

2017 Incentive Formularies:

This Incentive Formulary applies to members of an employer/retiree, union, or trust fund health plan

For Medicare Part D: 5 Tier Incentive Formulary

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

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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.

*****: We provide additional coverage of this prescription drug in the coverage gap. The plans that have additional coverage in the coverage gap are Freedom Blue PPO Classic, Freedom Blue PPO Deluxe, Security Blue HMO Deluxe, Community Blue Medicare HMO Prestige, and Blue RX PDP Complete. Please refer to your Evidence of Coverage for more information about this coverage.

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

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

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
<i>abacavir oral tablet</i>	T2	
ABACAVIR-LAMIVUDINE	T5	
<i>abacavir-lamivudine-zidovudine</i>	T2	
ABELCET	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	
ALBENZA	T4	
ALINIA	T4	
<i>amantadine hcl</i>	T2	
AMBISOME	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	
ANCOBON	T4	
APTIVUS	T5	
<i>atovaquone</i>	T5	
<i>atovaquone-proguanil</i>	T2	
ATRIPLA	T5	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	T4	
AVELOX	T4	
AVELOX IN NACL (ISO-OSMOTIC)	T3	
AVYCAZ	T5	
AZACTAM IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 1 GRAM/50 ML	T4	

Drug Name	Drug Tier	Requirements/Limits
AZACTAM IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2 GRAM/50 ML	T3	
<i>azithromycin</i>	T2	
<i>aztreonam injection recon soln 1 gram</i>	T2	
<i>baciim</i>	T2	
<i>bacitracin intramuscular</i>	T2	
BACTRIM	T4	
BACTRIM DS	T4	
BARACLUDGE ORAL SOLUTION	T3	
BARACLUDGE ORAL TABLET	T5	
BETHKIS	T4	PA
BICILLIN C-R	T3	
BICILLIN L-A	T3	
BILTRICIDE	T3	
CANCIDAS	T4	
CAPASTAT	T4	
CASPOFUNGIN	T4	
CAYSTON	T5	
CEDAX	T4	
<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	

Drug Name	Drug Tier	Requirements/Limits
CEFTIN ORAL SUSPENSION FOR RECONSTITUTION	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	
<i>chloramphenicol sod succinate</i>	T2	
<i>chloroquine phosphate</i>	T2	
<i>cidofovir</i>	T2	
CIPRO IN D5W INTRAVENOUS PIGGYBACK 400 MG/200 ML	T4	
CIPRO ORAL SUSPENSION, MICROCAPSULE RECON	T3	
CIPRO ORAL TABLET 250 MG, 500 MG	T4	
<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	
CLEOCIN HCL ORAL CAPSULE 150 MG, 300 MG	T4	
CLEOCIN HCL ORAL CAPSULE 75 MG	T3	
CLEOCIN IN 5 % DEXTROSE	T4	
CLEOCIN INJECTION	T4	
CLEOCIN PEDIATRIC	T4	
<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	
COARTEM	T4	
<i>colistin (colistimethate na)</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
COMBIVIR	T5	
COMPLERA	T5	
COPEGUS	T4	
CRESEMBA	T5	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	T3	
CUBICIN	T5	
CYTOVENE	T4	PA-BvD
DAKLINZA	T5	PA; QL (28 EA per 28 days)
DALVANCE	T5	
DAPSONE ORAL	T3	
DAPTOMYCIN	T5	
DARAPRIM	T3	
<i>demeclocycline</i>	T2	
DESCOVY	T5	QL (31 EA per 31 days)
<i>dicloxacillin</i>	T2	
<i>didanosine</i>	T2	
DIFICID	T5	QL (20 EA per 10 days)
DIFLUCAN	T4	
DORIBAX INTRAVENOUS RECON SOLN 500 MG	T4	
DORYX MPC	T4	
DORYX ORAL TABLET,DELAYED RELEASE (DR/EC) 200 MG, 50 MG	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	
E.E.S. GRANULES	T4	
EDURANT	T4	
EMTRIVA	T3	

Drug Name	Drug Tier	Requirements/Limits
EMVERM	T4	
<i>entecavir</i>	T5	
EPCLUSA	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T3	
EPIVIR HBV ORAL TABLET	T4	
EPIVIR ORAL SOLUTION	T3	
EPIVIR ORAL TABLET	T4	
EPZICOM	T5	
ERAXIS(WATER DILUENT)	T4	
ERYPED 200	T4	
ERYPED 400	T4	
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	T2	
ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG	T3	
<i>erythrocin (as stearate) oral tablet 250 mg</i>	T2	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	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	
<i>erythromycin oral tablet</i>	T2	
<i>ethambutol</i>	T2	
EVOTAZ	T3	
<i>famciclovir</i>	T2	
FLAGYL	T4	
<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	
FLUMADINE ORAL TABLET	T4	
FURADANTIN	T4	
FUZEON SUBCUTANEOUS RECON SOLN	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	
GENVOYA	T5	

Drug Name	Drug Tier	Requirements/Limits
<i>griseofulvin microsize</i>	T2	
<i>griseofulvin ultramicrosize</i>	T2	
GRIS-PEG (ULTRAMICROSIZE)	T4	
HARVONI	T5	PA; QL (28 EA per 28 days)
HEPSERA	T5	
HIPREX	T4	
<i>hydroxychloroquine</i>	T2	
<i>imipenem-cilastatin</i>	T2	
INTELENCE ORAL TABLET 100 MG, 200 MG	T5	
INTELENCE ORAL TABLET 25 MG	T4	
INVANZ INJECTION	T4	
INVIRASE ORAL CAPSULE	T4	
INVIRASE ORAL TABLET	T5	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T4	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	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	
KALETRA ORAL SOLUTION	T5	
KALETRA ORAL TABLET 100-25 MG	T3	
KALETRA ORAL TABLET 200-50 MG	T5	
<i>ketoconazole oral</i>	T2	
LAMISIL ORAL TABLET	T4	QL (90 EA per 180 days)
<i>lamivudine</i>	T2	
<i>lamivudine-zidovudine</i>	T2	
LEVAQUIN ORAL TABLET	T4	
<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	
LEXIVA ORAL SUSPENSION	T3	

Drug Name	Drug Tier	Requirements/Limits
LEXIVA ORAL TABLET	T5	
LINCOCIN	T4	
<i>lincomycin</i>	T2	
<i>linezolid intravenous</i>	T4	
<i>linezolid oral</i>	T5	
LOPINA VIR-RITONAVIR	T5	
MACROBID	T4	
MACRODANTIN	T4	
MALARONE	T4	
MALARONE PEDIATRIC	T4	
MAVYRET	T5	PA; QL (84 EA per 28 days)
MAXIPIME INJECTION	T4	
<i>mefloquine</i>	T2	
MEPRON	T5	
<i>meropenem</i>	T2	
MERREM INTRAVENOUS RECON SOLN 500 MG	T4	
<i>methenamine hippurate</i>	T2	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral</i>	T1	
MINOCIN ORAL CAPSULE 100 MG, 50 MG	T4	
<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	
MONUROL	T4	
<i>morgidox oral capsule 50 mg</i>	T3	
<i>moxifloxacin oral</i>	T3	
MOXIFLOXACIN-SOD.ACE,SUL-WATER	T4	
MYAMBUTOL ORAL TABLET 400 MG	T4	
MYCAMINE	T4	
MYCOBUTIN	T3	
<i>nafcillin injection recon soln 1 gram, 10 gram</i>	T2	
NEBUPENT	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)

Drug Name	Drug Tier	Requirements/Limits
<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)
NORVIR	T3	
NOXAFIL ORAL SUSPENSION	T5	
NOXAFIL ORAL TABLET,DELAYED RELEASE (DR/EC)	T4	
<i>nystatin oral suspension</i>	T2	
<i>nystatin oral tablet</i>	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T2	
OLYSIO	T5	PA; QL (28 EA per 28 days)
ONMEL	T4	
ORACEA	T4	
ORAVIG	T4	
ORBACTIV	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	
PASER	T4	
PCE	T4	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	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	
PENTAM	T4	
<i>piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram, 40.5 gram</i>	T2	
PLAQUENIL	T4	
<i>polymyxin b sulfate</i>	T2	
PREZCOBIX	T3	
PREZISTA ORAL SUSPENSION	T3	
PREZISTA ORAL TABLET 150 MG, 75 MG	T3	
PREZISTA ORAL TABLET 600 MG, 800 MG	T5	
PRIFTIN	T4	

Drug Name	Drug Tier	Requirements/Limits
PRIMAQUINE	T3	
PRIMAXIN IV	T4	
PRIMSOL	T4	
<i>pyrazinamide</i>	T2	
QUALAQUIN	T4	
<i>quinine sulfate</i>	T2	
REBETOL ORAL SOLUTION	T4	
RELENZA DISKHALER	T3	
RESCRIPTOR	T3	
RETROVIR INTRAVENOUS	T3	
RETROVIR ORAL CAPSULE	T4	
RETROVIR ORAL SYRUP	T4	
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	T3	
REYATAZ ORAL POWDER IN PACKET	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	
RIFADIN ORAL CAPSULE 150 MG	T4	
RIFAMATE	T4	
<i>rifampin</i>	T2	
RIFATER	T4	
<i>rimantadine</i>	T2	
SELZENTRY ORAL TABLET	T5	
SIRTURO	T5	
SIVEXTRO INTRAVENOUS	T5	
SIVEXTRO ORAL	T5	QL (6 EA per 31 days)
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	T4	
SOVALDI	T5	PA; QL (28 EA per 28 days)
SPORANOX ORAL CAPSULE	T4	

Drug Name	Drug Tier	Requirements/Limits
SPORANOX ORAL SOLUTION	T3	
<i>stavudine oral capsule</i>	T2	
STREPTOMYCIN	T3	
STRIBILD	T5	
STROMEKTOL	T4	
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole-trimethoprim</i>	T1	
SUPRAX ORAL CAPSULE	T3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION	T3	
SUPRAX ORAL TABLET,CHEWABLE	T3	
SUSTIVA	T3	
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML	T5	
SYNERCID	T4	
TAMIFLU	T3	
TARGADOX	T4	
TAZICEF INJECTION	T4	
TECHNIVIE	T5	PA; QL (56 EA per 28 days)
TEFLARO	T4	
<i>terbinafine hcl oral</i>	T1	QL (90 EA per 180 days)
<i>tetracycline</i>	T2	
TIGECYCLINE	T5	
TINDAMAX ORAL TABLET 500 MG	T4	
<i>tinidazole</i>	T2	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TOBI	T4	PA
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T3	PA
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T1	
TRECATOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRIZIVIR	T4	
TRUVADA	T5	
TYBOST	T3	
TYGACIL	T5	

Drug Name	Drug Tier	Requirements/Limits
UNASYN INJECTION RECON SOLN 15 GRAM, 3 GRAM	T4	
<i>valacyclovir</i>	T2	
VALCYTE ORAL RECON SOLN	T4	
VALCYTE ORAL TABLET	T5	
VALGANCICLOVIR ORAL RECON SOLN	T4	
<i>valganciclovir oral tablet</i>	T5	
VALTREX	T4	
VANCOCIN	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	
VEMLIDY	T5	QL (31 EA per 31 days)
VFEND	T5	
VFEND IV	T4	
VIBATIV INTRAVENOUS RECON SOLN 750 MG	T4	
VIBRAMYCIN ORAL CAPSULE 100 MG	T4	
VIBRAMYCIN ORAL SUSPENSION FOR RECONSTITUTION	T4	
VIBRAMYCIN ORAL SYRUP	T4	
VIDEX 2 GRAM PEDIATRIC	T3	
VIDEX EC	T4	
VIEKIRA PAK	T5	PA; QL (112 EA per 28 days)
VIEKIRA XR	T5	PA; QL (84 EA per 28 days)
VIRACEPT ORAL TABLET	T5	
VIRAMUNE	T4	
VIRAMUNE XR	T4	
VIREAD	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	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T4	QL (9 EA per 3 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
ZEPATIER	T5	PA; QL (28 EA per 28 days)
ZERBAXA	T4	

Drug Name	Drug Tier	Requirements/Limits
ZERIT	T4	
ZIAGEN ORAL SOLUTION	T3	
ZIAGEN ORAL TABLET	T4	
<i>zidovudine</i>	T2	
ZITHROMAX	T4	
ZITHROMAX TRI-PAK	T4	
ZITHROMAX Z-PAK	T4	
ZMAX	T4	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML, 3.375 GRAM/50 ML	T3	
ZOSYN INTRAVENOUS RECON SOLN 40.5 GRAM	T4	
ZOVIRAX ORAL CAPSULE	T4	
ZOVIRAX ORAL SUSPENSION	T4	
ZOVIRAX ORAL TABLET 800 MG	T4	
ZYVOX INTRAVENOUS PARENTERAL SOLUTION 600 MG/300 ML	T5	
ZYVOX ORAL	T5	
Antineoplastic / Immunosuppressant Drugs		
ABRAXANE	T4	
ADRIAMYCIN INTRAVENOUS SOLUTION 20 MG/10 ML	T4	PA-BvD
<i>adrucil intravenous solution 500 mg/10 ml</i>	T2	PA-BvD
AFINITOR	T5	PA-NS; QL (31 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALIMTA INTRAVENOUS RECON SOLN 500 MG	T3	
ALKERAN INTRAVENOUS	T4	
ALUNBRIG	T5	PA-NS; QL (186 EA per 31 days)
<i>anastrozole</i>	T2	
ARIMIDEX	T4	
AROMASIN	T4	
ARRANON	T4	
ASTAGRAF XL	T3	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
AVASTIN	T5	
<i>azacitidine</i>	T5	
AZASAN	T4	PA-BvD
<i>azathioprine</i>	T2	PA-BvD
<i>azathioprine sodium</i>	T3	PA-BvD
BAVENCIO	T5	PA-NS
BELEODAQ	T5	PA-NS
<i>bexarotene</i>	T5	
<i>bicalutamide</i>	T2	
BICNU	T4	
<i>bleomycin injection recon soln 30 unit</i>	T2	PA-BvD
BOSULIF	T5	PA-NS
<i>busulfan</i>	T4	
BUSULFEX	T4	
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CAMPTOSAR INTRAVENOUS SOLUTION 100 MG/5 ML	T4	
CAPRELSA	T5	PA-NS
<i>carboplatin intravenous solution</i>	T2	
CASODEX	T4	
CELLCEPT INTRAVENOUS	T4	PA-BvD
CELLCEPT ORAL CAPSULE	T4	PA-BvD
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	T4	PA-BvD
CELLCEPT ORAL TABLET	T5	PA-BvD
<i>cisplatin</i>	T2	
<i>cladribine</i>	T2	PA-BvD
<i>clofarabine</i>	T4	
CLOLAR	T4	
COMETRIQ	T5	PA-NS
COSMEGEN	T4	
COTELLIC	T5	PA-NS
CYCLOPHOSPHAMIDE ORAL CAPSULE	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
CYRAMZA	T5	
<i>cytarabine</i>	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
<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	
DACOGEN	T5	
DARZALEX	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	
DOXIL	T4	
<i>doxorubicin intravenous solution 50 mg/25 ml</i>	T2	PA-BvD
<i>doxorubicin, peg-liposomal</i>	T2	PA-BvD
DROXIA	T4	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
ELITEK	T5	
ELLENCEN INTRAVENOUS SOLUTION 200 MG/100 ML	T4	
EMCYT	T3	
EMPLICITI	T5	PA-BvD
ENVARUSUS XR	T4	PA-BvD
EPIRUBICIN INTRAVENOUS SOLUTION 200 MG/100 ML	T4	
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML	T3	
ERIVEDGE	T5	PA-NS
ERWINAZE	T5	
ETOPOPHOS	T4	
<i>etoposide intravenous</i>	T2	
<i>exemestane</i>	T2	
FARESTON	T3	
FARYDAK	T5	PA-NS
FASLODEX	T5	
FEMARA	T4	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	

Drug Name	Drug Tier	Requirements/Limits
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	
<i>fludarabine intravenous recon soln</i>	T2	
<i>fluorouracil intravenous solution 2.5 gram/50 ml</i>	T2	PA-BvD
<i>flutamide</i>	T2	
FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	T5	
FUSILEV	T4	
<i>gemcitabine intravenous recon soln 1 gram</i>	T2	
GEMZAR INTRAVENOUS RECON SOLN 1 GRAM	T4	
<i>gengraf</i>	T2	PA-BvD
GILOTRIF	T5	PA-NS
GLEEVEC ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
GLEEVEC ORAL TABLET 400 MG	T5	PA-NS; QL (62 EA per 31 days)
GLEOSTINE	T4	
HALAVEN	T5	
HERCEPTIN INTRAVENOUS RECON SOLN 440 MG	T5	
HEXALEN	T3	
HYCAMTIN INTRAVENOUS	T4	
HYDREA	T4	
<i>hydroxyurea</i>	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NS
IDAMYCIN PFS	T4	
<i>idarubicin</i>	T2	
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
IFEX INTRAVENOUS RECON SOLN 1 GRAM	T4	
<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)
IMBRUVICA	T5	PA-NS; QL (124 EA per 31 days)
IMFINZI	T5	PA-NS
IMURAN	T4	PA-BvD
INLYTA	T5	PA-NS
IRESSA	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
<i>irinotecan intravenous solution 100 mg/5 ml</i>	T2	
ISTODAX	T5	
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
JEVTANA	T5	
KADCYLA INTRAVENOUS RECON SOLN 100 MG	T5	
KEPIVANCE	T5	
KEYTRUDA	T5	PA-NS
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
KYPROLIS	T5	
LARTRUVO	T5	
LENVIMA	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	
LEUKERAN	T3	
<i>leuprolide subcutaneous kit</i>	T2	
<i>levoleucovorin intravenous recon soln 50 mg</i>	T4	
<i>levoleucovorin intravenous solution</i>	T4	
LONSURF	T5	PA-NS
LUPRON DEPOT (3 MONTH)	T5	
LUPRON DEPOT (4 MONTH)	T5	
LUPRON DEPOT (6 MONTH)	T5	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	T3	
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	T5	
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	T5	

Drug Name	Drug Tier	Requirements/Limits
LYNPARZA ORAL CAPSULE	T5	PA-NS
LYNPARZA ORAL TABLET	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
MEGACE ES	T4	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	T2	
<i>megestrol oral tablet</i>	T2	
MEKINIST	T5	PA-NS
<i>melphalan hcl</i>	T5	
<i>mercaptopurine</i>	T2	
<i>mesna</i>	T2	
MESNEX INTRAVENOUS	T4	
MESNEX ORAL	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	
MUSTARGEN	T4	
<i>mycophenolate mofetil</i>	T2	PA-BvD
<i>mycophenolate mofetil hcl</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T2	PA-BvD
MYFORTIC	T3	PA-BvD
NEORAL	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
NEXAVAR	T5	PA-NS
NILANDRON	T5	
<i>nilutamide</i>	T5	
NINLARO	T5	PA-NS
NIPENT	T4	
NULOJIX	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	
ODOMZO	T5	PA-NS

Drug Name	Drug Tier	Requirements/Limits
OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML	T5	PA-NS
<i>oxaliplatin intravenous solution 100 mg/20 ml</i>	T4	
<i>paclitaxel</i>	T2	
PERJETA	T5	
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF INTRAVENOUS	T3	PA-BvD
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG	T4	PA-BvD
PROGRAF ORAL CAPSULE 5 MG	T5	PA-BvD
PURIXAN	T4	
RAPAMUNE ORAL SOLUTION	T3	PA-BvD
RAPAMUNE ORAL TABLET 0.5 MG	T4	PA-BvD
RAPAMUNE ORAL TABLET 1 MG, 2 MG	T5	PA-BvD
REVLIMID	T5	PA-NS; QL (21 EA per 28 days)
RITUXAN	T5	
RUBRACA ORAL TABLET 200 MG, 300 MG	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE	T3	PA-BvD
SANDOSTATIN INJECTION SOLUTION 1,000 MCG/ML, 100 MCG/ML, 200 MCG/ML	T5	
SANDOSTATIN INJECTION SOLUTION 50 MCG/ML, 500 MCG/ML	T4	
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON	T5	
SIGNIFOR	T5	PA
SIGNIFOR LAR	T5	
SIMULECT INTRAVENOUS RECON SOLN 20 MG	T4	PA-BvD
<i>sirolimus</i>	T2	PA-BvD
SOLTAMOX	T4	
SOMATULINE DEPOT	T5	
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS
SUTENT	T5	PA-NS
SYLVANT INTRAVENOUS RECON SOLN 100 MG	T5	PA-NS
SYNRIBO	T5	
TABLOID	T3	
<i>tacrolimus oral capsule 0.5 mg, 1 mg</i>	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
<i>tacrolimus oral capsule 5 mg</i>	T5	PA-BvD
TAFINLAR	T5	PA-NS
TAGRISO	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
TARCEVA	T5	PA-NS; QL (31 EA per 31 days)
TARGRETIN	T5	
TASIGNA	T5	PA-NS
TAXOTERE INTRAVENOUS SOLUTION 80 MG/4 ML (20 MG/ML)	T4	
TECENTRIQ	T5	
THALOMID	T5	PA-NS
<i>thiotepa</i>	T5	
<i>toposar</i>	T2	
<i>topotecan intravenous recon soln</i>	T2	
TORISEL	T5	
TREANDA INTRAVENOUS RECON SOLN 100 MG	T4	
TRELSTAR INTRAMUSCULAR SYRINGE	T3	
<i>tretinoin (chemotherapy)</i>	T2	
TREXALL	T3	PA-BvD
TRISENOX	T4	
TYKERB	T5	PA-NS
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)	T4	
VELCADE	T5	
VENCLEXTA ORAL TABLET 10 MG, 50 MG	T4	PA-NS
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS
VENCLEXTA STARTING PACK	T5	PA-NS
VIDAZA	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	
VOTRIENT	T5	PA-NS
VYXEOS	T5	PA-NS
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XATMEP	T4	
XERMELO	T5	PA; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
XGEVA	T5	
XTANDI	T5	PA-NS; QL (124 EA per 31 days)
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	T5	
YONDELIS	T5	
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	T5	
ZANOSAR	T4	
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 250 MG	T4	
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 0.25 MG	T4	PA-BvD
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG	T5	PA-BvD
ZYDELIG	T5	PA-NS
ZYKADIA	T5	PA-NS
ZYTIGA ORAL TABLET 250 MG	T5	PA-NS; QL (124 EA per 31 days)
ZYTIGA ORAL TABLET 500 MG	T5	PA-NS; QL (62 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG	T5	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING	T5	
ABILIFY ORAL TABLET 10 MG, 20 MG, 30 MG	T5	PA-NS
ABILIFY ORAL TABLET 15 MG, 2 MG, 5 MG	T4	PA-NS
ABSTRAL SUBLINGUAL TABLET 100 MCG	T4	PA; QL (124 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 200 MCG, 300 MCG	T5	PA; QL (124 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 400 MCG	T5	PA; QL (119 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 600 MCG	T5	PA; QL (79 EA per 31 days)
ABSTRAL SUBLINGUAL TABLET 800 MCG	T5	PA; QL (60 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<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)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG	T5	PA; QL (40 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,600 MCG	T5	PA; QL (30 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 200 MCG	T5	PA; QL (124 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 400 MCG	T5	PA; QL (119 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 600 MCG	T5	PA; QL (79 EA per 31 days)
ACTIQ BUCCAL LOZENGE ON A HANDLE 800 MCG	T5	PA; QL (59 EA per 31 days)
ADDERALL ORAL TABLET 20 MG, 5 MG, 7.5 MG	T4	
ADDERALL XR	T4	
ADZENYS XR-ODT	T4	
ALLZITAL	T4	QL (372 EA per 31 days)
<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)
AMBIEN	T4	
AMBIEN CR	T4	
AMERGE ORAL TABLET 1 MG	T4	QL (20 EA per 31 days)
AMERGE ORAL TABLET 2.5 MG	T4	QL (8 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amitriptyline-chlordiazepoxide</i>	T2	PA-NS
<i>amoxapine</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
AMPYRA	T5	PA; QL (62 EA per 31 days)
AMRIX	T4	
ANAFRANIL	T4	
ANAPROX DS	T4	
APLENZIN	T4	
APOKYN	T5	
APTENSIO XR	T4	
APTIOM	T4	
ARICEPT	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
ARISTADA	T4	
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
ARTHROTEC 50	T4	
ARTHROTEC 75	T4	
<i>ascomp with codeine</i>	T2	PA; QL (372 EA per 31 days)
ATIVAN ORAL	T4	
ATOMOXETINE	T4	PA
AUBAGIO	T5	PA; QL (31 EA per 31 days)
AUSTEDO ORAL TABLET 12 MG, 6 MG	T5	PA; QL (124 EA per 31 days)
AUSTEDO ORAL TABLET 9 MG	T5	PA; QL (155 EA per 31 days)
AXERT ORAL TABLET 12.5 MG	T4	QL (8 EA per 31 days)
AXERT ORAL TABLET 6.25 MG	T4	QL (16 EA per 31 days)
AZILECT	T3	
<i>baclofen oral tablet 10 mg</i>	T1	
<i>baclofen oral tablet 20 mg</i>	T2	
BANZEL ORAL SUSPENSION	T4	
BANZEL ORAL TABLET 200 MG	T4	
BANZEL ORAL TABLET 400 MG	T5	
BELBUCA	T4	PA; QL (62 EA per 31 days)
BELSOMRA	T4	
<i>benztropine</i>	T2	
BRISDELLE	T4	
BRIVIACT	T4	
<i>bromocriptine</i>	T2	
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	T4	QL (62 EA per 31 days)
BUPAP ORAL TABLET 50-300 MG	T4	QL (403 EA per 31 days)
BUPRENEX	T4	QL (267 ML per 30 days)
BUPRENORPHINE	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>bupirone oral tablet 10 mg, 15 mg, 5 mg</i>	T1	
<i>bupirone 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	
BUTISOL ORAL TABLET 30 MG	T4	
<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)
BUTRANS	T4	PA; QL (4 EA per 28 days)
CAFERGOT	T4	
CAMBIA	T4	
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<i>carbamazepine oral tablet</i>	T1	
<i>carbamazepine oral tablet extended release 12 hr</i>	T2	
<i>carbamazepine oral tablet, chewable</i>	T1	
CARBATROL	T4	
<i>carbidopa</i>	T2	
<i>carbidopa-levodopa</i>	T2	
<i>carbidopa-levodopa-entacapone</i>	T2	
<i>carisoprodol</i>	T2	
<i>carisoprodol-asa-codeine</i>	T2	PA; QL (2582 EA per 31 days)
<i>carisoprodol-aspirin</i>	T2	
CELEBREX	T4	
<i>celecoxib</i>	T2	
CELEXA ORAL TABLET	T4	
CELONTIN ORAL CAPSULE 300 MG	T3	
CEREBYX INJECTION SOLUTION 500 MG PE/10 ML	T4	
<i>chlordiazepoxide hcl</i>	T2	
<i>chlorpromazine</i>	T2	
<i>chlorzoxazone oral tablet 500 mg</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	
CLOZAPINE ORAL TABLET, DISINTEGRATING 150 MG, 200 MG	T4	
CLOZARIL	T4	
<i>codeine sulfate oral tablet</i>	T2	PA; QL (186 EA per 31 days)
COGENTIN	T4	
COMTAN	T4	
CONCERTA	T4	
CONZIP	T4	QL (30 EA per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)

Drug Name	Drug Tier	Requirements/Limits
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet</i>	T2	PA
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG, 60 MG	T4	QL (62 EA per 31 days)
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG	T4	QL (31 EA per 31 days)
DANTRIUM ORAL CAPSULE 25 MG, 50 MG	T4	
<i>dantrolene</i>	T2	
DAYPRO	T4	
DAYTRANA	T4	
DEMEROL INJECTION SOLUTION 50 MG/ML	T4	PA-BvD; QL (412 ML per 31 days)
DEMEROL ORAL TABLET 100 MG	T4	QL (620 EA per 31 days)
DEPACON	T4	
DEPAKENE	T4	
DEPAKOTE	T4	
DEPAKOTE ER	T4	
DEPAKOTE SPRINKLES	T4	
<i>desipramine</i>	T2	
DESOXYN	T4	PA
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR	T4	
<i>desvenlafaxine succinate</i>	T4	
DEXEDRINE SPANSULE	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)
DIASTAT	T4	
DIASTAT ACUDIAL	T4	
<i>diazepam intensol</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<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)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
DILANTIN-125	T4	
DILAUDID ORAL LIQUID	T4	PA; QL (1550 ML per 31 days)
DILAUDID ORAL TABLET	T4	PA; QL (186 EA per 31 days)
<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	
DOLOPHINE ORAL TABLET 10 MG	T4	PA; QL (206 EA per 31 days)
DOLOPHINE ORAL TABLET 5 MG	T4	PA; QL (248 EA per 31 days)
<i>donepezil</i>	T2	
<i>doxepin oral</i>	T2	PA-NS
DUEXIS	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)
DUOPA	T4	PA-BvD
DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR	T4	PA; QL (10 EA per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 12 MCG/HR, 25 MCG/HR	T4	PA; QL (20 EA per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 50 MCG/HR	T4	PA; QL (17 EA per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 75 MCG/HR	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)

Drug Name	Drug Tier	Requirements/Limits
<i>duramorph (pf) injection solution 1 mg/ml</i>	T2	PA-BvD; QL (2000 ML per 30 days)
EC-NAPROSYN	T4	
EDLUAR	T4	
EFFEXOR XR	T4	
ELDEPRYL	T4	
<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)
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL	T4	PA; QL (62 EA per 31 days)
EMSAM	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	
EQUETRO	T4	
<i>ergoloid</i>	T2	
ERGOTAMINE-CAFFEINE	T4	
<i>escitalopram oxalate</i>	T4	
ESGIC ORAL TABLET	T4	QL (372 EA per 31 days)
<i>estazolam</i>	T2	
<i>eszopiclone</i>	T2	
<i>ethosuximide</i>	T2	
<i>etodolac</i>	T2	
EVZIO INJECTION AUTO-INJECTOR 0.4 MG/0.4 ML	T4	
EVZIO INJECTION AUTO-INJECTOR 2 MG/0.4 ML	T5	
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 16 MG, 8 MG	T4	PA; QL (62 EA per 31 days)
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 32 MG	T4	PA; QL (48 EA per 31 days)
EXELON TRANSDERMAL	T3	
EXONDYS 51	T5	PA
FANAPT	T4	
FAZACLO ORAL TABLET,DISINTEGRATING 100 MG, 12.5 MG, 25 MG	T4	
FAZACLO ORAL TABLET,DISINTEGRATING 150 MG, 200 MG	T5	

Drug Name	Drug Tier	Requirements/Limits
<i>felbamate</i>	T2	
FELBATOL	T4	
FELDENE	T4	
FENOPROFEN ORAL CAPSULE 400 MG	T4	
<i>fenopropfen 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)
FENTANYL TRANSDERMAL PATCH 72 HOUR 37.5 MCG/HOUR	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)
FENTANYL TRANSDERMAL PATCH 72 HOUR 62.5 MCG/HOUR	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)
FENTANYL TRANSDERMAL PATCH 72 HOUR 87.5 MCG/HOUR	T4	PA; QL (11 EA per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA	T4	PA-NS
FEXMID	T4	
FIORICET ORAL CAPSULE	T4	QL (403 EA per 31 days)
FIORICET WITH CODEINE ORAL CAPSULE 50-300-40-30 MG	T4	QL (403 EA per 31 days)
FIORINAL	T4	

Drug Name	Drug Tier	Requirements/Limits
FIORINAL-CODEINE #3	T4	QL (372 EA per 31 days)
FLECTOR	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	
FLUOXETINE ORAL TABLET 60 MG	T4	
<i>fluphenazine decanoate</i>	T2	
<i>fluphenazine hcl</i>	T1	
<i>flurazepam</i>	T2	
<i>flurbiprofen</i>	T2	
<i>fluvoxamine</i>	T2	
FOCALIN	T4	
FOCALIN XR	T4	
FORFIVO XL	T4	
<i>fosphenytoin injection solution 100 mg pe/2 ml</i>	T2	
FROVA	T4	QL (12 EA per 31 days)
<i>frovatriptan</i>	T3	QL (12 EA per 31 days)
FYCOMPA ORAL SUSPENSION	T4	
FYCOMPA ORAL TABLET	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	
GABITRIL ORAL TABLET 12 MG, 16 MG	T3	
GABITRIL ORAL TABLET 2 MG, 4 MG	T4	
GABLOFEN INTRATHECAL SOLUTION 10,000 MCG/20ML (500 MCG/ML), 40,000 MCG/20ML (2,000 MCG/ML)	T4	PA-BvD
GABLOFEN INTRATHECAL SYRINGE 50 MCG/ML (1 ML)	T4	PA-BvD
<i>galantamine</i>	T2	
GEODON INTRAMUSCULAR	T3	
GEODON ORAL	T4	
GILENYA	T5	PA; QL (31 EA per 31 days)
<i>glatopa</i>	T5	QL (31 ML per 31 days)
GRALISE	T3	PA-NS
GRALISE 30-DAY STARTER PACK	T3	PA-NS
<i>guanfacine oral tablet extended release 24 hr</i>	T2	PA
<i>guanidine</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
HALCION ORAL TABLET 0.25 MG	T4	PA
HALDOL	T4	
HALDOL DECANOATE	T4	
<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	
HETLIOZ	T5	PA
HORIZANT	T4	PA-NS
HYCET	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)
HYSINGLA ER	T4	PA; QL (31 EA per 31 days)
IBUDONE ORAL TABLET 10-200 MG	T4	QL (155 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)
<i>imipramine hcl</i>	T2	PA-NS
<i>imipramine pamoate</i>	T2	
IMITREX NASAL SPRAY, NON-AEROSOL 20 MG/ACTUATION	T4	QL (8 EA per 31 days)
IMITREX NASAL SPRAY, NON-AEROSOL 5 MG/ACTUATION	T4	QL (32 EA per 31 days)
IMITREX ORAL TABLET 100 MG	T4	QL (9 EA per 31 days)

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

Drug Name	Drug Tier	Requirements/Limits
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	T2	
<i>ketorolac oral</i>	T2	
KEVEYIS	T4	PA; QL (124 EA per 31 days)
KHEDEZLA	T4	
KLONOPIN	T4	
LAMICTAL ODT	T3	
LAMICTAL ORAL TABLET	T4	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	T4	
LAMICTAL STARTER (BLUE) KIT	T4	
LAMICTAL STARTER (GREEN) KIT	T4	
LAMICTAL STARTER (ORANGE) KIT	T4	
LAMICTAL XR	T4	
LAMICTAL XR STARTER (BLUE)	T4	
LAMICTAL XR STARTER (GREEN)	T4	
LAMICTAL XR STARTER (ORANGE)	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	
LATUDA ORAL TABLET 120 MG, 80 MG	T5	
LATUDA ORAL TABLET 20 MG, 40 MG, 60 MG	T4	
LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY	T5	PA; QL (31 EA per 31 days)
LAZANDA NASAL SPRAY, NON-AEROSOL 300 MCG/SPRAY	T5	PA; QL (16 EA per 31 days)
LAZANDA NASAL SPRAY, NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (12 EA per 31 days)
LEVETIRACETAM IN NA CL (ISO-OS)	T4	
<i>levetiracetam intravenous</i>	T2	
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
<i>levorphanol tartrate</i>	T1	PA; QL (186 EA per 31 days)
LEXAPRO ORAL TABLET	T4	
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	T4	PA-BvD
<i>lithium carbonate</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<i>lithium citrate oral solution 8 meq/5 ml</i>	T1	
LITHOBID	T4	
<i>lodine oral tablet</i>	T4	
LODOSYN	T4	
<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)
LORZONE	T4	
<i>loxapine succinate</i>	T2	
LUNESTA	T4	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	T4	PA-NS; QL (93 EA per 31 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	T4	PA-NS; QL (62 EA per 31 days)
LYRICA ORAL SOLUTION	T4	PA-NS; QL (930 ML per 31 days)
<i>maprotiline</i>	T2	
MARPLAN	T3	
MAXALT ORAL TABLET 10 MG	T4	QL (12 EA per 31 days)
MAXALT ORAL TABLET 5 MG	T4	QL (24 EA per 31 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG	T4	QL (12 EA per 31 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 5 MG	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	
MEMANTINE ORAL TABLETS,DOSE PACK	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)
<i>meperidine oral solution</i>	T2	QL (6200 ML per 31 days)
<i>meperidine oral tablet 100 mg</i>	T2	QL (620 EA per 31 days)
<i>meperidine oral tablet 50 mg</i>	T2	QL (1240 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<i>meprobamate</i>	T2	
MESTINON ORAL SYRUP	T3	
MESTINON ORAL TABLET	T4	
MESTINON TIMESPAN	T3	
<i>metadate er</i>	T2	QL (93 EA per 31 days)
<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>methocarbamol</i>	T2	
METHYLIN ORAL SOLUTION	T4	
<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	
MIGRANAL	T4	QL (8 ML per 31 days)

Drug Name	Drug Tier	Requirements/Limits
MIRAPEX	T4	
MIRAPEX ER	T4	
<i>mirtazapine</i>	T2	
MOBIC ORAL TABLET	T4	
<i>modafinil</i>	T2	PA; QL (31 EA per 31 days)
MORPHABOND ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 100 MG	T4	PA; QL (62 EA per 31 days)
MORPHABOND ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 15 MG, 30 MG, 60 MG	T4	PA; QL (100 EA per 31 days)
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
MORPHINE INTRAVENOUS SYRINGE 10 MG/ML	T4	PA; QL (200 ML per 30 days)
<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)
MORPHINE INTRAVENOUS SYRINGE 8 MG/ML	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)
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG	T4	PA; QL (62 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG, 60 MG	T4	PA; QL (100 EA per 31 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 200 MG	T4	PA; QL (31 EA per 31 days)
MYDAYIS	T4	QL (31 EA per 31 days)
MYSOLINE	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	

Drug Name	Drug Tier	Requirements/Limits
<i>naloxone injection syringe 1 mg/ml</i>	T2	
<i>naltrexone</i>	T2	
NAMENDA ORAL TABLET	T4	PA
NAMENDA TITRATION PAK	T4	PA
NAMENDA XR	T4	PA
NAMZARIC	T4	PA
NAPRELAN CR	T4	
NAPROSYN ORAL TABLET 500 MG	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)
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	T4	
NARDIL	T4	
<i>nefazodone</i>	T2	
NEUPRO	T4	
NEURONTIN	T4	
NORCO	T4	PA; QL (372 EA per 31 days)
NORPRAMIN ORAL TABLET 10 MG, 25 MG	T4	
<i>nortriptyline</i>	T2	
NUCYNTA ER	T4	QL (62 EA per 31 days)
NUCYNTA ORAL TABLET 100 MG	T4	QL (155 EA per 31 days)
NUCYNTA ORAL TABLET 50 MG, 75 MG	T4	QL (186 EA per 31 days)
NUEDEXTA	T3	
NUPLAZID	T5	PA-NS
NUVIGIL	T4	PA; QL (31 EA per 31 days)
<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	
ONFI ORAL SUSPENSION	T4	
ONFI ORAL TABLET 10 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
ONFI ORAL TABLET 20 MG	T5	
ONZETRA XSAIL	T4	QL (16 EA per 31 days)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 5 MG, 7.5 MG	T4	PA; QL (100 EA per 31 days)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 30 MG	T4	PA; QL (69 EA per 31 days)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 40 MG	T4	PA; QL (51 EA per 31 days)
OPANA ORAL	T4	PA; QL (186 EA per 31 days)
ORAP ORAL TABLET 1 MG	T3	
<i>orphenadrine citrate</i>	T2	
<i>oxaprozin</i>	T2	
<i>oxazepam</i>	T2	
<i>oxcarbazepine</i>	T2	
OXTELLAR XR	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)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	T4	PA; QL (100 EA per 31 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T4	PA; QL (69 EA per 31 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	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)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	T4	PA; QL (100 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 60 MG	T4	PA; QL (69 EA per 31 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	T4	PA; QL (62 EA per 31 days)
<i>oxymorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
<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	
PAMELOR	T4	
PARLODEL	T4	
PARNATE	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	
PAXIL	T4	
PAXIL CR	T4	
PEGANONE	T3	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	T4	
<i>pentazocine-naloxone</i>	T2	QL (335 EA per 31 days)
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	T4	PA; QL (372 EA per 31 days)
<i>perphenazine</i>	T2	
<i>perphenazine-amitriptyline</i>	T2	PA-NS
PEXEVA	T4	
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	
PHENYTEK	T4	
<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	
PONSTEL	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>pramipexole</i>	T2	
<i>primidone</i>	T2	
PRIMLEV	T4	PA; QL (403 EA per 31 days)
PRISTIQ	T4	
<i>procentra</i>	T2	
<i>protriptyline</i>	T2	
PROVIGIL ORAL TABLET 100 MG	T4	PA; QL (31 EA per 31 days)
PROVIGIL ORAL TABLET 200 MG	T5	PA; QL (31 EA per 31 days)
PROZAC ORAL CAPSULE	T4	
<i>pyridostigmine bromide</i>	T2	
QUDEXY XR	T4	
<i>quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	T2	
<i>quetiapine oral tablet 25 mg</i>	T1	
QUETIAPINE ORAL TABLET EXTENDED RELEASE 24 HR	T4	
QUILLICHEW ER	T4	
QUILLIVANT XR	T4	
RADICAVA	T5	PA
<i>rasagiline</i>	T3	
RAZADYNE ER	T4	
RAZADYNE ORAL TABLET	T4	
RELPAK ORAL TABLET 20 MG	T4	QL (12 EA per 31 days)
RELPAK ORAL TABLET 40 MG	T4	QL (6 EA per 31 days)
REMERON	T4	
REMERON SOLTAB	T4	
REQUIP	T4	
REQUIP XL	T4	
RESTORIL	T4	
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML	T4	
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 50 MG/2 ML	T5	
RISPERDAL M-TAB	T4	
RISPERDAL ORAL SOLUTION	T5	
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 4 MG	T4	
RISPERDAL ORAL TABLET 3 MG	T5	

Drug Name	Drug Tier	Requirements/Limits
<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	
RITALIN	T4	
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG	T4	QL (186 EA per 31 days)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 20 MG, 30 MG, 40 MG	T4	
<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	
ROXICODONE ORAL TABLET 15 MG, 5 MG	T4	PA; QL (186 EA per 31 days)
ROXICODONE ORAL TABLET 30 MG	T4	PA; QL (138 EA per 31 days)
ROZEREM	T4	
RYTARY	T4	
SABRIL	T5	
SAPHRIS (BLACK CHERRY)	T4	
SARAFEM ORAL TABLET 10 MG, 20 MG	T4	
<i>selegiline hcl</i>	T2	
SEROQUEL	T4	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR	T3	
<i>sertraline</i>	T1	
SILENOR	T4	PA-NS
SINEMET	T4	
SINEMET CR	T4	
SKELAXIN	T4	
SOMA	T4	
SONATA	T4	
SPRITAM	T4	
STALEVO 100	T4	

Drug Name	Drug Tier	Requirements/Limits
STALEVO 125	T4	
STALEVO 150	T4	
STALEVO 200	T4	
STALEVO 50	T4	
STALEVO 75	T4	
STRATTERA	T4	PA
SUBOXONE SUBLINGUAL FILM 12-3 MG	T3	QL (62 EA per 31 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG	T3	QL (93 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY	T5	PA; QL (124 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 400 MCG/SPRAY	T5	PA; QL (86 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 600 MCG/SPRAY	T5	PA; QL (57 EA per 31 days)
SUBSYS SUBLINGUAL SPRAY, NON-AEROSOL 800 MCG/SPRAY	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)
<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)
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 4 MG/0.5 ML	T4	QL (6 ML per 31 days)
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 6 MG/0.5 ML	T4	QL (4 ML per 31 days)
SURMONTIL	T4	PA-NS

Drug Name	Drug Tier	Requirements/Limits
SYMBYAX	T4	
SYNALGOS-DC	T4	PA; QL (300 EA per 30 days)
TALWIN	T4	QL (559 ML per 31 days)
TASMAR ORAL TABLET 100 MG	T5	
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	T5	PA; QL (120 EA per 365 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 240 MG	T5	PA; QL (62 EA per 31 days)
TEGRETOL ORAL SUSPENSION	T4	
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG	T3	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 200 MG, 400 MG	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	
TIVORBEX	T4	
<i>tizanidine</i>	T2	
TOFRANIL	T4	
<i>tolcapone</i>	T5	
<i>tolmetin oral capsule</i>	T2	
<i>tolmetin oral tablet 600 mg</i>	T2	
TOPAMAX	T4	
<i>topiramate oral capsule, sprinkle</i>	T2	
TOPIRAMATE ORAL CAPSULE,SPRINKLE,ER 24HR	T4	
<i>topiramate oral tablet</i>	T2	
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83	T4	QL (30 EA per 30 days)
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG	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)

Drug Name	Drug Tier	Requirements/Limits
<i>tramadol-acetaminophen</i>	T2	QL (372 EA per 31 days)
TRANXENE T-TAB ORAL TABLET 7.5 MG	T4	
<i>tranylcypromine</i>	T2	
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trazodone oral tablet 300 mg</i>	T2	
TREXIMET ORAL TABLET 10-60 MG	T4	QL (9 EA per 31 days)
TREXIMET ORAL TABLET 85-500 MG	T4	QL (10 EA per 31 days)
TREZIX ORAL CAPSULE 320.5-30-16 MG	T4	QL (372 EA per 31 days)
<i>triazolam</i>	T2	PA
<i>trifluoperazine</i>	T2	
<i>trihexyphenidyl</i>	T2	
TRILEPTAL	T4	
<i>trimipramine</i>	T3	PA-NS
TRINTELLIX	T4	PA-NS
TROKENDI XR	T4	
TYLENOL-CODEINE #3	T4	PA; QL (403 EA per 31 days)
TYLENOL-CODEINE #4	T4	PA; QL (403 EA per 31 days)
TYSABRI	T5	QL (15 ML per 28 days)
ULTRACET	T4	QL (372 EA per 31 days)
ULTRAM	T4	QL (240 EA per 30 days)
VALIUM	T4	
<i>valproate sodium</i>	T2	
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
VANATOL LQ	T4	QL (5723 ML per 31 days)
<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)
VENLAFAXINE ORAL TABLET EXTENDED RELEASE 24HR 225 MG	T4	QL (31 EA per 31 days)
VERSACLOZ	T3	
<i>vicodin</i>	T2	PA; QL (403 EA per 31 days)
<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	
VIIBRYD ORAL TABLET	T4	PA-NS

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

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

Drug Name	Drug Tier	Requirements/Limits
ACCURETIC	T4	
<i>acebutolol</i>	T1	
ADALAT CC	T4	
<i>afeditab cr</i>	T1	
AGGRENOL	T3	
ALDACTAZIDE	T4	
ALDACTONE	T4	
ALTACE	T4	
ALTOPREV	T4	
<i>amiloride</i>	T1	
<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	
AMLODIPINE-OLMESARTAN	T3	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>amlodipine-valsartan-hctiazid</i>	T2	
ANTARA ORAL CAPSULE 30 MG, 90 MG	T4	
ARGATROBAN	T4	
ARGATROBAN IN 0.9 % SOD CHLOR INTRAVENOUS SOLUTION	T4	
ARIIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	T5	
ARIIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T4	
<i>aspirin-dipyridamole</i>	T2	
ATACAND	T4	
ATACAND HCT	T4	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T1	
<i>atorvastatin</i>	T1	
AVALIDE	T4	
AVAPRO	T4	
AZOR	T4	QL (31 EA per 31 days)
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
BENICAR HCT	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
BENICAR ORAL TABLET 20 MG, 40 MG	T4	QL (31 EA per 31 days)
BENICAR ORAL TABLET 5 MG	T4	QL (93 EA per 31 days)
BETAPACE AF ORAL TABLET 120 MG, 160 MG	T4	
BETAPACE ORAL TABLET 80 MG	T4	
<i>betaxolol oral tablet 10 mg</i>	T2	
<i>betaxolol oral tablet 20 mg</i>	T1	
BIDIL	T4	
<i>bisoprolol fumarate</i>	T1	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
BRILINTA	T3	
<i>bumetanide</i>	T1	
BYSTOLIC	T4	
BYVALSON	T4	
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	T4	
CALAN	T4	
CALAN SR	T4	
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
<i>captopril-hydrochlorothiazide</i>	T1	
CARDENE IV IN SODIUM CHLORIDE	T4	
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 240 MG, 360 MG	T4	
CARDIZEM LA	T4	
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	T4	
CARDURA	T4	
CARDURA XL	T4	
<i>cartia xt</i>	T1	
<i>carvedilol</i>	T1	
CATAPRES	T4	
CATAPRES-TTS-1	T4	
CATAPRES-TTS-2	T4	
CATAPRES-TTS-3	T4	
<i>chlorothiazide</i>	T1	
<i>chlorothiazide sodium</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<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	
CLOPRES ORAL TABLET 0.3-15 MG	T3	
COLESTID ORAL GRANULES	T4	
COLESTID ORAL TABLET	T4	
<i>colestipol oral granules</i>	T2	
<i>colestipol oral tablet</i>	T2	
COREG	T4	
COREG CR	T4	
CORGARD	T4	
CORLANOR ORAL TABLET 5 MG	T4	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T4	PA; QL (62 EA per 31 days)
CORZIDE	T4	
COUMADIN ORAL	T4	
COZAAR	T4	
CRESTOR	T4	
CYKLOKAPRON	T4	
DEMADEX ORAL TABLET 10 MG, 20 MG	T4	
DEMSER	T3	
DIBENZYLINE	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	

Drug Name	Drug Tier	Requirements/Limits
DIOVAN	T4	
DIOVAN HCT	T4	
<i>dipyridamole oral</i>	T2	
<i>disopyramide phosphate oral capsule</i>	T2	
DIURIL	T3	
DIURIL IV	T4	
<i>dofetilide</i>	T3	
<i>doxazosin</i>	T1	
DURLAZA	T4	
DUTOPROL	T4	
DYAZIDE	T4	
DYRENIUM	T4	
EDARBI	T4	
EDARBYCLOR	T4	
EDECIN	T3	
EFFIENT	T3	
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 31 days)
<i>enalapril maleate</i>	T1	
<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	
ENTRESTO	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	
EXFORGE	T4	
EXFORGE HCT	T4	
EZETIMIBE	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	

Drug Name	Drug Tier	Requirements/Limits
FENOFIBRATE ORAL CAPSULE	T4	
FENOFIBRATE ORAL TABLET 120 MG, 40 MG	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	
FENOGLIDE	T4	
FIBRICOR	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	
FRAGMIN SUBCUTANEOUS SOLUTION	T5	
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	T5	
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	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	
GONITRO	T4	
<i>guanfacine oral tablet</i>	T2	
<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	
HYZAAR	T4	
<i>indapamide</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
INDERAL LA	T4	
INNOPRAN XL	T4	
INSPRA	T4	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
ISORDIL	T4	
ISORDIL TITRADOSE ORAL TABLET 5 MG	T4	
<i>isosorbide dinitrate oral</i>	T2	
<i>isosorbide mononitrate</i>	T1	
<i>isradipine</i>	T2	
<i>jantoven</i>	T2	
JUXTAPID	T5	PA
KYNAMRO	T5	PA
<i>labetalol intravenous solution</i>	T1	
<i>labetalol oral</i>	T1	
LANOXIN	T4	PA
LASIX	T4	
LESCOL XL	T4	
LIPITOR	T4	
LIPOFEN	T4	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
LIVALO	T4	
LOPID	T4	
LOPRESSOR HCT	T4	
LOPRESSOR ORAL TABLET 100 MG	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	
LOTENSIN ORAL TABLET 20 MG, 40 MG	T4	
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG	T4	
<i>lovastatin</i>	T1	
LOVAZA	T3	
LOVENOX	T4	
<i>matzim la</i>	T1	
MAXZIDE	T4	

Drug Name	Drug Tier	Requirements/Limits
MAXZIDE-25MG	T4	
<i>methyclothiazide</i>	T2	
<i>methyldopa</i>	T2	
<i>methyldopa-hydrochlorothiazide</i>	T1	
<i>methyldopate</i>	T2	
<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	
MICARDIS	T4	
MICARDIS HCT	T4	
MICROZIDE	T4	
MINIPRESS	T4	
MINITRAN	T4	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
<i>moexipril-hydrochlorothiazide</i>	T1	
MULTAQ	T4	
<i>nadolol</i>	T1	
<i>nadolol-bendroflumethiazide</i>	T1	
NEXTERONE	T4	
<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)
NIACOR	T4	
NIASPAN EXTENDED-RELEASE	T4	
<i>nicardipine intravenous solution</i>	T2	
<i>nicardipine oral</i>	T2	
<i>nifedipine</i>	T2	
<i>nimodipine</i>	T2	
<i>nisoldipine</i>	T2	
<i>nitro-bid</i>	T2	
NITRO-DUR	T3	
<i>nitroglycerin intravenous</i>	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>nitroglycerin translingual spray,non-aerosol</i>	T2	
NITROMIST	T4	
NITROSTAT	T4	
NORPACE	T4	
NORPACE CR	T4	
NORVASC	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)
<i>olmesartan-amlodipin-hcthiazid</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T3	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	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	
PLAVIX	T4	
PRADAXA	T3	QL (62 EA per 31 days)
PRALUENT PEN	T5	PA; QL (2 ML per 28 days)
<i>prasugrel</i>	T3	
PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG	T4	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T1	
<i>prevalite oral powder</i>	T2	
PRINIVIL ORAL TABLET 10 MG, 20 MG, 5 MG	T4	
<i>procainamide injection</i>	T2	
PROCARDIA	T4	
PROCARDIA XL	T4	
PROMACTA	T5	PA
<i>propafenone</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<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	
QBRELIS	T4	
QUESTRAN LIGHT ORAL POWDER	T4	
QUESTRAN ORAL POWDER IN PACKET	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	
RANEXA	T3	
REMODULIN	T5	PA-BvD
REPATHA PUSHTRONEX	T5	PA; QL (3.5 ML per 28 days)
REPATHA SURECLICK	T5	PA; QL (2 ML per 28 days)
REPATHA SYRINGE	T5	PA; QL (2 ML per 28 days)
<i>rosuvastatin</i>	T3	
RYTHMOL SR	T4	
SAVAYSA	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	
SOTYLIZE	T4	
<i>spironolactone</i>	T1	
<i>spironolacton-hydrochlorothiaz</i>	T1	
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	T4	
TARKA	T4	
<i>taztia xt</i>	T1	
TEKTRUNA	T4	
TEKTRUNA HCT	T4	
<i>telmisartan</i>	T1	
<i>telmisartan-amlodipine</i>	T1	
<i>telmisartan-hydrochlorothiazid</i>	T1	
TENORETIC 100	T4	

Drug Name	Drug Tier	Requirements/Limits
TENORETIC 50	T4	
TENORMIN	T4	
<i>terazosin</i>	T1	
TIAZAC	T4	
TIKOSYN	T3	
<i>timolol maleate oral</i>	T1	
TOPROL XL	T4	
<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	
TRIBENZOR	T3	
TRICOR	T4	
TRIGLIDE ORAL TABLET 160 MG	T4	
TRILIPIX	T4	
TWYNSTA	T4	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (144 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	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)
VASCEPA	T4	
VASERETIC	T4	
VASOTEC	T4	
VECAMYL	T4	
<i>verapamil intravenous solution</i>	T2	
<i>verapamil oral</i>	T2	
VERELAN	T4	
VERELAN PM	T4	
VYTORIN 10-10	T4	
VYTORIN 10-20	T4	
VYTORIN 10-40	T4	
VYTORIN 10-80	T4	
<i>warfarin</i>	T1	
WELCHOL	T3	

Drug Name	Drug Tier	Requirements/Limits
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLETS,DOSE PACK	T3	QL (51 EA per 30 days)
YOSPRALA	T4	PA; QL (31 EA per 31 days)
ZESTORETIC	T4	
ZESTRIL	T4	
ZETIA	T3	
ZIAC	T4	
ZOCOR	T4	
ZONTIVITY	T4	
Dermatologicals/Topical Therapy		
ABSORICA	T4	
ACANYA TOPICAL GEL WITH PUMP	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	
ACZONE TOPICAL GEL	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	
ALA-SCALP	T4	
<i>alclometasone</i>	T1	
ALDARA	T4	
<i>amcinonide</i>	T2	
<i>ammonium lactate</i>	T2	
<i>amnesteem</i>	T2	
<i>apexicon e</i>	T2	
ATRALIN	T4	
<i>avita topical cream</i>	T2	
AVITA TOPICAL GEL	T4	
AZELEX	T4	
BACTROBAN TOPICAL CREAM	T4	
BENZAACLIN	T4	
BENZAMYCIN	T4	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
<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	
CAPEX	T4	
CARAC	T5	
<i>ciclopirox</i>	T2	
<i>claravis</i>	T2	
CLEOCIN T	T4	
CLINDACIN P	T4	
CLINDAGEL	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	
CLOBEX	T4	
<i>clodan</i>	T2	
CLODERM	T4	
<i>clotrimazole topical</i>	T2	
<i>clotrimazole-betamethasone</i>	T2	
CONDYLOX TOPICAL GEL	T3	
CORDRAN TAPE LARGE ROLL	T3	
<i>cormax scalp</i>	T2	
CORTISPORIN TOPICAL	T3	
COSENTYX	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN	T5	PA; QL (2 ML per 28 days)
CUTIVATE TOPICAL LOTION	T4	
DENAVIR	T3	

Drug Name	Drug Tier	Requirements/Limits
DERMATOP TOPICAL CREAM	T4	
DESONATE	T4	
<i>desonide</i>	T2	
DESOWEN	T4	
<i>desoximetasone</i>	T2	
<i>diclofenac sodium topical gel 3 %</i>	T4	
DIFFERIN TOPICAL CREAM	T4	
DIFFERIN TOPICAL GEL	T4	
DIFFERIN TOPICAL LOTION	T4	
<i>diflorasone</i>	T2	
DIPROLENE AF	T4	
DIPROLENE TOPICAL OINTMENT	T4	
DOVONEX TOPICAL	T4	
<i>doxepin topical</i>	T2	
DUAC	T4	
DUPIXENT	T5	PA; QL (4 ML per 28 days)
<i>econazole</i>	T2	
EFUDEX TOPICAL CREAM	T4	
ELIDEL	T4	
ELIMITE	T4	
ELOCON TOPICAL CREAM	T4	
ELOCON TOPICAL OINTMENT	T4	
ENSTILAR	T4	
EPIDUO FORTE	T4	
EPIDUO TOPICAL GEL WITH PUMP	T4	
ERTACZO	T4	
<i>ery pads</i>	T2	
<i>erygel</i>	T2	
<i>erythromycin with ethanol topical gel</i>	T2	
<i>erythromycin with ethanol topical solution</i>	T2	
<i>erythromycin-benzoyl peroxide</i>	T2	
EUCRISA	T4	PA; QL (60 GM per 30 days)
EURAX TOPICAL CREAM	T3	
EURAX TOPICAL LOTION	T4	
EVOCLIN	T4	
EXELDERM	T4	
EXTINA	T4	
FABIOR	T4	

Drug Name	Drug Tier	Requirements/Limits
FINACEA	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	
FLUOROURACIL TOPICAL CREAM 0.5 %	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	
HALOG	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	
JUBLIA	T4	
KENALOG TOPICAL	T3	
KERYDIN	T4	
<i>ketoconazole topical</i>	T2	
KLARON	T4	
<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	
<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)

Drug Name	Drug Tier	Requirements/Limits
<i>lidocaine topical ointment</i>	T2	
<i>lidocaine viscous</i>	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	
LIDODERM	T4	PA; QL (124 EA per 31 days)
<i>lindane topical shampoo</i>	T2	
LOCOID	T4	
LOPROX (AS OLAMINE) TOPICAL CREAM	T4	
LOPROX TOPICAL SHAMPOO	T4	
LOTRISONE TOPICAL CREAM	T4	
LUZU	T4	
<i>malathion</i>	T2	
MENTAX	T4	
<i>methoxsalen</i>	T2	
METROCREAM	T4	
METROGEL TOPICAL GEL 1 %	T4	
METROLOTION	T4	
<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	
MIRVASO TOPICAL GEL	T4	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<i>mupirocin calcium</i>	T2	
<i>myorisan</i>	T2	
NAFTIFINE TOPICAL CREAM 1 %	T4	
<i>naftifine topical cream 2 %</i>	T3	
NAFTIN TOPICAL CREAM 2 %	T4	
NAFTIN TOPICAL GEL	T4	
NEO-SYNALAR	T4	
<i>neuac</i>	T2	
NIZORAL TOPICAL SHAMPOO	T4	
<i>nolix</i>	T3	
NORITATE	T4	
<i>nyamyc</i>	T2	
<i>nyata</i>	T2	
<i>nystatin topical</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>nystatin-triamcinolone</i>	T3	
<i>nystop</i>	T2	
OLUX	T4	
ONEXTON TOPICAL GEL WITH PUMP	T4	
OVIDE	T4	
<i>oxiconazole</i>	T2	
OXISTAT	T4	
OXSORALEN ULTRA	T3	
PANDEL	T4	
PANRETIN	T5	
<i>permethrin topical cream</i>	T2	
PICATO	T3	
<i>podofilox</i>	T2	
<i>prednicarbate</i>	T2	
PROTOPIC	T4	
<i>pradoxin</i>	T2	
PSORCON	T4	
REGRANEX	T5	
RETIN-A	T4	
RETIN-A MICRO	T4	
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	T4	
SANTYL	T3	
<i>selenium sulfide topical lotion</i>	T1	
SILIQ	T5	PA; QL (3 ML per 28 days)
SILVADENE	T4	
<i>silver sulfadiazine</i>	T1	
SKLICE	T4	
SOLARAZE	T4	
SOOLANTRA	T4	
SORIATANE ORAL CAPSULE 10 MG, 17.5 MG	T5	
SORIATANE ORAL CAPSULE 25 MG	T4	
SORILUX	T4	
<i>ssd</i>	T2	
STELARA INTRAVENOUS	T5	PA; QL (104 ML per 180 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 28 days)
<i>sulfacetamide sodium (acne)</i>	T1	
SULFAMYLON TOPICAL CREAM	T3	
SULFAMYLON TOPICAL PACKET	T4	
SYNALAR TOPICAL CREAM	T4	
TACLONEX TOPICAL OINTMENT	T4	
TACLONEX TOPICAL SUSPENSION	T5	
<i>tacrolimus topical</i>	T2	
TALTZ AUTOINJECTOR (3 PACK)	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
<i>tazarotene</i>	T4	
TAZORAC	T4	
TEMOVATE TOPICAL OINTMENT	T4	
TOLAK	T4	
TOPICORT	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	
TRIDESILON	T4	
ULTRAVATE	T4	
VALCHLOR	T4	PA-NS
VANOS	T4	
VECTICAL	T4	
VEREGEN	T4	
XERESE	T4	
XYLOCAINE INJECTION SOLUTION 20 MG/ML (2 %)	T4	
XYLOCAINE MUCOUS MEMBRANE SOLUTION	T4	
<i>zenatane</i>	T2	
ZIANA	T4	
ZONALON	T4	

Drug Name	Drug Tier	Requirements/Limits
ZOVIRAX TOPICAL CREAM	T3	
ZOVIRAX TOPICAL OINTMENT	T4	
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 %	T4	
ZYCLARA TOPICAL CREAM IN PACKET	T5	
Diagnostics / Miscellaneous Agents		
<i>acamprosate</i>	T2	
ACTONEL ORAL TABLET 30 MG	T4	
ADAGEN	T5	
AGRYLIN	T4	
<i>alendronate oral tablet 40 mg</i>	T1	
<i>anagrelide</i>	T2	
ANTABUSE	T4	
ARALAST NP INTRAVENOUS RECON SOLN 500 MG	T5	PA
AURYXIA	T4	
BUPHENYL	T5	
<i>bupropion hcl (smoking deter)</i>	T3	QL (62 EA per 31 days)
CARBAGLU	T5	PA
CARNITOR	T4	PA-BvD
<i>cevimeline</i>	T2	
CHANTIX	T4	
CHANTIX CONTINUING MONTH BOX	T4	
CHANTIX STARTING MONTH BOX	T4	
CHEMET	T3	
CLINIMIX 4.25%/D5W SULFIT FREE	T3	PA-BvD
CLINIMIX E 2.75%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	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	

Drug Name	Drug Tier	Requirements/Limits
<i>dextrose with sodium chloride</i>	T2	
<i>disulfiram</i>	T2	
<i>etidronate disodium</i>	T2	
EVOXAC	T4	
EXJADE	T5	
FERRIPROX	T5	
FOSRENOL ORAL POWDER IN PACKET	T4	
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 750 MG	T4	
FOSRENOL ORAL TABLET,CHEWABLE 500 MG	T5	
GLASSIA	T5	PA
INCRELEX	T5	PA
JADENU	T4	
JADENU SPRINKLE	T4	
<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
LITHOSTAT	T4	
<i>midodrine</i>	T2	
<i>neomycin-polymyxin b gu</i>	T1	
NICOTROL	T4	
NICOTROL NS	T3	
NORTHERA	T5	PA
NUTRESTORE	T4	
ORFADIN	T5	
PHYSIOLYTE	T4	
PHYSIOSOL IRRIGATION	T4	
<i>pilocarpine hcl oral</i>	T2	
PROLASTIN-C	T5	PA
RAVICTI	T5	PA
RECLAST	T4	
RENAGEL	T3	
REVELA	T3	
RILUTEK	T5	
<i>riluzole</i>	T5	
<i>ringer's irrigation</i>	T2	
<i>risedronate oral tablet 30 mg</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
SALAGEN (PILOCARPINE)	T4	
<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	
SYPRINE	T3	
THIOLA	T4	
VELPHORO	T5	
VELTASSA	T4	PA; QL (30 EA per 30 days)
<i>water for irrigation, sterile</i>	T2	
ZEMAIRA	T5	PA
<i>zoledronic acid-mannitol-water</i>	T2	
ZYBAN	T4	
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T2	
ASTEPRO NASAL SPRAY, NON-AEROSOL	T4	
<i>azelastine nasal</i>	T2	
BACTROBAN NASAL	T3	
<i>chlorhexidine gluconate mucous membrane</i>	T1	
CIPRO HC	T4	
CIPRODEX	T3	
COLY-MYCIN S	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	
OTOVEL	T4	
PATANASE	T4	
<i>periogard</i>	T2	
<i>triamcinolone acetonide dental</i>	T2	
Endocrine/Diabetes		
<i>acarbose</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
ACTHAR H.P.	T5	PA
ACTOPLUS MET	T4	
ACTOPLUS MET XR	T4	
ACTOS	T4	
ADLYXIN	T4	QL (6 ML per 28 days)
AFREZZA	T4	
<i>alcohol pads</i>	T2	
ALDURAZYME	T5	
ALOGLIPTIN	T4	
ALOGLIPTIN-METFORMIN	T4	
ALOGLIPTIN-PIOGLITAZONE	T4	
AMARYL	T4	
ANADROL-50	T4	PA
ANDRODERM	T3	PA
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	T3	PA
ANDROGEL TRANSDERMAL GEL IN PACKET	T3	PA
APIDRA	T4	
APIDRA SOLOSTAR	T4	
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
AVANDIA ORAL TABLET 2 MG, 4 MG	T3	
AVEED	T4	PA
AXIRON	T4	PA
BASAGLAR KWIKPEN	T3	
BYDUREON	T3	QL (4 EA per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	T4	QL (2.4 ML per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	T4	QL (1.2 ML per 30 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
CERDELGA	T5	PA

Drug Name	Drug Tier	Requirements/Limits
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	T5	
<i>chlorpropamide</i>	T2	
<i>chorionic gonadotropin, human</i>	T2	PA-BvD
CORTEF	T4	
<i>cortisone</i>	T2	
CYCLOSET	T4	
CYTOMEL	T4	
<i>danazol</i>	T2	
DDAVP	T4	
DEPO-MEDROL	T4	
DEPO-TESTOSTERONE	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	
DEXPAK 13 DAY	T4	
<i>doxercalciferol intravenous</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 0.5 mcg, 2.5 mcg</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 1 mcg</i>	T5	PA-BvD
DUETACT	T4	
ELAPRASE	T5	
ELELYSO	T5	
EMFLAZA	T5	PA
FABRAZYME INTRAVENOUS RECON SOLN 35 MG	T5	
FARXIGA	T3	
<i>fludrocortisone</i>	T2	
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 1,000 MG	T4	PA; QL (62 EA per 31 days)
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 500 MG	T4	PA; QL (31 EA per 31 days)
FORTESTA	T4	PA
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>glimepiride</i>	T1	
<i>glipizide</i>	T1	
<i>glipizide-metformin</i>	T1	
GLUCAGEN HYPOKIT	T3	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLUCOPHAGE	T4	QL (62 EA per 31 days)
GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG	T4	QL (124 EA per 31 days)
GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 750 MG	T4	QL (62 EA per 31 days)
GLUCOTROL	T4	
GLUCOTROL XL	T4	
GLUCOVANCE	T4	
GLUMETZA	T4	PA
<i>glyburide</i>	T2	PA
<i>glyburide micronized</i>	T2	PA
<i>glyburide-metformin</i>	T2	PA
GLYNASE	T4	
GLYSET	T3	
GLYXAMBI	T4	
HECTOROL INTRAVENOUS SOLUTION 4 MCG/2 ML	T4	PA-BvD
HECTOROL ORAL CAPSULE 0.5 MCG	T4	PA-BvD
HECTOROL ORAL CAPSULE 1 MCG, 2.5 MCG	T5	PA-BvD
HUMALOG	T3	
HUMALOG KWIKPEN	T3	
HUMALOG MIX 50-50	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMULIN 70/30	T3	
HUMULIN 70/30 KWIKPEN	T3	
HUMULIN N	T3	
HUMULIN N KWIKPEN	T3	
HUMULIN R U-100	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
HUMULIN R U-500 (CONCENTRATED)	T3	
<i>hydrocortisone oral</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	T3	
INVOKAMET	T3	
INVOKAMET XR	T3	
INVOKANA	T3	
JANUMET	T3	
JANUMET XR	T3	
JANUVIA	T3	
JARDIANCE	T3	
JENTADUETO	T3	
JENTADUETO XR	T3	
KANUMA	T5	PA
KAZANO	T4	
KENALOG INJECTION	T4	
KOMBIGLYZE XR	T4	
KORLYM	T5	PA
KUVAN ORAL POWDER IN PACKET	T4	
KUVAN ORAL TABLET,SOLUBLE	T5	
LANTUS	T3	
LANTUS SOLOSTAR	T3	
LEVEMIR	T3	
LEVEMIR FLEXTOUCH	T3	
LEVOthyroxine INTRAVENOUS RECON SOLN 100 MCG	T4	
<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	
LUMIZYME	T5	
MEDROL	T4	
MEDROL (PAK)	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	
METFORMIN ORAL TABLET,ER GAST.RETENTION 24 HR	T4	PA
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
METHITEST	T4	PA

Drug Name	Drug Tier	Requirements/Limits
<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
MIACALCIN INJECTION	T4	PA-BvD
<i>miglitol</i>	T2	
MILLIPRED ORAL SOLUTION	T4	
<i>millipred oral tablet</i>	T2	
MYALEPT	T5	PA
NAGLAZYME	T5	
<i>nateglinide</i>	T1	
NATESTO	T4	PA
NATPARA	T5	PA
NESINA	T4	
<i>novarel intramuscular recon soln 10,000 unit</i>	T2	PA-BvD
NOVOLIN 70/30	T3	
NOVOLIN N	T3	
NOVOLIN R	T3	
NOVOLOG	T3	
NOVOLOG FLEXPEN	T3	
NOVOLOG MIX 70-30	T3	
NOVOLOG MIX 70-30 FLEXPEN	T3	
NOVOLOG PENFILL	T3	
ONGLYZA	T4	
ORAPRED ODT	T4	
OSENI	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
PARICALCITOL INTRAVENOUS	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
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	T4	
<i>pioglitazone</i>	T1	
<i>pioglitazone-glimepiride</i>	T1	
<i>pioglitazone-metformin</i>	T1	

Drug Name	Drug Tier	Requirements/Limits
PRANDIN ORAL TABLET 1 MG, 2 MG	T4	
PRECOSE	T4	
<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	
<i>prednisone oral solution</i>	T1	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets, dose pack</i>	T2	
PREGNYL	T4	PA-BvD
PROGLYCEM	T3	
<i>propylthiouracil</i>	T2	
RAYALDEE	T4	QL (31 EA per 31 days)
RAYOS	T4	
<i>repaglinide oral tablet 0.5 mg</i>	T1	
<i>repaglinide oral tablet 1 mg, 2 mg</i>	T2	
<i>repaglinide-metformin</i>	T2	
RIOMET	T4	PA; QL (791 ML per 31 days)
ROCALTROL	T4	PA-BvD
SAMSCA	T5	
SENSIPAR ORAL TABLET 30 MG	T3	
SENSIPAR ORAL TABLET 60 MG, 90 MG	T5	
SOLIQUA 100/33	T4	QL (15 ML per 30 days)
SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML	T4	
SOLU-MEDROL (PF) INJECTION	T4	
SOLU-MEDROL (PF) INTRAVENOUS RECON SOLN 500 MG/4 ML	T4	
SOLU-MEDROL INTRAVENOUS RECON SOLN 2 GRAM	T4	
SOMAVERT	T5	
STARLIX	T4	
STIMATE	T3	
STRENSIQ	T5	PA
STRIANT	T4	PA
SYMLINPEN 120	T3	
SYMLINPEN 60	T3	

Drug Name	Drug Tier	Requirements/Limits
SYNAREL	T5	
SYNJARDY	T4	QL (62 EA per 31 days)
SYNTHROID	T4	
TANZEUM	T4	QL (4 EA per 28 days)
TAPAZOLE	T4	
TESTIM	T4	PA
<i>testosterone cypionate</i>	T2	PA
<i>testosterone enanthate</i>	T2	PA
TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP	T3	PA
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i>	T3	PA
TESTOSTERONE TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	T3	PA
<i>testosterone transdermal solution in metered pump w/app</i>	T4	PA
TESTRED	T4	PA
THYROLAR-1	T4	
THYROLAR-1/2	T4	
THYROLAR-1/4	T4	
THYROLAR-2	T4	
THYROLAR-3	T4	
TIROSINT	T4	
<i>tolazamide</i>	T1	
<i>tolbutamide</i>	T1	
TOUJEO SOLOSTAR	T3	
TRADJENTA	T3	
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRIOSTAT	T4	
TRULICITY	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	
VICTOZA 3-PAK	T3	QL (9 ML per 30 days)
VOGELXO TRANSDERMAL GEL	T4	PA
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	T4	PA
VPRIV	T5	

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR	T3	
ZAVESCA	T5	
ZEMPLAR INTRAVENOUS	T4	PA-BvD
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	T4	PA-BvD
<i>zoledronic acid intravenous solution</i>	T2	
ZOMETA	T5	
Gastroenterology		
ACIPHEX	T4	
ACIPHEX SPRINKLE	T4	
ACTIGALL	T4	
AKYNZEO	T4	PA-BvD
<i>alosetron oral tablet 0.5 mg</i>	T2	
<i>alosetron oral tablet 1 mg</i>	T5	
ALOXI	T4	
AMITIZA	T3	QL (62 EA per 31 days)
<i>amoxicil-clarithromy-lansopraz</i>	T2	
ANUSOL-HC TOPICAL CREAM WITH PERINEAL APPLICATOR	T4	
ANZEMET ORAL	T4	PA-BvD
APREPITANT	T4	PA-BvD
APRISO	T3	
ASACOL HD	T3	
<i>atropine injection syringe 0.05 mg/ml</i>	T2	
AZULFIDINE	T4	
AZULFIDINE EN-TABS	T4	
<i>balsalazide</i>	T2	
BENTYL INTRAMUSCULAR	T4	
BENTYL ORAL CAPSULE	T4	
<i>budesonide oral</i>	T4	
CANASA	T3	
<i>carafate oral suspension</i>	T3	
CARAFATE ORAL TABLET	T4	
CESAMET	T4	PA-BvD
CHENODAL	T5	PA
CHOLBAM	T5	PA
<i>cimetidine</i>	T2	
<i>cimetidine hcl oral</i>	T2	
CIMZIA	T5	PA; QL (2 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
CIMZIA POWDER FOR RECONST	T5	PA; QL (6 EA per 28 days)
COLAZAL	T4	
<i>colocort</i>	T2	
COLYTE WITH FLAVOR PACKS ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM	T4	
<i>compro</i>	T2	
<i>constulose</i>	T2	
CREON	T3	
<i>cromolyn oral</i>	T2	
CUVPOSA	T4	
CYSTADANE	T3	
CYTOTEC	T4	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	T3	
DEXILANT	T4	
<i>dicyclomine intramuscular</i>	T2	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
DIPENTUM	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
EMEND INTRAVENOUS	T4	
EMEND ORAL	T4	PA-BvD
ENTOCORT EC	T4	
<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	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
GASTROCROM	T4	
GATTEX ONE-VIAL	T5	PA
<i>gavilyte-c</i>	T2	
<i>gavilyte-g</i>	T2	
<i>gavilyte-n</i>	T2	
<i>generlac</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
GIAZO	T4	
<i>glycopyrrolate injection</i>	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
GOLYTELY	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	
INFLECTRA	T5	PA; QL (8 EA per 28 days)
KRISTALOSE	T4	
<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)
LIALDA	T3	
LINZESS	T3	QL (31 EA per 31 days)
LOMOTIL	T4	
<i>loperamide oral capsule</i>	T2	
LOTRONEX ORAL TABLET 0.5 MG	T3	
LOTRONEX ORAL TABLET 1 MG	T5	
MARINOL ORAL CAPSULE 10 MG, 5 MG	T4	PA-BvD
MARINOL ORAL CAPSULE 2.5 MG	T5	PA-BvD
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	T4	
MESALAMINE ORAL TABLET, DELAYED RELEASE (DR/EC) 800 MG	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	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	T4	
<i>misoprostol</i>	T2	
MOVANTI	T3	QL (31 EA per 31 days)
MOVIPREP	T4	
MYTESI	T4	QL (62 EA per 31 days)
NEXIUM	T4	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
NEXIUM IV INTRAVENOUS RECON SOLN 40 MG	T4	
NEXIUM PACKET	T3	
<i>nizatidine</i>	T2	
NULYTELY WITH FLAVOR PACKS	T4	
OCALIVA	T5	PA; QL (31 EA per 31 days)
<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
OSMOPREP	T4	
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	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	
PENTASA	T3	
PEPCID	T4	
PERTZYE	T3	
<i>polyethylene glycol 3350 oral powder</i>	T2	
PREPOPIK	T4	
PREVACID ORAL CAPSULE, DELAYED RELEASE(DR/EC) 15 MG	T4	QL (31 EA per 31 days)
PREVACID ORAL CAPSULE, DELAYED RELEASE(DR/EC) 30 MG	T4	QL (62 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAY REL 15 MG	T4	QL (31 EA per 31 days)
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAY REL 30 MG	T4	QL (62 EA per 31 days)
PREVPAC	T4	
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON	T4	
<i>prochlorperazine</i>	T2	
<i>prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>prochlorperazine maleate</i>	T2	
<i>procto-med hc</i>	T2	
<i>procto-pak</i>	T2	
<i>proctosol hc topical</i>	T2	
<i>proctozone-hc</i>	T2	
<i>propantheline</i>	T2	
PROTONIX	T4	
PYLERA	T4	
<i>rabeprazole</i>	T2	QL (62 EA per 31 days)
RANITIDINE HCL INJECTION SOLUTION 50 MG/2 ML (25 MG/ML)	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	
RECTIV	T4	
REGLAN ORAL	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T4	QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	T4	QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	T4	QL (12.4 ML per 31 days)
REMICADE	T5	PA; QL (8 EA per 28 days)
RENFLEXIS	T5	PA; QL (8 EA per 28 days)
ROBINUL	T4	
ROBINUL FORTE	T4	
SANCUSO	T4	
SFROWASA	T4	
SUCRAID	T5	
<i>sucrafate oral tablet</i>	T2	
<i>sulfasalazine</i>	T2	
SUPREP BOWEL PREP KIT	T3	
SYNDROS	T5	PA
TIGAN INTRAMUSCULAR	T4	
TIGAN ORAL CAPSULE 300 MG	T4	PA
TRANSDERM-SCOP	T3	
<i>trilyte with flavor packets</i>	T2	
<i>trimethobenzamide oral</i>	T2	PA
UCERIS	T4	

Drug Name	Drug Tier	Requirements/Limits
URSO 250	T4	
URSO FORTE	T4	
<i>ursodiol</i>	T3	
VARUBI	T4	PA-BvD
VIBERZI	T5	PA; QL (62 EA per 31 days)
VIOKACE	T4	
ZANTAC INJECTION SOLUTION 25 MG/ML	T4	
ZANTAC ORAL TABLET	T4	
ZEGERID	T4	
ZENPEP	T3	
ZOFRAN (AS HYDROCHLORIDE) ORAL	T5	PA-BvD
ZOFRAN ODT ORAL TABLET,DISINTEGRATING 4 MG	T4	PA-BvD
ZOFRAN ODT ORAL TABLET,DISINTEGRATING 8 MG	T5	PA-BvD
ZUPLENZ	T4	PA-BvD
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA-NS
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION	T3	
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	T3	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 200 MCG/ML, 300 MCG/ML	T5	PA-BvD
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	T3	PA-BvD
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	T5	PA-BvD
ARCALYST	T5	PA
ATGAM	T3	PA-BvD
AVONEX (WITH ALBUMIN)	T5	QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
BCG VACCINE, LIVE (PF)	T4	
BETASERON SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T4	
BOTOX	T4	PA
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM	T5	PA
DAPTACEL (DTAP PEDIATRIC) (PF)	T4	
DYSPORT	T4	PA
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	T5	PA-NS
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
EXTAVIA SUBCUTANEOUS KIT	T5	QL (15 EA per 31 days)
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	T5	PA
<i>fomepizole</i>	T1	
GAMASTAN S/D	T4	PA
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GARDASIL 9 (PF)	T3	
GENOTROPIN	T5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA

Drug Name	Drug Tier	Requirements/Limits
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	T5	PA
GRANIX	T5	
GRASTEK	T4	PA
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	T3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	T3	
HIBERIX (PF)	T4	
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	T5	PA
HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)	T4	PA
HUMATROPE INJECTION RECON SOLN	T5	PA
HYPERRAB S/D (PF)	T4	PA-BvD
ILARIS (PF) SUBCUTANEOUS RECON SOLN	T5	PA
IMOGAM RABIES-HT (PF)	T4	PA-BvD
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	T3	
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	T3	PA-NS
INTRON A INJECTION RECON SOLN 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	T5	PA-NS
INTRON A INJECTION SOLUTION	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T4	
KINRIX (PF)	T4	
LEUKINE INJECTION RECON SOLN	T5	
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENVEO A-C-Y-W-135-DIP (PF)	T4	
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 200 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	T4	PA-BvD
M-M-R II (PF)	T4	

Drug Name	Drug Tier	Requirements/Limits
MOZOBIL	T5	PA
NEULASTA SUBCUTANEOUS SYRINGE	T5	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML	T4	
NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML	T5	
NEUPOGEN INJECTION SYRINGE	T5	
NORDITROPIN FLEXPRO 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)	T5	PA
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
NUTROPIN AQ NUSPIN	T5	PA
OCTAGAM	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PEDIARIX (PF)	T4	PA-BvD
PEDVAX HIB (PF)	T4	
PEGASYS	T5	PA
PEGASYS PROCLICK	T5	PA
PEGINTRON REDIPEN SUBCUTANEOUS PEN INJECTOR KIT 120 MCG/0.5 ML	T5	PA
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML	T5	PA
PLEGRIDY SUBCUTANEOUS PEN INJECTOR	T5	QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 40,000 UNIT/ML	T5	PA-BvD
PROLEUKIN	T5	

Drug Name	Drug Tier	Requirements/Limits
PROQUAD (PF)	T3	
QUADRACEL (PF)	T4	
RABAVERT (PF)	T4	
RAGWITEK	T4	PA
REBIF (WITH ALBUMIN)	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	T5	QL (6 ML per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	T5	QL (4.2 ML per 365 days)
REBIF TITRATION PACK	T5	QL (8.4 ML per 365 days)
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T4	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T4	PA-BvD
ROTARIX	T4	
ROTATEQ VACCINE	T3	
SAIZEN	T5	PA
SAIZEN CLICK.EASY	T5	PA
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SYLATRON	T5	PA-NS
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T4	
TETANUS,DIPHThERIA TOX PED(PF)	T4	
TETANUS-DIPHThERIA TOXOIDS-TD	T3	
THYMOGLOBULIN	T4	
TRUMENBA	T3	
TWINRIX (PF) INTRAMUSCULAR SUSPENSION	T3	
TYPHIM VI INTRAMUSCULAR SOLUTION	T3	
TYPHIM VI INTRAMUSCULAR SYRINGE	T4	
VAQTA (PF) INTRAMUSCULAR SYRINGE	T3	
VARIVAX (PF)	T3	
VARIZIG INTRAMUSCULAR SOLUTION	T4	
XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT	T4	PA
YF-VAX (PF)	T3	
ZARXIO	T5	
ZINPLAVA	T5	PA

Drug Name	Drug Tier	Requirements/Limits
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	T5	PA
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	T4	PA
ZORBTIVE	T5	PA
ZOSTAVAX (PF)	T3	
Musculoskeletal / Rheumatology		
ACTEMRA INTRAVENOUS	T5	PA; QL (40 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
ACTONEL ORAL TABLET 150 MG, 35 MG, 5 MG	T4	
<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	
ALLOPURINOL SODIUM	T5	
<i>aloprim</i>	T2	
ARAVA	T5	
AELVIA	T4	
BENLYSTA INTRAVENOUS RECON SOLN 120 MG	T4	
BENLYSTA INTRAVENOUS RECON SOLN 400 MG	T5	
BENLYSTA SUBCUTANEOUS	T5	
BINOSTO	T4	
BONIVA INTRAVENOUS	T4	PA-BvD
BONIVA ORAL	T4	
COLCHICINE	T4	
COLCRYS	T3	
CUPRIMINE	T5	
DEPEN TITRATABS	T5	
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (0.98 ML)	T5	PA; QL (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
EVISTA	T3	
FORTEO	T5	PA; QL (2.4 ML per 28 days)
FOSAMAX ORAL TABLET 70 MG	T4	

Drug Name	Drug Tier	Requirements/Limits
FOSAMAX PLUS D	T4	
HUMIRA	T5	PA; QL (2 EA per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHN'S-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSORIASIS-UVEITIS	T5	PA; QL (4 EA per 28 days)
<i>ibandronate intravenous solution</i>	T2	PA-BvD
<i>ibandronate oral</i>	T2	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T2	
MITIGARE	T4	QL (62 EA per 31 days)
ORENCIA (WITH MALTOSE)	T5	PA; QL (8 EA per 28 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
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	T4	PA
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	
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	T4	PA
RIDAURA	T3	

Drug Name	Drug Tier	Requirements/Limits
<i>risedronate</i>	T2	
SAVELLA	T4	PA
SIMPONI ARIA	T5	PA; QL (16 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 31 days)
ULORIC	T3	
XELJANZ	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
ZURAMPIC	T4	
ZYLOPRIM	T4	
Obstetrics / Gynecology		
ACTIVELLA	T4	
ALORA	T4	
<i>alyacen 1/35 (28)</i>	T2	
<i>amabelz</i>	T2	
<i>amethia</i>	T2	
<i>amethia lo</i>	T2	
ANGELIQ	T4	
<i>apri</i>	T2	
<i>aranelle (28)</i>	T2	
<i>ashlyna</i>	T2	
<i>aubra</i>	T2	
AVC VAGINAL	T4	
<i>aviane</i>	T2	
AYGESTIN	T4	
<i>balziva (28)</i>	T2	
<i>bekyree (28)</i>	T2	
BEYAZ	T4	
<i>blisovi 24 fe</i>	T2	
<i>blisovi fe 1.5/30 (28)</i>	T2	
<i>blisovi fe 1/20 (28)</i>	T2	
BREVICON (28)	T4	
<i>briellyn</i>	T2	
<i>camila</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>camrese lo</i>	T2	
<i>caziant (28)</i>	T2	
CLEOCIN VAGINAL	T4	
CLIMARA	T4	
CLIMARA PRO	T4	
<i>clindamycin phosphate vaginal</i>	T2	
CLINDESSE	T4	
COMBIPATCH	T4	
CRINONE	T4	PA
<i>cryselle (28)</i>	T2	
<i>cyclafem 1/35 (28)</i>	T2	
<i>cyclafem 7/7/7 (28)</i>	T2	
CYCLESSA (28)	T4	
<i>deblitane</i>	T2	
DELESTROGEN	T4	
<i>delyla (28)</i>	T2	
DEPO-ESTRADIOL	T4	
DEPO-PROVERA INTRAMUSCULAR SOLUTION	T4	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION	T4	
DEPO-SUBQ PROVERA 104	T4	
<i>desog-e.estradiol/e.estradiol</i>	T2	
DESOGEN	T4	
<i>desogestrel-ethinyl estradiol</i>	T2	
DIVIGEL TRANSDERMAL GEL IN PACKET 0.5 MG/0.5 GRAM (0.1 %)	T4	
<i>drospirenone-e.estradiol-lm.fa</i>	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
DUAVEE	T4	
ELESTRIN	T4	
<i>emoquette</i>	T2	
<i>enpresse</i>	T2	
<i>errin</i>	T2	
ESTRACE	T4	
<i>estradiol oral</i>	T1	
<i>estradiol transdermal</i>	T2	
<i>estradiol vaginal</i>	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	T2	
<i>estradiol-norethindrone acet</i>	T2	
ESTRING	T4	
<i>estropipate</i>	T1	
<i>ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg</i>	T2	
EVAMIST	T4	
<i>falmina (28)</i>	T2	
<i>fayosim</i>	T2	
FEMHRT LOW DOSE	T4	
FEMRING	T4	
<i>femynor</i>	T2	
<i>fyavolv</i>	T2	
GENERESS FE	T4	
<i>gianvi (28)</i>	T2	
<i>gildagia</i>	T2	
GYNAZOLE-1	T4	
<i>hydroxyprogesterone caproate</i>	T5	
<i>introvale</i>	T2	
<i>isibloom</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	
<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.estradiol oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)</i>	T2	
<i>larin 1.5/30 (21)</i>	T2	
<i>larin 1/20 (21)</i>	T2	
<i>larin fe 1.5/30 (28)</i>	T2	
<i>larin fe 1/20 (28)</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>larissia</i>	T2	
<i>layolis fe</i>	T2	
<i>leena 28</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	
LO LOESTRIN FE	T4	
LOESTRIN 1.5/30 (21)	T4	
LOESTRIN 1/20 (21)	T4	
LOESTRIN FE 1.5/30 (28-DAY)	T4	
LOESTRIN FE 1/20 (28-DAY)	T4	
<i>lomedica 24 fe</i>	T2	
<i>loryna (28)</i>	T2	
LOSEASONIQUE	T4	
<i>low-ogestrel (28)</i>	T2	
LUPANETA PACK (1 MONTH)	T5	
LUPANETA PACK (3 MONTH)	T5	
<i>lutra (28)</i>	T2	
LYSTEDA	T4	
<i>lyza</i>	T2	
MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)	T5	
<i>marlissa</i>	T2	
<i>medroxyprogesterone intramuscular suspension</i>	T2	
<i>medroxyprogesterone oral</i>	T2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	T4	
MENOSTAR	T4	
METROGEL VAGINAL	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	

Drug Name	Drug Tier	Requirements/Limits
<i>microgestin fe 1.5/30 (28)</i>	T2	
<i>microgestin fe 1/20 (28)</i>	T2	
<i>mimvey</i>	T2	
<i>mimvey lo</i>	T2	
MINASTRIN 24 FE	T4	
MINIVELLE	T4	
<i>mononessa (28)</i>	T2	
NATAZIA	T4	
<i>necon 0.5/35 (28)</i>	T2	
<i>necon 1/50 (28)</i>	T2	
<i>necon 7/7/7 (28)</i>	T2	
<i>nikki (28)</i>	T2	
<i>nora-be</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>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (24)/75 mg (4)</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet,chewable</i>	T2	
<i>norgestimate-ethinyl estradiol</i>	T2	
<i>norlyroc</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	
NUVARING	T3	
NUVESSA	T4	
<i>ocella</i>	T2	
<i>ogestrel (28)</i>	T2	
<i>orsythia</i>	T2	
ORTHO MICRONOR	T4	
ORTHO TRI-CYCLEN (28)	T4	
ORTHO TRI-CYCLEN LO (28)	T3	
ORTHO-CYCLEN (28)	T4	
ORTHO-NOVUM 1/35 (28)	T4	
ORTHO-NOVUM 7/7/7 (28)	T4	
OVCON-35 (28)	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>pimtreea (28)</i>	T2	
<i>pirmella oral tablet 1-35 mg-mcg</i>	T2	
<i>portia</i>	T2	
PREFEST	T4	
PREMARIN INJECTION	T4	
PREMARIN ORAL	T4	
PREMARIN VAGINAL	T3	
PREMPHASE	T4	
PREMPRO	T4	
<i>previfem</i>	T2	
<i>progesterone micronized</i>	T2	
PROMETRIUM	T4	
PROVERA	T4	
QUARTETTE	T4	
<i>quasense</i>	T2	
<i>reclipsen (28)</i>	T2	
<i>rivelsa</i>	T2	
SAFYRAL	T4	
SEASONIQUE	T4	
<i>setlakin</i>	T2	
<i>sharobel</i>	T2	
<i>sprintec (28)</i>	T2	
<i>sronyx</i>	T2	
<i>tarina fe 1/20 (28)</i>	T2	
TERAZOL 7	T4	
<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	
TRI-NORINYL (28)	T4	
<i>tri-previfem (28)</i>	T2	
<i>tri-sprintec (28)</i>	T2	
<i>trivora (28)</i>	T2	
VAGIFEM	T4	
<i>vandazole</i>	T2	
<i>velivet triphasic regimen (28)</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
<i>vestura (28)</i>	T2	
<i>vienva</i>	T2	
VIVELLE-DOT	T4	
<i>vyfemla (28)</i>	T2	
<i>wymzya fe</i>	T2	
<i>xulane</i>	T2	
YASMIN (28)	T4	
YAZ (28)	T4	
YUVAFEM	T4	
<i>zarah</i>	T2	
<i>zenchent (28)</i>	T2	
<i>zenchent fe</i>	T2	
<i>zovia 1/35e (28)</i>	T2	
<i>zovia 1/50e (28)</i>	T2	
Ophthalmology		
<i>acetazolamide</i>	T2	
<i>acetazolamide sodium</i>	T2	
ACULAR	T4	
ACULAR LS	T4	
ACUVAIL (PF)	T4	
ALOCRIAL	T4	
ALOMIDE	T3	
ALPHAGAN P	T3	
ALREX	T4	
<i>apraclonidine</i>	T2	
<i>atropine ophthalmic (eye) drops</i>	T2	
AZASITE	T4	
<i>azelastine ophthalmic (eye)</i>	T2	
AZOPT	T3	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	T2	
BEPREVE	T4	
BESIVANCE	T4	
BETAGAN OPHTHALMIC (EYE) DROPS 0.5 %	T4	
<i>betaxolol ophthalmic (eye)</i>	T2	
BETIMOL	T4	
BETOPTIC S	T4	

Drug Name	Drug Tier	Requirements/Limits
<i>bimatoprost ophthalmic (eye)</i>	T2	
BLEPH-10	T4	
BLEPHAMIDE	T3	
BLEPHAMIDE S.O.P.	T3	
<i>brimonidine</i>	T2	
<i>bromfenac</i>	T2	
<i>carteolol</i>	T2	
CILOXAN OPHTHALMIC (EYE) DROPS	T4	
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T1	
COMBIGAN	T3	
COSOPT	T4	
COSOPT (PF)	T4	
<i>cromolyn ophthalmic (eye)</i>	T2	
CYSTARAN	T5	
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
DIAMOX SEQUELS	T4	
<i>diclofenac sodium ophthalmic (eye)</i>	T1	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
DUREZOL	T3	
ELESTAT	T4	
EMADINE	T4	
<i>epinastine</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
FLAREX	T4	
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
FML FORTE	T4	
FML LIQUIFILM	T4	
FML S.O.P.	T4	
<i>gatifloxacin</i>	T2	
<i>gentak ophthalmic (eye) ointment</i>	T2	
<i>gentamicin ophthalmic (eye) drops</i>	T1	
ILEVRO	T3	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	T3	

Drug Name	Drug Tier	Requirements/Limits
IOPIDINE OPHTHALMIC (EYE) DROPS	T4	
ISOPTO CARPINE	T4	
ISTALOL	T4	
<i>ketorolac ophthalmic (eye)</i>	T2	
LACRISERT	T3	
LASTACAFT	T4	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T1	
<i>levofloxacin ophthalmic (eye)</i>	T2	
LOTEMAX	T4	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
MAXIDEX	T4	
MAXITROL	T4	
<i>methazolamide</i>	T2	
<i>metipranolol</i>	T2	
MOXEZA	T4	
<i>moxifloxacin ophthalmic (eye)</i>	T4	
NATACYN	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	
NEOSPORIN (NEO-POLYM-GRAMICID)	T4	
NEVANAC	T4	
OCUFEN	T4	
OCUFLOX	T4	
<i>ofloxacin ophthalmic (eye)</i>	T2	
<i>olopatadine ophthalmic (eye)</i>	T3	
OMNIPRED	T4	
PATADAY	T3	
PATANOL	T4	
PAZEO	T3	
PHOSPHOLINE IODIDE	T3	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
<i>polymyxin b sulf-trimethoprim</i>	T2	
POLYTRIM	T4	

Drug Name	Drug Tier	Requirements/Limits
PRED FORTE	T4	
PRED MILD	T4	
PRED-G	T4	
PRED-G S.O.P.	T4	
<i>prednisolone acetate</i>	T3	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
PROLENSA	T4	
RESTASIS	T3	
SIMBRINZA	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	
TIMOPTIC OCUDOSE (PF)	T3	
TIMOPTIC-XE	T4	
TOBRADEX OPHTHALMIC (EYE) DROPS,SUSPENSION	T4	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
<i>tobramycin</i>	T1	
<i>tobramycin-dexamethasone</i>	T2	
TOBREX OPHTHALMIC (EYE) DROPS	T4	
TOBREX OPHTHALMIC (EYE) OINTMENT	T3	
TRAVATAN Z	T3	
<i>trifluridine</i>	T2	
TRUSOPT	T4	
VIGAMOX	T4	
VIROPTIC	T4	
XALATAN	T4	
XIIDRA	T4	
ZIOPTAN (PF)	T4	
ZIRGAN	T4	
ZYLET	T4	
ZYMAXID	T3	

Drug Name	Drug Tier	Requirements/Limits
Respiratory And Allergy		
ACCOLATE	T4	
<i>acetylcysteine</i>	T2	PA-BvD
ADCIRCA	T5	PA; QL (62 EA per 31 days)
ADEMPAS	T5	PA; QL (93 EA per 31 days)
<i>adrenalin injection solution 1 mg/ml (1 ml)</i>	T2	
ADVAIR DISKUS	T3	QL (60 EA per 30 days)
ADVAIR HFA	T3	QL (12 GM per 30 days)
AEROSPAN	T4	QL (17.8 GM per 30 days)
AIRDUO RESPICLICK	T4	QL (1 EA 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	
ALVESCO	T4	QL (12.2 GM per 30 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
ARCAPTA NEOHALER	T4	QL (30 EA per 30 days)
ARMONAIR RESPICLICK	T4	QL (1 EA per 30 days)
ARNUITY ELLIPTA	T4	QL (30 EA per 30 days)
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (120 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
AUVI-Q	T4	
BECONASE AQ	T4	
BERINERT INTRAVENOUS KIT	T5	PA
BEVESPI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BROVANA	T3	PA-BvD
<i>budesonide inhalation</i>	T2	PA-BvD
<i>budesonide nasal</i>	T2	
<i>carbinoxamine maleate</i>	T2	
<i>cetirizine oral solution 1 mg/ml</i>	T2	
CINRYZE	T5	PA

Drug Name	Drug Tier	Requirements/Limits
CLARINEX ORAL SYRUP	T4	
CLARINEX ORAL TABLET	T4	
CLARINEX-D 12 HOUR	T4	
<i>clemastine oral tablet 2.68 mg</i>	T2	
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T2	PA-BvD
<i>cyproheptadine</i>	T2	
DALIRESP	T3	QL (31 EA per 31 days)
<i>desloratadine</i>	T2	
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	T2	
<i>diphenhydramine hcl oral elixir</i>	T2	
DULERA	T4	QL (13 GM per 30 days)
DYMISTA	T4	
EPINEPHRINE INJECTION AUTO-INJECTOR	T3	
EPIPEN 2-PAK	T3	
EPIPEN JR 2-PAK	T3	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FIRAZYR	T5	PA; QL (18 ML per 30 days)
FLOVENT DISKUS	T3	QL (60 EA per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION, 220 MCG/ACTUATION	T3	QL (24 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	T3	QL (12 GM per 30 days)
<i>flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)</i>	T2	
<i>fluticasone nasal</i>	T2	
FLUTICASONE-SALMETEROL	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>hydroxyzine pamoate</i>	T2	
INCRUSE ELLIPTA	T4	QL (30 EA per 30 days)
<i>ipratropium bromide inhalation</i>	T1	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET	T5	PA; QL (56 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
KARBINAL ER	T4	
LETAIRIS	T5	PA; QL (31 EA per 31 days)
<i>levalbuterol hcl</i>	T2	PA-BvD
LEVALBUTEROL TARTRATE	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)
NASONEX	T4	
NUCALA	T5	PA
OFEV	T5	PA; QL (62 EA per 31 days)
OMNARIS	T4	
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI	T5	PA; QL (124 EA per 31 days)
PERFOROMIST	T4	PA-BvD
<i>phenadoz rectal suppository 12.5 mg</i>	T2	
PHENERGAN INJECTION	T4	
<i>phenergan rectal</i>	T2	
PROAIR HFA	T3	QL (17 GM per 30 days)
PROAIR RESPICLICK	T3	QL (2 EA per 30 days)
<i>promethazine injection solution</i>	T2	
<i>promethazine oral syrup</i>	T2	PA
<i>promethazine oral tablet</i>	T2	
<i>promethazine rectal</i>	T2	
<i>promethazine vc</i>	T2	
<i>promethegan rectal suppository 25 mg, 50 mg</i>	T2	
PROVENTIL HFA	T4	QL (13.4 GM per 30 days)
PULMICORT	T4	PA-BvD
PULMICORT FLEXHALER	T4	QL (1 EA per 30 days)
PULMOZYME	T5	PA
QNASL	T4	
QVAR INHALATION AEROSOL 40 MCG/ACTUATION	T3	QL (8.7 GM per 30 days)
QVAR INHALATION AEROSOL 80 MCG/ACTUATION	T3	QL (17.4 GM per 30 days)
REVATIO INTRAVENOUS	T5	PA

Drug Name	Drug Tier	Requirements/Limits
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	T5	PA; QL (224 ML per 31 days)
REVATIO ORAL TABLET	T5	PA; QL (93 EA per 31 days)
RUCONEST	T5	PA
RYVENT	T4	
SEMPREX-D	T4	
SEREVENT DISKUS	T3	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)
SINGULAIR	T4	QL (31 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
<i>terbutaline</i>	T2	
THEO-24	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	
TRACLEER	T5	PA; QL (62 EA per 31 days)
<i>triamcinolone acetonide nasal</i>	T3	
TUDORZA PRESSAIR	T4	QL (1 EA per 30 days)
VENTAVIS	T5	PA-BvD
VENTOLIN HFA	T3	QL (36 GM per 30 days)
VISTARIL	T4	
XOLAIR	T5	
XOPENEX	T4	PA-BvD
XOPENEX CONCENTRATE	T4	PA-BvD
XOPENEX HFA	T4	QL (30 GM per 30 days)
XYZAL ORAL SOLUTION	T4	
<i>zafirlukast</i>	T2	
ZETONNA	T4	
<i>zileuton</i>	T5	PA
ZYFLO	T4	PA
ZYFLO CR	T5	PA
Urologicals		
<i>alfuzosin</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
AVODART	T4	
<i>bethanechol chloride</i>	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T3	
<i>darifenacin</i>	T3	
DETROL LA	T4	PA; QL (31 EA per 31 days)
DETROL ORAL TABLET 1 MG	T4	PA; QL (31 EA per 31 days)
DETROL ORAL TABLET 2 MG	T4	PA; QL (62 EA per 31 days)
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG	T4	PA; QL (31 EA per 31 days)
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 15 MG	T4	PA; QL (62 EA per 31 days)
<i>dutasteride</i>	T3	
<i>dutasteride-tamsulosin</i>	T3	
ELMIRON	T3	
ENABLEX	T4	PA; QL (31 EA per 31 days)
<i>finasteride oral tablet 5 mg</i>	T2	
<i>flavoxate</i>	T2	
FLOMAX	T4	
GELNIQUE TRANSDERMAL GEL IN PACKET	T3	PA; QL (30 GM per 30 days)
JALYN	T4	
MYRBETRIQ	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	
OXYTROL	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	
PROCYSBI	T5	PA
PROSCAR	T4	
RAPAFLO	T3	
<i>tamsulosin</i>	T1	
<i>tolterodine</i>	T3	
TOVIAZ	T3	QL (31 EA per 31 days)
<i>tropium</i>	T2	

Drug Name	Drug Tier	Requirements/Limits
URECHOLINE	T4	
UROCIT-K 10	T4	
UROCIT-K 15	T4	
UROCIT-K 5	T4	
UROXATRAL	T4	
VESICARE	T3	QL (31 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
<i>amino acids 15 %</i>	T2	PA-BvD
AMINOSYN 7 % WITH ELECTROLYTES	T4	PA-BvD
AMINOSYN 8.5 %-ELECTROLYTES	T4	PA-BvD
AMINOSYN II 10 %	T4	PA-BvD
AMINOSYN II 15 %	T4	PA-BvD
AMINOSYN II 8.5 %	T4	PA-BvD
AMINOSYN II 8.5 %-ELECTROLYTES	T4	PA-BvD
AMINOSYN-HBC 7%	T3	PA-BvD
AMINOSYN-PF 10 %	T3	PA-BvD
AMINOSYN-PF 7 % (SULFITE-FREE)	T3	PA-BvD
AMINOSYN-RF 5.2 %	T4	PA-BvD
<i>calcium acetate oral capsule</i>	T2	
<i>calcium acetate oral tablet 667 mg</i>	T2	
CLINIMIX 5%/D15W SULFITE FREE	T3	PA-BvD
CLINIMIX 5%/D25W SULFITE-FREE	T3	PA-BvD
CLINIMIX 2.75%/D5W SULFIT FREE	T3	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T3	PA-BvD
CLINIMIX 4.25%-D20W SULF-FREE	T3	PA-BvD
CLINIMIX 4.25%-D25W SULF-FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T3	PA-BvD
CLINIMIX E 4.25%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D25W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D5W SULF FREE	T4	PA-BvD
CLINIMIX E 5%/D15W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D20W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D25W SULFIT FREE	T4	PA-BvD
CLINISOL SF 15 %	T4	PA-BvD
<i>dextrose-kcl-nacl</i>	T2	
<i>eliphos</i>	T2	
<i>fluoride (sodium) oral tablet</i>	T2	
FREAMINE HBC 6.9 %	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
HEPATAMINE 8%	T3	PA-BvD
<i>intralipid intravenous emulsion 20 %</i>	T2	PA-BvD
INTRALIPID INTRAVENOUS EMULSION 30 %	T4	PA-BvD
IONOSOL-B IN D5W	T4	PA-BvD
IONOSOL-MB IN D5W	T4	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T3	PA-BvD
ISOLYTE-S	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	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	T4	
<i>k-tab oral tablet extended release 8 meq</i>	T1	
<i>lactated ringers intravenous</i>	T2	
<i>magnesium sulfate injection</i>	T2	
NEPHRAMINE 5.4 %	T3	PA-BvD
NORMOSOL-M IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R IN 5 % DEXTROSE	T4	PA-BvD
NORMOSOL-R PH 7.4	T4	PA-BvD
NUTRILIPID	T4	PA-BvD
PHOSLYRA	T4	
PLASMA-LYTE 148	T4	PA-BvD
PLASMA-LYTE A	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	

Drug Name	Drug Tier	Requirements/Limits
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<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
PREMASOL 6 %	T3	PA-BvD
<i>prenatal vitamin plus low iron</i>	T2	
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PROSOL 20 %	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	
<i>sodium chloride 5 %</i>	T2	
<i>sodium chloride intravenous parenteral solution 2.5 meq/ml</i>	T2	
<i>sodium lactate</i>	T2	
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<i>chlorthalidone</i>	52	CLINIMIX 5%/D25W		<i>codeine sulfate</i>	28
<i>chlorzoxazone</i>	28	SULFITE-FREE	104	COGENTIN	28
CHOLBAM	77	CLINIMIX 2.75%/D5W		COLAZAL	78
<i>cholestyramine light</i>	52	SULFIT FREE	104	COLCHICINE	87
<i>chorionic gonadotropin, human</i> . 71		CLINIMIX 4.25%/D10W		COLCRYS	87
CIALIS	103	SULF FREE	104	COLESTID	52
<i>ciclopirox</i>	61	CLINIMIX 4.25%/D5W		<i>colestipol</i>	52
<i>cidofovir</i>	7	SULFIT FREE	67	<i>colistin (colistimethate na)</i>	7
<i>cilostazol</i>	52	CLINIMIX 4.25%-D20W		<i>colocort</i>	78
CILOXAN	96	SULF-FREE	104	COLY-MYCIN S	69
<i>cimetidine</i>	77	CLINIMIX 4.25%-D25W		COLYTE WITH FLAVOR	
<i>cimetidine hcl</i>	77	SULF-FREE	104	PACKS	78
CIMZIA	77	CLINIMIX 5%-		COMBIGAN	96
CIMZIA POWDER FOR		D20W(SULFITE-FREE)	104	COMBIPATCH	90
RECONST	78	CLINIMIX E 2.75%/D10W		COMBIVENT RESPIMAT ..	100
CINRYZE	99	SUL FREE	67	COMBIVIR	8
CIPRO	7	CLINIMIX E 2.75%/D5W		COMETRIQ	17
CIPRO HC	69	SULF FREE	67	COMPLERA	8
CIPRO IN D5W	7	CLINIMIX E 4.25%/D10W		<i>compro</i>	78
CIPRODEX	69	SUL FREE	104	COMTAN	28
<i>ciprofloxacin</i>	7	CLINIMIX E 4.25%/D25W		CONCERTA	28
<i>ciprofloxacin (mixture)</i>	7	SUL FREE	104	CONDYLOX	61
<i>ciprofloxacin hcl</i>	7, 96	CLINIMIX E 4.25%/D5W		<i>constulose</i>	78
<i>ciprofloxacin in 5 % dextrose</i>	7	SULF FREE	104	CONZIP	28
<i>ciprofloxacin lactate</i>	7	CLINIMIX E 5%/D15W		COPAXONE	28, 29
<i>cisplatin</i>	17	SULFIT FREE	104	COPEGUS	8
<i>citalopram</i>	28	CLINIMIX E 5%/D20W		CORDRAN TAPE LARGE	
<i>cladribine</i>	17	SULFIT FREE	104	ROLL	61
<i>claravis</i>	61	CLINIMIX E 5%/D25W		COREG	52
CLARINEX	100	SULFIT FREE	104	COREG CR	52
CLARINEX-D 12 HOUR	100	CLINISOL SF 15 %	104	CORGARD	52
<i>clarithromycin</i>	7	<i>clobetasol</i>	61	CORLANOR	52
<i>clemastine</i>	100	<i>clobetasol-emollient</i>	61	<i>cormax</i>	61

CORTEF	71	DALVANCE	8	DETROL LA	103
<i>cortisone</i>	71	<i>danazol</i>	71	<i>dexamethasone</i>	71
CORTISPORIN	61	DANTRIUM	29	<i>dexamethasone intensol</i>	71
CORZIDE	52	<i>dantrolene</i>	29	<i>dexamethasone sodium</i>	
COSENTYX	61	DAPSONE	8	<i>phosphate</i>	71, 96
COSENTYX PEN	61	DAPTACEL (DTAP		DEXEDRINE SPANSULE	29
COSMEGEN	17	PEDIATRIC) (PF)	83	DEXILANT	78
COSOPT	96	DAPTOMYCIN	8	<i>dexmethylphenidate</i>	29
COSOPT (PF)	96	DARAPRIM	8	DEXPAK 13 DAY	71
COTELLIC	17	<i>darifenacin</i>	103	<i>dexrazoxane hcl</i>	18
COUMADIN	52	DARZALEX	18	<i>dextroamphetamine</i>	29
COZAAR	52	<i>daunorubicin</i>	18	<i>dextroamphetamine-</i>	
CREON	78	DAYPRO	29	<i>amphetamine</i>	29
CRESEMBA	8	DAYTRANA	29	<i>dextrose 10 % and 0.2 % nacl</i>	67
CRESTOR	52	DDAVP	71	<i>dextrose 10 % in water (d10w)</i> ...67	
CRINONE	90	<i>deblitane</i>	90	<i>dextrose 5 % in water (d5w)</i>67	
CRIXIVAN	8	<i>decitabine</i>	18	<i>dextrose 5 %-lactated ringers</i>67	
<i>cromolyn</i>	78, 96, 100	DELESTROGEN	90	<i>dextrose 5%-0.2 % sod chloride</i> .67	
<i>cryselle (28)</i>	90	<i>delyla (28)</i>	90	<i>dextrose 5%-0.3 % sod.chloride</i> .67	
CUBICIN	8	DELZICOL	78	<i>dextrose with sodium chloride</i>68	
CUPRIMINE	87	DEMADEX	52	<i>dextrose-kcl-nacl</i>	104
CUTIVATE	61	<i>demeclocycline</i>	8	DIAMOX SEQUELS	96
CUVPOSA	78	DEMEROL	29	DIASTAT	29
<i>cyclafem 1/35 (28)</i>	90	DEMSEER	52	DIASTAT ACUDIAL	29
<i>cyclafem 7/7/7 (28)</i>	90	DENAVIR	61	<i>diazepam</i>	30
CYCLESSA (28)	90	DEPACON	29	<i>diazepam intensol</i>	29
<i>cyclobenzaprine</i>	29	DEPAKENE	29	DIBENZYLINE	52
CYCLOPHOSPHAMIDE	17	DEPAKOTE	29	<i>diclofenac potassium</i>	30
CYCLOSET	71	DEPAKOTE ER	29	<i>diclofenac sodium</i>	30, 62, 96
<i>cyclosporine</i>	17	DEPAKOTE SPRINKLES	29	<i>diclofenac-misoprostol</i>	30
<i>cyclosporine modified</i>	17	DEPEN TITRATABS	87	<i>dicloxacillin</i>	8
CYKLOKAPRON	52	DEPO-ESTRADIOL	90	<i>dicyclomine</i>	78
CYMBALTA	29	DEPO-MEDROL	71	<i>didanosine</i>	8
<i>cyproheptadine</i>	100	DEPO-PROVERA	90	DIFFERIN	62
CYRAMZA	17	DEPO-SUBQ PROVERA 104.	90	DIFICID	8
CYSTADANE	78	DEPO-TESTOSTERONE	71	<i>diflorasone</i>	62
CYSTAGON	103	DERMATOP	62	DIFLUCAN	8
CYSTARAN	96	DESCOVY	8	<i>diflunisal</i>	30
<i>cytarabine</i>	17	<i>desipramine</i>	29	<i>digitek</i>	52
<i>cytarabine (pf)</i>	18	<i>desloratadine</i>	100	<i>digoxin</i>	52
CYTOMEL	71	<i>desmopressin</i>	71	<i>dihydroergotamine</i>	30
CYTOTEC	78	<i>desog-e.estradiol/e.estradiol</i>	90	DILANTIN	30
CYTOVENE	8	DESOGEN	90	DILANTIN EXTENDED	30
<i>d10 %-0.45 % sodium chloride</i> ...67		<i>desogestrel-ethinyl estradiol</i>	90	DILANTIN INFATABS	30
<i>d2.5 %-0.45 % sodium chloride</i> ..67		DESONATE	62	DILANTIN-125	30
<i>d5 % and 0.9 % sodium</i>		<i>desonide</i>	62	DILAUDID	30
<i>chloride</i>	67	DESOWEN	62	<i>diltiazem hcl</i>	52
<i>d5 %-0.45 % sodium chloride</i>67		<i>desoximetasone</i>	62	<i>dilt-xr</i>	52
<i>dacarbazine</i>	18	DESOXYN	29	DIOVAN	53
DACOGEN	18	DESVENLAFAXINE	29	DIOVAN HCT	53
DAKLINZA	8	<i>desvenlafaxine succinate</i>	29	DIPENTUM	78
DALIRESP	100	DETROL	103	<i>diphenhydramine hcl</i>	100

<i>diphenoxylate-atropine</i>	78	DYSPORT	83	<i>enpresse</i>	90
DIPROLENE	62	<i>e.e.s. 400</i>	8	ENSTILAR	62
DIPROLENE AF	62	E.E.S. GRANULES	8	<i>entacapone</i>	31
<i>dipyridamole</i>	53	EC-NAPROSYN	31	<i>entecavir</i>	9
<i>disopyramide phosphate</i>	53	<i>econazole</i>	62	ENTOCORT EC	78
<i>disulfiram</i>	68	EDARBI	53	ENTRESTO	53
DITROPAN XL	103	EDARBYCLOR	53	<i>enulose</i>	78
DIURIL	53	EDECIN	53	ENVARBUS XR	18
DIURIL IV	53	EDLUAR	31	EPCLUSA	9
<i>divalproex</i>	30	EDURANT	8	EPIDUO	62
DIVIGEL	90	EFFEXOR XR	31	EPIDUO FORTE	62
<i>docetaxel</i>	18	EFFIENT	53	<i>epinastine</i>	96
<i>dofetilide</i>	53	EFUDEX	62	EPINEPHRINE	100
DOLOPHINE	30	EGRIFTA	83	EPIPEN 2-PAK	100
<i>donepezil</i>	30	ELAPRASE	71	EPIPEN JR 2-PAK	100
DORIBAX	8	ELDEPRYL	31	EPIRUBICIN	18
DORYX	8	ELELYSO	71	<i>epitol</i>	31
DORYX MPC	8	ELESTAT	96	EPIVIR	9
<i>dorzolamide</i>	96	ELESTRIN	90	EPIVIR HBV	9
<i>dorzolamide-timolol</i>	96	<i>eletriptan hbr</i>	31	<i>eplerenone</i>	53
DOVONEX	62	ELIDEL	62	EPOGEN	83
<i>doxazosin</i>	53	ELIGARD	18	<i>eprosartan</i>	53
<i>doxepin</i>	30, 62	ELIGARD (3 MONTH)	18	EPZICOM	9
<i>doxercalciferol</i>	71	ELIGARD (4 MONTH)	18	EQUETRO	31
DOXIL	18	ELIGARD (6 MONTH)	18	ERAXIS(WATER DILUENT) ..	9
<i>doxorubicin</i>	18	ELIMITE	62	ERBITUX	18
<i>doxorubicin, peg-liposomal</i>	18	<i>eliphos</i>	104	<i>ergoloid</i>	31
<i>doxy-100</i>	8	ELIQUIS	53	ERGOTAMINE-CAFFEINE ..	31
<i>doxycycline hyclate</i>	8	ELITEK	18	ERIVEDGE	18
<i>doxycycline monohydrate</i>	8	ELLENCE	18	<i>errin</i>	90
<i>dronabinol</i>	78	ELMIRON	103	ERTACZO	62
<i>drospirenone-e.estradiol-lm,fa</i> ... 90	90	ELOCON	62	ERWINAZE	18
<i>drospirenone-ethinyl estradiol</i> ... 90	90	EMADINE	96	<i>ery pads</i>	62
DROXIA	18	EMBEDA	31	<i>erygel</i>	62
DUAC	62	EMCYT	18	ERYPED 200	9
DUAVEE	90	EMEND	78	ERYPED 400	9
DUETACT	71	EMFLAZA	71	<i>ery-tab</i>	9
DUEXIS	30	<i>emoquette</i>	90	ERY-TAB	9
DULERA	100	EMPLICITI	18	ERYTHROCIN	9
<i>duloxetine</i>	30	EMSAM	31	<i>erythrocin (as stearate)</i>	9
DUOPA	30	EMTRIVA	8	<i>erythromycin</i>	9, 96
DUPIXENT	62	EMVERM	9	<i>erythromycin ethylsuccinate</i>	9
DURAGESIC	30	ENABLEX	103	<i>erythromycin with ethanol</i>	62
<i>duramorph (pf)</i>	30, 31	<i>enalapril maleate</i>	53	<i>erythromycin-benzoyl peroxide</i> ...62	62
DUREZOL	96	<i>enalapril-hydrochlorothiazide</i> ... 53	53	ESBRIET	100
DURLAZA	53	ENBREL	87	<i>escitalopram oxalate</i>	31
<i>dutasteride</i>	103	ENBREL SURECLICK	87	ESGIC	31
<i>dutasteride-tamsulosin</i>	103	<i>endocet</i>	31	<i>esomeprazole magnesium</i>	78
DUTOPROL	53	ENGERIX-B (PF)	83	<i>esomeprazole sodium</i>	78
DYAZIDE	53	ENGERIX-B PEDIATRIC		<i>estazolam</i>	31
DYMISTA	100	(PF)	83	ESTRACE	90
DYRENIUM	53	<i>enoxaparin</i>	53	<i>estradiol</i>	90

<i>estradiol valerate</i>	91	FEMARA	18	<i>fluorometholone</i>	96
<i>estradiol-norethindrone acet</i>	91	FEMHRT LOW DOSE	91	<i>fluorouracil</i>	19, 63
ESTRING	91	FEMRING	91	FLUOROURACIL	63
<i>estropipate</i>	91	<i>femynor</i>	91	<i>fluoxetine</i>	33
<i>eszopiclone</i>	31	FENOFIBRATE	54	FLUOXETINE	33
<i>ethacrynate sodium</i>	53	<i>fenofibrate</i>	54	<i>fluphenazine decanoate</i>	33
<i>ethacrynic acid</i>	53	<i>fenofibrate micronized</i>	53	<i>fluphenazine hcl</i>	33
<i>ethambutol</i>	9	<i>fenofibrate nanocrystallized</i>	53	<i>flurandrenolide</i>	63
<i>ethosuximide</i>	31	<i>fenofibric acid</i>	54	<i>flurazepam</i>	33
<i>ethynodiol diac-eth estradiol</i>	91	<i>fenofibric acid (choline)</i>	54	<i>flurbiprofen</i>	33
<i>etidronate disodium</i>	68	FENOGLIDE	54	<i>flurbiprofen sodium</i>	96
<i>etodolac</i>	31	FENOPROFEN	32	<i>flutamide</i>	19
ETOPOPHOS	18	<i>fenopropfen</i>	32	<i>fluticasone</i>	63, 100
<i>etoposide</i>	18	<i>fentanyl</i>	32	FLUTICASONE-	
EUCRISA	62	FENTANYL	32	SALMETEROL	100
EURAX	62	<i>fentanyl citrate</i>	32	<i>fluvastatin</i>	54
EVAMIST	91	FENTORA	32	<i>fluvoxamine</i>	33
EVISTA	87	FERRIPROX	68	FML FORTE	96
EVOCLIN	62	FETZIMA	32	FML LIQUIFILM	96
EVOTAZ	9	FEXMID	32	FML S.O.P.	96
EVOXAC	68	FIBRICOR	54	FOCALIN	33
EVZIO	31	FINACEA	63	FOCALIN XR	33
EXALGO ER	31	<i>finasteride</i>	103	FOLOTYN	19
EXELDERM	62	FIORICET	32	<i>fomepizole</i>	83
EXELON	31	FIORICET WITH CODEINE	32	<i>fondaparinux</i>	54
<i>exemestane</i>	18	FIORINAL	32	FORFIVO XL	33
EXFORGE	53	FIORINAL-CODEINE #3	33	FORTAMET	71
EXFORGE HCT	53	FIRAZYR	100	FORTEO	87
EXJADE	68	FIRMAGON KIT W		FORTESTA	71
EXONDYS 51	31	DILUENT SYRINGE	18, 19	FOSAMAX	87
EXTAVIA	83	FLAGYL	9	FOSAMAX PLUS D	88
EXTINA	62	FLAREX	96	<i>fosinopril</i>	54
EZETIMIBE	53	<i>flavoxate</i>	103	<i>fosinopril-hydrochlorothiazide</i> ...	54
<i>ezetimibe-simvastatin</i>	53	FLEBOGAMMA DIF	83	<i>fosphenytoin</i>	33
FABIOR	62	<i>flecainide</i>	54	FOSRENOL	68
FABRAZYME	71	FLECTOR	33	FRAGMIN	54
<i>falmina (28)</i>	91	FLOMAX	103	FREAMINE HBC 6.9 %	104
<i>famciclovir</i>	9	FLOVENT DISKUS	100	FROVA	33
<i>famotidine</i>	78	FLOVENT HFA	100	<i>frovatriptan</i>	33
<i>famotidine (pf)</i>	78	<i>floxin</i>	69	FURADANTIN	9
<i>famotidine (pf)-nacl (iso-os)</i>	78	<i>fluconazole</i>	9	<i>furosemide</i>	54
FANAPT	31	<i>fluconazole in nacl (iso-osm)</i>	9	FUSILEV	19
FARESTON	18	<i>flucytosine</i>	9	FUZEON	9
FARXIGA	71	<i>fludarabine</i>	19	<i>fyavolv</i>	91
FARYDAK	18	<i>fludrocortisone</i>	71	FYCOMPA	33
FASLODEX	18	FLUMADINE	9	<i>gabapentin</i>	33
<i>fayosim</i>	91	<i>flunisolide</i>	100	GABITRIL	33
FAZACLO	31	<i>fluocinolone</i>	63	GABLOFEN	33
<i>felbamate</i>	32	<i>fluocinolone acetonide oil</i>	69	<i>galantamine</i>	33
FELBATOL	32	<i>fluocinonide</i>	63	GAMASTAN S/D	83
FELDENE	32	<i>fluocinonide-e</i>	63	GAMMAGARD LIQUID	83
<i>felodipine</i>	53	<i>fluoride (sodium)</i>	104		

GAMMAGARD S-D (IGA < 1 MCG/ML)	83	<i>glyburide</i>	72	HUMALOG MIX 75-25	
GAMMAKED	83	<i>glyburide micronized</i>	72	KWIKPEN	72
GAMMAPLEX	83	<i>glyburide-metformin</i>	72	HUMATROPE	84
GAMMAPLEX (WITH SORBITOL)	83	<i>glycopyrrolate</i>	79	HUMIRA	88
GAMUNEX-C	83	GLYNASE	72	HUMIRA PEDIATRIC CROHN'S START	88
<i>ganciclovir sodium</i>	9	GLYSET	72	HUMIRA PEN	88
GARDASIL 9 (PF)	83	GLYXAMBI	72	HUMIRA PEN CROHN'S-UC-HS START	88
GASTROCROM	78	GOLYTELY	79	HUMIRA PEN PSORIASIS-UVEITIS	88
<i>gatifloxacin</i>	96	GONITRO	54	HUMULIN 70/30	72
GATTEX ONE-VIAL	78	GRALISE	33	HUMULIN 70/30 KWIKPEN ..	72
GAUZE PAD	71	GRALISE 30-DAY STARTER PACK	33	HUMULIN N	72
<i>gavilyte-c</i>	78	<i>granisetron (pf)</i>	79	HUMULIN N KWIKPEN	72
<i>gavilyte-g</i>	78	<i>granisetron hcl</i>	79	HUMULIN R U-100	72
<i>gavilyte-n</i>	78	GRANIX	84	HUMULIN R U-500 (CONC) KWIKPEN	72
GELNIQUE	103	GRASTEK	84	HUMULIN R U-500 (CONCENTRATED)	72
<i>gemcitabine</i>	19	<i>griseofulvin microsize</i>	10	HYCANTIN	19
<i>gemfibrozil</i>	54	<i>griseofulvin ultramicrosize</i>	10	HYCET	34
GEMZAR	19	GRIS-PEG (ULTRAMICROSIZED)	10	<i>hydralazine</i>	54
GENERESS FE	91	<i>guanfacine</i>	33, 54	HYDREA	19
<i>generlac</i>	78	<i>guanidine</i>	33	<i>hydrochlorothiazide</i>	54
<i>gengraf</i>	19	GYNAZOLE-1	91	<i>hydrocodone-acetaminophen</i>	34
GENOTROPIN	83	HALAVEN	19	<i>hydrocodone-ibuprofen</i>	34
GENOTROPIN MINIQUICK	83, 84	HALCION	34	<i>hydrocortisone</i>	63, 72, 79
<i>gentak</i>	96	HALDOL	34	<i>hydrocortisone butyrate</i>	63
<i>gentamicin</i>	9, 63, 96	HALDOL DECANOATE	34	<i>hydrocortisone butyr-emollient</i> ..	63
<i>gentamicin in nacl (iso-osm)</i>	9	<i>halobetasol propionate</i>	63	<i>hydrocortisone valerate</i>	63
GENVOYA	9	HALOG	63	<i>hydrocortisone-acetic acid</i>	69
GEODON	33	<i>haloperidol</i>	34	<i>hydromorphone</i>	34
<i>gianvi (28)</i>	91	<i>haloperidol decanoate</i>	34	<i>hydromorphone (pf)</i>	34
GIAZO	79	<i>haloperidol lactate</i>	34	<i>hydroxychloroquine</i>	10
<i>gildagia</i>	91	HARVONI	10	<i>hydroxyprogesterone caproate</i> ...	91
GILENYA	33	HAVRIX (PF)	84	<i>hydroxyurea</i>	19
GILOTRIF	19	HECTOROL	72	<i>hydroxyzine hcl</i>	100
GLASSIA	68	<i>heparin (porcine)</i>	54	<i>hydroxyzine pamoate</i>	100
<i>glatopa</i>	33	<i>heparin (porcine) in 5 % dex</i>	54	HYPERRAB S/D (PF)	84
GLEEVEC	19	HEPATAMINE 8%	105	HYSINGLA ER	34
GLEOSTINE	19	HEPSERA	10	HYZAAR	54
<i>glimepiride</i>	72	HERCEPTIN	19	<i>ibandronate</i>	88
<i>glipizide</i>	72	HETLIOZ	34	IBRANCE	19
<i>glipizide-metformin</i>	72	HEXALEN	19	IBUDONE	34
GLUCAGEN HYPOKIT	72	HIBERIX (PF)	84	<i>ibuprofen</i>	34
GLUCAGON EMERGENCY KIT (HUMAN)	72	HIPREX	10	<i>ibuprofen-oxycodone</i>	34
GLUCOPHAGE	72	HORIZANT	34	ICLUSIG	19
GLUCOPHAGE XR	72	HUMALOG	72	IDAMYCIN PFS	19
GLUCOTROL	72	HUMALOG KWIKPEN	72	<i>idarubicin</i>	19
GLUCOTROL XL	72	HUMALOG MIX 50-50	72	IDHIFA	19
GLUCOVANCE	72	HUMALOG MIX 50-50 KWIKPEN	72	IFEX	19
GLUMETZA	72	HUMALOG MIX 75-25	72		

<i>ifosfamide</i>	19	<i>irbesartan</i>	55	<i>kariva (28)</i>	91
ILARIS (PF)	84	<i>irbesartan-hydrochlorothiazide</i> ..	55	KAZANO	73
ILEVRO	96	IRESSA	19	<i>kelnor 1/35 (28)</i>	91
<i>imatinib</i>	19	<i>irinotecan</i>	20	KENALOG	63, 73
IMBRUVICA	19	ISENTRESS	10	KEPIVANCE	20
IMFINZI	19	ISENTRESS HD	10	KEPPRA	35
<i>imipenem-cilastatin</i>	10	<i>isibloom</i>	91	KEPPRA XR	35
<i>imipramine hcl</i>	34	ISOLYTE-P IN 5 %		KERYDIN	63
<i>imipramine pamoate</i>	34	DEXTROSE	105	<i>ketoconazole</i>	10, 63
<i>imiquimod</i>	63	ISOLYTE-S	105	<i>ketoprofen</i>	35
IMITREX	34, 35	<i>isoniazid</i>	10	<i>ketorolac</i>	35, 36, 97
IMITREX STATDOSE KIT		ISOPTO CARPINE	97	KEVEYIS	36
REFILL	35	ISORDIL	55	KEVZARA	88
IMOGAM RABIES-HT (PF) ..	84	ISORDIL TITRADOSE	55	KEYTRUDA	20
IMOVAX RABIES		<i>isosorbide dinitrate</i>	55	KHEDEZLA	36
VACCINE (PF)	84	<i>isosorbide mononitrate</i>	55	<i>kimidess (28)</i>	91
IMURAN	19	<i>isradipine</i>	55	KINERET	88
INCRELEX	68	ISTALOL	97	KINRIX (PF)	84
INCRUSE ELLIPTA	100	ISTODAX	20	<i>kionex</i>	68
<i>indapamide</i>	54	<i>itraconazole</i>	10	KISQALI	20
INDERAL LA	55	<i>ivermectin</i>	10	KISQALI FEMARA CO-	
INDOCIN	35	IXIARO (PF)	84	PACK	20
<i>indomethacin</i>	35	JADENU	68	KLARON	63
INFANRIX (DTAP) (PF)	84	JADENU SPRINKLE	68	KLONOPIN	36
INFLECTRA	79	JAKAFI	20	<i>klor-con 10</i>	105
INGREZZA	35	JALYN	103	<i>klor-con 8</i>	105
INLYTA	19	<i>jantoven</i>	55	<i>klor-con m10</i>	105
INNOPRAN XL	55	JANUMET	73	<i>klor-con m15</i>	105
INSPIRA	55	JANUMET XR	73	<i>klor-con m20</i>	105
INSULIN SYRINGE-		JANUVIA	73	<i>klor-con sprinkle</i>	105
NEEDLE U-100	73	JARDIANCE	73	KOMBIGLYZE XR	73
INTELENCE	10	JENTADUETO	73	KORLYM	73
INTERMEZZO	35	JENTADUETO XR	73	KRISTALOSE	79
<i>intralipid</i>	105	JEVTANA	20	K-TAB	105
INTRALIPID	105	<i>jinteli</i>	91	<i>k-tab</i>	105
INTRON A	84	<i>jolivette</i>	91	KUVAN	73
<i>introvale</i>	91	JUBLIA	63	KYNAMRO	55
INTUNIV ER	35	<i>juleber</i>	91	KYPROLIS	20
INVANZ	10	<i>junel 1.5/30 (21)</i>	91	<i>l norgest/e.estradiol-e.estrad</i>	91
INVEGA	35	<i>junel 1/20 (21)</i>	91	<i>labetalol</i>	55
INVEGA SUSTENNA	35	<i>junel fe 1.5/30 (28)</i>	91	LACRISERT	97
INVEGA TRINZA	35	<i>junel fe 1/20 (28)</i>	91	<i>lactated ringers</i>	68, 105
INVIRASE	10	<i>junel fe 24</i>	91	<i>lactulose</i>	79
INVOKAMET	73	JUXTAPID	55	LAMICTAL	36
INVOKAMET XR	73	KADCYLA	20	LAMICTAL ODT	36
INVOKANA	73	KADIAN	35	LAMICTAL STARTER	
IONOSOL-B IN D5W	105	<i>kaitlib fe</i>	91	(BLUE) KIT	36
IONOSOL-MB IN D5W	105	KALETRA	10	LAMICTAL STARTER	
IOPIDINE	96, 97	KALYDECO	100, 101	(GREEN) KIT	36
IPOL	84	KANUMA	73	LAMICTAL STARTER	
<i>ipratropium bromide</i>	69, 100	KAPVAY	35	(ORANGE) KIT	36
<i>ipratropium-albuterol</i>	100	KARBINAL ER	101	LAMICTAL XR	36

LAMICTAL XR STARTER (BLUE)	36	<i>levoleucovorin</i>	20	LOPROX	64
LAMICTAL XR STARTER (GREEN)	36	<i>levonest (28)</i>	92	LOPROX (AS OLAMINE)	64
LAMICTAL XR STARTER (ORANGE)	36	<i>levonorgestrel-ethinyl estrad</i>	92	<i>lorazepam</i>	37
LAMISIL	10	<i>levonorg-eth estrad triphasic</i>	92	<i>lorazepam intensol</i>	37
<i>lamivudine</i>	10	<i>levora-28</i>	92	<i>lorcet (hydrocodone)</i>	37
<i>lamivudine-zidovudine</i>	10	<i>levorphanol tartrate</i>	36	<i>lorcet hd</i>	37
<i>lamotrigine</i>	36	LEVOTHYROXINE	73	<i>lorcet plus</i>	37
LANOXIN	55	<i>levothyroxine</i>	73	<i>loryna (28)</i>	92
<i>lansoprazole</i>	79	<i>levoxyl</i>	73	LORZONE	37
LANTUS	73	LEXAPRO	36	<i>losartan</i>	55
LANTUS SOLOSTAR	73	LEXIVA	10, 11	<i>losartan-hydrochlorothiazide</i>	55
<i>larin 1.5/30 (21)</i>	91	LIALDA	79	LOSEASONIQUE	92
<i>larin 1/20 (21)</i>	91	<i>lidocaine</i>	63, 64	LOTEMAX	97
<i>larin fe 1.5/30 (28)</i>	91	<i>lidocaine (pf)</i>	63	LOTENSIN	55
<i>larin fe 1/20 (28)</i>	91	<i>lidocaine hcl</i>	63	LOTREL	55
<i>larissia</i>	92	<i>lidocaine viscous</i>	64	LOTRISONE	64
LARTRUVO	20	<i>lidocaine-prilocaine</i>	64	LOTRONEX	79
LASIX	55	LIDODERM	64	<i>lovastatin</i>	55
LASTACFT	97	LINCOCIN	11	LOVAZA	55
<i>latanoprost</i>	97	<i>lincomycin</i>	11	LOVENOX	55
LATUDA	36	<i>lindane</i>	64	<i>low-ogestrel (28)</i>	92
<i>layolis fe</i>	92	<i>linezolid</i>	11	<i>loxapine succinate</i>	37
LAZANDA	36	LINZESS	79	LUMIGAN	97
<i>leena 28</i>	92	LIORESAL	36	LUMIZYME	73
<i>leflunomide</i>	88	<i>liothyronine</i>	73	LUNESTA	37
LENVIMA	20	LIPITOR	55	LUPANETA PACK (1 MONTH)	92
LESCOL XL	55	LIPOFEN	55	LUPANETA PACK (3 MONTH)	92
<i>lessina</i>	92	<i>lisinopril</i>	55	LUPRON DEPOT	20
LETAIRIS	101	<i>lisinopril-hydrochlorothiazide</i>	55	LUPRON DEPOT (3 MONTH)	20
<i>letrozole</i>	20	<i>lithium carbonate</i>	36	LUPRON DEPOT (4 MONTH)	20
<i>leucovorin calcium</i>	20	<i>lithium citrate</i>	37	LUPRON DEPOT (6 MONTH)	20
LEUKERAN	20	LITHOBID	37	LUPRON DEPOT-PED	20
LEUKINE	84	LITHOSTAT	68	<i>lutea (28)</i>	92
<i>leuprolide</i>	20	LIVALO	55	LUZU	64
<i>levalbuterol hcl</i>	101	LO LOESTRIN FE	92	LYNPARZA	21
LEVALBUTEROL TARTRATE	101	LOCOID	64	LYRICA	37
LEVAQUIN	10	<i>lodine</i>	37	LYSODREN	21
LEVEMIR	73	LODOSYN	37	LYSTEDA	92
LEVEMIR FLEXTOUCH	73	LOESTRIN 1.5/30 (21)	92	<i>lyza</i>	92
<i>levetiracetam</i>	36	LOESTRIN 1/20 (21)	92	MACROBID	11
LEVETIRACETAM IN NACL (ISO-OS)	36	LOESTRIN FE 1.5/30 (28-DAY)	92	MACRODANTIN	11
<i>levobunolol</i>	97	LOESTRIN FE 1/20 (28-DAY)	92	<i>magnesium sulfate</i>	105
<i>levocarnitine</i>	68	<i>lomedina 24 fe</i>	92	MAKENA	92
<i>levocarnitine (with sugar)</i>	68	LOMOTIL	79	MALARONE	11
<i>levocetirizine</i>	101	LONSURF	20	MALARONE PEDIATRIC	11
<i>levofloxacin</i>	10, 97	<i>loperamide</i>	79	<i>malathion</i>	64
<i>levofloxacin in d5w</i>	10	LOPID	55	<i>maprotiline</i>	37
		LOPINAVIR-RITONAVIR	11		
		LOPRESSOR	55		
		LOPRESSOR HCT	55		

MARINOL	79	METFORMIN	73	<i>millipred</i>	74
<i>marlissa</i>	92	<i>methadone</i>	38	<i>mimvey</i>	93
MARPLAN	37	<i>methamphetamine</i>	38	<i>mimvey lo</i>	93
MATULANE	21	<i>methazolamide</i>	97	MINASTRIN 24 FE	93
<i>matzim la</i>	55	<i>methenamine hippurate</i>	11	MINIPRESS	56
MAVYRET	11	<i>methimazole</i>	73	MINITRAN	56
MAXALT	37	METHITEST	73	MINIVELLE	93
MAXALT-MLT	37	<i>methocarbamol</i>	38	MINOCIN	11
MAXIDEX	97	<i>methotrexate sodium</i>	21	<i>minocycline</i>	11
MAXIPIME	11	<i>methotrexate sodium (pf)</i>	21	<i>minoxidil</i>	56
MAXITROL	97	<i>methoxsalen</i>	64	MIRAPEX	39
MAXZIDE	55	<i>methscopolamine</i>	79	MIRAPEX ER	39
MAXZIDE-25MG	56	<i>methyclothiazide</i>	56	MIRCERA	84
<i>meclizine</i>	79	<i>methyldopa</i>	56	<i>mirtazapine</i>	39
<i>meclofenamate</i>	37	<i>methyldopa-</i>		MIRVASO	64
MEDROL	73	<i>hydrochlorothiazide</i>	56	<i>misoprostol</i>	79
MEDROL (PAK)	73	<i>methyldopate</i>	56	MITIGARE	88
<i>medroxyprogesterone</i>	92	METHYLIN	38	<i>mitomycin</i>	21
<i>mefenamic acid</i>	37	<i>methylphenidate hcl</i>	38	<i>mitoxantrone</i>	21
<i>mefloquine</i>	11	<i>methylprednisolone</i>	74	M-M-R II (PF)	84
MEGACE ES	21	<i>methylprednisolone acetate</i>	74	MOBIC	39
<i>megestrol</i>	21	<i>methylprednisolone sodium succ</i>	74	<i>modafinil</i>	39
MEKINIST	21	<i>methyltestosterone</i>	74	<i>moderiba</i>	11
<i>meloxicam</i>	37	<i>metipranolol</i>	97	<i>moderiba dose pack</i>	11
<i>melphalan hcl</i>	21	<i>metoclopramide hcl</i>	79	<i>moexipril</i>	56
<i>memantine</i>	37	<i>metolazone</i>	56	<i>moexipril-hydrochlorothiazide</i> ...	56
MEMANTINE	37	<i>metoprolol succinate</i>	56	<i>mometasone</i>	64, 101
MENACTRA (PF)	84	<i>metoprolol ta-hydrochlorothiaz</i> ..	56	<i>mononessa (28)</i>	93
MENEST	92	<i>metoprolol tartrate</i>	56	<i>montelukast</i>	101
MENOSTAR	92	METROCREAM	64	MONUROL	11
MENTAX	64	METROGEL	64	<i>morgidox</i>	11
MENVEO A-C-Y-W-135-DIP		METROGEL VAGINAL	92	MORPHABOND ER	39
(PF)	84	METROLOTION	64	MORPHINE	39
<i>mepерidine</i>	37	<i>metronidazole</i>	11, 64, 92	<i>morphine</i>	39
<i>mepерidine (pf)</i>	37	<i>metronidazole in nacl (iso-os)</i>	11	<i>morphine concentrate</i>	39
<i>meprobamate</i>	38	<i>mexiletine</i>	56	MOVANTIK	79
MEPRON	11	MIACALCIN	74	MOVIPREP	79
<i>mercaptopurine</i>	21	<i>mibelas 24 fe</i>	92	MOXEZA	97
<i>meropenem</i>	11	MICARDIS	56	<i>moxifloxacin</i>	11, 97
MERREM	11	MICARDIS HCT	56	MOXIFLOXACIN-	
<i>mesalamine</i>	79	<i>miconazole-3</i>	92	SOD.ACE,SUL-WATER	11
MESALAMINE	79	MICORT-HC	79	MOZOBIL	85
<i>mesalamine with cleansing wipe</i>	79	<i>microgestin 1.5/30 (21)</i>	92	MS CONTIN	39
<i>mesna</i>	21	<i>microgestin 1/20 (21)</i>	92	MULTAQ	56
MESNEX	21	<i>microgestin fe 1.5/30 (28)</i>	93	<i>mupirocin</i>	64
MESTINON	38	<i>microgestin fe 1/20 (28)</i>	93	<i>mupirocin calcium</i>	64
MESTINON TIMESPAN	38	MICROZIDE	56	MUSTARGEN	21
<i>metadate er</i>	38	<i>midodrine</i>	68	MYALEPT	74
<i>metaproterenol</i>	101	<i>migergot</i>	38	MYAMBUTOL	11
<i>metaxall</i>	38	<i>miglitol</i>	74	MYCAMINE	11
<i>metaxalone</i>	38	MIGRANAL	38	MYCOBUTIN	11
<i>metformin</i>	73	MILLIPRED	74	<i>mycophenolate mofetil</i>	21

<i>mycophenolate mofetil hcl</i>	21	NEOSPORIN (NEO-POLYM-GRAMICID)	97	<i>norgestimate-ethinyl estradiol</i>	93
<i>mycophenolate sodium</i>	21	NEO-SYNALAR	64	NORITATE	64
MYDAYIS	39	NEPHRAMINE 5.4 %	105	<i>norlyroc</i>	93
MYFORTIC	21	NERLYNX	21	NORMOSOL-M IN 5 %	
<i>myorisan</i>	64	NESINA	74	DEXTROSE	105
MYRBETRIQ	103	<i>neuac</i>	64	NORMOSOL-R IN 5 %	
MYSOLINE	39	NEULASTA	85	DEXTROSE	105
MYTESI	79	NEUPOGEN	85	NORMOSOL-R PH 7.4	105
<i>nabumetone</i>	39	NEUPRO	40	NORPACE	57
<i>nadolol</i>	56	NEURONTIN	40	NORPACE CR	57
<i>nadolol-bendroflumethiazide</i>	56	NEVANAC	97	NORPRAMIN	40
<i>nafacillin</i>	11	<i>nevirapine</i>	11	NORTHERA	68
NAFTIFINE	64	NEXAVAR	21	<i>nortrel 0.5/35 (28)</i>	93
<i>naftifine</i>	64	NEXIUM	79	<i>nortrel 1/35 (21)</i>	93
NAFTIN	64	NEXIUM IV	80	<i>nortrel 1/35 (28)</i>	93
NAGLAZYME	74	NEXIUM PACKET	80	<i>nortrel 7/7/7 (28)</i>	93
<i>nalbuphine</i>	39	NEXTERONE	56	<i>nortriptyline</i>	40
<i>naloxone</i>	39, 40	<i>niacin</i>	56	NORVASC	57
<i>naltrexone</i>	40	NIACOR	56	NORVIR	12
NAMENDA	40	NIASPAN EXTENDED-RELEASE	56	<i>novarel</i>	74
NAMENDA TITRATION PAK	40	<i>nicardipine</i>	56	NOVOLIN 70/30	74
NAMENDA XR	40	NICOTROL	68	NOVOLIN N	74
NAMZARIC	40	NICOTROL NS	68	NOVOLIN R	74
NAPRELAN CR	40	<i>nifedipine</i>	56	NOVOLOG	74
NAPROSYN	40	<i>nikki (28)</i>	93	NOVOLOG FLEXPEN	74
<i>naproxen</i>	40	NILANDRON	21	NOVOLOG MIX 70-30	74
<i>naproxen sodium</i>	40	<i>nilutamide</i>	21	NOVOLOG MIX 70-30 FLEXPEN	74
<i>naratriptan</i>	40	<i>nimodipine</i>	56	NOVOLOG PENFILL	74
NARCAN	40	NINLARO	21	NOXAFIL	12
NARDIL	40	NIPENT	21	NUCALA	101
NASONEX	101	<i>nisoldipine</i>	56	NUCYNTA	40
NATACYN	97	<i>nitro-bid</i>	56	NUCYNTA ER	40
NATAZIA	93	NITRO-DUR	56	NUEDEXTA	40
<i>nateglinide</i>	74	<i>nitrofurantoin</i>	11	NULOJIX	21
NATESTO	74	<i>nitrofurantoin macrocrystal</i> ..	11, 12	NULYTELY WITH FLAVOR PACKS	80
NATPARA	74	<i>nitrofurantoin monohyd/m-cryst</i> ..	12	NUPLAZID	40
NEBUPENT	11	<i>nitroglycerin</i>	56, 57	NUTRESTORE	68
<i>necon 0.5/35 (28)</i>	93	NITROMIST	57	NUTRILIPID	105
<i>necon 1/50 (28)</i>	93	NITROSTAT	57	NUTROPIN AQ NUSPIN	85
<i>necon 7/7/7 (28)</i>	93	<i>nizatidine</i>	80	NUVARING	93
<i>nefazodone</i>	40	NIZORAL	64	NUVESSA	93
<i>neomycin</i>	11	<i>nolix</i>	64	NUVIGIL	40
<i>neomycin-bacitracin-poly-hc</i>	97	<i>nora-be</i>	93	<i>nyamyc</i>	64
<i>neomycin-bacitracin-polymyxin</i>	97	NORCO	40	<i>nyata</i>	64
<i>neomycin-polymyxin b gu</i>	68	NORDITROPIN FLEXPRO	85	<i>nystatin</i>	12, 64
<i>neomycin-polymyxin b-dexameth</i>	97	<i>noreth-ethinyl estradiol-iron</i>	93	<i>nystatin-triamcinolone</i>	65
<i>neomycin-polymyxin-gramicidin</i>	97	<i>norethindrone (contraceptive)</i>	93	<i>nystop</i>	65
<i>neomycin-polymyxin-hc</i>	69, 97	<i>norethindrone acetate</i>	93	OICALIVA	80
NEORAL	21	<i>norethindrone ac-eth estradiol</i>	93	<i>ocella</i>	93
		<i>norethindrone-e.estradiol-iron</i>	93	OCTAGAM	85

<i>octreotide acetate</i>	21	ORTHO TRI-CYCLEN LO	PAXIL	42
OCUFEN	97	(28)	PAXIL CR	42
OCUFLOX	97	ORTHO-CYCLEN (28)	PAZEO	97
ODEFSEY	12	ORTHO-NOVUM 1/35 (28)	PCE	12
ODOMZO	21	ORTHO-NOVUM 7/7/7 (28)	PEDIARIX (PF)	85
OFEV	101	<i>oseltamivir</i>	PEDVAX HIB (PF)	85
<i>ofloxacin</i>	12, 69, 97	OSENI	<i>peg 3350-electrolytes</i>	80
<i>ogestrel (28)</i>	93	OSMOPREP	PEGANONE	42
<i>olanzapine</i>	40	OTEZLA	PEGASYS	85
<i>olanzapine-fluoxetine</i>	40	OTEZLA STARTER	PEGASYS PROCLICK	85
<i>olmesartan</i>	57	OTOVEL	<i>peg-electrolyte soln</i>	80
<i>olmesartan-amlodipin-hcthiazyd</i>	57	OTREXUP (PF)	PEGINTRON	85
<i>olmesartan-hydrochlorothiazide</i>	57	OVCON-35 (28)	PEGINTRON REDIPEN	85
<i>olopatadine</i>	69, 97	OVIDE	PEN NEEDLE, DIABETIC	74
OLUX	65	<i>oxacillin</i>	PENICILLIN G POT IN	
OLYSIO	12	<i>oxacillin in dextrose(iso-osm)</i>	DEXTROSE	12
<i>omega-3 acid ethyl esters</i>	57	<i>oxaliplatin</i>	<i>penicillin g potassium</i>	12
<i>omeprazole</i>	80	<i>oxandrolone</i>	<i>penicillin g procaine</i>	12
<i>omeprazole-sodium bicarbonate</i>	80	<i>oxaprozin</i>	<i>penicillin g sodium</i>	12
OMNARIS	101	<i>oxazepam</i>	<i>penicillin v potassium</i>	12
OMNIPRED	97	<i>oxcarbazepine</i>	PENNSAID	42
OMNITROPE	85	<i>oxiconazole</i>	PENTAM	12
<i>ondansetron</i>	80	OXISTAT	PENTASA	80
<i>ondansetron hcl</i>	80	OXSORALEN ULTRA	<i>pentazocine-naloxone</i>	42
<i>ondansetron hcl (pf)</i>	80	OXTELLAR XR	<i>pentoxifylline</i>	57
ONEXTON	65	<i>oxybutynin chloride</i>	PEPCID	80
ONFI	40, 41	<i>oxycodone</i>	PERCOCET	42
ONGLYZA	74	OXYCODONE	PERFOROMIST	101
ONMEL	12	<i>oxycodone-acetaminophen</i>	<i>perindopril erbumine</i>	57
ONZETRA XSAIL	41	<i>oxycodone-aspirin</i>	<i>perio gard</i>	69
OPANA	41	OXYCONTIN	PERJETA	22
OPANA ER	41	<i>oxymorphone</i>	<i>permethrin</i>	65
OPDIVO	22	OXYTROL	<i>perphenazine</i>	42
OPSUMIT	101	<i>pacerone</i>	<i>perphenazine-amitriptyline</i>	42
ORACEA	12	<i>paclitaxel</i>	PERTZYE	80
ORALAIR	85	<i>paliperidone</i>	PEXEVA	42
ORAP	41	PAMELOR	<i>phenadoz</i>	101
ORAPRED ODT	74	<i>pamidronate</i>	<i>phenelzine</i>	42
ORAVIG	12	PANCREAZE	PHENERGAN	101
ORBACTIV	12	PANDEL	<i>phenergan</i>	101
ORENCIA	88	PANRETIN	<i>phenobarbital</i>	42
ORENCIA (WITH		<i>pantoprazole</i>	<i>phenoxybenzamine</i>	57
MALTOSE)	88	PARICALCITOL	PHENYTEK	42
ORENCIA CLICKJECT	88	<i>paricalcitol</i>	<i>phenytoin</i>	42
ORENITRAM	57	PARLODEL	<i>phenytoin sodium</i>	42
ORFADIN	68	PARNATE	<i>phenytoin sodium extended</i>	42
ORKAMBI	101	<i>paromomycin</i>	PHOSLYRA	105
<i>orphenadrine citrate</i>	41	<i>paroxetine hcl</i>	PHOSPHOLINE IODIDE	97
<i>orsythia</i>	93	PASER	PHYSIOLYTE	68
ORTHO MICRONOR	93	PATADAY	PHYSIOSOL IRRIGATION	68
ORTHO TRI-CYCLEN (28)	93	PATANASE	PICATO	65
		PATANOL	<i>pilocarpine hcl</i>	68, 97

<i>pimozide</i>	42	<i>prednisolone sodium phosphate</i>	75, 98	PROLENSA	98
<i>pimtreea (28)</i>	94		PROLEUKIN	85
<i>pindolol</i>	57	<i>prednisone</i>	75	PROLIA	88
<i>pioglitazone</i>	74	<i>prednisone intensol</i>	75	PROMACTA	57
<i>pioglitazone-glimepiride</i>	74	PREFEST	94	<i>promethazine</i>	101
<i>pioglitazone-metformin</i>	74	PREGNYL	75	<i>promethazine vc</i>	101
<i>piperacillin-tazobactam</i>	12	PREMARIN	94	<i>promethegan</i>	101
<i>pirmella</i>	94	<i>premasol 10 %</i>	106	PROMETRIUM	94
<i>piroxicam</i>	42	PREMASOL 6 %	106	<i>propafenone</i>	57
PLAQUENIL	12	PREMPHASE	94	<i>propantheline</i>	81
PLASMA-LYTE 148	105	PREMPRO	94	<i>propranolol</i>	58
PLASMA-LYTE A	105	<i>prenatal vitamin plus low iron</i> ..	106	<i>propranolol-hydrochlorothiazid</i> ..	58
PLAVIX	57	PREPOPIK	80	<i>propylthiouracil</i>	75
PLEGRIDY	85	PREVACID	80	PROQUAD (PF)	86
<i>podofilox</i>	65	PREVACID SOLUTAB	80	PROSCAR	103
<i>polyethylene glycol 3350</i>	80	<i>prevalite</i>	57	PROSOL 20 %	106
<i>polymyxin b sulfate</i>	12	<i>previfem</i>	94	PROTONIX	81
<i>polymyxin b sulf-trimethoprim</i>	97	PREVPAC	80	PROTOPIC	65
POLYTRIM	97	PREZCOBIX	12	<i>protriptyline</i>	43
POMALYST	22	PREZISTA	12	PROVENTIL HFA	101
PONSTEL	42	PRIFTIN	12	PROVERA	94
<i>portia</i>	94	PRIOSEC	80	PROVIGIL	43
<i>potassium chlorid-d5-</i>		PRIMAQUINE	13	PROZAC	43
<i>0.45%nacl</i>	105	PRIMAXIN IV	13	<i>prudoxin</i>	65
<i>potassium chloride</i>	105, 106	<i>primidone</i>	43	PSORCON	65
<i>potassium chloride in 0.9%nacl</i>	105	PRIMLEV	43	PULMICORT	101
<i>potassium chloride in 5 % dex</i> ..	105	PRIMSOL	13	PULMICORT FLEXHALER	101
<i>potassium chloride in lr-d5</i>	105	PRINIVIL	57	PULMOZYME	101
<i>potassium chloride-0.45 % nacl</i>	106	PRISTIQ	43	PURIXAN	22
<i>potassium chloride-d5-</i>		PRIVIGEN	85	PYLERA	81
<i>0.2%nacl</i>	106	PROAIR HFA	101	<i>pyrazinamide</i>	13
<i>potassium chloride-d5-</i>		PROAIR RESPICLICK	101	<i>pyridostigmine bromide</i>	43
<i>0.3%nacl</i>	106	<i>probenecid</i>	88	QBRELIS	58
<i>potassium chloride-d5-</i>		<i>probenecid-colchicine</i>	88	QNASL	101
<i>0.9%nacl</i>	106	<i>procainamide</i>	57	QUADRACEL (PF)	86
<i>potassium citrate</i>	103	PROCALAMINE 3%	106	QUALAQUIN	13
PRADAXA	57	PROCARDIA	57	QUARTETTE	94
PRALUENT PEN	57	PROCARDIA XL	57	<i>quasense</i>	94
<i>pramipexole</i>	43	<i>procentra</i>	43	QUDEXY XR	43
PRANDIN	75	<i>prochlorperazine</i>	80	QUESTRAN	58
<i>prasugrel</i>	57	<i>prochlorperazine edisylate</i>	80	QUESTRAN LIGHT	58
PRAVACHOL	57	<i>prochlorperazine maleate</i>	81	<i>quetiapine</i>	43
<i>pravastatin</i>	57	PROCROT	85	QUETIAPINE	43
<i>prazosin</i>	57	<i>procto-med hc</i>	81	QUILLICHEW ER	43
PRECOSE	75	<i>procto-pak</i>	81	QUILLIVANT XR	43
PRED FORTE	98	<i>proctosol hc</i>	81	<i>quinapril</i>	58
PRED MILD	98	<i>proctozone-hc</i>	81	<i>quinapril-hydrochlorothiazide</i>	58
PRED-G	98	PROCYSBI	103	<i>quinidine gluconate</i>	58
PRED-G S.O.P.	98	<i>progesterone micronized</i>	94	<i>quinidine sulfate</i>	58
<i>prednicarbate</i>	65	PROGLYCEM	75	<i>quinine sulfate</i>	13
<i>prednisolone acetate</i>	98	PROGRAF	22	QVAR	101
		PROLASTIN-C	68	RABAVERT (PF)	86

<i>rabeprazole</i>	81	REVLIMID	22	SANDIMMUNE	22
RADICAVA	43	REXULTI	43	SANDOSTATIN	22
RAGWITEK	86	REYATAZ	13	SANDOSTATIN LAR	
<i>raloxifene</i>	88	<i>ribasphere</i>	13	DEPOT	22
<i>ramipril</i>	58	<i>ribasphere ribapak</i>	13	SANTYL	65
RANEXA	58	<i>ribavirin</i>	13	SAPHRIS (BLACK	
RANITIDINE HCL	81	RIDAURA	88	CHERRY)	44
<i>ranitidine hcl</i>	81	<i>rifabutin</i>	13	SARAFEM	44
RAPAFLO	103	RIFADIN	13	SAVAYSA	58
RAPAMUNE	22	RIFAMATE	13	SAVELLA	89
<i>rasagiline</i>	43	<i>rifampin</i>	13	SEASONIQUE	94
RASUVO (PF)	88	RIFATER	13	<i>selegiline hcl</i>	44
RAVICTI	68	RILUTEK	68	<i>selenium sulfide</i>	65
RAYALDEE	75	<i>riluzole</i>	68	SELZENTRY	13
RAYOS	75	<i>rimantadine</i>	13	SEMPREX-D	102
RAZADYNE	43	<i>ringer's</i>	68, 106	SENSIPAR	75
RAZADYNE ER	43	RIOMET	75	SEREVENT DISKUS	102
REBETOL	13	<i>risedronate</i>	68, 89	SEROQUEL	44
REBIF (WITH ALBUMIN)	86	RISPERDAL	43	SEROQUEL XR	44
REBIF REBIDOSE	86	RISPERDAL CONSTA	43	SEROSTIM	86
REBIF TITRATION PACK	86	RISPERDAL M-TAB	43	<i>sertraline</i>	44
RECLAST	68	<i>risperidone</i>	44	<i>setlakin</i>	94
<i>reclipsen (28)</i>	94	RITALIN	44	<i>sevelamer carbonate</i>	69
RECOMBIVAX HB (PF)	86	RITALIN LA	44	SFROWASA	81
RECTIV	81	RITUXAN	22	<i>sharobel</i>	94
REGLAN	81	<i>rivastigmine</i>	44	SIGNIFOR	22
REGRANEX	65	<i>rivastigmine tartrate</i>	44	SIGNIFOR LAR	22
RELENZA DISKHALER	13	<i>rivelsa</i>	94	<i>sildenafil (antihypertensive)</i>	102
RELISTOR	81	<i>rizatriptan</i>	44	SILENOR	44
RELPAK	43	ROBINUL	81	SILIQ	65
REMERON	43	ROBINUL FORTE	81	SILVADENE	65
REMERON SOLTAB	43	ROCALTROL	75	<i>silver sulfadiazine</i>	65
REMICADE	81	<i>ropinirole</i>	44	SIMBRINZA	98
REMODULIN	58	<i>rosuvastatin</i>	58	SIMPONI	89
RENAGEL	68	ROTARIX	86	SIMPONI ARIA	89
RENFLEXIS	81	ROTATEQ VACCINE	86	SIMULECT	22
REVELA	68	<i>roweepa</i>	44	<i>simvastatin</i>	58
<i>repaglinide</i>	75	ROXICODONE	44	SINEMET	44
<i>repaglinide-metformin</i>	75	ROZEREM	44	SINEMET CR	44
REPATHA PUSHTRONEX	58	RUBRACA	22	SINGULAIR	102
REPATHA SURECLICK	58	RUCONEST	102	<i>sirolimus</i>	22
REPATHA SYRINGE	58	RYDAPT	22	SIRTURO	13
REQUIP	43	RYTARY	44	SIVEXTRO	13
REQUIP XL	43	RYTHMOL SR	58	SKELAXIN	44
RESCRIPTOR	13	RYVENT	102	SKLICE	65
RESTASIS	98	SABRIL	44	<i>sodium chloride</i>	69, 106
RESTORIL	43	SAFYRAL	94	<i>sodium chloride 0.45 %</i>	106
RETIN-A	65	SAIZEN	86	<i>sodium chloride 0.9 %</i>	69
RETIN-A MICRO	65	SAIZEN CLICK.EASY	86	<i>sodium chloride 3 %</i>	106
RETIN-A MICRO PUMP	65	SALAGEN (PILOCARPINE)	69	<i>sodium chloride 5 %</i>	106
RETROVIR	13	SAMSCA	75	<i>sodium lactate</i>	106
REVATIO	101, 102	SANCUSO	81	<i>sodium phenylbutyrate</i>	69

<i>sodium polystyrene (sorb free)</i> ...	69	SUBSYS	45	TARGRETIN	23
SOLARAZE	65	SUCRAID	81	<i>tarina fe 1/20 (28)</i>	94
SOLQUA 100/33	75	<i>sucralfate</i>	81	TARKA	58
SOLODYN	13	SULAR	58	TASIGNA	23
SOLTAMOX	22	<i>sulfacetamide sodium</i>	98	TASMAR	46
SOLU-CORTEF (PF)	75	<i>sulfacetamide sodium (acne)</i>	66	TAXOTERE	23
SOLU-MEDROL	75	<i>sulfacetamide-prednisolone</i>	98	<i>tazarotene</i>	66
SOLU-MEDROL (PF)	75	<i>sulfadiazine</i>	14	TAZICEF	14
SOMA	44	<i>sulfamethoxazole-trimethoprim</i> ..	14	TAZORAC	66
SOMATULINE DEPOT	22	SULFAMYLON	66	<i>taztia xt</i>	58
SOMAVERT	75	<i>sulfasalazine</i>	81	TECENTRIQ	23
SONATA	44	<i>sulindac</i>	45	TECFIDERA	46
SOOLANTRA	65	<i>sumatriptan</i>	45	TECHNIVIE	14
SORIATANE	65	<i>sumatriptan succinate</i>	45	TEFLARO	14
SORILUX	65	SUMAVEL DOSEPRO	45	TEGRETOL	46
<i>sorine</i>	58	SUPRAX	14	TEGRETOL XR	46
<i>sotalol</i>	58	SUPREP BOWEL PREP KIT	81	TEKTRUNA	58
<i>sotalol af</i>	58	SURMONTIL	45	TEKTRUNA HCT	58
SOTYLIZE	58	SUSTIVA	14	<i>telmisartan</i>	58
SOVALDI	13	SUTENT	22	<i>telmisartan-amlodipine</i>	58
SPIRIVA RESPIMAT	102	SYLATRON	86	<i>telmisartan-hydrochlorothiazid</i> ..	58
SPIRIVA WITH		SYLVANT	22	<i>temazepam</i>	46
HANDIHALER	102	SYMBICORT	102	TEMOVATE	66
<i>spironolactone</i>	58	SYMBYAX	46	<i>tencon</i>	46
<i>spironolacton-hydrochlorothiaz.</i>	58	SYMLINPEN 120	75	TENIVAC (PF)	86
SPORANOX	13, 14	SYMLINPEN 60	75	TENORETIC 100	58
<i>sprintec (28)</i>	94	SYNAGIS	14	TENORETIC 50	59
SPRITAM	44	SYNALAR	66	TENORMIN	59
SPRYCEL	22	SYNALGOS-DC	46	TERAZOL 7	94
<i>sps (with sorbitol)</i>	69	SYNAREL	76	<i>terazosin</i>	59
<i>sronyx</i>	94	SYNDROS	81	<i>terbinafine hcl</i>	14
<i>ssd</i>	65	SYNERCID	14	<i>terbutaline</i>	102
STALEVO 100	44	SYNJARDY	76	<i>terconazole</i>	94
STALEVO 125	45	SYNRIBO	22	TESTIM	76
STALEVO 150	45	SYNTHROID	76	TESTOSTERONE	76
STALEVO 200	45	SYPRINE	69	<i>testosterone</i>	76
STALEVO 50	45	TABLOID	22	<i>testosterone cypionate</i>	76
STALEVO 75	45	TACLONEX	66	<i>testosterone enanthate</i>	76
STARLIX	75	<i>tacrolimus</i>	22, 23, 66	TESTRED	76
<i>stavudine</i>	14	TAFINLAR	23	TETANUS,DIPHThERIA	
STELARA	65, 66	TAGRISSO	23	TOX PED(PF)	86
STIMATE	75	TALTZ AUTOINJECTOR (3		TETANUS-DIPHThERIA	
STIOLTO RESPIMAT	102	PACK)	66	TOXOIDS-TD	86
STIVARGA	22	TALTZ SYRINGE	66	<i>tetrabenazine</i>	46
STRATTERA	45	TALWIN	46	<i>tetracycline</i>	14
STRENSIQ	75	TAMIFLU	14	THALOMID	23
STREPTOMYCIN	14	<i>tamoxifen</i>	23	THEO-24	102
STRIANT	75	<i>tamsulosin</i>	103	<i>theophylline</i>	102
STRIBILD	14	TANZEUM	76	THIOLA	69
STRIVERDI RESPIMAT	102	TAPAZOLE	76	<i>thioridazine</i>	46
STROMECTOL	14	TARCEVA	23	<i>thiotepa</i>	23
SUBOXONE	45	TARGADOX	14	<i>thiothixene</i>	46

THYMOGLOBULIN	86	<i>tramadol-acetaminophen</i>	47	<i>trivora (28)</i>	94
THYROLAR-1	76	<i>trandolapril</i>	59	TRIZIVIR	14
THYROLAR-1/2	76	<i>trandolapril-verapamil</i>	59	TROKENDI XR	47
THYROLAR-1/4	76	<i>tranexamic acid</i>	59, 94	TROPHAMINE 10 %	106
THYROLAR-2	76	TRANSDERM-SCOP	81	TROPHAMINE 6%	106
THYROLAR-3	76	TRANXENE T-TAB	47	<i>trospium</i>	103
<i>tiagabine</i>	46	<i>tranylcypromine</i>	47	TRULICITY	76
TIAZAC	59	<i>travasol 10 %</i>	106	TRUMENBA	86
TIGAN	81	TRAVATAN Z	98	TRUSOPT	98
TIGECYCLINE	14	<i>trazodone</i>	47	TRUVADA	14
TIKOSYN	59	TREANDA	23	TUDORZA PRESSAIR	102
<i>timolol maleate</i>	59, 98	TRECTOR	14	TWINRIX (PF)	86
TIMOPTIC OCUDOSE (PF) ..	98	TRELSTAR	23	TWYNSTA	59
TIMOPTIC-XE	98	TRESIBA FLEXTOUCH U-		TYBOST	14
TINDAMAX	14	100	76	TYGACIL	14
<i>tinidazole</i>	14	TRESIBA FLEXTOUCH U-		TYKERB	23
TIROSINT	76	200	76	TYLENOL-CODEINE #3	47
TIVICAY	14	<i>tretinoin</i>	66	TYLENOL-CODEINE #4	47
TIVORBEX	46	<i>tretinoin (chemotherapy)</i>	23	TYMLOS	89
<i>tizanidine</i>	46	<i>tretinoin microspheres</i>	66	TYPHIM VI	86
TOBI	14	TREXALL	23	TYSABRI	47
TOBI PODHALER	14	TREXIMET	47	UCERIS	81
TOBRADEX	98	TREZIX	47	ULORIC	89
TOBRADEX ST	98	<i>triamcinolone acetonide</i>	66, 69, 102	ULTRACET	47
<i>tobramycin</i>	98	<i>triamterene-hydrochlorothiazid</i> ..	59	ULTRAM	47
<i>tobramycin in 0.225 % nacl</i>	14	<i>trianex</i>	66	ULTRAVATE	66
<i>tobramycin sulfate</i>	14	<i>triazolam</i>	47	UNASYN	15
<i>tobramycin-dexamethasone</i>	98	TRIBENZOR	59	<i>unithroid</i>	76
TOBREX	98	TRICOR	59	UPTRAVI	59
TOFRANIL	46	<i>triderm</i>	66	URECHOLINE	104
TOLAK	66	TRIDESILON	66	UROCIT-K 10	104
<i>tolazamide</i>	76	<i>trifluoperazine</i>	47	UROCIT-K 15	104
<i>tolbutamide</i>	76	<i>trifluridine</i>	98	UROCIT-K 5	104
<i>tolcapone</i>	46	TRIGLIDE	59	UROXATRAL	104
<i>tolmetin</i>	46	<i>trihexyphenidyl</i>	47	URSO 250	82
<i>tolterodine</i>	103	<i>tri-legest fe</i>	94	URSO FORTE	82
TOPAMAX	46	TRILEPTAL	47	<i>ursodiol</i>	82
TOPICORT	66	TRILIPIX	59	VAGIFEM	94
<i>topiramate</i>	46	<i>tri-lo-estarylla</i>	94	<i>valacyclovir</i>	15
TOPIRAMATE	46	<i>tri-lo-sprintec</i>	94	VALCHLOR	66
<i>toposar</i>	23	<i>trilyte with flavor packets</i>	81	VALCYTE	15
<i>topotecan</i>	23	<i>trimethobenzamide</i>	81	VALGANCICLOVIR	15
TOPROL XL	59	<i>trimethoprim</i>	14	<i>valganciclovir</i>	15
TORISEL	23	<i>trimipramine</i>	47	VALIUM	47
<i>torseamide</i>	59	<i>trinessa (28)</i>	94	<i>valproate sodium</i>	47
TOUJEO SOLOSTAR	76	TRI-NORINYL (28)	94	<i>valproic acid</i>	47
TOVIAZ	103	TRINTELLIX	47	<i>valproic acid (as sodium salt)</i>	47
TPN ELECTROLYTES	106	TRIOSTAT	76	<i>valsartan</i>	59
TRACLEER	102	<i>tri-previfem (28)</i>	94	<i>valsartan-hydrochlorothiazide</i> ...	59
TRADJENTA	76	TRISENOX	23	VALTRESX	15
TRAMADOL	46	<i>tri-sprintec (28)</i>	94	VANATOL LQ	47
<i>tramadol</i>	46	TRIUMEQ	14	VANCOCIN	15

<i>vancomycin</i>	15	VIMOVO	48	XIIDRA	98
<i>vandazole</i>	94	VIMPAT	48	XODOL 10/300	48
VANOS	66	<i>vinblastine</i>	23	XODOL 5/300	48
VAQTA (PF)	86	<i>vincasar pfs</i>	23	XODOL 7.5/300	48
VARIVAX (PF)	86	<i>vincristine</i>	23	XOLAIR	102
VARIZIG	86	<i>vinorelbine</i>	23	XOPENEX	102
VARUBI	82	VIOKACE	82	XOPENEX CONCENTRATE	
VASCEPA	59	VIRACEPT	15	102
VASERETIC	59	VIRAMUNE	15	XOPENEX HFA	102
VASOTEC	59	VIRAMUNE XR	15	XTAMPZA ER	48
VECAMYL	59	VIREAD	15	XTANDI	24
VECTIBIX	23	VIROPTIC	98	<i>xulane</i>	95
VECTICAL	66	VISTARIL	102	XYLOCAINE	66
VELCADE	23	VIVELLE-DOT	95	XYREM	48
<i>velivet triphasic regimen (28)</i>	94	VIVITROL	48	XYZAL	102
VELPHORO	69	VIVLODEX	48	YASMIN (28)	95
VELTASSA	69	VOGELXO	76	YAZ (28)	95
VEMLIDY	15	VOLTAREN	48	YERVOY	24
VENCLEXTA	23	<i>voriconazole</i>	15	YF-VAX (PF)	86
VENCLEXTA STARTING		VOSEVI	15	YONDELIS	24
PACK	23	VOTRIENT	23	YOSPRALA	60
<i>venlafaxine</i>	47	VPRIV	76	YUVAFEM	95
VENLAFAXINE	47	VRAYLAR	48	<i>zafirlukast</i>	102
VENTAVIS	102	<i>vyfemla (28)</i>	95	<i>zaleplon</i>	48
VENTOLIN HFA	102	VYTORIN 10-10	59	ZALTRAP	24
<i>verapamil</i>	59	VYTORIN 10-20	59	<i>zamicet</i>	48
VEREGEN	66	VYTORIN 10-40	59	ZANAFLEX	48
VERELAN	59	VYTORIN 10-80	59	ZANOSAR	24
VERELAN PM	59	VYVANSE	48	ZANTAC	82
<i>veripred 20</i>	76	VYXEOS	23	<i>zarah</i>	95
VERSACLOZ	47	<i>warfarin</i>	59	ZARONTIN	48
VESICARE	104	<i>water for irrigation, sterile</i>	69	ZARXIO	86
<i>vestura (28)</i>	95	WELCHOL	59	ZAVESCA	77
VFEND	15	WELLBUTRIN SR	48	<i>zebutal</i>	48
VFEND IV	15	WELLBUTRIN XL	48	ZEGERID	82
VIBATIV	15	<i>wymzya fe</i>	95	ZEJULA	24
VIBERZI	82	XADAGO	48	ZELAPAR	48
VIBRAMYCIN	15	XALATAN	98	ZELBORAF	24
<i>vicodin</i>	47	XALKORI	23	ZEMAIRA	69
<i>vicodin es</i>	47	XANAX	48	ZEMBRACE SYMTOUCH	48
<i>vicodin hp</i>	47	XANAX XR	48	ZEMPLAR	77
VICTOZA 3-PAK	76	XARELTO	60	<i>zenatane</i>	66
VIDAZA	23	XATMEP	23	<i>zenchent (28)</i>	95
VIDEX 2 GRAM		XELJANZ	89	<i>zenchent fe</i>	95
PEDIATRIC	15	XELJANZ XR	89	ZENPEP	82
VIDEX EC	15	XENAZINE	48	<i>zenzedi</i>	48
VIEKIRA PAK	15	XEOMIN	86	ZENZEDI	49
VIEKIRA XR	15	XERESE	66	ZEPATIER	15
<i>vienva</i>	95	XERMELO	23	ZERBAXA	15
<i>vigabatrin</i>	47	XGEVA	24	ZERIT	16
VIGAMOX	98	XIFAXAN	15	ZESTORETIC	60
VIIBRYD	47, 48	XIGDUO XR	77	ZESTRIL	60

ZETIA	60	ZYDELIG	24
ZETONNA	102	ZYFLO	102
ZIAC	60	ZYFLO CR	102
ZIAGEN	16	ZYKADIA	24
ZIANA	66	ZYLET	98
<i>zidovudine</i>	16	ZYLOPRIM	89
<i>zileuton</i>	102	ZYMAXID	98
ZINBRYTA	49	ZYPREXA	49
ZINECARD (AS HCL)	24	ZYPREXA RELPREVV	49
ZINPLAVA	86	ZYPREXA ZYDIS	49
ZIOPTAN (PF)	98	ZYTIGA	24
<i>ziprasidone hcl</i>	49	ZYVOX	16
ZIPSOR	49		
ZIRGAN	98		
ZITHROMAX	16		
ZITHROMAX TRI-PAK	16		
ZITHROMAX Z-PAK	16		
ZMAX	16		
ZOCOR	60		
ZOFRAN (AS			
HYDROCHLORIDE)	82		
ZOFRAN ODT	82		
ZOHYDRO ER	49		
<i>zoledronic acid</i>	77		
<i>zoledronic acid-mannitol-water</i> ..	69		
ZOLINZA	24		
<i>zolmitriptan</i>	49		
ZOLOFT	49		
<i>zolpidem</i>	49		
ZOMACTON	87		
ZOMETA	77		
ZOMIG	49		
ZOMIG ZMT	49		
ZONALON	66		
ZONEGRAN	49		
<i>zonisamide</i>	49		
ZONTIVITY	60		
ZORBTIVE	87		
ZORTRESS	24		
ZORVOLEX	49		
ZOSTAVAX (PF)	87		
ZOSYN	16		
ZOSYN IN DEXTROSE			
(ISO-OSM)	16		
<i>zovia 1/35e (28)</i>	95		
<i>zovia 1/50e (28)</i>	95		
ZOVIRAX	16, 67		
ZUBSOLV	49		
ZUPLENZ	82		
ZURAMPIC	89		
ZYBAN	69		
ZYCLARA	67		

actemra

Products Affected

- ACTEMRA INTRAVENOUS
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Kineret, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- documentation of moderate to severe juvenile idiopathic rheumatoid arthritis (Actemra IV only)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

Products Affected

- ACTIMMUNE

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

adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	cardiologist, pulmonologist
Coverage Duration	12 months
Other Criteria	

ADHD Drugs

Products Affected

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

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

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

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

Products Affected

- ALUNBRIG

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

ampyra

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	history of seizure disorder, Cr Cl less than 50ml/min
Required Medical Information	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	Doses greater than 20 mg/day will not be approved. For reauthorization, documentation supporting improvement in walking impairment from baseline is required.

anabolic steroids

Products Affected

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

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

atypical antipsychotics

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

Products Affected

- AUBAGIO

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

austedo

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

bavencio

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	Deny if less than 12 years of age for metastatic Merkel cell carcinoma
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

belbuca

Products Affected

- BELBUCA

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 chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Belbuca should not be used concomitantly with substance abuse therapies.

BELEODAQ

Products Affected

- BELEODAQ

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

berinert

Products Affected

- BERINERT INTRAVENOUS KIT

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

bosulif

Products Affected

- **BOSULIF**

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

botulinum toxin

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

- FORTAMET ORAL TABLET
EXTENDED RELEASE 24HR 1,000
MG, 500 MG
- METFORMIN ORAL TABLET,ER
GAST.RETENTION 24 HR
- GLUMETZA
- RIOMET

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- Either 1 or 2. 1) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

brand NSAIDs

Products Affected

- VOLTAREN TOPICAL

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 trial/failure of at least 2 generic formulary NSAIDs (e.g. diclofenac, ibuprofen, etc.) or contraindication to all oral NSAIDs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

butrans

Products Affected

• BUPRENORPHINE

• BUTRANS

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 chronic pain -AND- trial and failure of at least two previous federal legend medications for pain, including NSAIDs, tramadol, or opioid analgesics
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	buprenorphine patches should not be used concomitantly with substance abuse therapies.

cabometyx

Products Affected

- **CABOMETYX**

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 (RCC) and failure of one prior anti-angiogenic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

caprelsa

Products Affected

- CAPRELSA

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

carbaglu

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

CERDELGA

Products Affected

- CERDELGA

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

CF drugs

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

Products Affected

- CHENODAL

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

cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

cialis

Products Affected

- CIALIS ORAL TABLET 2.5 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 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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

cimzia

Products Affected

• CIMZIA

• CIMZIA POWDER FOR RECONST

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, Actemra, Kineret
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis -OR- moderate to severe Crohn's disease -OR- psoriatic arthritis -OR- ankylosing spondylitis
Age Restrictions	
Prescriber Restrictions	Gastroenterologist/ Rheumatologist
Coverage Duration	12 months
Other Criteria	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

Products Affected

- COMETRIQ

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

corlanor

Products Affected

- CORLANOR ORAL TABLET 5 MG, 7.5 MG

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

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

Products Affected

- COTELLIC

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

crinone

Products Affected

- CRINONE

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

daklinza

Products Affected

- DAKLINZA

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

darzalex

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

duexis

Products Affected

- DUEXIS

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) 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).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

dupixent

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	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

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

Products Affected

- EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG

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

emflaza

Products Affected

- EMFLAZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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)
Age Restrictions	Deny if less than 5 years of age
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	

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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Remicade, Cimzia, Humira, Orencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	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.
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	rheumatologist, dermatologist
Coverage Duration	12 months
Other Criteria	For psoriasis trial of 1 alternative therapy, either systemic therapy (e.g. methotrexate or cyclosporine) or phototherapy, is required.

entresto

Products Affected

- ENTRESTO

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

epclusa

Products Affected

- EPCLUSA

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

erivedge

Products Affected

- ERIVEDGE

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

eucrisa

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1 and 2): 1) mild to moderate atopic dermatitis 2) trial & failure, intolerance, or contraindication to at least two topical corticosteroids -OR- failure of at least one non-fluorinated topical corticosteroid for patients 2-15 years old -OR- trial & failure, intolerance, or contraindication to at least one non-fluorinated topical corticosteroid for patients requesting treatment for atopic dermatitis of the face
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Reauthorization or continuation of therapy will be approved when documentation of improvement or response to therapy is provided.

exondys

Products Affected

- EXONDYS 51

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	Neurologist or other physician who specializes in treatment of DMD
Coverage Duration	12 months
Other Criteria	

farydak

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

Products Affected

- FLECTOR

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 trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	

forteo

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	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.
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	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

Products Affected

- **GATTEX ONE-VIAL**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

gilenya

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of Gilenya and other disease modifying agents such as interferons, Copaxone , Tysabri
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	neurologist
Coverage Duration	12 months
Other Criteria	Doses greater than 0.5mg/day will not be approved

gleevec

Products Affected

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

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 alternatives tried or concomitant therapy, if applicable for diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

gralise

Products Affected

- GRALISE
- GRALISE 30-DAY STARTER PACK

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

GRASTEK

Products Affected

- GRASTEK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	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
Age Restrictions	Deny if less than 5 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

growth hormone

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

Products Affected

- HARVONI

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

HETLIOZ

Products Affected

- HETLIOZ

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

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

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

Products Affected

- HORIZANT

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 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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Remicade, Cimzia, Enbrel, Oencia, Simponi, Actemra, Kineret, Stelara
Required Medical Information	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)
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	rheumatologist, dermatologist, gastroenterologist, ophthalmologist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	<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

Products Affected

- IBRANCE

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

iclusig

Products Affected

- ICLUSIG

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

idhifa

Products Affected

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

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

Products Affected

- IMBRUVICA

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

imfinzi

Products Affected

- IMFINZI

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

increlex

Products Affected

- INCRELEX

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, stimulation test results, growth velocity, IGF-1 level
Age Restrictions	Deny if greater than 18 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

inflectra

Products Affected

- INFLECTRA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
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 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
Age Restrictions	For Crohn's disease, deny if less than 6 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

Products Affected

- INGREZZA ORAL CAPSULE 40 MG

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

inlyta

Products Affected

- INLYTA

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 (RCC) and failure one prior systemic therapy
Age Restrictions	
Prescriber Restrictions	oncologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

interferon alfa

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

Products Affected

- ARCALYST
- ILARIS (PF) SUBCUTANEOUS

RECON SOLN

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

iressa

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

jakafi

Products Affected

- **JAKAFI**

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

kalydeco

Products Affected

- KALYDECO ORAL GRANULES IN PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Homozygous for the F508del mutation in the CFTR gene
Required Medical Information	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)
Age Restrictions	Deny if less than 6 years of age for oral tablets and less than 2 years of age for oral granules
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	Doses greater than 300mg/day will not be approved

kanuma

Products Affected

- KANUMA

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 Lysosomal Acid Lipase (LAL) deficiency
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

keveyis

Products Affected

- KEVEYIS

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

kevzara

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant use of a biologic DMARD (e.g., Xeljanz, Enbrel, Humira, Kineret, Orencia, Remicade, Cimzia, or Simponi)
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	Deny if less than 18 years of age
Coverage Duration	12 months
Other Criteria	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

Products Affected

- KEYTRUDA

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

kineret

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Actemra, Remicade, Humira, Orencia, Enbrel, Simponi, Cimzia
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	rheumatologist, pediatrician
Coverage Duration	12 months
Other Criteria	Patients must have an adequate trial or intolerance to the preferred products, Enbrel and Humira, for rheumatoid arthritis.

kisqali

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)**

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

korlym

Products Affected

- **KORLYM**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

lenvima

Products Affected

- LENVIMA

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

leukotriene modifiers

Products Affected

- *zileuton*
- **ZYFLO**
- **ZYFLO CR**

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

Products Affected

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

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

lonsurf

Products Affected

- **LONSURF**

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

lynparza

Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

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

lyrica

Products Affected

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

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

mavyret

Products Affected

- MAVYRET

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

mekinist

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Disease progression on prior BRAF inhibitor therapy
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

methamphetamine

Products Affected

- DESOXYN
- *methamphetamine*

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

mozobil

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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).
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

namenda

Products Affected

- NAMENDA ORAL TABLET
- NAMENDA TITRATION PAK
- NAMENDA XR

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

namzarin

Products Affected

- NAMZARIC

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

natpara

Products Affected

- NATPARA

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

nerlynx

Products Affected

- NERLYNX

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

nexavar

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ninlaro

Products Affected

- NINLARO

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

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

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

Products Affected

- NUPLAZID

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

OAB drugs

Products Affected

- DETROL LA
- DETROL ORAL TABLET 1 MG, 2 MG
- DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 15 MG, 5 MG
- ENABLEX
- GELNIQUE TRANSDERMAL GEL IN PACKET
- OXYTROL

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- trial/failure of at least 2 generic alternatives (e.g. oxybutynin, trospium, tolterodine)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

odomzo

Products Affected

- ODOMZO

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

olysio

Products Affected

- OLYSIO

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

opdivo

Products Affected

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

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

oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300
INDX REACTIVITY**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	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
Age Restrictions	Deny if less than 10 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	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

Products Affected

- ORKAMBI

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

OTEZLA

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

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**

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 trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

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

prescription drug combo

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
- **DILAUDID ORAL LIQUID**
- **DILAUDID 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/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/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
- **MORPHABOND ER ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 100 MG, 15 MG, 30 MG, 60 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
- **MS CONTIN 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
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate+subs. abuse tx, approve opiate x 1mo. Opiate+benzo+carisoprodol, approve x 12mo.
Other Criteria	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

Products Affected

- FETZIMA

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

PROCYSBI

Products Affected

- PROCYSBI

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

prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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*
- **NUVIGIL**
- **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

Products Affected

- RADICAVA

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

RAGWITEK

Products Affected

- RAGWITEK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age or greater than 65 years of age
Prescriber Restrictions	allergy specialist, otolaryngologist, immunologist
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector

rasuvo

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**

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 trial/failure, intolerance, or contraindication to oral generic methotrexate tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

ravicti

Products Affected

- RAVICTI

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

relistor

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

remicade

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
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 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
Age Restrictions	For Crohn's disease and ulcerative colitis, deny if less than 6 years old
Prescriber Restrictions	rheumatologist, dermatologist, or gastroenterologist
Coverage Duration	12 months
Other Criteria	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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Humira, Cimzia, Enbrel, Orencia, Simponi, Actemra, Kineret, Stelara
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 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
Age Restrictions	For Crohn's disease, deny if less than 6 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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
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

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	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

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, lipid specialist, or endocrinologist
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	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

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Documentation of severe neutropenia, severe thrombocytopenia, or treatment-related MDS
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

rubraca

Products Affected

- RUBRACA ORAL TABLET 200 MG, 300 MG

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 deleterious BRCA mutated, advanced ovarian cancer -AND- Rubraca will be used as monotherapy -AND- trial and failure of 2 prior chemotherapy regimens
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

ruconest

Products Affected

- RUCONEST

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 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 13 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

rydapt

Products Affected

- RYDAPT

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

savella

Products Affected

- SAVELLA

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

signifor

Products Affected

- SIGNIFOR

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

siliq

Products Affected

- SILIQ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	History of or active Crohn's disease
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	4 months initial authorization, 12 months reauthorization
Other Criteria	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

Products Affected

- SIMPONI ARIA

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, Orencia, Enbrel, Cimzia
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and use in combination with methotrexate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

sovaldi

Products Affected

- SOVALDI

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

sprycel

Products Affected

- SPRYCEL

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 failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase PH+ CML).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Applies to new starts only

stelara

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Simponi
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	dermatologist, rheumatologist
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. 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

Products Affected

- STELARA INTRAVENOUS

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

stivarga

Products Affected

- STIVARGA

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

strensiq

Products Affected

- STRENSIQ

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

sutent

Products Affected

- SUTENT

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 failure of Gleevec therapy, if applicable
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

sylvant

Products Affected

- SYLVANT INTRAVENOUS RECON SOLN 100 MG

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

syndros

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

tagrisso

Products Affected

- TAGRISSO

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

taltz

Products Affected

- TALTZ AUTOINJECTOR (3 PACK)
- TALTZ SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Simponi, Stelara
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	dermatologist
Coverage Duration	12 months
Other Criteria	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

Products Affected

- TASIGNA

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 failure of Gleevec therapy (failure of Gleevec is not necessary for the indication of newly diagnosed adults with chronic phase PH+ CML).
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

tecfidera

Products Affected

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

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

technivie

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe hepatic impairment (Child-Pugh C)
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	

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/lapp*
- TESTRED
- 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

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

thalamid

Products Affected

- THALOMID

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

thrombopoiesis stimulating agents

Products Affected

- PROMACTA

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 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Platelet count to be provided

tigan

Products Affected

- TIGAN ORAL CAPSULE 300 MG
- *trimethobenzamide oral*

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

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

Products Affected

- **TYKERB**

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

tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	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.
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	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

Products Affected

- VALCHLOR

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

veltassa

Products Affected

- VELTASSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, documentation of reduction in serum potassium levels following Veltassa administration is required.

venclexta

Products Affected

• VENCLEXTA

• VENCLEXTA STARTING PACK

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

viberzi

Products Affected

- VIBERZI

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

VIEKIRA PAK

Products Affected

- VIEKIRA PAK

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

VIEKIRA XR

Products Affected

- VIEKIRA XR

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

viibryd

Products Affected

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

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

vimovo

Products Affected

- **VIMOVO**

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

vosevi

Products Affected

- VOSEVI

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

votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

vyxeos

Products Affected

- VYXEOS

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

xadago

Products Affected

- XADAGO

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 in patients with Parkinson's disease (1, 2, and 3) 1) Confirmation that patient will be using therapy in combination with carbidopa/levodopa -AND- 2) Documentation of wearing off (e.g., off episodes) between doses -AND- 3) Documentation of trial, failure, or intolerance to generic rasagiline and generic selegiline
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

xalkori

Products Affected

- XALKORI

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

xeljanz

Products Affected

• XELJANZ

• XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	concomitant use of Enbrel, Remicade, Humira, Kineret, Simponi, Orenzia, Stelara, Actemra, azathioprine, cyclosporine
Required Medical Information	Documentation of moderate to severe rheumatoid arthritis and an inadequate response or intolerance to methotrexate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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

Products Affected

• *tetrabenazine*

• XENAZINE

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

xermelo

Products Affected

- XERMELO

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

xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: 1 year. IBS-D: 14 days.
Other Criteria	No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime.

xtandi

Products Affected

- XTANDI

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

xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

yosprala

Products Affected

- YOSPRALA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

zejula

Products Affected

- ZEJULA

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

zelboraf

Products Affected

• TAFINLAR

• ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	Applies to new starts only

zepatier

Products Affected

- ZEPATIER

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

zinbryta

Products Affected

- ZINBRYTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Reauthorization or continuation of therapy will be approved when documentation of disease stability or improvement is provided

zinplava

Products Affected

- ZINPLAVA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	7 days
Other Criteria	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

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	oncologist, hematologist
Coverage Duration	12 months
Other Criteria	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

Products Affected

- ZYKADIA

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

zytiga

Products Affected

- ZYTIGA ORAL TABLET 250 MG, 500 MG

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

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