Gateway Health
Medicare Assured℠

2018

Comprehensive Formulary (List of Covered Drugs)

PLEASE READ: This document contains information about the drugs we cover in these plans.

Gateway Health Medicare Assured Diamond℠ (HMO SNP)
Gateway Health Medicare Assured Ruby℠ (HMO SNP)

This formulary was updated on December 1, 2018.
For more recent information or other questions, please contact Gateway Health Member Services toll free at:

Pennsylvania: 1-800-685-5209 (TTY: 711)
Ohio: 1-888-447-4505 (TTY: 711)
North Carolina: 1-855-847-6430 (TTY: 711)
Kentucky: 1-855-847-6380 (TTY: 711)

Our business hours are 8 a.m. - 8 p.m., 7 days a week from October 1 through February 14. From February 15 through September 30 our business hours are 8 a.m. - 8 p.m., Monday through Friday. Or visit us at **www.MedicareAssured.com.**

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MedicareRx
Prescription Drug Coverage℠

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

When this drug list (formulary) refers to "we," "us", or "our," it means Gateway Health[SM]. When it refers to "plan" or "our plan," it means Gateway Health Medicare Assured Diamond[SM] and Gateway Health Medicare Assured Ruby[SM].

This document includes a list of the drugs (formulary) for our plan which is current as of December 1, 2018. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2018, and from time to time during the year.

What is the Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary?

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

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2018 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2018 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of December 1, 2018. To get updated information about the drugs covered by Gateway Health Medicare Assured Diamond or Gateway Health Medicare Assured Ruby please contact us. Our contact information appears on the front and back cover pages. In the event we make changes to our formulary throughout the year, a Formulary Update Notice will be provided detailing date of change, drug affected, description & reason for change.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 3. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Drugs". If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 69. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, Gateway Health Medicare Assured Diamond, Gateway Health Medicare Assured Ruby may not cover the drug.

- **Quantity Limits:** For certain drugs, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby limit the amount of the drug that Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby will cover. Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby provide 60 tablets per prescription for a 30 day supply of metformin 1000 mg tablets. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 3. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We've posted on-line documents that explain our prior authorization restrictions and/ or step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Gateway Health Medicare Assured Diamond or Gateway Health Medicare Assured Ruby formulary?" on page iii for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that Gateway Health Medicare Assured Diamond or Gateway Health Medicare Assured Ruby does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Gateway Health Medicare Assured Diamond or Gateway Health Medicare Assured Ruby.

- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary?

You can ask Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30 day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30 day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with at least a 91 day, and maybe up to, a 98 day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31 day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

For more information

For more detailed information about your Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby prescription drug coverage, please review your Evidence of Coverage and other plan materials.

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

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

Gateway Health Medicare Assured Diamond and Gateway Health Medicare Assured Ruby Formulary

The formulary that begins on page 3 provides coverage information about some of the drugs covered by our plan. If you have trouble finding your drug in this list, turn to the Index that begins on page 69.

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

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

Plan Name	Drug Tier	Member Cost Share
Gateway Health Medicare Assured Diamond	1 – Generic (including brand drugs treated as generic)	$0.00, $1.25 or $3.35
	1 - All Other Drugs	$0.00, $3.70 or $8.35
Gateway Health Medicare Assured Ruby	1 – Generic (including brand drugs treated as generic)	$0.00, $1.25 or $3.35
	1 - All Other Drugs	$0.00, $3.70 or $8.35

Drug Table Notes

The following table lists the notes as they appear in the formulary.

PA – Prior Authorization
B/D – This drug may be covered under Medicare B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
ST – Step Therapy
LA – Limited Availability
QL – Quantity Limits

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italics = Generic 1 drugs
UPPERCASE = Brand name 1 drugs

Drug Tier
1 = Covered Drug (Brand or Generic)

Requirements/Limits
B/D = This drug may be covered under Medicare Part B or D
LA = Limited Access
PA = Prior Authorization
PA (NS) = Prior Authorization for New Starts Only
QL = Quantity Limits
ST = Step Therapy

Drug Name	Drug Tier	Requirements/Limits
Alkylating Agents		
Tetrahydroisoquinolines		
LEUKERAN	1	
YONDELIS	1	
Antihistamine Drugs		
Antihistamine Drugs		
Cetirizine HCl Oral Solution 1 MG/ML	1	
Cetirizine HCl Oral Syrup 1 MG/ML	1	
Cyproheptadine HCl Oral	1	PA
DiphenhydrAMINE HCl Injection	1	
Levocetirizine Dihydrochloride Oral	1	
Promethazine HCl Oral Tablet	1	PA
Anti-Infective Agents		
Amebicides		
Paromomycin Sulfate Oral	1	
Aminoglycosides		
Amikacin Sulfate Injection Solution 1 GM/4ML, 500 MG/2ML	1	
Gentamicin in Saline Intravenous Solution 0.8-0.9 MG/ML-%, 1-0.9 MG/ML-%, 1.2-0.9 MG/ML-%, 1.6-0.9 MG/ML-%, 2-0.9 MG/ML-%	1	
Gentamicin Sulfate Injection	1	
Neomycin Sulfate Oral	1	
Tobramycin Inhalation	1	B/D
Tobramycin Sulfate Injection	1	
Anthelmintics		
Albendazole Oral	1	
ALBENZA	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
BILTRICIDE	1	
Antibacterials, Miscellaneous		
Clindamycin HCl Oral	1	
Clindamycin Palmitate HCl	1	
Clindamycin Phosphate Injection Solution 300 MG/2ML, 600 MG/4ML, 900 MG/6ML	1	
Clindamycin Phosphate Intravenous Solution 600 MG/4ML	1	
Colistimethate Sodium (CBA)	1	
Colistimethate Sodium Injection	1	
DAPTOmycin Intravenous Solution Reconstituted 500 MG	1	
Linezolid in Sodium Chloride	1	PA
Linezolid Intravenous Solution 600 MG/300ML	1	PA
Linezolid Oral Suspension Reconstituted	1	PA
Linezolid Oral Tablet	1	PA; QL (60 EA per 30 days)
SYNERCID	1	
Vancomycin HCl Intravenous Solution Reconstituted 10 GM, 1000 MG, 500 MG, 5000 MG, 750 MG	1	
Vancomycin HCl Oral	1	
Antifungals		
AMBISOME	1	B/D
Amphotericin B Injection	1	B/D
CANCIDAS	1	
Caspofungin Acetate	1	
Fluconazole in Dextrose	1	
Fluconazole in Sodium Chloride Intravenous Solution 200-0.9 MG/100ML-%, 400-0.9 MG/200ML-%	1	
Fluconazole Oral	1	
Flucytosine Oral	1	
Griseofulvin Microsize Oral	1	
Griseofulvin Ultramicrosize	1	
Itraconazole Oral	1	
Ketoconazole Oral	1	
NOXAFIL ORAL SUSPENSION	1	PA
Nystatin Mouth/Throat	1	
Nystatin Oral Tablet	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
SPORANOX ORAL SOLUTION	1	
Terbinafine HCl Oral	1	QL (84 EA per 365 days)
Voriconazole Intravenous	1	
Voriconazole Oral	1	
Antimalarials		
Atovaquone Oral	1	
Atovaquone-Proguanil HCl	1	
Chloroquine Phosphate Oral	1	
DARAPRIM	1	
Hydroxychloroquine Sulfate Oral	1	
Mefloquine HCl	1	
Primaquine Phosphate Oral	1	
QuiNINE Sulfate Oral	1	
Antimycobacterials, Miscellaneous		
Dapsone Oral	1	
Antiprotozoals, Miscellaneous		
ALINIA	1	
MetroNIDAZOLE in NaCl Intravenous Solution 500-0.79 MG/100ML-%	1	
MetroNIDAZOLE Intravenous	1	
MetroNIDAZOLE Oral Tablet	1	
NEBUPENT	1	B/D
PENTAM	1	
Antiretrovirals		
Abacavir Sulfate	1	
Abacavir Sulfate-Lamivudine	1	
Abacavir-Lamivudine-Zidovudine	1	
APTIVUS	1	
Atazanavir Sulfate	1	
ATRIPLA	1	
BIKTARVY	1	
CIMDUO	1	
COMPLERA	1	
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	1	
DESCOVY	1	
Didanosine	1	
EDURANT	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Efavirenz	1	
EMTRIVA	1	
EPIVIR HBV ORAL SOLUTION	1	
EVOTAZ	1	QL (30 EA per 30 days)
Fosamprenavir Calcium	1	
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED	1	
GENVOYA	1	
INTELENCE ORAL TABLET 100 MG, 25 MG	1	QL (120 EA per 30 days)
INTELENCE ORAL TABLET 200 MG	1	QL (60 EA per 30 days)
INVIRASE	1	
Isentress HD	1	QL (60 EA per 30 days)
ISENTRESS ORAL PACKET	1	
ISENTRESS ORAL TABLET	1	QL (60 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE	1	
JULUCA	1	
KALETRA ORAL TABLET	1	
LamiVUDine	1	
Lamivudine-Zidovudine	1	
LEXIVA	1	
Lopinavir-Ritonavir	1	
Nevirapine ER	1	
Nevirapine Oral Tablet	1	
NORVIR ORAL CAPSULE	1	
NORVIR ORAL SOLUTION	1	
NORVIR ORAL TABLET	1	
ODEFSEY	1	
PREZCOBIX	1	QL (30 EA per 30 days)
PREZISTA ORAL SUSPENSION	1	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	1	
RESCRIPTOR	1	
RETROVIR INTRAVENOUS	1	
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	1	
REYATAZ ORAL PACKET	1	
Ritonavir	1	
Selzentry Oral Solution	1	QL (1800 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
SELZENTRY ORAL TABLET 150 MG, 75 MG	1	QL (60 EA per 30 days)
SELZENTRY ORAL TABLET 25 MG, 300 MG	1	QL (120 EA per 30 days)
Stavudine Oral Capsule	1	
STRIBILD	1	
SUSTIVA	1	
Symfi	1	
SYMFI LO	1	
SYMTUZA	1	QL (30 EA per 30 days)
Tenofovir Disoproxil Fumarate	1	
TIVICAY ORAL TABLET 10 MG, 25 MG	1	QL (30 EA per 30 days)
TIVICAY ORAL TABLET 50 MG	1	QL (60 EA per 30 days)
TRIUMEQ	1	
TROGARZO	1	
TRUVADA	1	
VIDEX	1	
VIDEX EC ORAL CAPSULE DELAYED RELEASE 125 MG	1	
VIRACEPT ORAL TABLET	1	
VIRAMUNE ORAL SUSPENSION	1	
VIREAD	1	
ZERIT ORAL SOLUTION RECONSTITUTED	1	
ZIAGEN ORAL SOLUTION	1	
Zidovudine	1	
Antituberculosis Agents		
CAPASTAT SULFATE	1	
Ethambutol HCl Oral	1	
Isoniazid Oral	1	
PASER	1	
PRIFTIN	1	
Pyrazinamide Oral	1	
Rifabutin	1	
RIFAMATE	1	
Rifampin Intravenous	1	
Rifampin Oral	1	
RIFATER	1	
TRECATOR	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Antivirals		
Acyclovir Oral	1	
Acyclovir Sodium Intravenous Solution	1	B/D
Acyclovir Sodium Intravenous Solution Reconstituted 500 MG	1	B/D
Adefovir Dipivoxil	1	QL (30 EA per 30 days)
BARACLUDE ORAL SOLUTION	1	PA (NS); QL (600 ML per 30 days)
Entecavir	1	PA (NS); QL (30 EA per 30 days)
EPCLUSA	1	PA; QL (28 EA per 28 days)
Famciclovir Oral	1	
Ganciclovir Sodium	1	B/D
HARVONI	1	PA; QL (28 EA per 28 days)
Intron A Injection Solution 10000000 UNIT/ML	1	
INTRON A INJECTION SOLUTION 6000000 UNIT/ML	1	
INTRON A INJECTION SOLUTION RECONSTITUTED	1	
Mavyret	1	PA; QL (90 EA per 30 days)
MODERIBA 1200 DOSE PACK	1	
MODERIBA 800 DOSE PACK	1	
MODERIBA ORAL TABLET 200 MG	1	
MODERIBA ORAL TABLET THERAPY PACK	1	
Norvir Oral Packet	1	
Oseltamivir Phosphate Oral Capsule 30 MG, 45 MG	1	
Oseltamivir Phosphate Oral Capsule 75 MG	1	QL (28 EA per 180 days)
Oseltamivir Phosphate Oral Suspension Reconstituted	1	QL (700 ML per 365 days)
PEGASYS PROCLICK	1	PA
PEGASYS SUBCUTANEOUS SOLUTION	1	PA
RELENZA DISKHALER	1	QL (60 EA per 180 days)
RIBASPHERE	1	
RIBASPHERE RIBAPAK ORAL TABLET 400 MG, 600 MG	1	
RIBASPHERE RIBAPAK ORAL TABLET THERAPY PACK 200 & 400 MG	1	
RIBATAB ORAL TABLET THERAPY PACK	1	
Ribavirin Oral Capsule	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Ribavirin Oral Tablet 200 MG	1	
Rimantadine HCl	1	
SOVALDI	1	PA; QL (28 EA per 28 days)
Synagis Intramuscular Solution 100 MG/ML	1	PA
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5ML	1	PA
TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML	1	QL (700 ML per 365 days)
ValACYclovir HCl Oral	1	
ValGANciclovir HCl	1	
Vosevi	1	PA; QL (30 EA per 30 days)
ZEPATIER	1	PA; QL (30 EA per 30 days)
Cephalosporins		
Cefaclor ER	1	
Cefaclor Oral Capsule	1	
Cefadroxil	1	
CeFAZolin in D5W Intravenous Solution 1 GM/50ML	1	
CeFAZolin Sodium Injection Solution Reconstituted 1 GM, 10 GM, 20 GM, 500 MG	1	
CeFAZolin Sodium Intravenous Solution Reconstituted	1	
CeFAZolin Sodium-Dextrose Intravenous Solution Reconstituted 1-4 GM-%	1	
Cefdinir	1	
Cefepime HCl	1	
Cefepime-Dextrose Intravenous Solution Reconstituted 1 GM/50ML, 2 GM/50ML	1	
Cefixime	1	
Cefpodoxime Proxetil	1	
Cefprozil	1	
CefTAZidime and Dextrose Intravenous Solution Reconstituted 1 GM/50ML, 2 GM/50ML	1	
CefTAZidime Injection Solution Reconstituted 1 GM, 2 GM, 6 GM	1	
CefTRIAXone Sodium in Dextrose	1	
CefTRIAXone Sodium Injection	1	
CefTRIAXone Sodium Intravenous	1	
Cefuroxime Axetil Oral Tablet	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Cefuroxime Sodium Injection Solution Reconstituted 1.5 GM, 7.5 GM, 750 MG	1	
Cefuroxime Sodium Intravenous Solution Reconstituted 1.5 GM	1	
Cephalexin Oral Capsule 250 MG, 500 MG	1	
Cephalexin Oral Suspension Reconstituted	1	
Cephalexin Oral Tablet	1	
TAZICEF INJECTION	1	
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED	1	
TEFLARO	1	PA
Chloramphenicol		
Chloramphenicol Sod Succinate	1	B/D
Macrolides		
Azithromycin Intravenous Solution Reconstituted 500 MG	1	
Azithromycin Oral Suspension Reconstituted	1	
Azithromycin Oral Tablet 250 MG, 500 MG, 600 MG	1	
Clarithromycin ER	1	
Clarithromycin Oral	1	
ERYPED 400	1	
ERY-TAB	1	
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	1	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	1	
Erythromycin Base Oral Tablet	1	
Erythromycin Ethylsuccinate Oral Suspension Reconstituted	1	
Miscellaneous B-Lactam Antibiotics		
AZACTAM	1	
AZACTAM IN DEXTROSE INTRAVENOUS SOLUTION 1 GM, 2 GM	1	
Aztreonam	1	
CAYSTON	1	PA
CefOXitin Sodium	1	
CefOXitin Sodium-Dextrose Intravenous Solution Reconstituted 1-4 GM-%, 2-2.2 GM-%	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Imipenem-Cilastatin	1	
Meropenem	1	
Meropenem-Sodium Chloride	1	
Penicillins		
Amoxicillin Oral Capsule	1	
Amoxicillin Oral Suspension Reconstituted	1	
Amoxicillin Oral Tablet	1	
Amoxicillin Oral Tablet Chewable 125 MG, 250 MG	1	
Amoxicillin-Pot Clavulanate ER	1	
Amoxicillin-Pot Clavulanate Oral	1	
Ampicillin Oral Capsule 500 MG	1	
Ampicillin Sodium Injection Solution Reconstituted 1 GM, 10 GM, 125 MG, 250 MG, 500 MG	1	
Ampicillin Sodium Intravenous Solution Reconstituted 1 GM, 10 GM	1	
Ampicillin-Sulbactam Sodium	1	
BACTOCILL IN DEXTROSE	1	
BICILLIN L-A	1	
Dicloxacillin Sodium	1	
Oxacillin Sodium	1	
Penicillin G Potassium	1	
Penicillin V Potassium	1	
Piperacillin Sod-Tazobactam So	1	
ZOSYN INTRAVENOUS SOLUTION	1	
Quinolones		
AVELOX INTRAVENOUS	1	
Ciprofloxacin HCl Oral	1	
Ciprofloxacin Intravenous Solution 200 MG/20ML, 400 MG/40ML	1	
Ciprofloxacin Oral	1	
Ciprofloxacin-Ciproflox HCl ER	1	
LevoFLOXacin Intravenous	1	
Levofloxacin Oral	1	
Moxifloxacin HCl in NaCl	1	
Moxifloxacin HCl Intravenous	1	
Moxifloxacin HCl Oral	1	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Ofloxacin Oral Tablet 400 MG	1	
Sulfonamides (Systemic)		
SulfADIAZINE Oral	1	
Sulfamethoxazole-Trimethoprim Intravenous	1	
Sulfamethoxazole-Trimethoprim Oral Suspension 200-40 MG/5ML	1	
Sulfamethoxazole-Trimethoprim Oral Tablet	1	
SulfaSALAzine Oral	1	
Tetracyclines		
Demeclocycline HCl Oral	1	
DOXY 100	1	B/D
Doxycycline Hyclate Oral Capsule	1	
Doxycycline Hyclate Oral Tablet 100 MG, 20 MG	1	
Doxycycline Monohydrate Oral	1	
Minocycline HCl Oral Capsule	1	
Minocycline HCl Oral Tablet 75 MG	1	
MORGIDOX ORAL CAPSULE 50 MG	1	
Tigecycline	1	
TYGACIL	1	
VIBRAMYCIN ORAL SYRUP	1	
Urinary Anti-Infectives		
Methenamine Hippurate	1	
Nitrofurantoin Macrocrystal Oral	1	PA
Nitrofurantoin Monohyd Macro	1	PA
Nitrofurantoin Oral Suspension	1	PA
Trimethoprim Oral	1	
Anti-Infectives		
Anti-Infectives - Miscellaneous		
CLEOCIN PHOSPHATE INJECTION SOLUTION 9 GM/60ML	1	
Clindamycin Phosphate Intravenous Solution 150 MG/ML, 300 MG/2ML, 900 MG/6ML	1	
Penicillins		
Ampicillin Sodium Injection Solution Reconstituted 2 GM	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Antineoplastic Agents		
Antineoplastic Agents		
ABRAXANE	1	PA (NS)
ADRIAMYCIN INTRAVENOUS SOLUTION	1	B/D
ADRUCIL INTRAVENOUS SOLUTION 500 MG/10ML	1	B/D
AFINITOR	1	PA (NS); QL (60 EA per 30 days)
AFINITOR DISPERZ	1	PA (NS); QL (60 EA per 30 days)
ALECENSA	1	PA (NS)
Alimta Intravenous Solution Reconstituted 100 MG	1	PA (NS)
ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	1	PA (NS)
Aliqopa	1	PA (NS); QL (3 EA per 28 days)
Alunbrig Oral Tablet 180 MG, 90 MG	1	PA (NS)
ALUNBRIG ORAL TABLET 30 MG	1	PA (NS)
Alunbrig Oral Tablet Therapy Pack	1	PA (NS)
Anastrozole Oral	1	QL (30 EA per 30 days)
ARRANON	1	B/D
AVASTIN	1	PA (NS)
AzaCITIDine	1	B/D
BAVENCIO	1	PA (NS)
BELEODAQ	1	PA (NS)
BESPONSA	1	PA (NS); QL (4 EA per 28 days)
Bexarotene	1	
Bicalutamide	1	
BICNU	1	B/D
Bleomycin Sulfate	1	B/D
Bortezomib	1	PA (NS)
BOSULIF ORAL TABLET 100 MG, 500 MG	1	PA (NS)
Bosulif Oral Tablet 400 MG	1	PA (NS)
BRAFTOVI ORAL CAPSULE 50 MG	1	PA (NS); QL (270 EA per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	1	PA (NS); QL (180 EA per 30 days)
Busulfan	1	B/D
BUSULFEX	1	B/D
CABOMETYX	1	PA (NS)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
CALQUENCE	1	PA (NS)
CAPRELSA ORAL TABLET 100 MG	1	PA (NS); LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	1	PA (NS); LA; QL (30 EA per 30 days)
CARBOplatin Intravenous Solution	1	B/D
Carmustine	1	B/D
CISplatin Intravenous Solution 100 MG/100ML, 200 MG/200ML, 50 MG/50ML	1	B/D
Cladribine Intravenous Solution 10 MG/10ML	1	B/D
Clofarabine	1	B/D
COMETRIQ (100 MG DAILY DOSE)	1	PA (NS)
COMETRIQ (140 MG DAILY DOSE)	1	PA (NS)
COMETRIQ (60 MG DAILY DOSE)	1	PA (NS)
COSMEGEN	1	B/D
COTELLIC	1	PA (NS)
Cyclophosphamide Oral Capsule	1	B/D
CYRAMZA	1	B/D
Cytarabine (PF)	1	B/D
Cytarabine Injection Solution	1	B/D
Dacarbazine Intravenous	1	B/D
DACTINomycin	1	B/D
DARZALEX	1	PA (NS)
DAUNOrubicin HCl Intravenous Injectable	1	B/D
DAUNOrubicin HCl Intravenous Solution	1	B/D
Decitabine	1	PA (NS)
DOCEtaxel Intravenous Concentrate 160 MG/8ML, 20 MG/ML, 200 MG/10ML, 80 MG/4ML	1	B/D
DOCEtaxel Intravenous Solution 160 MG/16ML, 20 MG/2ML, 80 MG/8ML	1	B/D
DOXOrubicin HCl	1	B/D
DOXOrubicin HCl Liposomal	1	
DROXIA	1	
ELIGARD	1	
EMCYT	1	
EMPLICITI	1	PA (NS)
Epirubicin HCl Intravenous Solution 200 MG/100ML	1	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
ERBITUX	1	B/D
ERIVEDGE	1	PA (NS)
ERLEADA	1	PA (NS)
ERWINAZE INJECTION	1	B/D
Etoposide Intravenous Solution 100 MG/5ML, 500 MG/25ML	1	B/D
Exemestane	1	
FARESTON	1	
FARYDAK	1	PA (NS)
FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML	1	PA (NS); QL (10 ML per 30 days)
FIRMAGON	1	PA (NS)
Fludarabine Phosphate	1	B/D
Fluorouracil Intravenous Solution 1 GM/20ML, 2.5 GM/50ML, 5 GM/100ML	1	B/D
Flutamide	1	
FOLOTYN	1	B/D
Gemcitabine HCl Intravenous Solution	1	B/D
Gemcitabine HCl Intravenous Solution Reconstituted 1 GM	1	B/D
GILOTRIF	1	PA (NS); QL (30 EA per 30 days)
GLEOSTINE	1	
HALAVEN	1	PA (NS)
Herceptin Intravenous Solution Reconstituted 150 MG	1	PA (NS)
HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED 440 MG	1	PA (NS)
HEXALEN	1	
Hydroxyurea Oral	1	
IBRANCE	1	PA (NS)
ICLUSIG	1	PA (NS)
IDArubicin HCl	1	B/D
IDHIFA	1	PA (NS)
Ifosfamide Intravenous Solution	1	B/D
Ifosfamide Intravenous Solution Reconstituted 1 GM	1	B/D
Imatinib Mesylate	1	PA (NS)
IMBRUVICA ORAL CAPSULE 140 MG	1	PA (NS); QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Imbruvica Oral Capsule 70 MG	1	PA (NS); QL (240 EA per 30 days)
Imbruvica Oral Tablet 140 MG	1	PA (NS); QL (120 EA per 30 days)
Imbruvica Oral Tablet 280 MG	1	PA (NS); QL (60 EA per 30 days)
Imbruvica Oral Tablet 420 MG, 560 MG	1	PA (NS); QL (30 EA per 30 days)
IMFINZI	1	PA (NS)
INLYTA	1	PA (NS)
IRESSA	1	PA (NS)
Irinotecan HCl	1	B/D
ISTODAX (OVERFILL)	1	
JAKAFI	1	PA (NS)
JEVTANA	1	B/D
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	1	B/D
Kadcyla Intravenous Solution Reconstituted 160 MG	1	B/D
KEYTRUDA	1	B/D
KISQALI 200 DOSE	1	PA (NS)
KISQALI 400 DOSE	1	PA (NS)
KISQALI 600 DOSE	1	PA (NS)
KISQALI FEMARA 200 DOSE	1	PA (NS)
KISQALI FEMARA 400 DOSE	1	PA (NS)
KISQALI FEMARA 600 DOSE	1	PA (NS)
KYMRIAH	1	PA (NS)
KYPROLIS	1	PA (NS)
Lartruvo Intravenous Solution 190 MG/19ML	1	PA (NS)
LARTRUVO INTRAVENOUS SOLUTION 500 MG/50ML	1	PA (NS)
LENVIMA 10 MG DAILY DOSE	1	PA (NS)
LENVIMA 12 MG DAILY DOSE	1	PA (NS)
LENVIMA 14 MG DAILY DOSE	1	PA (NS)
LENVIMA 18 MG DAILY DOSE	1	PA (NS)
LENVIMA 20 MG DAILY DOSE	1	PA (NS)
LENVIMA 24 MG DAILY DOSE	1	PA (NS)
LENVIMA 4 MG DAILY DOSE	1	PA (NS)
LENVIMA 8 MG DAILY DOSE	1	PA (NS)
Letrozole Oral	1	
Leuprolide Acetate Injection	1	PA (NS)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
LONSURF	1	PA (NS)
LUPANETA PACK	1	PA
LUPRON DEPOT (1-MONTH)	1	PA (NS)
LUPRON DEPOT (3-MONTH)	1	PA (NS)
LUPRON DEPOT (4-MONTH)	1	PA (NS)
LUPRON DEPOT (6-MONTH)	1	PA (NS)
LUPRON DEPOT-PED (1-MONTH)	1	PA (NS)
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG (PED)	1	PA (NS)
Lupron Depot-Ped (3-Month) Intramuscular Kit 30 MG (Ped)	1	PA (NS)
LYNPARZA ORAL CAPSULE	1	PA (NS)
Lynparza Oral Tablet	1	PA (NS)
LYSODREN	1	
MATULANE	1	
Megestrol Acetate Oral Suspension 40 MG/ML	1	PA (NS)
Megestrol Acetate Oral Suspension 625 MG/5ML	1	
Megestrol Acetate Oral Tablet	1	PA (NS)
MEKINIST ORAL TABLET 0.5 MG	1	PA (NS)
MEKINIST ORAL TABLET 2 MG	1	PA (NS); QL (30 EA per 30 days)
MEKTOVI	1	PA (NS); QL (180 EA per 30 days)
Melphalan HCl	1	B/D
Mercaptopurine Oral	1	
Methotrexate Oral	1	B/D
Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 100 MG/4ML, 200 MG/8ML, 250 MG/10ML	1	B/D
Methotrexate Sodium (PF) Injection Solution 50 MG/2ML	1	
Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML	1	B/D
Methotrexate Sodium Injection Solution Reconstituted	1	B/D
Mitoxantrone HCl	1	B/D
MUSTARGEN	1	B/D
Mylotarg Intravenous Solution Reconstituted 4.5 MG	1	PA (NS)
Nerlynx	1	PA (NS)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
NEXAVAR	1	PA (NS); QL (120 EA per 30 days)
Nilutamide	1	
NINLARO	1	PA (NS)
NIPENT	1	B/D
ODOMZO	1	PA (NS)
Opdivo Intravenous Solution 100 MG/10ML	1	PA (NS)
OPDIVO INTRAVENOUS SOLUTION 240 MG/24ML, 40 MG/4ML	1	PA (NS)
Oxaliplatin Intravenous Solution	1	B/D
Oxaliplatin Intravenous Solution Reconstituted 100 MG	1	B/D
PACLitaxel	1	B/D
PERJETA	1	PA (NS)
POMALYST	1	PA (NS)
PROLEUKIN	1	PA (NS)
PURIXAN	1	
REVLIMID	1	PA (NS); LA; QL (30 EA per 30 days)
RITUXAN HYCELA	1	PA (NS)
Rituxan Intravenous Solution 100 MG/10ML	1	PA (NS)
RITUXAN INTRAVENOUS SOLUTION 500 MG/50ML	1	PA (NS)
RUBRACA ORAL TABLET 200 MG, 300 MG	1	PA (NS)
Rubraca Oral Tablet 250 MG	1	PA (NS)
RYDAPT	1	PA (NS)
SOLTAMOX	1	
SPRYCEL	1	PA (NS); QL (60 EA per 30 days)
STIVARGA	1	PA (NS)
SUTENT	1	PA (NS); QL (30 EA per 30 days)
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG	1	PA (NS)
SYLVANT INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	1	PA (NS)
Sylvant Intravenous Solution Reconstituted 400 MG	1	PA (NS)
SYNRIBO	1	PA (NS)
TABLOID	1	
TAFINLAR ORAL CAPSULE 50 MG	1	PA (NS)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
TAFINLAR ORAL CAPSULE 75 MG	1	PA (NS); QL (120 EA per 30 days)
TAGRISSO	1	PA (NS)
Tamoxifen Citrate Oral	1	
TARCEVA	1	PA (NS)
TASIGNA ORAL CAPSULE 150 MG, 50 MG	1	PA (NS)
TASIGNA ORAL CAPSULE 200 MG	1	PA (NS); QL (120 EA per 30 days)
TECENTRIQ	1	PA (NS)
TEPADINA INJECTION SOLUTION RECONSTITUTED 100 MG	1	B/D
Thiotepa Injection	1	B/D
TIBSOVO	1	PA (NS); QL (60 EA per 30 days)
TOPOSAR INTRAVENOUS SOLUTION 1 GM/50ML	1	
TOPOSAR INTRAVENOUS SOLUTION 100 MG/5ML	1	B/D
Topotecan HCl	1	B/D
TORISEL	1	B/D
TREANDA INTRAVENOUS SOLUTION	1	B/D
TREANDA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	1	B/D
Treanda Intravenous Solution Reconstituted 25 MG	1	B/D
TRELSTAR MIXJECT	1	PA (NS)
Tretinoin Oral	1	
TREXALL	1	B/D
TRISENOX	1	PA (NS)
TYKERB	1	PA (NS); QL (150 EA per 30 days)
VALCHLOR	1	PA (NS)
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5ML, 400 MG/20ML	1	B/D
VELCADE INJECTION	1	PA (NS)
VENCLEXTA	1	
VENCLEXTA STARTING PACK	1	
Verzenio Oral Tablet 100 MG	1	PA (NS); QL (120 EA per 30 days)
Verzenio Oral Tablet 150 MG, 200 MG	1	PA (NS); QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Verzenio Oral Tablet 50 MG	1	PA (NS); QL (180 EA per 30 days)
VinBLAStine Sulfate Intravenous Solution	1	B/D
VINCASAR PFS	1	B/D
VinCRIStine Sulfate Intravenous	1	B/D
Vinorelbine Tartrate	1	B/D
VOTRIENT	1	QL (120 EA per 30 days)
Vyxeos	1	B/D
XALKORI	1	PA (NS)
XATMEP	1	PA (NS)
XTANDI	1	PA (NS)
YERVOY	1	PA (NS)
YESCARTA	1	PA (NS)
YONSA	1	PA (NS); QL (120 EA per 30 days)
ZALTRAP	1	B/D
ZANOSAR	1	B/D
ZEJULA	1	PA (NS)
ZELBORAF	1	PA (NS)
ZOLINZA	1	PA (NS); QL (120 EA per 30 days)
ZYDELIG	1	PA (NS); QL (60 EA per 30 days)
ZYKADIA	1	PA (NS)
ZYTIGA ORAL TABLET 250 MG	1	PA (NS)
Zytiga Oral Tablet 500 MG	1	PA (NS)
Autonomic Drugs		
Alpha- And Beta-Adrenergic Agonists		
EPINEPHrine Injection Solution Auto-Injector 0.15 MG/0.15ML, 0.3 MG/0.3ML	1	
NORTHERA	1	PA
Alpha-Adrenergic Agonists		
Midodrine HCl	1	
Antimuscarinics/Antispasmodics		
ANORO ELLIPTA	1	QL (60 EA per 30 days)
ATROVENT HFA	1	QL (51.6 GM per 30 days)
Dicyclomine HCl Oral	1	PA
INCRUSE ELLIPTA	1	QL (30 EA per 30 days)
Ipratropium Bromide Inhalation	1	B/D; QL (300 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Methscopolamine Bromide Oral	1	
SPIRIVA HANDIHALER	1	QL (30 EA per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	1	QL (4 GM per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	1	QL (8 GM per 28 days)
Autonomic Drugs, Miscellaneous		
CHANTIX	1	ST; QL (336 EA per 168 days)
CHANTIX CONTINUING MONTH PAK	1	ST; QL (336 EA per 168 days)
CHANTIX STARTING MONTH PAK	1	ST
NICOTROL	1	
NICOTROL NS	1	
Beta-Adrenergic Agonists		
Albuterol Sulfate ER	1	
Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, 0.63 MG/3ML, 1.25 MG/3ML	1	B/D; QL (375 ML per 30 days)
Albuterol Sulfate Inhalation Nebulization Solution (5 MG/ML) 0.5%	1	B/D; QL (80 EA per 30 days)
Albuterol Sulfate Oral	1	
COMBIVENT RESPIMAT	1	QL (8 GM per 30 days)
Ipratropium-Albuterol	1	B/D
Metaproterenol Sulfate Oral	1	
SEREVENT DISKUS	1	QL (60 EA per 30 days)
Terbutaline Sulfate Oral	1	
VENTOLIN HFA	1	QL (36 GM per 30 days)
Parasympathomimetic (Cholinergic Agents)		
Bethanechol Chloride Oral	1	
Cevimeline HCl	1	
Donepezil HCl	1	QL (30 EA per 30 days)
Galantamine Hydrobromide ER	1	QL (60 EA per 30 days)
Galantamine Hydrobromide Oral Tablet	1	QL (60 EA per 30 days)
MESTINON ORAL SYRUP	1	
Pilocarpine HCl Oral	1	
Pyridostigmine Bromide ER	1	
Pyridostigmine Bromide Oral	1	
Rivastigmine	1	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Rivastigmine Tartrate	1	QL (60 EA per 30 days)
Skeletal Muscle Relaxants		
Chlorzoxazone Oral Tablet 500 MG	1	PA
Cyclobenzaprine HCl Oral Tablet 10 MG, 5 MG	1	PA; QL (90 EA per 30 days)
Dantrolene Sodium Oral	1	
Methocarbamol Oral	1	PA
Orphenadrine Citrate ER	1	PA
TiZANidine HCl Oral	1	
Sympatholytic Adrenergic Blocking Agents		
Alfuzosin HCl ER	1	
Dihydroergotamine Mesylate Injection	1	
Dihydroergotamine Mesylate Nasal	1	
Tamsulosin HCl	1	
Blood Formation, Coagulation, And Thrombosis		
Anticoagulants		
COUMADIN ORAL	1	
Enoxaparin Sodium	1	
Fondaparinux Sodium	1	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML, 95000 UNIT/3.8ML	1	
Heparin Sodium (Porcine) Injection Solution 1000 UNIT/ML, 10000 UNIT/ML, 20000 UNIT/ML, 5000 UNIT/ML	1	B/D
Heparin Sodium (Porcine) PF	1	
JANTOVEN	1	
PRADAXA	1	QL (60 EA per 30 days)
Warfarin Sodium Oral	1	
XARELTO ORAL TABLET 10 MG, 20 MG	1	QL (30 EA per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	1	QL (60 EA per 30 days)
XARELTO STARTER PACK	1	QL (51 EA per 30 days)
Hematopoietic Agents		
LEUKINE INTRAVENOUS	1	
MOZOBIL	1	PA; QL (9.6 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
NEULASTA ONPRO	1	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML	1	PA
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE	1	PA
PROCRIT	1	PA
PROMACTA	1	PA; LA; QL (30 EA per 30 days)
Hemorrheologic Agents		
Pentoxifylline ER	1	
Hemostatics		
Tranexamic Acid Intravenous Solution 1000 MG/10ML	1	
Tranexamic Acid Oral	1	
Platelet-Aggregation Inhibitors		
BRILINTA	1	
Cilostazol	1	
Clopidogrel Bisulfate Oral	1	
Cardiovascular Drugs		
Alpha-Adrenergic Blocking Agents		
Doxazosin Mesylate Oral	1	
Prazosin HCl Oral	1	
Terazosin HCl Oral	1	
Antiarrhythmic Agents		
Amiodarone HCl Intravenous Solution 150 MG/3ML	1	
Amiodarone HCl Oral	1	
Dofetilide	1	
Flecainide Acetate	1	
Mexiletine HCl Oral	1	
MULTAQ	1	
PACERONE ORAL TABLET 200 MG, 400 MG	1	
Propafenone HCl	1	
Propafenone HCl ER	1	
QuiNIDine Gluconate ER	1	
QuiNIDine Sulfate Oral	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Antilipemic Agents		
Atorvastatin Calcium Oral	1	
Cholestyramine Light	1	
Cholestyramine Oral Packet	1	
Colestipol HCl	1	
Ezetimibe	1	QL (30 EA per 30 days)
Fenofibrate Micronized	1	
Fenofibrate Oral Tablet 145 MG, 160 MG, 48 MG, 54 MG	1	
Fenofibric Acid Oral Tablet	1	
Gemfibrozil Oral	1	
KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1	PA
Lovastatin	1	
Niacin ER (Antihyperlipidemic)	1	
NIACOR	1	
Omega-3-acid Ethyl Esters	1	QL (120 EA per 30 days)
Pravastatin Sodium	1	
PREVALITE	1	
REPATHA	1	PA; QL (3 ML per 28 days)
REPATHA PUSHTRONEX SYSTEM	1	PA; QL (3.5 ML per 28 days)
REPATHA SURECLICK	1	PA; QL (3 ML per 28 days)
Rosuvastatin Calcium	1	QL (30 EA per 30 days)
Simvastatin Oral	1	
Beta-Adrenergic Blocking Agents		
Acebutolol HCl Oral	1	
Atenolol Oral	1	
Atenolol-Chlorthalidone	1	
Betaxolol HCl Oral	1	
Bisoprolol Fumarate	1	
Bisoprolol-Hydrochlorothiazide	1	
Carvedilol	1	
Labetalol HCl Oral	1	
Metoprolol Succinate ER	1	
Metoprolol Tartrate Oral Tablet 100 MG, 25 MG, 50 MG	1	
Metoprolol-Hydrochlorothiazide	1	
Nadolol Oral Tablet 20 MG, 40 MG, 80 MG	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Pindolol	1	
Propranolol HCl ER	1	
Propranolol HCl Oral	1	
Propranolol-HCTZ	1	
SORINE	1	
Sotalol HCl (AF)	1	
Sotalol HCl Oral Tablet 160 MG, 240 MG, 80 MG	1	
Timolol Maleate Oral	1	
Calcium-Channel Blocking Agents		
AFEDITAB CR	1	
Amlodipine Besy-Benazepril HCl	1	
AmLODIPine Besylate Oral	1	
Amlodipine-Olmesartan	1	
CARTIA XT	1	
Diltiazem HCl ER Beads Oral Capsule Extended Release 24 Hour 180 MG, 360 MG, 420 MG	1	
DilTIAZem HCl ER Coated Beads Oral Capsule Extended Release 24 Hour	1	
Diltiazem HCl ER Oral Capsule Extended Release 12 Hour	1	
Diltiazem HCl Intravenous	1	
Diltiazem HCl Oral	1	
Dilt-XR	1	
Felodipine ER	1	
MATZIM LA	1	
NIFEdipine ER	1	
NIFEdipine ER Osmotic Release	1	
NIFEdipine Oral	1	PA
NiMODipine Oral	1	
TAZTIA XT	1	
Verapamil HCl ER Oral Capsule Extended Release 24 Hour	1	
Verapamil HCl ER Oral Tablet Extended Release 120 MG, 180 MG, 240 MG	1	
Verapamil HCl Oral	1	
Cardiac Drugs, Miscellaneous		
CORLANOR	1	PA; QL (60 EA per 30 days)
ENTRESTO	1	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
RANEXA ORAL TABLET EXTENDED RELEASE 12 HOUR 1000 MG	1	PA; QL (60 EA per 30 days)
RANEXA ORAL TABLET EXTENDED RELEASE 12 HOUR 500 MG	1	PA; QL (120 EA per 30 days)
Cardiotonic Agents		
DIGITEK ORAL TABLET 125 MCG	1	
DIGITEK ORAL TABLET 250 MCG	1	ST
DIGOX ORAL TABLET 125 MCG	1	
DIGOX ORAL TABLET 250 MCG	1	ST
Digoxin Injection	1	
Digoxin Oral Solution	1	
Digoxin Oral Tablet 125 MCG	1	
Digoxin Oral Tablet 250 MCG	1	ST
Hypotensive Agents		
CloNIDine HCl Oral	1	
CloNIDine HCl Transdermal	1	
GuanFACINE HCl Oral	1	PA
HydrALAZINE HCl Oral	1	
Minoxidil Oral	1	
PROGLYCEM	1	
Renin-Angiotensin-Aldosterone System Inhibitors		
Benazepril HCl Oral	1	
Benazepril-Hydrochlorothiazide	1	
Candesartan Cilexetil	1	
Candesartan Cilexetil-HCTZ	1	
Captopril Oral	1	
Captopril-Hydrochlorothiazide	1	
Enalapril Maleate Oral	1	
Enalapril-Hydrochlorothiazide	1	
Eplerenone	1	
Fosinopril Sodium	1	
Fosinopril Sodium-HCTZ	1	
Irbesartan	1	
Irbesartan-Hydrochlorothiazide	1	
Lisinopril Oral	1	
Lisinopril-Hydrochlorothiazide	1	
Losartan Potassium	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Losartan Potassium-HCTZ	1	
Quinapril HCl	1	
Quinapril-Hydrochlorothiazide	1	
Ramipril	1	
Spironolactone Oral	1	
Spironolactone-HCTZ	1	
Valsartan	1	
Valsartan-Hydrochlorothiazide	1	
Vasodilating Agents		
ADCIRCA	1	PA; QL (60 EA per 30 days)
Aspirin-Dipyridamole ER	1	QL (60 EA per 30 days)
ISORDIL TITRADOSE ORAL TABLET 40 MG	1	
Isosorbide Dinitrate ER	1	
Isosorbide Dinitrate Oral	1	
Isosorbide Mononitrate	1	
Isosorbide Mononitrate ER	1	
LETAIRIS	1	PA; QL (30 EA per 30 days)
NITRO-BID	1	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	1	
Nitroglycerin Sublingual	1	
Nitroglycerin Transdermal Patch 24 Hour	1	
Nitroglycerin Translingual	1	
NITROMIST	1	
Sildenafil Citrate Oral Tablet 20 MG	1	PA; QL (90 EA per 30 days)
VENTAVIS	1	PA
Central Nervous System Agents		
Analgesics And Antipyretics, Misc.		
Butalbital-Acetaminophen Oral Tablet 50-325 MG	1	PA; QL (180 EA per 30 days)
Butalbital-APAP-Caffeine Oral Tablet 50-325-40 MG	1	PA; QL (180 EA per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE	1	QL (60 EA per 30 days)
TENCON ORAL TABLET 50-325 MG	1	QL (180 EA per 30 days)
Tramadol-Acetaminophen	1	QL (240 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Anorexigenic Agents And Respiratory And Cns Stimulants		
Amphetamine-Dextroamphetamine	1	QL (60 EA per 30 days)
Dextroamphetamine Sulfate ER Oral Capsule Extended Release 24 Hour 10 MG	1	QL (60 EA per 30 days)
Dextroamphetamine Sulfate ER Oral Capsule Extended Release 24 Hour 15 MG	1	QL (120 EA per 30 days)
Dextroamphetamine Sulfate ER Oral Capsule Extended Release 24 Hour 5 MG	1	QL (30 EA per 30 days)
Dextroamphetamine Sulfate Oral Tablet 10 MG	1	QL (180 EA per 30 days)
Dextroamphetamine Sulfate Oral Tablet 5 MG	1	QL (120 EA per 30 days)
Modafinil	1	PA
ZENZEDI ORAL TABLET 10 MG	1	QL (180 EA per 30 days)
ZENZEDI ORAL TABLET 5 MG	1	QL (120 EA per 30 days)
Anticonvulsants		
BANZEL ORAL SUSPENSION	1	
BANZEL ORAL TABLET	1	PA (NS)
BRIVIACT	1	PA (NS)
CarBAMazepine ER	1	
CarBAMazepine Oral	1	
CELONTIN	1	
ClonazePAM Oral	1	
Clorazepate Dipotassium Oral Tablet 15 MG	1	QL (180 EA per 30 days)
Clorazepate Dipotassium Oral Tablet 3.75 MG	1	QL (720 EA per 30 days)
Clorazepate Dipotassium Oral Tablet 7.5 MG	1	QL (360 EA per 30 days)
DIASTAT ACUDIAL	1	
DIASTAT PEDIATRIC	1	
DIAZEPAM INTENSOL	1	QL (240 ML per 30 days)
DiazePAM Oral Solution	1	QL (1200 ML per 30 days)
DiazePAM Oral Tablet	1	QL (120 EA per 30 days)
DILANTIN ORAL CAPSULE 30 MG	1	
Divalproex Sodium ER Oral Tablet Extended Release 24 Hour	1	
Divalproex Sodium Oral Capsule Delayed Release Sprinkle	1	
Divalproex Sodium Oral Tablet Delayed Release	1	
EPITOL	1	
Ethosuximide Oral	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Felbamate	1	
FYCOMPA ORAL SUSPENSION	1	PA (NS); QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 8 MG	1	PA (NS); QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 6 MG	1	PA (NS); QL (60 EA per 30 days)
Gabapentin Oral Capsule	1	
Gabapentin Oral Solution 250 MG/5ML	1	
Gabapentin Oral Tablet	1	
GABITRIL ORAL TABLET 12 MG, 16 MG	1	
LamoTRIgine ER	1	
LamoTRIgine Oral Tablet	1	
LamoTRIgine Oral Tablet Chewable	1	
LevETIRAcetam ER	1	
LevETIRAcetam in NaCl	1	
LevETIRAcetam Intravenous	1	
LevETIRAcetam Oral	1	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	1	QL (90 EA per 30 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	1	QL (60 EA per 30 days)
LYRICA ORAL SOLUTION	1	
ONFI ORAL SUSPENSION	1	
ONFI ORAL TABLET 10 MG, 20 MG	1	
OXcarbazepine	1	
PHENobarbital Oral Elixir	1	PA (NS)
PHENobarbital Oral Tablet	1	PA (NS); QL (90 EA per 30 days)
Phenytoin Oral Suspension 125 MG/5ML	1	
Phenytoin Oral Tablet Chewable	1	
Phenytoin Sodium Extended	1	
Phenytoin Sodium Injection	1	
Primidone Oral	1	
ROWEEPRA	1	
ROWEEPRA XR	1	
SABRIL	1	PA (NS)
SPRITAM	1	PA (NS)
TiaGABine HCl	1	
Topiramate Oral	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Valproate Sodium Intravenous Solution 100 MG/ML	1	
Valproate Sodium Oral Solution	1	
Valproic Acid Oral Capsule	1	
Vigabatrin	1	PA (NS)
VIMPAT	1	
Zonisamide Oral	1	
Anticonvulsants, Miscellaneous		
APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	1	QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG	1	QL (60 EA per 30 days)
Magnesium Sulfate Injection Solution 50 %	1	B/D
Antidepressants		
Amitriptyline HCl Oral	1	PA (NS)
Amoxapine	1	PA (NS)
BuPROPion HCl ER (Smoking Det)	1	
BuPROPion HCl ER (SR)	1	
BuPROPion HCl ER (XL) Oral Tablet Extended Release 24 Hour 150 MG, 300 MG	1	
BuPROPion HCl Oral	1	
Citalopram Hydrobromide Oral Solution	1	
Citalopram Hydrobromide Oral Tablet 10 MG, 20 MG	1	QL (30 EA per 30 days)
Citalopram Hydrobromide Oral Tablet 40 MG	1	
ClomiPRAMINE HCl Oral	1	PA (NS)
Desipramine HCl Oral	1	PA (NS)
Desvenlafaxine Succinate ER	1	QL (30 EA per 30 days)
Doxepin HCl Oral	1	PA (NS)
DULoxetine HCl Oral Capsule Delayed Release Particles 20 MG, 30 MG, 60 MG	1	QL (60 EA per 30 days)
DULoxetine HCl Oral Capsule Delayed Release Particles 40 MG	1	QL (30 EA per 30 days)
Escitalopram Oxalate Oral Solution	1	
Escitalopram Oxalate Oral Tablet	1	QL (30 EA per 30 days)
FETZIMA	1	QL (30 EA per 30 days)
FETZIMA TITRATION	1	QL (28 EA per 28 days)
FLUoxetine HCl (PMDD) Oral Capsule 10 MG	1	QL (30 EA per 30 days)
FLUoxetine HCl (PMDD) Oral Capsule 20 MG	1	
FLUoxetine HCl (PMDD) Oral Tablet 10 MG	1	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
FLUoxetine HCl (PMDD) Oral Tablet 20 MG	1	QL (120 EA per 30 days)
FLUoxetine HCl Oral Capsule 10 MG	1	QL (30 EA per 30 days)
FLUoxetine HCl Oral Capsule 20 MG, 40 MG	1	
FLUoxetine HCl Oral Solution	1	
FLUoxetine HCl Oral Tablet 10 MG	1	QL (60 EA per 30 days)
FLUoxetine HCl Oral Tablet 20 MG	1	QL (120 EA per 30 days)
FluvoxaMINE Maleate Oral Tablet 100 MG	1	
FluvoxaMINE Maleate Oral Tablet 25 MG, 50 MG	1	QL (30 EA per 30 days)
Imipramine HCl Oral	1	PA (NS)
Maprotiline HCl	1	
MARPLAN	1	
Mirtazapine Oral Tablet 15 MG	1	QL (30 EA per 30 days)
Mirtazapine Oral Tablet 30 MG, 45 MG, 7.5 MG	1	
Mirtazapine Oral Tablet Dispersible 15 MG	1	QL (30 EA per 30 days)
Mirtazapine Oral Tablet Dispersible 30 MG, 45 MG	1	
Nefazodone HCl	1	
Nortriptyline HCl Oral	1	PA (NS)
OLANZapine-FLUoxetine HCl	1	QL (30 EA per 30 days)
PARoxetine HCl ER Oral Tablet Extended Release 24 Hour 12.5 MG, 25 MG	1	ST; QL (30 EA per 30 days)
PARoxetine HCl ER Oral Tablet Extended Release 24 Hour 37.5 MG	1	ST; QL (60 EA per 30 days)
PARoxetine HCl Oral Tablet 10 MG, 20 MG, 40 MG	1	ST; QL (30 EA per 30 days)
PARoxetine HCl Oral Tablet 30 MG	1	ST; QL (60 EA per 30 days)
PAXIL ORAL SUSPENSION	1	ST; QL (900 ML per 30 days)
Phenelzine Sulfate Oral	1	
Protriptyline HCl	1	PA (NS)
Sertraline HCl Oral Concentrate	1	
Sertraline HCl Oral Tablet 100 MG	1	
Sertraline HCl Oral Tablet 25 MG, 50 MG	1	QL (30 EA per 30 days)
Tranylcypromine Sulfate	1	
TraZODone HCl Oral	1	
Trimipramine Maleate Oral	1	PA (NS)
TRINTELLIX	1	QL (30 EA per 30 days)
Venlafaxine HCl	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour	1	
VIIBRYD ORAL TABLET	1	QL (30 EA per 30 days)
VIIBRYD STARTER PACK	1	QL (30 EA per 30 days)
Antimanic Agents		
Lithium	1	
Lithium Carbonate ER	1	
Lithium Carbonate Oral	1	
Antimigraine Agents		
Rizatriptan Benzoate Oral Tablet 10 MG	1	QL (18 EA per 30 days)
Rizatriptan Benzoate Oral Tablet Dispersible	1	QL (18 EA per 30 days)
SUMAtriptan Succinate Oral Tablet 100 MG	1	QL (9 EA per 30 days)
SUMAtriptan Succinate Oral Tablet 25 MG, 50 MG	1	QL (18 EA per 30 days)
SUMAtriptan Succinate Refill Subcutaneous Solution Cartridge 6 MG/0.5ML	1	QL (4 ML per 30 days)
SUMAtriptan Succinate Subcutaneous Solution 6 MG/0.5ML	1	QL (4 ML per 30 days)
SUMAtriptan Succinate Subcutaneous Solution Auto-Injector 6 MG/0.5ML	1	QL (4 ML per 30 days)
SUMAtriptan Succinate Subcutaneous Solution Prefilled Syringe 6 MG/0.5ML	1	QL (4 ML per 30 days)
Antiparkinsonian Agents		
Amantadine HCl Oral	1	
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE	1	
Benztropine Mesylate Injection	1	PA
Benztropine Mesylate Oral	1	PA
Bromocriptine Mesylate Oral	1	
Carbidopa-Levodopa	1	
Carbidopa-Levodopa ER Oral Tablet Extended Release 25-100 MG, 50-200 MG	1	
Carbidopa-Levodopa-Entacapone	1	
EMSAM	1	QL (30 EA per 30 days)
Entacapone	1	
NEUPRO	1	PA; QL (30 EA per 30 days)
Pramipexole Dihydrochloride	1	
Rasagiline Mesylate Oral	1	QL (30 EA per 30 days)
ROPINIRole HCl	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
ROPINIRole HCl ER	1	
Selegiline HCl Oral	1	
Tolcapone	1	
Trihexyphenidyl HCl	1	PA
Antipsychotic Agents		
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 300 MG, 405 MG	1	PA (NS); QL (2 EA per 28 days)
Antipsychotics		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE	1	PA (NS); QL (1 EA per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED	1	PA (NS); QL (1 EA per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG	1	PA (NS); QL (1 EA per 28 days)
Abilify Maintena Intramuscular Suspension Reconstituted ER 400 MG	1	PA (NS); LA; QL (1 EA per 28 days)
ARIPiprazole Oral Solution	1	QL (750 ML per 30 days)
ARIPiprazole Oral Tablet 10 MG	1	QL (90 EA per 30 days)
ARIPiprazole Oral Tablet 15 MG, 2 MG, 5 MG	1	QL (60 EA per 30 days)
ARIPiprazole Oral Tablet 20 MG, 30 MG	1	QL (30 EA per 30 days)
ARIPiprazole Oral Tablet Dispersible 10 MG	1	QL (90 EA per 30 days)
ARIPiprazole Oral Tablet Dispersible 15 MG	1	QL (60 EA per 30 days)
ARISTADA INITIO	1	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	1	QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	1	QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	1	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	1	QL (3.2 ML per 28 days)
ChlorproMAZINE HCl Injection	1	
ChlorproMAZINE HCl Oral	1	
CloZAPine	1	
FANAPT	1	PA (NS); QL (60 EA per 30 days)
FANAPT TITRATION PACK	1	PA (NS); QL (60 EA per 30 days)
FluPHENAZine Decanoate Injection	1	
FluPHENAZine HCl Injection	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
FluPHENAZine HCl Oral	1	
GEODON INTRAMUSCULAR	1	QL (6 EA per 30 days)
Haloperidol Decanoate Intramuscular	1	
Haloperidol Lactate	1	
Haloperidol Oral	1	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION 117 MG/0.75ML	1	PA (NS); QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION 156 MG/ML	1	PA (NS); QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION 234 MG/1.5ML	1	PA (NS); QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION 39 MG/0.25ML	1	PA (NS); QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION 78 MG/0.5ML	1	PA (NS); QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION 273 MG/0.875ML	1	PA (NS); QL (0.875 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION 410 MG/1.315ML	1	PA (NS); QL (1.315 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION 546 MG/1.75ML	1	PA (NS); QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION 819 MG/2.625ML	1	PA (NS); QL (2.625 ML per 84 days)
LATUDA ORAL TABLET 120 MG	1	QL (30 EA per 30 days)
LATUDA ORAL TABLET 20 MG, 60 MG, 80 MG	1	QL (60 EA per 30 days)
LATUDA ORAL TABLET 40 MG	1	QL (120 EA per 30 days)
Loxapine Succinate Oral	1	
NUPLAZID ORAL CAPSULE	1	PA (NS); QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 10 MG	1	PA (NS); QL (30 EA per 30 days)
NUPLAZID ORAL TABLET 17 MG	1	PA (NS); QL (60 EA per 30 days)
OLANZapine Intramuscular	1	
OLANZapine Oral Tablet 10 MG, 2.5 MG	1	QL (60 EA per 30 days)
OLANZapine Oral Tablet 15 MG, 20 MG, 7.5 MG	1	QL (30 EA per 30 days)
OLANZapine Oral Tablet 5 MG	1	QL (120 EA per 30 days)
OLANZapine Oral Tablet Dispersible 10 MG, 15 MG, 20 MG	1	QL (30 EA per 30 days)
OLANZapine Oral Tablet Dispersible 5 MG	1	QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Paliperidone ER Oral Tablet Extended Release 24 Hour 1.5 MG, 3 MG, 9 MG	1	QL (30 EA per 30 days)
Paliperidone ER Oral Tablet Extended Release 24 Hour 6 MG	1	QL (60 EA per 30 days)
Perphenazine Oral	1	
Pimozide	1	
QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 150 MG, 200 MG, 400 MG, 50 MG	1	QL (60 EA per 30 days)
QUEtiapine Fumarate ER Oral Tablet Extended Release 24 Hour 300 MG	1	QL (30 EA per 30 days)
QUEtiapine Fumarate Oral Tablet 100 MG	1	QL (180 EA per 30 days)
QUEtiapine Fumarate Oral Tablet 200 MG, 50 MG	1	QL (120 EA per 30 days)
QUEtiapine Fumarate Oral Tablet 25 MG	1	QL (360 EA per 30 days)
QUEtiapine Fumarate Oral Tablet 300 MG, 400 MG	1	QL (60 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 1 MG	1	PA (NS); QL (120 EA per 30 days)
REXULTI ORAL TABLET 0.5 MG, 2 MG	1	PA (NS); QL (60 EA per 30 days)
REXULTI ORAL TABLET 3 MG, 4 MG	1	PA (NS); QL (30 EA per 30 days)
RISPERDAL CONSTA	1	PA (NS); QL (4 EA per 28 days)
RisperiDONE Oral Solution	1	QL (480 ML per 30 days)
RisperiDONE Oral Tablet 0.25 MG, 0.5 MG, 2 MG	1	QL (60 EA per 30 days)
RisperiDONE Oral Tablet 1 MG, 4 MG	1	QL (120 EA per 30 days)
RisperiDONE Oral Tablet 3 MG	1	QL (150 EA per 30 days)
RisperiDONE Oral Tablet Dispersible 0.25 MG	1	QL (30 EA per 30 days)
RisperiDONE Oral Tablet Dispersible 0.5 MG, 2 MG	1	QL (60 EA per 30 days)
RisperiDONE Oral Tablet Dispersible 1 MG, 4 MG	1	QL (120 EA per 30 days)
RisperiDONE Oral Tablet Dispersible 3 MG	1	QL (150 EA per 30 days)
SAPHRIS	1	
Thioridazine HCl Oral	1	
Thiothixene Oral	1	
Trifluoperazine HCl Oral	1	
VERSACLOZ	1	QL (540 ML per 30 days)
VRAYLAR ORAL CAPSULE	1	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
VRAYLAR ORAL CAPSULE THERAPY PACK	1	
Ziprasidone HCl Oral Capsule 20 MG, 40 MG	1	QL (120 EA per 30 days)
Ziprasidone HCl Oral Capsule 60 MG, 80 MG	1	QL (60 EA per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	1	PA (NS); QL (2 EA per 28 days)
Anxiolytics, Sedatives And Hypnotics,Misc.		
BusPIRone HCl Oral	1	
HETLIOZ	1	PA
HydrOXYzine HCl Oral Syrup	1	PA (NS)
HydrOXYzine HCl Oral Tablet	1	PA (NS)
HydrOXYzine Pamoate Oral	1	PA (NS)
ROZEREM	1	QL (30 EA per 30 days)
Zaleplon	1	ST; QL (30 EA per 30 days)
Zolpidem Tartrate Oral	1	ST; QL (30 EA per 30 days)
Benzodiazepines (Anxiolytic,Sedativ/Hyp)		
ALPRAZolam ER	1	QL (90 EA per 30 days)
ALPRAZOLAM INTENSOL	1	QL (300 ML per 30 days)
ALPRAZolam Oral Tablet 0.25 MG, 0.5 MG, 1 MG	1	QL (120 EA per 30 days)
ALPRAZolam Oral Tablet 2 MG	1	QL (150 EA per 30 days)
ALPRAZolam Oral Tablet Dispersible 0.25 MG, 0.5 MG, 1 MG	1	QL (120 EA per 30 days)
ALPRAZolam Oral Tablet Dispersible 2 MG	1	QL (150 EA per 30 days)
LORAZEPAM INTENSOL	1	QL (150 ML per 30 days)
LORazepam Oral Concentrate	1	QL (150 ML per 30 days)
LORazepam Oral Tablet	1	QL (120 EA per 30 days)
Central Nervous System Agents, Misc.		
Acamprosate Calcium	1	
Atomoxetine HCl	1	
GuanFACINE HCl ER	1	PA; QL (30 EA per 30 days)
Memantine HCl Oral Solution	1	QL (360 ML per 30 days)
Memantine HCl Oral Tablet 10 MG, 5 (28)-10 (21) MG	1	
Memantine HCl Oral Tablet 5 MG	1	QL (60 EA per 30 days)
NUEDEXTA	1	PA; QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Riluzole	1	
Tetrabenazine	1	PA; LA
XYREM	1	LA
Hydantoins		
Fosphenytoin Sodium	1	
PEGANONE	1	
Nonsteroidal Anti-Inflammatory Agents		
Celecoxib Oral	1	QL (60 EA per 30 days)
Diclofenac Sodium ER	1	
Diclofenac Sodium Oral	1	
Diclofenac Sodium Transdermal Gel 1 %	1	
Diflunisal Oral	1	
Etodolac ER	1	
Etodolac Oral	1	
Flurbiprofen Oral	1	
IBU ORAL TABLET 600 MG, 800 MG	1	
Ibuprofen Oral Suspension	1	
Ibuprofen Oral Tablet 400 MG, 600 MG, 800 MG	1	
Ketoprofen ER	1	
Ketoprofen Oral Capsule 50 MG, 75 MG	1	
Meloxicam Oral Tablet	1	
Nabumetone Oral	1	
Naproxen DR	1	
Naproxen Oral	1	
Naproxen Sodium Oral Tablet 275 MG, 550 MG	1	
Piroxicam Oral	1	
Sulindac Oral	1	
Opiate Agonists		
Acetaminophen-Codeine #2	1	QL (180 EA per 30 days)
Acetaminophen-Codeine #3	1	QL (180 EA per 30 days)
Acetaminophen-Codeine #4	1	QL (180 EA per 30 days)
Acetaminophen-Codeine Oral Solution	1	QL (2700 ML per 30 days)
Acetaminophen-Codeine Oral Tablet	1	QL (180 EA per 30 days)
Codeine Sulfate Oral Tablet	1	QL (180 EA per 30 days)
Duramorph	1	B/D
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	1	QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
FentaNYL	1	QL (10 EA per 30 days)
FentaNYL Citrate Buccal	1	PA; QL (120 EA per 30 days)
Hydrocodone-Acetaminophen Oral Tablet 10-300 MG, 10-325 MG, 5-300 MG, 5-325 MG, 7.5-300 MG, 7.5-325 MG	1	QL (180 EA per 30 days)
Hydrocodone-Ibuprofen Oral Tablet 7.5-200 MG	1	QL (150 EA per 30 days)
HYDROmorphone HCl Injection Solution 1 MG/ML, 2 MG/ML, 4 MG/ML	1	
HYDROmorphone HCl Oral Liquid	1	QL (1500 ML per 30 days)
HYDROmorphone HCl Oral Tablet	1	QL (180 EA per 30 days)
HYDROmorphone HCl PF Injection Solution 10 MG/ML	1	
HYDROmorphone HCl PF Injection Solution 50 MG/5ML, 500 MG/50ML	1	B/D
LAZANDA	1	PA; QL (30 EA per 30 days)
LORCET	1	QL (180 EA per 30 days)
LORCET HD	1	QL (180 EA per 30 days)
LORCET PLUS ORAL TABLET 7.5-325 MG	1	QL (180 EA per 30 days)
Meperidine HCl Injection Solution 10 MG/ML, 100 MG/ML, 25 MG/ML, 50 MG/ML	1	PA; QL (180 ML per 30 days)
Meperidine HCl Oral Solution	1	ST; QL (1000 ML per 30 days)
Meperidine HCl Oral Tablet	1	ST; QL (180 EA per 30 days)
Methadone HCl Oral Tablet	1	QL (300 EA per 30 days)
Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML	1	QL (180 ML per 30 days)
Morphine Sulfate (PF) Intravenous Solution 10 MG/ML, 2 MG/ML, 4 MG/ML, 8 MG/ML	1	B/D
Morphine Sulfate ER Oral Tablet Extended Release	1	QL (90 EA per 30 days)
Morphine Sulfate Injection Solution 10 MG/ML, 2 MG/ML, 4 MG/ML, 8 MG/ML	1	B/D
Morphine Sulfate Intravenous Solution 1 MG/ML, 150 MG/30ML, 25 MG/ML, 50 MG/ML	1	B/D
Morphine Sulfate Oral Solution	1	QL (1000 ML per 30 days)
Morphine Sulfate Oral Tablet	1	QL (180 EA per 30 days)
OxyCODONE HCl Oral Capsule	1	QL (180 EA per 30 days)
OxyCODONE HCl Oral Concentrate 100 MG/5ML	1	QL (180 ML per 30 days)
OxyCODONE HCl Oral Solution	1	QL (3600 ML per 30 days)
OxyCODONE HCl Oral Tablet	1	QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Oxycodone-Acetaminophen Oral Tablet 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	1	QL (180 EA per 30 days)
Oxycodone-Aspirin Oral Tablet 4.8355-325 MG	1	QL (180 EA per 30 days)
Oxycodone-Ibuprofen	1	QL (150 EA per 30 days)
Oxymorphone HCl	1	QL (120 EA per 30 days)
OxyMORphone HCl ER	1	QL (60 EA per 30 days)
PERCOCET ORAL TABLET 10-325 MG, 5-325 MG	1	QL (180 EA per 30 days)
TraMADol HCl ER (Biphasic) Oral Tablet Extended Release 24 Hour 100 MG	1	QL (90 EA per 30 days)
TraMADol HCl ER (Biphasic) Oral Tablet Extended Release 24 Hour 200 MG, 300 MG, 300 MG (matrix delivery)	1	QL (30 EA per 30 days)
TraMADol HCl ER Oral Tablet Extended Release 24 Hour 100 MG	1	QL (90 EA per 30 days)
TraMADol HCl ER Oral Tablet Extended Release 24 Hour 200 MG, 300 MG	1	QL (30 EA per 30 days)
TraMADol HCl Oral	1	QL (240 EA per 30 days)
VICODIN ES ORAL TABLET 7.5-300 MG	1	QL (180 EA per 30 days)
VICODIN HP ORAL TABLET 10-300 MG	1	QL (180 EA per 30 days)
VICODIN ORAL TABLET 5-300 MG	1	QL (180 EA per 30 days)
Opiate Antagonists		
Naloxone HCl Injection Solution 0.4 MG/ML, 4 MG/10ML	1	
Naloxone HCl Injection Solution Cartridge	1	
Naloxone HCl Injection Solution Prefilled Syringe	1	
Naltrexone HCl Oral	1	
Opiate Partial Agonists		
Buprenorphine HCl Sublingual Tablet Sublingual 2 MG	1	QL (90 EA per 30 days)
Buprenorphine HCl Sublingual Tablet Sublingual 8 MG	1	QL (60 EA per 30 days)
Pentazocine-Naloxone HCl	1	ST; QL (360 EA per 30 days)
SUBOXONE SUBLINGUAL FILM	1	QL (60 EA per 30 days)
TALWIN	1	PA; ST; QL (360 ML per 30 days)
Respiratory And Cns Stimulants		
Dexmethylphenidate HCl	1	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 10 MG, 15 MG, 20 MG	1	QL (60 EA per 30 days)
Dexmethylphenidate HCl ER Oral Capsule Extended Release 24 Hour 30 MG, 40 MG, 5 MG	1	QL (30 EA per 30 days)
METADATE ER ORAL TABLET EXTENDED RELEASE 20 MG	1	QL (120 EA per 30 days)
Methylphenidate HCl ER Oral Tablet Extended Release 18 MG, 27 MG, 36 MG, 54 MG, 72 MG	1	QL (30 EA per 30 days)
Methylphenidate HCl ER Oral Tablet Extended Release 20 MG	1	QL (120 EA per 30 days)
Methylphenidate HCl ER Oral Tablet Extended Release 24 Hour	1	QL (30 EA per 30 days)
Methylphenidate HCl Oral Tablet 10 MG, 5 MG	1	QL (90 EA per 30 days)
Methylphenidate HCl Oral Tablet 20 MG	1	QL (120 EA per 30 days)
Selective Serotonin Agonists		
Rizatriptan Benzoate Oral Tablet 5 MG	1	QL (18 EA per 30 days)
SUMAtriptan Nasal Solution 20 MG/ACT	1	QL (12 EA per 30 days)
Devices		
Devices		
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML	1	
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML	1	
DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML, 30G X 15/64" 0.5 ML, 30G X 15/64" 1 ML	1	
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM	1	
Preferred Plus Insulin Syringe 28G X 1/2" 0.5 ML	1	
RELI-ON INSULIN SYRINGE 29G 0.3 ML	1	
Electrolytic, Caloric, And Water Balance		
Alkalinizing Agents		
Potassium Citrate ER	1	
Sodium Lactate Intravenous Solution 5 MEQ/ML	1	
Ammonia Detoxicants		
CARBAGLU	1	PA
Constulose	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Enulose	1	
Generlac	1	
Lactulose Oral Solution 10 GM/15ML	1	
RAVICTI	1	PA
Sodium Phenylbutyrate Oral Powder 3 GM/TSP	1	PA
Caloric Agents		
AMINOSYN II INTRAVENOUS SOLUTION 10 %, 15 %, 8.5 %	1	B/D
AMINOSYN II/ELECTROLYTES	1	B/D
AMINOSYN/ELECTROLYTES INTRAVENOUS SOLUTION 8.5 %	1	B/D
AMINOSYN-HBC	1	B/D
AMINOSYN-PF	1	B/D
Dextrose Intravenous Solution 10 %, 250 MG/ML, 30 %, 5 %, 50 %, 70 %	1	
Dextrose-NaCl Intravenous Solution 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.33 %, 5-0.45 %, 5-0.9 %	1	
INTRALIPID	1	B/D
Nutrilipid Intravenous Emulsion 20 %	1	B/D
PREMASOL INTRAVENOUS SOLUTION 10 %	1	B/D
TRAVASOL	1	B/D
TROPHAMINE INTRAVENOUS SOLUTION 10 %	1	B/D
Diuretics		
AMILoride HCl Oral	1	
Amiloride-Hydrochlorothiazide	1	
Bumetanide Injection	1	
Bumetanide Oral	1	
Chlorothiazide Oral	1	
Chlorthalidone Oral Tablet 25 MG, 50 MG	1	
DIURIL	1	
Furosemide Injection Solution 10 MG/ML	1	
Furosemide Oral Solution 10 MG/ML, 8 MG/ML	1	
Furosemide Oral Tablet	1	
HydroCHLOROthiazide Oral	1	
Indapamide Oral	1	
Methyclothiazide Oral	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Metolazone	1	
Torsemide Oral	1	
Triamterene-HCTZ Oral Capsule 37.5-25 MG	1	
Triamterene-HCTZ Oral Tablet	1	
Ion-Removing Agents		
Calcium Acetate (Phos Binder)	1	
ELIPHOS	1	
KIONEX	1	
RENVELA ORAL TABLET	1	
Sevelamer Carbonate Oral Tablet	1	
Sodium Polystyrene Sulfonate Oral	1	
Sodium Polystyrene Sulfonate Rectal Suspension 30 GM/120ML	1	
SPS	1	
Irrigating Solutions		
Sodium Chloride Irrigation Solution 0.9 %	1	
Sterile Water for Irrigation	1	
Replacement Preparations		
Dextrose in Lactated Ringers	1	
KCl in Dextrose-NaCl Intravenous Solution 10-5-0.45 MEQ/L-%-%, 20-5-0.2 MEQ/L-%-%, 20-5-0.225 MEQ/L-%-%, 20-5-0.33 MEQ/L-%-%, 20-5-0.9 MEQ/L-%-%	1	
KCl in Dextrose-NaCl Intravenous Solution 20-5-0.45 MEQ/L-%-%, 30-5-0.45 MEQ/L-%-%, 40-5-0.45 MEQ/L-%-%	1	B/D
KLOR-CON 10	1	
KLOR-CON M10	1	
KLOR-CON M15	1	
KLOR-CON M20	1	
KLOR-CON ORAL TABLET EXTENDED RELEASE	1	
KLOR-CON SPRINKLE	1	
Lactated Ringers Intravenous	1	
Potassium Chloride Crys ER	1	
Potassium Chloride ER	1	
Potassium Chloride Intravenous Solution 0.4 MEQ/ML, 10 MEQ/100ML, 2 MEQ/ML, 20 MEQ/100ML, 20 MEQ/50ML, 40 MEQ/100ML	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Potassium Chloride Oral Solution 20 MEQ/15ML (10%), 40 MEQ/15ML (20%)	1	
Sodium Chloride Injection Solution 2.5 MEQ/ML	1	
Sodium Chloride Intravenous Solution 0.45 %, 0.9 %, 3 %, 4 MEQ/ML, 5 %	1	
TPN ELECTROLYTES INTRAVENOUS SOLUTION	1	B/D
Uricosuric Agents		
Colchicine-Probenecid	1	
Probenecid Oral	1	
Enzymes		
Enzymes		
ADAGEN	1	PA; LA
ALDURAZYME	1	PA; LA
CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT	1	PA; LA
ELAPRASE	1	PA
ELELYSO	1	PA
ELITEK	1	PA (NS)
FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG	1	PA
Fabrazyme Intravenous Solution Reconstituted 5 MG	1	PA
NAGLAZYME	1	PA
PULMOZYME	1	PA; QL (150 ML per 30 days)
VPRIV	1	PA
Eye, Ear, Nose, And Throat (Eent) Preparations		
Antiallergic Agents		
Azelastine HCl Nasal Solution 0.1 %, 0.15 %	1	
Olopatadine HCl Ophthalmic	1	
Antiglaucoma Agents		
AcetaZOLAMIDE ER	1	
AcetaZOLAMIDE Oral	1	
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %	1	
AZOPT	1	
Betaxolol HCl Ophthalmic	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
BETOPTIC-S	1	
Brimonidine Tartrate Ophthalmic	1	
COMBIGAN	1	
Dorzolamide HCl Ophthalmic	1	
Dorzolamide HCl-Timolol Mal	1	
Latanoprost Ophthalmic	1	
Levobunolol HCl Ophthalmic Solution 0.5 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	1	
Methazolamide Oral	1	
PHOSPHOLINE IODIDE	1	
Pilocarpine HCl Ophthalmic Solution 1 %, 2 %, 4 %	1	
Timolol Maleate Ophthalmic Gel Forming Solution	1	
Timolol Maleate Ophthalmic Solution 0.25 %, 0.5 %	1	
TRAVATAN Z	1	
Anti-Infectives (Eent)		
ACETASOL HC	1	
Acetic Acid Otic	1	
Bacitracin Ophthalmic	1	
Bacitracin-Polymyxin B Ophthalmic Ointment 500-10000 UNIT/GM	1	
Bacitra-Neomycin-Polymyxin-HC	1	
BACTROBAN NASAL	1	
BLEPHAMIDE	1	
BLEPHAMIDE S.O.P.	1	
Chlorhexidine Gluconate Mouth/Throat	1	
CILOXAN OPHTHALMIC OINTMENT	1	
CIPRODEX	1	
Ciprofloxacin HCl Ophthalmic	1	
Erythromycin Ophthalmic	1	
GENTAK OPHTHALMIC OINTMENT	1	
Gentamicin Sulfate Ophthalmic Solution	1	
Hydrocortisone-Acetic Acid	1	
Levofloxacin Ophthalmic	1	
MOXEZA	1	
Moxifloxacin HCl Ophthalmic	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
NATACYN	1	
Neomycin-Bacitracin Zn-Polymyx Ophthalmic Ointment 5-400-10000	1	
Neomycin-Polymyxin-Dexameth Ophthalmic Ointment	1	
Neomycin-Polymyxin-Dexameth Ophthalmic Suspension 3.5-10000-0.1	1	
Neomycin-Polymyxin-Gramicidin Ophthalmic Solution 1.75-10000-.025	1	
Neomycin-Polymyxin-HC Ophthalmic Suspension 3.5-10000-1	1	
Neomycin-Polymyxin-HC Otic Solution 1 %	1	
Neomycin-Polymyxin-HC Otic Suspension	1	
NEOSPORIN	1	
Ofloxacin Ophthalmic	1	
Ofloxacin Otic	1	
PERIOGARD	1	
Polymyxin B-Trimethoprim	1	
Sulfacetamide Sodium Ophthalmic	1	
Sulfacetamide-Prednisolone Ophthalmic Solution	1	
TOBRADEX OPHTHALMIC OINTMENT	1	
Tobramycin Ophthalmic	1	
Tobramycin-Dexamethasone	1	
TOBREX OPHTHALMIC OINTMENT	1	
Trifluridine Ophthalmic	1	
VIGAMOX	1	
ZIRGAN	1	
Anti-Inflammatory Agents (Eent)		
Dexamethasone Sodium Phosphate Ophthalmic	1	
Diclofenac Sodium Ophthalmic	1	
DUREZOL	1	
Flunisolide Nasal Solution 25 MCG/ACT (0.025%)	1	
Flurbiprofen Sodium	1	
Fluticasone Propionate Nasal	1	QL (16 GM per 30 days)
FML FORTE	1	
Ketorolac Tromethamine Ophthalmic	1	
MAXIDEX	1	
PRED MILD	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
PrednisoLONE Acetate Ophthalmic	1	
PrednisoLONE Sodium Phosphate Ophthalmic	1	
RESTASIS	1	
Eent Drugs, Miscellaneous		
Apraclonidine HCl	1	
Carteolol HCl	1	
CYSTARAN	1	
IOPIDINE OPHTHALMIC SOLUTION 1 %	1	
Ipratropium Bromide Nasal	1	QL (30 ML per 30 days)
Local Anesthetics (Eent)		
Lidocaine HCl External Gel 2 %	1	
Lidocaine HCl External Solution	1	
Lidocaine HCl Mouth/Throat	1	
Lidocaine Viscous	1	
Proparacaine HCl Ophthalmic	1	
Gastrointestinal Drugs		
5-Ht3 Receptor Antagonists		
Dronabinol	1	PA; QL (60 EA per 30 days)
Granisetron HCl Oral	1	B/D
Antidiarrhea Agents		
Diphenoxylate-Atropine Oral Tablet	1	PA
Loperamide HCl Oral Capsule	1	
Antiemetics		
Aprepitant Oral Capsule 125 MG	1	PA; QL (2 EA per 30 days)
Aprepitant Oral Capsule 40 MG, 80 MG	1	PA; QL (4 EA per 30 days)
Aprepitant Oral Capsule 80 & 125 MG	1	PA; QL (6 EA per 30 days)
COMPRO	1	
EMEND ORAL SUSPENSION RECONSTITUTED	1	B/D
Meclizine HCl Oral Tablet	1	PA
Ondansetron	1	B/D
Ondansetron HCl Injection Solution 4 MG/2ML, 40 MG/20ML	1	
Ondansetron HCl Oral	1	B/D
Prochlorperazine	1	
Prochlorperazine Edisylate Injection	1	
Prochlorperazine Maleate Oral	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Scopolamine	1	
TRANSDERM-SCOP (1.5 MG)	1	
Anti-Inflammatory Agents (Gi Drugs)		
APRISO	1	QL (120 EA per 30 days)
Balsalazide Disodium	1	
DELZICOL	1	
Mesalamine Oral	1	
Mesalamine Rectal	1	
Mesalamine-Cleanser	1	
Antiulcer Agents And Acid Suppressants		
Amoxicill-Clarithro-Lansopraz	1	
CARAFATE ORAL SUSPENSION	1	
Cimetidine HCl Oral	1	
Cimetidine Oral	1	
Famotidine Intravenous Solution 20 MG/2ML, 200 MG/20ML, 40 MG/4ML	1	
Famotidine Oral Tablet 20 MG, 40 MG	1	
Lansoprazole Oral Capsule Delayed Release	1	QL (60 EA per 30 days)
Misoprostol Oral	1	
Omeprazole Oral Capsule Delayed Release	1	QL (60 EA per 30 days)
Pantoprazole Sodium Intravenous	1	B/D
Pantoprazole Sodium Oral	1	QL (60 EA per 30 days)
RABEprazole Sodium	1	QL (60 EA per 30 days)
RaNITidine HCl Injection Solution 150 MG/6ML, 50 MG/2ML	1	
Ranitidine HCl Oral Capsule	1	
Ranitidine HCl Oral Syrup 75 MG/5ML	1	
RaNITidine HCl Oral Tablet 150 MG, 300 MG	1	
Sucralfate Oral Tablet	1	
Cathartics And Laxatives		
AMITIZA	1	QL (60 EA per 30 days)
GAVILYTE-C	1	
GAVILYTE-G	1	
GAVILYTE-H	1	
GAVILYTE-N WITH FLAVOR PACK	1	
GOLYTELY ORAL SOLUTION RECONSTITUTED 236 GM	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
PEG 3350/Electrolytes	1	
PEG 3350-KCl-Na Bicarb-NaCl	1	
PEG-3350/Electrolytes	1	
Polyethylene Glycol 3350 Oral	1	
TRILYTE	1	
Cholelitholytic Agents		
CHENODAL	1	ST; LA
Ursodiol Oral	1	
Digestants		
PANCREAZE	1	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000 UNIT, 10000-32000 UNIT, 15000-47000 UNIT, 15000-51000 UNIT, 20000-68000 UNIT, 25000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 3000-14000 UNIT, 40000-136000 UNIT, 5000 UNIT, 5000-24000 UNIT	1	
Zenpep Oral Capsule Delayed Release Particles 20000-63000 UNIT, 40000-126000 UNIT	1	
Gi Drugs, Miscellaneous		
Alosetron HCl	1	PA
GATTEX	1	PA
LINZESS	1	QL (30 EA per 30 days)
MOVANTIK	1	QL (30 EA per 30 days)
RELISTOR ORAL	1	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML	1	PA; QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SOLUTION 8 MG/0.4ML	1	PA; QL (12 ML per 30 days)
Prokinetic Agents		
Metoclopramide HCl Injection	1	
Metoclopramide HCl Oral Solution 5 MG/5ML	1	
Metoclopramide HCl Oral Tablet	1	
Gold Compounds		
Gold Compounds		
RIDAURA	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Heavy Metal Antagonists		
Heavy Metal Antagonists		
CHEMET	1	
DEPEN TITRATABS	1	
SYPRINE	1	PA
Trientine HCl	1	PA
Metallic Poison,Agents To Treat		
EXJADE	1	PA
FERRIPROX ORAL TABLET	1	PA
Hormones And Synthetic Substitutes		
Adrenals		
Budesonide Oral	1	
Cortisone Acetate Oral	1	
DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML	1	
DEXAMETHASONE INTENSOL	1	
Dexamethasone Oral Elixir	1	
Dexamethasone Oral Solution	1	
Dexamethasone Oral Tablet	1	
Dexamethasone Sod Phosphate PF	1	
Dexamethasone Sodium Phosphate Injection	1	
Fludrocortisone Acetate Oral	1	
Hydrocortisone Oral	1	
MethylPREDNISolone Acetate Injection Suspension 40 MG/ML, 50 MG/ML, 80 MG/ML	1	
MethylPREDNISolone Oral	1	
MethylPREDNISolone Sodium Succ Injection Solution Reconstituted 1000 MG, 125 MG, 40 MG	1	
MILLIPRED ORAL TABLET	1	
PrednisoLONE Oral Solution	1	
PrednisoLONE Oral Syrup 15 MG/5ML	1	
PrednisoLONE Sodium Phosphate Oral Solution 15 MG/5ML, 20 MG/5ML, 25 MG/5ML, 6.7 (5 Base) MG/5ML	1	
PREDNISONE INTENSOL	1	
PredniSONE Oral Solution	1	
PredniSONE Oral Tablet	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Solu-MEDROL Injection Solution Reconstituted 1000 MG	1	
SOLU-MEDROL INJECTION SOLUTION RECONSTITUTED 125 MG, 2 GM, 40 MG, 500 MG	1	
Androgens		
AXIRON	1	QL (180 ML per 30 days)
Danazol Oral	1	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML	1	
Oxandrolone Oral Tablet 10 MG	1	PA; QL (60 EA per 30 days)
Oxandrolone Oral Tablet 2.5 MG	1	PA; QL (90 EA per 30 days)
Testosterone Cypionate Intramuscular Solution 100 MG/ML, 200 MG/ML	1	
Testosterone Enanthate Intramuscular Solution	1	
Testosterone Transdermal Solution	1	QL (180 ML per 30 days)
Antidiabetic Agents		
Acarbose Oral Tablet 100 MG, 50 MG	1	QL (90 EA per 30 days)
Acarbose Oral Tablet 25 MG	1	
AVANDIA ORAL TABLET 2 MG	1	QL (30 EA per 30 days)
AVANDIA ORAL TABLET 4 MG	1	QL (60 EA per 30 days)
BYDUREON BCISE	1	
BYDUREON SUBCUTANEOUS PEN-INJECTOR	1	
BYDUREON SUBCUTANEOUS SUSPENSION RECONSTITUTED ER	1	
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	QL (2.4 ML per 30 days)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	QL (1.2 ML per 30 days)
Fiasp	1	QL (30 ML per 30 days)
FIASP FLEXTOUCH	1	QL (30 ML per 30 days)
Glimepiride Oral Tablet 1 MG	1	
Glimepiride Oral Tablet 2 MG	1	QL (30 EA per 30 days)
Glimepiride Oral Tablet 4 MG	1	QL (60 EA per 30 days)
GlipiZIDE ER	1	
GlipiZIDE Oral Tablet 10 MG	1	QL (120 EA per 30 days)
GlipiZIDE Oral Tablet 5 MG	1	QL (90 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
GlipiZIDE-MetFORMIN HCl Oral Tablet 2.5-250 MG	1	QL (60 EA per 30 days)
GlipiZIDE-MetFORMIN HCl Oral Tablet 2.5-500 MG	1	QL (90 EA per 30 days)
GlipiZIDE-MetFORMIN HCl Oral Tablet 5-500 MG	1	QL (120 EA per 30 days)
GLYXAMBI	1	QL (30 EA per 30 days)
HUMULIN R U-500 (CONCENTRATED)	1	QL (30 ML per 30 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	QL (30 ML per 30 days)
INVOKAMET	1	QL (60 EA per 30 days)
INVOKAMET XR	1	QL (60 EA per 30 days)
INVOKANA	1	QL (30 EA per 30 days)
JANUMET	1	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	1	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	1	QL (60 EA per 30 days)
JANUVIA	1	QL (30 EA per 30 days)
JARDIANCE	1	QL (30 EA per 30 days)
JENTADUETO	1	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG	1	QL (60 EA per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG	1	QL (30 EA per 30 days)
LANTUS	1	QL (30 ML per 30 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	QL (30 ML per 30 days)
LEVEMIR	1	QL (30 ML per 30 days)
LEVEMIR FLEXTOUCH	1	QL (30 ML per 30 days)
MetFORMIN HCl ER Oral Tablet Extended Release 24 Hour 500 MG	1	QL (120 EA per 30 days)
MetFORMIN HCl ER Oral Tablet Extended Release 24 Hour 750 MG	1	QL (90 EA per 30 days)
MetFORMIN HCl Oral Tablet 1000 MG	1	QL (60 EA per 30 days)
MetFORMIN HCl Oral Tablet 500 MG	1	QL (120 EA per 30 days)
MetFORMIN HCl Oral Tablet 850 MG	1	QL (90 EA per 30 days)
Miglitol Oral Tablet 100 MG, 50 MG	1	QL (90 EA per 30 days)
Miglitol Oral Tablet 25 MG	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
NOVOLIN 70/30	1	QL (30 ML per 30 days)
NOVOLIN N	1	QL (30 ML per 30 days)
NOVOLIN R	1	QL (30 ML per 30 days)
NOVOLOG	1	QL (30 ML per 30 days)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	QL (30 ML per 30 days)
NOVOLOG MIX 70/30	1	QL (30 ML per 30 days)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR	1	QL (30 ML per 30 days)
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE	1	QL (30 ML per 30 days)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.25 OR 0.5 MG/DOSE	1	QL (1.5 ML per 28 days)
OZEMPIC SUBCUTANEOUS SOLUTION PEN-INJECTOR 1 MG/DOSE	1	QL (3 ML per 28 days)
Pioglitazone HCl	1	QL (30 EA per 30 days)
Pioglitazone HCl-Glimepiride	1	QL (30 EA per 30 days)
Pioglitazone HCl-Metformin HCl	1	QL (90 EA per 30 days)
SOLIQUA	1	ST; QL (18 ML per 30 days)
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	PA
SYNJARDY	1	QL (60 EA per 30 days)
SYNJARDY XR	1	QL (30 EA per 30 days)
TOUJEO MAX SOLOSTAR	1	QL (30 ML per 30 days)
TOUJEO SOLOSTAR	1	QL (30 ML per 30 days)
TRADJENTA	1	QL (30 EA per 30 days)
TRESIBA FLEXTOUCH	1	QL (30 ML per 30 days)
TRULICITY	1	
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR	1	QL (9 ML per 30 days)
XULTOPHY	1	ST; QL (15 ML per 30 days)
Antihypoglycemic Agents		
GlucaGen Diagnostic	NC	
GLUCAGEN HYPOKIT	1	
GLUCAGON EMERGENCY	1	
Glucagon HCl (Diagnostic)	NC	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
KORLYM	1	PA
Contraceptives		
ALTAVERA	1	
Alyacen 1/35	1	
APRI	1	
AUBRA	1	
AVIANE	1	
BALZIVA	1	
BEKYREE	1	
BLISOVI 24 FE	1	
BLISOVI FE 1.5/30	1	
BLISOVI FE 1/20	1	
Briellyn	1	
CAMILA	1	
CAZIANT	1	
CRYSELLE-28	1	
CYCLAFEM 1/35	1	
CYCLAFEM 7/7/7	1	
DEBLITANE	1	
DELYLA	1	
Desogestrel-Ethinyl Estradiol	1	
EMOQUETTE	1	
ENPRESSE-28	1	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	1	
ERRIN	1	
ESTARYLLA	1	
Ethynodiol Diac-Eth Estradiol	1	
FALMINA	1	
FEMYNOR	1	
GILDAGIA	1	
INCASSIA	1	
INTROVALE	1	
ISIBLOOM	1	
JOLIVETTE	1	
JULEBER	1	
JUNEL FE 1.5/30	1	
JUNEL FE 1/20	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
JUNEL FE 24	1	
KAITLIB FE	1	
KARIVA	1	
KELNOR 1/35	1	
KELNOR 1/50	1	
KIMIDESS	1	
KURVELO	1	
LARIN 24 FE	1	
LARIN FE 1.5/30	1	
LARIN FE 1/20	1	
LARISSIA	1	
LAYOLIS FE	1	
LESSINA	1	
LEVONEST	1	
Levonorgest-Eth Estrad 91-Day Oral Tablet 0.15-0.03 MG	1	
Levonorgestrel-Ethinyl Estrad Oral Tablet 0.1-20 MG-MCG, 0.15-30 MG-MCG	1	
Levonorg-Eth Estrad Triphasic	1	
LEVORA 0.15/30 (28)	1	
LOMEDIA 24 FE	1	
LOW-OGESTREL	1	
LUTERA	1	
LYZA	1	
Marlissa	1	
MICROGESTIN FE 1.5/30	1	
MICROGESTIN FE 1/20	1	
MILI	1	
MONONESSA	1	
NECON 0.5/35 (28)	1	
NECON 7/7/7	1	
NORA-BE	1	
Norethin Ace-Eth Estrad-FE Oral Tablet 1-20 MG-MCG(24)	1	
Norethindrone Oral	1	
Norethin-Eth Estradiol-Fe Oral Tablet Chewable 0.8-25 MG-MCG	1	
Norgestim-Eth Estrad Triphasic	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
NORLYROC	1	
NORTREL 0.5/35 (28)	1	
NORTREL 1/35 (21)	1	
NORTREL 1/35 (28)	1	
NORTREL 7/7/7	1	
NUVARING	1	QL (1 EA per 28 days)
OGESTREL	1	
ORSYTHIA	1	
PIMTREA	1	
PIRMELLA 1/35	1	
PORTIA-28	1	
PREVIFEM	1	
QUASENSE	1	
RECLIPSEN	1	
SETLAKIN	1	
SHAROBEL	1	
SPRINTEC 28	1	
SRONYX	1	
TARINA FE 1/20	1	
TRI-LEGEST FE	1	
TRI-LO-ESTARYLLA	1	
TRI-LO-SPRINTEC	1	
TRI-MILI	1	
TRINESSA (28)	1	
TRI-PREVIFEM	1	
TRI-SPRINTEC	1	
TRIVORA (28)	1	
TRI-VYLIBRA	1	
VELIVET	1	
VIENVA	1	
VYFEMLA	1	
VYLIBRA	1	
ZENCHENT	1	
ZOVIA 1/35E (28)	1	
ZOVIA 1/50E (28)	1	
Estrogens And Antiestrogens		
DUAVEE	1	PA (NS)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Estradiol Oral	1	PA (NS)
ESTRING	1	
Estropipate Oral	1	PA (NS)
PREMARIN ORAL TABLET 0.3 MG, 0.9 MG, 1.25 MG	1	PA (NS)
PREMARIN ORAL TABLET 0.45 MG, 0.625 MG	1	PA (NS); QL (30 EA per 30 days)
PREMARIN VAGINAL	1	
PREMPHASE	1	PA (NS)
PREMPRO	1	PA (NS)
Raloxifene HCl	1	
Gonadotropins		
Chorionic Gonadotropin Intramuscular	1	PA
NOVAREL	1	PA
PREGNYL	1	PA
SYNAREL	1	
Meglitinides		
Nateglinide	1	
Repaglinide Oral Tablet 0.5 MG	1	
Repaglinide Oral Tablet 1 MG	1	QL (120 EA per 30 days)
Repaglinide Oral Tablet 2 MG	1	QL (240 EA per 30 days)
Parathyroid		
Calcitonin (Salmon)	1	B/D
FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML	1	QL (2.4 ML per 28 days)
MIACALCIN INJECTION	1	B/D
NATPARA	1	
Pituitary		
DDAVP RHINAL TUBE	1	
Desmopressin Ace Rhinal Tube	1	
Desmopressin Ace Spray Refrig	1	
Desmopressin Acetate Injection	1	
Desmopressin Acetate Oral	1	
Desmopressin Acetate Spray	1	
NORDITROPIN FLEXPRO	1	PA
Progestins		
MedroxyPROGESTERone Acetate Intramuscular	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
MedroxyPROGESTERone Acetate Oral	1	
Norethindrone Acetate Oral	1	
Somatostatin Agonists		
Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML	1	
SIGNIFOR	1	PA
Somatotropin Agonists		
EGRIFTA	1	PA
INCRELEX	1	PA
SOMATULINE DEPOT	1	PA (NS)
Somatotropin Antagonists		
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG	1	PA
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG, 30 MG	1	
Thyroid And Antithyroid Agents		
LEVO-T	1	
Levothyroxine Sodium Oral	1	
LEVOXYL	1	
Liothyronine Sodium Intravenous	1	
Liothyronine Sodium Oral	1	
MethIMAzole Oral	1	
Propylthiouracil Oral	1	
SYNTHROID	1	
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	1	
Local Anesthetics		
Local Anesthetics (Parenteral)		
Lidocaine HCl (Cardiac) Intravenous Solution 20 MG/ML	1	
Lidocaine HCl (PF) Injection Solution	1	
Lidocaine HCl Injection Solution 0.5 %, 1 %, 2 %	1	
Miscellaneous Therapeutic Agents		
5-Alpha-Reductase Inhibitors		
Dutasteride Oral	1	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Finasteride Oral Tablet 5 MG	1	
Complement Inhibitors		
CINRYZE	1	PA
FIRAZYR	1	PA; QL (18 ML per 30 days)
Miscellaneous Therapeutic Agents		
ACTIMMUNE	1	PA (NS)
Alendronate Sodium Oral Solution	1	
Alendronate Sodium Oral Tablet 10 MG, 40 MG, 5 MG	1	QL (30 EA per 30 days)
Alendronate Sodium Oral Tablet 35 MG	1	QL (4 EA per 28 days)
Alendronate Sodium Oral Tablet 70 MG	1	
Allopurinol Oral	1	
AMPYRA	1	PA; QL (60 EA per 30 days)
Anagrelide HCl	1	
ARCALYST	1	PA
ATGAM	1	B/D
AVONEX	1	PA; QL (4 EA per 30 days)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT	1	PA; QL (4 EA per 30 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT	1	PA; QL (4 EA per 30 days)
AzaTHIOprine Oral	1	B/D
AzaTHIOprine Sodium	1	B/D
BENLYSTA INTRAVENOUS	1	PA
Benlysta Subcutaneous	1	PA
BETASERON SUBCUTANEOUS KIT	1	PA; QL (14 EA per 28 days)
BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT	1	PA
Colchicine Oral	1	
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	1	PA; QL (12 ML per 28 days)
CycloSPORINE Intravenous	1	B/D
CycloSPORINE Modified	1	B/D
CycloSPORINE Oral Capsule	1	B/D
CYSTADANE	1	
CYSTAGON	1	PA
Dalfampridine ER	1	PA; QL (60 EA per 30 days)
DEMSER	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Disulfiram Oral	1	
ELMIRON	1	
Etidronate Disodium	1	
GENGRAF	1	B/D
GILENYA ORAL CAPSULE 0.5 MG	1	PA; QL (30 EA per 30 days)
Glatiramer Acetate Subcutaneous Solution Prefilled Syringe 20 MG/ML	1	PA
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	1	PA
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML	1	PA; QL (6 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	1	PA; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML	1	PA; QL (2 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT	1	PA; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	1	PA; QL (6 EA per 28 days)
Humira Pen-CD/UC/HS Starter Subcutaneous Pen-Injector Kit 80 MG/0.8ML	1	PA; QL (3 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	1	PA; QL (6 EA per 28 days)
Humira Pen-Ps/UV/Adol HS Start Subcutaneous Pen-Injector Kit 80 MG/0.8ML & 40MG/0.4ML	1	PA; QL (3 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML	1	PA; QL (2 EA per 28 days)
Humira Subcutaneous Prefilled Syringe Kit 20 MG/0.2ML	1	PA; QL (2 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML	1	PA; QL (12 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML, 40 MG/0.8ML	1	PA; QL (6 EA per 28 days)
Ibandronate Sodium Intravenous Solution 3 MG/3ML	1	
Ibandronate Sodium Oral	1	
KUVAN	1	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Leflunomide Oral Tablet 10 MG	1	QL (30 EA per 30 days)
Leflunomide Oral Tablet 20 MG	1	
Leucovorin Calcium Injection Solution Reconstituted	1	B/D
Leucovorin Calcium Oral	1	
LevOCARNitine Oral Solution	1	B/D
LevOCARNitine Oral Tablet	1	B/D
Levoleucovorin Calcium	1	
Mesna	1	B/D
MESNEX ORAL	1	
Miglustat	1	PA
Mycophenolate Mofetil	1	B/D
Mycophenolate Mofetil HCl	1	B/D
Mycophenolate Sodium	1	B/D
NULOJIX	1	B/D
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG	1	PA
Orfadin Oral Capsule 20 MG	1	PA
ORFADIN ORAL SUSPENSION	1	PA
Pamidronate Disodium	1	PA
PROGRAF INTRAVENOUS	1	B/D
PROLIA	1	PA; QL (1 ML per 180 days)
RAPAMUNE ORAL SOLUTION	1	B/D
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR	1	PA; QL (12 ML per 28 days)
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR	1	PA; QL (12 ML per 28 days)
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1	PA; QL (12 ML per 28 days)
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	1	PA; QL (12 ML per 28 days)
REMICADE	1	PA
Risedronate Sodium Oral Tablet 150 MG	1	QL (1 EA per 30 days)
Risedronate Sodium Oral Tablet 30 MG, 5 MG	1	QL (30 EA per 30 days)
Risedronate Sodium Oral Tablet 35 MG	1	QL (4 EA per 28 days)
Risedronate Sodium Oral Tablet Delayed Release	1	QL (4 EA per 28 days)
SANDIMMUNE ORAL SOLUTION	1	B/D
SANDOSTATIN LAR DEPOT	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
SENSIPAR	1	B/D
SIMULECT	1	
Sirolimus Oral	1	B/D
Tacrolimus Oral	1	B/D
TECFIDERA	1	PA; QL (60 EA per 30 days)
THALOMID	1	
THYMOGLOBULIN	1	B/D
TYBOST	1	
TYSABRI	1	PA
XELJANZ	1	PA; QL (60 EA per 30 days)
XELJANZ XR	1	PA; QL (30 EA per 30 days)
XGEVA	1	PA (NS)
ZAVESCA	1	PA; LA
Zoledronic Acid Intravenous Concentrate	1	PA
ZORTRESS	1	B/D
Other Miscellaneous Therapeutic Agents		
Baclofen Oral	1	
BOTOX INJECTION SOLUTION RECONSTITUTED 200 UNIT	1	PA
Nutritional/Supplements		
Vitamins		
Prenatal Oral Tablet 27-1 MG	1	
Pharmaceutical Aids		
Pharmaceutical Aids		
Global Alcohol Prep Ease	1	
Respiratory Tract Agents		
Corticosteroids (Respiratory Tract)		
ADVAIR DISKUS	1	QL (60 EA per 30 days)
ADVAIR HFA	1	QL (60 GM per 30 days)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT	1	QL (30 EA per 30 days)
Arnuity Ellipta Inhalation Aerosol Powder Breath Activated 50 MCG/ACT	1	QL (30 EA per 30 days)
ASMANEX 120 METERED DOSES	1	QL (120 EA per 30 days)
ASMANEX 30 METERED DOSES	1	QL (30 EA per 30 days)
ASMANEX 60 METERED DOSES	1	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
ASMANEX HFA	1	QL (13 GM per 30 days)
BREO ELLIPTA	1	
Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML	1	B/D
Budesonide Inhalation Suspension 1 MG/2ML	1	B/D; QL (120 ML per 30 days)
DULERA	1	QL (13 GM per 30 days)
FLOVENT DISKUS	1	QL (60 EA per 30 days)
FLOVENT HFA	1	QL (26 GM per 30 days)
SYMBICORT	1	QL (10.2 GM per 30 days)
Cystic Fibrosis (Cftr) Potentiators		
KALYDECO	1	PA; QL (60 EA per 30 days)
ORKAMBI ORAL TABLET	1	PA; QL (112 EA per 28 days)
Leukotriene Modifiers		
Montelukast Sodium Oral	1	QL (30 EA per 30 days)
Zafirlukast	1	QL (60 EA per 30 days)
Mast-Cell Stabilizers		
Cromolyn Sodium Inhalation	1	B/D; QL (240 ML per 30 days)
Cromolyn Sodium Ophthalmic	1	
Cromolyn Sodium Oral	1	
Mucolytic Agents		
Acetylcysteine Inhalation	1	B/D
Respiratory Tract Agents, Miscellaneous		
ADEMPAS	1	PA
DALIRESP ORAL TABLET 500 MCG	1	PA; QL (30 EA per 30 days)
ESBRIET	1	PA
NUCALA	1	PA
OFEV	1	PA
PROLASTIN-C INTRAVENOUS SOLUTION	1	PA
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	1	PA
TRELEGY ELLIPTA	1	QL (60 EA per 30 days)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG	1	PA; QL (60 EA per 30 days)
UPTRAVI ORAL TABLET 200 MCG	1	PA; QL (140 EA per 28 days)
UPTRAVI ORAL TABLET THERAPY PACK	1	PA

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED	1	PA
ZEMAIRA	1	PA
Serums, Toxoids, And Vaccines		
Serums		
GAMMAGARD	1	B/D
GAMMAGARD S/D LESS IGA	1	B/D
GAMUNEX-C	1	B/D
HYPERRAB	1	
IMOGAM RABIES-HT INJECTION SOLUTION 300 UNIT/2ML	1	
IMOGAM RABIES-HT INTRAMUSCULAR	1	
Toxoids		
ADACEL	1	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5	1	
Diphtheria-Tetanus Toxoids DT	1	
INFANRIX	1	
TENIVAC	1	
Tetanus-Diphtheria Toxoids Td	1	
Vaccines		
ACTHIB	1	
BCG Vaccine	1	
BEXSERO	1	
ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML	1	B/D
GARDASIL 9	1	
HAVRIX	1	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE	1	B/D
HIBERIX INJECTION	1	
IMOVAX RABIES	1	
IPOL INJECTION INJECTABLE	1	
IXIARO	1	
KINRIX INTRAMUSCULAR SUSPENSION	1	
MENACTRA	1	
MENHIBRIX	1	
MENVEO	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
M-M-R II	1	
PEDIARIX	1	
PEDVAX HIB INTRAMUSCULAR SUSPENSION	1	
PROQUAD SUBCUTANEOUS INJECTABLE	1	
QUADRACEL	1	
RABAVERT	1	
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	1	B/D
ROTARIX	1	
ROTATEQ ORAL SOLUTION	1	
Shingrix Intramuscular Suspension Reconstituted 50 MCG	1	QL (2 EA per 365 days)
Stamaril	1	
TRUMENBA	1	
TWINRIX	1	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML	1	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	1	
VARIVAX	1	
VARIZIG INTRAMUSCULAR SOLUTION	1	
YF-VAX	1	
ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED	1	QL (1 EA per 365 days)
Skin And Mucous Membrane Agents		
Antibacterials (Skin And Mucous Membrane)		
Benzoyl Peroxide-Erythromycin	1	
CLINDACIN ETZ EXTERNAL KIT	1	
CLINDACIN-P	1	
Clindamycin Phosphate External	1	
Clindamycin Phosphate Vaginal	1	
Ery	1	
Erythromycin External Gel	1	
Erythromycin External Solution	1	
Gentamicin Sulfate External	1	
MetroNIDAZOLE Vaginal	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Mupirocin Calcium	1	
Mupirocin External	1	
Antifungals (Skin And Mucous Membrane)		
Ciclopirox External Solution	1	
Clotrimazole External	1	
Clotrimazole Mouth/Throat Lozenge	1	
Clotrimazole-Betamethasone	1	
Ketoconazole External	1	
Miconazole 3 Vaginal Suppository	1	
NYAMYC	1	
NYATA EXTERNAL POWDER	1	
Nystatin External	1	
Nystatin-Triamcinolone	1	
NYSTOP	1	
Terconazole	1	
Anti-Inflammatory Agents (Skin And Mucous)		
Ala-Cort External Cream	1	
Betamethasone Dipropionate Aug	1	
Betamethasone Dipropionate External	1	
Betamethasone Valerate External	1	
Clobetasol Propionate E	1	
Clobetasol Propionate Emulsion	1	
Clobetasol Propionate External	1	
CLODAN EXTERNAL SHAMPOO	1	
COLOCORT	1	
CORDRAN EXTERNAL TAPE	1	
CORMAX SCALP APPLICATION	1	
Desonide External	1	
Desoximetasone External Cream	1	
Desoximetasone External Gel	1	
Desoximetasone External Ointment	1	
Fluocinolone Acetonide Body	1	
Fluocinolone Acetonide External	1	
Fluocinolone Acetonide Scalp	1	
Fluocinonide External Cream 0.05 %	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Fluocinonide External Gel	1	
Fluocinonide External Ointment	1	
Fluocinonide External Solution	1	
Hydrocortisone External Cream 1 %, 2.5 %	1	
Hydrocortisone External Lotion 2.5 %	1	
Hydrocortisone External Ointment 1 %, 2.5 %	1	
Hydrocortisone Rectal Enema	1	
Hydrocortisone Valerate	1	
Mometasone Furoate External	1	
PROCTO-MED HC	1	
PROCTO-PAK	1	
PROCTOSOL HC	1	
PROCTOZONE-HC RECTAL	1	
Triamcinolone Acetonide External	1	
Triamcinolone Acetonide Mouth/Throat	1	
TRIDERM EXTERNAL CREAM 0.1 %	1	
Antipruritics And Local Anesthetics		
Lidocaine External Ointment	1	QL (180 GM per 30 days)
Lidocaine External Patch 5 %	1	PA; QL (90 EA per 30 days)
Lidocaine-Prilocaine External Cream	1	B/D
Antivirals (Skin And Mucous Membrane)		
Acyclovir External	1	
DENAVIR	1	
ZOVIRAX EXTERNAL CREAM	1	
Cell Stimulants And Proliferants		
AVITA	1	
KEPIVANCE	1	PA
Tretinoin External	1	
Emollients, Demulcents, And Protectants		
Ammonium Lactate External	1	
Local Anti-Infectives, Miscellaneous		
MetroNIDAZOLE External	1	
Selenium Sulfide External Lotion	1	
Silver Sulfadiazine External	1	
SSD	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
Sulfacetamide Sodium (Acne)	1	
Pigmenting Agents		
Methoxsalen Rapid	1	
Scabicides And Pediculicides		
CROTAN	1	
EURAX	1	
Lindane External Shampoo	1	
Malathion External	1	
Permethrin External Cream	1	
Skin And Mucous Membrane Agents, Misc.		
Acitretin	1	PA
Adapalene External Cream	1	
Adapalene External Gel	1	
AMNESTEEM	1	
Calcipotriene External	1	
CLARAVIS	1	
CONDYLOX EXTERNAL GEL	1	
Diclofenac Sodium Transdermal Gel 3 %	1	PA
ELIDEL	1	ST
Fluorouracil External	1	
Imiquimod External	1	
ISOtretinoin Oral	1	
MYORISAN	1	
PANRETIN	1	
Podofilox External	1	
SANTYL	1	QL (90 GM per 30 days)
TARGRETIN EXTERNAL	1	PA (NS)
Tazarotene External	1	
TAZORAC	1	
ZENATANE	1	
Smooth Muscle Relaxants		
Genitourinary Smooth Muscle Relaxants		
FlavoxATE HCl	1	
Oxybutynin Chloride ER	1	QL (60 EA per 30 days)
Oxybutynin Chloride Oral	1	

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

Drug Name	Drug Tier	Requirements/Limits
TOVIAZ	1	QL (30 EA per 30 days)
Respiratory Smooth Muscle Relaxants		
Aminophylline Intravenous	1	
Theophylline	1	
Theophylline ER	1	
Vitamins		
Vitamin D		
Calcitriol Oral	1	B/D
Paricalcitol	1	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page 3.

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

Gateway Health[SM]:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Services at PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380, 8 AM to 8 PM, 7 days a week from October 1 through February 14. From February 15 through September 30 our business hours are 8 a.m. - 8 p.m., Monday through Friday. TTY users should call 711.

If you believe that Gateway Health[SM] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Gateway Health[SM] Appeals and Grievances
PO Box 22278
Pittsburgh, PA 15222

Phone: 1-844-207-0336
Fax: 1-412-255-4503

You can file a grievance by mail, or by fax. If you need help filing a grievance, Gateway Health[SM] Appeals and Grievances is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

ENGLISH
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

SPANISH
ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

CHINESE
小贴士：**如果您**说普通话，欢迎使用免费语言协助服务。请拨 PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711)。

VIETNAMESE
CHÚ Ý: Nếu quý vị nói tiếng Việt, thì có sẵn các dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

KOREAN
알림: 한국어를 하시는 경우 무료 통역 서비스가 준비되어 있습니다. PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711)로 연락주시기 바랍니다.

TAGALOG
Pansinin: Kung nagsasalita ka ng Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tawagan ang PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, вам будут бесплатно предоставлены услуги переводчика. Звоните по телефону: PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (телетайп: 711).

ARABIC
لامحظة: ذإا كنت تتحثد البرعية، توترف مدخات السماعدة اللغةيو مجاناً من أجكل. اصتل بلاقرم PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (لهلاتف النصي: **711**).

FRENCH CREOLE
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

FRENCH
ATTENTION : Si vous parlez français, des services gratuits d’interprétation sont à votre disposition. Veuillez appeler le PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

POLISH
UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

PORTUGUESE
ATENÇÃO: Se fala português, estão disponíveis serviços gratuitos de assistência linguística na sua língua. Telefone para PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

ITALIAN
ATTENZIONE: Se lei parla italiano, sono disponibili servizi gratuiti di assistenza linguistica nella sua lingua. Chiami PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

JAPANESE
お知らせ: 日本語での対応を望まれる方には、無料で通訳サービスをご利用になれます。電話番号 PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711)までお問い合わせ下さい。

GERMAN
BITTE BEACHTEN: Wenn Sie Deutsch sprechen, stehen Ihnen unsere Dolmetscher unter der Nummer PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711) kostenlos zur Verfügung.

FARSI
توجه: چانه‌چ، به زبان فارسی صحبت می‌کنید، مدخات کمک زبانی، به صو ر رایگان، رد اخایتر مشا قرار خواهد گرفت.
PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711) ا مشاره متسا گبییرد.

SERBO-CROATIAN
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PENNSYLVANIA DUTCH
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

NEPALI
ध्यान दिनहोस: तपाइल नेपाली बोल्नहन्छ भने तपाइको निमित भाषा स हायता सेवाह निःशल्क पमा उपलब्ध छ। फोन गन होस PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (ट्टवाइ

OROMO
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

BANTU
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

CAMBODIAN
ប្រយ័ត្ន៖ បើសិនអ្នកនិយ័ ខ្មែរ, សេវជំនយ ជក យមិនគិតឈ្ល គឺជនសបបេរអ្កៗ
ជួរ ទរស័ព្ PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711)ៗ

HMONG
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

HINDI

ध्यान द: यद आप िहंदी बोलत ह तो आपके िलए मुफ्त म भाषा सहायता सवाए उपलब्ध ह। PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711) पर कॉल कर।

LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ຽ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

GUJARATI

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (телетайп: 711).

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la PA: 1-800-685-5209, OH: 1-888-447-4505, NC: 1-855-847-6430, KY: 1-855-847-6380 (TTY: 711).

2018 Comprehensive Formulary (List of Covered Drugs)

This formulary was updated on December 1, 2018.
For more recent information or other questions, please contact Gateway Health Member Services toll free at:

Pennsylvania: 1-800-685-5209 (TTY: 711)
Ohio: 1-888-447-4505 (TTY: 711)
North Carolina: 1-855-847-6430 (TTY: 711)
Kentucky: 1-855-847-6380 (TTY: 711)

Our business hours are 8 a.m. - 8 p.m., 7 days a week from October 1 through February 14. From February 15 through September 30 our business hours are 8 a.m. - 8 p.m., Monday through Friday. Or visit us at **www.MedicareAssured.com.**

Member Services also has free language interpreter services available for non-English speakers.

Gateway Health
Medicare Assured℠

Gateway Health℠ offers HMO plans with a Medicare Contract. Some Gateway Health plans have a contract with Medicaid in the states where they are offered. Enrollment in these plans depends on contract renewal.

Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222