	T3	
<b>ACTIMMUNE</b>	T5	PA-NS
<b>ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION</b>	T3	
<b>ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML</b>	T3	PA-BvD
<b>ARANESP (IN POLYSORBATE) INJECTION SOLUTION 200 MCG/ML, 300 MCG/ML</b>	T5	PA-BvD
<b>ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML</b>	T3	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML</b>	T5	PA-BvD
<b>ARCALYST</b>	T5	PA
<b>ATGAM</b>	T3	PA-BvD
<b>AVONEX (WITH ALBUMIN)</b>	T5	QL (1 EA per 28 days)
<b>AVONEX INTRAMUSCULAR PEN INJECTOR KIT</b>	T5	QL (4 EA per 28 days)
<b>AVONEX INTRAMUSCULAR SYRINGE KIT</b>	T5	QL (4 EA per 28 days)
<b>BCG VACCINE, LIVE (PF)</b>	T4	
<b>BETASERON SUBCUTANEOUS KIT</b>	T5	QL (15 EA per 31 days)
<b>BEXSERO</b>	T3	
<b>BIVIGAM</b>	T5	PA
<b>BOOSTRIX TDAP</b>	T4	
<b>BOTOX</b>	T4	PA
<b>CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM</b>	T5	PA
<b>DAPTACEL (DTAP PEDIATRIC) (PF)</b>	T4	
<b>DYSPORT</b>	T4	PA
<b>EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG</b>	T5	PA-NS
<b>ENGERIX-B (PF) INTRAMUSCULAR SYRINGE</b>	T3	PA-BvD
<b>ENGERIX-B PEDIATRIC (PF)</b>	T3	PA-BvD
<b>EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML</b>	T3	PA-BvD
<b>EXTAVIA SUBCUTANEOUS KIT</b>	T5	QL (15 EA per 31 days)
<b>FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %</b>	T5	PA
<i>fomepizole</i>	T1	
<b>GAMASTAN S/D</b>	T4	PA
<b>GAMMAGARD LIQUID</b>	T5	PA
<b>GAMMAGARD S-D (IGA &lt; 1 MCG/ML)</b>	T5	PA
<b>GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)</b>	T5	PA
<b>GAMMAPLEX</b>	T5	PA
<b>GAMMAPLEX (WITH SORBITOL)</b>	T5	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)</b>	T5	PA
<b>GARDASIL 9 (PF)</b>	T3	
<b>GENOTROPIN</b>	T5	PA
<b>GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML</b>	T4	PA
<b>GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML</b>	T5	PA
<b>GRANIX</b>	T5	
<b>GRASTEK</b>	T4	PA
<b>HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML</b>	T3	
<b>HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML</b>	T3	
<b>HIBERIX (PF)</b>	T4	
<b>HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)</b>	T5	PA
<b>HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)</b>	T4	PA
<b>HUMATROPE INJECTION RECON SOLN</b>	T5	PA
<b>HYPERRAB S/D (PF)</b>	T4	PA-BvD
<b>ILARIS (PF) SUBCUTANEOUS RECON SOLN</b>	T5	PA
<b>IMOGAM RABIES-HT (PF)</b>	T4	PA-BvD
<b>IMOVAX RABIES VACCINE (PF)</b>	T4	PA-BvD
<b>INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION</b>	T3	
<b>INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)</b>	T3	PA-NS
<b>INTRON A INJECTION RECON SOLN 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)</b>	T5	PA-NS
<b>INTRON A INJECTION SOLUTION</b>	T5	PA-NS
<b>IPOL</b>	T3	
<b>IXIARO (PF)</b>	T4	
<b>KINRIX (PF)</b>	T4	
<b>LEUKINE INJECTION RECON SOLN</b>	T5	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MENACTRA (PF) INTRAMUSCULAR SOLUTION</b>	T3	
<b>MENVEO A-C-Y-W-135-DIP (PF)</b>	T4	
<b>MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 200 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML</b>	T4	PA-BvD
<b>M-M-R II (PF)</b>	T4	
<b>MOZOBIL</b>	T5	PA
<b>NEULASTA SUBCUTANEOUS SYRINGE</b>	T5	
<b>NEUPOGEN INJECTION SOLUTION 300 MCG/ML</b>	T4	
<b>NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML</b>	T5	
<b>NEUPOGEN INJECTION SYRINGE</b>	T5	
<b>NORDITROPIN FLEXP RO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)</b>	T5	PA
<b>NORDITROPIN FLEXP RO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)</b>	T4	PA
<b>NUTROPIN AQ NUSPIN</b>	T5	PA
<b>OCTAGAM</b>	T5	PA
<b>OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)</b>	T4	PA
<b>OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)</b>	T5	PA
<b>OMNITROPE SUBCUTANEOUS RECON SOLN</b>	T5	PA
<b>ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY</b>	T4	PA
<b>PEDIARIX (PF)</b>	T4	PA-BvD
<b>PEDVAX HIB (PF)</b>	T4	
<b>PEGASYS</b>	T5	PA
<b>PEGASYS PROCLICK</b>	T5	PA
<b>PEGINTRON REDIPEN SUBCUTANEOUS PEN INJECTOR KIT 120 MCG/0.5 ML</b>	T5	PA
<b>PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML</b>	T5	PA
<b>PLEGRIDY SUBCUTANEOUS PEN INJECTOR</b>	T5	QL (1 ML per 28 days)
<b>PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML</b>	T5	QL (1 ML per 28 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PRIVIGEN</b>	T5	PA
<b>PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML</b>	T3	PA-BvD
<b>PROCRIT INJECTION SOLUTION 40,000 UNIT/ML</b>	T5	PA-BvD
<b>PROLEUKIN</b>	T5	
<b>PROQUAD (PF)</b>	T3	
<b>QUADRACEL (PF)</b>	T4	
<b>RABAVERT (PF)</b>	T4	PA-BvD
<b>RAGWITEK</b>	T4	PA
<b>REBIF (WITH ALBUMIN)</b>	T5	QL (6 ML per 28 days)
<b>REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML</b>	T5	QL (6 ML per 28 days)
<b>REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)</b>	T5	QL (4.2 ML per 365 days)
<b>REBIF TITRATION PACK</b>	T5	QL (8.4 ML per 365 days)
<b>RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML</b>	T4	PA-BvD
<b>RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE</b>	T4	PA-BvD
<b>ROTARIX</b>	T4	
<b>ROTATEQ VACCINE</b>	T3	
<b>SAIZEN</b>	T5	PA
<b>SAIZEN CLICK.EASY</b>	T5	PA
<b>SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG</b>	T5	PA
<b>SYLATRON</b>	T5	PA-NS
<b>TENIVAC (PF) INTRAMUSCULAR SYRINGE</b>	T4	
<b>TETANUS,DIPHThERIA TOX PED(PF)</b>	T4	
<b>TETANUS-DIPHThERIA TOXOIDS-TD</b>	T3	
<b>THYMOGLOBULIN</b>	T4	
<b>TRUMENBA</b>	T3	
<b>TWINRIX (PF) INTRAMUSCULAR SUSPENSION</b>	T3	
<b>TYPHIM VI INTRAMUSCULAR SOLUTION</b>	T3	
<b>TYPHIM VI INTRAMUSCULAR SYRINGE</b>	T4	
<b>VAQTA (PF) INTRAMUSCULAR SYRINGE</b>	T3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VARIVAX (PF)</b>	T3	
<b>VARIZIG INTRAMUSCULAR SOLUTION</b>	T4	
<b>XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT</b>	T4	PA
<b>YF-VAX (PF)</b>	T3	
<b>ZARXIO</b>	T5	
<b>ZINPLAVA</b>	T5	PA
<b>ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG</b>	T5	PA
<b>ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG</b>	T4	PA
<b>ZORBTIVE</b>	T5	PA
<b>ZOSTAVAX (PF)</b>	T3	
<b>Musculoskeletal / Rheumatology</b>		
<b>ACTEMRA INTRAVENOUS</b>	T5	PA; QL (40 ML per 28 days)
<b>ACTEMRA SUBCUTANEOUS</b>	T5	PA; QL (3.6 ML per 28 days)
<i>alendronate oral solution</i>	T1	
<i>alendronate oral tablet 10 mg</i>	T2	
<i>alendronate oral tablet 35 mg, 5 mg, 70 mg</i>	T1	
<i>allopurinol</i>	T1	
<b>ALLOPURINOL SODIUM</b>	T5	
<i>aloprim</i>	T2	
<b>ARAVA</b>	T5	
<b>BENLYSTA INTRAVENOUS RECON SOLN 120 MG</b>	T4	
<b>BENLYSTA INTRAVENOUS RECON SOLN 400 MG</b>	T5	
<b>BENLYSTA SUBCUTANEOUS</b>	T5	
<b>BONIVA INTRAVENOUS</b>	T4	PA-BvD
<b>COLCHICINE</b>	T4	
<b>COLCRYS</b>	T3	
<b>CUPRIMINE</b>	T5	
<b>DEPEN TITRATABS</b>	T5	
<b>ENBREL SUBCUTANEOUS RECON SOLN</b>	T5	PA; QL (8 EA per 28 days)
<b>ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51)</b>	T5	PA; QL (4 ML per 28 days)
<b>ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (0.98 ML)</b>	T5	PA; QL (7.84 ML per 28 days)
<b>ENBREL SURECLICK</b>	T5	PA; QL (7.84 ML per 28 days)
<b>FORTEO</b>	T5	PA; QL (2.4 ML per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>HUMIRA</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML</b>	T5	PA; QL (3 EA per 28 days)
<b>HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)</b>	T5	PA; QL (6 EA per 28 days)
<b>HUMIRA PEN</b>	T5	PA; QL (2 EA per 28 days)
<b>HUMIRA PEN CROHN'S-UC-HS START</b>	T5	PA; QL (6 EA per 28 days)
<b>HUMIRA PEN PSORIASIS-UVEITIS</b>	T5	PA; QL (4 EA per 28 days)
<i>ibandronate intravenous solution</i>	T2	PA-BvD
<i>ibandronate oral</i>	T2	
<b>KEVZARA</b>	T5	PA; QL (2.28 ML per 28 days)
<b>KINERET</b>	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T2	
<b>MITIGARE</b>	T4	QL (62 EA per 31 days)
<b>ORENCIA (WITH MALTOSE)</b>	T5	PA; QL (8 EA per 28 days)
<b>ORENCIA CLICKJECT</b>	T5	PA; QL (4 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML</b>	T5	PA; QL (4 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML</b>	T5	PA; QL (1.6 ML per 28 days)
<b>ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML</b>	T5	PA; QL (2.8 ML per 28 days)
<b>OTEZLA</b>	T5	PA; QL (62 EA per 31 days)
<b>OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)</b>	T5	PA; QL (55 EA per 28 days)
<b>OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML</b>	T4	PA
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
<b>PROLIA</b>	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	
<b>RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML</b>	T4	PA
<b>RIDAURA</b>	T3	
<i>risedronate</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>SAVELLA</b>	T4	PA
<b>SIMPONI ARIA</b>	T5	PA; QL (16 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML</b>	T5	PA; QL (1 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML</b>	T5	PA; QL (0.5 ML per 28 days)
<b>TYMLOS</b>	T5	PA; QL (1.56 ML per 31 days)
<b>ULORIC</b>	T3	
<b>XELJANZ</b>	T5	PA; QL (62 EA per 31 days)
<b>XELJANZ XR</b>	T5	PA; QL (31 EA per 31 days)
<b>ZURAMPIC</b>	T4	
<b>Obstetrics / Gynecology</b>		
<i>alyacen 1/35 (28)</i>	T2	
<i>amabelz</i>	T2	
<i>amethia</i>	T2	
<i>amethia lo</i>	T2	
<b>ANGELIQ ORAL TABLET 0.5-1 MG</b>	T4	
<i>apri</i>	T2	
<i>aranelle (28)</i>	T2	
<i>ashlyna</i>	T2	
<b>AVC VAGINAL</b>	T4	
<i>aviane</i>	T2	
<i>balziva (28)</i>	T2	
<i>bekyree (28)</i>	T2	
<b>BEYAZ</b>	T4	
<i>blisovi 24 fe</i>	T2	
<i>blisovi fe 1.5/30 (28)</i>	T2	
<i>blisovi fe 1/20 (28)</i>	T2	
<i>briellyn</i>	T2	
<i>camila</i>	T2	
<i>camrese lo</i>	T2	
<i>caziant (28)</i>	T2	
<b>CLEOCIN VAGINAL SUPPOSITORY</b>	T4	
<b>CLIMARA PRO</b>	T4	
<i>clindamycin phosphate vaginal</i>	T2	
<b>CLINDESSE</b>	T4	
<b>CRINONE</b>	T4	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cryselle (28)</i>	T2	
<i>cyclafem 1/35 (28)</i>	T2	
<i>cyclafem 7/7/7 (28)</i>	T2	
<b>DEPO-ESTRADIOL</b>	T4	
<b>DEPO-PROVERA INTRAMUSCULAR SOLUTION</b>	T4	
<b>DIVIGEL TRANSDERMAL GEL IN PACKET 0.5 MG/0.5 GRAM (0.1 %)</b>	T4	
<i>drospirenone-e.estradiol-lm.fa</i>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
<i>emoquette</i>	T2	
<i>enpresse</i>	T2	
<i>errin</i>	T2	
<b>ESTRACE VAGINAL</b>	T4	
<i>estradiol oral</i>	T1	
<i>estradiol transdermal</i>	T2	
<i>estradiol vaginal</i>	T4	
<i>estradiol valerate intramuscular oil 20 mg/ml</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
<b>ESTRING</b>	T4	
<i>estropipate</i>	T1	
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	T2	
<b>EVAMIST</b>	T4	
<b>FEMRING</b>	T4	
<i>femynor</i>	T2	
<i>fyavolv</i>	T2	
<i>gildagia</i>	T2	
<b>GYNAZOLE-1</b>	T4	
<i>hydroxyprogesterone caproate</i>	T5	
<i>introvale</i>	T2	
<i>jinteli</i>	T2	
<i>jolivette</i>	T2	
<i>juleber</i>	T2	
<i>junel 1.5/30 (21)</i>	T2	
<i>junel 1/20 (21)</i>	T2	
<i>junel fe 1.5/30 (28)</i>	T2	
<i>junel fe 1/20 (28)</i>	T2	
<i>junel fe 24</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>kaitlib fe</i>	T2	
<i>kariva (28)</i>	T2	
<i>kelnor 1/35 (28)</i>	T2	
<i>kimidess (28)</i>	T2	
<i>l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)</i>	T2	
<i>larissia</i>	T2	
<i>layolis fe</i>	T2	
<i>lessina</i>	T2	
<i>levonest (28)</i>	T2	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg</i>	T2	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
<i>levora-28</i>	T2	
<b>LO LOESTRIN FE</b>	T4	
<i>loryna (28)</i>	T2	
<i>low-ogestrel (28)</i>	T2	
<b>LUPANETA PACK (1 MONTH)</b>	T5	
<b>LUPANETA PACK (3 MONTH)</b>	T5	
<i>lutura (28)</i>	T2	
<i>lyza</i>	T2	
<b>MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)</b>	T5	
<i>marlissa</i>	T2	
<i>medroxyprogesterone intramuscular suspension</i>	T2	
<i>medroxyprogesterone oral</i>	T2	
<b>MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG</b>	T4	
<i>metronidazole vaginal</i>	T2	
<i>mibelas 24 fe</i>	T2	
<i>miconazole-3 vaginal suppository</i>	T2	
<i>microgestin 1.5/30 (21)</i>	T2	
<i>microgestin 1/20 (21)</i>	T2	
<i>microgestin fe 1.5/30 (28)</i>	T2	
<i>microgestin fe 1/20 (28)</i>	T2	
<i>mononessa (28)</i>	T2	
<i>necon 0.5/35 (28)</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>necon 7/7/7 (28)</i>	T2	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol</i>	T2	
<i>norgestimate-ethinyl estradiol</i>	T2	
<i>nortrel 0.5/35 (28)</i>	T2	
<i>nortrel 1/35 (21)</i>	T2	
<i>nortrel 1/35 (28)</i>	T2	
<i>nortrel 7/7/7 (28)</i>	T2	
<b>NUVARING</b>	T3	
<b>NUVESSA</b>	T4	
<i>ogestrel (28)</i>	T2	
<i>orsythia</i>	T2	
<b>ORTHO TRI-CYCLEN LO (28)</b>	T3	
<i>pimtreea (28)</i>	T2	
<i>pirmella oral tablet 1-35 mg-mcg</i>	T2	
<i>portia</i>	T2	
<b>PREFEST</b>	T4	
<b>PREMARIN VAGINAL</b>	T3	
<i>previfem</i>	T2	
<i>progesterone micronized</i>	T2	
<i>quasense</i>	T2	
<i>reclipsen (28)</i>	T2	
<b>SAFYRAL</b>	T4	
<i>setlakin</i>	T2	
<i>sprintec (28)</i>	T2	
<i>sronyx</i>	T2	
<i>terconazole</i>	T2	
<i>tranexamic acid oral</i>	T2	
<i>tri-legest fe</i>	T2	
<i>tri-lo-estarylla</i>	T2	
<i>tri-lo-sprintec</i>	T2	
<i>trinessa (28)</i>	T2	
<i>tri-previfem (28)</i>	T2	
<i>tri-sprintec (28)</i>	T2	
<i>trivora (28)</i>	T2	
<b>VAGIFEM</b>	T4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>vandazole</i>	T2	
<i>velivet triphasic regimen (28)</i>	T2	
<i>vestura (28)</i>	T2	
<i>vienva</i>	T2	
<i>vyfemla (28)</i>	T2	
<b>YUVAFEM</b>	T4	
<i>zarah</i>	T2	
<i>zenchent fe</i>	T2	
<i>zovia 1/35e (28)</i>	T2	
<i>zovia 1/50e (28)</i>	T2	
<b>Ophthalmology</b>		
<i>acetazolamide</i>	T2	
<i>acetazolamide sodium</i>	T2	
<b>ACUVAIL (PF)</b>	T4	
<b>ALOCRI</b>	T4	
<b>ALOMIDE</b>	T3	
<b>ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %</b>	T3	
<i>apraclonidine</i>	T2	
<i>atropine ophthalmic (eye) drops</i>	T2	
<b>AZASITE</b>	T4	
<i>azelastine ophthalmic (eye)</i>	T2	
<b>AZOPT</b>	T3	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	T2	
<b>BESIVANCE</b>	T4	
<i>betaxolol ophthalmic (eye)</i>	T2	
<b>BETIMOL</b>	T4	
<b>BETOPTIC S</b>	T4	
<i>bimatoprost ophthalmic (eye)</i>	T2	
<b>BLEPH-10</b>	T4	
<b>BLEPHAMIDE</b>	T3	
<b>BLEPHAMIDE S.O.P.</b>	T3	
<i>brimonidine</i>	T2	
<i>bromfenac</i>	T2	
<i>carteolol</i>	T2	
<b>CILOXAN OPHTHALMIC (EYE) OINTMENT</b>	T3	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T1	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>COMBIGAN</b>	T3	
<i>cromolyn ophthalmic (eye)</i>	T2	
<b>CYSTARAN</b>	T5	
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
<i>diclofenac sodium ophthalmic (eye)</i>	T1	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
<b>DUREZOL</b>	T3	
<b>EMADINE</b>	T4	
<i>epinastine</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T2	
<i>gentak ophthalmic (eye) ointment</i>	T2	
<i>gentamicin ophthalmic (eye) drops</i>	T1	
<b>ILEVRO</b>	T3	
<b>IOPIDINE OPHTHALMIC (EYE) DROPPERETTE</b>	T3	
<b>ISTALOL</b>	T4	
<i>ketorolac ophthalmic (eye)</i>	T2	
<b>LACRISERT</b>	T4	
<b>LASTACAFT</b>	T4	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T1	
<i>levofloxacin ophthalmic (eye)</i>	T2	
<b>LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %</b>	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T2	
<i>metipranolol</i>	T2	
<b>MOXEZA</b>	T4	
<i>moxifloxacin ophthalmic (eye)</i>	T4	
<b>NATACYN</b>	T3	
<i>neomycin-bacitracin-poly-hc</i>	T2	
<i>neomycin-bacitracin-polymyxin</i>	T2	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T2	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NEVANAC</b>	T4	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye)</i>	T3	
<b>PAZEO</b>	T3	
<b>PHOSPHOLINE IODIDE</b>	T3	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
<i>polymyxin b sulf-trimethoprim</i>	T2	
<b>PRED-G</b>	T4	
<b>PRED-G S.O.P.</b>	T4	
<i>prednisolone acetate</i>	T3	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
<b>RESTASIS</b>	T3	
<b>SIMBRINZA</b>	T3	
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	T2	
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	T1	
<i>sulfacetamide-prednisolone</i>	T2	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T2	
<b>TIMOPTIC OCUDOSE (PF)</b>	T4	
<b>TOBRADEX OPHTHALMIC (EYE) OINTMENT</b>	T3	
<b>TOBRADEX ST</b>	T3	
<i>tobramycin</i>	T1	
<i>tobramycin-dexamethasone</i>	T2	
<b>TOBREX OPHTHALMIC (EYE) OINTMENT</b>	T3	
<b>TRAVATAN Z</b>	T3	
<i>trifluridine</i>	T2	
<b>VIGAMOX</b>	T4	
<b>XIIDRA</b>	T4	
<b>ZIOPTAN (PF)</b>	T4	
<b>ZIRGAN</b>	T4	
<b>ZYLET</b>	T4	
<b>Respiratory And Allergy</b>		
<i>acetylcysteine</i>	T2	PA-BvD
<b>ADCIRCA</b>	T5	PA; QL (62 EA per 31 days)
<b>ADEMPAS</b>	T5	PA; QL (93 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>adrenalin injection solution 1 mg/ml (1 ml)</i>	T2	
<b>ADVAIR DISKUS</b>	T4	QL (60 EA per 30 days)
<b>ADVAIR HFA</b>	T4	QL (12 GM per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T1	
<i>albuterol sulfate oral tablet</i>	T1	
<i>albuterol sulfate oral tablet extended release 12 hr</i>	T2	
<b>ANORO ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>ASMANEX HFA</b>	T3	QL (13 GM per 30 days)
<b>ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (120 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)</b>	T3	QL (1 EA per 30 days)
<b>ATROVENT HFA</b>	T3	QL (25.8 GM per 30 days)
<b>BECONASE AQ</b>	T4	
<b>BERINERT INTRAVENOUS KIT</b>	T5	PA
<b>BEVESPI AEROSPHERE</b>	T3	QL (10.7 GM per 30 days)
<b>BREO ELLIPTA</b>	T3	QL (60 EA per 30 days)
<b>BROVANA</b>	T4	PA-BvD
<i>budesonide inhalation</i>	T2	PA-BvD
<i>budesonide nasal</i>	T2	
<i>cetirizine oral solution 1 mg/ml</i>	T2	
<b>CINRYZE</b>	T5	PA
<b>CLARINEX-D 12 HOUR</b>	T4	
<b>COMBIVENT RESPIMAT</b>	T4	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T2	PA-BvD
<i>cyproheptadine</i>	T2	
<b>DALIRESP</b>	T3	QL (31 EA per 31 days)
<i>desloratadine</i>	T2	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	T2	
<b>DYMISTA</b>	T4	
<b>EPINEPHRINE INJECTION AUTO-INJECTOR</b>	T3	
<b>EPIPEN 2-PAK</b>	T3	
<b>EPIPEN JR 2-PAK</b>	T3	
<b>ESBRIET ORAL CAPSULE</b>	T5	PA; QL (279 EA per 31 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ESBRIET ORAL TABLET 267 MG</b>	T5	PA; QL (279 EA per 31 days)
<b>ESBRIET ORAL TABLET 801 MG</b>	T5	PA; QL (93 EA per 31 days)
<b>FIRAZYR</b>	T5	PA; QL (18 ML per 30 days)
<i>flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)</i>	T2	
<i>fluticasone nasal</i>	T2	
<b>FLUTICASONE-SALMETEROL</b>	T3	QL (1 EA per 30 days)
<i>hydroxyzine hcl intramuscular</i>	T2	
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	
<i>hydroxyzine hcl oral tablet</i>	T2	
<i>ipratropium bromide inhalation</i>	T1	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
<b>KALYDECO ORAL GRANULES IN PACKET</b>	T5	PA; QL (56 EA per 28 days)
<b>KALYDECO ORAL TABLET</b>	T5	PA; QL (62 EA per 31 days)
<b>KARBINAL ER</b>	T4	
<b>LETAIRIS</b>	T5	PA; QL (31 EA per 31 days)
<i>levalbuterol hcl</i>	T2	PA-BvD
<b>LEVALBUTEROL TARTRATE</b>	T4	QL (30 GM per 30 days)
<i>levocetirizine</i>	T2	
<i>metaproterenol</i>	T2	
<i>mometasone nasal</i>	T3	
<i>montelukast oral granules in packet</i>	T2	QL (31 EA per 31 days)
<i>montelukast oral tablet</i>	T3	QL (31 EA per 31 days)
<i>montelukast oral tablet,chewable</i>	T2	QL (31 EA per 31 days)
<b>NASONEX</b>	T4	
<b>NUCALA</b>	T5	PA
<b>OFEV</b>	T5	PA; QL (62 EA per 31 days)
<b>OMNARIS</b>	T4	
<b>OPSUMIT</b>	T5	PA; QL (31 EA per 31 days)
<b>ORKAMBI</b>	T5	PA; QL (124 EA per 31 days)
<b>PERFOROMIST</b>	T4	PA-BvD
<i>phenadoz rectal suppository 12.5 mg</i>	T2	
<i>phenergan rectal</i>	T2	
<b>PROAIR HFA</b>	T3	QL (17 GM per 30 days)
<b>PROAIR RESPICLICK</b>	T3	QL (2 EA per 30 days)
<i>promethazine injection solution</i>	T2	
<i>promethazine oral syrup</i>	T2	PA
<i>promethazine rectal</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>promethazine vc</i>	T2	
<i>promethegan rectal suppository 25 mg, 50 mg</i>	T2	
<b>PULMICORT</b>	T4	PA-BvD
<b>PULMOZYME</b>	T5	PA
<b>QVAR INHALATION AEROSOL 40 MCG/ACTUATION</b>	T3	QL (8.7 GM per 30 days)
<b>QVAR INHALATION AEROSOL 80 MCG/ACTUATION</b>	T3	QL (17.4 GM per 30 days)
<b>REVATIO INTRAVENOUS</b>	T5	PA
<b>REVATIO ORAL SUSPENSION FOR RECONSTITUTION</b>	T5	PA; QL (224 ML per 31 days)
<b>REVATIO ORAL TABLET</b>	T5	PA; QL (93 EA per 31 days)
<b>RUCONEST</b>	T5	PA
<b>SEMPREX-D</b>	T4	
<b>SEREVENT DISKUS</b>	T4	QL (60 EA per 30 days)
<i>sildenafil (antihypertensive) intravenous</i>	T5	PA
<i>sildenafil (antihypertensive) oral</i>	T3	PA; QL (93 EA per 31 days)
<b>SPIRIVA RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>SPIRIVA WITH HANDIHALER</b>	T3	QL (30 EA per 30 days)
<b>STIOLTO RESPIMAT</b>	T3	QL (4 GM per 30 days)
<b>STRIVERDI RESPIMAT</b>	T4	QL (4 GM per 30 days)
<b>SYMBICORT</b>	T3	QL (10.2 GM per 30 days)
<i>terbutaline</i>	T2	
<b>THEO-24</b>	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
<b>TRACLEER</b>	T5	PA; QL (62 EA per 31 days)
<i>triamcinolone acetonide nasal</i>	T3	
<b>VENTAVIS</b>	T5	PA-BvD
<b>VENTOLIN HFA</b>	T3	QL (36 GM per 30 days)
<b>XOLAIR</b>	T5	
<b>XOPENEX</b>	T4	PA-BvD
<b>XOPENEX CONCENTRATE</b>	T4	PA-BvD
<i>zafirlukast</i>	T2	
<b>ZILEUTON</b>	T5	PA
<b>ZYFLO</b>	T4	PA
<b>Urologicals</b>		
<i>alfuzosin</i>	T2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bethanechol chloride</i>	T2	
<b>CIALIS ORAL TABLET 2.5 MG</b>	T4	PA; QL (62 EA per 31 days)
<b>CIALIS ORAL TABLET 5 MG</b>	T4	PA; QL (31 EA per 31 days)
<b>CYSTAGON</b>	T3	
<i>darifenacin</i>	T3	
<i>dutasteride</i>	T3	
<i>dutasteride-tamsulosin</i>	T3	
<b>ELMIRON</b>	T3	
<i>finasteride oral tablet 5 mg</i>	T2	
<i>flavoxate</i>	T2	
<b>GELNIQUE TRANSDERMAL GEL IN PACKET</b>	T3	PA; QL (30 GM per 30 days)
<b>MYRBETRIQ</b>	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T2	
<i>oxybutynin chloride oral tablet</i>	T2	
<i>oxybutynin chloride oral tablet extended release 24hr</i>	T3	
<b>OXYTROL</b>	T4	PA; QL (8 EA per 28 days)
<i>potassium citrate oral tablet extended release 10 meq (1,080 mg)</i>	T3	
<i>potassium citrate oral tablet extended release 15 meq, 5 meq (540 mg)</i>	T2	
<b>PROCYSBI</b>	T5	PA
<b>RAPAFLO</b>	T3	
<i>tamsulosin</i>	T1	
<i>tolterodine</i>	T3	
<b>TOVIAZ</b>	T3	QL (31 EA per 31 days)
<i>trospium</i>	T2	
<b>VESICARE</b>	T3	QL (31 EA per 31 days)
<b>Vitamins, Hematinics / Electrolytes</b>		
<i>amino acids 15 %</i>	T2	PA-BvD
<b>AMINOSYN 7 % WITH ELECTROLYTES</b>	T4	PA-BvD
<b>AMINOSYN 8.5 %-ELECTROLYTES</b>	T4	PA-BvD
<b>AMINOSYN II 10 %</b>	T4	PA-BvD
<b>AMINOSYN II 15 %</b>	T4	PA-BvD
<b>AMINOSYN II 8.5 %</b>	T4	PA-BvD
<b>AMINOSYN II 8.5 %-ELECTROLYTES</b>	T4	PA-BvD
<b>AMINOSYN-HBC 7%</b>	T3	PA-BvD
<b>AMINOSYN-PF 10 %</b>	T3	PA-BvD

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>AMINOSYN-PF 7 % (SULFITE-FREE)</b>	T3	PA-BvD
<b>AMINOSYN-RF 5.2 %</b>	T4	PA-BvD
<i>calcium acetate oral capsule</i>	T2	
<i>calcium acetate oral tablet 667 mg</i>	T2	
<b>CLINIMIX 5%/D15W SULFITE FREE</b>	T3	PA-BvD
<b>CLINIMIX 5%/D25W SULFITE-FREE</b>	T3	PA-BvD
<b>CLINIMIX 2.75%/D5W SULFIT FREE</b>	T3	PA-BvD
<b>CLINIMIX 4.25%/D10W SULF FREE</b>	T3	PA-BvD
<b>CLINIMIX 4.25%-D20W SULF-FREE</b>	T3	PA-BvD
<b>CLINIMIX 4.25%-D25W SULF-FREE</b>	T4	PA-BvD
<b>CLINIMIX 5%-D20W(SULFITE-FREE)</b>	T3	PA-BvD
<b>CLINIMIX E 4.25%/D10W SUL FREE</b>	T4	PA-BvD
<b>CLINIMIX E 4.25%/D25W SUL FREE</b>	T4	PA-BvD
<b>CLINIMIX E 4.25%/D5W SULF FREE</b>	T4	PA-BvD
<b>CLINIMIX E 5%/D15W SULFIT FREE</b>	T4	PA-BvD
<b>CLINIMIX E 5%/D20W SULFIT FREE</b>	T4	PA-BvD
<b>CLINIMIX E 5%/D25W SULFIT FREE</b>	T4	PA-BvD
<b>CLINISOL SF 15 %</b>	T4	PA-BvD
<i>dextrose-kcl-nacl</i>	T2	
<i>eliphos</i>	T2	
<i>fluoride (sodium) oral tablet</i>	T2	
<b>FREAMINE HBC 6.9 %</b>	T4	PA-BvD
<b>HEPATAMINE 8%</b>	T3	PA-BvD
<i>intralipid intravenous emulsion 20 %</i>	T2	PA-BvD
<b>INTRALIPID INTRAVENOUS EMULSION 30 %</b>	T4	PA-BvD
<b>IONOSOL-B IN D5W</b>	T4	PA-BvD
<b>IONOSOL-MB IN D5W</b>	T4	PA-BvD
<b>ISOLYTE-P IN 5 % DEXTROSE</b>	T3	PA-BvD
<b>ISOLYTE-S</b>	T3	PA-BvD
<i>klor-con 10</i>	T2	
<i>klor-con 8</i>	T2	
<i>klor-con m10</i>	T2	
<i>klor-con m15</i>	T2	
<i>klor-con m20</i>	T2	
<i>klor-con sprinkle</i>	T2	
<b>K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ</b>	T4	
<i>k-tab oral tablet extended release 8 meq</i>	T1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lactated ringers intravenous</i>	T2	
<i>magnesium sulfate injection</i>	T2	
<b>NEPHRAMINE 5.4 %</b>	T3	PA-BvD
<b>NORMOSOL-M IN 5 % DEXTROSE</b>	T4	PA-BvD
<b>NORMOSOL-R IN 5 % DEXTROSE</b>	T4	PA-BvD
<b>NORMOSOL-R PH 7.4</b>	T4	PA-BvD
<b>NUTRILIPID</b>	T4	PA-BvD
<b>PHOSLYRA</b>	T4	
<b>PLASMA-LYTE 148</b>	T4	PA-BvD
<b>PLASMA-LYTE A</b>	T4	PA-BvD
<i>potassium chlorid-d5-0.45%nacl</i>	T2	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l</i>	T2	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	T2	
<i>potassium chloride intravenous solution</i>	T2	
<i>potassium chloride oral capsule, extended release</i>	T1	
<i>potassium chloride oral liquid</i>	T2	
<i>potassium chloride oral tablet extended release</i>	T1	
<i>potassium chloride oral tablet,er particles/crystals</i>	T1	
<i>potassium chloride-0.45 % nacl</i>	T2	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride-d5-0.9%nacl</i>	T2	
<i>premasol 10 %</i>	T2	PA-BvD
<b>PREMASOL 6 %</b>	T3	PA-BvD
<i>prenatal vitamin plus low iron</i>	T2	
<b>PROCALAMINE 3%</b>	T4	PA-BvD
<b>PROSOL 20 %</b>	T4	PA-BvD
<i>ringer's intravenous</i>	T2	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	T2	
<i>sodium chloride 3 %</i>	T2	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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<i>sodium chloride intravenous parenteral solution 2.5 meq/ml</i>	T2	
<i>sodium lactate</i>	T2	
<i>travasol 10 %</i>	T2	PA-BvD
<b>TROPHAMINE 10 %</b>	T4	PA-BvD
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<b>FINACEA</b> .....	53	<i>furosemide</i> .....	47	<i>glyburide</i> .....	60
<i>finasteride</i> .....	85	<b>FUSILEV</b> .....	17	<i>glyburide micronized</i> .....	60
<b>FIRAZYR</b> .....	83	<b>FUZEON</b> .....	9	<i>glyburide-metformin</i> .....	60
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<i>fludrocortisone</i> .....	60	<b>GAMMAPLEX</b> .....	69	<i>griseofulvin microsize</i> .....	9
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<i>neomycin-polymyxin b-dexameth</i> .....	80	<i>nortrel 0.5/35 (28)</i> .....	78	<b>OMNARIS</b> .....	83
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<b>RECOMBIVAX HB (PF)</b> .....	72	<b>ROXICODONE</b> .....	39	<i>sodium polystyrene (sorb free)</i> ... 57	
<b>RECTIV</b> .....	67	<b>ROZEREM</b> .....	39	<b>SOLTAMOX</b> .....	20
<b>REGRANEX</b> .....	55	<b>RUBRACA</b> .....	20	<b>SOLU-CORTEF (PF)</b> .....	63
<b>RELENZA DISKHALER</b> .....	12	<b>RUCONEST</b> .....	84	<b>SOLU-MEDROL</b> .....	63
<b>RELISTOR</b> .....	67, 68	<b>RYDAPT</b> .....	20	<b>SOLU-MEDROL (PF)</b> .....	63
<b>RELPAK</b> .....	38	<b>SABRIL</b> .....	39	<b>SOMATULINE DEPOT</b> .....	20
<b>REMICADE</b> .....	68	<b>SAFYRAL</b> .....	78	<b>SOMAVERT</b> .....	63
<b>REMODULIN</b> .....	49	<b>SAIZEN</b> .....	72	<b>SORIATANE</b> .....	55
<b>RENAGEL</b> .....	57	<b>SAIZEN CLICK.EASY</b> .....	72	<i>sorine</i> .....	50
<b>RENFLEXIS</b> .....	68	<b>SAMSCA</b> .....	63	<i>sotalol</i> .....	50
<b>REVELA</b> .....	57	<b>SANCUSO</b> .....	68	<i>sotalol af</i> .....	50
<i>repaglinide</i> .....	63	<b>SANDIMMUNE</b> .....	20	<b>SOTYLIZE</b> .....	50

<b>SOVALDI</b> .....	12	<b>SYNERCID</b> .....	13	<b>THALOMID</b> .....	20
<b>SPIRIVA RESPIMAT</b> .....	84	<b>SYNRIBO</b> .....	20	<b>THEO-24</b> .....	84
<b>SPIRIVA WITH</b>		<b>SYNTHROID</b> .....	63	<i>theophylline</i> .....	84
<b>HANDHALER</b> .....	84	<b>SYPRINE</b> .....	58	<b>THIOLA</b> .....	58
<i>spironolactone</i> .....	50	<b>TABLOID</b> .....	20	<i>thioridazine</i> .....	40
<i>spironolacton-hydrochlorothiaz.</i>	50	<b>TACLONEX</b> .....	55	<i>thiotepa</i> .....	20
<b>SPORANOX</b> .....	12	<i>tacrolimus</i> .....	20, 55	<i>thiothixene</i> .....	40
<i>sprintec (28)</i> .....	78	<b>TAFINLAR</b> .....	20	<b>THYMOGLOBULIN</b> .....	72
<b>SPRITAM</b> .....	39	<b>TAGRISSE</b> .....	20	<b>THYROLAR-1</b> .....	64
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<i>sronyx</i> .....	78	<b>TALTZ SYRINGE</b> .....	55	<b>THYROLAR-2</b> .....	64
<i>ssd</i> .....	55	<b>TAMIFLU</b> .....	13	<b>THYROLAR-3</b> .....	64
<i>stavudine</i> .....	12	<i>tamoxifen</i> .....	20	<i>tiagabine</i> .....	40
<b>STELARA</b> .....	55	<i>tamsulosin</i> .....	85	<b>TIGECYCLINE</b> .....	13
<b>STIMATE</b> .....	63	<b>TARCEVA</b> .....	20	<b>TIKOSYN</b> .....	50
<b>STIOLTO RESPIMAT</b> .....	84	<b>TARGRETIN</b> .....	20	<i>timolol maleate</i> .....	50, 81
<b>STIVARGA</b> .....	20	<b>TASIGNA</b> .....	20	<b>TIMOPTIC OCUDOSE (PF)</b> ..	81
<b>STRENSIQ</b> .....	63	<b>TASMAR</b> .....	40	<i>tinidazole</i> .....	13
<b>STREPTOMYCIN</b> .....	12	<b>TAZAROTENE</b> .....	55	<b>TIROSINT</b> .....	64
<b>STRIANT</b> .....	63	<b>TAZICEF</b> .....	13	<b>TIVICAY</b> .....	13
<b>STRIBILD</b> .....	12	<b>TAZORAC</b> .....	55	<i>tizanidine</i> .....	40
<b>STRIVERDI RESPIMAT</b> .....	84	<i>taztia xt</i> .....	50	<b>TOBI</b> .....	13
<b>SUBOXONE</b> .....	39	<b>TECENTRIQ</b> .....	20	<b>TOBI PODHALER</b> .....	13
<b>SUBSYS</b> .....	39	<b>TECFIDERA</b> .....	40	<b>TOBRADEX</b> .....	81
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<i>sucrafate</i> .....	68	<b>TEFLARO</b> .....	13	<i>tobramycin</i> .....	81
<i>sulfacetamide sodium</i> .....	81	<b>TEGRETOL</b> .....	40	<i>tobramycin in 0.225 % nacl</i> .....	13
<i>sulfacetamide sodium (acne)</i> .....	55	<b>TEGRETOL XR</b> .....	40	<i>tobramycin sulfate</i> .....	13
<i>sulfacetamide-prednisolone</i> .....	81	<b>TEKTRUNA</b> .....	50	<i>tobramycin-dexamethasone</i> .....	81
<i>sulfadiazine</i> .....	12	<b>TEKTRUNA HCT</b> .....	50	<b>TOBEX</b> .....	81
<i>sulfamethoxazole-trimethoprim</i> ..	12	<i>telmisartan</i> .....	50	<b>TOLAK</b> .....	55
<b>SULFAMYLON</b> .....	55	<i>telmisartan-amlodipine</i> .....	50	<i>tolazamide</i> .....	64
<i>sulfasalazine</i> .....	68	<i>telmisartan-hydrochlorothiazid</i> ..	50	<i>tolbutamide</i> .....	64
<i>sulindac</i> .....	39	<i>temazepam</i> .....	40	<i>tolcapone</i> .....	40
<i>sumatriptan</i> .....	39	<i>tencon</i> .....	40	<i>tolmetin</i> .....	40
<i>sumatriptan succinate</i> .....	39, 40	<b>TENIVAC (PF)</b> .....	72	<i>tolterodine</i> .....	85
<b>SUMAVEL DOSEPRO</b> .....	40	<i>terazosin</i> .....	50	<b>TOPAMAX</b> .....	40
<b>SUPRAX</b> .....	12	<i>terbinafine hcl</i> .....	13	<i>topiramate</i> .....	41
<b>SUPREP BOWEL PREP KIT</b> .....	68	<i>terbutaline</i> .....	84	<b>TOPIRAMATE</b> .....	41
<b>SURMONTIL</b> .....	40	<i>terconazole</i> .....	78	<i>toposar</i> .....	20
<b>SUSTIVA</b> .....	12	<b>TESTIM</b> .....	63	<i>topotecan</i> .....	21
<b>SUTENT</b> .....	20	<b>TESTOSTERONE</b> .....	63	<b>TORISEL</b> .....	21
<b>SYLATRON</b> .....	72	<i>testosterone</i> .....	63	<i>torse mide</i> .....	50
<b>SYLVANT</b> .....	20	<i>testosterone cypionate</i> .....	63	<b>TOUJEO SOLOSTAR</b> .....	64
<b>SYMBICORT</b> .....	84	<i>testosterone enanthate</i> .....	63	<b>TOVIAZ</b> .....	85
<b>SYMLINPEN 120</b> .....	63	<b>TETANUS,DIPHThERIA</b>		<b>TRACLEER</b> .....	84
<b>SYMLINPEN 60</b> .....	63	<b>TOX PED(PF)</b> .....	72	<b>TRADJENTA</b> .....	64
<b>SYNAGIS</b> .....	12	<b>TETANUS-DIPHThERIA</b>		<b>TRAMADOL</b> .....	41
<b>SYNALGOS-DC</b> .....	40	<b>TOXOIDS-TD</b> .....	72	<i>tramadol</i> .....	41
<b>SYNAREL</b> .....	63	<i>tetrabenazine</i> .....	40	<i>tramadol-acetaminophen</i> .....	41
<b>SYNDROS</b> .....	68	<i>tetracycline</i> .....	13	<i>trandolapril</i> .....	50

<i>trandolapril-verapamil</i> .....	50	<b>TYGACIL</b> .....	13	<i>vicodin</i> .....	41
<i>tranexamic acid</i> .....	50, 78	<b>TYKERB</b> .....	21	<i>vicodin es</i> .....	42
<b>TRANSDERM-SCOP</b> .....	68	<b>TYLENOL-CODEINE #3</b> .....	41	<i>vicodin hp</i> .....	42
<i>tranylcypromine</i> .....	41	<b>TYLENOL-CODEINE #4</b> .....	41	<b>VICTOZA 3-PAK</b> .....	64
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<b>TRAVATAN Z</b> .....	81	<b>TYPHIM VI</b> .....	72	<b>VIDEX 2 GRAM</b>	
<i>trazodone</i> .....	41	<b>TYSABRI</b> .....	41	<b>PEDIATRIC</b> .....	13
<b>TREANDA</b> .....	21	<b>ULORIC</b> .....	75	<b>VIDEX EC</b> .....	13
<b>TRECTOR</b> .....	13	<i>unithroid</i> .....	64	<b>VIEKIRA PAK</b> .....	13
<b>TRELSTAR</b> .....	21	<b>UPTRAVI</b> .....	50	<b>VIEKIRA XR</b> .....	13
<b>TRESIBA FLEXTOUCH U-</b>		<i>ursodiol</i> .....	68	<i>vienna</i> .....	79
<b>100</b> .....	64	<b>VAGIFEM</b> .....	78	<i>vigabatrin</i> .....	42
<b>TRESIBA FLEXTOUCH U-</b>		<i>valacyclovir</i> .....	13	<b>VIGAMOX</b> .....	81
<b>200</b> .....	64	<b>VALCHLOR</b> .....	56	<b>VIIBRYD</b> .....	42
<i>tretinoin</i> .....	55	<b>VALCYTE</b> .....	13	<b>VIMOVO</b> .....	42
<i>tretinoin (chemotherapy)</i> .....	21	<b>VALGANCICLOVIR</b> .....	13	<b>VIMPAT</b> .....	42
<i>tretinoin microspheres</i> .....	55	<i>valganciclovir</i> .....	13	<i>vinblastine</i> .....	21
<b>TREXALL</b> .....	21	<i>valproate sodium</i> .....	41	<i>vincasar pfs</i> .....	21
<b>TREXIMET</b> .....	41	<i>valproic acid</i> .....	41	<i>vincristine</i> .....	21
<i>triamcinolone acetonide</i> .....	55, 58, 84	<i>valproic acid (as sodium salt)</i> .....	41	<i>vinorelbine</i> .....	21
<i>triamterene-hydrochlorothiazid</i> .....	50	<i>valsartan</i> .....	50	<b>VIRACEPT</b> .....	14
<i>trianex</i> .....	55	<i>valsartan-hydrochlorothiazide</i> .....	50	<b>VIRAMUNE</b> .....	14
<i>triazolam</i> .....	41	<b>VANCOCIN</b> .....	13	<b>VIRAMUNE XR</b> .....	14
<i>triderm</i> .....	55	<i>vancomycin</i> .....	13	<b>VIREAD</b> .....	14
<i>trifluoperazine</i> .....	41	<i>vandazole</i> .....	79	<b>VIVITROL</b> .....	42
<i>trifluridine</i> .....	81	<b>VAQTA (PF)</b> .....	72	<b>VOGELXO</b> .....	64
<i>trihexyphenidyl</i> .....	41	<b>VARIVAX (PF)</b> .....	73	<b>VOLTAREN</b> .....	42
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<b>TRILEPTAL</b> .....	41	<b>VARUBI</b> .....	68	<b>VOSEVI</b> .....	14
<i>tri-lo-estarylla</i> .....	78	<b>VASCEPA</b> .....	50	<b>VOTRIENT</b> .....	21
<i>tri-lo-sprintec</i> .....	78	<b>VECAMYL</b> .....	50	<b>VPRIV</b> .....	64
<i>trilyte with flavor packets</i> .....	68	<b>VECTIBIX</b> .....	21	<b>VRAYLAR</b> .....	42
<i>trimethobenzamide</i> .....	68	<b>VELCADE</b> .....	21	<i>vyfemla (28)</i> .....	79
<i>trimethoprim</i> .....	13	<i>velivet triphasic regimen (28)</i> .....	79	<b>VYVANSE</b> .....	42
<i>trimipramine</i> .....	41	<b>VELPHORO</b> .....	58	<b>VYXEOS</b> .....	21
<i>trinessa (28)</i> .....	78	<b>VELTASSA</b> .....	58	<i>warfarin</i> .....	50
<b>TRINTELLIX</b> .....	41	<b>VEMLIDY</b> .....	13	<i>water for irrigation, sterile</i> .....	58
<i>tri-previfem (28)</i> .....	78	<b>VENCLEXTA</b> .....	21	<b>WELCHOL</b> .....	50
<b>TRISENOX</b> .....	21	<b>VENCLEXTA STARTING</b>		<b>WELLBUTRIN SR</b> .....	42
<i>tri-sprintec (28)</i> .....	78	<b>PACK</b> .....	21	<b>WELLBUTRIN XL</b> .....	42
<b>TRIUMEQ</b> .....	13	<i>venlafaxine</i> .....	41	<b>XALKORI</b> .....	21
<i>trivora (28)</i> .....	78	<b>VENLAFAXINE</b> .....	41	<b>XANAX</b> .....	42
<b>TRIZIVIR</b> .....	13	<b>VENTAVIS</b> .....	84	<b>XANAX XR</b> .....	42
<b>TROKENDI XR</b> .....	41	<b>VENTOLIN HFA</b> .....	84	<b>XARELTO</b> .....	50, 51
<b>TROPHAMINE 10 %</b> .....	88	<i>verapamil</i> .....	50	<b>XELJANZ</b> .....	75
<b>TROPHAMINE 6%</b> .....	88	<b>VEREGEN</b> .....	56	<b>XELJANZ XR</b> .....	75
<i>tropium</i> .....	85	<i>veripred 20</i> .....	64	<b>XENAZINE</b> .....	42
<b>TRULICITY</b> .....	64	<b>VERSACLOZ</b> .....	41	<b>XEOMIN</b> .....	73
<b>TRUMENBA</b> .....	72	<b>VESICARE</b> .....	85	<b>XERMELO</b> .....	21
<b>TRUVADA</b> .....	13	<i>vestura (28)</i> .....	79	<b>XGEVA</b> .....	21
<b>TWINRIX (PF)</b> .....	72	<b>VFEND</b> .....	13	<b>XIFAXAN</b> .....	14
<b>TYBOST</b> .....	13	<b>VIBERZI</b> .....	68	<b>XIGDUO XR</b> .....	64

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<b>XODOL 10/300</b> .....	42	<b>ZOHYDRO ER</b> .....	43
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<b>XOLAIR</b> .....	84	<b>ZOLINZA</b> .....	21
<b>XOPENEX</b> .....	84	<i>zolmitriptan</i> .....	43
<b>XOPENEX CONCENTRATE</b> .....	84	<i>zolpidem</i> .....	43
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<b>XTANDI</b> .....	21	<b>ZOMETA</b> .....	64
<b>XYREM</b> .....	42	<b>ZOMIG</b> .....	43
<b>YERVOY</b> .....	21	<b>ZOMIG ZMT</b> .....	43
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<b>YONDELIS</b> .....	21	<i>zonisamide</i> .....	43
<b>YOSPRALA</b> .....	51	<b>ZONTIVITY</b> .....	51
<b>YUVAFEM</b> .....	79	<b>ZORBTIVE</b> .....	73
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<i>zaleplon</i> .....	42	<b>ZOSTAVAX (PF)</b> .....	73
<b>ZALTRAP</b> .....	21	<b>ZOSYN IN DEXTROSE</b>	
<i>zamicet</i> .....	42	<b>(ISO-OSM)</b> .....	14
<b>ZANOSAR</b> .....	21	<i>zovia 1/35e (28)</i> .....	79
<i>zarah</i> .....	79	<i>zovia 1/50e (28)</i> .....	79
<b>ZARONTIN</b> .....	42	<b>ZOVIRAX</b> .....	56
<b>ZARXIO</b> .....	73	<b>ZUBSOLV</b> .....	43
<b>ZAVESCA</b> .....	64	<b>ZUPLENZ</b> .....	68
<i>zebutal</i> .....	42	<b>ZURAMPIC</b> .....	75
<b>ZEJULA</b> .....	21	<b>ZYCLARA</b> .....	56
<b>ZELAPAR</b> .....	42	<b>ZYDELIG</b> .....	22
<b>ZELBORAF</b> .....	21	<b>ZYFLO</b> .....	84
<b>ZEMAIRA</b> .....	58	<b>ZYKADIA</b> .....	22
<b>ZEMBRACE SYMTOUCH</b> .....	42	<b>ZYLET</b> .....	81
<b>ZEMPLAR</b> .....	64	<b>ZYPREXA RELPREVV</b> .....	43
<i>zenatane</i> .....	56	<b>ZYTIGA</b> .....	22
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<b>ZETIA</b> .....	51		
<b>ZIAGEN</b> .....	14		
<i>zidovudine</i> .....	14		
<b>ZILEUTON</b> .....	84		
<b>ZINBRYTA</b> .....	43		
<b>ZINECARD (AS HCL)</b> .....	21		
<b>ZINPLAVA</b> .....	73		
<b>ZIOPTAN (PF)</b> .....	81		
<i>ziprasidone hcl</i> .....	43		
<b>ZIRGAN</b> .....	81		
<b>ZMAX</b> .....	14		
<b>ZOFRAN (AS</b>			
<b>HYDROCHLORIDE)</b> .....	68		



# actemra

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## Products Affected

- ACTEMRA INTRAVENOUS
- ACTEMRA SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Kineret, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis (Actemra IV only)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For Actemra SubQ, patients must have an adequate trial or intolerance to the preferred SubQ products, Enbrel and Humira, for rheumatoid arthritis. For Actemra IV, patients must have an adequate trial or intolerance to one of the preferred IV products, Remicade or Simponi Aria, for rheumatoid arthritis.

## acthar h.p.

### Products Affected

- ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Covered for the following indications: 1. Infantile spasms (West syndrome) 2. Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta, glatiramer acetate, dimethyl fumerate, fingolimod, teriflunomide) 3. Rheumatic disorders 4. Collagen diseases 5. Dermatologic diseases 6. Allergic states 7. Ophthalmic diseases 8. Respiratory diseases 9. Transfusion reaction due to serum protein reaction 10. Proteinuria in nephrotic syndrome and trial/failure or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g, cyclosporine or tacrolimus, per DRUGDEX). 11. Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin. 12. Gout and intolerance or contraindication to at least two first-line gout therapies (e.g, allopurinol, probenecid, colchicine). 13. Pediatric acquired epileptic aphasia. For covered indications 2 through 9, limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	
Prescriber Restrictions	neurologist for infantile spasm
Coverage Duration	1 month
Other Criteria	

# actimmune

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## Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# adempas

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## Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of pulmonary hypertension, substantiated by results from right heart catheterization and/or direct measurement of pulmonary arterial pressure, defined as a mean pulmonary arterial pressure of greater than or equal to 25 mmHg, with a pulmonary capillary wedge pressure of less than or equal to 15 mmHg -OR- diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) (WHO group 4) after surgical treatment or inoperable CTEPH.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	cardiologist, pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# ADHD Drugs

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## Products Affected

- **ATOMOXETINE**
- *clonidine hcl oral tablet extended release 12 hr*
- *guanfacine oral tablet extended release 24 hr*
- **INTUNIV ER**
- **KAPVAY**

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# afinitor

## Products Affected

- AFINITOR
- AFINITOR DISPERZ ORAL TABLET

FOR SUSPENSION 2 MG, 3 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of advanced renal cell carcinoma and trial/failure with sunitinib or sorafenib for clear cell histology -OR- documentation of patients with progressive neuroendocrine tumors of pancreatic origin (PNET) that is unresectable, locally advanced or metastatic -OR- documentation of renal angiomyolipoma and tuberous sclerosis complex (TSC) -OR- documentation of use in postmenopausal advanced hormone receptor-positive, HER2-negative breast cancer in combination with exemestane after failure of treatment with letrozole or anastrozole -OR- documentation of SEGA associated with tuberous sclerosis for those not a candidate for surgical resection-OR-documentation of progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only. For renal cell carcinoma with clear cell histology additional trial/failure of cabozantinib or nivolumab per NCCN guidelines.

# alecensa

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## Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive AND previous trial and failure or intolerance to crizotinib (Xalkori)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# ALPHA1-PROTEINASE INHIBITORS

## Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 500 MG
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of panacinar emphysema AND documentation of a decline in forced expiratory volume in 1 second (fev1) despite optimal medical therapy (bronchodilators, corticosteroids, oxygen if indicated) AND documentation of phenotype (pi*zz, pi*znull or pi*nullnull) associated with causing serum alpha 1-antitrypsin of less than 80 mg/dl AND documentation of an alpha 1-antitrypsin serum level below the value of 35% of normal (less than 80 mg/dl).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when furnished incident to a physician service and is not self-administered.



# alunbrig

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## Products Affected

- ALUNBRIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive AND previous trial and failure or intolerance to crizotinib (Xalkori)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# ampyra

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## Products Affected

- AMPYRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	history of seizure disorder, Cr Cl less than 50ml/min
<b>Required Medical Information</b>	Documentation of diagnosis -AND- documentation that the patient is ambulatory and has walking impairment as evidenced by one of the following. 1. Functional status score (EDSS score). 2. Timed 25-foot Walk Test (T25W).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	Doses greater than 20 mg/day will not be approved. For reauthorization, documentation supporting improvement in walking impairment from baseline is required.

## anabolic steroids

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### Products Affected

- **ANADROL-50**
- *oxandrolone*
- *methyltestosterone oral capsule*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis (methyltestosterone, oxymetholone, oxandrolone)-AND- either 1 or 2 when applicable to diagnosis. 1. For the diagnosis of anemia of chronic renal failure (oxymetholone) the trial/failure, intolerance or contraindication to an erythropoiesis stimulating agent is required. 2. For the diagnosis of osteoporosis (oxandrolone) the trial/failure, intolerance or contraindication to at least 2 federal legend drugs indicated for use in osteoporosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## atypical antipsychotics

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### Products Affected

- **ABILIFY ORAL TABLET**
- *aripiprazole oral tablet*
- *aripiprazole oral tablet, disintegrating*
- **REXULTI**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis. If medication is being used for major depressive disorder, documentation of adjunctive therapy and an adequate trial of 1 alternative antidepressant is required (e.g. SSRI, SNRI, NDRIs, TCA, MAOI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

# aubagio

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## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concomitant use of Aubagio and other disease modifying agents such as fingolimod, interferons, Copaxone , Tysabri
<b>Required Medical Information</b>	Documentation of relapsing-remitting or relapsing secondary progressive multiple sclerosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses greater than 14 mg per day will not be approved

# austedo

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## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of all of the following (1-4) 1) chorea associated with Huntington's disease 2) trial, failure, intolerance, or contraindication to generic tetrabenazine 3) attestation of controlled depression in patients with a comorbid diagnosis of depression -AND- confirmation that patient will be concomitantly utilizing antidepressant therapy 4) attestation that patient is not actively suicidal
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# bavencio

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## Products Affected

- BAVENCIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of one of the following (1 or 2) 1) metastatic Merkel cell carcinoma -OR- 2) locally advanced or metastatic urothelial carcinoma in patients with progression on or after platinum-based chemotherapy -OR-in patients with progression within 12 months of neoadjuvant or adjuvant platinum-based chemotherapy
<b>Age Restrictions</b>	Deny if less than 12 years of age for metastatic Merkel cell carcinoma
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# belbuca

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## Products Affected

- BELBUCA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of moderate to severe chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Belbuca should not be used concomitantly with substance abuse therapies.



# BELEODAQ

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## Products Affected

- BELEODAQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of relapsed or refractory peripheral T-cell lymphoma (PTCL)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# berinert

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## Products Affected

- BERINERT INTRAVENOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use for treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# bosulif

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## Products Affected

- BOSULIF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of chronic myelogenous leukemia (CML) of any phase and lack of response or intolerance to prior therapy (e.g. imatinib, dasatinib, nilotinib)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# botulinum toxin

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## Products Affected

- BOTOX
- XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Use for cosmetic purposes
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# brand metformin

## Products Affected

- **GLUMETZA ORAL TABLET,ER**                      • **RIOMET**  
**GAST.RETENTION 24 HR 500 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- Either 1, 2, or 3. 1) For oral immediate release (IR) tablets, trial/failure of generic metformin (IR). 2) For oral extended release (ER) tablets, trial/failure of generic metformin IR and metformin ER (i.e. generic Glucophage XR). 3) For Riomet oral solution, trial/failure of generic metformin IR OR documentation supporting the inability to swallow or difficulty swallowing tablets containing metformin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## brand NSAIDs

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### Products Affected

- VOLTAREN TOPICAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND trial/failure of at least 2 generic formulary NSAIDs (e.g. diclofenac, ibuprofen, etc.) or contraindication to all oral NSAIDs.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# butrans

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## Products Affected

• BUPRENORPHINE

• BUTRANS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of moderate to severe chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	buprenorphine patches should not be used concomitantly with substance abuse therapies.

# **cabometyx**

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## **Products Affected**

- **CABOMETYX**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced renal cell carcinoma (RCC) and failure of one prior anti-angiogenic therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# caprelsa

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## Products Affected

- CAPRELSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# carbaglu

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## Products Affected

- CARBAGLU

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use as an adjunct therapy for acute hyperammonemia or maintenance therapy for chronic hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# CERDELGA

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## Products Affected

- CERDELGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of type 1 Gaucher disease
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## CF drugs

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### Products Affected

- BETHKIS
- PULMOZYME
- 
- **TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE**
- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis. For Bethkis: failure on, intolerance to, or contraindication to generic tobramycin inhalation solution
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME).

# chenodal

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## Products Affected

- CHENODAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of small (less than 15mm in diameter), floatable radiolucent gallstones AND an inadequate response to ursodiol therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months for initial approval with an additional 12 months upon renewal
<b>Other Criteria</b>	Safety of use beyond 24 months is not established

# cholbam

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## Products Affected

- CHOLBAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of bile acid synthesis disorders due to single enzyme defects (SEDs) -OR- documentation of use as adjunctive therapy for peroxisomal disorders (PDs), including Zellweger spectrum disorders, in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# cialis

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## Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of benign prostatic hyperplasia (BPH) and trial/failure of at least two alternative medications in the following classes (alpha-1 adrenergic blockers and/or 5-alpha reductase inhibitors)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## **cimzia**

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### **Products Affected**

• CIMZIA

• CIMZIA POWDER FOR RECONST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Enbrel, Remicade, Humira, Orenzia, Simponi, Actemra, Kineret
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis -OR- moderate to severe Crohn's disease -OR- psoriatic arthritis -OR- ankylosing spondylitis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist/ Rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patients must have an adequate trial or intolerance to one corticosteroid (e.g., prednisone or hydrocortisone) or Remicade-AND- the preferred biologic product, Humira, for a diagnosis of Crohn's disease. Patients must have an adequate trial or intolerance to both preferred products, Enbrel and Humira, for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. For initial and indication therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication.



# cinryze

## Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Coverage for the following two indications: 1. Use as prophylaxis for hereditary angioedema (HAE) type I & II -AND- documentation that clinical laboratory performance C4 below lower limit of laboratory reference range -AND- C1 inhibitor level below lower limit of laboratory reference range -OR- normal C1 inhibitor level and a low C1INH functional level below laboratory reference range -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued. 2. Use as prophylaxis for hereditary angioedema (HAE) type III -AND- documentation that clinical laboratory performance C4, C1 inhibitor, and C1INH functional level are within normal limits of laboratory reference ranges -AND- documentation of family history of HAE -OR- FXII mutation -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

## cometriq

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### Products Affected

- COMETRIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of progressive, metastatic medullary thyroid cancer
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

## corlanor

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### Products Affected

- CORLANOR ORAL TABLET 5 MG, 7.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of stable, symptomatic heart failure and normal sinus rhythm AND left ventricular ejection fraction less than or equal to 35 percent AND resting heart rate greater than or equal to 70 beats per minute AND trial/failure of maximum tolerated dose of one beta-blocker used for treatment of heart failure (e.g., bisoprolol, carvedilol, metoprolol succinate) OR contraindication to beta-blocker use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# Cosentyx

## Products Affected

• COSENTYX

• COSENTYX PEN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe psoriasis and failure of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy -OR- active psoriatic arthritis -OR- active ankylosing spondylitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and the preferred products, Enbrel and Humira, for psoriatic arthritis and ankylosing spondylitis. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.

# cotellic

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## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Disease progression on prior BRAF inhibitor therapy
<b>Required Medical Information</b>	Documentation of unresectable or metastatic melanoma in patients with a BRAF V600E or V600K mutation AND used in combination with vemurafenib
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# crinone

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## Products Affected

- CRINONE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Use to promote fertility
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# daklinza

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## Products Affected

- DAKLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD-IDSA guidance.

# darzalex

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## Products Affected

- DARZALEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use in the treatment of multiple myeloma in one of the following (1, 2, or 3): 1) monotherapy in patients that have received at least 3 prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent 2) combination therapy with lenalidomide and dexamethasone, or bortezomib and dexamethasone in patients that have received at least one prior therapy 3) combination therapy with pomalidomide and dexamethasone in patients that have received at least 2 prior therapies, including lenalidomide and a PI
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# duexis

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## Products Affected

- DUEXIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- Both of the following. 1) Trial/failure of ibuprofen used in combination with famotidine. 2) Trial/failure of one additional generic formulary NSAID (other than ibuprofen) used in combination with one additional generic formulary H2-receptor blocker (other than famotidine).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# dupixent

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## Products Affected

- DUPIXENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of all of the following (1-3): 1) moderate to severe atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least one topical corticosteroid -OR- trial & failure, intolerance, or contraindication to at least one non-fluorinated topical corticosteroid for patients requesting treatment for atopic dermatitis of the face 3) trial & failure, intolerance, or contraindication to tacrolimus ointment, or pimecrolimus cream, or crisaborole ointment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	For induction dosing, doses above the plan quantity limit will be allowed upon prior authorization approval aligned with FDA approved induction therapy dosing regimen. For maintenance dosing, additional quantities above the plan limit will be reviewed via the quantity limit exception process. Reauthorization or continuation of therapy will be approved when attestation of improvement or response to therapy is provided.

## egfr tyrosine kinase inhibitors

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### Products Affected

• GILOTRIF

• TARCEVA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- both of the following. 1) Epidermal growth factor receptor (EGFR) mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Coverage of pancreatic cancer diagnosis applies only to erlotinib (Tarceva). The use of Tarceva and Gilotrif for non-small cell lung cancer (NSCLC) will be approved as a first-line therapy. Applies to new starts only.

# egrifta

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## Products Affected

- EGRIFTA SUBCUTANEOUS RECON  
SOLN 1 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of HIV and lipodystrophy, member must actively be receiving antiretroviral therapy including protease inhibitors, nucleoside reverse transcriptase inhibitors, or non-nucleoside reverse transcriptase inhibitors
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# emflaza

## Products Affected

- EMFLAZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- onset of weakness or history of DMD starting before age 5 -AND- One of the following (1 or 2). 1) Documented trial of prednisone has resulted in intolerable adverse events (e.g. diabetes, hypertension that is difficult to manage, Cushingoid features, truncal obesity, greater than or equal to 10 percent increase in body weight over a 6 month period). 2) Documented severe behavioral adverse event while on prednisone that warrants prednisone dose reduction impacting efficacy for management of DMD (i.e. abnormal behavior, aggression, irritability, disturbance in mood)
<b>Age Restrictions</b>	Deny if less than 5 years of age
<b>Prescriber Restrictions</b>	neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# enbrel

## Products Affected

- ENBREL SUBCUTANEOUS RECON SOLN      25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)
- ENBREL SUBCUTANEOUS SYRINGE    • ENBREL SURECLICK

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Remicade, Cimzia, Humira, Orencia, Simponi, Actemra, Kineret, Stelara
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe juvenile idiopathic rheumatoid arthritis and an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide) -OR- moderate to severe psoriasis after failure or intolerance of either systemic therapy (e.g., methotrexate or cyclosporine) or phototherapy or contraindication to systemic therapies or phototherapy.
<b>Age Restrictions</b>	Deny if less than 2 years old
<b>Prescriber Restrictions</b>	rheumatologist, dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required.

# entresto

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## Products Affected

- ENTRESTO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of an ACE inhibitor or ARB
<b>Required Medical Information</b>	Documentation of chronic heart failure (NYHA Class II to IV) AND systolic dysfunction (LVEF less than or equal to 40 percent)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# epclusa

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## Products Affected

- EPCLUSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	G1,2,3,4,5,6: 12w, 24w criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	Doses greater than one tablet per day will not be approved.



# erivedge

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## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced basal cell carcinoma (BCC), which includes metastatic and locally advanced basal cell carcinoma, for whom surgery is inappropriate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only, doses greater than 150mg/day will not be approved

# exondys

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## Products Affected

- EXONDYS 51

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of all of the following (1-5): 1. diagnosis of Duchenne muscular dystrophy (DMD) with confirmed mutation of the DMD gene that is amenable to exon 51 skipping. 2. Age less than 18 yo. 3. Documented use of stable doses of oral corticosteroids for at least 6 months prior to initiating therapy. 4. Member is ambulatory (with or without assistance), not wheelchair dependent.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist or other physician who specializes in treatment of DMD
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# farydak

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## Products Affected

- FARYDAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use in combination with bortezomib and dexamethasone for patients with multiple myeloma who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (i.e. Thalomid, Revlimid, Pomolyst)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# firazyr

## Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Acute hereditary angioedema (HAE) type I & II: Documentation that clinical laboratory performance C4 below lower limit of laboratory reference range -AND- C1 inhibitor level below lower limit of laboratory reference range -OR- normal C1 inhibitor level and a low C1INH functional level below laboratory reference range -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued. Acute hereditary angioedema (HAE) type III: Documentation that clinical laboratory performance C4, C1 inhibitor level and C1INH functional level are within normal limits of the laboratory's reference range -AND- documentation of HAE family history -OR- FXL mutation -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# flector

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## Products Affected

- FLECTOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	

# forteo

## Products Affected

- FORTEO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
<b>Required Medical Information</b>	Documentation to support use for treatment of osteoporosis and the prevention of fractures in postmenopausal women and men having a T score of less than -2.5 and a trial and failure or contraindication to at least one bisphosphonate -OR- use to prevent fractures in men and postmenopausal women with a low bone mass (T score between -1.0 and -2.5) and history of previous osteoporotic fracture or those who are found to have a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent and had a trial and failure or contraindication to at least one bisphosphonate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos or Forteo will be limited to a coverage duration of 24 months.

# **gattex**

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## **Products Affected**

- **GATTEX ONE-VIAL**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of short bowel syndrome (SBS) AND dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# gilenya

## Products Affected

- GILENYA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concomitant use of Gilenya and other disease modifying agents such as interferons, Copaxone , Tysabri
<b>Required Medical Information</b>	Members must have a documented diagnosis of relapsing-remitting, relapsing secondary progressive or progressive relapsing multiple sclerosis -AND- new starts to therapy have the following baseline information documented within 6 months of initiating therapy: ophthalmologic evaluation, liver transaminase and bilirubin, complete blood count, and electrocardiogram if using an antiarrhythmic agent or have second degree or greater AV block -AND- new starts to therapy do not have any of the following comorbid conditions or concomitant therapies: bradycardia, congestive heart failure, sick sinus syndrome, prolonged QT interval, ischemic cardiac disease, irregular heartbeat, current neutropenia, current chronic or acute infections, use of antineoplastics, immunosuppressive or immune modulating therapies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses greater than 0.5mg/day will not be approved



# gleevec

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## Products Affected

- **GLEEVEC ORAL TABLET 100 MG, 400 MG** • *imatinib oral tablet 100 mg, 400 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis and alternatives tried or concomitant therapy, if applicable for diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# gralise

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## Products Affected

- GRALISE
- GRALISE 30-DAY STARTER PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# GRASTEK

## Products Affected

- GRASTEK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
<b>Required Medical Information</b>	Documentation of allergic rhinitis and use for Timothy grass pollen or cross reactive grass pollens (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass pollen, Redtop, or meadow fescue) -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
<b>Age Restrictions</b>	Deny if less than 5 years of age or greater than 65 years of age
<b>Prescriber Restrictions</b>	allergy specialist, otolaryngologist, immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must also be prescribed an epinephrine auto injector

## growth hormone

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### Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN
- 
- SAIZEN
- SAIZEN CLICK.EASY
- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG
- ZOMACTON
- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis, growth chart, bone age, growth velocity, and response to stimulation test, when applicable
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# HARVONI

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## Products Affected

- HARVONI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	G1:12w txn nocir, t/f PR.24w txex cir, t/fPI,SOF.G4,5,6:12w.DcpG1,4:12,24w t/fSOF.PosttxG1,4:12,24w
<b>Other Criteria</b>	Doses greater than one tablet per day will not be approved.

# HETLIOZ

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## Products Affected

- HETLIOZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of Non-24 Sleep-Wake disorder -AND- patient is totally blind
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# high-risk meds

## Products Affected

- amitriptyline
- amitriptyline-chlordiazepoxide
- carisoprodol-asa-codeine
- clomipramine
- cyclobenzaprine oral tablet
- digitek
- digoxin injection solution
- digoxin oral solution 50 mcg/ml
- digoxin oral tablet
- doxepin oral
- glyburide
- glyburide micronized
- glyburide-metformin
- imipramine hcl
- **LANOXIN**
- nitrofurantoin
- nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg
- nitrofurantoin monohydlm-cryst
- perphenazine-amitriptyline
- promethazine oral syrup
- **SILENOR**
- **SURMONTIL**
- trimipramine

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	For all medications subject to this PA group, the following information (1 through 3) is required: 1. Documentation of diagnosis 2. Explanation of risk-benefit profile favoring use of the high-risk medication 3. Attestation of an intent to monitor and address treatment-related adverse events. In addition to requirements 1 through 3 above, for digoxin doses exceeding 0.125 mg daily, provider confirmation that a lower dose of digoxin has or would be ineffective in managing the member's condition is required. For the target high-risk medications glyburide, TCAs and nitrofurantoin, in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required. Non-high risk alternative medications for those target high-risk medications include the following: 1. Glyburide (non-high risk alternatives include glipizide and glimepiride) 2. TCAs (non-high risk alternatives include SSRIs and SNRIs) 3. Nitrofurantoin (non-high risk alternatives include Bactrim, Cipro, or cephalexin). If using one of the above 3 high-risk medications for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required for that target high-risk medication.
Age Restrictions	Automatic approval if less than 65 years of age

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only for protected class drugs. Digoxin doses less than or equal to 0.125 mg per day and doxepin doses less than or equal to 6 mg per day will receive automatic approval.



# homozygous fh

## Products Affected

• JUXTAPID

• KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic testing showing functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality -OR- untreated LDL-C concentrations greater than 500 mg/dL, treated LDL-C concentrations greater than or equal to 300 mg/dL, or a non-HDL-C concentration greater than or equal to 330mg/dL -AND- the presence of Xanthomas in the first decade of life -OR- documentation of elevated LDL-C greater than 190 mg/dL prior to lipid-lowering therapy consistent with HoFH in both parents -AND- will not be used concomitantly with a PCSK9 inhibitor [e.g. alirocumab (Praluent), evolocumab (Repatha)].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Patients must have an adequate trial/failure or contraindication to the preferred product Repatha.

# horizant

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## Products Affected

- HORIZANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of moderate to severe active primary restless leg syndrome and trial and failure of two accepted medications for the treatment of this condition one of which must include pramipexole or ropinirole -OR- documentation of post herpetic neuralgia
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# humira

## Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)
- HUMIRA PEN
- HUMIRA PEN CROHN'S-UC-HS START
- HUMIRA PEN PSORIASIS-UVEITIS

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Remicade, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
<b>Required Medical Information</b>	Documentation of moderate to severe hidradenitis suppurativa -OR- moderate to severe rheumatoid arthritis -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe juvenile idiopathic rheumatoid arthritis and an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunamide) -OR- moderate to severe psoriasis after failure of either systemic therapy (e.g., methotrexate or cyclosporine) or phototherapy. -OR- moderate to severe Crohn's disease after failure of two immunosuppressants (e.g., corticosteroids, azathioprine) or monotherapy with infliximab -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine)-OR-non-infectious uveitis (including intermediate, posterior, and panuveitis)
<b>Age Restrictions</b>	Deny if less than 2 years old
<b>Prescriber Restrictions</b>	rheumatologist, dermatologist, gastroenterologist, ophthalmologist
<b>Coverage Duration</b>	12 months

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	<p>For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease in adults (18 years or older), trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Crohn's disease in pediatrics, trial of 1 immunosuppressant (e.g. corticosteroids, azathioprine) or monotherapy with infliximab is required. For Ulcerative Colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine or 6-mercaptopurine) is required. For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit.</p>

# Ibrance

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## Products Affected

- IBRANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ER-positive, HER2-negative breast cancer in postmenopausal women and used as initial endocrine-based therapy for advanced disease in combination with an aromatase inhibitor-OR- documentation of use with fulvestrant (Faslodex) in women with HR-positive, HER2-negative metastatic breast cancer with disease progression following endocrine therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# iclusig

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## Products Affected

- ICLUSIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of T3151 chronic phase, accelerated phase or blast phase CML -OR- documentation of T3151 Ph+ ALL -OR- documentation of chronic phase, accelerated phase or blast phase CML in patients for whom no other tyrosine kinase inhibitor therapy is indicated -OR- documentation of Ph+ ALL in patients for whom no other tyrosine kinase inhibitor therapy is indicated.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# idhifa

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## Products Affected

- **IDHIFA ORAL TABLET 100 MG, 50 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA approved test
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

**Products Affected**

- BIVIGAM
- CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMASTAN S/D
- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA)
- GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- GAMMAPLEX
- GAMMAPLEX (WITH SORBITOL)
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- OCTAGAM
- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For select diagnoses the following apply- 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant of/has a contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months, OR is intolerant of/has a contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months, OR is intolerant of/has a contraindication to corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when administered in the home to a member with a diagnosis of primary immunodeficiency disease



# imbruvica

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## Products Affected

- IMBRUVICA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of mantle cell lymphoma and treatment with at least one prior therapy -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma -OR- documentation of chronic lymphocytic leukemia or small lymphocytic lymphoma with 17p deletion -OR- documentation of Waldenstrom macroglobulinemia -OR- documentation of marginal zone lymphoma in patients who require systemic therapy and have received at least one prior anti-CD20-based therapy -OR- documentation of chronic graft versus host disease in patients who have tried and failed one or more lines of systemic therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# imfinzi

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## Products Affected

- IMFINZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of locally advanced or metastatic urothelial carcinoma in patients with progression on or after platinum-based chemotherapy -OR- in patients with progression within 12 months of neoadjuvant or adjuvant platinum-based chemotherapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# increlex

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## Products Affected

- INCRELEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis, growth chart, stimulation test results, growth velocity, IGF-1 level
<b>Age Restrictions</b>	Deny if greater than 18 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# inflectra

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## Products Affected

- INFLECTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
<b>Age Restrictions</b>	For Crohn's disease, deny if less than 6 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

# ingrezza

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## Products Affected

- INGREZZA ORAL CAPSULE 40 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of tardive dyskinesia and trial, failure, or intolerance of generic tetrabenazine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# inlyta

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## Products Affected

- INLYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of advanced renal cell carcinoma (RCC) and failure one prior systemic therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# interferon alfa

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## Products Affected

- INTRON A INJECTION
- PEGASYS
- PEGASYS PROCLICK
- PEGINTRON REDIPEN  
SUBCUTANEOUS PEN INJECTOR
- KIT 120 MCG/0.5 ML
- PEGINTRON SUBCUTANEOUS KIT  
50 MCG/0.5 ML
- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of diagnosis only
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

## interleukin-1b blockers

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### Products Affected

- ARCALYST
- ILARIS (PF) SUBCUTANEOUS

RECON SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concomitant use with agents that inhibit IL-1 or TNF including Remicade, Humira, Enbrel, Orencia, or Kineret
<b>Required Medical Information</b>	documentation of diagnosis
<b>Age Restrictions</b>	Deny if less than 12 years of age (Arcalyst) or less than 2 years of age (Ilaris)
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	





# iressa

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## Products Affected

- IRESSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors express EGFR exon 19 deletion mutations or exon 21 (L858R) mutations as detected by an FDA-approved test
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# **jakafi**

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## **Products Affected**

- **JAKAFI**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only. Platelet count to be provided.

# kalydeco

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## Products Affected

- KALYDECO ORAL GRANULES IN PACKET
- KALYDECO ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Homozygous for the F508del mutation in the CFTR gene
<b>Required Medical Information</b>	Documentation of cystic fibrosis (CF) in patients who have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to ivacaftor based on clinical and or in vitro assay (e.g. G551D, G1244E, G1349D)
<b>Age Restrictions</b>	Deny if less than 6 years of age for oral tablets and less than 2 years of age for oral granules
<b>Prescriber Restrictions</b>	pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses greater than 300mg/day will not be approved

# kanuma

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## Products Affected

- KANUMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of Lysosomal Acid Lipase (LAL) deficiency
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# keveyis

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## Products Affected

- KEVEYIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of one of the following: 1. Primary hyperkalemic periodic paralysis 2. Primary hypokalemic periodic paralysis 3. Related variants of primary periodic paralysis
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses exceeding 200 mg per day will not be approved.

# kevzara

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## Products Affected

- KEVZARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concomitant use of a biologic DMARD (e.g., Xeljanz, Enbrel, Humira, Kineret, Orencia, Remicade, Cimzia, or Simponi)
<b>Required Medical Information</b>	Documentation of all of the following (1 AND 2). 1)Diagnosis of rheumatoid arthritis (RA) -AND- 2) Trial, failure, or intolerance to at least one DMARD (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine, cyclosporine)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Deny if less than 18 years of age
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patients must have an adequate trial, failure, or intolerance to at least two biologic products indicated for the treatment of RA (e.g. Humira, Enbrel, Actemra, Xeljanz, Xeljanz XR)

# KEYTRUDA

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## Products Affected

- KEYTRUDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of unresectable or metastatic melanoma -OR- metastatic non-small cell lung cancer (NSCLC) with PD-L1-positive expressing tumor, as determined by an FDA-approved test, after failure of prior platinum-based chemotherapy-OR-recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy-OR-classical Hodgkins lymphoma that is refractory, or has relapsed after three or more prior lines of therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# kineret

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## Products Affected

- KINERET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Actemra, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis and trial and failure of one DMARD -OR- neonatal-onset multisystem inflammatory disease (NOMID) or chronic infantile neurological, cutaneous and articular (CINCA) syndrome
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	rheumatologist, pediatrician
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

# kisqali

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## Products Affected

- **KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG**
- **KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of ER-positive, HER2-negative advanced or metastatic breast cancer in postmenopausal women AND used as initial endocrine-based therapy for advanced or metastatic disease in combination with letrozole (Femara) or another aromatase inhibitor
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# **korlym**

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## **Products Affected**

- **KORLYM**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome who have Type 2 Diabetes Mellitus or glucose intolerance AND patient is not a candidate for surgery or radiotherapy or where surgery or radiotherapy has failed
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# lenvima

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## Products Affected

- LENVIMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of locally recurrent or metastatic, progressive, radioactive iodine refractory differentiated thyroid cancer-OR-advanced renal cell carcinoma when both of the following are met. 1) Lenvima will be used in combination with everolimus AND 2) trial of at least one prior anti-angiogenic therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# leukotriene modifiers

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## Products Affected

• ZILEUTON

• ZYFLO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of asthma -AND- trial/failure of generic montelukast
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# lidoderm

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## Products Affected

- *lidocaine topical adhesive patch,medicated* • **LIDODERM**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of postherpetic neuralgia (PHN) and trial and failure of 1 other agent used to treat PHN (e.g. gabapentin) -OR- documentation of diabetic neuropathy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# Ionsurf

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## Products Affected

- LONSURF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic colorectal cancer in patients who have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# lynparza

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## Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use as monotherapy in patients with deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer after trial of three or more prior lines of chemotherapy (e.g. carboplatin, cisplatin, paclitaxel, gemcitabine) -OR- documentation of use as maintenance treatment in patients with recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, who are in a complete or partial response to platinum-based chemotherapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# lyrica

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## Products Affected

- LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG
- LYRICA ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of DPN and trial/failure or intolerance to duloxetine-OR- PHN and trial/failure or intolerance to gabapentin -OR- seizures and trial/failure or intolerance to two AEDS -OR- neuropathic pain associated with spinal cord injury -OR- documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# mavyret

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## Products Affected

- MAVYRET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	Doses greater than three tablets per day will not be approved.

# mekinist

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## Products Affected

- MEKINIST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Disease progression on prior BRAF inhibitor therapy
<b>Required Medical Information</b>	Documentation of unresectable or metastatic melanoma with BRAFV600E or BRAFV600K mutations -OR- documentation of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# methamphetamine

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## Products Affected

- *methamphetamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# mozobil

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## Products Affected

- MOZOBIL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	used in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with multiple myeloma (MM) and non-Hodgkins lymphoma (NHL).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# myalept

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## Products Affected

- MYALEPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of congenital or acquired generalized lipodystrophy with absence or loss of subcutaneous body fat -AND- Leptin levels less than 8 ng/mL for males or less than 12 ng/mL for females -AND- the patient has been optimized on current diabetic medication and/or hypertriglyceridemia medication as needed -AND- the member has a diagnosis of diabetes or fasting insulin levels greater than 30uU/mL or fasting hypertriglyceridemia greater than 200mg/dL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# namenda

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## Products Affected

- NAMENDA ORAL TABLET
- NAMENDA TITRATION PAK
- NAMENDA XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and trial/failure of generic memantine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# **namzarin**

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## **Products Affected**

- **NAMZARIC**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and trial/failure of generic memantine and generic donepezil
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	



# natpara

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## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use as an adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# nerlynx

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## Products Affected

- NERLYNX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of early-stage HR-positive, HER2-positive breast cancer in patients who have received adjuvant trastuzumab-based therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

## nexavar

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### Products Affected

- NEXAVAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hepatocellular carcinoma -OR- advanced renal cell carcinoma after treatment of 1 other systemic therapy -OR- locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# ninlaro

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## Products Affected

- NINLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of multiple myeloma AND previous treatment with at least 1 prior therapy AND used in combination with lenalidomide and dexamethasone
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# NORTHERA

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## Products Affected

- NORTHERA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of neurogenic orthostatic hypotension caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# nucala

## Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma evidenced by pretreatment forced expiratory volume in 1 second (FEV1) less than 80% predicted and FEV1 reversibility of at least 12% after albuterol administration -AND- Either 1 or 2. 1)History of 2 or more exacerbations in the previous year despite at least 12 months of high-dose inhaled corticosteroid (ICS) given in combination with at least 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], or theophylline), unless intolerant of or contraindication to all of these agents. 2)Symptoms are inadequately controlled with use of 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (e.g. LABA, LTRA, or theophylline), unless intolerant of or contraindication to all of these agents. -AND- 3 or 4. 3)Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 4)Greater than or equal to 300 cells/uL within 12 months of screening.
Age Restrictions	Deny if less than 12 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# nuplazid

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## Products Affected

- NUPLAZID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# OAB drugs

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## Products Affected

- GELNIQUE TRANSDERMAL GEL IN PACKET
- OXYTROL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis -AND- trial/failure of at least 2 generic alternatives (e.g. oxybutynin, trospium, tolterodine)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	



# ocaliva

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## Products Affected

- OCALIVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of primary biliary cholangitis -AND- trial and failure, contraindication, or intolerance to ursodiol monotherapy -AND- will use concomitantly with Ursodiol unless contraindicated or intolerant.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## odomzo

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### Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of locally advanced basal cell carcinoma (laBCC) that has recurred following surgery or radiation therapy or for use in patients who are not candidates for surgery or radiation therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# olysio

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## Products Affected

- OLYSIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Previous failure of a Protease Inhibitor used in hepatitis C (boceprevir, telaprevir or simeprevir) -OR- decompensated cirrhosis
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 wks or 24 wks depending on treatment regimen and presence or absence of cirrhosis
<b>Other Criteria</b>	Doses greater than or less than 150mg/day will not be approved

# opdivo

## Products Affected

- **OPDIVO INTRAVENOUS SOLUTION**  
**40 MG/4 ML**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of unresectable or metastatic melanoma in combination with ipilimumab (Yervoy) or, as monotherapy if BRAF V600 mutation positive or BRAF V600 wild-type -OR- documentation of metastatic squamous non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy -OR- documentation of advanced renal cell carcinoma in patients who have received prior antiangiogenic therapy -OR- documentation of classical Hodgkin lymphoma that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and brentuximab vedotin or 3 or more lines of systemic therapy that includes autologous HSCT -OR- documentation of recurrent or metastatic squamous cell carcinoma of the head and neck with disease progression on or after a platinum-based therapy -OR- documentation of locally advanced or metastatic urothelial carcinoma that has progressed during or following platinum-based chemotherapy or that has progressed w/in 12 mos of neoadjuvant or adjuvant treatment with platinum-based chemotherapy -OR- documentation of microsatellite instability-high or mismatch repair deficient metastatic colorectal cancer that has progressed after treatment w/ a fluoropyrimidine, oxaliplatin, and irinotecan -OR- documentation of hepatocellular carcinoma in patients who have been previously treated with sorafenib
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# oralair

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## Products Affected

- **ORALAIR SUBLINGUAL TABLET 300  
INDX REACTIVITY**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
<b>Required Medical Information</b>	Documentation of allergic rhinitis and use for Sweet Vernal, Orchard, Perennial Rye, or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies - AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
<b>Age Restrictions</b>	Deny if less than 10 years of age or greater than 65 years of age
<b>Prescriber Restrictions</b>	allergy specialist, otolaryngologist, immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must also be prescribed an epinephrine auto injector

# orencia

## Products Affected

- ORENCIA (WITH MALTOSE) SYRINGE 125 MG/ML, 50 MG/0.4 ML,
- ORENCIA CLICKJECT 87.5 MG/0.7 ML
- ORENCIA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Orenzia, Simponi, Kineret, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis -OR- documentation of psoriatic arthritis
Age Restrictions	
Prescriber Restrictions	rheumatologist
Coverage Duration	12 months
Other Criteria	For Orenzia SubQ, patients must have an adequate trial or intolerance to the preferred SubQ products, Enbrel and Humira, for rheumatoid arthritis and psoriatic arthritis. For Orenzia IV, patients must have an adequate trial or intolerance to one of the preferred IV products, Remicade or Simponi Aria, for rheumatoid arthritis or Remicade for psoriatic arthritis.

# orkambi

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## Products Affected

- ORKAMBI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cystic fibrosis and homozygous F508del mutation
<b>Age Restrictions</b>	Deny if less than 6 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, documentation showing a FEV1 improvement from baseline must be provided.

# OTEZLA

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## Products Affected

- OTEZLA
- OTEZLA STARTER ORAL

TABLETS,DOSE PACK 10 MG (4)-20  
MG (4)-30 MG (47)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of active psoriatic arthritis -OR- documentation of moderate to severe psoriasis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	rheumatologist, dermatologist
Coverage Duration	12 months
Other Criteria	Maintenance doses greater than 60 mg per day will not be approved. Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for psoriatic arthritis and psoriasis.



## otrexup

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### Products Affected

- **OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# pomalyst

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## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of multiple myeloma, previous trial of at least 2 therapies including lenalidomide and bortezomib, and disease progression on or within 60 days of last therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# praluent

## Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of the following: 1. Heterozygous Familial Hypercholesterolemia (HeFH) as supported by the presence of causal mutation of familial hypercholesterolemia by genetic testing, physical signs of FD (e.g. xanthomas, xanthelasma), clinical diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register diagnostic criteria AND LDL-C greater than or equal to 190 mg/dL prior to lipid lowering therapy (greater than or equal to 160 mg/dL if age less than 20) or LDL-C greater than or equal to 160 mg/dL after treatment with antihyperlipidemic agents but prior to Praluent therapy AND Previous treatment with at least two trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has been ineffective in achieving LDL-C goal AND Praluent must be used concomitantly with a statin which is dosed at maximally tolerated dose OR documentation of statin intolerance is provided as defined by statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin. 2. Hypercholesterolemia ASCVD (e.g. acute coronary syndrome, history of myocardial infarction) AND Previous treatment with at least two trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has been ineffective in achieving LDL-C goal (LDL-C is still greater than or equal to 100 mg/dL) AND Praluent must be used concomitantly with a statin which is dosed at maximally tolerated dose OR documentation of statin intolerance is provided as defined by statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	For reauthorization, documentation showing an LDL-C reduction on Praluent therapy from baseline must be provided.

## prescription drug combo

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### Products Affected

- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- *alprazolam intensol*
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *ascomp with codeine*
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- *codeine sulfate oral tablet*
- **DOLOPHINE ORAL TABLET 10 MG, 5 MG**
- **DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR, 12 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR**
- **EMBEDA ORAL CAPSULE, ORAL ONLY, EXT. REL PELL**
- *endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg*
- **EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 16 MG, 32 MG, 8 MG**
- *fentanyl transdermal patch 72 hour 100 mcg/12 hr, 12 mcg/12 hr, 25 mcg/12 hr, 50 mcg/12 hr, 75 mcg/12 hr*
- **FENTANYL TRANSDERMAL PATCH 72 HOUR 37.5 MCG/HOUR, 62.5 MCG/HOUR, 87.5 MCG/HOUR**
- **HALCION ORAL TABLET 0.25 MG**
- **HYCET**
- *hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml*
- *hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg*
- *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg*
- *hydromorphone (pf)*
- *hydromorphone injection syringe 2 mg/ml*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet*
- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*
- **HYSINGLA ER**
- *ibuprofen-oxycodone*
- **KADIAN ORAL CAPSULE, EXTEND. RELEASE PELLETS 10 MG, 100 MG, 20 MG, 200 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG**
- *levorphanol tartrate*
- *lorcet (hydrocodone)*
- *lorcet hd*
- *lorcet plus oral tablet 7.5-325 mg*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- **MORPHINE INTRAVENOUS SYRINGE 10 MG/ML, 8 MG/ML**
- *morphine intravenous syringe 2 mg/ml, 4 mg/ml*
- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral capsule, extend. release pellets*
- *morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)*
- *morphine oral tablet*
- *morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- **NORCO**
- **OPANA ER ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 5 MG, 7.5 MG**
- **OPANA ORAL**
- *oxycodone oral capsule*
- *oxycodone oral concentrate*
- *oxycodone oral solution*

- *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg*
- **OXYCODONE ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- *oxycodone-acetaminophen oral solution*
- *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*
- *oxycodone-aspirin*
- **OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG**
- *oxymorphone oral tablet*
- *oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg, 7.5 mg*
- **PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG**
- **PRIMLEV**
- **ROXICODONE ORAL TABLET 15 MG, 30 MG, 5 MG**
- **SYNALGOS-DC**
- *triazolam*
- **TYLENOL-CODEINE #3**
- **TYLENOL-CODEINE #4**
- *vicodin*
- *vicodin es*
- *vicodin hp*
- **XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG**
- **XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG, 2 MG, 3 MG**
- **XODOL 10/300**
- **XODOL 5/300**
- **XODOL 7.5/300**
- **XTAMPZA ER**
- *zamicet*
- **ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has a documented acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxant (e.g, methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Opiate+subs. abuse tx, approve opiate x 1mo. Opiate+benzo+carisoprodol, approve x 12mo.
<b>Other Criteria</b>	Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g, buprenorphine-naloxone) OR a benzodiazepine (e.g., triazolam, alprazolam) AND a centrally acting skeletal muscle relaxant (e.g., carisoprodol). Benzodiazepines (e.g, triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g., oxycodone, hydrocodone, oxymorphone) AND a centrally acting skeletal muscle relaxant (e.g., carisoprodol).

# pristiq

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## Products Affected

- FETZIMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of major depressive disorder and trial and failure of two other antidepressants.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# PROCYSBI

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## Products Affected

- PROCYSBI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of nephropathic cystinosis AND previous trial and failure or intolerance to immediate-release cysteamine bitartrate (Cystagon)
<b>Age Restrictions</b>	Deny if less than 2 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# prolia

## Products Affected

- PROLIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of use to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy or women at high risk for fracture receiving adjuvant aromatase inhibitor therapy -OR- use for treatment of osteoporosis and the prevention of fractures in postmenopausal women and men having a T score of less than -2.5 and a trial and failure or contraindication to at least one bisphosphonate -OR- use to prevent fractures in men and postmenopausal women with a low bone mass (T score between -1.0 and -2.5) and history of previous osteoporotic fracture or those who are found to have a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent and had a trial and failure or contraindication to at least one bisphosphonate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Covered under Part B for female patients eligible for home health services when provider certifies that patient sustained bone fracture related to postmenopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug

# provigil

## Products Affected

- *armodafinil*
- *modafinil*

- **PROVIGIL**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of 1 of the following. 1) Diagnosis of shift work sleep disorder (SWSD) as defined by a minimum of 5 night shifts per month with at least 3 of those nights occurring consecutively and the shift is 6 to 12 hours in duration occurring between 10pm and 8am. 2) Diagnosis of narcolepsy documented by MSLT less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) or other appropriate testing. 3) Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography. Diagnosis established in accordance with ICSD or DSM V criteria acceptable for all indications.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# pulmonary arterial hypertension

## Products Affected

- ADCIRCA
- LETAIRIS
- OPSUMIT
- ORENITRAM ORAL TABLET  
EXTENDED RELEASE 0.125 MG, 0.25  
MG, 1 MG, 2.5 MG, 5 MG
- REVATIO INTRAVENOUS
- REVATIO ORAL SUSPENSION FOR  
RECONSTITUTION
- REVATIO ORAL TABLET
- sildenafil (antihypertensive) intravenous
- sildenafil (antihypertensive) oral
- TRACLEER
- UPTRAVI ORAL TABLET 1,000 MCG,  
1,200 MCG, 1,400 MCG, 1,600 MCG, 200  
MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS,DOSE  
PACK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization and/or direct measurement of pulmonary arterial pressure, defined as a mean pulmonary arterial pressure of greater than or equal to 25 mmHg at rest, with a pulmonary capillary wedge pressure of less than or equal to 15 mmHg, and a PVR greater than 3 Wood units -AND- WHO Group -AND- WHO/NYHA Functional Class II or III symptoms (Adcirca, Orenitram, Letairis, Revatio, Opsumit, Uptravi), WHO/NYHA Functional Class II, III, or IV (Tracleer), WHO/NYHA Functional Class III (Orenitram)
Age Restrictions	
Prescriber Restrictions	cardiologist, pulmonologist
Coverage Duration	12 months
Other Criteria	

# radicava

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## Products Affected

- RADICAVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# RAGWITEK

## Products Affected

- RAGWITEK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
<b>Required Medical Information</b>	Documentation of allergic rhinitis and use for ragweed pollen -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
<b>Age Restrictions</b>	Deny if less than 18 years of age or greater than 65 years of age
<b>Prescriber Restrictions</b>	allergy specialist, otolaryngologist, immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Member must also be prescribed an epinephrine auto injector

## **rasuvo**

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### **Products Affected**

- **RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# ravicti

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## Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Urea cycle disorders due to N-acetylglutamatesynthetase deficiency
<b>Required Medical Information</b>	Documentation of chronic management of a urea cycle disorders (UCDs)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	



# relistor

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## Products Affected

- RELISTOR ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of opioid induced constipation due to chronic non-cancer pain -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following 1.)laxatives, 2.)Amitiza, 3.)Movantik.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# remicade

## Products Affected

- REMICADE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
<b>Age Restrictions</b>	For Crohn's disease and ulcerative colitis, deny if less than 6 years old
<b>Prescriber Restrictions</b>	rheumatologist, dermatologist, or gastroenterologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

# renflexis

## Products Affected

- RENFLEXIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe psoriasis after failure of systemic therapy or phototherapy -OR- moderate to severe Crohn's disease after failure of two immunosuppressants -OR- moderate to severe ulcerative colitis after failure of two immunosuppressants
<b>Age Restrictions</b>	For Crohn's disease, deny if less than 6 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required. For Crohn's disease and ulcerative colitis, trial of 2 immunosuppressants (e.g. corticosteroids, azathioprine, 6-mercaptopurine) is required.

# repatha

## Products Affected

- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>1.Homozygous Familial Hypercholesterolemia(HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, OCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or heterozygous familial hypercholesterolemia (HeFH) in both parents AND Repatha will be used with a maximally tolerated statin unless all statins are contraindicated or not tolerated AND Repatha will not be used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2.HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FH(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin. 3. Hypercholesterolemia ASCVD AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal(LDL-C is still greater than or equal to 100mg/dL) AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin.</p>
<b>Age Restrictions</b>	Deny if less than 18 years of age for HeFH and ASCVD or less than 13 years of age for HoFH

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. For HoFH diagnosis, 3 syringes per month will be approved aligned with recommended dosing regimen for this indication.

# repatha pushtronex

## Products Affected

- REPATHA PUSHTRONEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	<p>1.Homozygous Familial Hypercholesterolemia(HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, OCSK9, or LDLRAP1 gene or untreated LDL-C greater than 500mg/dL(or treated LDL-C greater than 300mg/dL) with cutaneous or tendon xanthoma before age 10 yrs or heterozygous familial hypercholesterolemia (HeFH) in both parents AND Repatha will be used with a maximally tolerated statin unless all statins are contraindicated or not tolerated AND Repatha will not be used with lomitapide, mipomersen, or another PCSK9 inhibitor. 2.HeFH supported by presence of causal mutation of FH by genetic testing, physical signs of FH(e.g. xanthomas, xanthelasma), diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or Simon Broome register criteria AND LDL-C greater than or equal to 190mg/dL prior to lipid lowering therapy (greater than or equal to 160mg/dL if age less than 20) or LDL-C greater than or equal to 160mg/dL after treatment with antihyperlipidemic agents but prior to Repatha therapy AND Prior therapy with at least 2 trials of different high-intensity statins(e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin. 3. Hypercholesterolemia ASCVD AND Prior therapy with at least 2 trials of different high-intensity statins (e.g. atorvastatin, rosuvastatin) has not achieved LDL-C goal(LDL-C is still greater than or equal to 100mg/dL) AND must be used with maximally tolerated statin dose OR documentation of statin intolerance as defined by statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different high intensity statin which resolved upon discontinuation of statin.</p>
Age Restrictions	Deny if less than 18 years of age for HeFH and ASCVD or less than 13 years of age for HoFH

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
<b>Coverage Duration</b>	6 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Requests for greater than 1 Pushtonex System per month will not be approved.

# revlimid

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## Products Affected

- REVLIMID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Documentation of severe neutropenia, severe thrombocytopenia, or treatment-related MDS
<b>Required Medical Information</b>	Diagnosis of multiple myeloma -OR- diagnosis of myelodysplastic syndrome (MDS) with 5-q deletion along with documentation of transfusion-dependent anemia or an anemia with documented hemoglobin of less than 10g/dL -OR- diagnosis of mantle cell lymphoma (MCL) in which disease has relapsed or progressed after two prior therapies (e.g. anthracycline, mitoxantrone, cyclophosphamide, rituximab, bortezomib) one of which included bortezomib
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# rubraca

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## Products Affected

- RUBRACA ORAL TABLET 200 MG, 300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis of deleterious BRCA mutated, advanced ovarian cancer -AND- Rubraca will be used as monotherapy -AND- trial and failure of 2 prior chemotherapy regimens
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

## ruconest

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### Products Affected

- RUCONEST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Acute hereditary angioedema (HAE) type I & II: Documentation that clinical laboratory performance C4 below lower limit of laboratory reference range -AND- C1 inhibitor level below lower limit of laboratory reference range -OR- normal C1 inhibitor level and a low C1INH functional level below laboratory reference range -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued. Acute hereditary angioedema (HAE) type III: Documentation that clinical laboratory performance C4, C1 inhibitor level and C1INH functional level are within normal limits of the laboratory's reference range -AND- documentation HAE family history -OR- FXL mutation -AND- documentation of at least 1 symptom of angioedema attack -AND- medications that cause angioedema have been evaluated and discontinued
<b>Age Restrictions</b>	Deny if less than 13 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# rydapt

## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of one of the following (1 or 2) 1)Diagnosis of FLT3 mutation-positive acute myeloid leukemia -AND- confirmation that therapy will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy regimens -OR- 2) Diagnosis of aggressive systemic mastocytosis (ASM) or systemic mastocytosis with associated hematological neoplasm (SM-AHN) or mast cell leukemia (MCL)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# savella

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## Products Affected

- SAVELLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# signifor

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# siliq

## Products Affected

- SILIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	History of or active Crohn's disease
<b>Required Medical Information</b>	Documentation of moderate to severe psoriasis -AND- (1 or 2) 1) Trial/failure or intolerance of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy. 2) Contraindication to all systemic therapies or phototherapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 months initial authorization, 12 months reauthorization
<b>Other Criteria</b>	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation supporting improvement in psoriatic lesions or disease stability is required.

# simponi

## Products Affected

- SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML
- SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Actemra, Kineret, Remicade, Humira, Oencia, Enbrel, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate -OR- psoriatic arthritis -OR- ankylosing spondylitis -OR- moderate to severe ulcerative colitis and an inadequate response to two immunosuppressants or in those patients requiring continuous steroid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Alternatives for Ulcerative Colitis include immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine. Patients must have an adequate trial or intolerance to the preferred product, Humira, for ulcerative colitis and the preferred products, Enbrel and Humira, for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. For ulcerative colitis indication therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

# simponi aria

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## Products Affected

- SIMPONI ARIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Actemra, Kineret, Remicade, Humira, Orencia, Enbrel, Cimzia
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	



# sovaldi

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## Products Affected

- SOVALDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	Doses greater than or less than 400 mg/day will not be approved.

# sprycel

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## Products Affected

- SPRYCEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase PH+ CML).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# stelara

## Products Affected

- STELARA SUBCUTANEOUS  
SYRINGE 45 MG/0.5 ML, 90 MG/ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Enbrel, Remicade, Humira, Simponi
<b>Required Medical Information</b>	Documentation of one of the following (1-3): 1) Moderate to severe plaque psoriasis and failure of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy. 2) Psoriatic arthritis. 3) Crohn's Disease and documentation of trial and failure, intolerance, or contraindication to an immunosuppressant (e.g. corticosteroids, azathioprine, 6-mercaptopurine, methotrexate) and Humira and documentation of clinical remission following IV administration of Stelara. -AND- Documentation of member weight and prescribed dose.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	dermatologist, rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis and the preferred products, Enbrel and Humira, for psoriatic arthritis. Must follow recommended dosing guidelines based upon weight. Psoriasis: For patients weighing less than 100 kilograms (220 pounds), 45 mg dosing will be approved. For patients weighing more than 100 kilograms (220 pounds), 90 mg dosing will be approved. Psoriatic Arthritis: 45 mg dosing will be approved. For patients with co-existent moderate to severe plaque psoriasis weighing greater than 100 kilograms (220 pounds), 90 mg dosing will be approved.

## stelara iv

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### Products Affected

- STELARA INTRAVENOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Enbrel, Remicade, Humira, Simponi
<b>Required Medical Information</b>	Documentation of Crohn's disease -AND- trial and failure, contraindication, or intolerance to at least 2 immunosuppressants (corticosteroids, azathioprine, 6-mercaptopurine, or methotrexate)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses greater than 520 mg single dose IV will not be approved

# stivarga

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## Products Affected

- STIVARGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic colorectal cancer and trial of a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy (i.e. FOLFIRINOX), AND an anti-VEGF therapy (i.e. aflibercept) AND if KRAS wild type, an anti-EGFR therapy (i.e. cetuximab, panitumumab) - OR- documentation of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with both imatinib and sunitinib
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# strensiq

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## Products Affected

- STRENSIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of perinatal/infantile-onset or juvenile-onset hypophosphatasia (HPP)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# sutent

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## Products Affected

- SUTENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis and failure of Gleevec therapy, if applicable
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# sylvant

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## Products Affected

- SYLVANT INTRAVENOUS RECON SOLN 100 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented diagnosis of multicentric Castleman's disease -AND- negative HIV and HHV-8 test -AND- baseline absolute neutrophil count greater than or equal to $1.0 \times 10^9/L$ -AND- baseline platelet count greater than or equal to $75 \times 10^9/L$ -AND- baseline hemoglobin less than 17g/dL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# syndros

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## Products Affected

- SYNDROS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of one of the following (1 or 2): 1) anorexia associated with weight loss in patients with AIDS -and- trial and failure, contraindication, or intolerance to generic dronabinol capsules -OR- 2) nausea and vomiting associated with cancer chemotherapy in adults who have trial and failure, contraindication, or intolerance to a conventional antiemetic treatment (e.g., metoclopramide, promethazine, ondansetron, perphenazine, etc.) -and- trial and failure, contraindication, or intolerance to generic dronabinol capsules
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# tagrisso

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## Products Affected

- TAGRISSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic EGFR T790M mutation-positive NSCLC AND progression on or after EGFR TKI therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# taltz

## Products Affected

- TALTZ AUTOINJECTOR (3 PACK)
- TALTZ SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Enbrel, Remicade, Humira, Simponi, Stelara
<b>Required Medical Information</b>	Documentation of moderate to severe psoriasis and trial/failure or intolerance of one systemic therapy (e.g. methotrexate, cyclosporine) or phototherapy-OR-contraindication to systemic therapies or phototherapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patients must have an adequate trial or intolerance to the preferred product, Humira, for psoriasis. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.

# tasigna

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## Products Affected

- TASIGNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis and failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase PH+ CML).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# tecfidera

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## Products Affected

- **TECFIDERA ORAL  
CAPSULE, DELAYED  
RELEASE(DR/EC) 120 MG, 120 MG  
(14)- 240 MG (46), 240 MG**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use with other disease modifying agents such as interferons, Copaxone , Tysabri, Aubagio, Gilenya
<b>Required Medical Information</b>	Documentation of relapsing form of multiple sclerosis (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses greater than 240 mg twice-daily will not be approved

# technivie

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## Products Affected

- TECHNIVIE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Severe hepatic impairment (Child-Pugh C)
<b>Required Medical Information</b>	Documentation of chronic hepatitis C genotype 4 without cirrhosis AND using with ribavirin unless the member is treatment-naive and has a contraindication or intolerance to ribavirin
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	

## testosterone (androgens)

### Products Affected

- ANDRODERM
- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL IN PACKET
- AVEED
- AXIRON
- DEPO-TESTOSTERONE
- FORTESTA
- METHITEST
- NATESTO
- STRIANT
- TESTIM
- *testosterone cypionate*
- *testosterone enanthate*
- TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram)*
- TESTOSTERONE TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)
- TESTOSTERONE TRANSDERMAL SOLUTION IN METERED PUMP W/APP
- VOGELXO TRANSDERMAL GEL
- VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of primary or secondary hypogonadism in males with testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, radiation or toxic damage -OR- documentation of primary or secondary hypogonadism in males with multiple symptoms of hypogonadism including at least one of the following specific symptoms: height loss due to vertebral fractures, low trauma fractures, low bone density, incomplete or delayed sexual development, breast discomfort, loss of axillar and/or pubic body hair, hot flushes -OR- documentation of HIV infection in men with weight loss -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range. Additional approvable indications include vulvar dystrophies in women (topical ointment only) - AND- palliative treatment in female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Age Restrictions</b>	Deny if less than recommended age per FDA product labeling
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	



# thalamid

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## Products Affected

- THALOMID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of multiple myeloma -OR- documentation for use in the treatment or prophylaxis of cutaneous manifestations of moderate to severe erythema nodosum leprosum
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

## thrombopoiesis stimulating agents

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### Products Affected

- PROMACTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis of chronic immune idiopathic thrombocytopenia purpura and trial and failure of corticosteroid or immunoglobulin therapy or splenectomy -OR- documentation of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy (eltrombopag only)-OR- severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Platelet count to be provided

# tigan

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## Products Affected

- *trimethobenzamide oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## transmucosal fentanyl citrate

### Products Affected

- **ABSTRAL SUBLINGUAL TABLET 100 MCG, 200 MCG, 300 MCG, 400 MCG, 600 MCG, 800 MCG**
- **ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- *fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg*
- **FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 300 MCG/SPRAY, 400 MCG/SPRAY**
- **SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	documentation of therapeutic use and long acting opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

# tykerb

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## Products Affected

- **TYKERB**

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Tykerb in combination with Xeloda (capecitabine) for patients with advanced, metastatic breast cancer that is HER2 positive who have received prior therapy, including a taxane, an anthracycline and trastuzumab (Herceptin) -OR- documentation of Tykerb in combination with Femara (letrozole) for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that over expresses the HER2 receptor for whom hormonal therapy is indicated
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# tymlos

## Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Diagnosis of underlying hypercalcemic disorder such as hypercalcemia, hyperparathyroidism or hypoparathyroidism, or high risk for osteosarcoma (Paget's disease, prior radiation therapy, bone metastases, open epiphyses, etc.). Treatment duration greater than 24 months.
<b>Required Medical Information</b>	Documentation to support use for treatment of osteoporosis and the prevention of fractures for patients meeting the following criteria (1 AND 2, 3, or 4) 1) documentation of trial, failure, or contraindication to at least one bisphosphonate -AND- 2) diagnosis of osteoporosis in postmenopausal women with a t-score of -2.5 or less-OR- 3) documentation of osteopenia with a t-score between -1 and -2.5 and a history of previous osteoporotic fracture or glucocorticoid use for at least 3 months at a dose of 5mg per day of prednisone (or equivalent) -OR- 4) documentation of a 10-year risk of major osteoporotic fracture greater than or equal to 20 percent or a risk of hip fracture greater than or equal to 3 percent
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 months
<b>Other Criteria</b>	Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos or Forteo will be limited to a coverage duration of 24 months.

# VALCHLOR

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## Products Affected

- VALCHLOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have limited localized or generalized skin involvement who received at least one prior skin directed therapy -OR- documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma who have limited localized or generalized skin involvement and mechlorethamine gel will be used in combination with other skin directed therapies. Skin directed therapies may include but are not limited to topical corticosteroids, topical chemotherapy, local radiation and topical retinoids.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# veltassa

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## Products Affected

- VELTASSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 6.4 mmol/L on at least two (2) screenings -AND- modification of medications to reduce serum potassium levels, when applicable -AND- trial and failure, intolerance, or contraindication to sodium polystyrene sulfonate
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	For reauthorization, documentation of reduction in serum potassium levels following Veltassa administration is required.



# venclexta

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## Products Affected

• VENCLEXTA

• VENCLEXTA STARTING PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of chronic lymphocytic leukemia (CLL) with 17p deletion -AND- previous treatment with at least one prior therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# viberzi

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## Products Affected

- VIBERZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Severe (Child-Pugh C) hepatic impairment
<b>Required Medical Information</b>	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- no alcohol abuse in the previous six months.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# VIEKIRA PAK

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## Products Affected

- VIEKIRA PAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Severe (Child-Pugh C) hepatic impairment
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12wk: gt 1a noncirr -OR- gt 1b. 24wk: gt1a cirr -OR- gt 1 in allograft
<b>Other Criteria</b>	Doses greater than four tablets per day will not be approved.

# VIEKIRA XR

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## Products Affected

- VIEKIRA XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Severe (Child-Pugh C) hepatic impairment
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12wk: gt 1a noncirr -OR- gt 1b. 24wk: gt1a cirr -OR- gt 1 in allograft
<b>Other Criteria</b>	Doses greater than three tablets per day will not be approved.

# viibryd

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## Products Affected

- TRINTELLIX
- VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis major depressive disorder and trial and failure of any two antidepressants
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

## **vimovo**

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### **Products Affected**

- VIMOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of diagnosis (e.g., osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis in adults or juvenile idiopathic arthritis in adolescent patients) -AND- Both of the following. 1) Trial/failure of naproxen used in combination with omeprazole. 2) Trial/failure of one additional generic formulary NSAID (other than naproxen) used in combination with another generic formulary PPI (other than omeprazole).
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## vosevi

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### Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Criteria/duration applied consistent with current AASLD-IDSA guidance
<b>Other Criteria</b>	Doses greater than one tablet per day will not be approved.

# votrient

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## Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis (renal cell carcinoma) -OR- documentation of advanced soft- tissue sarcoma excluding adipocytic soft tissue sarcoma or gastrointestinal stromal tumors after failure of at least one prior chemotherapy regimen
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only





## vyxeos

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### Products Affected

- VYXEOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of newly-diagnosed therapy-related acute myeloid leukemia (t-AML) -OR- documentation of myelodysplasia-related changes (AML-MRC)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# xalkori

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## Products Affected

- XALKORI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# xeljanz

## Products Affected

• XELJANZ

• XELJANZ XR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orenzia, Stelara, Actemra, azathioprine, cyclosporine
<b>Required Medical Information</b>	Documentation of moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved. Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

## xenazine

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### Products Affected

• *tetrabenazine*

• XENAZINE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	documentation of diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patients with comorbid depression should be on an antidepressant medication.

# xermelo

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## Products Affected

- XERMELO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of carcinoid syndrome diarrhea AND used in combination with a somatostatin analog AND trial and failure of somatostatin analog monotherapy
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# xifaxan

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## Products Affected

- XIFAXAN ORAL TABLET 550 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of 1 or 2. 1) Diagnosis of hepatic encephalopathy AND trial/failure, intolerance, or contraindication to lactulose. 2) Diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D) AND trial/failure, intolerance to two of the following medications for IBS-D or documentation of contraindication to all: loperamide, cholestyramine, Colestipol, dicyclomine, tricyclic antidepressants, selective serotonin reuptake inhibitors.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Hepatic encephalopathy: 1 year. IBS-D: 14 days.
<b>Other Criteria</b>	No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime.

# xtandi

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## Products Affected

- XTANDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic castration-resistant prostate cancer
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



## xyrem

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### Products Affected

- XYREM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of excessive daytime sleepiness in patients with a diagnosis of narcolepsy as documented by MSLT less than 10 min or other appropriate testing -OR- documentation of cataplexy associated with narcolepsy as documented by MSLT or other appropriate testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# yosprala

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## Products Affected

- YOSPRALA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation supporting requirement of secondary prevention of cardiovascular and cerebrovascular events -AND- one of the following (1 or 2): 1. risk of developing aspirin associated gastric ulcers due to age being 55. 2. risk of developing aspirin associated gastric ulcers due to a history of gastric ulcers. -AND- both of the following (3 and 4): 3. trial and failure of aspirin plus omeprazole taken concomitantly. 4. trial and failure of aspirin plus pantoprazole taken concomitantly.
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

# zejula

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## Products Affected

- ZEJULA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with a complete or partial response to platinum-based chemotherapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# zelboraf

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## Products Affected

• TAFINLAR

• ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Wild-type BRAF melanoma
<b>Required Medical Information</b>	Documentation of unresectable or metastatic melanoma with BRAFV600E mutation-OR-unresectable or metastatic melanoma with BRAF V600E or V600K mutations in combination with trametinib (Mekinist) -OR- documentation of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation in use of dabrafenib (Tafinlar) in combination with trametinib (Mekinist)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# zepatier

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## Products Affected

- ZEPATIER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Severe (Child-Pugh C) hepatic impairment
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guidance
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12wk:gt1a without NS5A-OR-gt1b-OR-gt4 tx naive. 16wk:gt1a with NS5A-OR-gt4 tx exp.
<b>Other Criteria</b>	

# zinbryta

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## Products Affected

- ZINBRYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of relapsing forms of multiple sclerosis (relapsing-remitting, relapsing secondary progressive, or progressive relapsing multiple sclerosis) -AND- trial and failure, contraindication, or intolerance to two alternative treatments for MS (interferon, Copaxone, Tecfidera, Gilenya, Tysabri, etc.)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauthorization or continuation of therapy will be approved when documentation of disease stability or improvement is provided

# zinplava

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## Products Affected

- ZINPLAVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of high risk for Clostridium Difficile (C.diff) infection defined as meeting one or more of the following criteria: 1. 65 yo or older. 2. receipt one or more systemic antibacterial therapy in the past 3 months prior to current active C.diff infection. 3. one or more episodes of C. Diff within the six months prior to current active infection. 4. immunocompromised state. 5. clinically severe C.diff or C.diff ribotype 027 upon presentation. -AND- Zinplava is being used for the prevention of C.diff recurrence with standard of care antibacterial drugs such as metronidazole, vancomycin, or fidaxomyin
<b>Age Restrictions</b>	Deny if less than 18 years of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	Zinplava will only be approved for one dose per active Clostridium Difficile infection. Zinplava will not be approved for repeat doses for recurrence of the same active infection.

# zolinza

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## Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	oncologist, hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



# ZYDELIG

## Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of relapsed chronic lymphocytic leukemia (CLL) and use in combination with rituximab in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities -OR- documentation of relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies (e.g. alkylating agents, single or multi-drug chemotherapy, target immunotherapy) -OR- documentation of relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies (e.g. alkylating agents, single or multi-drug chemotherapy, target immunotherapy)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

# zykadia

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## Products Affected

- ZYKADIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only

# zytiga

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## Products Affected

- ZYTIGA ORAL TABLET 250 MG, 500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of metastatic castration resistant prostate cancer and concurrent use with prednisone
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to new starts only



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