2016 Drug Formulary

For HealthPlus Legacy Commercial

HealthPlus

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DRUG FORMULARY
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PREFACE TO THE CURRENT EDITION

Recommendations in the formulary are intended to promote the most cost-effective therapy while maintaining a high quality drug benefit. The drug formulary is not meant to take the place of the product package insert, and users are encouraged to refer to the full prescribing information provided with the product.

Input and suggestions for inclusion in next year's edition are encouraged. Please direct your comments and suggestions to:

HealthPlus® - Now part of the HAP® family
Pharmacy Department
2050 S Linden Road
P.O. Box 1700
Flint, MI 48501-1700

Or e-mail:

rx@healthplus.org

Formulary information is also available at www.healthplus.org**.**

Formulary information is also available through various e-prescribing applications (along with eligibility verification and prescription history).

HOW TO USE THIS FORMULARY

ORGANIZATION

The HealthPlus HMO Legacy Commercial drug formulary contains information about drug coverage, generic drugs, preferred and non-preferred brand drugs, and information about HealthPlus pharmacy policies, procedures and programs.

There are two ways to find a drug in the formulary:

Category of Drug/Medical Condition

The drugs in this formulary are grouped into categories based on the type of drug or medical conditions they are used to treat. For example, drugs used to treat infections are listed under the category "ANTI-INFECTIVE AGENTS." If you know what a drug is used for, look for the drug category name under the Table of Contents that follows. Then look under the category name for your drug.

Alphabetical Listing

You may also look for the drug name in the formulary Index. The Index is an alphabetical list of all of the drugs on the formulary. Both brand name drugs (in bold capital letters) and generic drugs (in lower case italic letters) are listed. Find the drug in the Index and then scroll to that page to find the drug and coverage information.

CONTENT

The drug formulary is a list of recommended drugs selected by HealthPlus with a team of health care providers including doctors and pharmacists, called the Pharmacy & Therapeutics Committee. Recommendations for the drug formulary are developed through the Pharmacy & Therapeutics Committee and are based on a review of current drug information and medical literature. HealthPlus recognizes that it is the sole responsibility of the physician to determine the best course of care for a particular patient.

The drug formulary is an open formulary with restrictions. This means that preferred and non-preferred drugs that are listed on the formulary are covered. "Restrictions" means that prior authorization, quantity limits and other restrictions may apply to both preferred and non-preferred drugs. The process for requesting addition of a non-formulary drug to the formulary is included under the heading "Formulary Updates and Revisions" on page 9.

DRUG LISTING

For each drug category, drugs are listed alphabetically. Generic drugs are listed in *lower case italic* letters. Brand name drugs are listed in **UPPER CASE bold** letters. The copayment level/drug tier is included for each medication, along with any type of restrictions such as prior authorization (PA), quantity limits, etc.

Drug Status/Tier

Tier 1= Generic drugs
Tier 2= Preferred brand drugs
Tier 3= Non-preferred brand drugs
Tier 4= Specialty drugs
Tier 5= Zero copay (preventative drugs with coverage required by health care reform)
Tier 6/MB = Medical benefit (administered in an office or facility)
Tier 7 = Not Covered

Here are some common abbreviations that appear in the drug formulary:

PA (Prior Authorization): This means that there are established criteria that must be met before this drug is covered. The criteria may require the use of generic drugs before certain brand name drugs, or a specific diagnosis or clinical conditions.

QL (Quantity Limit): This means that coverage for this drug is limited to a specific quantity based on the day supply dispensed by the pharmacy.

30D (30 Day Supply): This means that coverage for this drug is limited to a 30 day supply per prescription fill. This may include drugs with special handling requirements. All specialty drugs are limited to a 30 day supply per fill.

AL (Age Limit): This means that this drug is covered, or limited, with age criteria that must be met.

For each listed drug, the drug formulary includes the drug status/copay tier and restrictions, when applicable. Members and providers can view or print the drug formulary, or formulary updates, at www.healthplus.org. A printed copy of formulary documents is also available upon request.

HealthPlus encourages the use of OTC (over-the-counter) products when appropriate. Some OTC products are covered based on health care reform regulations. In addition, HealthPlus may choose to cover specific OTC products with a written prescription; in this case, the product will be included in the drug category listing.

COPAYS

In general, copays vary based on the type of drug:

Generic drugs= Tier 1, lowest copay
Preferred brand drugs= Tier 2, medium copay
Non-preferred brand drugs= Tier 3, higher copay

However, copays may vary based on the benefit purchased by the employer group or member. For benefits with a two-tier copay (generic/brand), the standard brand copay applies for all drugs in copay tiers 2 and 3. For some benefits, a fourth tier copay applies for specific medications or for all specialty medications.

Please refer to your Certificate of Coverage, Benefit Rider, or Subscriber Contract for specific copay amounts and copay tiers.

Members also have access to up-to-date information about prescription drugs, the formulary and information that is specific to their benefit at www.healthplus.org. Go to the Pharmacy Center/My Pharmacy Tools/Drug Price Check.

MEMBER PRESCRIPTION BENEFIT

Prescriptions must be written by a participating physician, or a non-participating physician with the required referral. If the medication is a covered benefit, members may fill their prescription at a participating HealthPlus pharmacy by presenting their identification card. A list of participating pharmacies may be found in the Provider Directory, on-line at www.healthplus.org or by contacting the Customer Service department.

GENERIC SUBSTITUTION

When a drug is generically available, HealthPlus covers the generic drug (not the brand equivalent). These drugs appear in *lower case italic* letters in the formulary. A generic drug has the same active ingredient as the brand name drug. Generic drugs cost less than brand name drugs but they are equivalent. Brand name drugs (when there is a generic equivalent) are non-preferred. Prior authorization based on medical necessity is required for coverage of a brand name drug instead of the generic, when a generic equivalent is available. If a member prefers to receive the brand drug instead of the generic equivalent (not based on medical necessity), he or she may do so by paying the difference in cost and/or any applicable copay.

STEP THERAPY/PRIOR AUTHORIZATION PROGRAM

HealthPlus requires step therapy or prior authorization for certain drugs based on clinical, safety, or cost reasons. A copy of the Pharmacy Prior Authorization/Exception Request form is included as Appendix C on page 11. Prior Authorization means that there are established criteria that must be met before the drug is covered. In some cases, prior authorization is based on step therapy. Step therapy means that there are “first step” drugs that must be used before the “second step” drug is covered. Established criteria for prior authorization are included in this drug formulary and are also available at the HealthPlus website.

To request approval for a drug that requires prior authorization:

- The physician or office staff may complete the Pharmacy Prior Authorization/Exception Request form.
- The form may be faxed to the HealthPlus Pharmacy department:
  FAX (810) 720-2757 (FLINT)

If the patient presents a prescription to the pharmacy and prior authorization has not been requested, the pharmacy should contact the prescribing physician and suggest preferred alternatives or instruct the physician to complete the Pharmacy Prior Authorization/Exception Request form. For medications included in the specialty pharmacy program, the physician may initiate the request for medication through the specialty vendor. The specialty vendor will then contact HealthPlus.

HealthPlus processes all prior authorization requests in a timely manner based on required timeframes and circumstances. Requests are reviewed by HealthPlus pharmacy staff, including pharmacists. If a request is approved, HealthPlus notifies the physician by fax. If a request is denied, HealthPlus notifies the physician by fax and also mails a copy of the denial notice to the member. This notice contains the reason for the denial and an explanation of the appeal process.

7-Day Starter Dose:
As a safeguard, the pharmacy may dispense a 7-day starter dose when a claims processing edit is in place for a medication or quantity that requires prior authorization (when the prescribing physician is unavailable for consult). HealthPlus pharmacies are aware of this override. This is a one-time override and is subject to audit.

Emergency Override:
As a safeguard, the pharmacy may override non-participating physician edits that may apply when a prescription is written for an urgent/emergency situation. HealthPlus pharmacies are aware of this override. This is a one-time override and is subject to audit.

PREFERRED MEDICATION PROGRAM

HealthPlus administers a Preferred Medication Program to promote the use of certain brand drugs. HealthPlus uses messaging with the claim to provide information to the dispensing pharmacist.

PHARMACY AUDIT PROGRAM

HealthPlus (or its designee) performs pharmacy audits to help ensure consistent and accurate electronic submission of prescription claims by the pharmacy network. Prescription claim audit activities may include a review of utilization by pharmacies, physicians, and members. The pharmacy audit program includes desk (paper) audits, on-site audits, and an appeals process.

DRUG RECALL SURVEILLANCE PROGRAM

When a drug product is recalled or withdrawn from the market due to safety reasons, HealthPlus reviews prescription use to identify members receiving that drug. HealthPlus notifies members and physicians affected by the recall, as appropriate.

DOSE OPTIMIZATION PROGRAM

HealthPlus administers a Dose Optimization Program for specific drugs taken once a day or drugs with maximum dosing limits. This program may result in quantity limits for some medications but it also improves medication adherence. For requests above the allowed quantity, the physician may submit the standard Pharmacy Prior Authorization/Exception Request form, with information that includes a current diagnosis and medical necessity for the dosage regimen.

DRUG UTILIZATION REVIEW (DUR)

HealthPlus administers a comprehensive DUR program to help ensure the quality and safety of prescribing and dispensing medications to members. The program includes point-of-service quality and safety edits to the pharmacist when a prescription is being filled, and retrospective analysis of claims data (with integration of medical and pharmacy data) to identify opportunities for educational intervention and improve quality and outcomes. For more information regarding the DUR program, please contact the HealthPlus Pharmacy department at 1-810-720-2758 or toll-free at 1-877-710-0993.

CONTROLLED SUBSTANCES PHARMACY PROGRAM (CSPP)

HealthPlus offers services through a Controlled Substances Pharmacy Program to support the appropriate management of pain, ensure patient safety of narcotic use, and monitor for and prevent potential fraud and abuse of narcotics. For more information about the CSPP program, please contact the HealthPlus Pharmacy department at 1-810-720-2758 or toll-free at 1-877-710-0993.

ASK FOR 90 RX PROGRAM

Based on the benefit, the member may be eligible for the HealthPlus Ask for 90 Rx program for an extended supply of medication. Members may obtain a 90-day supply of chronic medications at their local HealthPlus participating pharmacy, or by mail order through Express Scripts. Copay savings may apply.

Most chronic medications are covered in a 90-day supply. To receive a 90-day supply, HealthPlus requires that the member has already received a 30-day supply of the same drug and same strength within the last year (to help assure that the member is stabilized on the drug and dose before receiving a 90-day supply). This is a quality requirement and helps to avoid wasted medication. Compounded medications and specialty/injectable medications are not covered in a 90-day supply.

For some benefits, the 90-day medication program is mandatory. This means that members are required to receive a 90-day supply for most chronic medications.

SPECIALTY PHARMACY PROGRAM

HealthPlus administers a specialty pharmacy program for oral and injectable specialty medications. This means that specific drugs may be obtained through a HealthPlus-contracted specialty pharmacy. The specialty pharmacy will mail the medication to the physician's office or the member's home.

For some benefits, the specialty pharmacy program is mandatory. This means that members are required to use a HealthPlus-contracted specialty pharmacy for certain specialty medications.

For more information about the specialty pharmacy program or specialty drugs, please contact the HealthPlus Customer Service department at 1-800-332-9161.

DENTAL FORMULARY

The HealthPlus dental formulary is a restricted list of drugs that are covered when prescribed by dentists. Drugs that are not listed on the dental formulary are not a covered benefit when prescribed by a dentist. HealthPlus covers the generic drug (not the brand equivalent). A copy of the dental formulary is printed on the next page.

HEALTHPLUS DENTAL FORMULARY

Antifungals	
nystatin	MYCOSTATIN*
Antivirals	
acyclovir	ZOVIRAX*
valacyclovir	VALTREX*
Antibiotics	
Cephalosporins	
cephalexin HCL	KEFLEX* (NOT 750MG)
cefadroxil	DURICEF*
cefuroxime	CEFTIN*
Erythromycins	
erythromycin	ERYTHROMYCIN*
Penicillins	
amoxicillin	AMOXIL*
amoxicillin-clavulanate potassium	AUGMENTIN*
penicillin V potassium	PENVEEK*
Tetracyclines	
doxycycline hyclate	VIBRAMYCIN*, VIBRATABS*
tetracycline HCL	(NOT DORYX, ORACEA)
Miscellaneous Antibiotics	
clindamycin HCL	CLEOCIN 150mg*
Miscellaneous Anti-Infectives	
metronidazole	FLAGYL*
Skeletal Muscle Relaxants	
diazepam	VALIUM*
Nonsteroidal Anti-Inflammatory Agents	
ibuprofen	RX MOTRIN*
indomethacin	INDOCIN CAPSULES*
naproxen	NAPROSYN*
Narcotic Analgesics	
acetaminophen/codeine	TYLENOL W/CODEINE*
acetaminophen 325/oxycodone 5	PERCOCET*
aspirin/caffeine/dihydrocodeine	SYNALGOS-DC*
aspirin/codeine	EMPIRIN W/CODEINE*
aspirin 325/oxycodone 5	PERCODAN*
butalbital/aspirin/caffeine/codeine	FIORINAL W/CODEINE*
acetaminophen 325/hydrocodone 10	NORCO*
acetaminophen 325/hydrocodone 7.5	NORCO*
acetaminophen 325/hydrocodone 5	NORCO*
ibuprofen 200/hydrocodone 7.5	VICOPROFEN*
Systemic Corticosteroids	
methylprednisolone	MEDROL DOSE PAK*
Miscellaneous Rinses	
chlorhexidine gluconate	PERIDEX*
Miscellaneous	
lidocaine viscous solution/ointment	LIDOCAINE*

*generic available

PHARMACY & THERAPEUTICS COMMITTEE

The Pharmacy & Therapeutics Committee is a group of doctors and pharmacists from the community, in addition to HealthPlus staff. The committee may invite persons within or outside the organization who can contribute specialized or unique knowledge, skills, and judgments. The function of the committee is to serve in an evaluative, educational, and advisory capacity to the physician providers in all matters pertaining to drug use. The committee also provides strategic guidance for pharmacy programs. The committee is involved in the development and updating of pharmaceutical management procedures. In addition, the committee meets at least four times annually to evaluate drugs for the formulary. The recommendations of the Pharmacy & Therapeutics Committee are communicated to the Medical Affairs Committee and finally sent to the Board of Directors for approval.

FORMULARY UPDATES AND REVISIONS

The drug formulary is revised regularly through recommendations from the Pharmacy & Therapeutics Committee. HealthPlus reviews drugs and drug categories on an ongoing basis to help ensure that the formulary provides an ample, up-to-date selection of quality, cost-effective medication choices. The formulary is revised and republished annually with notification to members and providers, with periodic updates on the website at www.healthplus.org; providers and members may also receive a printed copy of the formulary upon request. HealthPlus routinely provides updated information to physicians, pharmacies and members with updates at the website and articles in the newsletters. The formulary is also available for providers through various e-prescribing software applications. Specifically for negative changes to the formulary (addition of prior authorization requirements, step therapy, or a change in status from preferred to non-preferred when a generic equivalent is not available), HealthPlus notifies affected members and their prescribers of the change.

Members may also obtain up-to-date formulary and cost information specific to their benefit at www.healthplus.org. For more information, please contact the HealthPlus Pharmacy department at 1-810-230-2118.

Physician requests for additions to the formulary must be made on a Request for Addition to the Formulary form, which includes the reason for the request and any clinical data supporting that request. Please refer to APPENDIX A (page 10) for a copy of the Request for Addition to the HealthPlus Formulary form. Member requests for additions to the formulary are forwarded to the Pharmacy department for appropriate review and consideration.

SMOKING CESSATION PHARMACOTHERAPY

All OTC and prescription FDA-approved smoking cessation products are covered. These products are covered with no copay and prior authorization is not required. Duration limits may apply for specific products.

APPENDIX A

REQUEST FOR ADDITION TO THE HEALTHPLUS FORMULARY

Completed forms will be reviewed by the Pharmacy & Therapeutics Committee. The need for the drug, alternative therapy available, efficacy, safety and cost-effectiveness will be considered. It is *essential* that this form be completed for proper evaluation.

1. Generic Names: _____
2. Brand Name & Manufacturer: _____
3. Dosage Form(s) & Strength(s): _____
4. Specific pharmacologic action and indications for use:
   _____

   _____
5. Comparable drugs currently on the formulary: _____

   _____
6. If the requested drug is added to the formulary, can any of the brand drugs above be removed from the formulary?
   _____
7. List the therapeutic advantages of the requested drugs over those already listed on the formulary. Supply references to support these advantages:

   _____

   _____
8. Estimate the anticipated cost impact if the requested drug is added to the formulary:
   _____

_____ _____

DATE PRINT NAME

_____

SIGNATURE

Send to: HealthPlus
ATTN: Pharmacy Department
2050 S Linden Road; PO Box 1700
Flint, MI 48501-1700
FAX: 810-720-2757
E-MAIL: rx@healthplus.org

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STATUS

APPENDIX C

PHARMACY PRIOR AUTHORIZATION/EXCEPTION REQUEST FORM

Forward form to the HealthPlus Pharmacy Department via facsimile:
Flint facsimile: 810-720-2757
For questions or to request via telephone:
Flint local phone: 810-720-2758 Toll free phone: 877-710-0993

FOR A TIMELY RESPONSE, PLEASE PROVIDE **COMPLETE** INFORMATION.

HealthPlus ID#: _____ Patient Name: _____

Date of Birth: _____ Height: _____ Weight: _____ BMI: _____

This is a request for (check one): ☐ DAW ☐ Medication Requiring P/A ☐ P/A for Dosage Regimen

MedicarePlus Advantage Part D: ☐ Exception Request ☐ Medically Urgent

Closed Formulary: ☐ Exception Request

Prescribed Drug and Dosing Regimen: _____

Reason for Use (Diagnosis): _____

Previous Medications: _____

Please attach pertinent laboratory test(s) or procedure(s): (if applicable)

Reason why an alternative drug (or dosing regimen) cannot be used: _____

_____

DEA#: _____ HealthPlus Provider ID#: _____

Office Phone: (_____) _____ Office Facsimile: (_____) _____

Pharmacy Name (optional): _____ Pharmacy Phone: _____

Infusions/Injections (if applicable)
Place of Infusion/injection: _____
Provider ID: _____

Lab Results (if applicable)
CrCL: _____
TG: _____

I represent to the best of my knowledge and belief that the information provided is true, complete, and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Physician's Name (please print) _____ Physician's Signature _____

Office Contact Person: _____

For HealthPlus Use Only

Request Date: _____ LOB: _____ L ____ E ____ N ____

Non-Urgent Request: _____ Urgent Request: _____

Exception Request: _____

CPT Review Time _____ RPh Review Time _____ Med Dir Review Time _____

Comments: _____

Approved ☐ Partial Approval ☐ Denied ☐

Approved by: _____ Reason for Denial: _____

Effective Date: _____

Faxed to Indigent Program: _____

If you would like to discuss this case with a pharmacist or physician reviewer, please call (800) 332-9161.

**THIS DOCUMENT MAY BE PHOTOCOPIED, or you may request additional copies by calling the HealthPlus Pharmacy Department at the telephone number(s) listed above.

Rev January 2015

Michigan Prior Authorization Request Form
For Prescription Drugs

Instructions

Important: Please read all instructions below before completing FIS 2288.

Section 2212c of Public Act 218 of 1956, MCL 500.2212c, requires the use of a standard prior authorization form when a policy, certificate or contract requires prior authorization for prescription drug benefits.

A standard form, FIS 2288, is being made available by the Department of Insurance and Financial Services to simplify exchanges of information between prescribers and health insurers as part of the process of requesting prescription drug prior authorization. This form will be updated periodically and the form number and most recent revision date are displayed in the top left-hand corner.

- **This form is made available for use by prescribers to initiate a prior authorization request with the health insurer.**
- Prior authorization requests are defined as requests for pre-approval from an insurer for specified medications before they are dispensed.
- "Prescriber" means the term as defined in section 17708 of the Public Health Code, 1978 PA 368, MCL 333.17708.
- "Prescription drug" means the term as defined in section 17708 of the Public Health Code, 1978 PA 368, MCL 333.17708.
- Pursuant to MCL 500.2212c, prescribers and insurers must comply with required timeframes pertaining to the processing of a prior authorization request. Insurers may request additional information or clarification needed to process a prior authorization request.
- The prior authorization is considered granted if the insurer fails to grant the request, deny the request, or require additional information of the prescriber within 72 hours after the date and time of submission of an expedited prior authorization request or within 15 days after the date and time of submission of a standard prior authorization request. If additional information is requested by an insurer, a prior authorization request is considered to have been granted by the insurer if the insurer fails to grant the request, deny the request, or otherwise respond to the request of the prescriber within 72 hours after the date and time of submission of the additional information for an expedited prior authorization request; or within 15 days after the date and time of submission of the additional information for standard prior authorization request.
- The prior authorization is considered void if the prescriber fails to submit the additional information within 5 days after the date and time of the original submission of a properly completed expedited prior authorization request or within 21 days after the date and time of the original submission of a properly completed standard prior authorization request.
- In order to designate a prior authorization request for expedited review, a prescriber must certify that applying the 15-day standard review period may seriously jeopardize the life and health of the patient or the patient's ability to regain maximum function.

Michigan Prior Authorization Request Form for Prescription Drugs

(PRESCRIBERS SUBMIT THIS FORM TO THE PATIENT'S HEALTH PLAN)

□ **Expedited Review Request:** *I hereby certify that a standard review period may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*
Physician's Direct Contact Phone Number ( ) _____-_____ Initials: _____

A) Reason for Request

□ Initial Authorization Request □ Renewal Request □ DAW

B) Patient Demographics

Is patient hospitalized: □ Yes □ No

Patient Name: _____ DOB: _____

Patient Health Plan ID: _____

□ Male □ Female

C) Pharmacy Insurance Plan

□ Priority □ Magellan □ Blue Cross Blue Shield of Michigan □ HAP □ _____

□ Total Health Care □ Blue Care Network □ HealthPlus of Michigan □ Meridian Health Plan

D) Prescriber Information

Prescriber Name: _____ NPI: _____ Specialty: _____

DEA (required for controlled substance requests only): _____

Contact Name: _____ Contact Phone: _____ Contact Fax: _____

Health Plan Provider ID (if accessible): _____

E) Pharmacy Information (optional)

Pharmacy Name_____ Pharmacy Telephone_____

F) Requested Prescription Drug Information

Drug Name: _____ Strength: _____

Dosing Schedule: _____ Duration: _____

Diagnosis (specific) with ICD#: _____

Place of infusion / injection (if applicable): _____

Facility Provider ID / NPI: _____

Has the patient already started the medication? _____ Yes _____No If so, when? _____

G) Rationale for Prior Authorization (e.g., information such as history of present illness, past medical history, current medications, etc.; you may also attach chart notes to support your request if you believe they will assist with the review process)

_____

_____

_____

H) Failed/Contraindicated Therapies

Drug Name	Strength	Dosing Schedule	Duration	Adverse Event/Specific Failure

I) Other Pertinent Information (Optional - to be filled out if other information is necessary such as relevant diagnostic labs, measures of response to treatment, etc.) Please refer to plan's website for additional information that may be necessary for review. Please note that sending this form with insufficient clinical information may result in extended review period or adverse determination.

_____

_____

_____

I represent to the best of my knowledge and belief that the information provided is true, complete and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Physician's Name: _____

Physician's Signature: _____

Date: _____

PA 218 of 1956 as amended requires the use of a standard prior authorization form by prescribers when a patient's health plan requires prior authorization for prescription drug benefits.

For Health Plan Use Only

Request Date: _____ LOB: _____
Approved: _____ Denied: _____
Approved By: _____ Denied By: _____
Effective Date: _____ Reason for Denial: _____
Additional Comments: _____

PRESCRIPTION BENEFIT LIMITATIONS

APPENDIX E

Some general limitations and exclusions are provided here for reference. Administrative limitations are also included in the list of drugs. For a complete list of benefit limitations and exclusions, please refer to your Subscriber Contract, Certificate of Coverage or Benefit Rider.

Limitations

- Prescription drugs are limited to the reasonable cost of generically-available products, unless no generically-equivalent product exists or a member-specific review for medical necessity determines the need for the brand name medication.
- Prescription drugs are limited to FDA-approved indications when reviewed, unless a member-specific review for medical necessity determines the need for a particular medication for an off-label use.
- Prescriptions written by a dentist are limited to those medications on the HealthPlus Dental Formulary.
- Covered medications are limited to a 30-day supply at participating retail and specialty pharmacies, and up to a 90-day supply through participating HealthPlus retail pharmacies and the mail order provider. Refills may be obtained when 80% of the day supply received has passed.
- Prior Authorization based on specific criteria is required for drugs included in the Pharmacy Prior Authorization Program including the Dose Optimization Program.
- Coverage for medications included in the Dose Optimization Program is limited to an allowed quantity based on once daily dosing or maximum dose recommendations; unless a member specific review determines medical necessity for the specified dosing regimen.
- Coverage for specific migraine medications is limited to a maximum quantity per month, unless a member specific review determines that the member is also currently taking medication for the prophylaxis of migraine and still requires more than the established limit.
- Medications for weight loss require Prior Authorization, initiated through the Pharmacy department.
- Prescriptions for compounded medications require Prior Authorization based on established criteria for safety and appropriateness.
- Coverage for prescription drugs for primary oral drug therapy for Hepatitis C shall be subject to quantity limits and other restrictions that may include step therapy, prior authorization or duration limits. Authorization of primary oral Hepatitis C agents is limited to one treatment course per lifetime.
- Coverage for prescription drugs with potential for abuse and/or dependency shall be subject to quantity limits and other restrictions that may include step therapy, prior authorization or duration limits. Prescription drugs with potential for abuse and/or dependency shall be limited to established quantities approved by the HealthPlus Pharmacy and Therapeutics Committee and only for FDA-approved indications.
- There is no coverage for replacement of lost, stolen or destroyed medication.

Exclusions

- Drugs used for cosmetic purposes
- Non-prescription drugs, dietary supplements and medical foods
- Prescription drugs when there is an over-the-counter equivalent drug available

Legacy Commercial Formulary
2016 Drug Formulary

Table of Contents

Legacy Commercial Formulary
2016 Drug Formulary

CURRENT AS OF 12/1/2016

lowercase italics = Generic drugs
UPPERCASE BOLD = Brand name drugs

Drug Tier
Non-Formulary = Non-Formulary
Not Covered = Not Covered
Tier 1 = Generic
Tier 2 = Preferred Brand
Tier 3 = Non-Preferred Brand
Tier 4 = Specialty Coinsurance
Tier 5 = Zero Cost Share
Tier 6 = Medical Coinsurance
Tier 7 = Not Covered
Tier 8 = Specialty Non-Preferred

Notes
30D = 30 Day Supply
DDS = Dental Formulary Drug
ED = ED Restriction
Infert. = Infertility Drug
Mand 90 = Mandatory 90
PA = Prior Authorization
PA (New) = PA for New Starts
QL/DS = Quantity & Day Supply Limits
Retail = Only available at retail pharmacy
Specialty = Specialty Pharmacy Contact Info

Drug Name	Drug Tier	Notes
Analgesic, Anti-Inflammatory Or Antipyretic		
Analgesic Narcotic Agonists		
ABSTRAL SUBLINGUAL TABLET 100 MCG, 200 MCG, 300 MCG, 400 MCG, 600 MCG, 800 MCG	Tier 3	PA (New); QL (4 tablets per 1 day)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	Tier 3	PA; QL (4 lonzenges per 1 day)
codeine sulfate oral tablet 15 mg, 30 mg, 60 mg	Tier 1	
CONZIP ORAL CAPSULE,ER BIPHASE 24 HR 17-83 300 MG	Tier 3	PA; QL (1 capsule per 1 day)
CONZIP ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG	Tier 3	PA; QL (1 capsule per 1 day)
DEMEROL ORAL TABLET 100 MG	Tier 3	
DILAUDID ORAL LIQUID 1 MG/ML	Tier 3	

Drug Name	Drug Tier	Notes
DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG	Tier 3	
DOLOPHINE ORAL TABLET 10 MG, 5 MG	Tier 3	
DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR, 12 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR	Tier 3	QL (15 patches per 30 days)
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL 100-4 MG, 20-0.8 MG, 30-1.2 MG, 50-2 MG, 60-2.4 MG, 80-3.2 MG	Tier 3	QL (2 capsules per 1 day)
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 16 MG, 8 MG	Tier 3	PA; QL (1 tablet per 1 day)
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 32 MG	Tier 3	PA; QL (2 tablets per 1 day)
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	Tier 1	PA; QL (4 lonzenges per 1 day)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour	Tier 1	QL (15 patches per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	Tier 3	PA; QL (4 tablets per 1 day)
hydromorphone oral liquid 1 mg/ml	Tier 1	
hydromorphone oral tablet 2 mg, 4 mg, 8 mg	Tier 1	
hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg	Tier 1	PA; QL (1 tablet per 1 day)
hydromorphone oral tablet extended release 24 hr 32 mg	Tier 1	PA; QL (2 tablets per 1 day)
hydromorphone rectal suppository 3 mg	Tier 1	
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 120 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG	Tier 3	PA; QL (1 tablet per 1 day)
KADIAN ORAL CAPSULE,EXTEND.RELEASE PELLETS 10 MG, 100 MG, 20 MG, 200 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG	Tier 3	QL (2 capsules per 1 day)
LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY	Tier 3	PA (New); QL (1 bottle (5ml) per 1 day)
LAZANDA NASAL SPRAY,NON-AEROSOL 300 MCG/SPRAY	Tier 3	PA; QL (1 bottle (5ml) per 1 day)
levorphanol tartrate oral tablet 2 mg	Tier 1	
meperidine oral solution 50 mg/5 ml	Tier 1	
meperidine oral tablet 100 mg, 50 mg	Tier 1	

Drug Name	Drug Tier	Notes
METHADONE INTENSOL ORAL CONCENTRATE 10 MG/ML	Tier 1	
methadone oral solution 10 mg/5 ml, 5 mg/5 ml	Tier 1	
methadone oral tablet 10 mg, 5 mg	Tier 1	
methadone oral tablet,soluble 40 mg	Tier 1	
METHADOSE ORAL CONCENTRATE 10 MG/ML	Tier 3	
METHADOSE ORAL TABLET,SOLUBLE 40 MG	Tier 1	
morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)	Tier 1	
morphine concentrate oral syringe 20 mg/ml	Tier 1	
morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	Tier 1	PA; QL (1 capsule per 1 day)
morphine oral capsule,extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg	Tier 1	QL (2 capsules per 1 day)
morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)	Tier 1	
morphine oral tablet 15 mg	Tier 2	
morphine oral tablet 30 mg	Tier 1	
morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg	Tier 1	QL (3 tablets per 1 day)
morphine rectal suppository 10 mg, 20 mg, 30 mg, 5 mg	Tier 1	
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 15 MG, 200 MG, 30 MG, 60 MG	Tier 3	QL (3 tablets per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG	Tier 3	QL (2 tablets per 1 day)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG	Tier 3	QL (6 tablets per 1 day)
OPANA ER ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 5 MG, 7.5 MG	Tier 3	PA; QL (3 tablets per 1 day)
OPANA ORAL TABLET 10 MG, 5 MG	Tier 3	QL (8 tablets per 1 day)
oxycodone oral capsule 5 mg	Tier 1	
oxycodone oral concentrate 20 mg/ml	Tier 1	
oxycodone oral solution 5 mg/5 ml	Tier 1	
oxycodone oral syringe 10 mg/0.5 ml	Tier 1	
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	Tier 1	

Drug Name	Drug Tier	Notes
oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	Tier 1	QL (3 tablets per 1 day)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG	Tier 3	QL (3 tablets per 1 day)
oxymorphone oral tablet 10 mg, 5 mg	Tier 1	QL (8 tablets per 1 day)
oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 7.5 mg	Tier 1	PA; QL (3 tablets per 1 day)
oxymorphone oral tablet extended release 12 hr 5 mg	Tier 1	PA; QL (3 tablets per 1 day)
ROXICODONE ORAL TABLET 15 MG, 30 MG, 5 MG	Tier 3	
SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 1,200 MCG (600 MCG/SPRAY X 2), 1,600 MCG (800 MCG/SPRAY X 2), 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY	Tier 8	PA; 30D; Specialty; QL (4 sprays per 1 day)
tramadol oral capsule,er biphase 24 hr 17-83 300 mg	Tier 1	QL (1 capsule per 1 day)
tramadol oral capsule,er biphase 24 hr 25-75 100 mg, 200 mg	Tier 1	QL (1 capsule per 1 day)
tramadol oral tablet 50 mg	Tier 1	QL (8 tablets per 1 day)
tramadol oral tablet extended release 24 hr 100 mg, 200 mg, 300 mg	Tier 1	QL (1 tablet per 1 day)
tramadol oral tablet, er multiphase 24 hr 100 mg, 200 mg, 300 mg	Tier 1	QL (1 tablet per 1 day)
ULTRAM ER ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	Tier 3	QL (1 tablet per 1 day)
ULTRAM ORAL TABLET 50 MG	Tier 3	QL (8 tablets per 1 day)
XTAMPZA ER ORAL CAPSULE,SPRINKLE,ER 12HR TMPRR 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG	Tier 3	
ZOHYDRO ER ORAL CAPSULE, ORAL ONLY, ER 12HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG	Tier 3	PA; QL (2 capsules per 1 day)
Analgesic Narcotic Codeine Combinations		
acetaminophen-codeine oral solution 120-12 mg/5 ml	Tier 1	DDS
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	Tier 1	DDS; QL (13 tablets per 1 day)
ASCOMP WITH CODEINE ORAL CAPSULE 30-50-325-40 MG	Tier 1	QL (12 capsules per 1 day)

Drug Name	Drug Tier	Notes
BUTALBITAL COMPOUND W/CODEINE ORAL CAPSULE 30-50-325-40 MG	Tier 1	QL (12 capsules per 1 day)
butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	Tier 1	QL (12 capsules per 1 day)
CAPITAL WITH CODEINE ORAL SUSPENSION 120-12 MG/5 ML	Tier 3	
FIORICET WITH CODEINE ORAL CAPSULE 50-300-40-30 MG	Tier 3	QL (12 capsules per 1 day)
FIORINAL-CODEINE #3 ORAL CAPSULE 30-50-325-40 MG	Tier 3	QL (12 capsules per 1 day)
TYLENOL-CODEINE #3 ORAL TABLET 300-30 MG	Tier 3	QL (13 tablets per 1 day)
TYLENOL-CODEINE #4 ORAL TABLET 300-60 MG	Tier 3	QL (13 tablets per 1 day)
Analgesic Narcotic Dihydrocodeine Combinations		
acetaminophen-caff-dihydrocod oral capsule 320.5-30-16 mg	Tier 1	
aspirin-caffeine-dihydrocodein oral capsule 356.4-30-16 mg	Tier 1	DDS
SYNALGOS-DC ORAL CAPSULE 356.4-30-16 MG	Tier 3	
TREZIX ORAL CAPSULE 320.5-30-16 MG	Tier 3	
Analgesic Narcotic Dihydrocodeine, Non-Salicylate Analgesic,Xanthine		
acetaminophen-caff-dihydrocod oral capsule 320.5-30-16 mg	Tier 1	
TREZIX ORAL CAPSULE 320.5-30-16 MG	Tier 3	
Analgesic Narcotic Dihydrocodeine, Salicylate Analgesic, Xanthine Comb		
aspirin-caffeine-dihydrocodein oral capsule 356.4-30-16 mg	Tier 1	DDS
SYNALGOS-DC ORAL CAPSULE 356.4-30-16 MG	Tier 3	
Analgesic Narcotic Hydrocodone And Non-Salicylate Combinations		
HYCET ORAL SOLUTION 7.5-325 MG/15 ML	Tier 3	
hydrocodone-acetaminophen oral solution 2.5-167 mg/5 ml, 5-163 mg/7.5ml(7.5ml), 7.5-325 mg/15 ml	Tier 1	

Drug Name	Drug Tier	Notes
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	Tier 1	QL (13 tabs per 1 day)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	Tier 1	DDS; QL (12 tabs per 1 day)
hydrocodone-acetaminophen oral tablet 5-325 mg	Tier 1	QL (12 tabs per 1 day)
LORCET (HYDROCODONE) ORAL TABLET 5-325 MG	Tier 1	QL (12 tablets per 1 day)
LORCET HD ORAL TABLET 10-325 MG	Tier 1	QL (12 tablets per 1 day)
LORCET PLUS ORAL TABLET 7.5-325 MG	Tier 1	QL (12 tablets per 1 day)
LORTAB 10-325 ORAL TABLET 10-325 MG	Tier 3	QL (12 tablets per 1 day)
LORTAB 5-325 ORAL TABLET 5-325 MG	Tier 3	QL (12 tablets per 1 day)
LORTAB 7.5-325 ORAL TABLET 7.5-325 MG	Tier 3	QL (12 tablets per 1 day)
LORTAB ELIXIR ORAL SOLUTION 10-300 MG/15 ML	Tier 3	
NORCO ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	Tier 3	QL (12 Tablets per 1 day)
vicodin es oral tablet 7.5-300 mg	Tier 1	PA; QL (6 tablets per 1 day)
vicodin hp oral tablet 10-300 mg	Tier 1	PA; QL (6 tablets per 1 day)
vicodin oral tablet 5-300 mg	Tier 1	PA; QL (8 tablets per 1 day)
XODOL 10/300 ORAL TABLET 10-300 MG	Tier 3	QL (13 tablets per 1 day)
XODOL 5/300 ORAL TABLET 5-300 MG	Tier 3	QL (13 tablets per 1 day)
XODOL 7.5/300 ORAL TABLET 7.5-300 MG	Tier 3	QL (13 tablets per 1 day)
Analgesic Narcotic Hydrocodone And Nsaid Combinations		
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg	Tier 1	
hydrocodone-ibuprofen oral tablet 7.5-200 mg	Tier 1	DDS
IBUDONE ORAL TABLET 10-200 MG, 5-200 MG	Tier 3	
REPREXAIN ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG	Tier 1	
XYLON 10 ORAL TABLET 10-200 MG	Tier 1	
Analgesic Narcotic Hydrocodone Combinations		
HYCET ORAL SOLUTION 7.5-325 MG/15 ML	Tier 3	
hydrocodone-acetaminophen oral solution 2.5-167 mg/5 ml, 5-163 mg/7.5ml(7.5ml), 7.5-325 mg/15 ml	Tier 1	

Drug Name	Drug Tier	Notes
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	Tier 1	QL (13 tabs per 1 day)
hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	Tier 1	DDS; QL (12 tabs per 1 day)
hydrocodone-acetaminophen oral tablet 5-325 mg	Tier 1	QL (12 tabs per 1 day)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg	Tier 1	
hydrocodone-ibuprofen oral tablet 7.5-200 mg	Tier 1	DDS
IBUDONE ORAL TABLET 10-200 MG, 5-200 MG	Tier 3	
LORCET (HYDROCODONE) ORAL TABLET 5-325 MG	Tier 1	QL (12 tablets per 1 day)
LORCET HD ORAL TABLET 10-325 MG	Tier 1	QL (12 tablets per 1 day)
LORCET PLUS ORAL TABLET 7.5-325 MG	Tier 1	QL (12 tablets per 1 day)
LORTAB 10-325 ORAL TABLET 10-325 MG	Tier 3	QL (12 tablets per 1 day)
LORTAB 5-325 ORAL TABLET 5-325 MG	Tier 3	QL (12 tablets per 1 day)
LORTAB 7.5-325 ORAL TABLET 7.5-325 MG	Tier 3	QL (12 tablets per 1 day)
LORTAB ELIXIR ORAL SOLUTION 10-300 MG/15 ML	Tier 3	
NORCO ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	Tier 3	QL (12 Tablets per 1 day)
REPREXAIN ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG	Tier 1	
vicodin es oral tablet 7.5-300 mg	Tier 1	PA; QL (6 tablets per 1 day)
vicodin hp oral tablet 10-300 mg	Tier 1	PA; QL (6 tablets per 1 day)
vicodin oral tablet 5-300 mg	Tier 1	PA; QL (8 tablets per 1 day)
XODOL 10/300 ORAL TABLET 10-300 MG	Tier 3	QL (13 tablets per 1 day)
XODOL 5/300 ORAL TABLET 5-300 MG	Tier 3	QL (13 tablets per 1 day)
XODOL 7.5/300 ORAL TABLET 7.5-300 MG	Tier 3	QL (13 tablets per 1 day)
XYLON 10 ORAL TABLET 10-200 MG	Tier 1	
Analgesic Narcotic Oxycodone And Non-Salicylate Combinations		
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	Tier 1	QL (12 tabs per 1 day)
oxycodone-acetaminophen oral solution 5-325 mg/5 ml	Tier 1	QL (60 ML per 1 day)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	Tier 1	QL (12 tablets per 1 day)
oxycodone-acetaminophen oral tablet 5-325 mg	Tier 1	DDS; QL (12 tablets per 1 day)

Drug Name	Drug Tier	Notes
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	Tier 3	QL (12 tablets per 1 day)
PRIMLEV ORAL TABLET 10-300 MG, 5-300 MG, 7.5-300 MG	Tier 3	QL (13 tabs per 1 day)
XARTEMIS XR ORAL TAB,ORAL ONLY,IR - ER, BIPHASE 7.5-325 MG	Tier 3	PA; QL (4 tablets per 1 day)
Analgesic Narcotic Oxycodone And Nsaid Combinations		
ibuprofen-oxycodone oral tablet 400-5 mg	Tier 1	QL (28 tablets per 30 days)
Analgesic Narcotic Oxycodone And Salicylate Combinations		
oxycodone-aspirin oral tablet 4.8355-325 mg	Tier 1	DDS
Analgesic Narcotic Oxycodone Combinations		
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	Tier 1	QL (12 tabs per 1 day)
ibuprofen-oxycodone oral tablet 400-5 mg	Tier 1	QL (28 tablets per 30 days)
oxycodone-acetaminophen oral solution 5-325 mg/5 ml	Tier 1	QL (60 ML per 1 day)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg	Tier 1	QL (12 tablets per 1 day)
oxycodone-acetaminophen oral tablet 5-325 mg	Tier 1	DDS; QL (12 tablets per 1 day)
oxycodone-aspirin oral tablet 4.8355-325 mg	Tier 1	DDS
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	Tier 3	QL (12 tablets per 1 day)
PRIMLEV ORAL TABLET 10-300 MG, 5-300 MG, 7.5-300 MG	Tier 3	QL (13 tabs per 1 day)
XARTEMIS XR ORAL TAB,ORAL ONLY,IR - ER, BIPHASE 7.5-325 MG	Tier 3	PA; QL (4 tablets per 1 day)
Analgesic Narcotic Partial-Mixed Agonists		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG	Tier 3	
butorphanol tartrate nasal spray,non-aerosol 10 mg/ml	Tier 1	QL (2 bottles (5ml) per 30 days)
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HOUR, 15 MCG/HOUR, 20 MCG/HOUR, 5 MCG/HOUR, 7.5 MCG/HOUR	Tier 3	PA; QL (4 patches per 28 days)
pentazocine-naloxone oral tablet 50-0.5 mg	Tier 1	

Drug Name	Drug Tier	Notes
Analgesic Narcotic Tramadol And Non-Salicylate Combinations		
tramadol-acetaminophen oral tablet 37.5-325 mg	Tier 1	QL (8 tablets per 1 day)
ULTRACET ORAL TABLET 37.5-325 MG	Tier 3	QL (8 tablets per 1 day)
Analgesic Narcotic Tramadol Combinations		
tramadol-acetaminophen oral tablet 37.5-325 mg	Tier 1	QL (8 tablets per 1 day)
ULTRACET ORAL TABLET 37.5-325 MG	Tier 3	QL (8 tablets per 1 day)
Analgesic Or Antipyretic Non-Narcotic/Sedative Combinations		
ALLZITAL ORAL TABLET 25-325 MG	Tier 3	PA
BUPAP ORAL TABLET 50-300 MG	Tier 3	PA
butalbital-acetaminophen oral tablet 50-325 mg	Tier 1	
butalbital-acetaminophen-caff oral capsule 50-300-40 mg, 50-325-40 mg	Tier 1	
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	Tier 1	
ESGIC ORAL CAPSULE 50-325-40 MG	Tier 3	
ESGIC ORAL TABLET 50-325-40 MG	Tier 3	
FIORICET ORAL CAPSULE 50-300-40 MG	Tier 3	
MARGESIC ORAL CAPSULE 50-325-40 MG	Tier 1	
MARTEN-TAB ORAL TABLET 50-325 MG	Tier 1	
TENCON ORAL TABLET 50-325 MG	Tier 1	
VANATOL LQ ORAL SOLUTION 50-325-40 MG/15 ML	Tier 3	
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Non-Seiective		
ENBREL SUBCUTANEOUS RECON SOLN 25 MG (1 ML)	Tier 4	PA; 30D; Specialty
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)	Tier 4	PA; 30D; Specialty
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (0.98 ML)	Tier 4	PA; 30D; Specialty
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Tnf-Alpha Sel		
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	Tier 8	PA; 30D; Specialty
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	Tier 8	PA; 30D; Specialty

Drug Name	Drug Tier	Notes
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
HUMIRA PEN CROHN'S-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML	Tier 6	PA; Specialty
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML	Tier 8	PA; Specialty; 30D; Specialty
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML	Tier 8	PA; Specialty; 30D; Specialty
Dmard - Antimalarials		
hydroxychloroquine oral tablet 200 mg	Tier 1	
PLAQUENIL ORAL TABLET 200 MG	Tier 3	
Dmard - Antimetabolites		
methotrexate sodium oral tablet 2.5 mg	Tier 1	Mand 90
OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML, 7.5 MG/0.4 ML	Tier 8	Specialty; 30D; Specialty
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 27.5 MG/0.55 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	Tier 3	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	Tier 3	
Dmard - Antinflammatory, Select. Costimulation Modulator,T-Cell Inhib.		
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR 125 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	Tier 8	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
Dmard - Gold Compounds		
RIDAURA ORAL CAPSULE 3 MG	Tier 2	
Dmard - Immunosuppressives		
AZASAN ORAL TABLET 100 MG, 75 MG	Tier 2	Mand 90
azathioprine oral tablet 50 mg	Tier 1	Mand 90
CELLCEPT ORAL CAPSULE 250 MG	Tier 3	
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION 200 MG/ML	Tier 8	30D; Specialty
CELLCEPT ORAL TABLET 500 MG	Tier 3	
cyclophosphamide oral capsule 25 mg, 50 mg	Tier 2	
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
cyclosporine modified oral solution 100 mg/ml	Tier 1	Mand 90
cyclosporine oral capsule 100 mg, 25 mg	Tier 1	
gengraf oral capsule 100 mg, 25 mg	Tier 1	Mand 90
GENGRAF ORAL CAPSULE 50 MG	Tier 3	
gengraf oral solution 100 mg/ml	Tier 1	Mand 90
IMURAN ORAL TABLET 50 MG	Tier 3	Mand 90
mycophenolate mofetil oral capsule 250 mg	Tier 1	Mand 90
mycophenolate mofetil oral suspension for reconstitution 200 mg/ml	Tier 1	Mand 90
mycophenolate mofetil oral tablet 500 mg	Tier 1	Mand 90
NEORAL ORAL CAPSULE 100 MG, 25 MG	Tier 3	
NEORAL ORAL SOLUTION 100 MG/ML	Tier 3	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG	Tier 3	
SANDIMMUNE ORAL SOLUTION 100 MG/ML	Tier 2	
Dmard - Interleukin-1 Receptor Antagonist (Il-1Ra)		
KINERET SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	Tier 8	PA; Specialty; 30D; Specialty
Dmard - Interleukin-6 (Il-6) Receptor Inhibitors, Monoclonal Antibody		
ACTEMRA SUBCUTANEOUS SYRINGE 162 MG/0.9 ML	Tier 8	PA; Retail; Specialty
Dmard - Janus Kinase (Jak) Inhibitors		
XELJANZ ORAL TABLET 5 MG	Tier 8	PA; Specialty; 30D; Specialty
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG	Tier 3	

Drug Name	Drug Tier	Notes
Dmard - Other		
AZULFIDINE EN-TABS ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	Tier 3	
AZULFIDINE ORAL TABLET 500 MG	Tier 3	
CUPRIMINE ORAL CAPSULE 250 MG	Tier 3	Mand 90
DEPEN TITRATABS ORAL TABLET 250 MG	Tier 3	Mand 90
MINOCIN ORAL CAPSULE 100 MG, 50 MG, 75 MG	Tier 3	
minocycline oral capsule 100 mg, 50 mg, 75 mg	Tier 1	
minocycline oral tablet 100 mg, 50 mg, 75 mg	Tier 1	
sulfasalazine oral tablet 500 mg	Tier 1	Mand 90
sulfasalazine oral tablet,delayed release (dr/ec) 500 mg	Tier 1	Mand 90
sulfazine oral tablet 500 mg	Tier 1	Mand 90
Dmard - Phosphodiesterase-4 (Pde4) Inhibitors		
OTEZLA ORAL TABLET 30 MG	Tier 8	PA; Specialty; 30D; Specialty
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 8	PA; 30D; Specialty
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG(19)	Tier 8	PA; Specialty; 30D; Specialty
Dmard - Pyrimidine Synthesis Inhibitors		
ARAVA ORAL TABLET 10 MG, 20 MG	Tier 3	
leflunomide oral tablet 10 mg, 20 mg	Tier 1	
Nsaid Analgesic And Histamine H2 Receptor Antagonist Combinations		
DUEXIS ORAL TABLET 800-26.6 MG	Tier 8	PA; 30D
Nsaid Analgesic And Prostaglandin Analog Combinations		
ARTHROTEC 50 ORAL TABLET,IR,DELAYED REL,BIPHASIC 50-200 MG-MCG	Tier 3	PA
ARTHROTEC 75 ORAL TABLET,IR,DELAYED REL,BIPHASIC 75-200 MG-MCG	Tier 3	PA
diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic 50-200 mg-mcg, 75-200 mg-mcg	Tier 1	PA

Drug Name	Drug Tier	Notes
Nsaid Analgesic And Proton Pump Inhibitor Combinations		
VIMOVO ORAL TABLET,IR,DELAYED REL,BIPHASIC 375-20 MG, 500-20 MG	Tier 8	PA
Nsaid Analgesic, Cyclooxygenase-2 (Cox-2) Selective Inhibitors		
CELEBREX ORAL CAPSULE 100 MG, 200 MG, 400 MG, 50 MG	Tier 3	QL (1 capsule per 1 day)
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	Tier 1	QL (1 capsule per 1 day)
Nsaid Analgesics (Cox Non-Specific) - Anthranilic Acid Derivatives		
meclofenamate oral capsule 100 mg, 50 mg	Tier 1	
mefenamic acid oral capsule 250 mg	Tier 1	
PONSTEL ORAL CAPSULE 250 MG	Tier 3	
Nsaid Analgesics (Cox Non-Specific) - Other		
ketorolac oral tablet 10 mg	Tier 1	AR; AR
nabumetone oral tablet 500 mg, 750 mg	Tier 1	
SPRIX NASAL SPRAY,NON-AEROSOL 15.75 MG/SPRAY	Tier 8	PA; Specialty; Specialty; QL (5 bottles per 30 days)
sulindac oral tablet 150 mg, 200 mg	Tier 1	
tolmetin oral capsule 400 mg	Tier 1	
tolmetin oral tablet 200 mg, 600 mg	Tier 1	
Nsaid Analgesics (Cox Non-Specific) - Oxicam Derivatives		
FELDENE ORAL CAPSULE 10 MG, 20 MG	Tier 3	
meloxicam oral suspension 7.5 mg/5 ml	Tier 1	
meloxicam oral tablet 15 mg, 7.5 mg	Tier 1	
MOBIC ORAL TABLET 15 MG, 7.5 MG	Tier 3	
piroxicam oral capsule 10 mg, 20 mg	Tier 1	
VIVLODEX ORAL CAPSULE 10 MG, 5 MG	Tier 3	
Nsaid Analgesics (Cox Non-Specific) - Phenylacetic Acid Derivatives		
CAMBIA ORAL POWDER IN PACKET 50 MG	Tier 3	PA
diclofenac potassium oral tablet 50 mg	Tier 1	
diclofenac sodium oral tablet extended release 24 hr 100 mg	Tier 1	

Drug Name	Drug Tier	Notes
diclofenac sodium oral tablet,delayed release (dr/ec) 25 mg, 50 mg, 75 mg	Tier 1	
VOLTAREN-XR ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	Tier 3	
ZIPSOR ORAL CAPSULE 25 MG	Tier 3	PA
ZORVOLEX ORAL CAPSULE 18 MG, 35 MG	Tier 3	PA
Nsaid Analgesics (Cox Non-Specific) - Propionic Acid Derivatives		
ANAPROX DS ORAL TABLET 550 MG	Tier 3	
DAYPRO ORAL TABLET 600 MG	Tier 3	
EC-NAPROSYN ORAL TABLET,DELAYED RELEASE (DR/EC) 375 MG, 500 MG	Tier 3	
fenoprofen oral capsule 200 mg	Tier 1	
fenoprofen oral tablet 600 mg	Tier 1	
flurbiprofen oral tablet 100 mg, 50 mg	Tier 1	
ibuprofen oral suspension 100 mg/5 ml	Tier 1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	Tier 1	DDS
ketoprofen oral capsule 50 mg, 75 mg	Tier 1	
ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg	Tier 1	
NALFON ORAL CAPSULE 400 MG	Tier 3	
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 375 MG, 500 MG, 750 MG	Tier 3	PA
NAPROSYN ORAL TABLET 500 MG	Tier 3	
naproxen oral suspension 125 mg/5 ml	Tier 1	
naproxen oral tablet 250 mg, 375 mg, 500 mg	Tier 1	DDS
naproxen oral tablet,delayed release (dr/ec) 375 mg, 500 mg	Tier 1	
naproxen sodium oral tablet 275 mg, 550 mg	Tier 1	
naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg	Tier 1	PA
oxaprozin oral tablet 600 mg	Tier 1	
Nsaid Analgesics (Cyclooxygenase Inhibitors-Non-Selective)		
CAMBIA ORAL POWDER IN PACKET 50 MG	Tier 3	PA
Nsaid Analgesics, (Cox Non-Specific) - Indole Acetic Acid Derivatives		
etodolac oral capsule 200 mg, 300 mg	Tier 1	

Drug Name	Drug Tier	Notes
etodolac oral tablet 400 mg, 500 mg	Tier 1	
etodolac oral tablet extended release 24 hr 400 mg, 500 mg, 600 mg	Tier 1	
INDOCIN ORAL SUSPENSION 25 MG/5 ML	Tier 2	PA; AR; AR
indomethacin oral capsule 25 mg, 50 mg	Tier 1	AR; DDS; AR
indomethacin oral capsule, extended release 75 mg	Tier 1	AR; DDS; AR
LODINE ORAL TABLET 400 MG	Tier 3	
TIVORBEX ORAL CAPSULE 20 MG, 40 MG	Tier 3	PA; AR; AR
Salicylate Analgesic And Sedative Combinations		
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	Tier 1	
FIORINAL ORAL CAPSULE 50-325-40 MG	Tier 3	
Salicylate Analgesic Combinations		
choline,magnesium salicylate oral liquid 500 mg/5 ml	Tier 1	
Salicylate Analgesics		
ADULT LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR
aspirin oral tablet 325 mg	Tier 5	AR; AR
aspirin oral tablet,chewable 81 mg	Tier 5	AR; AR
aspirin oral tablet,delayed release (dr/ec) 325 mg, 500 mg, 81 mg	Tier 5	AR; AR
ASPIR-LOW ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR; AR
BAYER CHEWABLE ASPIRIN ORAL TABLET,CHEWABLE 81 MG	Tier 5	AR; AR
diflunisal oral tablet 500 mg	Tier 1	
DISALCID ORAL TABLET 500 MG, 750 MG	Tier 3	
DURLAZA ORAL CAPSULE,EXTENDED RELEASE 24HR 162.5 MG	Tier 3	
E.C. PRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG	Tier 5	AR
ECOTRIN LOW STRENGTH ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR; AR
ECOTRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG	Tier 5	AR; AR
salsalate oral tablet 500 mg, 750 mg	Tier 1	

Drug Name	Drug Tier	Notes
ST JOSEPH ASPIRIN ORAL TABLET,CHEWABLE 81 MG	Tier 5	AR; AR
ST. JOSEPH ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR; AR
Salicylate Analgesics, Buffered		
BAYER PLUS EXTRA STRENGTH ORAL TABLET 500 MG	Tier 5	AR; AR
BUFFERIN ORAL TABLET 325 MG	Tier 5	
TRI-BUFFERED ASPIRIN ORAL TABLET 325 MG	Tier 5	
Anesthetics		
Local Anesthetic - Amides		
bupivacaine (pf) injection solution 0.5 % (5 mg/ml), 0.75 % (7.5 mg/ml)	Tier 6	Specialty
bupivacaine injection solution 0.25 % (2.5 mg/ml), 0.5 % (5 mg/ml)	Tier 6	Specialty
bupivacaine-dextrose-water(pf) injection solution 0.75 % (7.5 mg/ml)	Tier 6	Specialty
lidocaine (pf) injection syringe 10 mg/ml (1 %)	Tier 6	
lidocaine hcl laryngotracheal solution 4 %	Tier 1	
lidocaine topical ointment 5 %	Tier 1	
LTA PRE-ATTACHED LARYNGOTRACHEAL SOLUTION 4 %	Tier 3	
MARCAINE (PF) INJECTION SOLUTION 0.25 % (2.5 MG/ML), 0.5 % (5 MG/ML), 0.75 % (7.5 MG/ML)	Tier 6	Specialty
MARCAINE INJECTION SOLUTION 0.25 % (2.5 MG/ML), 0.5 % (5 MG/ML)	Tier 6	Specialty
MARCAINE SPINAL (PF) INJECTION SOLUTION 0.75 % (7.5 MG/ML)	Tier 6	Specialty
Anorectal Preparations		
Anal Fissure Pain/Treatment Agents - Nitrates		
RECTIV RECTAL OINTMENT 0.4 % (W/W)	Tier 3	
Anorectal - Glucocorticoids		
ANUCORT-HC RECTAL SUPPOSITORY 25 MG	Tier 1	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG	Tier 3	

Drug Name	Drug Tier	Notes
hydrocortisone acetate rectal suppository 25 mg, 30 mg	Tier 1	
hydrocortisone topical cream with perineal applicator 1 %	Tier 1	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Tier 3	
PROCTOCORT RECTAL SUPPOSITORY 30 MG	Tier 3	
PROCTOCORT TOPICAL CREAM 1 %	Tier 3	
PROCTO-PAK TOPICAL CREAM WITH PERINEAL APPLICATOR 1 %	Tier 1	
PROCTOZONE-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Tier 1	
Anorectal - Hemorrhoidal Rectal Glucocorticoid-Local Anesthetic Comb		
ANALPRAM E RECTAL KIT,CREAM AND TOWELETTE 2.5 %-1 % (4 GRAM)-1 %	Tier 3	
ANALPRAM-HC RECTAL CREAM 1-1 %, 2.5-1 %	Tier 3	PA
hydrocortisone-pramoxine rectal cream 1-1 %, 2.5-1 %	Tier 1	
lidocaine-hydrocortisone-aloe rectal gel 2.8-0.55 %	Tier 1	
PRAMCORT RECTAL CREAM 1-1 %	Tier 3	
PROCORT RECTAL CREAM 1.85-1.15 %	Tier 3	
PROCTOFOAM HC RECTAL FOAM 1-1 %	Tier 2	
Antidotes And Other Reversal Agents		
Antidote - Acetaminophen Poisoning		
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)	Tier 1	
CETYLEV ORAL TABLET, EFFERVESCENT 2.5 GRAM, 500 MG	Tier 3	
Antidote - Radioactive Agents		
RADIOGARDASE ORAL CAPSULE 0.5 GRAM	Tier 3	
Antidote Others		
GALZIN ORAL CAPSULE 25 MG (ZINC), 50 MG (ZINC)	Tier 3	
RADIOGARDASE ORAL CAPSULE 0.5 GRAM	Tier 3	

Drug Name	Drug Tier	Notes
Chelating Agents - Copper		
CUPRIMINE ORAL CAPSULE 250 MG	Tier 3	Mand 90
DEPEN TITRATABS ORAL TABLET 250 MG	Tier 3	Mand 90
SYPRINE ORAL CAPSULE 250 MG	Tier 8	PA; Specialty
Chelating Agents - Iron		
EXJADE ORAL TABLET, DISPERSIBLE 125 MG, 250 MG, 500 MG	Tier 4	30D; Specialty
FERRIPROX ORAL SOLUTION 100 MG/ML	Tier 3	
FERRIPROX ORAL TABLET 500 MG	Tier 8	30D; Specialty
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty
Chelating Agents - Lead Poisoning		
CHEMET ORAL CAPSULE 100 MG	Tier 3	
Mu-Opioid Receptor Antagonists, Peripherally-Acting		
ENTEREG ORAL CAPSULE 12 MG	Tier 8	30D; Specialty
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	Tier 3	PA; QL (1 tablet per 1 day)
RELISTOR ORAL TABLET 150 MG	Tier 3	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6 ML	Tier 3	PA
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML	Tier 3	PA
Opiate/Narcotic Reversal Agents - Opiate Antagonists		
naltrexone oral tablet 50 mg	Tier 1	
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	Tier 3	
Anti-Infective Agents		
Amebicides		
paromomycin oral capsule 250 mg	Tier 1	
Aminoglycoside Antibiotic		
neomycin oral tablet 500 mg	Tier 1	
Aminopenicillin Antibiotic		
amoxicillin oral capsule 250 mg, 500 mg	Tier 1	DDS
amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml	Tier 1	DDS

Drug Name	Drug Tier	Notes
amoxicillin oral tablet 500 mg, 875 mg	Tier 1	DDS
amoxicillin oral tablet,chewable 125 mg, 250 mg, 400 mg	Tier 1	DDS
ampicillin oral capsule 250 mg, 500 mg	Tier 1	
ampicillin oral suspension for reconstitution 250 mg/5 ml	Tier 1	
MOXATAG ORAL TABLET, ER MULTIPHASE 24 HR 775 MG	Tier 3	
Aminopenicillin Antibiotic - Beta-Lactamase Inhibitor Combinations		
amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 250-62.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml	Tier 1	DDS
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	Tier 1	DDS
amoxicillin-pot clavulanate oral tablet extended release 12 hr 1,000-62.5 mg	Tier 1	
amoxicillin-pot clavulanate oral tablet,chewable 200-28.5 mg, 400-57 mg	Tier 1	DDS
AUGMENTIN ES-600 ORAL SUSPENSION FOR RECONSTITUTION 600-42.9 MG/5 ML	Tier 3	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	Tier 2	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 250-62.5 MG/5 ML	Tier 3	
AUGMENTIN ORAL TABLET 500-125 MG, 875-125 MG	Tier 3	
AUGMENTIN XR ORAL TABLET EXTENDED RELEASE 12 HR 1,000-62.5 MG	Tier 3	
Anthelmintic Agents - Benzimidazole Derivatives		
ALBENZA ORAL TABLET 200 MG	Tier 3	
EMVERM ORAL TABLET,CHEWABLE 100 MG	Tier 3	
Anthelmintic Agents Other		
BILTRICIDE ORAL TABLET 600 MG	Tier 2	
ivermectin oral tablet 3 mg	Tier 1	
STROMECTOL ORAL TABLET 3 MG	Tier 3	
Antibacterial Folate Antagonist - Other Combinations		
BACTRIM DS ORAL TABLET 800-160 MG	Tier 3	

Drug Name	Drug Tier	Notes
BACTRIM ORAL TABLET 400-80 MG	Tier 3	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml	Tier 1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	Tier 1	
Antibacterial Folate Antagonist Others		
PRIMSOL ORAL SOLUTION 50 MG/5 ML	Tier 3	
trimethoprim oral tablet 100 mg	Tier 1	
Antifungal - Allylamines		
LAMISIL ORAL TABLET 250 MG	Tier 3	
terbinafine hcl oral tablet 250 mg	Tier 1	
Antifungal - Amphoteric Polyene Macrolides		
nystatin oral powder 150 million unit, 50 million unit, 500 million unit	Tier 1	
nystatin oral tablet 500,000 unit	Tier 1	
Antifungal - Imidazoles		
ketoconazole oral tablet 200 mg	Tier 1	
ORAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET 50 MG	Tier 3	
Antifungal - Triazoles		
CRESEMBA ORAL CAPSULE 186 MG	Tier 8	PA; Specialty; 30D; Specialty
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 10 MG/ML, 40 MG/ML	Tier 3	
DIFLUCAN ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	Tier 3	
fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml	Tier 1	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	Tier 1	
itraconazole oral capsule 100 mg	Tier 1	
NOXAFIL ORAL SUSPENSION 200 MG/5 ML (40 MG/ML)	Tier 8	30D; Specialty
NOXAFIL ORAL TABLET,DELAYED RELEASE (DR/EC) 100 MG	Tier 8	30D; Specialty
ONMEL ORAL TABLET 200 MG	Tier 3	
SPORANOX ORAL CAPSULE 100 MG	Tier 3	
SPORANOX ORAL SOLUTION 10 MG/ML	Tier 3	
SPORANOX PULSEPAK ORAL CAPSULE 100 MG	Tier 3	

Drug Name	Drug Tier	Notes
VFEND ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML (40 MG/ML)	Tier 3	
VFEND ORAL TABLET 200 MG, 50 MG	Tier 3	
voriconazole oral suspension for reconstitution 200 mg/5 ml (40 mg/ml)	Tier 1	
voriconazole oral tablet 200 mg, 50 mg	Tier 1	
Antifungal Other		
ANCOBON ORAL CAPSULE 250 MG, 500 MG	Tier 3	
flucytosine oral capsule 250 mg, 500 mg	Tier 1	
griseofulvin microsize oral suspension 125 mg/5 ml	Tier 1	
griseofulvin microsize oral tablet 500 mg	Tier 1	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	Tier 1	
GRIS-PEG (ULTRAMICROSIZE) ORAL TABLET 125 MG, 250 MG	Tier 3	
Anti-Infective Immunologic Adjuvants - Interferons		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML	Tier 8	Specialty
Antileprotic - Immunomodulators		
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	Tier 4	PA; Specialty; 30D; Specialty
Antileprotic - Sulfone Agents		
dapsone oral tablet 100 mg, 25 mg	Tier 1	
Antimalarial Combinations		
atovaquone-proguanil oral tablet 250-100 mg, 62.5-25 mg	Tier 1	
COARTEM ORAL TABLET 20-120 MG	Tier 3	
MALARONE ORAL TABLET 250-100 MG	Tier 3	
MALARONE PEDIATRIC ORAL TABLET 62.5-25 MG	Tier 3	
Antimalarials		
chloroquine phosphate oral tablet 250 mg, 500 mg	Tier 1	
DARAPRIM ORAL TABLET 25 MG	Tier 2	
hydroxychloroquine oral tablet 200 mg	Tier 1	
mefloquine oral tablet 250 mg	Tier 1	

Drug Name	Drug Tier	Notes
PLAQUENIL ORAL TABLET 200 MG	Tier 3	
primaquine oral tablet 26.3 mg	Tier 2	
QUALAQUIN ORAL CAPSULE 324 MG	Tier 3	
quinine sulfate oral capsule 324 mg	Tier 1	
Antiprotozoal Agents - Other		
ALINIA ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML	Tier 8	
ALINIA ORAL TABLET 500 MG	Tier 8	
atovaquone oral suspension 750 mg/5 ml	Tier 1	
MEPRON ORAL SUSPENSION 750 MG/5 ML	Tier 4	
Antiprotozoal-Antibacterial 1St Generation 2-Methyl-5-Nitroimidazole		
FLAGYL ER ORAL TABLET EXTENDED RELEASE 750 MG	Tier 3	PA
FLAGYL ORAL CAPSULE 375 MG	Tier 3	
FLAGYL ORAL TABLET 250 MG, 500 MG	Tier 3	
metronidazole oral capsule 375 mg	Tier 1	
metronidazole oral tablet 250 mg, 500 mg	Tier 1	DDS
Antiprotozoal-Antibacterial 2Nd Generation 2-Methyl-5-Nitroimidazole		
TINDAMAX ORAL TABLET 500 MG	Tier 3	
tinidazole oral tablet 250 mg, 500 mg	Tier 1	
Antiretroviral - Ccr5 Co-Receptor Antagonist		
SELZENTRY ORAL TABLET 150 MG, 300 MG	Tier 4	PA (New); 30D; Specialty
Antiretroviral - Hiv-1 Fusion Inhibitors		
FUZEON SUBCUTANEOUS RECON SOLN 90 MG	Tier 4	PA; Specialty; 30D; Specialty
Antiretroviral - Hiv-1 Integrase Strand Transfer Inhibitors		
ISENTRESS ORAL POWDER IN PACKET 100 MG	Tier 2	
ISENTRESS ORAL TABLET 400 MG	Tier 4	30D; Specialty
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG	Tier 2	
TIVICAY ORAL TABLET 10 MG, 25 MG, 50 MG	Tier 4	PA; Specialty; 30D; Specialty; QL (1 tablet per 1 day)

Drug Name	Drug Tier	Notes
VITEKTA ORAL TABLET 150 MG, 85 MG	Tier 4	PA; 30D; Specialty; QL (1 tablet per 1 day)
Antiretroviral - Non-Nucleoside Reverse Transcriptase Inhib (Nnrti)		
EDURANT ORAL TABLET 25 MG	Tier 4	PA (New); Specialty
INTELENCE ORAL TABLET 100 MG, 200 MG, 25 MG	Tier 4	30D; Specialty
nevirapine oral suspension 50 mg/5 ml	Tier 1	
nevirapine oral tablet 200 mg	Tier 1	
nevirapine oral tablet extended release 24 hr 100 mg	Tier 1	
nevirapine oral tablet extended release 24 hr 400 mg	Tier 4	30D; Specialty
RESCRIPTOR ORAL TABLET 200 MG	Tier 4	30D; Specialty
RESCRIPTOR ORAL TABLET, DISPERSIBLE 100 MG	Tier 4	30D; Specialty
SUSTIVA ORAL CAPSULE 200 MG, 50 MG	Tier 4	30D; Specialty
SUSTIVA ORAL TABLET 600 MG	Tier 4	30D; Specialty
VIRAMUNE ORAL SUSPENSION 50 MG/5 ML	Tier 3	
VIRAMUNE ORAL TABLET 200 MG	Tier 3	
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 400 MG	Tier 8	30D; Specialty
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (Nrti)		
abacavir oral tablet 300 mg	Tier 1	PA
didanosine oral capsule,delayed release(dr/ec) 125 mg, 200 mg, 250 mg, 400 mg	Tier 1	
EMTRIVA ORAL CAPSULE 200 MG	Tier 4	30D; Specialty
EMTRIVA ORAL SOLUTION 10 MG/ML	Tier 2	
EPIVIR ORAL SOLUTION 10 MG/ML	Tier 4	30D; Specialty
EPIVIR ORAL TABLET 150 MG, 300 MG	Tier 3	
lamivudine oral solution 10 mg/ml	Tier 1	
lamivudine oral tablet 150 mg, 300 mg	Tier 1	
RETROVIR ORAL CAPSULE 100 MG	Tier 3	
RETROVIR ORAL SYRUP 10 MG/ML	Tier 3	
stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg	Tier 1	
stavudine oral recon soln 1 mg/ml	Tier 4	

Drug Name	Drug Tier	Notes
VIDEX 2 GRAM PEDIATRIC ORAL RECON SOLN 10 MG/ML (FINAL)	Tier 2	
VIDEX 4 GRAM PEDIATRIC ORAL RECON SOLN 10 MG/ML (FINAL)	Tier 2	
VIDEX EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 125 MG, 200 MG, 250 MG, 400 MG	Tier 3	
ZERIT ORAL CAPSULE 15 MG, 20 MG, 30 MG, 40 MG	Tier 3	
ZERIT ORAL RECON SOLN 1 MG/ML	Tier 3	
ZIAGEN ORAL SOLUTION 20 MG/ML	Tier 4	PA (New); 30D; Specialty
ZIAGEN ORAL TABLET 300 MG	Tier 3	PA (New)
zidovudine oral capsule 100 mg	Tier 1	
zidovudine oral syrup 10 mg/ml	Tier 1	
zidovudine oral tablet 300 mg	Tier 1	
Antiretroviral - Nucleotide Analog Reverse Transcriptase Inhibitors		
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM)	Tier 4	30D; Specialty
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG, 300 MG	Tier 4	30D; Specialty
Antiretroviral Combinations - Nrti's		
abacavir-lamivudine oral tablet 600-300 mg	Tier 4	PA; Specialty; Specialty
abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg	Tier 4	PA; Specialty; 30D; Specialty
COMBIVIR ORAL TABLET 150-300 MG	Tier 8	Specialty; 30D; Specialty
EPZICOM ORAL TABLET 600-300 MG	Tier 8	PA (New); Specialty; 30D; Specialty
lamivudine-zidovudine oral tablet 150-300 mg	Tier 4	Specialty; 30D; Specialty
TRIZIVIR ORAL TABLET 300-150-300 MG	Tier 8	PA (New); 30D; Specialty
Antiretroviral Combinations - Nucleoside And Nucleotide Analog Rtis		
DESCOVY ORAL TABLET 200-25 MG	Tier 8	Specialty; 30D; Specialty
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG, 200-300 MG	Tier 4	Specialty; 30D; Specialty; QL (1 tablet per 1 day)
Antiretroviral Combinations - Protease Inhibitors		
EVOTAZ ORAL TABLET 300-150 MG	Tier 4	30D; Specialty; QL (1 tablet per 1 day)
KALETRA ORAL SOLUTION 400-100 MG/5 ML	Tier 4	30D; Specialty

Drug Name	Drug Tier	Notes
KALETRA ORAL TABLET 100-25 MG, 200-50 MG	Tier 4	30D; Specialty
PREZCOBIX ORAL TABLET 800-150 MG-MG	Tier 4	30D; Specialty; QL (1 tablet per 1 day)
Antiretroviral Combinations-Nucleoside Analogs And Integrase Inhibitor		
TRIUMEQ ORAL TABLET 600-50-300 MG	Tier 4	PA (New); 30D; Specialty
Antiretroviral- Nucleoside And Nucleotide Analogs,Integrase Inhibitors		
GENVOYA ORAL TABLET 150-150-200-10 MG	Tier 8	Specialty; 30D; Specialty
STRIBILD ORAL TABLET 150-150-200-300 MG	Tier 4	30D; Specialty
Antiretroviral-Nucleoside, Nucleotide Analogs And Non-Nucleoside Rti		
ATRIPLA ORAL TABLET 600-200-300 MG	Tier 4	30D; Specialty
COMPLERA ORAL TABLET 200-25-300 MG	Tier 4	PA (New); 30D; Specialty
ODEFSEY ORAL TABLET 200-25-25 MG	Tier 4	PA; Specialty; 30D; Specialty
Antitubercular - Aminobenzoic Acid Analogs		
PASER ORAL GRANULES DR FOR SUSP IN PACKET 4 GRAM	Tier 3	
Antitubercular - D-Alanine Analogs		
cycloserine oral capsule 250 mg	Tier 1	
Antitubercular - Diarylquinoline Antibiotics		
SIRTURO ORAL TABLET 100 MG	Tier 8	30D; Specialty
Antitubercular - Isonicotinic Acid Derivatives		
isoniazid oral solution 50 mg/5 ml	Tier 1	
isoniazid oral tablet 100 mg, 300 mg	Tier 1	
Antitubercular - Niacinamide Derivatives		
pyrazinamide oral tablet 500 mg	Tier 1	
Antitubercular - Rifamycin And Derivatives		
MYCOBUTIN ORAL CAPSULE 150 MG	Tier 3	
PRIFTIN ORAL TABLET 150 MG	Tier 3	

Drug Name	Drug Tier	Notes
rifabutin oral capsule 150 mg	Tier 1	
RIFADIN ORAL CAPSULE 150 MG, 300 MG	Tier 3	
rifampin oral capsule 150 mg, 300 mg	Tier 1	
Antitubercular Agents Other		
ethambutol oral tablet 100 mg, 400 mg	Tier 1	
MYAMBUTOL ORAL TABLET 400 MG	Tier 3	
TRECATOR ORAL TABLET 250 MG	Tier 3	
Antitubercular Combinations		
RIFAMATE ORAL CAPSULE 300-150 MG	Tier 3	
RIFATER ORAL TABLET 50-120-300 MG	Tier 3	
Cephalosporin Antibiotics - 1St Generation		
cefadroxil oral capsule 500 mg	Tier 1	DDS
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	Tier 1	DDS
cefadroxil oral tablet 1 gram	Tier 1	DDS
cephalexin oral capsule 250 mg, 500 mg	Tier 1	DDS
cephalexin oral capsule 750 mg	Tier 1	
cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	Tier 1	DDS
cephalexin oral tablet 250 mg, 500 mg	Tier 1	DDS
KEFLEX ORAL CAPSULE 250 MG, 500 MG, 750 MG	Tier 3	
Cephalosporin Antibiotics - 2Nd Generation		
cefaclor oral capsule 250 mg, 500 mg	Tier 1	
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml	Tier 1	
cefaclor oral tablet extended release 12 hr 500 mg	Tier 1	
cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	Tier 1	
cefprozil oral tablet 250 mg, 500 mg	Tier 1	
CEFTIN ORAL SUSPENSION FOR RECONSTITUTION 125 MG/5 ML	Tier 3	PA
CEFTIN ORAL SUSPENSION FOR RECONSTITUTION 250 MG/5 ML	Tier 3	
cefuroxime axetil oral suspension for reconstitution 125 mg/5 ml	Tier 3	DDS
cefuroxime axetil oral tablet 250 mg, 500 mg	Tier 1	DDS

Drug Name	Drug Tier	Notes
Cephalosporin Antibiotics - 3Rd Generation		
CEDAX ORAL CAPSULE 400 MG	Tier 3	
CEDAX ORAL SUSPENSION FOR RECONSTITUTION 180 MG/5 ML	Tier 3	
cefdinir oral capsule 300 mg	Tier 1	
cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	Tier 1	
cefixime oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml	Tier 1	
cefpodoxime oral suspension for reconstitution 100 mg/5 ml, 50 mg/5 ml	Tier 1	
cefpodoxime oral tablet 100 mg, 200 mg	Tier 1	
ceftibuten oral capsule 400 mg	Tier 1	
ceftibuten oral suspension for reconstitution 180 mg/5 ml	Tier 1	
SPECTRACEF ORAL TABLET 400 MG	Tier 3	
SUPRAX ORAL CAPSULE 400 MG	Tier 3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML, 200 MG/5 ML, 500 MG/5 ML	Tier 3	
SUPRAX ORAL TABLET,CHEWABLE 100 MG, 200 MG	Tier 3	
Cmv Antiviral Agent - Nucleoside Analogs		
VALCYTE ORAL RECON SOLN 50 MG/ML	Tier 8	Specialty; 30D; Specialty
VALCYTE ORAL TABLET 450 MG	Tier 4	30D; Specialty
valganciclovir oral recon soln 50 mg/ml	Tier 4	Specialty; 30D; Specialty
valganciclovir oral tablet 450 mg	Tier 1	
Fluoroquinolone Antibiotics		
AVELOX ABC PACK ORAL TABLET 400 MG	Tier 3	
AVELOX ORAL TABLET 400 MG	Tier 3	
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON 250 MG/5 ML, 500 MG/5 ML	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG	Tier 3	
ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg	Tier 1	
ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml, 500 mg/5 ml	Tier 1	

Drug Name	Drug Tier	Notes
FACTIVE ORAL TABLET 320 MG	Tier 3	PA
LEVAQUIN ORAL TABLET 250 MG, 500 MG, 750 MG	Tier 3	
levofloxacin oral solution 250 mg/10 ml	Tier 1	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	Tier 1	
moxifloxacin oral tablet 400 mg	Tier 1	
ofloxacin oral tablet 400 mg	Tier 1	
Glycopeptide Antibiotics		
VANCOCIN ORAL CAPSULE 125 MG, 250 MG	Tier 3	
vancomycin oral capsule 125 mg, 250 mg	Tier 1	
Hepatitis B Treatment- Nucleoside Analogs (Antiviral)		
BARACLUDE ORAL SOLUTION 0.05 MG/ML	Tier 8	30D; Specialty
BARACLUDE ORAL TABLET 0.5 MG, 1 MG	Tier 8	30D; Specialty
entecavir oral tablet 0.5 mg, 1 mg	Tier 4	Specialty; 30D; Specialty
EPIVIR HBV ORAL SOLUTION 25 MG/5 ML (5 MG/ML)	Tier 3	
EPIVIR HBV ORAL TABLET 100 MG	Tier 3	
TYZEKA ORAL TABLET 600 MG	Tier 4	30D; Specialty
Hepatitis B Treatment- Nucleotide Analogs (Antiviral)		
adefovir oral tablet 10 mg	Tier 4	Specialty; 30D; Specialty
HEPSERA ORAL TABLET 10 MG	Tier 8	Specialty; 30D; Specialty
VEMLIDY ORAL TABLET 25 MG	Tier 8	30D; Specialty
Hepatitis C - Interferons		
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 135 MCG/0.5 ML, 180 MCG/0.5 ML	Tier 4	PA; Specialty; 30D; Specialty
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	Tier 4	PA; Specialty; 30D; Specialty
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	Tier 4	PA; Specialty; 30D; Specialty
PEGINTRON REDIPEN SUBCUTANEOUS PEN INJECTOR KIT 120 MCG/0.5 ML, 150 MCG/0.5 ML, 50 MCG/0.5 ML, 80 MCG/0.5 ML	Tier 8	PA; 30D; Specialty

Drug Name	Drug Tier	Notes
PEGINTRON SUBCUTANEOUS KIT 120 MCG/0.5 ML, 150 MCG/0.5 ML, 50 MCG/0.5 ML, 80 MCG/0.5 ML	Tier 8	PA; 30D; Specialty
Hepatitis C - Ns3/4A Serine Protease Inhibitors		
OLYSIO ORAL CAPSULE 150 MG	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty
Hepatitis C - Ns5a Inhibitor And Ns3/4A Protease Inhibitor Combination		
TECHNIVIE ORAL TABLET 12.5-75-50 MG	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty; QL (28 tablets per 14 days)
ZEPATIER ORAL TABLET 50-100 MG	Tier 4	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty
Hepatitis C - Ns5a Replication Complex Inhibitors		
DAKLINZA ORAL TABLET 30 MG, 60 MG	Tier 8	PA; Specialty; QL/DS (Limited to 14 day supply per prescription); Specialty; QL (14 tablets per 14 days)
DAKLINZA ORAL TABLET 90 MG	Tier 8	PA; Specialty; QL/DS (Limited to 14 day supply per prescription); Specialty; QL (14 tablets per 14 dats)
Hepatitis C - Ns5b Polymerase And Ns5a Inhibitor Combinations		
EPCLUSA ORAL TABLET 400-100 MG	Tier 8	PA; Specialty; QL/DS (Limited to 14 day supply per prescription); Specialty
HARVONI ORAL TABLET 90-400 MG	Tier 4	PA; Specialty; QL/DS (Limited to 14 day supply per prescription); Specialty
Hepatitis C - Nucleos(T)Ide Analog Ns5b Polymerase Inhibitors		
SOVALDI ORAL TABLET 400 MG	Tier 4	PA; Specialty; QL/DS (Limited to 14 day supply per prescription); Specialty
Hepatitis C - Nucleoside Analogs		
COPEGUS ORAL TABLET 200 MG	Tier 8	30D; Specialty

Drug Name	Drug Tier	Notes
MODERIBA DOSE PACK ORAL TABLETS,DOSE PACK 200 MG (7)- 400 MG (7), 400 MG (7)- 400 MG (7), 600 MG (7)- 400 MG (7), 600 MG (7)- 600 MG (7)	Tier 8	30D; Specialty
MODERIBA ORAL TABLET 200 MG	Tier 8	30D; Specialty
REBETOL ORAL SOLUTION 40 MG/ML	Tier 8	Specialty
RIBASPHERE ORAL CAPSULE 200 MG	Tier 1	
RIBASPHERE ORAL TABLET 200 MG, 400 MG, 600 MG	Tier 1	
RIBASPHERE RIBAPAK ORAL TABLETS,DOSE PACK 200 MG (28)- 400 MG (28), 200 MG (7)- 400 MG (7), 400 MG (7)- 400 MG (7), 400-400 MG (28)-MG (28), 600 MG (7)- 400 MG (7), 600 MG (7)- 600 MG (7), 600-400 MG (28)-MG (28), 600-600 MG (28)-MG (28)	Tier 8	PA; 30D; Specialty
ribavirin oral capsule 200 mg	Tier 4	30D; Specialty
ribavirin oral tablet 200 mg	Tier 4	30D; Specialty
Hepatitis C- Ns5a, Ns3/4A Protease And Non-Nucleo.Ns5b Poly Inh. Comb		
VIEKIRA PAK ORAL TABLETS,DOSE PACK 12.5 MG-75 MG -50 MG/250 MG	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty
VIEKIRA XR ORAL TABLET, IR - ER, BIPHASIC 24HR 8.33 MG-50 MG- 33.33 MG-200 MG	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty
Herpes Antiviral Agent - Purine Analogs		
acyclovir oral capsule 200 mg	Tier 1	DDS
acyclovir oral suspension 200 mg/5 ml	Tier 1	
acyclovir oral tablet 400 mg, 800 mg	Tier 1	DDS
SITAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET 50 MG	Tier 3	
valacyclovir oral tablet 1 gram, 500 mg	Tier 1	DDS
VALTREX ORAL TABLET 1 GRAM, 500 MG	Tier 3	
ZOVIRAX ORAL CAPSULE 200 MG	Tier 3	
ZOVIRAX ORAL SUSPENSION 200 MG/5 ML	Tier 3	
ZOVIRAX ORAL TABLET 400 MG, 800 MG	Tier 3	

Drug Name	Drug Tier	Notes
Herpes Antiviral Agent - Thymidine Analogs		
famciclovir oral tablet 125 mg, 250 mg, 500 mg	Tier 1	
FAMVIR ORAL TABLET 125 MG, 250 MG, 500 MG	Tier 3	
Influenza Antiviral Agents - Neuraminidase Inhibitors		
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION	Tier 2	
TAMIFLU ORAL CAPSULE 30 MG, 45 MG, 75 MG	Tier 2	
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION 6 MG/ML	Tier 2	
Influenza-A Antiviral Agents		
FLUMADINE ORAL TABLET 100 MG	Tier 3	
rimantadine oral tablet 100 mg	Tier 1	
Ketolide Antibiotics		
KETEK ORAL TABLET 300 MG, 400 MG	Tier 3	
Lincosamide Antibiotics		
CLEOCIN ORAL CAPSULE 150 MG, 300 MG, 75 MG	Tier 3	
CLEOCIN ORAL RECON SOLN 75 MG/5 ML	Tier 3	
clindamycin hcl oral capsule 150 mg	Tier 1	DDS
clindamycin hcl oral capsule 300 mg, 75 mg	Tier 1	
clindamycin palmitate hcl oral recon soln 75 mg/5 ml	Tier 1	
Macrolides		
azithromycin oral packet 1 gram	Tier 1	
azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml	Tier 1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	Tier 1	
BIAXIN ORAL SUSPENSION FOR RECONSTITUTION 250 MG/5 ML	Tier 3	
BIAXIN ORAL TABLET 250 MG, 500 MG	Tier 3	
clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	Tier 1	
clarithromycin oral tablet 250 mg, 500 mg	Tier 1	
clarithromycin oral tablet extended release 24 hr 500 mg	Tier 1	

Drug Name	Drug Tier	Notes
DIFICID ORAL TABLET 200 MG	Tier 3	PA
E.E.S. 400 ORAL TABLET 400 MG	Tier 1	
E.E.S. GRANULES ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML	Tier 3	
ERYPED 200 ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML	Tier 3	
ERYPED 400 ORAL SUSPENSION FOR RECONSTITUTION 400 MG/5 ML	Tier 3	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 500 MG	Tier 1	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 333 MG	Tier 2	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	Tier 1	
erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml	Tier 1	
erythromycin ethylsuccinate oral tablet 400 mg	Tier 2	DDS
erythromycin oral capsule,delayed release(dr/ec) 250 mg	Tier 1	DDS
erythromycin oral tablet 250 mg, 500 mg	Tier 1	DDS
erythromycin stearate oral tablet 250 mg	Tier 1	DDS
PCE ORAL TABLET, PARTICLES/CRYSTALS 333 MG, 500 MG	Tier 3	
ZITHROMAX ORAL PACKET 1 GRAM	Tier 3	
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML, 200 MG/5 ML	Tier 3	
ZITHROMAX ORAL TABLET 250 MG, 500 MG, 600 MG	Tier 3	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG	Tier 3	
ZITHROMAX Z-PAK ORAL TABLET 250 MG	Tier 3	
ZMAX ORAL SUSPENSION,EXTENDED REL RECON 2 GRAM/60 ML	Tier 3	
Misc Anti-Infective		
NEBUPENT INHALATION RECON SOLN 300 MG	Tier 3	
Oxazolidinone Antibiotics		
linezolid oral tablet 600 mg	Tier 4	Specialty
ZYVOX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML	Tier 4	30D; Specialty

Drug Name	Drug Tier	Notes
ZYVOX ORAL TABLET 600 MG	Tier 8	30D; Specialty
Penicillin Antibiotic - Natural		
penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml	Tier 1	DDS
penicillin v potassium oral tablet 250 mg, 500 mg	Tier 1	DDS
Penicillin Antibiotic - Penicillinase-Resistant		
dicloxacillin oral capsule 250 mg, 500 mg	Tier 1	
Protease Inhibitors (Non-Peptidic) Antiretroviral		
APTIVUS ORAL CAPSULE 250 MG	Tier 4	PA (New); Specialty
APTIVUS ORAL SOLUTION 100 MG/ML	Tier 4	PA (New); Specialty
PREZCOBIX ORAL TABLET 800-150 MG-MG	Tier 4	30D; Specialty; QL (1 tablet per 1 day)
PREZISTA ORAL SUSPENSION 100 MG/ML	Tier 4	PA (New); Specialty
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	Tier 4	PA (New); Specialty
Protease Inhibitors (Peptidic) Antiretroviral		
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	Tier 4	30D; Specialty
EVOTAZ ORAL TABLET 300-150 MG	Tier 4	30D; Specialty; QL (1 tablet per 1 day)
INVIRASE ORAL CAPSULE 200 MG	Tier 2	PA (New); 30D
INVIRASE ORAL TABLET 500 MG	Tier 4	PA (New); 30D; Specialty
LEXIVA ORAL SUSPENSION 50 MG/ML	Tier 2	
LEXIVA ORAL TABLET 700 MG	Tier 4	30D; Specialty
NORVIR ORAL CAPSULE 100 MG	Tier 4	30D; Specialty
NORVIR ORAL SOLUTION 80 MG/ML	Tier 4	30D; Specialty
NORVIR ORAL TABLET 100 MG	Tier 4	30D; Specialty
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	Tier 4	30D; Specialty
REYATAZ ORAL POWDER IN PACKET 50 MG	Tier 4	30D; Specialty
VIRACEPT ORAL TABLET 250 MG, 625 MG	Tier 4	30D; Specialty

Drug Name	Drug Tier	Notes
Respiratory Syncytial Virus (Rsv) Antiviral Agents		
VIRAZOLE INHALATION RECON SOLN 6 GRAM	Tier 3	
Rifamycins And Related Derivative Antibiotics		
MYCOBUTIN ORAL CAPSULE 150 MG	Tier 3	
PRIFTIN ORAL TABLET 150 MG	Tier 3	
rifabutin oral capsule 150 mg	Tier 1	
RIFADIN ORAL CAPSULE 150 MG, 300 MG	Tier 3	
rifampin oral capsule 150 mg, 300 mg	Tier 1	
XIFAXAN ORAL TABLET 200 MG	Tier 3	
XIFAXAN ORAL TABLET 550 MG	Tier 8	Specialty; 30D; Specialty
Sulfonamide Antibiotic		
sulfadiazine oral tablet 500 mg	Tier 1	
Tetracycline Antibiotics		
ACTICLATE ORAL TABLET 150 MG, 75 MG	Tier 8	PA; Specialty; 30D; Specialty
AVIDOXY ORAL TABLET 100 MG	Tier 3	
demeclocycline oral tablet 150 mg, 300 mg	Tier 1	
DORYX ORAL TABLET,DELAYED RELEASE (DR/EC) 200 MG	Tier 8	PA; Specialty; Specialty
DORYX ORAL TABLET,DELAYED RELEASE (DR/EC) 50 MG	Tier 3	PA
doxycycline hyclate oral capsule 100 mg, 50 mg	Tier 1	DDS
doxycycline hyclate oral tablet 100 mg	Tier 1	DDS
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 150 mg, 50 mg, 75 mg	Tier 1	
doxycycline hyclate oral tablet,delayed release (dr/ec) 200 mg	Tier 4	Specialty; Specialty
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	Tier 1	
doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg	Tier 1	PA
doxycycline monohydrate oral suspension for reconstitution 25 mg/5 ml	Tier 1	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 50 mg, 75 mg	Tier 1	
MINOCIN ORAL CAPSULE 100 MG, 50 MG, 75 MG	Tier 3	
minocycline oral capsule 100 mg, 50 mg, 75 mg	Tier 1	

Drug Name	Drug Tier	Notes
minocycline oral tablet 100 mg, 50 mg, 75 mg	Tier 1	
minocycline oral tablet extended release 24 hr 135 mg, 45 mg, 90 mg	Tier 1	
MONODOX ORAL CAPSULE 100 MG, 50 MG, 75 MG	Tier 8	30D
MORGIDOX 1X100 KIT 100 MG	Tier 3	
MORGIDOX ORAL CAPSULE 100 MG, 50 MG	Tier 3	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG	Tier 3	PA
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	Tier 8	PA; 30D
TARGADOX ORAL TABLET 50 MG	Tier 3	PA
tetracycline oral capsule 250 mg, 500 mg	Tier 1	DDS
VIBRAMYCIN ORAL CAPSULE 100 MG	Tier 3	
VIBRAMYCIN ORAL SUSPENSION FOR RECONSTITUTION 25 MG/5 ML	Tier 3	
VIBRAMYCIN ORAL SYRUP 50 MG/5 ML	Tier 3	PA
Antineoplastics		
Antineoplasic-Epiderm.Growth Factor-Egfr (Erbb1),Her-2 (Erbb2)R.Inhib		
TYKERB ORAL TABLET 250 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Cyp17 (17 Alpha-Hydroxylase/C17,20-Lyase) Inhibitor		
ZYTIGA ORAL TABLET 250 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - 1St Generation Egfr Tyrosine Kinase Inhibitor		
IRESSA ORAL TABLET 250 MG	Tier 4	PA; Specialty; Specialty; QL (1 tablet per 1 day)
TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - 2Nd Generation Egfr Tyrosine Kinase Inhibitor		
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - 3Rd Generation Egfr Tyrosine Kinase Inhibitor		
TAGRISSO ORAL TABLET 40 MG, 80 MG	Tier 8	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
Antineoplastic - Alkylating Agent - Alkyl Sulfonates		
MYLERAN ORAL TABLET 2 MG	Tier 2	
Antineoplastic - Alkylating Agent - Ethylenimines And Methylmelamines		
HEXALEN ORAL CAPSULE 50 MG	Tier 4	Specialty
Antineoplastic - Alkylating Agent - Methylhydrazines		
MATULANE ORAL CAPSULE 50 MG	Tier 4	30D; Specialty
Antineoplastic - Alkylating Agent - Nitrogen Mustards		
ALKERAN ORAL TABLET 2 MG	Tier 4	Specialty
cyclophosphamide oral capsule 25 mg, 50 mg	Tier 2	
EVOMELA INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; Specialty
ifosfamide intravenous solution 1 gram/20 ml	Tier 6	30D
LEUKERAN ORAL TABLET 2 MG	Tier 4	30D; Specialty
Antineoplastic - Alkylating Agent - Nitrosoureas		
GLEOSTINE ORAL CAPSULE 10 MG	Tier 8	Specialty; Specialty
GLEOSTINE ORAL CAPSULE 100 MG, 40 MG, 5 MG	Tier 8	Specialty; 30D; Specialty
Antineoplastic - Alkylating Agent - Triazenes		
TEMODAR ORAL CAPSULE 100 MG, 140 MG, 180 MG, 20 MG, 250 MG, 5 MG	Tier 8	PA; Specialty; 30D; Specialty
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	Tier 1	PA; Specialty; 30D; Specialty
Antineoplastic - Anaplastic Lymphoma Kinase (Alk) Inhibitors		
ALECENSA ORAL CAPSULE 150 MG	Tier 8	Specialty; 30D; Specialty
XALKORI ORAL CAPSULE 200 MG, 250 MG	Tier 4	PA; Specialty; 30D; Specialty
ZYKADIA ORAL CAPSULE 150 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Antiadrenals		
LYSODREN ORAL TABLET 500 MG	Tier 4	30D; Specialty
Antineoplastic - Antiandrogens		
bicalutamide oral tablet 50 mg	Tier 1	
CASODEX ORAL TABLET 50 MG	Tier 3	

Drug Name	Drug Tier	Notes
flutamide oral capsule 125 mg	Tier 1	
NILANDRON ORAL TABLET 150 MG	Tier 8	Specialty; 30D; Specialty
nilutamide oral tablet 150 mg	Tier 4	Specialty; 30D; Specialty
XTANDI ORAL CAPSULE 40 MG	Tier 4	PA; Specialty; 30D; Specialty
ZYTIGA ORAL TABLET 250 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Anti-Gd2 Ganglioside Monoclonal Antibody		
UNITUXIN INTRAVENOUS SOLUTION 3.5 MG/ML	Tier 6	Specialty
Antineoplastic - Antimetabolite - Folic Acid Analogs		
methotrexate sodium oral tablet 2.5 mg	Tier 1	Mand 90
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	Tier 3	
Antineoplastic - Antimetabolite - Purine Analogs		
mercaptopurine oral tablet 50 mg	Tier 1	
PURIXAN ORAL SUSPENSION 20 MG/ML	Tier 2	
TABLOID ORAL TABLET 40 MG	Tier 2	
Antineoplastic - Antimetabolite - Pyrimidine Analogs		
capecitabine oral tablet 150 mg, 500 mg	Tier 1	PA; Specialty; 30D; Specialty
XELODA ORAL TABLET 150 MG, 500 MG	Tier 8	PA; Specialty; 30D; Specialty
Antineoplastic - Antimetabolite - Urea Derivatives		
HYDREA ORAL CAPSULE 500 MG	Tier 3	
hydroxyurea oral capsule 500 mg	Tier 1	
Antineoplastic - Antimetabolites - Pyrimidine Analog Combinations		
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Aromatase Inhibitors		
anastrozole oral tablet 1 mg	Tier 5	
ARIMIDEX ORAL TABLET 1 MG	Tier 5	
AROMASIN ORAL TABLET 25 MG	Tier 5	
exemestane oral tablet 25 mg	Tier 5	
FEMARA ORAL TABLET 2.5 MG	Tier 5	
letrozole oral tablet 2.5 mg	Tier 5	

Drug Name	Drug Tier	Notes
Antineoplastic - B-Cell Lymphoma-2 (Bcl-2) Inhibitors		
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG	Tier 8	Specialty; 30D; Specialty
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG	Tier 8	Specialty; 30D; Specialty
Antineoplastic - Braf Kinase Inhibitors		
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	Tier 4	PA; Specialty; 30D; Specialty
ZELBORAF ORAL TABLET 240 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Bruton's Tyrosine Kinase (Btk) Inhibitor		
IMBRUVICA ORAL CAPSULE 140 MG	Tier 4	PA; Specialty; QL/DS (DS-Limited to 14 day supply per prescription. QL-Limited to 56 capsules per 14 days for MCL or 42 capsules per 14 days for CLL &amp& WM); Specialty
Antineoplastic - Cyclin-Dependent Kinase (Cdk) 4/6 Inhibitors		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Epipodophyllotoxins		
etoposide oral capsule 50 mg	Tier 4	30D; Specialty
Antineoplastic - Estrogens		
EMCYT ORAL CAPSULE 140 MG	Tier 4	30D; Specialty
Antineoplastic - Hedgehog Pathway Inhibitor		
ERIVEDGE ORAL CAPSULE 150 MG	Tier 4	PA; Specialty; 30D; Specialty
ODOMZO ORAL CAPSULE 200 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Histone Deacetylase (Hdac) Inhibitors		
FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG	Tier 4	PA; Specialty; 30D; Specialty
ZOLINZA ORAL CAPSULE 100 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Interferons		
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML), 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	Tier 4	PA; Specialty; 30D; Specialty
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML, 6 MILLION UNIT/ML	Tier 4	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Janus Kinase (Jak) Inhibitors		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Mast Cell Stabilizers		
cromolyn oral concentrate 100 mg/5 ml	Tier 1	
GASTROCROM ORAL CONCENTRATE 100 MG/5 ML	Tier 3	
Antineoplastic - Mek1 And Mek2 Kinase Inhibitors		
COTELLIC ORAL TABLET 20 MG	Tier 8	Specialty; 30D; Specialty
MEKINIST ORAL TABLET 0.5 MG, 2 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Mtor Kinase Inhibitors		
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG	Tier 4	30D; Specialty
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Multikinase Inhibitors		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	Tier 4	PA; Specialty; 30D; Specialty
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)	Tier 4	30D; Specialty
ICLUSIG ORAL TABLET 15 MG, 45 MG	Tier 4	Specialty
NEXAVAR ORAL TABLET 200 MG	Tier 4	PA; Specialty; 30D; Specialty
STIVARGA ORAL TABLET 40 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Pi3k-Delta Inhibitors		
ZYDELIG ORAL TABLET 100 MG, 150 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Platinum Complexes		
carboplatin intravenous solution 10 mg/ml	Tier 6	30D
Antineoplastic - Progestins		
megestrol oral tablet 20 mg, 40 mg	Tier 1	
Antineoplastic - Proteasome Enzyme Inhibitors		
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	Tier 4	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
Antineoplastic - Protein-Tyrosine Kinase Inhibitors		
BOSULIF ORAL TABLET 100 MG, 500 MG	Tier 4	PA; Specialty; 30D; Specialty
CAPRELSA ORAL TABLET 100 MG, 300 MG	Tier 4	PA; Specialty; 30D; Specialty
GLEEVEC ORAL TABLET 100 MG, 400 MG	Tier 8	PA; Specialty; 30D; Specialty
imatinib oral tablet 100 mg, 400 mg	Tier 4	PA; Specialty; 30D; Specialty
IMBRUVICA ORAL CAPSULE 140 MG	Tier 4	PA; Specialty; 30D; Specialty
INLYTA ORAL TABLET 1 MG, 5 MG	Tier 4	PA; Specialty; 30D; Specialty
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1/DAY), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty
LENVIMA ORAL CAPSULE 24 MG/DAY(10 MG X 2-4 MG X 1)	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty; QL (1 capsule per 1 day)
OFEV ORAL CAPSULE 100 MG, 150 MG	Tier 4	30D; Specialty
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	Tier 4	PA; Specialty; 30D; Specialty
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG	Tier 4	PA; Specialty; 30D; Specialty
TASIGNA ORAL CAPSULE 150 MG, 200 MG	Tier 4	PA; Specialty; 30D; Specialty
VOTRIENT ORAL TABLET 200 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Retinoids		
TRETINOIN (CHEMOTHERAPY) ORAL CAPSULE 10 MG	Tier 4	Specialty; 30D; Specialty
Antineoplastic - Selective Estrogen Receptor Modulators (Serms)		
FARESTON ORAL TABLET 60 MG	Tier 5	
SOLTAMOX ORAL SOLUTION 10 MG/5 ML	Tier 5	
tamoxifen oral tablet 10 mg, 20 mg	Tier 5	
Antineoplastic - Selective Retinoid X Receptor Agonists		
bexarotene oral capsule 75 mg	Tier 4	PA; Specialty; 30D; Specialty
TARGRETIN ORAL CAPSULE 75 MG	Tier 8	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
Antineoplastic - Thalidomide Analogs		
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	Tier 4	PA; Specialty; 30D; Specialty
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	Tier 4	PA; Specialty; 30D; Specialty
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	Tier 4	PA; Specialty; 30D; Specialty
Antineoplastic - Topoisomerase I Inhibitors		
CAMPTOSAR INTRAVENOUS SOLUTION 40 MG/2 ML	Tier 6	30D
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG	Tier 4	Specialty
Antineoplastic Antibiotic - Anthracyclines		
LIPODOX 50 INTRAVENOUS SUSPENSION 2 MG/ML	Tier 6	Specialty; 30D; Specialty
Antineoplastic- Poly (Adp-Ribose) Polymerase (Parp) Inhibitors		
LYNPARZA ORAL CAPSULE 50 MG	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty; QL (224 capsules per 14 days)
Methotrexate Rescue Agents		
leucovorin calcium oral tablet 10 mg, 25 mg, 5 mg	Tier 1	
Methotrexate Rescue Agents - Folic Acid Antagonist Type		
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	Tier 1	
Urinary Tract Protective Agents Used In Conjunction With Chemotherapy		
MESNEX ORAL TABLET 400 MG	Tier 2	
Antiseptics And Disinfectants		
Antiseptic - Iodine/Iodophores		
IODOFLEX TOPICAL PADS, MEDICATED 0.9 %	Tier 3	
IODOSORB TOPICAL GEL 0.9 %	Tier 3	
Antiseptic - Others		
FORMADON TOPICAL SOLUTION 10 %	Tier 1	

Drug Name	Drug Tier	Notes
formaldehyde (bulk) solution 10 %	Tier 1	
formaldehyde topical solution with applicator 10 %	Tier 1	
FORMA-RAY SOLUTION 20 %	Tier 2	
Disinfectants - Aldehydes		
FORMADON TOPICAL SOLUTION 10 %	Tier 1	
Biologicals		
Allergenic Extracts - Grass Pollen		
GRASTEK SUBLINGUAL TABLET 2,800 BAU	Tier 3	PA; QL (1 tablet per 1 day)
ORALAIR SUBLINGUAL TABLET 100 IR (3) /300 IR (6)	Tier 3	PA; QL (1 tablet per 1 day)
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	Tier 3	PA; QL (1 tabet per 1 day)
Immune Globulin - Gamma Globulin (Igg), Human		
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 12 GRAM, 6 GRAM	Tier 6	PA; Specialty
CUVITRU SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %), 8 GRAM/40 ML (20 %)	Tier 6	PA
Vaccine Bacterial - Gram Negative Bacilli (Non-Enteric)		
HIBERIX (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	Tier 6	
Cardiovascular Therapy Agents		
Ace Inhibitor And Calcium Channel Blocker Combinations		
amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	Tier 1	Mand 90
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG, 5-40 MG	Tier 3	
PRESTALIA ORAL TABLET 14-10 MG, 3.5-2.5 MG, 7-5 MG	Tier 3	
TARKA ORAL TABLET, IR - ER, BIPHASIC 24HR 1-240 MG, 2-180 MG, 2-240 MG, 4-240 MG	Tier 3	
trandolapril-verapamil oral tablet, ir - er, biphasic 24hr 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
Ace Inhibitor And Diuretic Combinations		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG	Tier 3	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	Tier 1	Mand 90
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	Tier 1	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	Tier 1	Mand 90
fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg	Tier 1	Mand 90
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Tier 1	Mand 90
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG	Tier 3	
moexipril-hydrochlorothiazide oral tablet 15-12.5 mg, 15-25 mg, 7.5-12.5 mg	Tier 1	Mand 90
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Tier 1	Mand 90
VASERETIC ORAL TABLET 10-25 MG	Tier 3	
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG	Tier 3	
Ace Inhibitors		
ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG	Tier 3	
ACEON ORAL TABLET 4 MG, 8 MG	Tier 3	
ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG	Tier 3	
benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1	Mand 90
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	Tier 1	Mand 90
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Tier 1	Mand 90
EPANED ORAL RECON SOLN 1 MG/ML	Tier 3	
fosinopril oral tablet 10 mg, 20 mg, 40 mg	Tier 1	Mand 90
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	Tier 1	Mand 90
LOTENSIN ORAL TABLET 20 MG, 40 MG	Tier 3	
MAVIK ORAL TABLET 1 MG, 2 MG	Tier 3	
moexipril oral tablet 15 mg, 7.5 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	Tier 1	Mand 90
PRINIVIL ORAL TABLET 10 MG, 20 MG, 5 MG	Tier 3	
QBRELIS ORAL SOLUTION 1 MG/ML	Tier 3	
quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1	Mand 90
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	Tier 1	Mand 90
trandolapril oral tablet 1 mg, 2 mg, 4 mg	Tier 1	Mand 90
VASOTEC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	Tier 3	
ZESTRIL ORAL TABLET 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG	Tier 3	
Aldosterone Receptor Antagonists		
ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	
eplerenone oral tablet 25 mg, 50 mg	Tier 1	Mand 90
INSPRA ORAL TABLET 25 MG, 50 MG	Tier 3	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
Alpha-Beta Blockers		
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	Tier 1	Mand 90
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG	Tier 3	PA; Mand 90
COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG	Tier 3	
labetalol oral tablet 100 mg, 200 mg, 300 mg	Tier 1	Mand 90
Angiotensin Ii Receptor Blocker (Arb)-Beta-Adrenergic Blocker Comb.		
BYVALSON ORAL TABLET 5-80 MG	Tier 3	
Angiotensin Ii Receptor Blocker (Arb)-Calcium Channel Blocker Comb.		
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	Tier 1	
amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	Tier 1	Mand 90
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG	Tier 3	Mand 90
EXFORGE ORAL TABLET 10-160 MG, 10-320 MG, 5-160 MG, 5-320 MG	Tier 3	

Drug Name	Drug Tier	Notes
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	Tier 1	Mand 90
TWYNSTA ORAL TABLET 40-10 MG, 40-5 MG, 80-10 MG, 80-5 MG	Tier 3	
Angiotensin Ii Receptor Blocker (Arb)-Calcium Channel Blocker-Diuretic		
amlodipine-valsartan-hcthiazid oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	Tier 1	Mand 90
EXFORGE HCT ORAL TABLET 10-160-12.5 MG, 10-160-25 MG, 10-320-25 MG, 5-160-12.5 MG, 5-160-25 MG	Tier 3	
olmesartan-amlodipin-hcthiazid oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	Tier 1	
TRIBENZOR ORAL TABLET 20-5-12.5 MG, 40-10-12.5 MG, 40-10-25 MG, 40-5-12.5 MG, 40-5-25 MG	Tier 3	Mand 90
Angiotensin Ii Receptor Blocker (Arb)-Diuretic Combinations		
ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG	Tier 3	
AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG	Tier 3	
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG	Tier 3	Mand 90
candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	Tier 1	Mand 90
DIOVAN HCT ORAL TABLET 160-12.5 MG, 160-25 MG, 320-12.5 MG, 320-25 MG, 80-12.5 MG	Tier 3	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG	Tier 3	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	Tier 1	Mand 90
losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	Tier 1	Mand 90
MICARDIS HCT ORAL TABLET 40-12.5 MG, 80-12.5 MG, 80-25 MG	Tier 3	
olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	Tier 1	

Drug Name	Drug Tier	Notes
telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	Tier 1	Mand 90
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	Tier 1	Mand 90
Angiotensin Ii Receptor Blocker-Neprilysin Inhibitor Comb. (Arni)		
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	Tier 3	PA
Angiotensin Ii Receptor Blockers (Arbs)		
ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG	Tier 3	QL (1 tablet per 1 day)
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG	Tier 3	QL (1 tablet per 1 day)
BENICAR ORAL TABLET 20 MG, 40 MG, 5 MG	Tier 3	Mand 90; QL (1 tab per 1 day)
candesartan oral tablet 16 mg, 32 mg, 4 mg, 8 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	
DIOVAN ORAL TABLET 160 MG, 320 MG, 40 MG, 80 MG	Tier 3	QL (1 tablet per 1 day)
EDARBI ORAL TABLET 40 MG, 80 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
eprosartan oral tablet 600 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
irbesartan oral tablet 150 mg, 300 mg, 75 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
losartan oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
MICARDIS ORAL TABLET 20 MG, 40 MG, 80 MG	Tier 3	QL (1 tablet per 1 day)
olmesartan oral tablet 20 mg, 40 mg, 5 mg	Tier 1	QL (1 tablet per 1 day)
telmisartan oral tablet 20 mg, 40 mg, 80 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
Antianginal - Coronary Vasodilators (Nitrates)		
DILATRATE-SR ORAL CAPSULE, EXTENDED RELEASE 40 MG	Tier 2	
ISOCHRON ORAL TABLET EXTENDED RELEASE 40 MG	Tier 3	
ISORDIL ORAL TABLET 40 MG	Tier 3	
ISORDIL TITRADOSE ORAL TABLET 5 MG	Tier 3	

Drug Name	Drug Tier	Notes
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	Tier 1	Mand 90
isosorbide dinitrate oral tablet extended release 40 mg	Tier 1	Mand 90
isosorbide mononitrate oral tablet 10 mg, 20 mg	Tier 1	Mand 90
isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg	Tier 1	Mand 90
MINITRAN TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR	Tier 1	Mand 90
NITRO-BID TRANSDERMAL OINTMENT 2 %	Tier 2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR	Tier 3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	Tier 2	
nitroglycerin oral capsule, extended release 2.5 mg, 6.5 mg, 9 mg	Tier 1	Mand 90
nitroglycerin sublingual tablet 0.3 mg, 0.4 mg, 0.6 mg	Tier 1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	Tier 1	Mand 90
nitroglycerin translingual aerosol,spray 400 mcg/spray	Tier 1	Mand 90
nitroglycerin translingual spray,non-aerosol 400 mcg/spray	Tier 1	Mand 90
NITROLINGUAL TRANSLINGUAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	Tier 3	
NITROMIST TRANSLINGUAL AEROSOL,SPRAY 400 MCG/SPRAY	Tier 3	
NITROSTAT SUBLINGUAL TABLET 0.3 MG, 0.4 MG, 0.6 MG	Tier 3	
Antianginal And Anti-Ischemic Agents, Non-Hemodynamic		
RANEXA ORAL TABLET EXTENDED RELEASE 12 HR 1,000 MG, 500 MG	Tier 2	
Antiarrhythmic - Class Ia		
disopyramide phosphate oral capsule 100 mg, 150 mg	Tier 1	Mand 90
NORPACE CR ORAL CAPSULE, EXTENDED RELEASE 100 MG, 150 MG	Tier 3	

Drug Name	Drug Tier	Notes
NORPACE ORAL CAPSULE 100 MG, 150 MG	Tier 3	
quinidine gluconate oral tablet extended release 324 mg	Tier 1	
quinidine sulfate oral tablet 200 mg, 300 mg	Tier 1	
Antiarrhythmic - Class Ib		
mexiletine oral capsule 150 mg, 200 mg, 250 mg	Tier 1	
Antiarrhythmic - Class Ic		
flecainide oral tablet 100 mg, 150 mg	Tier 1	Mand 90
flecainide oral tablet 50 mg	Tier 1	
propafenone oral capsule,extended release 12 hr 225 mg, 325 mg, 425 mg	Tier 1	Mand 90
propafenone oral tablet 150 mg, 225 mg, 300 mg	Tier 1	Mand 90
RYTHMOL ORAL TABLET 225 MG	Tier 3	
RYTHMOL SR ORAL CAPSULE,EXTENDED RELEASE 12 HR 225 MG, 325 MG, 425 MG	Tier 3	
Antiarrhythmic - Class Ii		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	
BETAPACE ORAL TABLET 120 MG, 160 MG, 240 MG, 80 MG	Tier 3	
sorine oral tablet 120 mg, 160 mg, 240 mg, 80 mg	Tier 1	Mand 90
sotalol af oral tablet 120 mg, 160 mg, 80 mg	Tier 1	Mand 90
sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg	Tier 1	Mand 90
SOTYLIZE ORAL SOLUTION 5 MG/ML	Tier 3	
Antiarrhythmic - Class Iii		
amiodarone oral tablet 100 mg, 200 mg, 400 mg	Tier 1	Mand 90
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	Tier 1	
MULTAQ ORAL TABLET 400 MG	Tier 2	
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	Tier 1	Mand 90
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG	Tier 3	Mand 90
Antiarrhythmic - Class Iv		
CALAN ORAL TABLET 120 MG, 80 MG	Tier 3	
verapamil oral tablet 120 mg, 40 mg, 80 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
Antihyperlipidemic - Apolipoprotein B-100 Synthesis Inhibitor		
KYNAMRO SUBCUTANEOUS SYRINGE 200 MG/ML	Tier 4	PA; Specialty; 30D; Specialty
Antihyperlipidemic - Bile Acid Sequestrants		
cholestyramine (with sugar) oral powder 4 gram	Tier 1	Mand 90
cholestyramine (with sugar) oral powder in packet 4 gram	Tier 1	Mand 90
cholestyramine light oral powder 4 gram	Tier 1	Mand 90
cholestyramine light oral powder in packet 4 gram	Tier 1	Mand 90
COLESTID ORAL PACKET 5 GRAM	Tier 3	
COLESTID ORAL TABLET 1 GRAM	Tier 3	
colestipol oral granules 5 gram	Tier 1	Mand 90
colestipol oral packet 5 gram	Tier 1	Mand 90
colestipol oral tablet 1 gram	Tier 1	Mand 90
prevalite oral powder 4 gram	Tier 1	Mand 90
prevalite oral powder in packet 4 gram	Tier 1	Mand 90
QUESTRAN ORAL POWDER IN PACKET 4 GRAM	Tier 3	
WELCHOL ORAL POWDER IN PACKET 3.75 GRAM	Tier 2	Mand 90
WELCHOL ORAL TABLET 625 MG	Tier 2	Mand 90
Antihyperlipidemic - Fibric Acid Derivatives		
ANTARA ORAL CAPSULE 30 MG, 90 MG	Tier 3	PA
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg	Tier 1	Mand 90
fenofibrate nanocrystallized oral tablet 145 mg, 48 mg	Tier 1	Mand 90
fenofibrate oral capsule 150 mg, 50 mg	Tier 1	Mand 90
fenofibrate oral tablet 120 mg	Tier 1	
fenofibrate oral tablet 160 mg, 54 mg	Tier 1	Mand 90
fenofibric acid (choline) oral capsule,delayed release(dr/ec) 135 mg, 45 mg	Tier 1	Mand 90
fenofibric acid oral tablet 105 mg, 35 mg	Tier 1	Mand 90
FENOGLIDE ORAL TABLET 120 MG, 40 MG	Tier 3	
FIBRICOR ORAL TABLET 105 MG, 35 MG	Tier 3	

Drug Name	Drug Tier	Notes
gemfibrozil oral tablet 600 mg	Tier 1	Mand 90
LIPOFEN ORAL CAPSULE 150 MG, 50 MG	Tier 3	
LOFIBRA ORAL CAPSULE 134 MG, 200 MG, 67 MG	Tier 3	
LOFIBRA ORAL TABLET 160 MG, 54 MG	Tier 3	
LOPID ORAL TABLET 600 MG	Tier 3	
TRICOR ORAL TABLET 145 MG, 48 MG	Tier 3	
TRIGLIDE ORAL TABLET 160 MG	Tier 3	PA
TRILIPIX ORAL CAPSULE,DELAYED RELEASE(DR/EC) 135 MG, 45 MG	Tier 3	
Antihyperlipidemic - Hmg Coa Reductase Inhibitors (Statins)		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 20 MG, 40 MG, 60 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
CRESTOR ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
fluvastatin oral capsule 20 mg, 40 mg	Tier 1	Mand 90; QL (1 capsule per 1 day)
LESCOL ORAL CAPSULE 20 MG, 40 MG	Tier 3	QL (1 capsule per 1 day)
LESCOL XL ORAL TABLET EXTENDED RELEASE 24 HR 80 MG	Tier 3	PA; QL (1 capsule per 1 day)
LIPITOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG	Tier 3	QL (1 tablet per 1 day)
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
lovastatin oral tablet 10 mg, 20 mg, 40 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG	Tier 3	QL (1 tablet per 1 day)
pravastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
rosuvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1	PA; Mand 90; QL (1 tablet per 1 day)
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
simvastatin oral tablet 80 mg	Tier 1	PA; Mand 90; QL (1 tablet per 1 day)
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG, 80 MG	Tier 3	QL (1 tablet per 1 day)
Antihyperlipidemic - Nicotinic Acid Derivatives		
niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
NIACOR ORAL TABLET 500 MG	Tier 1	
NIASPAN EXTENDED-RELEASE ORAL TABLET EXTENDED RELEASE 24 HR 1,000 MG, 500 MG, 750 MG	Tier 3	
Antihyperlipidemic - Selective Cholesterol Absorption Inhibitor		
ZETIA ORAL TABLET 10 MG	Tier 2	PA; Mand 90
Antihyperlipidemic Agents - Dietary Source		
LOVAZA ORAL CAPSULE 1 GRAM	Tier 3	PA
omega-3 acid ethyl esters oral capsule 1 gram	Tier 1	PA; Mand 90
VASCEPA ORAL CAPSULE 0.5 GRAM	Tier 3	PA
VASCEPA ORAL CAPSULE 1 GRAM	Tier 3	PA; Mand 90
Antihyperlipidemic Hmg Coa Reduct Inhib And Calcium Channel Blocker		
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 2.5-10 MG, 2.5-20 MG, 2.5-40 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	Tier 3	QL (1 tablet per 1 day)
Antihyperlipidemic-Hmg Coa Reduct Inhib And Cholesterol Absorp Inhibit		
VYTORIN 10-10 ORAL TABLET 10-10 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
VYTORIN 10-20 ORAL TABLET 10-20 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
VYTORIN 10-40 ORAL TABLET 10-40 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
VYTORIN 10-80 ORAL TABLET 10-80 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
Antihyperlipidemic-Microsomal Triglyceride Transfer Protein (Mtp)Inhib		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG	Tier 8	PA; Specialty; 30D; Specialty
Anti-Pcsk9 Monoclonal Antibodies		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML	Tier 4	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty; QL (1 injection per 14 days)

Drug Name	Drug Tier	Notes
PRALUENT SYRINGE SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/ML	Tier 4	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty; QL (1 injection per 14 days)
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML	Tier 4	PA; Specialty; 30D; Specialty
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML	Tier 4	PA; Specialty; QL/DS (1 (140mg/ml) injection per 14 days for patients with HeFH or clinical atherosclerotic cardiovascular disease OR 3 (140mg/ml) injections per 28 days for patients with HoFH); Specialty
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML	Tier 4	PA; Specialty; QL/DS (1 (140mg/ml) injection per 14 days for patients with HeFH or clinical atherosclerotic cardiovascular disease OR 3 (140mg/ml) injections per 28 days for patients with HoFH); Specialty
Beta Blockers Cardiac Selective		
atenolol oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
betaxolol oral tablet 10 mg, 20 mg	Tier 1	Mand 90
bisoprolol fumarate oral tablet 10 mg, 5 mg	Tier 1	Mand 90
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
LOPRESSOR INTRAVENOUS SOLUTION 5 MG/5 ML	Tier 6	
metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg	Tier 1	Mand 90
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 200 MG, 25 MG, 50 MG	Tier 3	
ZEBETA ORAL TABLET 10 MG, 5 MG	Tier 3	
Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity		
acebutolol oral capsule 200 mg, 400 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
SECTRAL ORAL CAPSULE 200 MG, 400 MG	Tier 3	
Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity		
LEVATOL ORAL TABLET 20 MG	Tier 3	Mand 90
pindolol oral tablet 10 mg, 5 mg	Tier 1	
Beta Blockers Non-Cardiac Selective		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG	Tier 3	
BETAPACE ORAL TABLET 120 MG, 160 MG, 240 MG, 80 MG	Tier 3	
CORGARD ORAL TABLET 20 MG, 40 MG, 80 MG	Tier 3	
HEMANGEOL ORAL SOLUTION 4.28 MG/ML	Tier 3	
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 160 MG, 60 MG, 80 MG	Tier 3	
INDERAL XL ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 80 MG	Tier 3	
INNOPRAN XL ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 80 MG	Tier 3	
nadolol oral tablet 20 mg, 40 mg, 80 mg	Tier 1	Mand 90
propranolol intravenous solution 1 mg/ml	Tier 3	
propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg	Tier 1	Mand 90
propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)	Tier 1	Mand 90
propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	Tier 1	Mand 90
sorine oral tablet 120 mg, 160 mg, 240 mg, 80 mg	Tier 1	Mand 90
sotalol af oral tablet 120 mg, 160 mg, 80 mg	Tier 1	Mand 90
sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg	Tier 1	Mand 90
SOTYLIZE ORAL SOLUTION 5 MG/ML	Tier 3	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	Tier 1	Mand 90
Bradykinin B2 Receptor Antagonists		
FIRAZYR SUBCUTANEOUS SYRINGE 30 MG/3 ML	Tier 8	PA; Specialty; 30D

Drug Name	Drug Tier	Notes
Calcium Channel Blockers - Benzothiazepines		
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	Tier 3	
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 120 MG	Tier 3	PA
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	Tier 3	
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	Tier 3	
CARTIA XT ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 300 MG	Tier 1	Mand 90
cartia xt oral capsule,extended release 24hr 240 mg	Tier 1	Mand 90
diltiazem hcl oral capsule, extended release 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	Tier 1	Mand 90
diltiazem hcl oral capsule,ext release degradable 120 mg, 180 mg, 240 mg	Tier 1	Mand 90
diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg	Tier 1	Mand 90
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	Tier 1	Mand 90
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	Tier 1	Mand 90
diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	Tier 1	Mand 90
dilt-xr oral capsule,ext release degradable 120 mg, 240 mg	Tier 1	Mand 90
DILT-XR ORAL CAPSULE,EXT RELEASE DEGRADABLE 180 MG	Tier 1	
matzim la oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	Tier 1	Mand 90
taztia xt oral capsule, extended release 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	Tier 1	Mand 90
TIAZAC ORAL CAPSULE, EXTENDED RELEASE 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	Tier 3	
Calcium Channel Blockers - Dihydropyridines		
ADALAT CC ORAL TABLET EXTENDED RELEASE 30 MG, 60 MG, 90 MG	Tier 3	

Drug Name	Drug Tier	Notes
afeditab cr oral tablet extended release 30 mg	Tier 1	Mand 90
AFEDITAB CR ORAL TABLET EXTENDED RELEASE 60 MG	Tier 1	Mand 90
amlodipine oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1	Mand 90
CARDENE IV INTRAVENOUS SOLUTION 25 MG/10 ML	Tier 6	
felodipine oral tablet extended release 24 hr 10 mg, 2.5 mg, 5 mg	Tier 1	
isradipine oral capsule 2.5 mg, 5 mg	Tier 1	Mand 90
nicardipine oral capsule 20 mg, 30 mg	Tier 1	Mand 90
NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24HR 30 MG, 60 MG	Tier 1	Mand 90
nifedipine oral capsule 10 mg, 20 mg	Tier 1	Mand 90
nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg	Tier 1	Mand 90
nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg	Tier 1	Mand 90
nisoldipine oral tablet extended release 24 hr 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	Tier 1	Mand 90
NORVASC ORAL TABLET 10 MG, 2.5 MG, 5 MG	Tier 3	
PROCARDIA ORAL CAPSULE 10 MG	Tier 3	
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24HR 30 MG, 60 MG, 90 MG	Tier 3	
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	Tier 3	
Calcium Channel Blockers - Dihydropyridines - Cerebrovascular Specific		
nimodipine oral capsule 30 mg	Tier 1	
NYMALIZE ORAL SOLUTION 60 MG/20 ML	Tier 3	
Calcium Channel Blockers - Phenylakylamines		
CALAN ORAL TABLET 120 MG, 80 MG	Tier 3	
CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 180 MG, 240 MG	Tier 3	
verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg	Tier 1	Mand 90
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg, 360 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
verapamil oral tablet 120 mg, 40 mg, 80 mg	Tier 1	Mand 90
verapamil oral tablet extended release 120 mg, 180 mg, 240 mg	Tier 1	Mand 90
VERELAN ORAL CAPSULE,EXT REL. PELLETS 24 HR 120 MG, 180 MG, 240 MG, 360 MG	Tier 3	
VERELAN PM ORAL CAPSULE, 24 HR ER PELLET CT 100 MG, 200 MG, 300 MG	Tier 3	
Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb.		
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	Tier 1	Mand 90
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	Tier 1	Mand 90
DUTOPROL ORAL TABLET EXTENDED RELEASE 24 HR 100-12.5 MG, 25-12.5 MG, 50-12.5 MG	Tier 3	Mand 90
LOPRESSOR HCT ORAL TABLET 50-25 MG	Tier 3	
metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg	Tier 1	Mand 90
TENORETIC 100 ORAL TABLET 100-25 MG	Tier 3	
TENORETIC 50 ORAL TABLET 50-25 MG	Tier 3	
ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG	Tier 3	
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents		
ADRENACLICK INJECTION AUTO-INJECTOR 0.15 MG/0.15 ML, 0.3 MG/0.3 ML	Tier 3	
epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.3 mg/0.3 ml	Tier 1	
epinephrine injection solution 1 mg/ml (1 ml)	Tier 3	
EPIPEN 2-PAK INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	Tier 2	
EPIPEN INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML	Tier 2	
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML	Tier 2	
Cardiovascular Sympathomimetics		
epinephrine injection solution 1 mg/ml (1 ml)	Tier 3	

Drug Name	Drug Tier	Notes
midodrine oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1	
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG	Tier 3	PA
Central Alpha-2 Agonists-Thiazide Diuretic And Related Comb.		
CLORPRES ORAL TABLET 0.1-15 MG, 0.2-15 MG, 0.3-15 MG	Tier 3	
methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg	Tier 1	
Central Alpha-2 Receptor Agonists		
CATAPRES ORAL TABLET 0.1 MG, 0.2 MG, 0.3 MG	Tier 3	
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY 0.1 MG/24 HR	Tier 3	
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY 0.2 MG/24 HR	Tier 3	
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY 0.3 MG/24 HR	Tier 3	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	Tier 1	Mand 90
clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr	Tier 1	Mand 90
guanfacine oral tablet 1 mg, 2 mg	Tier 1	Mand 90
methyldopa oral tablet 250 mg, 500 mg	Tier 1	Mand 90
TENEX ORAL TABLET 1 MG, 2 MG	Tier 3	
Digitalis Glycosides		
DIGITEK ORAL TABLET 125 MCG, 250 MCG	Tier 1	Mand 90
DIGOX ORAL TABLET 125 MCG, 250 MCG	Tier 1	Mand 90
digoxin oral solution 50 mcg/ml	Tier 1	
digoxin oral tablet 125 mcg, 250 mcg	Tier 1	Mand 90
LANOXIN INJECTION SOLUTION 250 MCG/ML	Tier 3	
LANOXIN ORAL TABLET 125 MCG, 250 MCG	Tier 2	Mand 90
Direct Acting Vasodilators		
hydralazine injection solution 20 mg/ml	Tier 6	Specialty
hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
minoxidil oral tablet 10 mg, 2.5 mg	Tier 1	
NITROPRESS INTRAVENOUS SOLUTION 25 MG/ML	Tier 6	Specialty

Drug Name	Drug Tier	Notes
Diuretic - Aldosterone Receptor Antagonist, Non-Selective		
ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
Diuretic - Aldosterone Receptor Antagonist, Selective		
eplerenone oral tablet 25 mg, 50 mg	Tier 1	Mand 90
INSPRA ORAL TABLET 25 MG, 50 MG	Tier 3	
Diuretic - Carbonic Anhydrase Inhibitors		
acetazolamide oral capsule, extended release 500 mg	Tier 1	
acetazolamide oral tablet 125 mg, 250 mg	Tier 1	
DIAMOX SEQUELS ORAL CAPSULE, EXTENDED RELEASE 500 MG	Tier 3	
methazolamide oral tablet 25 mg, 50 mg	Tier 1	
NEPTAZANE ORAL TABLET 25 MG, 50 MG	Tier 3	
Diuretic - Loop		
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	
DEMADEX ORAL TABLET 10 MG, 20 MG	Tier 3	
EDECRIN ORAL TABLET 25 MG	Tier 3	
ethacrynic acid oral tablet 25 mg	Tier 1	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	Tier 1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	Tier 1	Mand 90
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG	Tier 3	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	Tier 1	Mand 90
Diuretic - Potassium Sparing		
amiloride oral tablet 5 mg	Tier 1	
DYRENIUM ORAL CAPSULE 100 MG, 50 MG	Tier 3	Mand 90
Diuretic - Potassium Sparing-Thiazide And Related Combinations		
ALDACTAZIDE ORAL TABLET 25-25 MG, 50-50 MG	Tier 3	Mand 90
amiloride-hydrochlorothiazide oral tablet 5-50 mg	Tier 1	

Drug Name	Drug Tier	Notes
DYAZIDE ORAL CAPSULE 37.5-25 MG	Tier 3	
MAXZIDE ORAL TABLET 75-50 MG	Tier 3	
MAXZIDE-25MG ORAL TABLET 37.5-25 MG	Tier 3	
spironolacton-hydrochlorothiaz oral tablet 25-25 mg	Tier 1	Mand 90
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg, 50-25 mg	Tier 1	Mand 90
triamterene-hydrochlorothiazid oral tablet 37.5-25 mg	Tier 1	Mand 90
triamterene-hydrochlorothiazid oral tablet 75-50 mg	Tier 1	
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists		
SAMSCA ORAL TABLET 15 MG	Tier 8	PA; Specialty; 30D; Specialty; QL (1 tablet per 1 day)
SAMSCA ORAL TABLET 30 MG	Tier 8	PA; Specialty; 30D; Specialty; QL (2 tablets per 1 day)
Diuretic - Thiazides And Related		
chlorothiazide oral tablet 250 mg, 500 mg	Tier 1	
chlorthalidone oral tablet 25 mg, 50 mg	Tier 1	Mand 90
DIURIL ORAL SUSPENSION 250 MG/5 ML	Tier 3	
hydrochlorothiazide oral capsule 12.5 mg	Tier 1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	Tier 1	
indapamide oral tablet 1.25 mg, 2.5 mg	Tier 1	Mand 90
methyclothiazide oral tablet 5 mg	Tier 1	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1	Mand 90
MICROZIDE ORAL CAPSULE 12.5 MG	Tier 3	
Ganglionic Blocking, Non-Depolarizing		
VECAMYL ORAL TABLET 2.5 MG	Tier 8	
Hyperpolarization-Activated Cyclic Nucleotide-Gated Channel Inhibitors		
CORLANOR ORAL TABLET 5 MG, 7.5 MG	Tier 3	PA; QL (2 tablets per 1 day)
Muscarinic Receptor Antagonists		
ATROPEN INTRAMUSCULAR PEN INJECTOR 0.5 MG/0.7 ML, 1 MG/0.7 ML, 2 MG/0.7 ML	Tier 3	

Drug Name	Drug Tier	Notes
Non-Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb.		
CORZIDE ORAL TABLET 40-5 MG, 80-5 MG	Tier 3	
nadolol-bendroflumethiazide oral tablet 40-5 mg, 80-5 mg	Tier 1	Mand 90
propranolol-hydrochlorothiazid oral tablet 40-25 mg, 80-25 mg	Tier 1	
Pah Agents - Selective Prostacyclin Receptor (Ip) Agonists		
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	Tier 8	PA; Specialty; 30D; Specialty
UPTRAVI ORAL TABLETS,DOSE PACK 200 MCG (140)- 800 MCG (60)	Tier 8	PA; Specialty; 30D; Specialty
Patent Ductus Arteriosus (Pda) Treatment Agents, Prostaglandin-Type		
PROSTIN VR PEDIATRIC INJECTION SOLUTION 500 MCG/ML	Tier 3	
Peripheral Alpha-1 Receptor Blockers		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG	Tier 3	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24HR 4 MG, 8 MG	Tier 3	PA
DIBENZYLINE ORAL CAPSULE 10 MG	Tier 3	
doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg	Tier 1	Mand 90
MINIPRESS ORAL CAPSULE 1 MG, 2 MG, 5 MG	Tier 3	
phenoxybenzamine oral capsule 10 mg	Tier 1	
prazosin oral capsule 1 mg, 2 mg, 5 mg	Tier 1	Mand 90
terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg	Tier 1	
Peripheral Vasodilators, Single Agents		
isoxsuprine oral tablet 10 mg, 20 mg	Tier 1	
Pheochromocytoma, Agents To Treat		
DEMSER ORAL CAPSULE 250 MG	Tier 3	
Pulmonary Antihypertensive Agents - Prostacyclin-Type		
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG	Tier 8	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)	Tier 8	30D; Specialty
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)	Tier 8	30D; Specialty
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML	Tier 8	30D; Specialty
VENTAVIS INHALATION SOLUTION FOR NEBULIZATION 10 MCG/ML, 20 MCG/ML	Tier 8	30D; Specialty
Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	Tier 8	Specialty
Pulmonary Arterial Hypertension - Endothelin Receptor Antagonists		
LETAIRIS ORAL TABLET 10 MG, 5 MG	Tier 8	30D; Specialty
OPSUMIT ORAL TABLET 10 MG	Tier 8	Specialty; 30D; Specialty
TRACLEER ORAL TABLET 125 MG, 62.5 MG	Tier 4	Specialty; 30D; Specialty
Pulmonary Arterial Hypertension Agents-Selective Cgmp-Pde5 Inhibitors		
ADCIRCA ORAL TABLET 20 MG	Tier 4	PA; Specialty
REVATIO ORAL SUSPENSION FOR RECONSTITUTION 10 MG/ML	Tier 8	PA; 30D; Specialty
REVATIO ORAL TABLET 20 MG	Tier 8	PA; 30D; Specialty
sildenafil oral tablet 20 mg	Tier 1	PA; QL (30 tablets per 30 days)
Renin Inhibitor, Direct		
TEKTURNA ORAL TABLET 150 MG, 300 MG	Tier 2	Mand 90
Renin Inhibitor, Direct And Calcium Channel Blocker Combinations		
TEKAMLO ORAL TABLET 150-10 MG, 150-5 MG, 300-10 MG, 300-5 MG	Tier 2	Mand 90
Renin Inhibitor, Direct And Diuretic Combinations		
TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 MG	Tier 2	Mand 90

Drug Name	Drug Tier	Notes
Reserpine And Derivatives		
reserpine oral tablet 0.1 mg, 0.25 mg	Tier 1	
Vasodilator Combinations		
BIDIL ORAL TABLET 20-37.5 MG	Tier 3	
Central Nervous System Agents		
Antianxiety Agent - Antihistamine Type		
hydroxyzine hcl oral solution 10 mg/5 ml	Tier 1	AR; AR
hydroxyzine hcl oral solution 10 mg/5 ml (5 ml)	Tier 1	AR
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	Tier 1	AR; AR
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	Tier 1	AR; AR
VISTARIL ORAL CAPSULE 25 MG, 50 MG	Tier 3	AR; AR
Antianxiety Agent - Benzodiazepines		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	Tier 2	
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1	
alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg	Tier 1	
alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1	
ATIVAN ORAL TABLET 1 MG, 2 MG	Tier 3	
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	Tier 1	
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1	
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	Tier 1	
DIAZEPAM INTENSOL ORAL CONCENTRATE 5 MG/ML	Tier 2	
diazepam oral solution 5 mg/5 ml (1 mg/ml)	Tier 1	
diazepam oral tablet 10 mg, 2 mg, 5 mg	Tier 1	DDS
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG	Tier 3	
LORAZEPAM INTENSOL ORAL CONCENTRATE 2 MG/ML	Tier 1	
lorazepam oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	
oxazepam oral capsule 10 mg, 15 mg, 30 mg	Tier 1	
TRANXENE T-TAB ORAL TABLET 7.5 MG	Tier 3	

Drug Name	Drug Tier	Notes
VALIUM ORAL TABLET 10 MG, 2 MG, 5 MG	Tier 3	
XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG	Tier 3	
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG, 2 MG, 3 MG	Tier 3	
Antianxiety Agent - Dicarbamate Type		
meprobamate oral tablet 200 mg, 400 mg	Tier 1	
Antianxiety Agent - Non-Benzodiazepine		
buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	Tier 1	
Anticonvulsant - Ampa-Type Glutamate Receptor Antagonists		
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	Tier 3	
FYCOMPA ORAL TABLET 2 MG, 4 MG, 6 MG, 8 MG	Tier 3	
Anticonvulsant - Barbiturates And Derivatives		
MYSOLINE ORAL TABLET 250 MG, 50 MG	Tier 3	
phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)	Tier 1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	Tier 1	
primidone oral tablet 250 mg, 50 mg	Tier 1	
Anticonvulsant - Benzodiazepines		
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	Tier 1	
DIASTAT ACUDIAL RECTAL KIT 12.5-15-17.5-20 MG	Tier 2	
DIASTAT ACUDIAL RECTAL KIT 5-7.5-10 MG	Tier 3	
DIASTAT RECTAL KIT 2.5 MG	Tier 3	
diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg	Tier 1	
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG	Tier 3	
ONFI ORAL SUSPENSION 2.5 MG/ML	Tier 2	
ONFI ORAL TABLET 10 MG, 20 MG	Tier 2	

Drug Name	Drug Tier	Notes
Anticonvulsant - Carbamates		
felbamate oral suspension 600 mg/5 ml	Tier 1	
felbamate oral tablet 400 mg, 600 mg	Tier 1	
FELBATOL ORAL SUSPENSION 600 MG/5 ML	Tier 3	
FELBATOL ORAL TABLET 400 MG, 600 MG	Tier 3	
Anticonvulsant - Carboxylic Acid Derivatives		
DEPACON INTRAVENOUS SOLUTION 500 MG/5 ML (100 MG/ML)	Tier 6	
DEPAKENE ORAL CAPSULE 250 MG	Tier 2	
DEPAKENE ORAL SOLUTION 250 MG/5 ML	Tier 2	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG	Tier 2	
DEPAKOTE ORAL TABLET,DELAYED RELEASE (DR/EC) 125 MG, 250 MG, 500 MG	Tier 2	
DEPAKOTE SPRINKLES ORAL CAPSULE, SPRINKLE 125 MG	Tier 2	
divalproex oral capsule, sprinkle 125 mg	Tier 1	
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	Tier 1	
divalproex oral tablet,delayed release (dr/ec) 125 mg, 250 mg, 500 mg	Tier 1	
valproic acid (as sodium salt) oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)	Tier 1	
valproic acid oral capsule 250 mg	Tier 1	
Anticonvulsant - Functionalized Amino Acid		
VIMPAT ORAL SOLUTION 10 MG/ML	Tier 2	
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	Tier 2	
VIMPAT ORAL TABLETS,DOSE PACK 50 MG (14)- 100 MG (14)	Tier 2	
Anticonvulsant - Gaba Analogs		
gabapentin oral capsule 100 mg, 300 mg, 400 mg	Tier 1	
gabapentin oral solution 250 mg/5 ml	Tier 1	
gabapentin oral tablet 600 mg, 800 mg	Tier 1	

Drug Name	Drug Tier	Notes
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	Tier 2	QL (3 capsules per 1 day)
LYRICA ORAL CAPSULE 225 MG, 300 MG	Tier 2	QL (2 capsules per 1 day)
LYRICA ORAL SOLUTION 20 MG/ML	Tier 2	
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG	Tier 3	
NEURONTIN ORAL SOLUTION 250 MG/5 ML	Tier 3	
NEURONTIN ORAL TABLET 600 MG, 800 MG	Tier 3	
Anticonvulsant - Gaba Re-Uptake Inhibitor, Nipecotic Acid Derivatives		
GABITRIL ORAL TABLET 12 MG, 16 MG	Tier 2	
GABITRIL ORAL TABLET 2 MG, 4 MG	Tier 3	
tiagabine oral tablet 2 mg, 4 mg	Tier 1	
Anticonvulsant - Gaba Transaminase (Gaba-T) Inhibitor		
SABRIL ORAL POWDER IN PACKET 500 MG	Tier 3	
SABRIL ORAL TABLET 500 MG	Tier 2	
Anticonvulsant - Hydantoins		
CEREBYX INJECTION SOLUTION 100 MG PE/2 ML	Tier 3	
DILANTIN EXTENDED ORAL CAPSULE 100 MG	Tier 2	
DILANTIN INFATABS ORAL TABLET,CHEWABLE 50 MG	Tier 2	
DILANTIN ORAL CAPSULE 30 MG	Tier 2	
DILANTIN-125 ORAL SUSPENSION 125 MG/5 ML	Tier 2	
PEGANONE ORAL TABLET 250 MG	Tier 2	
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	Tier 3	
phenytoin oral suspension 125 mg/5 ml	Tier 1	
phenytoin oral tablet,chewable 50 mg	Tier 1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	Tier 1	
Anticonvulsant - Iminostilbene Derivatives		
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG	Tier 8	PA; 30D

Drug Name	Drug Tier	Notes
carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg	Tier 1	
carbamazepine oral suspension 100 mg/5 ml, 200 mg/10 ml	Tier 1	
carbamazepine oral tablet 200 mg	Tier 1	
carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg	Tier 1	
carbamazepine oral tablet,chewable 100 mg	Tier 1	
CARBATROL ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG	Tier 3	
EPITOL ORAL TABLET 200 MG	Tier 1	
oxcarbazepine oral suspension 300 mg/5 ml	Tier 1	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	Tier 1	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG, 600 MG	Tier 3	PA
TEGRETOL ORAL SUSPENSION 100 MG/5 ML	Tier 2	
TEGRETOL ORAL TABLET 200 MG	Tier 2	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 200 MG, 400 MG	Tier 2	
TRILEPTAL ORAL SUSPENSION 300 MG/5 ML	Tier 3	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG	Tier 3	
Anticonvulsant - Monosaccharide Derivatives		
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 100 MG, 150 MG, 200 MG, 25 MG, 50 MG	Tier 3	
TOPAMAX ORAL CAPSULE, SPRINKLE 15 MG, 25 MG	Tier 3	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG	Tier 3	
topiramate oral capsule, sprinkle 15 mg, 25 mg	Tier 1	
topiramate oral capsule,sprinkle,er 24hr 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	Tier 1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Tier 1	

Drug Name	Drug Tier	Notes
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG, 50 MG	Tier 3	PA
Anticonvulsant - Phenyltriazine Derivatives		
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG, 200 MG, 25 MG, 50 MG	Tier 3	
LAMICTAL ODT STARTER (BLUE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG (21) -50 MG (7)	Tier 3	
LAMICTAL ODT STARTER (GREEN) ORAL TABLET DISINTEGRATING, DOSE PK 50 MG (42) -100 MG (14)	Tier 3	
LAMICTAL ODT STARTER (ORANGE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG(14)-50 MG (14)-100 MG (7)	Tier 3	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG	Tier 3	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	Tier 3	
LAMICTAL STARTER (BLUE) KIT ORAL TABLETS,DOSE PACK 25 MG (35)	Tier 3	
LAMICTAL STARTER (GREEN) KIT ORAL TABLETS,DOSE PACK 25 MG (84) -100 MG (14)	Tier 2	
LAMICTAL STARTER (ORANGE) KIT ORAL TABLETS,DOSE PACK 25 MG (42) -100 MG (7)	Tier 2	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG	Tier 3	
LAMICTAL XR STARTER (BLUE) ORAL TABLET EXTENDED REL,DOSE PACK 25 MG (21) -50 MG (7)	Tier 2	
LAMICTAL XR STARTER (GREEN) ORAL TABLET EXTENDED REL,DOSE PACK 50 MG(14)-100MG (14)-200 MG (7)	Tier 2	
LAMICTAL XR STARTER (ORANGE) ORAL TABLET EXTENDED REL,DOSE PACK 25MG (14)-50 MG (14)-100MG (7)	Tier 2	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	Tier 1	

Drug Name	Drug Tier	Notes
lamotrigine oral tablet disintegrating, dose pk 25 mg (21) -50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg (42) -100 mg (14)	Tier 1	
lamotrigine oral tablet extended release 24hr 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	Tier 1	
lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg	Tier 1	
lamotrigine oral tablet,disintegrating 100 mg, 200 mg, 25 mg, 50 mg	Tier 1	
lamotrigine oral tablets,dose pack 25 mg (35)	Tier 1	
Anticonvulsant - Potassium Channel Opener		
POTIGA ORAL TABLET 200 MG, 300 MG, 400 MG, 50 MG	Tier 3	
Anticonvulsant - Pyrrolidine Derivatives		
BRIVIACT ORAL SOLUTION 10 MG/ML	Tier 8	Specialty; 30D; Specialty
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	Tier 8	Specialty; 30D; Specialty
KEPPRA INTRAVENOUS SOLUTION 500 MG/5 ML	Tier 6	
KEPPRA ORAL SOLUTION 100 MG/ML	Tier 3	
KEPPRA ORAL TABLET 1,000 MG, 250 MG, 500 MG, 750 MG	Tier 3	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG, 750 MG	Tier 3	
levetiracetam oral solution 100 mg/ml	Tier 1	
levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg	Tier 1	
levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg	Tier 1	
ROWEEPRA ORAL TABLET 500 MG	Tier 3	
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 250 MG, 500 MG, 750 MG	Tier 3	
Anticonvulsant - Succinimides		
CELONTIN ORAL CAPSULE 300 MG	Tier 2	
ethosuximide oral capsule 250 mg	Tier 1	
ethosuximide oral solution 250 mg/5 ml	Tier 1	
ZARONTIN ORAL CAPSULE 250 MG	Tier 3	
ZARONTIN ORAL SOLUTION 250 MG/5 ML	Tier 3	

Drug Name	Drug Tier	Notes
Anticonvulsant - Sulfonamide Derivatives		
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	Tier 3	
zonisamide oral capsule 100 mg, 25 mg, 50 mg	Tier 1	
Anticonvulsant - Triazole Derivatives		
BANZEL ORAL SUSPENSION 40 MG/ML	Tier 2	
BANZEL ORAL TABLET 200 MG, 400 MG	Tier 2	
Antidepressant - Alpha-2 Receptor Antagonists (Nassa)		
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	Tier 1	
mirtazapine oral tablet,disintegrating 15 mg, 30 mg, 45 mg	Tier 1	
REMERON ORAL TABLET 15 MG, 30 MG, 45 MG	Tier 3	
REMERON SOLTAB ORAL TABLET,DISINTEGRATING 15 MG, 30 MG, 45 MG	Tier 3	
Antidepressant - Mao Inhibitor Nonselective And Irreversible-Types A,B		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR	Tier 3	
MARPLAN ORAL TABLET 10 MG	Tier 3	
NARDIL ORAL TABLET 15 MG	Tier 3	
PARNATE ORAL TABLET 10 MG	Tier 3	
phenelzine oral tablet 15 mg	Tier 1	
tranylcypromine oral tablet 10 mg	Tier 1	
Antidepressant - Selective Serotonin Reuptake Inhibitors (Ssris)		
CELEXA ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	
citalopram oral solution 10 mg/5 ml	Tier 1	
citalopram oral tablet 10 mg, 20 mg, 40 mg	Tier 1	
escitalopram oxalate oral solution 5 mg/5 ml	Tier 1	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	Tier 1	QL (1 tablet per 1 day)
fluoxetine oral capsule 10 mg, 20 mg, 40 mg	Tier 1	
fluoxetine oral capsule,delayed release(dr/ec) 90 mg	Tier 1	QL (12 EA per 90 days)

Drug Name	Drug Tier	Notes
fluoxetine oral solution 20 mg/5 ml (4 mg/ml)	Tier 1	
fluoxetine oral tablet 10 mg, 20 mg	Tier 1	PA
fluoxetine oral tablet 60 mg	Tier 1	
fluvoxamine oral capsule,extended release 24hr 100 mg, 150 mg	Tier 1	PA; QL (1 capsule per 1 day)
fluvoxamine oral tablet 100 mg, 25 mg, 50 mg	Tier 1	
LEXAPRO ORAL SOLUTION 5 MG/5 ML	Tier 3	
LEXAPRO ORAL TABLET 10 MG, 20 MG, 5 MG	Tier 3	QL (1 tablet per 1 day)
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	Tier 1	
paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg	Tier 1	
PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HR 12.5 MG, 25 MG, 37.5 MG	Tier 3	
PAXIL ORAL SUSPENSION 10 MG/5 ML	Tier 2	
PAXIL ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG	Tier 3	
PEXEVA ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG	Tier 3	PA
PROZAC ORAL CAPSULE 10 MG, 20 MG, 40 MG	Tier 3	
PROZAC WEEKLY ORAL CAPSULE,DELAYED RELEASE(DR/EC) 90 MG	Tier 3	PA
SARAFEM ORAL TABLET 10 MG, 20 MG	Tier 3	PA
sertraline oral concentrate 20 mg/ml	Tier 1	
sertraline oral tablet 100 mg, 25 mg, 50 mg	Tier 1	
ZOLOFT ORAL CONCENTRATE 20 MG/ML	Tier 3	
ZOLOFT ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	
Antidepressant - Serotonin-2 Antagonist-Reuptake Inhibitors (Saris)		
nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	Tier 1	
OLEPTRO ER ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	Tier 3	PA
trazodone oral tablet 100 mg, 150 mg, 300 mg, 50 mg	Tier 1	

Drug Name	Drug Tier	Notes
Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors (Snris)		
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG, 30 MG, 60 MG	Tier 3	
desvenlafaxine oral tablet extended release 24 hr 100 mg, 50 mg	Tier 3	
desvenlafaxine oral tablet extended release 24hr 100 mg, 50 mg	Tier 3	
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 40 mg, 60 mg	Tier 1	
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG, 75 MG	Tier 3	QL (1 capsule per 1 day)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	Tier 3	PA
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG	Tier 3	PA
IRENKA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40 MG	Tier 3	
KHEDEZLA ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 50 MG	Tier 3	
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 25 MG, 50 MG	Tier 2	QL (1 tablet per 1 day)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	Tier 2	PA
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)	Tier 2	PA
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg, 75 mg	Tier 1	QL (1 capsule per 1 day)
venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	Tier 1	
venlafaxine oral tablet extended release 24hr 150 mg, 225 mg, 75 mg	Tier 1	QL (1 tablet per 1 day)
venlafaxine oral tablet extended release 24hr 37.5 mg	Tier 1	
Antidepressant - Ssri And 5Ht1a Partial Agonist		
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG	Tier 3	PA; QL (1 tablet per 1 day)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	Tier 3	PA; QL (1 tablet per 1 day)

Drug Name	Drug Tier	Notes
Antidepressant - Ssri And Serotonin (5-Ht) Receptor Modulator		
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	Tier 3	PA (New)
Antidepressant - Tricyclic And Antipsychotic, Phenothiazine Comb		
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	Tier 1	
Antidepressant - Tricyclic-Benzodiazepine Combinations		
amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg	Tier 1	
Antidepressant- Ssri And Atypical Antipsych,Dopamine,Serotonin Antagon		
olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	Tier 1	
SYMBYAX ORAL CAPSULE 12-25 MG, 12-50 MG, 3-25 MG, 6-25 MG, 6-50 MG	Tier 3	
Antidepressant-Norepinephrine And Dopamine Reuptake Inhibitors (Ndris)		
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HR 174 MG, 348 MG, 522 MG	Tier 3	PA
bupropion hcl oral tablet 100 mg, 75 mg	Tier 1	
bupropion hcl oral tablet extended release 100 mg, 150 mg, 200 mg	Tier 1	
bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg	Tier 1	QL (1 tablet per 1 day)
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	Tier 3	
WELLBUTRIN SR ORAL TABLET EXTENDED RELEASE 100 MG, 150 MG, 200 MG	Tier 3	
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	Tier 3	QL (1 tablet per 1 day)
Antidepressant-Tricyclics And Related (Non-Select Reuptake Inhibitors)		
amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Tier 1	AR; AR
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	Tier 1	

Drug Name	Drug Tier	Notes
ANAFRANIL ORAL CAPSULE 25 MG, 50 MG, 75 MG	Tier 3	
clomipramine oral capsule 25 mg, 50 mg, 75 mg	Tier 1	
desipramine oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Tier 1	
doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Tier 1	
doxepin oral concentrate 10 mg/ml	Tier 1	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	Tier 1	AR; AR
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	Tier 1	AR; AR
maprotiline oral tablet 25 mg, 50 mg, 75 mg	Tier 1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG	Tier 3	
nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg	Tier 1	
PAMELOR ORAL CAPSULE 10 MG, 25 MG, 50 MG, 75 MG	Tier 3	
protriptyline oral tablet 10 mg, 5 mg	Tier 1	
SURMONTIL ORAL CAPSULE 100 MG, 25 MG, 50 MG	Tier 3	
TOFRANIL ORAL TABLET 10 MG, 25 MG, 50 MG	Tier 3	AR; AR
trimipramine oral capsule 100 mg, 25 mg, 50 mg	Tier 1	
Antiparkinson - Dopaminergic-Periph Comt-Dopa-Decarboxylase Inhib Comb		
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	Tier 1	
STALEVO 100 ORAL TABLET 25-100-200 MG	Tier 3	
STALEVO 125 ORAL TABLET 31.25-125-200 MG	Tier 3	
STALEVO 150 ORAL TABLET 37.5-150-200 MG	Tier 3	
STALEVO 200 ORAL TABLET 50-200-200 MG	Tier 3	
STALEVO 50 ORAL TABLET 12.5-50-200 MG	Tier 3	
STALEVO 75 ORAL TABLET 18.75-75-200 MG	Tier 3	

Drug Name	Drug Tier	Notes
Antiparkinson - Dopaminerg-Peripheral Dopa-Decarboxylase Inhibit Comb		
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	Tier 1	Mand 90
carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg	Tier 1	Mand 90
carbidopa-levodopa oral tablet,disintegrating 10-100 mg, 25-100 mg, 25-250 mg	Tier 1	Mand 90
DUOPA J-TUBE INTESTINAL PUMP SUSPENSION 4.63-20 MG/ML	Tier 3	PA; QL (100 ml per 1 day)
RYTARY ORAL CAPSULE, EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG	Tier 3	PA
SINEMET CR ORAL TABLET EXTENDED RELEASE 25-100 MG, 50-200 MG	Tier 3	
SINEMET ORAL TABLET 10-100 MG, 25-100 MG, 25-250 MG	Tier 3	
Antiparkinson Adjuvant - Central/Peripheral Comt Inhibitors		
TASMAR ORAL TABLET 100 MG	Tier 8	30D; Specialty
tolcapone oral tablet 100 mg	Tier 4	Specialty; 30D; Specialty
Antiparkinson Adjuvant - Peripheral Comt Inhibitors		
COMTAN ORAL TABLET 200 MG	Tier 3	
entacapone oral tablet 200 mg	Tier 1	
Antiparkinson Adjuvant - Peripheral Dopa-Decarboxylase Inhibitors		
carbidopa oral tablet 25 mg	Tier 1	
LODOSYN ORAL TABLET 25 MG	Tier 3	
Antiparkinson Therapy - Anticholinergic Agents		
benztropine oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	Mand 90
COGENTIN INJECTION SOLUTION 2 MG/2 ML	Tier 3	
trihexyphenidyl oral elixir 0.4 mg/ml	Tier 1	
trihexyphenidyl oral tablet 2 mg, 5 mg	Tier 1	
Antiparkinson Therapy - Ergot Alkaloids And Derivatives		
bromocriptine oral capsule 5 mg	Tier 1	
bromocriptine oral tablet 2.5 mg	Tier 1	

Drug Name	Drug Tier	Notes
PARLODEL ORAL CAPSULE 5 MG	Tier 3	
PARLODEL ORAL TABLET 2.5 MG	Tier 3	
Antiparkinson Therapy - Monoamine Oxidase Inhibitor(Mao-B)		
AZILECT ORAL TABLET 0.5 MG, 1 MG	Tier 2	
ELDEPRYL ORAL CAPSULE 5 MG	Tier 3	Mand 90
selegiline hcl oral capsule 5 mg	Tier 1	Mand 90
selegiline hcl oral tablet 5 mg	Tier 1	Mand 90
ZELAPAR ORAL TABLET,DISINTEGRATING 1.25 MG	Tier 3	
Antiparkinson Therapy - Non-Ergot Dopamine Agonist Agents		
amantadine hcl oral capsule 100 mg	Tier 1	
amantadine hcl oral solution 50 mg/5 ml	Tier 1	
amantadine hcl oral tablet 100 mg	Tier 1	
APOKYN SUBCUTANEOUS CARTRIDGE 10 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HR 0.375 MG, 0.75 MG, 1.5 MG, 2.25 MG, 3 MG, 3.75 MG, 4.5 MG	Tier 3	
MIRAPEX ORAL TABLET 0.125 MG, 0.25 MG, 0.5 MG, 0.75 MG, 1 MG, 1.5 MG	Tier 3	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR	Tier 3	
pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	Tier 1	
pramipexole oral tablet extended release 24 hr 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg	Tier 1	
REQUIP ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG, 5 MG	Tier 3	
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	Tier 3	
ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	Tier 1	
ropinirole oral tablet extended release 24 hr 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	Tier 1	

Drug Name	Drug Tier	Notes
Antipsychotic - Atyp Dopamine-Serotonin Antag Dibenzo-Oxepino Pyrroles		
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG	Tier 2	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Benzisothiazolones		
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG	Tier 3	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG	Tier 3	PA
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	Tier 1	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Benzisoxazole Deriv		
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	Tier 3	
FANAPT ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)- 4MG(2)-6MG(2)	Tier 3	
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 1.5 MG, 3 MG, 6 MG, 9 MG	Tier 3	
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg	Tier 1	
RISPERDAL M-TAB ORAL TABLET,DISINTEGRATING 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	Tier 3	
RISPERDAL ORAL SOLUTION 1 MG/ML	Tier 3	
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	Tier 3	
risperidone oral solution 1 mg/ml	Tier 1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Tier 1	
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Tier 1	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Dibenzodiazepine Der		
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Tier 1	

Drug Name	Drug Tier	Notes
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	Tier 1	
CLOZARIL ORAL TABLET 100 MG, 25 MG	Tier 3	
FAZACLO ORAL TABLET,DISINTEGRATING 100 MG, 12.5 MG, 150 MG, 200 MG, 25 MG	Tier 3	
VERSACLOZ ORAL SUSPENSION 50 MG/ML	Tier 3	
Antipsychotic - Butyrophenone Derivatives		
haloperidol lactate oral concentrate 2 mg/ml	Tier 1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	Tier 1	
Antipsychotic - Dibenzoxazepine Derivatives		
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	Tier 1	
Antipsychotic - Diphenylbutylpiperidine Derivatives		
ORAP ORAL TABLET 1 MG, 2 MG	Tier 3	
pimozide oral tablet 1 mg, 2 mg	Tier 1	
Antipsychotic - Phenothiazines, Aliphatic		
chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	Tier 1	
Antipsychotic - Phenothiazines, Piperazine		
fluphenazine hcl oral concentrate 5 mg/ml	Tier 1	
fluphenazine hcl oral elixir 2.5 mg/5 ml	Tier 1	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	Tier 1	
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	Tier 1	
trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg	Tier 1	
Antipsychotic - Phenothiazines, Piperidine		
thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg	Tier 1	
Antipsychotic - Thioxanthenes		
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	Tier 1	

Drug Name	Drug Tier	Notes
Antipsychotic -Atypical Dopamine-Serotonin Antag-Dibenzothiazepine Der		
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	Tier 1	
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	Tier 1	
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG	Tier 3	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG	Tier 3	
SEROQUEL XR ORAL TABLET, EXT REL 24HR DOSE PACK 50 MG(3)-200 MG (1)-300 MG(11)	Tier 3	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Thienobenzodiazepines		
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	Tier 1	QL (1 tablet per 1 day)
olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg	Tier 1	QL (1 tablet per 1 day)
ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG, 7.5 MG	Tier 3	QL (1 tablet per 1 day)
ZYPREXA ORAL TABLET 15 MG	Tier 3	QL (1 tablets per 1 day)
ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 10 MG, 15 MG, 20 MG, 5 MG	Tier 3	QL (1 tablet per 1 day)
Antipsychotic-Atyp Selective Serotonin 5-Ht2a Inverse Agonists (Ssia)		
NUPLAZID ORAL TABLET 17 MG	Tier 3	
Antipsychotic-Atypical,D3/D2 Receptor Partial Agonist-Serotonin Mixed		
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	Tier 8	Specialty; 30D; Specialty
VRAYLAR ORAL CAPSULE,DOSE PACK 1.5 MG (1)- 3 MG (6)	Tier 8	Specialty; 30D; Specialty
Attention Deficit-Hyperact. Disorder (Adhd)- Alpha-2 Receptor Agonist		
clonidine hcl oral tablet extended release 12 hr 0.1 mg	Tier 1	

Drug Name	Drug Tier	Notes
guanfacine oral tablet extended release 24 hr 1 mg	Tier 1	PA; QL (1 tablet per 1 day)
guanfacine oral tablet extended release 24 hr 2 mg, 3 mg, 4 mg	Tier 1	PA; QL (1 tablet per 1 day)
INTUNIV ER ORAL TABLET EXTENDED RELEASE 24 HR 1 MG, 2 MG, 3 MG, 4 MG	Tier 3	PA; QL (1 tablet per 1 day)
KAPVAY ORAL TABLET EXTENDED RELEASE 12 HR 0.1 MG	Tier 3	
Attention Deficit-Hyperactivity (Adhd) Therapy, Stimulant-Type		
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG, 7.5 MG	Tier 3	
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG	Tier 1	
ADZENYS XR-ODT ORAL TABLET,DISINTIG ER BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG	Tier 3	
APTENSIO XR ORAL CAP,ER SPRINKLE,BIPHASIC 40-60 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG	Tier 3	PA
CONCERTA ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 36 MG, 54 MG	Tier 3	
DAYTRANA TRANSDERMAL PATCH 24 HOUR 10 MG/9 HR, 15 MG/9 HR, 20 MG/9 HR, 30 MG/9 HR	Tier 3	PA
DESOXYN ORAL TABLET 5 MG	Tier 3	
DEXEDRINE ORAL TABLET 10 MG, 5 MG	Tier 3	
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG, 15 MG, 5 MG	Tier 3	
dexmethylphenidate oral capsule,er biphasic 50-50 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 5 mg	Tier 1	
dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1	
dextroamphetamine oral capsule, extended release 10 mg, 15 mg, 5 mg	Tier 1	
dextroamphetamine oral tablet 10 mg, 5 mg	Tier 1	
dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	Tier 1	ED
dextroamphetamine-amphetamine oral tablet 15 mg, 20 mg, 30 mg, 5 mg	Tier 1	

Drug Name	Drug Tier	Notes
EVEKEO ORAL TABLET 10 MG, 5 MG	Tier 3	PA
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG	Tier 3	
FOCALIN XR ORAL CAPSULE,ER BIPHASIC 50-50 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	Tier 3	
FOCALIN XR ORAL CAPSULE,ER BIPHASIC 50-50 25 MG, 35 MG, 5 MG	Tier 3	PA
METADATE CD ORAL CAPSULE, ER BIPHASIC 30-70 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG	Tier 3	
metadate er oral tablet extended release 20 mg	Tier 1	
methamphetamine oral tablet 5 mg	Tier 1	
METHYLIN ORAL SOLUTION 10 MG/5 ML, 5 MG/5 ML	Tier 3	
METHYLIN ORAL TABLET,CHEWABLE 10 MG, 2.5 MG, 5 MG	Tier 3	
methylphenidate oral capsule, er biphasic 30-70 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	Tier 1	
methylphenidate oral capsule,er biphasic 50-50 20 mg, 30 mg, 40 mg	Tier 1	
methylphenidate oral solution 10 mg/5 ml, 5 mg/5 ml	Tier 1	
methylphenidate oral tablet 10 mg, 20 mg, 5 mg	Tier 1	
methylphenidate oral tablet extended release 10 mg, 20 mg	Tier 1	
methylphenidate oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg	Tier 1	
methylphenidate oral tablet,chewable 10 mg, 2.5 mg, 5 mg	Tier 1	
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 20 MG, 30 MG, 40 MG	Tier 3	
QUILLIVANT XR ORAL SUSPENSION,EXT REL 24HR,RECON 5 MG/ML (25 MG/5 ML)	Tier 3	PA
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG, 20 MG, 30 MG, 40 MG	Tier 3	
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG	Tier 3	
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG	Tier 3	PA; QL (1 capsule per 1 day)
ZENZEDI ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG, 30 MG, 5 MG, 7.5 MG	Tier 3	

Drug Name	Drug Tier	Notes
Attention Deficit-Hyperactivity Disorder (Adhd) Therapy, Nri-Type		
STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG	Tier 2	PA; QL (2 capsules per 1 day)
STRATTERA ORAL CAPSULE 100 MG, 60 MG, 80 MG	Tier 2	PA; QL (1 capsule per 1 day)
Benzodiazepines		
ONFI ORAL SUSPENSION 2.5 MG/ML	Tier 2	
ONFI ORAL TABLET 10 MG, 20 MG	Tier 2	
Bipolar Therapy Agents - Anticonvulsant Type		
carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg	Tier 1	
carbamazepine oral suspension 100 mg/5 ml, 200 mg/10 ml	Tier 1	
carbamazepine oral tablet 200 mg	Tier 1	
carbamazepine oral tablet extended release 12 hr 200 mg, 400 mg	Tier 1	
carbamazepine oral tablet,chewable 100 mg	Tier 1	
CARBATROL ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG	Tier 3	
DEPAKENE ORAL CAPSULE 250 MG	Tier 2	
DEPAKENE ORAL SOLUTION 250 MG/5 ML	Tier 2	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG	Tier 2	
DEPAKOTE ORAL TABLET,DELAYED RELEASE (DR/EC) 125 MG, 250 MG, 500 MG	Tier 2	
DEPAKOTE SPRINKLES ORAL CAPSULE, SPRINKLE 125 MG	Tier 2	
divalproex oral capsule, sprinkle 125 mg	Tier 1	
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	Tier 1	
divalproex oral tablet,delayed release (dr/ec) 125 mg, 250 mg, 500 mg	Tier 1	
EPITOL ORAL TABLET 200 MG	Tier 1	
EQUETRO ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG	Tier 3	

Drug Name	Drug Tier	Notes
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG, 200 MG, 25 MG, 50 MG	Tier 3	
LAMICTAL ODT STARTER (BLUE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG (21) -50 MG (7)	Tier 3	
LAMICTAL ODT STARTER (GREEN) ORAL TABLET DISINTEGRATING, DOSE PK 50 MG (42) -100 MG (14)	Tier 3	
LAMICTAL ODT STARTER (ORANGE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG(14)-50 MG (14)-100 MG (7)	Tier 3	
LAMICTAL STARTER (BLUE) KIT ORAL TABLETS,DOSE PACK 25 MG (35)	Tier 3	
LAMICTAL STARTER (GREEN) KIT ORAL TABLETS,DOSE PACK 25 MG (84) -100 MG (14)	Tier 2	
LAMICTAL STARTER (ORANGE) KIT ORAL TABLETS,DOSE PACK 25 MG (42) -100 MG (7)	Tier 2	
lamotrigine oral tablet disintegrating, dose pk 25 mg (21) -50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg (42) -100 mg (14)	Tier 1	
lamotrigine oral tablet,disintegrating 100 mg, 200 mg, 25 mg, 50 mg	Tier 1	
lamotrigine oral tablets,dose pack 25 mg (35)	Tier 1	
TEGRETOL ORAL SUSPENSION 100 MG/5 ML	Tier 2	
TEGRETOL ORAL TABLET 200 MG	Tier 2	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 200 MG, 400 MG	Tier 2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml, 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)	Tier 1	
valproic acid oral capsule 250 mg	Tier 1	
Bipolar Therapy Agents - Atypical Antipsychotics		
ABILIFY ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG	Tier 3	QL (1 tablet per 1 day)
aripiprazole oral solution 1 mg/ml	Tier 1	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	Tier 1	QL (1 tablet per 1 day)

Drug Name	Drug Tier	Notes
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG	Tier 3	
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	Tier 1	QL (1 tablet per 1 day)
olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg	Tier 1	QL (1 tablet per 1 day)
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	Tier 1	
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	Tier 1	
RISPERDAL M-TAB ORAL TABLET,DISINTEGRATING 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	Tier 3	
RISPERDAL ORAL SOLUTION 1 MG/ML	Tier 3	
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	Tier 3	
risperidone oral solution 1 mg/ml	Tier 1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Tier 1	
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Tier 1	
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG	Tier 2	
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG	Tier 3	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG	Tier 3	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	Tier 8	Specialty; 30D; Specialty
VRAYLAR ORAL CAPSULE,DOSE PACK 1.5 MG (1)- 3 MG (6)	Tier 8	Specialty; 30D; Specialty
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	Tier 1	
ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG, 7.5 MG	Tier 3	QL (1 tablet per 1 day)
ZYPREXA ORAL TABLET 15 MG	Tier 3	QL (1 tablets per 1 day)
ZYPREXA ZYDIS ORAL TABLET,DISINTEGRATING 10 MG, 15 MG, 20 MG, 5 MG	Tier 3	QL (1 tablet per 1 day)

Drug Name	Drug Tier	Notes
Bipolar Therapy Agents - Lithium		
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	Tier 1	
lithium carbonate oral tablet 300 mg	Tier 1	
lithium carbonate oral tablet extended release 300 mg, 450 mg	Tier 1	
lithium citrate oral solution 8 meq/5 ml, 8 meq/5 ml (5 ml)	Tier 1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG	Tier 3	
Cns Stimulant - Amphetamine Combinations		
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG, 7.5 MG	Tier 3	
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 5 MG	Tier 1	
ADZENYS XR-ODT ORAL TABLET,DISINTIG ER BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG	Tier 3	
dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg	Tier 1	ED
dextroamphetamine-amphetamine oral tablet 15 mg, 20 mg, 30 mg	Tier 1	
Cns Stimulant - Amphetamines		
DESOXYN ORAL TABLET 5 MG	Tier 3	
DEXEDRINE ORAL TABLET 10 MG, 5 MG	Tier 3	
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG, 15 MG, 5 MG	Tier 3	
dextroamphetamine oral capsule, extended release 10 mg, 15 mg, 5 mg	Tier 1	
dextroamphetamine oral solution 5 mg/5 ml	Tier 1	
dextroamphetamine oral tablet 10 mg, 5 mg	Tier 1	
EVEKEO ORAL TABLET 10 MG, 5 MG	Tier 3	PA
methamphetamine oral tablet 5 mg	Tier 1	
PROCENTRA ORAL SOLUTION 5 MG/5 ML	Tier 3	
ZENZEDI ORAL TABLET 10 MG, 5 MG	Tier 1	
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	Tier 3	

Drug Name	Drug Tier	Notes
Cns Stimulant - Analeptics		
caffeine citrated oral solution 60 mg/3 ml (20 mg/ml)	Tier 1	
Fibromyalgia Agents - Gaba Analogs		
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	Tier 2	QL (3 capsules per 1 day)
LYRICA ORAL CAPSULE 225 MG, 300 MG	Tier 2	QL (2 capsules per 1 day)
LYRICA ORAL SOLUTION 20 MG/ML	Tier 2	
Fibromyalgia Agents - Serotonin-Norepinephrine Reuptake-Inhib (Snris)		
CYMBALTA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG, 30 MG, 60 MG	Tier 3	
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 40 mg, 60 mg	Tier 1	
IRENKA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40 MG	Tier 3	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	Tier 2	PA
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)	Tier 2	PA
Hsdd Agents-Mixed Serotonin Agonist/Antagonists		
ADDYI ORAL TABLET 100 MG	Tier 8	PA; Specialty; 30D; Specialty
Hypnotics - Melatonin M1/M2 Receptor Agonists		
HETLIOZ ORAL CAPSULE 20 MG	Tier 3	PA; QL (1 capsule per 1 day)
ROZEREM ORAL TABLET 8 MG	Tier 3	PA; QL (1 tablet per 1 day)
Migraine Therapy - Analgesic-Vasoconstrictors		
isomethepten-caf-acetaminophen oral tablet 65-20-325 mg	Tier 1	
PRODRIN ORAL TABLET 65-20-325 MG	Tier 3	
Migraine Therapy - Analgesic-Vasoconstrictor-Sedative Combinations		
NODOLOR ORAL CAPSULE 65-100-325 MG	Tier 3	

Drug Name	Drug Tier	Notes
Migraine Therapy - Carboxylic Acid Derivatives		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG	Tier 2	
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	Tier 1	
Migraine Therapy - Ergot Alkaloids And Derivatives		
D.H.E.45 INJECTION SOLUTION 1 MG/ML	Tier 3	
dihydroergotamine injection solution 1 mg/ml	Tier 1	
dihydroergotamine nasal spray,non-aerosol 0.5 mg/pump act. (4 mg/ml)	Tier 1	PA; QL (8 units per 30 days)
MIGRANAL NASAL SPRAY,NON-AEROSOL 0.5 MG/PUMP ACT. (4 MG/ML)	Tier 3	PA; QL (8 units per 30 days)
Migraine Therapy - Ergot Combinations		
CAFERGOT ORAL TABLET 1-100 MG	Tier 3	PA; QL (40 tablets per 30 days)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG	Tier 3	PA; QL (20 suppositories per 30 days)
Migraine Therapy - Nsaid Analgesics(Cyclooxygenase Inhib-Non-Selectiv)		
CAMBIA ORAL POWDER IN PACKET 50 MG	Tier 3	PA
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1)		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	Tier 1	QL (9 tablets per 30 days)
ALSUMA SUBCUTANEOUS PEN INJECTOR 6 MG/0.5 ML	Tier 3	QL (6 injections per 30 days)
AMERGE ORAL TABLET 1 MG, 2.5 MG	Tier 3	QL (9 tablets per 30 days)
AXERT ORAL TABLET 12.5 MG, 6.25 MG	Tier 3	QL (9 tablets per 30 days)
FROVA ORAL TABLET 2.5 MG	Tier 3	PA; QL (9 tablets per 30 days)
frovatriptan oral tablet 2.5 mg	Tier 1	PA; QL (9 tablets per 30 days)
IMITREX NASAL SPRAY,NON-AEROSOL 20 MG/ACTUATION, 5 MG/ACTUATION	Tier 3	QL (6 units per 30 days)
IMITREX ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	QL (9 tablets per 30 days)

Drug Name	Drug Tier	Notes
IMITREX STATDOSE KIT REFILL SUBCUTANEOUS CARTRIDGE 4 MG/0.5 ML, 6 MG/0.5 ML	Tier 3	QL (6 injections per 30 days)
IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML, 6 MG/0.5 ML	Tier 3	QL (6 injections per 30 days)
IMITREX SUBCUTANEOUS SOLUTION 6 MG/0.5 ML	Tier 3	QL (6 injections per 30 days)
MAXALT ORAL TABLET 10 MG, 5 MG	Tier 3	QL (9 tablets per 30 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG, 5 MG	Tier 3	QL (9 tablets per 30 days)
naratriptan oral tablet 1 mg, 2.5 mg	Tier 1	QL (9 tablets per 30 days)
ONZETRA XSAIL NASAL AEROSOL POWDR BREATH ACTIVATED 11 MG	Tier 3	QL (6 units per 30 days)
RELPAX ORAL TABLET 20 MG, 40 MG	Tier 2	QL (9 tablets per 30 days)
rizatriptan oral tablet 10 mg, 5 mg	Tier 1	QL (9 tablets per 30 days)
rizatriptan oral tablet,disintegrating 10 mg, 5 mg	Tier 1	QL (9 tablets per 30 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation, 5 mg/actuation	Tier 1	QL (6 units per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	Tier 1	QL (9 tablets per 30 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml	Tier 1	QL (6 injections per 30 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml	Tier 1	QL (6 injections per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5 ml	Tier 1	QL (6 injections per 30 days)
sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml	Tier 1	QL (6 injections per 30 days)
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 4 MG/0.5 ML	Tier 8	PA; 30D; Specialty
SUMAVEL DOSEPRO SUBCUTANEOUS NEEDLE-FREE INJECTOR 6 MG/0.5 ML	Tier 8	PA; 30D; Specialty; QL (6 injections per 30 days)
ZEMBRACE SYMTOUCH SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML	Tier 3	QL (6 injections per 30 days)
zolmitriptan oral tablet 2.5 mg, 5 mg	Tier 1	QL (9 tablets per 30 days)
zolmitriptan oral tablet,disintegrating 2.5 mg, 5 mg	Tier 1	QL (9 tablets per 30 days)
ZOMIG NASAL SPRAY,NON-AEROSOL 2.5 MG, 5 MG	Tier 3	QL (6 units per 30 days)
ZOMIG ORAL TABLET 2.5 MG, 5 MG	Tier 3	QL (9 tablets per 30 days)

Drug Name	Drug Tier	Notes
ZOMIG ZMT ORAL TABLET,DISINTEGRATING 2.5 MG, 5 MG	Tier 3	QL (9 tablets per 30 days)
Migraine Therapy - Serotonin Agonist 5-Ht(1) And Nsaid Comb.		
TREXIMET ORAL TABLET 10-60 MG, 85-500 MG	Tier 3	PA; QL (9 tablets per 30 days)
Movement Disorder Therapy - Huntington's Disease		
tetrabenazine oral tablet 12.5 mg, 25 mg	Tier 4	PA; Specialty; 30D; Specialty
XENAZINE ORAL TABLET 12.5 MG, 25 MG	Tier 8	PA; Specialty; 30D; Specialty
Movement Disorder Therapy - Restless Legs Syndrome		
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG	Tier 3	PA; QL (1 tablet per 1 day)
Narcolepsy And Cataplexy Therapy Agents - Sedative-Type		
XYREM ORAL SOLUTION 500 MG/ML	Tier 4	PA; Specialty; 30D; QL (540 mls per 30 days)
Narcolepsy Therapy Agents - Non-Sympathomimetic		
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	Tier 1	PA; QL (1 tablet per 1 day)
modafinil oral tablet 100 mg, 200 mg	Tier 1	
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG, 50 MG	Tier 3	PA; QL (1 tablet per day per 1 day)
PROVIGIL ORAL TABLET 100 MG, 200 MG	Tier 3	
Narcolepsy Therapy Agents - Stimulant-Type, Piperadine Derivative		
METHYLIN ORAL SOLUTION 10 MG/5 ML, 5 MG/5 ML	Tier 3	
METHYLIN ORAL TABLET,CHEWABLE 10 MG, 2.5 MG, 5 MG	Tier 3	
methylphenidate oral solution 10 mg/5 ml, 5 mg/5 ml	Tier 1	
methylphenidate oral tablet 10 mg, 20 mg, 5 mg	Tier 1	
methylphenidate oral tablet,chewable 10 mg, 2.5 mg, 5 mg	Tier 1	
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG	Tier 3	

Drug Name	Drug Tier	Notes
Narcolepsy Therapy Agents-Stimulant-Type,Sympathomimetic,Amphetamines		
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG, 7.5 MG	Tier 3	
DEXEDRINE ORAL TABLET 10 MG, 5 MG	Tier 3	
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG, 15 MG, 5 MG	Tier 3	
dextroamphetamine oral capsule, extended release 10 mg, 15 mg, 5 mg	Tier 1	
dextroamphetamine oral tablet 10 mg, 5 mg	Tier 1	
dextroamphetamine-amphetamine oral tablet 15 mg, 20 mg, 30 mg, 5 mg	Tier 1	
EVEKEO ORAL TABLET 10 MG, 5 MG	Tier 3	PA
ZENZEDI ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG, 30 MG, 5 MG, 7.5 MG	Tier 3	
Postherpetic Neuralgia Agents		
GRALISE 30-DAY STARTER PACK ORAL TABLET EXTENDED RELEASE 24 HR 300 MG (9)- 600 MG (69)	Tier 3	PA
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG	Tier 3	PA
Pseudobulbar Affect (Pba) Agents, Nmda Antagonists Type		
NUEDEXTA ORAL CAPSULE 20-10 MG	Tier 3	PA
Sedative-Hypnotic - Antihistamines		
diphenhydramine hcl oral capsule 50 mg	Tier 1	
Sedative-Hypnotic - Barbiturates		
BUTISOL ORAL TABLET 30 MG	Tier 3	PA; QL (1 tablet per 1 day)
phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)	Tier 1	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	Tier 1	
SECONAL SODIUM ORAL CAPSULE 100 MG	Tier 3	PA; QL (1 capsule per 1 day)
Sedative-Hypnotic - Benzodiazepines		
estazolam oral tablet 1 mg, 2 mg	Tier 1	
flurazepam oral capsule 15 mg, 30 mg	Tier 1	
HALCION ORAL TABLET 0.25 MG	Tier 3	
midazolam oral syrup 2 mg/ml	Tier 1	

Drug Name	Drug Tier	Notes
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG	Tier 3	QL (1 capsule per 1 day)
temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg	Tier 1	QL (1 capsule per 1 day)
triazolam oral tablet 0.125 mg, 0.25 mg	Tier 1	
Sedative-Hypnotic - Gaba-Receptor Modulators		
AMBIEN CR ORAL TABLET,EXT RELEASE MULTIPHASE 12.5 MG, 6.25 MG	Tier 3	QL (1 tablet per 1 day)
AMBIEN ORAL TABLET 10 MG, 5 MG	Tier 3	QL (1 tablet per 1 day)
EDLUAR SUBLINGUAL TABLET 10 MG, 5 MG	Tier 3	PA; QL (1 tablet per 1 day)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	Tier 1	QL (1 tab per 1 day)
INTERMEZZO SUBLINGUAL TABLET 1.75 MG, 3.5 MG	Tier 3	PA; QL (1 tablet per 1 day)
LUNESTA ORAL TABLET 1 MG, 2 MG, 3 MG	Tier 3	QL (1 tablet per 1 day)
SONATA ORAL CAPSULE 10 MG, 5 MG	Tier 3	QL (1 capsule per 1 day)
zaleplon oral capsule 10 mg, 5 mg	Tier 1	QL (1 capsule per 1 day)
zolpidem oral tablet 10 mg, 5 mg	Tier 1	QL (1 tablet per 1 day)
zolpidem oral tablet,ext release multiphase 12.5 mg, 6.25 mg	Tier 1	QL (1 tablet per 1 day)
zolpidem sublingual tablet 1.75 mg, 3.5 mg	Tier 1	QL (1 tablet per 1 day)
ZOLPIMIST ORAL SPRAY,NON-AEROSOL 5 MG/SPRAY (0.1 ML)	Tier 3	PA; QL (1 spray per 1 day)
Sedative-Hypnotic - Orexin Receptor Antagonist		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	Tier 3	PA; QL (1 tablet per 1 day)
Sedative-Hypnotic - Tricyclic Antidepressant Type		
SILENOR ORAL TABLET 3 MG, 6 MG	Tier 3	PA; QL (1 tablet per 1 day)
Chemical Dependency, Agents To Treat		
Agents For Narcotic Withdrawal		
BUNAVAIL BUCCAL FILM 2.1-0.3 MG, 4.2-0.7 MG, 6.3-1 MG	Tier 3	PA; QL (2 films per 1 day)
buprenorphine hcl sublingual tablet 2 mg, 8 mg	Tier 1	PA; QL (3 tablets per 1 day)
buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg	Tier 1	PA; QL (3 tablets per 1 day)
SUBOXONE SUBLINGUAL FILM 12-3 MG, 4-1 MG	Tier 2	PA; QL (2 films per 1 day)

Drug Name	Drug Tier	Notes
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 8-2 MG	Tier 2	PA; QL (3 films per 1 day)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG	Tier 3	PA; QL (3 tablets per 1 day)
Alcohol Abstinence Therapy - Glutamate And Gaba System Type		
acamprosate oral tablet,delayed release (dr/ec) 333 mg	Tier 1	
Alcohol Deterrents		
ANTABUSE ORAL TABLET 250 MG, 500 MG	Tier 3	
disulfiram oral tablet 250 mg, 500 mg	Tier 1	
Smoking Deterrents - Ne And Dopamine Reuptake Inhibitor (Ndri)-Type		
bupropion hcl oral tablet extended release 150 mg	Tier 1	
ZYBAN ORAL TABLET EXTENDED RELEASE 150 MG	Tier 5	
Smoking Deterrents - Nicotine-Type		
NICODERM CQ TRANSDERMAL PATCH 24 HOUR 14 MG/24 HR, 21 MG/24 HR, 7 MG/24 HR	Tier 5	
NICORELIEF BUCCAL GUM 2 MG, 4 MG	Tier 5	
NICORETTE BUCCAL GUM 2 MG, 4 MG	Tier 5	
NICORETTE BUCCAL LOZENGE 2 MG, 4 MG	Tier 5	
nicotine (polacrilex) buccal gum 2 mg, 4 mg	Tier 5	
nicotine (polacrilex) buccal lozenge 2 mg, 4 mg	Tier 5	
nicotine transdermal patch 24 hour 14 mg/24 hr, 21 mg/24 hr, 22 mg/24 hr, 7 mg/24 hr	Tier 5	
nicotine transdermal patch, td daily, sequential 21-14-7 mg/24 hr	Tier 5	
NICOTROL INHALATION CARTRIDGE 10 MG	Tier 5	
NICOTROL NS NASAL SPRAY,NON-AEROSOL 10 MG/ML	Tier 5	
NTS STEP 1 TRANSDERMAL PATCH 24 HOUR 21 MG/24 HR	Tier 5	
QUIT 2 BUCCAL GUM 2 MG	Tier 5	
QUIT 2 BUCCAL LOZENGE 2 MG	Tier 5	

Drug Name	Drug Tier	Notes
QUIT 4 BUCCAL GUM 4 MG	Tier 5	
QUIT 4 BUCCAL LOZENGE 4 MG	Tier 5	
STOP SMOKING AID BUCCAL LOZENGE 2 MG, 4 MG	Tier 5	
Smoking Deterrents - Nicotinic Receptor Partial Agonist, Alpha4beta2		
CHANTIX CONTINUING MONTH BOX ORAL TABLET 1 MG	Tier 5	
CHANTIX ORAL TABLET 0.5 MG, 1 MG	Tier 5	
CHANTIX STARTING MONTH BOX ORAL TABLETS,DOSE PACK 0.5 MG (11)- 1 MG (42)	Tier 5	
Chemicals-Pharmaceutical Adjuvants		
Bulk Chemicals		
formaldehyde (bulk) solution 10 %	Tier 1	
phytonadione (bulk) liquid 100 %	Tier 1	
Pharmaceutical Adjuvant - Inhalation Vehicles		
HYPER-SAL INHALATION SOLUTION FOR NEBULIZATION 3.5 %, 7 %	Tier 3	
NEBUSAL INHALATION SOLUTION FOR NEBULIZATION 6 %	Tier 3	
sodium chloride inhalation solution for nebulization 0.9 %, 10 %, 3 %, 7 %	Tier 1	
Cognitive Disorder Therapy		
Alzheimer's Disease Therapy - Cholinesterase Inhibitors		
ARICEPT ORAL TABLET 10 MG, 23 MG, 5 MG	Tier 3	
donepezil oral tablet 10 mg, 23 mg, 5 mg	Tier 1	
donepezil oral tablet,disintegrating 10 mg, 5 mg	Tier 1	
EXELON TRANSDERMAL PATCH 24 HOUR 13.3 MG/24 HOUR, 4.6 MG/24 HR, 9.5 MG/24 HR	Tier 3	
galantamine oral capsule,ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg	Tier 1	
galantamine oral solution 4 mg/ml	Tier 1	
galantamine oral tablet 12 mg, 4 mg, 8 mg	Tier 1	
RAZADYNE ER ORAL CAPSULE,EXT REL. PELLETS 24 HR 16 MG, 24 MG, 8 MG	Tier 3	

Drug Name	Drug Tier	Notes
RAZADYNE ORAL TABLET 12 MG, 4 MG, 8 MG	Tier 3	
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	Tier 1	
rivastigmine transdermal patch 24 hour 13.3 mg/24 hour, 4.6 mg/24 hr, 9.5 mg/24 hr	Tier 1	
Alzheimer's Disease Therapy - Nmda Receptor Antagonists		
memantine oral solution 2 mg/ml	Tier 1	
memantine oral tablet 10 mg, 5 mg	Tier 1	
memantine oral tablets,dose pack 5-10 mg	Tier 1	
NAMENDA ORAL SOLUTION 2 MG/ML	Tier 3	
NAMENDA ORAL TABLET 10 MG, 5 MG	Tier 3	
NAMENDA TITRATION PAK ORAL TABLETS,DOSE PACK 5-10 MG	Tier 3	
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7-14-21-28 MG	Tier 3	
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 14 MG, 21 MG, 28 MG, 7 MG	Tier 3	
Alzheimer's Thx - Nmda Receptor Antag. And Cholinesterase Inhib. Comb		
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7/14/21/28 MG-10 MG	Tier 3	QL (1 capsule per 1 day)
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	Tier 3	QL (1 capsule per 1 day)
Cognitive Disorder Therapy - Cerebral Vasodilators		
ergoloid oral tablet 1 mg	Tier 1	
Contraceptives		
Contraceptive Injectable - Progestin		
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE 104 MG/0.65 ML	Tier 5	
Contraceptive Intrauterine - Copper Iud		
PARAGARD T 380A INTRAUTERINE INTRAUTERINE DEVICE 380 SQUARE MM	Tier 5	

Drug Name	Drug Tier	Notes
Contraceptive Intrauterine - Progesterone Iud		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 17.5 MCG/24 HR (5 YEARS)	Tier 5	
LILETTA INTRAUTERINE INTRAUTERINE DEVICE 18.6 MCG/24 HR (3 YEARS)	Tier 5	
MIRENA INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/24 HR (5 YEARS)	Tier 5	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 14 MCG/24 HOUR (3 YEARS)	Tier 5	
Contraceptive Oral - Biphasic		
amethia lo oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	Tier 5	Mand 90
amethia oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	Tier 5	Mand 90
ashlyna oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	Tier 5	Mand 90
azurette (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	Mand 90
bekyree (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	
camrese lo oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	Tier 5	Mand 90
camrese oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	Tier 5	Mand 90
daysee oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	Tier 5	Mand 90
desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	Mand 90
kariva (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	Mand 90
kimidess (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	Tier 5	Mand 90
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG (24)/10 MCG (2)	Tier 5	PA
LOSEASONIQUE ORAL TABLETS,DOSE PACK,3 MONTH 0.10 MG-20 MCG (84)/10 MCG (7)	Tier 5	

Drug Name	Drug Tier	Notes
MIRCETTE (28) ORAL TABLET 0.15-0.02 MGX21 /0.01 MG X 5	Tier 5	
necon 10/11 (28) oral tablet 0.5-35/1-35 mg-mcg/mg-mcg	Tier 5	Mand 90
pimtrea (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	Mand 90
SEASONIQUE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7)	Tier 5	
viorele (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	Tier 5	Mand 90
Contraceptive Oral - Monophasic		
altavera (28) oral tablet 0.15-0.03 mg	Tier 5	Mand 90
alyacen 1/35 (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
AMETHYST ORAL TABLET 90-20 MCG	Tier 5	
apri oral tablet 0.15-0.03 mg	Tier 5	Mand 90
aubra oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
aviane oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
balziva (28) oral tablet 0.4-35 mg-mcg	Tier 5	Mand 90
BEYAZ ORAL TABLET 3-0.02-0.451 MG (24)	Tier 5	PA; Mand 90
blisovi 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	Tier 5	Mand 90
BLISOVI FE 1.5/30 (28) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	Tier 5	Mand 90
blisovi fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	Tier 5	Mand 90
brevicon (28) oral tablet 0.5-35 mg-mcg	Tier 5	PA; Mand 90
briellyn oral tablet 0.4-35 mg-mcg	Tier 5	Mand 90
chateal oral tablet 0.15-0.03 mg	Tier 5	Mand 90
cryselle (28) oral tablet 0.3-30 mg-mcg	Tier 5	Mand 90
cyclafem 1/35 (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
cyred oral tablet 0.15-0.03 mg	Tier 5	
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
delyla (28) oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
DESOGEN ORAL TABLET 0.15-0.03 MG	Tier 5	
desogestrel-ethinyl estradiol oral tablet 0.15-0.03 mg	Tier 5	Mand 90
drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24)	Tier 5	

Drug Name	Drug Tier	Notes
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg	Tier 5	
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	Tier 5	Mand 90
elinest oral tablet 0.3-30 mg-mcg	Tier 5	Mand 90
emoquette oral tablet 0.15-0.03 mg	Tier 5	Mand 90
enskyce oral tablet 0.15-0.03 mg	Tier 5	Mand 90
estarylla oral tablet 0.25-35 mg-mcg	Tier 5	Mand 90
falmina (28) oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
FEMCON FE ORAL TABLET,CHEWABLE 0.4MG-35MCG(21) AND 75 MG (7)	Tier 5	
GENERESS FE ORAL TABLET,CHEWABLE 0.8MG-25MCG(24) AND 75 MG (4)	Tier 5	
gianvi (28) oral tablet 3-0.02 mg	Tier 5	Mand 90
gildagia oral tablet 0.4-35 mg-mcg	Tier 5	Mand 90
introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg	Tier 5	Mand 90
jolessa oral tablets,dose pack,3 month 0.15 mg-30 mcg	Tier 5	Mand 90
junel 1.5/30 (21) oral tablet 1.5-30 mg-mcg	Tier 5	Mand 90
junel 1/20 (21) oral tablet 1-20 mg-mcg	Tier 5	Mand 90
junel fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	Tier 5	Mand 90
junel fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	Tier 5	Mand 90
junel fe 24 oral tablet 1 mg-20 mcg (24)/75 mg (4)	Tier 5	
kelnor 1/35 (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
kurvelo oral tablet 0.15-0.03 mg	Tier 5	Mand 90
larin 1.5/30 (21) oral tablet 1.5-30 mg-mcg	Tier 5	Mand 90
larin 1/20 (21) oral tablet 1-20 mg-mcg	Tier 5	Mand 90
larin 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	Tier 5	
larin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	Tier 5	Mand 90
larin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	Tier 5	Mand 90
LAYOLIS FE ORAL TABLET,CHEWABLE 0.8MG-25MCG(24) AND 75 MG (4)	Tier 5	
lessina oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg	Tier 5	Mand 90

Drug Name	Drug Tier	Notes
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg	Tier 5	Mand 90
levora 0.15/30 (28) oral tablet 0.15-0.03 mg	Tier 5	Mand 90
levora-28 oral tablet 0.15-0.03 mg	Tier 5	Mand 90
LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	Tier 5	Mand 90
LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	Tier 5	Mand 90
LOESTRIN FE 1.5/30 (28-DAY) ORAL TABLET 1.5 MG-30 MCG (21)/75 MG (7)	Tier 5	
LOESTRIN FE 1/20 (28-DAY) ORAL TABLET 1 MG-20 MCG (21)/75 MG (7)	Tier 5	
lomedia 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	Tier 5	Mand 90
loryna (28) oral tablet 3-0.02 mg	Tier 5	Mand 90
low-ogestrel (28) oral tablet 0.3-30 mg-mcg	Tier 5	Mand 90
lutera (28) oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
marlissa oral tablet 0.15-0.03 mg	Tier 5	Mand 90
microgestin 1.5/30 (21) oral tablet 1.5-30 mg-mcg	Tier 5	Mand 90
microgestin 1/20 (21) oral tablet 1-20 mg-mcg	Tier 5	Mand 90
MICROGESTIN 24 FE ORAL TABLET 1 MG-20 MCG (24)/75 MG (4)	Tier 5	Mand 90
microgestin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	Tier 5	Mand 90
microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	Tier 5	Mand 90
MINASTRIN 24 FE ORAL TABLET,CHEWABLE 1 MG-20 MCG(24) /75 MG (4)	Tier 5	PA
mono-linyah oral tablet 0.25-35 mg-mcg	Tier 5	Mand 90
mononessa (28) oral tablet 0.25-35 mg-mcg	Tier 5	Mand 90
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg	Tier 5	Mand 90
necon 1/35 (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
necon 1/50 (28) oral tablet 1-50 mg-mcg	Tier 5	Mand 90
nikki (28) oral tablet 3-0.02 mg	Tier 5	Mand 90
noreth-ethinyl estradiol-iron oral tablet,chewable 0.4mg-35mcg(21) and 75 mg (7)	Tier 5	
noreth-ethinyl estradiol-iron oral tablet,chewable 0.8mg-25mcg(24) and 75 mg (4)	Tier 5	Mand 90
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	Tier 5	Mand 90

Drug Name	Drug Tier	Notes
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1 mg-20 mcg (24)/75 mg (4)	Tier 5	Mand 90
norgestimate-ethinyl estradiol oral tablet 0.25-35 mg-mcg	Tier 5	Mand 90
norinyl 1+35 (28) oral tablet 1-35 mg-mcg	Tier 5	PA; Mand 90
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg	Tier 5	Mand 90
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
ocella oral tablet 3-0.03 mg	Tier 5	Mand 90
ogestrel (28) oral tablet 0.5-50 mg-mcg	Tier 5	Mand 90
orsythia oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
ORTHO-CYCLEN (28) ORAL TABLET 0.25-35 MG-MCG	Tier 5	
ORTHO-NOVUM 1/35 (28) ORAL TABLET 1-35 MG-MCG	Tier 5	
OVCON-35 (28) ORAL TABLET 0.4-35 MG-MCG	Tier 5	
philith oral tablet 0.4-35 mg-mcg	Tier 5	Mand 90
pirmella oral tablet 1-35 mg-mcg	Tier 5	Mand 90
portia oral tablet 0.15-0.03 mg	Tier 5	Mand 90
previfem oral tablet 0.25-35 mg-mcg	Tier 5	Mand 90
quasense oral tablets,dose pack,3 month 0.15 mg-30 mcg	Tier 5	Mand 90
RAJANI ORAL TABLET 3-0.02-0.451 MG (24)	Tier 5	
reclipsen (28) oral tablet 0.15-0.03 mg	Tier 5	Mand 90
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (21/7)	Tier 5	PA; Mand 90
setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg	Tier 5	
sprintec (28) oral tablet 0.25-35 mg-mcg	Tier 5	Mand 90
sronyx oral tablet 0.1-20 mg-mcg	Tier 5	Mand 90
syeda oral tablet 3-0.03 mg	Tier 5	Mand 90
tarina fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	Tier 5	Mand 90
TAYTULLA ORAL CAPSULE 1 MG-20 MCG (24)/75 MG (4)	Tier 5	
vestura (28) oral tablet 3-0.02 mg	Tier 5	Mand 90
VIENVA ORAL TABLET 0.1-20 MG-MCG	Tier 5	Mand 90
vyfemla (28) oral tablet 0.4-35 mg-mcg	Tier 5	Mand 90

Drug Name	Drug Tier	Notes
wera (28) oral tablet 0.5-35 mg-mcg	Tier 5	Mand 90
wymzya fe oral tablet,chewable 0.4mg-35mcg(21) and 75 mg (7)	Tier 5	Mand 90
YASMIN (28) ORAL TABLET 3-0.03 MG	Tier 5	
YAZ (28) ORAL TABLET 3-0.02 MG	Tier 5	
zarah oral tablet 3-0.03 mg	Tier 5	Mand 90
zenchent (28) oral tablet 0.4-35 mg-mcg	Tier 5	Mand 90
zenchent fe oral tablet,chewable 0.4mg-35mcg(21) and 75 mg (7)	Tier 5	Mand 90
zovia 1/35e (28) oral tablet 1-35 mg-mcg	Tier 5	Mand 90
zovia 1/50e (28) oral tablet 1-50 mg-mcg	Tier 5	Mand 90
Contraceptive Oral - Progestin		
camila oral tablet 0.35 mg	Tier 5	Mand 90
deblitane oral tablet 0.35 mg	Tier 5	Mand 90
errin oral tablet 0.35 mg	Tier 5	Mand 90
heather oral tablet 0.35 mg	Tier 5	Mand 90
jencycla oral tablet 0.35 mg	Tier 5	Mand 90
jolivette oral tablet 0.35 mg	Tier 5	Mand 90
lyza oral tablet 0.35 mg	Tier 5	Mand 90
nora-be oral tablet 0.35 mg	Tier 5	Mand 90
norethindrone (contraceptive) oral tablet 0.35 mg	Tier 5	Mand 90
norlyroc oral tablet 0.35 mg	Tier 5	Mand 90
NOR-QD ORAL TABLET 0.35 MG	Tier 5	
ORTHO MICRONOR ORAL TABLET 0.35 MG	Tier 5	
sharobel oral tablet 0.35 mg	Tier 5	Mand 90
Contraceptive Oral - Quadraphasic		
NATAZIA ORAL TABLET 3 MG/2 MG-2 MG/ 2 MG-3 MG/1 MG	Tier 5	PA; Mand 90
QUARTETTE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-20 MCG/ 0.15 MG-25 MCG	Tier 5	PA
Contraceptive Oral - Triphasic		
alyacen 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	Tier 5	Mand 90
aranelle (28) oral tablet 0.5/1/0.5-35 mg-mcg	Tier 5	Mand 90
caziant (28) oral tablet 0.1/.125/.15-25 mg-mcg	Tier 5	Mand 90
cyclafem 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	Tier 5	Mand 90

Drug Name	Drug Tier	Notes
CYCLESSA (28) ORAL TABLET 0.1/.125/.15-25 MG-MCG	Tier 5	
dasetta 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	Tier 5	Mand 90
enpresse oral tablet 50-30 (6)/75-40 (5)/125-30(10)	Tier 5	Mand 90
ESTROSTEP FE-28 ORAL TABLET 1-20(5)/1-30(7) /1MG-35MCG (9)	Tier 5	
leena 28 oral tablet 0.5/1/0.5-35 mg-mcg	Tier 5	Mand 90
levonest (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	Tier 5	Mand 90
myzilra oral tablet 50-30 (6)/75-40 (5)/125-30(10)	Tier 5	Mand 90
necon 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	Tier 5	Mand 90
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg	Tier 5	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	Tier 5	Mand 90
nortrel 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg	Tier 5	Mand 90
ORTHO TRI-CYCLEN (28) ORAL TABLET 0.18/0.215/0.25 MG-35 MCG (28)	Tier 5	
ORTHO TRI-CYCLEN LO (28) ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	Tier 5	PA
ORTHO-NOVUM 7/7/7 (28) ORAL TABLET 0.5/0.75/1 MG- 35 MCG	Tier 5	
pirmella oral tablet 0.5/0.75/1 mg- 35 mcg	Tier 5	Mand 90
tilia fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	Tier 5	Mand 90
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	Tier 5	Mand 90
tri-legest fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	Tier 5	Mand 90
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	Tier 5	Mand 90
TRI-LO-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	Tier 5	Mand 90
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	Tier 5	Mand 90
trinessa (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	Tier 5	Mand 90

Drug Name	Drug Tier	Notes
TRINESSA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	Tier 5	Mand 90
TRI-NORINYL (28) ORAL TABLET 0.5/1/0.5-35 MG-MCG	Tier 5	
tri-previfem (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	Tier 5	Mand 90
tri-sprintec (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	Tier 5	Mand 90
trivora (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	Tier 5	Mand 90
velivet triphasic regimen (28) oral tablet 0.1/.125/.15-25 mg-mcg	Tier 5	Mand 90
Contraceptive Transdermal Combinations		
xulane transdermal patch weekly 150-35 mcg/24 hr	Tier 5	
Contraceptives - Intravaginal, Systemic		
NUVARING VAGINAL RING 0.12-0.015 MG/24 HR	Tier 5	
Emergency Contraceptives		
ELLA ORAL TABLET 30 MG	Tier 5	
MY WAY ORAL TABLET 1.5 MG	Tier 5	
NEXT CHOICE ONE DOSE ORAL TABLET 1.5 MG	Tier 5	
PLAN B ONE-STEP ORAL TABLET 1.5 MG	Tier 5	
Emergency Contraceptives - Progesterone Agonist/Antagonist Type		
ELLA ORAL TABLET 30 MG	Tier 5	
Emergency Contraceptives - Progestin Type		
MY WAY ORAL TABLET 1.5 MG	Tier 5	
NEXT CHOICE ONE DOSE ORAL TABLET 1.5 MG	Tier 5	
PLAN B ONE-STEP ORAL TABLET 1.5 MG	Tier 5	
Dermatological		
Acne Therapy Systemic - Retinoids And Derivatives		
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG	Tier 8	PA; Specialty; 30D; Specialty
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	Tier 1	

Drug Name	Drug Tier	Notes
myorisan oral capsule 10 mg, 20 mg, 30 mg, 40 mg	Tier 1	
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	Tier 1	
zenatane oral capsule 30 mg	Tier 1	
Acne Therapy Systemic - Tetracyclines		
minocycline oral tablet extended release 24 hr 135 mg, 45 mg, 90 mg	Tier 1	
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	Tier 8	PA; 30D
Acne Therapy Topical - Anti-Infective		
ACZONE TOPICAL GEL 5 %	Tier 3	PA
ACZONE TOPICAL GEL WITH PUMP 7.5 %	Tier 3	PA
AZELEX TOPICAL CREAM 20 %	Tier 3	
CLEOCIN T TOPICAL GEL 1 %	Tier 3	
CLEOCIN T TOPICAL LOTION 1 %	Tier 3	
CLEOCIN T TOPICAL SOLUTION 1 %	Tier 3	
CLEOCIN T TOPICAL SWAB 1 %	Tier 3	
CLINDACIN P TOPICAL SWAB 1 %	Tier 3	
CLINDAGEL TOPICAL GEL 1 %	Tier 3	PA
clindamycin phosphate topical foam 1 %	Tier 1	
clindamycin phosphate topical gel 1 %	Tier 1	
clindamycin phosphate topical lotion 1 %	Tier 1	
clindamycin phosphate topical solution 1 %	Tier 1	
clindamycin phosphate topical swab 1 %	Tier 1	
ERY PADS TOPICAL SWAB 2 %	Tier 3	
ERYGEL TOPICAL GEL 2 %	Tier 3	
erythromycin with ethanol topical gel 2 %	Tier 1	
erythromycin with ethanol topical solution 2 %	Tier 1	
erythromycin with ethanol topical swab 2 %	Tier 1	
EVOCLIN TOPICAL FOAM 1 %	Tier 3	
FINACEA TOPICAL FOAM 15 %	Tier 3	
FINACEA TOPICAL GEL 15 %	Tier 3	PA
KLARON TOPICAL SUSPENSION 10 %	Tier 3	
METROCREAM TOPICAL CREAM 0.75 %	Tier 3	
METROLOTION TOPICAL LOTION 0.75 %	Tier 3	
metronidazole topical cream 0.75 %	Tier 1	

Drug Name	Drug Tier	Notes
metronidazole topical lotion 0.75 %	Tier 1	
NORITATE TOPICAL CREAM 1 %	Tier 3	
ROSADAN TOPICAL CREAM 0.75 %	Tier 1	
sulfacetamide sodium (acne) topical suspension 10 %	Tier 1	
Acne Therapy Topical - Anti-Infective-Keratolytic Combinations		
AVAR LS TOPICAL CLEANSER 10-2 %	Tier 3	
AVAR LS TOPICAL PADS, MEDICATED 10-2 %	Tier 3	PA
AVAR TOPICAL CLEANSER 10-5 % (W/W)	Tier 3	
AVAR TOPICAL PADS, MEDICATED 9.5-5 %	Tier 3	PA
AVAR-E LS TOPICAL CREAM 10-2 %	Tier 3	
BENZACLIN PUMP TOPICAL GEL WITH PUMP 1-5 %	Tier 3	
BENZACLIN TOPICAL GEL 1-5 %	Tier 3	
BENZAMYCIN TOPICAL GEL 3-5 %	Tier 3	
BP 10-1 TOPICAL CLEANSER 10-1 %	Tier 1	
CLEANSING WASH TOPICAL CLEANSER 10-4-10 %	Tier 1	
clindamycin-benzoyl peroxide topical gel 1-5 %, 1.2 %(1 % base) -5 %	Tier 1	
DUAC TOPICAL GEL 1.2 %(1 % BASE) -5 %	Tier 3	PA
erythromycin-benzoyl peroxide topical gel 3-5 %	Tier 1	
NEUAC TOPICAL GEL 1.2 %(1 % BASE) -5 %	Tier 1	
ONEXTON TOPICAL GEL 1.2 %(1 % BASE) -3.75 %	Tier 3	PA
PLEXION CLEANSING CLOTHS TOPICAL PADS, MEDICATED 9.8-4.8 %	Tier 3	PA
PLEXION TOPICAL CLEANSER 9.8-4.8 %	Tier 3	
PLEXION TOPICAL CREAM 9.8-4.8 %	Tier 3	
PLEXION TOPICAL LOTION 9.8-4.8 %	Tier 3	
ROSANIL TOPICAL CLEANSER 10-5 % (W/W)	Tier 3	PA
ROSULA CLEANSING CLOTHS TOPICAL PADS, MEDICATED 10-5 %	Tier 3	
ROSULA TOPICAL CLEANSER 10-4.5 %	Tier 3	PA

Drug Name	Drug Tier	Notes
SS 10-2 TOPICAL CLEANSER 10-2 %	Tier 3	
SSS 10-5 TOPICAL FOAM 10-5 %	Tier 1	
sulfacetamide sodium-sulfur topical cleanser 10-2 %, 10-5 % (w/w), 9-4 %, 9-4.5 %, 9.8-4.8 %	Tier 1	
sulfacetamide sodium-sulfur topical cream 10-2 %, 9.8-4.8 %	Tier 1	
sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 9.8-4.8 %	Tier 1	
sulfacetamide sodium-sulfur topical pads, medicated 10-4 %	Tier 1	
sulfacetamide sodium-sulfur topical suspension 8-4 %	Tier 1	
SUMADAN TOPICAL CLEANSER 9-4.5 %	Tier 3	PA
SUMAXIN TOPICAL CLEANSER 9-4 %	Tier 3	
SUMAXIN TOPICAL PADS, MEDICATED 10-4 %	Tier 3	
SUMAXIN TS TOPICAL SUSPENSION 8-4 %	Tier 3	
ZENCIA TOPICAL CLEANSER 9-4 %	Tier 3	
Acne Therapy Topical - Anti-Infective-Retinoid Combinations		
clindamycin-tretinoin topical gel 1.2-0.025 %	Tier 1	PA
VELTIN TOPICAL GEL 1.2-0.025 %	Tier 3	PA
ZIANA TOPICAL GEL 1.2-0.025 %	Tier 3	PA
Acne Therapy Topical - Keratolytic		
benzepro (microspheres) topical cleanser 7 %	Tier 1	
benzepro topical towelette 6 %	Tier 1	
benzoyl peroxide topical cleanser 6 %, 7 %	Tier 1	
benzoyl peroxide topical gel 5 %	Tier 1	
BP WASH TOPICAL CLEANSER 10 %, 2.5 %, 5 %, 7 %	Tier 3	
BPO TOPICAL GEL 4 %, 8 %	Tier 1	
PACNEX TOPICAL CLEANSER 7 %	Tier 3	
Acne Therapy Topical - Keratolytic Mixtures		
NUOX TOPICAL GEL 6-3 %	Tier 3	PA

Drug Name	Drug Tier	Notes
Acne Therapy Topical - Keratolytic-Glucocorticoid Combinations		
VANOXIDE-HC TOPICAL SUSPENSION 5-0.5 %	Tier 3	PA
Acne Therapy Topical - Retinoid Combinations Other		
EPIDUO FORTE TOPICAL GEL WITH PUMP 0.3-2.5 %	Tier 3	PA
EPIDUO TOPICAL GEL 0.1-2.5 %	Tier 3	PA
EPIDUO TOPICAL GEL WITH PUMP 0.1-2.5 %	Tier 3	PA
Acne Therapy Topical - Retinoids And Derivatives		
adapalene topical cream 0.1 %	Tier 1	
adapalene topical gel 0.1 %, 0.3 %	Tier 1	
adapalene topical lotion 0.1 %	Tier 1	
ATRALIN TOPICAL GEL 0.05 %	Tier 3	PA; AR; AR
AVITA TOPICAL CREAM 0.025 %	Tier 1	AR; AR
AVITA TOPICAL GEL 0.025 %	Tier 1	AR; AR
DIFFERIN TOPICAL CREAM 0.1 %	Tier 3	
DIFFERIN TOPICAL GEL 0.1 %, 0.3 %	Tier 3	
DIFFERIN TOPICAL LOTION 0.1 %	Tier 3	
FABIOR TOPICAL FOAM 0.1 %	Tier 3	
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.04 %, 0.1 %	Tier 3	AR; AR
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %	Tier 3	PA; AR; AR
RETIN-A MICRO TOPICAL GEL 0.04 %, 0.1 %	Tier 3	AR; AR
RETIN-A TOPICAL CREAM 0.025 %, 0.05 %, 0.1 %	Tier 3	AR; AR
RETIN-A TOPICAL GEL 0.01 %, 0.025 %	Tier 3	AR; AR
tretinoin microspheres topical gel 0.04 %, 0.1 %	Tier 1	AR; AR
tretinoin microspheres topical gel with pump 0.04 %, 0.1 %	Tier 1	AR; AR
tretinoin topical cream 0.025 %, 0.05 %, 0.1 %	Tier 1	AR; AR
tretinoin topical gel 0.01 %, 0.025 %, 0.05 %	Tier 1	AR; AR
TRETIN-X TOPICAL CREAM 0.075 %	Tier 3	PA; AR

Drug Name	Drug Tier	Notes
Antipsoriatic - Vitamin D Analog - Glucocorticoid Combinations		
calcipotriene-betamethasone topical ointment 0.005-0.064 %	Tier 1	QL (100 GM per 7 days)
ENSTILAR TOPICAL FOAM 0.005-0.064 %	Tier 3	
TACLONEX TOPICAL OINTMENT 0.005-0.064 %	Tier 3	QL (100 GM per 7 days)
TACLONEX TOPICAL SUSPENSION 0.005-0.064 %	Tier 3	
Antipsoriatic Agents-Interleukin-17A (Il-17A) Antagonist, Mc Antibody		
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML	Tier 8	PA; Specialty
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Tier 8	PA; Specialty
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML	Tier 8	PA; Specialty
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML	Tier 8	PA; Specialty
TALTZ AUTOINJECTOR (2 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
TALTZ AUTOINJECTOR (3 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
TALTZ AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
TALTZ SYRINGE (2 PACK) SUBCUTANEOUS SYRINGE 80 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
TALTZ SYRINGE (3 PACK) SUBCUTANEOUS SYRINGE 80 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
Dermatological - Antibacterial Aminoglycosides		
gentamicin topical cream 0.1 %	Tier 1	
gentamicin topical ointment 0.1 %	Tier 1	
Dermatological - Antibacterial And Antifungal Agents		
ALOQUIN TOPICAL GEL 1.25-1 %	Tier 3	

Drug Name	Drug Tier	Notes
Dermatological - Antibacterial Other		
BACTROBAN TOPICAL CREAM 2 %	Tier 3	
CENTANY TOPICAL OINTMENT 2 %	Tier 3	
mupirocin calcium topical cream 2 %	Tier 1	
mupirocin topical ointment 2 %	Tier 1	
silver nitrate topical ointment 10 %	Tier 1	
silver nitrate topical solution 0.5 %, 10 %, 25 %, 50 %	Tier 1	
Dermatological - Antibacterial Pleuromutilin Derivatives		
ALTABAX TOPICAL OINTMENT 1 %	Tier 3	PA
Dermatological - Antibacterial Sulfonamides		
AVAR-E GREEN TOPICAL CREAM 10-5 % (W/W)	Tier 3	
AVAR-E TOPICAL CREAM 10-5 % (W/W)	Tier 3	
SSS 10-5 TOPICAL CREAM 10-5 % (W/W)	Tier 1	
Dermatological - Antibacterial,Antifungal Agent With Glucocorticoid		
ALA-QUIN TOPICAL CREAM 3-0.5 %	Tier 3	
ALCORTIN A TOPICAL GEL IN PACKET 2-1-1 %	Tier 3	
Dermatological - Antibacterial-Glucocorticoid Combinations		
CORTISPORIN TOPICAL CREAM 3.5-10,000-0.5 MG/G-UNIT/G-%	Tier 2	
CORTISPORIN TOPICAL OINTMENT 1 %	Tier 2	
NEO-SYNALAR TOPICAL CREAM 0.5 % (0.35 % BASE)-0.025 %	Tier 3	
Dermatological - Antifungal Allylamines		
naftifine topical cream 1 %, 2 %	Tier 1	
NAFTIN TOPICAL CREAM 2 %	Tier 3	PA
NAFTIN TOPICAL GEL 1 %, 2 %	Tier 3	PA
Dermatological - Antifungal Amphoteric Polyene Macrolides		
NYAMYC TOPICAL POWDER 100,000 UNIT/GRAM	Tier 1	

Drug Name	Drug Tier	Notes
nystatin topical cream 100,000 unit/gram	Tier 1	
nystatin topical ointment 100,000 unit/gram	Tier 1	
nystatin topical powder 100,000 unit/gram	Tier 1	
NYSTOP TOPICAL POWDER 100,000 UNIT/GRAM	Tier 1	
Dermatological - Antifungal Benzylamines		
MENTAX TOPICAL CREAM 1 %	Tier 3	PA
Dermatological - Antifungal Combinations Other		
EXODERM TOPICAL LOTION 25-1 %	Tier 1	
Dermatological - Antifungal Hydroxypyridinone		
CICLODAN KIT TOPICAL SOLUTION 8 %	Tier 3	
CICLODAN TOPICAL CREAM 0.77 %	Tier 3	
CICLODAN TOPICAL SOLUTION 8 %	Tier 3	
ciclopirox topical cream 0.77 %	Tier 1	
ciclopirox topical gel 0.77 %	Tier 1	
ciclopirox topical shampoo 1 %	Tier 1	
ciclopirox topical solution 8 %	Tier 1	
ciclopirox topical suspension 0.77 %	Tier 1	
ciclopirox-ure-camph-menth-euc topical solution 8 %	Tier 1	
LOPROX (AS OLAMINE) TOPICAL CREAM 0.77 %	Tier 3	
LOPROX (AS OLAMINE) TOPICAL SUSPENSION 0.77 %	Tier 3	
LOPROX TOPICAL SHAMPOO 1 %	Tier 3	
PENLAC TOPICAL SOLUTION 8 %	Tier 3	
Dermatological - Antifungal Imidazole And Related Agents		
clotrimazole topical cream 1 %	Tier 1	
clotrimazole topical solution 1 %	Tier 1	
econazole topical cream 1 %	Tier 1	
ECOZA TOPICAL FOAM 1 %	Tier 3	PA
ERTACZO TOPICAL CREAM 2 %	Tier 3	PA
EXELDERM TOPICAL CREAM 1 %	Tier 3	PA
EXELDERM TOPICAL SOLUTION 1 %	Tier 3	PA
EXTINA TOPICAL FOAM 2 %	Tier 3	

Drug Name	Drug Tier	Notes
ketoconazole topical cream 2 %	Tier 1	
ketoconazole topical foam 2 %	Tier 1	
ketoconazole topical shampoo 2 %	Tier 1	
LUZU TOPICAL CREAM 1 %	Tier 3	PA
NIZORAL TOPICAL SHAMPOO 2 %	Tier 3	
OXISTAT TOPICAL CREAM 1 %	Tier 3	PA
OXISTAT TOPICAL LOTION 1 %	Tier 3	PA
VUSION TOPICAL OINTMENT 0.25-15-81.35 %	Tier 3	PA
XOLEGEL TOPICAL GEL 2 %	Tier 3	PA
Dermatological - Antifungal Oxaborole		
KERYDIN TOPICAL SOLUTION WITH APPLICATOR 5 %	Tier 3	PA
Dermatological - Antifungal Triazole		
JUBLIA TOPICAL SOLUTION WITH APPLICATOR 10 %	Tier 3	PA
Dermatological - Antifungal-Glucocorticoid Combinations		
clotrimazole-betamethasone topical cream 1-0.05 %	Tier 1	
clotrimazole-betamethasone topical lotion 1-0.05 %	Tier 1	
DERMAZENE TOPICAL CREAM 1-1 %	Tier 1	
iodoquinol-hc topical cream 1-1 %	Tier 1	
LOTRISONE TOPICAL CREAM 1-0.05 %	Tier 3	
nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%	Tier 1	
nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%	Tier 1	
Dermatological - Antineoplastic Alkylating Agents		
VALCHLOR TOPICAL GEL 0.016 %	Tier 8	30D; Specialty
Dermatological - Antineoplastic Antimetabolites		
CARAC TOPICAL CREAM 0.5 %	Tier 8	PA; 30D; Specialty
EFUDEX TOPICAL CREAM 5 %	Tier 3	
FLUOROPLEX TOPICAL CREAM 1 %	Tier 3	PA
fluorouracil topical cream 0.5 %	Tier 4	PA; Specialty; Specialty
fluorouracil topical cream 5 %	Tier 1	

Drug Name	Drug Tier	Notes
fluorouracil topical solution 2 %, 5 %	Tier 1	
TOLAK TOPICAL CREAM 4 %	Tier 3	
Dermatological - Antineoplastic Or Premalig. Lesions -Diterpene Esters		
PICATO TOPICAL GEL 0.015 %, 0.05 %	Tier 8	30D; Specialty
Dermatological - Antineoplastic Or Premalignant Lesions - Nsaid's		
diclofenac sodium topical gel 3 %	Tier 1	PA
SOLARAZE TOPICAL GEL 3 %	Tier 3	PA
Dermatological - Antineoplastic Retinoids		
PANRETIN TOPICAL GEL 0.1 %	Tier 2	
Dermatological - Antineoplastic Selective Retinoid X Receptor Agonist		
TARGRETIN TOPICAL GEL 1 %	Tier 4	30D; Specialty
Dermatological - Antiperspirants		
DRYSOL DAB-O-MATIC TOPICAL SOLUTION 20 %	Tier 3	
Dermatological - Antipsoriatic Agents Systemic, Photosensitizing		
methoxsalen rapid oral capsule 10 mg	Tier 4	Specialty; 30D; Specialty
OXSORALEN ULTRA ORAL CAPSULE 10 MG	Tier 8	Specialty; 30D; Specialty
Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives		
acitretin oral capsule 10 mg, 17.5 mg, 25 mg	Tier 4	30D
SORIATANE ORAL CAPSULE 10 MG, 17.5 MG, 25 MG	Tier 8	30D
Dermatological - Antipsoriatic Agents Topical		
calcipotriene scalp solution 0.005 %	Tier 1	QL (100 mls per 7 days)
calcipotriene topical cream 0.005 %	Tier 1	QL (100 grams per 7 days)
calcipotriene topical ointment 0.005 %	Tier 1	QL (100 grams per 7 days)
CALCITRENE TOPICAL OINTMENT 0.005 %	Tier 1	QL (100 grams per 7 days)
calcitriol topical ointment 3 mcg/gram	Tier 3	QL (200 grams per 7 days)
DOVONEX TOPICAL CREAM 0.005 %	Tier 3	QL (100 grams per 7 days)
DRITHOCREME HP TOPICAL CREAM 1 %	Tier 3	

Drug Name	Drug Tier	Notes
SORILUX TOPICAL FOAM 0.005 %	Tier 3	
TAZORAC TOPICAL CREAM 0.05 %, 0.1 %	Tier 3	
TAZORAC TOPICAL GEL 0.05 %, 0.1 %	Tier 3	
VECTICAL TOPICAL OINTMENT 3 MCG/GRAM	Tier 3	QL (200 grams per 7 days)
ZITHRANOL TOPICAL SHAMPOO 1 %	Tier 3	
ZITHRANOL-RR TOPICAL CREAM, RAPID RELEASE 1.2 %	Tier 3	
Dermatological - Antipsoriatics Systemic, Phosphodiesterase 4 Inhib.		
OTEZLA ORAL TABLET 30 MG	Tier 8	PA; Specialty; 30D; Specialty
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	Tier 8	PA; 30D; Specialty
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG(19)	Tier 8	PA; Specialty; 30D; Specialty
Dermatological - Antiseborrheic		
OVACE PLUS SHAMPOO TOPICAL SHAMPOO 10 %	Tier 3	PA
OVACE PLUS TOPICAL CREAM 10 %	Tier 3	PA
OVACE PLUS TOPICAL LOTION 9.8 %	Tier 3	PA
OVACE PLUS WASH TOPICAL CLEANSER,GEL EXTENDED RELEASE 10 %	Tier 3	
SEB-PREV TOPICAL CLEANSER 10 %	Tier 1	
selenium sulfide topical shampoo 2.25 %	Tier 1	
SELRX TOPICAL SHAMPOO 2.3 %	Tier 2	
sulfacetamide sodium topical cleanser 10 %	Tier 1	
TERSI FOAM TOPICAL FOAM 2.25 %	Tier 3	PA
Dermatological - Antiviral, Herpes		
acyclovir topical ointment 5 %	Tier 1	ED; QL (15 grams per 21 days)
DENAVIR TOPICAL CREAM 1 %	Tier 3	
ZOVIRAX TOPICAL CREAM 5 %	Tier 3	ED; QL (5 grams per 7 days)
ZOVIRAX TOPICAL OINTMENT 5 %	Tier 3	ED; QL (15 grams per 21 days)
Dermatological - Antiviral-Glucocorticoid Combinations		
XERESE TOPICAL CREAM 5-1 %	Tier 3	
Dermatological - Burn Products Anti-Infective		
SILVADENE TOPICAL CREAM 1 %	Tier 3	
SSD TOPICAL CREAM 1 %	Tier 1	

Drug Name	Drug Tier	Notes
SULFAMYLON TOPICAL CREAM 85 MG/G	Tier 3	
SULFAMYLON TOPICAL PACKET 50 GRAM	Tier 3	
THERMAZENE TOPICAL CREAM 1 %	Tier 3	
Dermatological - Calcineurin Inhibitors		
ELIDEL TOPICAL CREAM 1 %	Tier 2	PA
PROTOPIC TOPICAL OINTMENT 0.03 %, 0.1 %	Tier 3	
tacrolimus topical ointment 0.03 %, 0.1 %	Tier 1	
Dermatological - Emollient Mixtures		
ATOPICLAIR TOPICAL CREAM	Tier 3	
EPICERAM TOPICAL EMULSION, EXTENDED RELEASE	Tier 3	
HYLATOPICPLUS TOPICAL LOTION	Tier 3	
PRUCLAIR TOPICAL CREAM	Tier 3	
Dermatological - Emollients		
ammonium lactate topical cream 12 %	Tier 1	
ammonium lactate topical lotion 12 %	Tier 1	
GORDONS UREA TOPICAL OINTMENT 40 %	Tier 3	
LACTIC ACID E TOPICAL CREAM 10 %	Tier 1	
lactic acid topical lotion 10 %	Tier 1	
REA LO 39 TOPICAL CREAM 39 %	Tier 3	
urea topical cream 39 %	Tier 1	
Dermatological - Enzymes		
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM	Tier 3	
Dermatological - Glucocorticoid		
ALA-CORT TOPICAL CREAM 1 %	Tier 1	
ALA-SCALP TOPICAL LOTION 2 %	Tier 3	PA
alclometasone topical cream 0.05 %	Tier 1	
alclometasone topical ointment 0.05 %	Tier 1	
amcinonide topical cream 0.1 %	Tier 1	
amcinonide topical lotion 0.1 %	Tier 1	
amcinonide topical ointment 0.1 %	Tier 1	
APEXICON E TOPICAL CREAM 0.05 %	Tier 2	
betamethasone dipropionate topical cream 0.05 %	Tier 1	

Drug Name	Drug Tier	Notes
betamethasone dipropionate topical lotion 0.05 %	Tier 1	
betamethasone dipropionate topical ointment 0.05 %	Tier 1	
betamethasone valerate topical cream 0.1 %	Tier 1	
betamethasone valerate topical foam 0.12 %	Tier 1	
betamethasone valerate topical lotion 0.1 %	Tier 1	
betamethasone valerate topical ointment 0.1 %	Tier 1	
betamethasone, augmented topical cream 0.05 %	Tier 1	
betamethasone, augmented topical gel 0.05 %	Tier 1	
betamethasone, augmented topical lotion 0.05 %	Tier 1	
betamethasone, augmented topical ointment 0.05 %	Tier 1	
CAPEX TOPICAL SHAMPOO 0.01 %	Tier 3	
clobetasol scalp solution 0.05 %	Tier 1	
clobetasol topical cream 0.05 %	Tier 1	PA
clobetasol topical foam 0.05 %	Tier 1	
clobetasol topical gel 0.05 %	Tier 1	
clobetasol topical lotion 0.05 %	Tier 1	
clobetasol topical ointment 0.05 %	Tier 1	PA
clobetasol topical shampoo 0.05 %	Tier 1	
clobetasol topical spray,non-aerosol 0.05 %	Tier 1	
clobetasol-emollient topical cream 0.05 %	Tier 1	PA
clobetasol-emollient topical foam 0.05 %	Tier 1	
CLOBEX TOPICAL LOTION 0.05 %	Tier 3	
CLOBEX TOPICAL SHAMPOO 0.05 %	Tier 3	
CLOBEX TOPICAL SPRAY,NON-AEROSOL 0.05 %	Tier 3	
clocortolone pivalate topical cream 0.1 %	Tier 1	
CLODAN TOPICAL SHAMPOO 0.05 %	Tier 3	
CLODERM TOPICAL CREAM 0.1 %	Tier 3	
CORDRAN TAPE LARGE ROLL TOPICAL TAPE 4 MCG/CM2	Tier 3	PA
CORDRAN TOPICAL CREAM 0.05 %	Tier 3	PA
CORDRAN TOPICAL LOTION 0.05 %	Tier 3	PA
CORDRAN TOPICAL OINTMENT 0.05 %	Tier 3	PA
cormax scalp solution 0.05 %	Tier 1	
CUTIVATE TOPICAL CREAM 0.05 %	Tier 3	
CUTIVATE TOPICAL LOTION 0.05 %	Tier 3	

Drug Name	Drug Tier	Notes
DERMA-SMOOTHE/FS BODY OIL TOPICAL OIL 0.01 %	Tier 3	
DERMA-SMOOTHE/FS SCALP OIL SCALP OIL 0.01 %	Tier 3	
DERMATOP TOPICAL CREAM 0.1 %	Tier 3	
DERMATOP TOPICAL OINTMENT 0.1 %	Tier 3	
DESONATE TOPICAL GEL 0.05 %	Tier 3	PA
desonide topical cream 0.05 %	Tier 1	
desonide topical lotion 0.05 %	Tier 1	
desonide topical ointment 0.05 %	Tier 1	
DESOWEN TOPICAL CREAM 0.05 %	Tier 3	
DESOWEN TOPICAL LOTION 0.05 %	Tier 3	
desoximetasone topical cream 0.05 %, 0.25 %	Tier 1	
desoximetasone topical gel 0.05 %	Tier 1	
desoximetasone topical ointment 0.05 %, 0.25 %	Tier 1	
diflorasone topical cream 0.05 %	Tier 1	
diflorasone topical ointment 0.05 %	Tier 1	
DIPROLENE AF TOPICAL CREAM 0.05 %	Tier 3	
DIPROLENE TOPICAL LOTION 0.05 %	Tier 3	
DIPROLENE TOPICAL OINTMENT 0.05 %	Tier 3	
ELOCON TOPICAL CREAM 0.1 %	Tier 3	
ELOCON TOPICAL OINTMENT 0.1 %	Tier 3	
ELOCON TOPICAL SOLUTION 0.1 %	Tier 3	
fluocinolone and shower cap scalp oil 0.01 %	Tier 1	
fluocinolone topical cream 0.01 %, 0.025 %	Tier 1	
fluocinolone topical oil 0.01 %	Tier 1	
fluocinolone topical ointment 0.025 %	Tier 1	
fluocinolone topical solution 0.01 %	Tier 1	
fluocinonide topical cream 0.05 %, 0.1 %	Tier 1	
fluocinonide topical gel 0.05 %	Tier 1	
fluocinonide topical ointment 0.05 %	Tier 1	
fluocinonide topical solution 0.05 %	Tier 1	
flurandrenolide topical cream 0.05 %	Tier 1	
flurandrenolide topical lotion 0.05 %	Tier 1	PA
fluticasone topical cream 0.05 %	Tier 1	
fluticasone topical lotion 0.05 %	Tier 1	
fluticasone topical ointment 0.005 %	Tier 1	
halobetasol propionate topical cream 0.05 %	Tier 1	
halobetasol propionate topical ointment 0.05 %	Tier 1	

Drug Name	Drug Tier	Notes
HALOG TOPICAL CREAM 0.1 %	Tier 3	PA
HALOG TOPICAL OINTMENT 0.1 %	Tier 3	PA
hydrocortisone butyrate topical cream 0.1 %	Tier 1	
hydrocortisone butyrate topical ointment 0.1 %	Tier 1	
hydrocortisone butyrate topical solution 0.1 %	Tier 1	
hydrocortisone topical cream 1 %, 2.5 %	Tier 1	
hydrocortisone topical cream with perineal applicator 1 %	Tier 1	
hydrocortisone topical lotion 1 %, 2.5 %	Tier 1	
hydrocortisone topical ointment 2.5 %	Tier 1	
hydrocortisone valerate topical cream 0.2 %	Tier 1	
hydrocortisone valerate topical ointment 0.2 %	Tier 1	
hydrocortisone-pramoxine topical cream 2.5-1 %	Tier 1	
KENALOG TOPICAL AEROSOL 0.147 MG/GRAM	Tier 3	
LOCOID LIPOCREAM TOPICAL CREAM 0.1 %	Tier 3	PA
LOCOID TOPICAL LOTION 0.1 %	Tier 3	PA
LOCOID TOPICAL OINTMENT 0.1 %	Tier 3	
LOCOID TOPICAL SOLUTION 0.1 %	Tier 3	
LUXIQ TOPICAL FOAM 0.12 %	Tier 3	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Tier 3	
mometasone topical cream 0.1 %	Tier 1	
mometasone topical ointment 0.1 %	Tier 1	
mometasone topical solution 0.1 %	Tier 1	
OLUX-E TOPICAL FOAM 0.05 %	Tier 3	
PANDEL TOPICAL CREAM 0.1 %	Tier 3	PA
prednicarbate topical cream 0.1 %	Tier 1	
prednicarbate topical ointment 0.1 %	Tier 1	
PROCTOCORT TOPICAL CREAM 1 %	Tier 3	
PROCTO-PAK TOPICAL CREAM WITH PERINEAL APPLICATOR 1 %	Tier 1	
PROCTOZONE-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	Tier 1	
PSORCON TOPICAL CREAM 0.05 %	Tier 3	
SCALACORT TOPICAL LOTION 2 %	Tier 3	
SERNIVO TOPICAL SPRAY WITH PUMP 0.05 %	Tier 3	
SYNALAR TOPICAL CREAM 0.025 %	Tier 3	

Drug Name	Drug Tier	Notes
SYNALAR TOPICAL OINTMENT 0.025 %	Tier 3	
SYNALAR TOPICAL SOLUTION 0.01 %	Tier 3	
TEMOVATE TOPICAL CREAM 0.05 %	Tier 3	
TEMOVATE TOPICAL OINTMENT 0.05 %	Tier 3	
TEXACORT TOPICAL SOLUTION 2.5 %	Tier 3	
TOPICORT TOPICAL CREAM 0.05 %, 0.25 %	Tier 3	
TOPICORT TOPICAL GEL 0.05 %	Tier 3	
TOPICORT TOPICAL OINTMENT 0.05 %, 0.25 %	Tier 3	
TOPICORT TOPICAL SPRAY,NON-AEROSOL 0.25 %	Tier 3	PA
triamcinolone acetonide topical aerosol 0.147 mg/gram	Tier 1	
triamcinolone acetonide topical cream 0.025 %, 0.1 %, 0.5 %	Tier 1	
triamcinolone acetonide topical lotion 0.025 %, 0.1 %	Tier 1	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	Tier 1	
trianex topical ointment 0.05 %	Tier 1	PA; QL (90 grams per 30 days)
TRIDERM TOPICAL CREAM 0.1 %	Tier 1	
ULTRAVATE TOPICAL CREAM 0.05 %	Tier 3	
ULTRAVATE TOPICAL LOTION 0.05 %	Tier 3	
ULTRAVATE TOPICAL OINTMENT 0.05 %	Tier 3	
VANOS TOPICAL CREAM 0.1 %	Tier 3	
VERDESO TOPICAL FOAM 0.05 %	Tier 3	PA
Dermatological - Glucocorticoid-Emollient Combinations		
ULTRAVATE X TOPICAL COMBO PACK 0.05-10 %	Tier 3	PA
ULTRAVATE X TOPICAL COMBO PACK,OINTMENT AND CREAM 0.05-10 %	Tier 3	PA
Dermatological - Glucocorticoid-Local Anesthetic Combinations		
EPIFOAM TOPICAL FOAM 1-1 %	Tier 3	
hydrocortisone-pramoxine topical cream 2.5-1 %	Tier 1	
NOVACORT (WITH ALOE) TOPICAL GEL 2-1-1 %	Tier 3	
PRAMOSONE E TOPICAL CREAM 2.5-1 %	Tier 3	PA

Drug Name	Drug Tier	Notes
PRAMOSONE TOPICAL CREAM 1-1 %, 2.5-1 %	Tier 3	
PRAMOSONE TOPICAL LOTION 1-1 %, 2.5-1 %	Tier 3	PA
PRAMOSONE TOPICAL OINTMENT 1-1 %, 2.5-1 %	Tier 3	PA
Dermatological - Immunomodulator - Catechins - Genital Wart/Hpv Tx		
VEREGEN TOPICAL OINTMENT 15 %	Tier 8	PA; 30D
Dermatological - Immunomodulator - Imidazoquinolinamines		
ALDARA TOPICAL CREAM IN PACKET 5 %	Tier 3	
imiquimod topical cream in packet 5 %	Tier 1	
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 %, 3.75 %	Tier 8	PA; 30D
ZYCLARA TOPICAL CREAM IN PACKET 3.75 %	Tier 8	PA; 30D
Dermatological - Keratolytic-Antimitotic Combinations		
SALKERA TOPICAL FOAM 6 %	Tier 3	
SALVAX DUO PLUS TOPICAL FOAM 6-35 %	Tier 3	
silver nitrate applicators topical stick 75-25 %	Tier 3	
Dermatological - Keratolytic-Antimitotic Single Agents		
BENSAL HP TOPICAL OINTMENT 3 %	Tier 3	
BP-50% UREA TOPICAL EMULSION 50 %	Tier 1	
CEM-UREA TOPICAL GEL 45 %	Tier 1	
CONDYLOX TOPICAL GEL 0.5 %	Tier 3	
CONDYLOX TOPICAL SOLUTION 0.5 %	Tier 3	
HYDRO 35 TOPICAL FOAM 35 %	Tier 3	PA
HYDRO 40 TOPICAL FOAM 40 %	Tier 3	
KERAFOAM TOPICAL FOAM 30 %, 42 %	Tier 3	
KERALAC TOPICAL CREAM 47 %	Tier 3	
KERALYT RX TOPICAL GEL 6 %	Tier 3	
PODOCON TOPICAL LIQUID 25 %	Tier 1	
podofilox topical solution 0.5 %	Tier 1	
REA LO 40 TOPICAL CREAM 40 %	Tier 3	
REA LO 40 TOPICAL LOTION 40 %	Tier 3	

Drug Name	Drug Tier	Notes
REMEVEN TOPICAL CREAM 50 %	Tier 1	
RYNODERM TOPICAL CREAM 37.5 %	Tier 3	
SALACYN TOPICAL CREAM 6 %	Tier 3	
SALACYN TOPICAL LOTION 6 %	Tier 1	
SALEX TOPICAL SHAMPOO 6 %	Tier 3	
salicylic acid topical cream 6 %	Tier 1	
salicylic acid topical gel 6 %	Tier 1	
salicylic acid topical lotion 6 %	Tier 1	
salicylic acid topical shampoo 6 %	Tier 1	
SALVAX TOPICAL FOAM 6 %	Tier 1	
TRI-CHLOR TOPICAL SOLUTION 80 %	Tier 3	
UMECTA PD TOPICAL EMULSION, ADHESIVE 40 %	Tier 3	PA
UMECTA TOPICAL EMULSION 40 %	Tier 3	PA
UMECTA TOPICAL FOAM 40 %	Tier 3	
URAMAXIN GT TOPICAL GEL 45 %	Tier 3	
URAMAXIN TOPICAL CREAM 45 %	Tier 3	
URAMAXIN TOPICAL FOAM 20 %	Tier 3	
URAMAXIN TOPICAL GEL 45 %	Tier 3	
URAMAXIN TOPICAL LOTION 45 %	Tier 3	
UREA NAIL STICK TOPICAL SOLUTION 50 %	Tier 3	
urea topical cream 40 %, 45 %, 47 %, 50 %	Tier 1	
urea topical foam 35 %	Tier 1	
urea topical gel 45 %	Tier 1	
urea topical lotion 40 %, 45 %	Tier 1	
URE-K TOPICAL CREAM 50 %	Tier 3	
UREVAZ TOPICAL CREAM 44 %	Tier 3	
UTOPIC TOPICAL CREAM 41 %	Tier 3	
VIRASAL TOPICAL FILM FORMING LIQUID W/APPL 27.5 %	Tier 3	
Dermatological - Local Anesthetic Combinations		
lidocaine-prilocaine topical cream 2.5-2.5 %	Tier 1	
lidocaine-prilocaine topical kit 2.5-2.5 %	Tier 1	
Dermatological - Local Anesthetic Gas Combinations		
PAIN EASE TOPICAL AEROSOL,SPRAY	Tier 3	

Drug Name	Drug Tier	Notes
SPRAY AND STRETCH TOPICAL AEROSOL,SPRAY	Tier 3	
Dermatological - Local Anesthetic Gas Single Agents		
ethyl chloride topical aerosol,spray 100 %	Tier 1	
Dermatological - Miscellaneous Single Agents		
PYROGALLIC ACID TOPICAL OINTMENT 25-2 %	Tier 3	
Dermatological - Nsaid Single Agents		
diclofenac sodium topical drops 1.5 %	Tier 1	
diclofenac sodium topical gel 1 %	Tier 1	PA
FLECTOR TRANSDERMAL PATCH 12 HOUR 1.3 %	Tier 3	PA
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)	Tier 3	
VOLTAREN TOPICAL GEL 1 %	Tier 3	PA
Dermatological - Photodynamic Therapy Agents Topical		
LEVULAN TOPICAL SOLUTION 20 %	Tier 3	
Dermatological - Retinoids (Vitamin A Derivatives) - Topical Cosmetic		
tretinoin (emollient) topical cream 0.05 %	Tier 1	AR; AR
Dermatological - Rosacea Therapy, Systemic		
doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg	Tier 1	PA
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG	Tier 3	PA
Dermatological - Rosacea Therapy, Topical		
AZELEX TOPICAL CREAM 20 %	Tier 3	
CLEANSING WASH TOPICAL CLEANSER 10-4-10 %	Tier 1	
FINACEA TOPICAL FOAM 15 %	Tier 3	
FINACEA TOPICAL GEL 15 %	Tier 3	PA
metronidazole topical gel 1 %	Tier 1	PA
MIRVASO TOPICAL GEL 0.33 %	Tier 3	
SOOLANTRA TOPICAL CREAM 1 %	Tier 3	PA

Drug Name	Drug Tier	Notes
Dermatological - Topical Local Anesthetic Amides		
GLYDO MUCOUS MEMBRANE JELLY IN APPLICATOR 2 %	Tier 1	
lidocaine hcl mucous membrane jelly 2 %	Tier 1	DDS
lidocaine hcl mucous membrane jelly in applicator 2 %	Tier 1	DDS
lidocaine hcl topical cream 3 %	Tier 1	
lidocaine hcl topical lotion 3 %	Tier 1	
lidocaine topical adhesive patch,medicated 5 %	Tier 1	
lidocaine topical ointment 5 %	Tier 1	
lidocaine-tetracaine topical cream 7-7 %	Tier 1	
LIDODERM TOPICAL ADHESIVE PATCH,MEDICATED 5 %	Tier 3	
LIDO-K TOPICAL LOTION 3 %	Tier 3	
LIDOPIN TOPICAL CREAM 3 %, 3.25 %	Tier 3	
LIDORX TOPICAL GEL WITH PUMP 3 %	Tier 3	
LIDOTRAL TOPICAL CREAM 3.88 %	Tier 3	
PLIAGLIS TOPICAL CREAM 7-7 %	Tier 3	
REGENECARE WITH ALOE TOPICAL GEL 2 %	Tier 3	
SYNERA TOPICAL PATCH, MEDICATED SELF-HEATING 70-70 MG	Tier 3	
Dermatological - Topical Local Anesthetic Esters		
ANACAINE TOPICAL OINTMENT 10 %	Tier 3	
PONTOCAINE TOPICAL SOLUTION 2 %	Tier 3	
Dermatological Antipruritics - Antihistamines		
PRUDOXIN TOPICAL CREAM 5 %	Tier 3	
ZONALON TOPICAL CREAM 5 %	Tier 3	
Scabicide And Pediculicide Single Agents		
ELIMITE TOPICAL CREAM 5 %	Tier 3	
EURAX TOPICAL CREAM 10 %	Tier 3	
EURAX TOPICAL LOTION 10 %	Tier 3	
lindane topical shampoo 1 %	Tier 1	
malathion topical lotion 0.5 %	Tier 1	
OVIDE TOPICAL LOTION 0.5 %	Tier 3	

Drug Name	Drug Tier	Notes
permethrin topical cream 5 %	Tier 1	
SKLICE TOPICAL LOTION 0.5 %	Tier 3	
spinosad topical suspension 0.9 %	Tier 3	
ULESFIA TOPICAL LOTION 5 %	Tier 3	
Wound Care - Growth Factor Agents		
REGRANEX TOPICAL GEL 0.01 %	Tier 3	
Wound Care Combinations Other		
VENELEX TOPICAL OINTMENT 87-788 MG/GRAM	Tier 3	
Diagnostic Agents		
Diagnostic - Blood Test Others		
PRECISION XTRA B-KETONE STRIP	Tier 5	QL (10 strips per 30 days)
Drugs To Treat Erectile Dysfunction		
Erectile Dysfunction (Ed) Drugs - Prostaglandin, Alpha Blocker		
phentolam-alprostadil in water intracavernosal solution 0.5 mg- 20 mcg/ml	Tier 1	PA; QL/DS (QL (total of all ED meds limited to qty of 6 units per month))
Erectile Dysfunction (Ed) Drugs - Prostaglandins		
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG	Tier 3	PA; QL/DS (QL (Total of non-oral ED meds limited to qty of 6 units per month))
CAVERJECT INTRACAVERNOSAL RECON SOLN 20 MCG, 40 MCG	Tier 3	PA; QL/DS (QL (Total of non-oral ED meds limited to qty of 6 units per month))
EDEX INTRACAVERNOSAL KIT 10 MCG, 20 MCG, 40 MCG	Tier 3	PA; QL/DS (QL (Total of non-oral ED meds limited to qty of 6 units per month))
MUSE URETHRAL SUPPOSITORY 1,000 MCG, 125 MCG, 250 MCG, 500 MCG	Tier 3	PA; QL/DS (QL (Total of non-oral ED meds limited to qty of 6 units per month))
Erectile Dysfunction (Ed) Drugs-Prostaglandin, Peripheral Vasodilator		
papaverine-alprostadil-water intracavernosal solution 30 mg- 10 mcg/ml, 30 mg- 20 mcg/ml	Tier 1	PA; QL/DS (QL (total of all ED meds limited to qty of 6 units per month))
papav-phentolam-alprost-water intracavernosal solution 12 mg-1 mg- 10 mcg/ml, 30 mg-1 mg- 20 mcg/ml	Tier 1	PA; QL/DS (QL (Total of non-oral ED meds limited to qty of 6 units per month))

Drug Name	Drug Tier	Notes
Erectile Dysfunction (Ed) Drugs-Sel.Cgmp Phosphodiesterase Type5 Inhib		
CIALIS ORAL TABLET 10 MG, 20 MG	Tier 7	
CIALIS ORAL TABLET 2.5 MG, 5 MG	Tier 2	PA; QL/DS (QL (limited to 30 tablets per month for indication of BPH) * No addtl qty of drugs for ED when receiving Cialis daily for BPH)
LEVITRA ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	Tier 7	
STAXYN ORAL TABLET,DISINTEGRATING 10 MG	Tier 7	
STENDRA ORAL TABLET 100 MG, 200 MG, 50 MG	Tier 7	
VIAGRA ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 7	
Eating Disorder Therapy		
Anorexiant Combinations		
QSYMIA ORAL CAPSULE, ER MULTIPHASE 24 HR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG	Tier 3	PA
Anorexiants		
ADIPEX-P ORAL CAPSULE 37.5 MG	Tier 3	PA
ADIPEX-P ORAL TABLET 37.5 MG	Tier 3	PA
benzphetamine oral tablet 50 mg	Tier 1	PA
diethylpropion oral tablet 25 mg	Tier 1	PA
diethylpropion oral tablet extended release 75 mg	Tier 1	PA
LOMAIRA ORAL TABLET 8 MG	Tier 3	PA
phendimetrazine tartrate oral capsule, extended release 105 mg	Tier 1	PA
phendimetrazine tartrate oral tablet 35 mg	Tier 1	PA
phentermine oral capsule 15 mg, 30 mg, 37.5 mg	Tier 1	PA
phentermine oral tablet 37.5 mg	Tier 1	PA
REGIMEX ORAL TABLET 25 MG	Tier 3	PA
Anti-Obesity - Fat Absorption Decreasing Agents		
XENICAL ORAL CAPSULE 120 MG	Tier 3	PA

Drug Name	Drug Tier	Notes
Anti-Obesity - Glucagon-Like Peptide-1 (Glp-1) Receptor Agonists		
SAXENDA SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML (18 MG/3 ML)	Tier 3	PA
Anti-Obesity - Serotonin 2C Receptor Agonists		
BELVIQ ORAL TABLET 10 MG	Tier 3	PA
BELVIQ XR ORAL TABLET EXTENDED RELEASE 24 HR 20 MG	Tier 3	PA
Anti-Obesity-Opioid Antag/Norepinephrine And Dopamine Reuptake Inhibit		
CONTRAVE ORAL TABLET EXTENDED RELEASE 8-90 MG	Tier 3	PA
Appetite Stimulants - Cannabinoids		
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	Tier 1	
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG	Tier 3	
Appetite Stimulants - Progestin Hormone Type		
MEGACE ES ORAL SUSPENSION 625 MG/5 ML	Tier 3	
MEGACE ORAL SUSPENSION 400 MG/10 ML (40 MG/ML)	Tier 3	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml	Tier 1	
Electrolyte Balance-Nutritional Products		
Amino Acids, Single Ingredient, Oral (Non-Injectable)		
ACETYLCYSTEINE ORAL CAPSULE 500 MG	Tier 3	
NUTRESTORE ORAL POWDER IN PACKET 5 GRAM	Tier 3	
B-Complex Vitamin Combinations		
DIALYVITE ORAL TABLET 100-1 MG	Tier 3	
FOLBEE PLUS ORAL TABLET 5 MG	Tier 1	
LYSIPLEX PLUS ORAL TABLET	Tier 3	
NEPHROCAPS ORAL CAPSULE 1 MG	Tier 3	

Drug Name	Drug Tier	Notes
NEPHROCAPS QT ORAL TABLET,DISINTEGRATING 1-1,750 MG-UNIT	Tier 3	
RENO CAPS ORAL CAPSULE 1 MG	Tier 1	
VIRT-VITE PLUS ORAL TABLET 5 MG	Tier 1	
B-Complex Vitamins And Combinations		
NEPHRO-VITE RX ORAL TABLET 1-60-300 MG-MG-MCG	Tier 3	PA
RENA-VITE RX ORAL TABLET 1-60-300 MG-MG-MCG	Tier 1	
VOL-CARE RX ORAL TABLET 1-60-300 MG-MG-MCG	Tier 1	
Dietary Product - Dietary Supplements		
ACETYLCYSTEINE ORAL CAPSULE 500 MG	Tier 3	
NICAZEL FORTE ORAL TABLET 700-500-8-12 MG-MCG-MG-MG	Tier 3	
NICAZEL ORAL TABLET 600-5-10-5-1.5 MG	Tier 3	
VP-ZEL ORAL TABLET 600-5-10-5-1.5 MG	Tier 1	
Electrolyte Depleters - Ion Exchange Resin		
KAYEXALATE ORAL POWDER	Tier 3	
KIONEX (WITH SORBITOL) ORAL SUSPENSION 15-19.3 GRAM/60 ML	Tier 1	
KIONEX ORAL POWDER	Tier 1	
sodium polystyrene sulfonate oral powder	Tier 1	
sodium polystyrene sulfonate oral suspension 15 gram/60 ml	Tier 1	
sodium polystyrene sulfonate rectal enema 30 gram/120 ml	Tier 1	
SPS (WITH SORBITOL) ORAL SUSPENSION 15-20 GRAM/60 ML	Tier 1	
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 25.2 GRAM, 8.4 GRAM	Tier 3	
Geriatric Vitamins		
REQ49+ ORAL TABLET 200-1.5-1.5 MCG-MG-MG	Tier 3	

Drug Name	Drug Tier	Notes
Irrigation Solutions		
PHYSIOLYTE IRRIGATION SOLUTION 140-5-3-98 MEQ/L	Tier 3	
PHYSIOSOL IRRIGATION IRRIGATION SOLUTION 140-5-3-98 MEQ/L	Tier 3	
Minerals And Electrolytes - Calcium Replacement		
calcium acetate oral tablet 667 mg	Tier 1	
Minerals And Electrolytes - Calcium Replacement Combinations		
FOLGARD OS ORAL TABLET 500-1.1 MG	Tier 3	
Minerals And Electrolytes - Electrolytes And Dextrose		
NORMOSOL-R IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION 5 %	Tier 6	
Minerals And Electrolytes - Iron Combinations		
BIFERA RX ORAL TABLET 22-6-1-25 MG-MG-MG-MCG	Tier 3	
FERIVA 21-7 TABLET ORAL TABLET 75 MG IRON- 1 MG-175 MG	Tier 3	
FERIVA FA (SUMALATE) ORAL CAPSULE 110 MG-1 MG -175 MG-12 MCG	Tier 3	
FERIVA ORAL CAPSULE,EXT RELEASE MULTIPHASE 75 MG IRON- 1 MG-175 MG	Tier 3	30D
ferocon oral capsule 110-0.5 mg	Tier 1	
FERRALET 90 DUAL-IRON DELIVERY ORAL TABLET 90-1-12-50 MG-MG-MCG-MG	Tier 3	
FERRAPLUS 90 ORAL TABLET 90-1-12-120-50 MG-MG-MCG-MG-MG	Tier 1	
FERROGELS FORTE ORAL CAPSULE 460-60-0.01-1 MG	Tier 1	
FOLIVANE-F ORAL CAPSULE 125-1-40-3 MG	Tier 3	PA
HEMATINIC/FOLIC ACID ORAL TABLET 324 MG (106 MG IRON)-1 MG	Tier 1	
HEMATOGEN FA ORAL CAPSULE 200-250-0.01-1 MG	Tier 1	
HEMATOGEN FORTE ORAL CAPSULE 460-60-0.01-1 MG	Tier 1	

Drug Name	Drug Tier	Notes
HEMATRON-AF ORAL TABLET EXTENDED RELEASE 24 HR 150-1-50 MG	Tier 3	
HEMOCYTE-F ORAL TABLET 324 MG (106 MG IRON)-1 MG	Tier 3	
HEMOCYTE-PLUS ORAL CAPSULE 106 MG IRON- 1 MG	Tier 3	
IFEREX 150 FORTE ORAL CAPSULE 150-25-1 MG-MCG-MG	Tier 1	
INTEGRA F ORAL CAPSULE 125-1-40-3 MG	Tier 3	
INTEGRA PLUS ORAL CAPSULE 125-1 MG	Tier 3	
IROSPAN 24/6 ORAL TABLET 65 MG-65 MG -1,000 MCG (24)	Tier 3	
POLY-IRON 150 FORTE ORAL CAPSULE 150-25-1 MG-MCG-MG	Tier 1	
SIDEROL ORAL TABLET	Tier 3	
tl icon oral capsule 110-0.5 mg	Tier 1	
tricon oral capsule 110-0.5 mg	Tier 1	
Minerals And Electrolytes - Phosphate		
K-PHOS-NEUTRAL ORAL TABLET 250 MG	Tier 3	
PHOSPHA 250 NEUTRAL ORAL TABLET 250 MG	Tier 1	
Minerals And Electrolytes - Potassium Combinations		
potassium bicarb and chloride oral tablet, effervescent 25 meq	Tier 1	
Minerals And Electrolytes - Potassium, Oral		
EFFER-K ORAL TABLET, EFFERVESCENT 10 MEQ, 20 MEQ	Tier 3	
EFFER-K ORAL TABLET, EFFERVESCENT 25 MEQ	Tier 1	
K-EFFERVESCENT ORAL TABLET, EFFERVESCENT 25 MEQ	Tier 1	
klor-con 10 oral tablet extended release 10 meq	Tier 1	Mand 90
klor-con 8 oral tablet extended release 8 meq	Tier 1	Mand 90
klor-con m10 oral tablet,er particles/crystals 10 meq	Tier 1	Mand 90
klor-con m15 oral tablet,er particles/crystals 15 meq	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
klor-con m20 oral tablet,er particles/crystals 20 meq	Tier 1	Mand 90
KLOR-CON ORAL PACKET 20 MEQ	Tier 2	
klor-con sprinkle oral capsule, extended release 10 meq, 8 meq	Tier 1	
KLOR-CON/EF ORAL TABLET, EFFERVESCENT 25 MEQ	Tier 1	
K-SOL ORAL LIQUID 20 MEQ/15 ML, 40 MEQ/15 ML	Tier 3	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	Tier 3	
potassium bicarb-citric acid oral tablet, effervescent 25 meq	Tier 1	
potassium chloride oral capsule, extended release 10 meq, 8 meq	Tier 1	Mand 90
potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml	Tier 1	
potassium chloride oral packet 20 meq	Tier 1	Mand 90
potassium chloride oral tablet extended release 10 meq, 8 meq	Tier 1	Mand 90
potassium chloride oral tablet,er particles/crystals 10 meq	Tier 1	
potassium chloride oral tablet,er particles/crystals 20 meq	Tier 1	Mand 90
Minerals And Electrolytes - Zinc		
zinc sulfate oral capsule 220 (50) mg	Tier 1	
Multivitamin And Mineral Combinations		
BACMIN ORAL TABLET 27-1 MG	Tier 3	
CORVITE FREE ORAL TABLET 1.25-400-125-35 MG-MCG-MCG-MG	Tier 3	
ELDERCAPS ORAL CAPSULE 1 MG	Tier 3	
NICOMIDE ORAL TABLET 500-750-1.5-25 MCG-MG-MG-MG	Tier 3	
NUTRICAP ORAL TABLET 1 MG	Tier 3	
REQ49+ ORAL TABLET 200-1.5-1.5 MCG-MG-MG	Tier 3	
STROVITE FORTE ORAL TABLET 10-1 MG	Tier 3	PA
STROVITE ONE ORAL TABLET 1-1,000-15-5 MG-UNIT-MG-MG	Tier 3	
V-C FORTE ORAL CAPSULE 1 MG	Tier 1	

Drug Name	Drug Tier	Notes
VIC-FORTE ORAL CAPSULE 1 MG	Tier 3	
Multivitamins		
ANIMI-3 WITH VITAMIN D ORAL CAPSULE 500-1,000-500 MG-UNIT-MCG	Tier 3	
FORTAVIT ORAL CAPSULE	Tier 3	
PUREVIT DUALFE PLUS ORAL CAPSULE 162-115.2-1 MG	Tier 3	
TANDEM PLUS ORAL CAPSULE 162-115.2-1 MG	Tier 3	
Nutritional Product - Medical Condition Specific Formulation		
NUTRESTORE ORAL POWDER IN PACKET 5 GRAM	Tier 3	
Parenteral Nutrition - Intravenous Fat Emulsions		
LIPOSYN III INTRAVENOUS EMULSION 30 %	Tier 5	
Pediatric Vitamins With Fluoride Combinations		
TEXAVITE LQ ORAL DROPS 7-0.25 MG/ML	Tier 3	
Prenatal Vitamins And Minerals		
VINATE DHA ORAL CAPSULE 27-400-1.13-250 MG-MCG-MG-MG	Tier 3	
Ringer's And Lactated Ringer's Solutions		
lactated ringers intravenous parenteral solution	Tier 6	
Vitamins - B Preparation Combinations		
FOLGARD RX ORAL TABLET 2.2-25-1 MG	Tier 3	
NEURIN-SL SUBLINGUAL TABLET 600-600 MCG	Tier 3	
Vitamins - B-12 And Folic Acid Combinations		
FOLTRATE ORAL TABLET 0.5-1 MG	Tier 3	
Vitamins - B-12, Cyanocobalamin And Derivatives		
NASCOBAL NASAL SPRAY,NON-AEROSOL 500 MCG/SPRAY	Tier 3	
NEURIN-SL SUBLINGUAL TABLET 600-600 MCG	Tier 3	

Drug Name	Drug Tier	Notes
Vitamins - D Derivatives		
calcitriol oral capsule 0.25 mcg, 0.5 mcg	Tier 1	
calcitriol oral solution 1 mcg/ml	Tier 1	
ergocalciferol (vitamin d2) oral capsule 50,000 unit	Tier 5	AR
ROCALTROL ORAL CAPSULE 0.25 MCG, 0.5 MCG	Tier 3	
ROCALTROL ORAL SOLUTION 1 MCG/ML	Tier 3	
VITAMIN D2 ORAL CAPSULE 50,000 UNIT	Tier 5	AR
Vitamins - Folic Acid And Derivatives		
folic acid oral tablet 1 mg	Tier 5	
Vitamins - Folic Acid Combinations		
FOLGARD RX ORAL TABLET 2.2-25-1 MG	Tier 3	
Vitamins - K, Phytonadione And Derivatives		
MEPHYTON ORAL TABLET 5 MG	Tier 2	
phytonadione (bulk) liquid 100 %	Tier 1	
Vitamins - Paba		
POTABA ORAL CAPSULE 500 MG	Tier 3	
Endocrine		
Abortifacients Or Cervical Ripening Agents - Prostaglandin Analogs		
CERVIDIL VAGINAL INSERT, EXTENDED RELEASE 10 MG	Tier 3	
PREPIDIL VAGINAL GEL 0.5 MG/3 G	Tier 3	
PROSTIN E2 VAGINAL SUPPOSITORY 20 MG	Tier 3	
Abortifacients- Progesterone Receptor Antagonist		
MIFEPREX ORAL TABLET 200 MG	Tier 3	
Adrenocorticotrophic Hormones		
ACTHAR H.P. INJECTION GEL 80 UNIT/ML	Tier 8	PA; Specialty; Specialty
Agents To Treat Hypoglycemia (Hyperglycemics)		
GLUCAGEN HYPOKIT INJECTION RECON SOLN 1 MG	Tier 2	

Drug Name	Drug Tier	Notes
GLUCAGON EMERGENCY KIT (HUMAN) INJECTION KIT 1 MG	Tier 2	
glucose oral tablet,chewable 4 gram	Tier 1	
PROGLYCEM ORAL SUSPENSION 50 MG/ML	Tier 3	
Anabolic Steroid - Single Agents		
ANADROL-50 ORAL TABLET 50 MG	Tier 3	
OXANDRIN ORAL TABLET 10 MG, 2.5 MG	Tier 3	
oxandrolone oral tablet 10 mg, 2.5 mg	Tier 1	Mand 90
Androgen - Single Agents		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR	Tier 3	PA; Mand 90
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ ACTUATION (1 %)	Tier 3	
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	Tier 2	Mand 90
ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (25 MG/2.5GRAM), 1 % (50 MG/5 GRAM)	Tier 3	
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)	Tier 2	Mand 90
ANDROID ORAL CAPSULE 10 MG	Tier 4	Specialty; 30D; Specialty
AXIRON TRANSDERMAL SOLUTION IN METERED PUMP W/APP 30 MG/ACTUATION (1.5 ML)	Tier 3	PA; Mand 90
DEPO-TESTOSTERONE INTRAMUSCULAR OIL 100 MG/ML, 200 MG/ML	Tier 8	30D
FORTESTA TRANSDERMAL GEL IN METERED-DOSE PUMP 10 MG/0.5 GRAM /ACTUATION	Tier 3	Mand 90
METHITEST ORAL TABLET 10 MG	Tier 3	PA; Mand 90
NATESTO NASAL GEL IN METERED-DOSE PUMP 5.5 MG/0.122 GRAM/ACTUATION	Tier 3	PA; Mand 90
STRIANT BUCCAL MUCOADHESIVE SYSTEM ER 12 HR 30 MG	Tier 3	PA; Mand 90
TESTIM TRANSDERMAL GEL 50 MG/5 GRAM (1 %)	Tier 3	Mand 90

Drug Name	Drug Tier	Notes
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	Tier 4	30D
testosterone enanthate intramuscular oil 200 mg/ml	Tier 4	30D
testosterone transdermal gel 50 mg/5 gram (1 %)	Tier 1	Mand 90
testosterone transdermal gel in metered-dose pump 1.25 gram/ actuation (1 %), 10 mg/0.5 gram /actuation	Tier 1	Mand 90
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	Tier 1	Mand 90
TESTRED ORAL CAPSULE 10 MG	Tier 8	PA; 30D; Specialty
VOGELXO TRANSDERMAL GEL 50 MG/5 GRAM (1 %)	Tier 3	Mand 90
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ ACTUATION (1 %)	Tier 3	Mand 90
VOGELXO TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	Tier 3	Mand 90
Antidiuretic And Vasopressor Hormones		
DDAVP INJECTION SOLUTION 4 MCG/ML	Tier 3	
DDAVP NASAL AEROSOL,SPRAY 10 MCG/SPRAY (0.1 ML)	Tier 3	
DDAVP NASAL SOLUTION 0.1 MG/ML (REFRIGERATE)	Tier 3	
DDAVP ORAL TABLET 0.1 MG, 0.2 MG	Tier 3	
desmopressin nasal solution 0.1 mg/ml (refrigerate)	Tier 1	
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	Tier 1	
desmopressin oral tablet 0.1 mg, 0.2 mg	Tier 1	
STIMATE NASAL SPRAY,NON-AEROSOL 150 MCG/SPRAY (0.1 ML)	Tier 3	
Antihyperglycemic - Alpha-Glucosidase Inhibitors		
acarbose oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
GLYSET ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	Mand 90
miglitol oral tablet 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
PRECOSE ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	

Drug Name	Drug Tier	Notes
Antihyperglycemic - Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors		
alogliptin oral tablet 12.5 mg, 25 mg, 6.25 mg	Tier 1	PA; QL (1 tablet per 1 day)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
NESINA ORAL TABLET 12.5 MG, 25 MG, 6.25 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
ONGLYZA ORAL TABLET 2.5 MG, 5 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
TRADJENTA ORAL TABLET 5 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
Antihyperglycemic - Dopamine Receptor Agonists		
CYCLOSET ORAL TABLET 0.8 MG	Tier 3	
Antihyperglycemic - Glucocorticoid (Cortisol) Receptor Blocker (Gr-Ii)		
KORLYM ORAL TABLET 300 MG	Tier 4	30D; Specialty
Antihyperglycemic - Meglitinide Analogs		
nateglinide oral tablet 120 mg, 60 mg	Tier 1	Mand 90
PRANDIN ORAL TABLET 0.5 MG, 1 MG, 2 MG	Tier 3	
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	Mand 90
STARLIX ORAL TABLET 120 MG, 60 MG	Tier 3	
Antihyperglycemic - Sglt-2 Inhibitor And Biguanide Combinations		
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG	Tier 2	
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG	Tier 3	
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG	Tier 3	PA; QL (2 tablets per 1 day)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-1,000 MG, 5-500 MG	Tier 3	PA; QL (1 tablet per 1 day)
Antihyperglycemic - Sglt-2 Inhibitor And Dpp-4 Inhibitor Combinations		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	Tier 3	PA; QL (1 tablet per 1 day)

Drug Name	Drug Tier	Notes
Antihyperglycemic - Sodium Glucose Cotransporter-2 (Sglt2) Inhibitors		
FARXIGA ORAL TABLET 10 MG, 5 MG	Tier 3	PA; QL (1 tablet per 1 day)
INVOKANA ORAL TABLET 100 MG, 300 MG	Tier 2	QL (1 tablet per 1 day)
JARDIANCE ORAL TABLET 10 MG, 25 MG	Tier 3	PA; QL (1 tablet per 1 day)
Antihyperglycemic - Sulfonylurea And Biguanide Combinations		
glipizide-metformin oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	Tier 1	
GLUCOVANCE ORAL TABLET 2.5-500 MG, 5-500 MG	Tier 3	AR; AR
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg	Tier 1	AR; Mand 90; AR
Antihyperglycemic - Sulfonylurea Derivatives		
AMARYL ORAL TABLET 1 MG, 2 MG, 4 MG	Tier 3	
chlorpropamide oral tablet 100 mg, 250 mg	Tier 1	AR; Mand 90; AR
glimepiride oral tablet 1 mg, 2 mg, 4 mg	Tier 1	Mand 90
glipizide oral tablet 10 mg, 5 mg	Tier 1	Mand 90
glipizide oral tablet extended release 24hr 10 mg, 2.5 mg, 5 mg	Tier 1	Mand 90
GLUCOTROL ORAL TABLET 10 MG, 5 MG	Tier 3	
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 2.5 MG, 5 MG	Tier 3	
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	Tier 1	AR; Mand 90; AR
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	Tier 1	AR; Mand 90; AR
GLYNASE ORAL TABLET 1.5 MG, 3 MG, 6 MG	Tier 3	AR; AR
tolazamide oral tablet 250 mg, 500 mg	Tier 1	
tolbutamide oral tablet 500 mg	Tier 1	
Antihyperglycemic - Thiazolidinedione And Biguanide Combinations		
ACTOPLUS MET ORAL TABLET 15-500 MG, 15-850 MG	Tier 3	
ACTOPLUS MET XR ORAL TABLET, ER MULTIPHASE 24 HR 15-1,000 MG, 30-1,000 MG	Tier 3	Mand 90

Drug Name	Drug Tier	Notes
AVANDAMET ORAL TABLET 2-1,000 MG, 2-500 MG	Tier 3	Mand 90
pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg	Tier 1	Mand 90
Antihyperglycemic - Thiazolidinedione And Sulfonylurea Combinations		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG	Tier 3	
pioglitazone-glimepiride oral tablet 30-2 mg, 30-4 mg	Tier 1	Mand 90
Antihyperglycemic, Amylin Analog-Type		
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR 2,700 MCG/2.7 ML	Tier 2	
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR 1,500 MCG/1.5 ML	Tier 2	
Antihyperglycemic, Incretin Mimetic,Glp-1 Receptor Agonist Analog-Type		
BYDUREON SUBCUTANEOUS PEN INJECTOR 2 MG/0.65 ML	Tier 2	
BYDUREON SUBCUTANEOUS SUSPENSION,EXTENDED REL RECON 2 MG	Tier 2	
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML, 5 MCG/DOSE (250 MCG/ML) 1.2 ML	Tier 2	
TANZEUM SUBCUTANEOUS PEN INJECTOR 30 MG/0.5 ML, 50 MG/0.5 ML	Tier 3	
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML	Tier 3	
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	Tier 2	
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	Tier 2	
Antihyperglycemic-Dipeptidyl Peptidase-4 Inhibit And Thiazolidinedione		
alogliptin-pioglitazone oral tablet 12.5-15 mg, 12.5-30 mg, 12.5-45 mg, 25-15 mg, 25-30 mg, 25-45 mg	Tier 1	PA

Drug Name	Drug Tier	Notes
OSENI ORAL TABLET 12.5-15 MG, 12.5-30 MG, 12.5-45 MG, 25-15 MG, 25-30 MG, 25-45 MG	Tier 3	PA; Mand 90
Antihyperglycemic-Dipeptidyl Peptidase-4(Dpp-4)Inhibitor And Biguanide		
alogliptin-metformin oral tablet 12.5-1,000 mg, 12.5-500 mg	Tier 1	PA
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG	Tier 3	PA; Mand 90
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG	Tier 3	PA; Mand 90
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG	Tier 2	Mand 90
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	Tier 3	
KAZANO ORAL TABLET 12.5-1,000 MG, 12.5-500 MG	Tier 3	PA; Mand 90
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	Tier 3	PA; Mand 90
Antihyperglycemic-Insulin, Long Acting And Glp-1 Receptor Agonist Comb		
XULTOPHY SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG/ML	Tier 3	
Antithyroid Agents, Thionamides - Imidazole Derivatives		
methimazole oral tablet 10 mg, 5 mg	Tier 1	Mand 90
TAPAZOLE ORAL TABLET 10 MG, 5 MG	Tier 3	
Antithyroid Agents, Thionamides - Thiouracil Derivatives		
propylthiouracil oral tablet 50 mg	Tier 1	Mand 90
Bone Formation Stimulating Agents - Parathyroid Hormone-Type		
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE - 600 MCG/2.4 ML	Tier 8	

Drug Name	Drug Tier	Notes
Bone Resorption Inhibitors - Bisphosphonate And Vitamin D Combinations		
FOSAMAX PLUS D ORAL TABLET 70 MG-2,800 UNIT, 70 MG- 5,600 UNIT	Tier 3	Mand 90
Bone Resorption Inhibitors - Bisphosphonates		
ACTONEL ORAL TABLET 150 MG	Tier 3	
ACTONEL ORAL TABLET 30 MG, 35 MG, 5 MG	Tier 2	Mand 90
alendronate oral solution 70 mg/75 ml	Tier 1	Mand 90
alendronate oral tablet 10 mg, 35 mg, 40 mg, 5 mg, 70 mg	Tier 1	Mand 90
ATELVIA ORAL TABLET,DELAYED RELEASE (DR/EC) 35 MG	Tier 3	
BINOSTO ORAL TABLET, EFFERVESCENT 70 MG	Tier 3	
BONIVA ORAL TABLET 150 MG	Tier 3	
etidronate disodium oral tablet 200 mg, 400 mg	Tier 1	Mand 90
FOSAMAX ORAL TABLET 70 MG	Tier 3	
ibandronate oral tablet 150 mg	Tier 1	Mand 90
risedronate oral tablet 150 mg	Tier 1	Mand 90
risedronate oral tablet,delayed release (dr/ec) 35 mg	Tier 1	Mand 90
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer		
SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG	Tier 8	30D; Specialty
Calcitonins		
calcitonin (salmon) nasal spray,non-aerosol 200 unit/actuation	Tier 1	Mand 90
MIACALCIN NASAL SPRAY,NON-AEROSOL 200 UNIT/ACTUATION	Tier 3	
Estrogen And Progestin With Antimineralocorticoid Activity,Combination		
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG	Tier 5	PA; Mand 90
Estrogen-Androgen		
covaryx h.s. oral tablet 0.625-1.25 mg	Tier 1	AR; Mand 90; AR

Drug Name	Drug Tier	Notes
covaryx oral tablet 1.25-2.5 mg	Tier 1	AR; Mand 90; AR
eemt hs oral tablet 0.625-1.25 mg	Tier 1	AR; Mand 90; AR
eemt oral tablet 1.25-2.5 mg	Tier 1	AR; Mand 90; AR
estrogens-methyltestosterone oral tablet 0.625-1.25 mg, 1.25-2.5 mg	Tier 1	AR; Mand 90; AR
Estrogen-Progestin		
ACTIVELLA ORAL TABLET 0.5-0.1 MG, 1-0.5 MG	Tier 3	AR
amabelz oral tablet 0.5-0.1 mg, 1-0.5 mg	Tier 1	
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/24 HR	Tier 3	AR; Mand 90; AR
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR, 0.05-0.25 MG/24 HR	Tier 2	AR; AR
estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg	Tier 1	AR; Mand 90
FEMHRT LOW DOSE ORAL TABLET 0.5-2.5 MG-MCG	Tier 3	Mand 90
fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	Tier 1	
JEVANTIQUE LO ORAL TABLET 0.5-2.5 MG-MCG	Tier 3	
jinteli oral tablet 1-5 mg-mcg	Tier 1	Mand 90
lopreeza oral tablet 0.5-0.1 mg, 1-0.5 mg	Tier 1	Mand 90
mimvey lo oral tablet 0.5-0.1 mg	Tier 1	AR; Mand 90
mimvey oral tablet 1-0.5 mg	Tier 1	AR; Mand 90
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	Tier 1	
PREFEST ORAL TABLET 1 MG (15)/1 MG-0.09 MG (15)	Tier 3	Mand 90
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14)	Tier 2	AR; Mand 90; AR
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	Tier 2	AR; Mand 90; AR
Estrogens		
ALORA TRANSDERMAL PATCH SEMIWEEKLY 0.025 MG/24 HR, 0.05 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR	Tier 2	AR; AR
CLIMARA TRANSDERMAL PATCH WEEKLY 0.025 MG/24 HR, 0.0375 MG/24 HR, 0.05 MG/24 HR, 0.06 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR	Tier 3	

Drug Name	Drug Tier	Notes
DIVIGEL TRANSDERMAL GEL IN PACKET 0.5 MG (0.1 %)	Tier 3	
ELESTRIN TRANSDERMAL GEL IN METERED-DOSE PUMP 0.87 GRAM/ACTUATION	Tier 3	
ESTRACE ORAL TABLET 0.5 MG, 1 MG, 2 MG	Tier 3	AR; AR
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	AR; Mand 90; AR
estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	Tier 1	AR; Mand 90
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	Tier 1	AR; Mand 90; AR
ESTROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ACTUATION	Tier 3	
estropipate oral tablet 0.75 mg, 1.5 mg, 3 mg	Tier 1	AR; Mand 90; AR
EVAMIST TRANSDERMAL SPRAY,NON-AEROSOL 1.53 MG/SPRAY (1.7%)	Tier 3	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG	Tier 3	AR; Mand 90; AR
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24 HR	Tier 3	AR; AR
MINIVELLE TRANSDERMAL PATCH SEMIWEEKLY 0.025 MG/24 HR, 0.0375 MG/24 HR, 0.05 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR	Tier 3	AR; AR
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	Tier 2	AR; Mand 90; AR
VIVELLE-DOT TRANSDERMAL PATCH SEMIWEEKLY 0.025 MG/24 HR, 0.0375 MG/24 HR, 0.05 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR	Tier 3	AR; AR
Fertility Enhancer - Luteal Phase Supporting, Progesterone-Type		
CRINONE VAGINAL GEL 8 %	Tier 3	Infert.
ENDOMETRIN VAGINAL INSERT 100 MG	Tier 8	Specialty; Infert.
Fertility Enhancer - Ovulation Stimulant - Synthetic (Non-Fsh)		
clomiphene citrate oral tablet 50 mg	Tier 1	
SEROPHENE ORAL TABLET 50 MG	Tier 3	

Drug Name	Drug Tier	Notes
Follicle-Stimulating And Luteinizing Hormones		
MENOPUR SUBCUTANEOUS RECON SOLN 75 UNIT	Tier 8	PA; Specialty; 30D; Specialty; Infert.
Follicle-Stimulating Hormone (Fsh)		
BRAVELLE INJECTION RECON SOLN 75 UNIT	Tier 8	PA; Specialty; Specialty
FOLLISTIM AQ INJECTION SOLUTION 75 UNIT/0.5 ML	Tier 8	PA; Specialty; 30D; Specialty; Infert.
FOLLISTIM AQ SUBCUTANEOUS CARTRIDGE 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML	Tier 8	PA; Specialty; 30D; Specialty; Infert.
GONAL-F RFF REDI-JECT SUBCUTANEOUS PEN INJECTOR 300/0.5 UNIT/ML, 450/0.75 UNIT/ML, 900/1.5 UNIT/ML	Tier 4	PA; Specialty; 30D; Infert.
GONAL-F RFF SUBCUTANEOUS RECON SOLN 75 UNIT	Tier 8	PA; Specialty; 30D; Specialty; Infert.
GONAL-F SUBCUTANEOUS RECON SOLN 1,050 UNIT, 450 UNIT	Tier 8	PA; Specialty; 30D; Specialty; Infert.
Glucocorticoids		
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG	Tier 3	
cortisone oral tablet 25 mg	Tier 1	
deltasone oral tablet 20 mg	Tier 1	
DEXAMETHASONE INTENSOL ORAL DROPS 1 MG/ML	Tier 3	
dexamethasone oral elixir 0.5 mg/5 ml	Tier 1	
dexamethasone oral solution 0.5 mg/5 ml	Tier 1	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	Tier 1	
DEXPAK 10 DAY ORAL TABLETS,DOSE PACK 1.5 MG (35 TABS)	Tier 3	
DEXPAK 13 DAY ORAL TABLETS,DOSE PACK 1.5 MG (51 TABS)	Tier 3	
DEXPAK 6 DAY ORAL TABLETS,DOSE PACK 1.5 MG (21 TABS)	Tier 3	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	Tier 1	
MEDROL (PAK) ORAL TABLETS,DOSE PACK 4 MG	Tier 3	
MEDROL ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG	Tier 3	

Drug Name	Drug Tier	Notes
MEDROL ORAL TABLET 2 MG	Tier 2	
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	Tier 1	
methylprednisolone oral tablets,dose pack 4 mg	Tier 1	DDS
MILLIPRED DP ORAL TABLETS,DOSE PACK 5 MG (21 TABS), 5 MG (48 TABS)	Tier 3	
MILLIPRED ORAL SOLUTION 10 MG/5 ML	Tier 3	
MILLIPRED ORAL TABLET 5 MG	Tier 3	
ORAPRED ODT ORAL TABLET,DISINTEGRATING 10 MG, 15 MG, 30 MG	Tier 3	
PEDIAPRED ORAL SOLUTION 5 MG BASE/5 ML (6.7 MG/5 ML)	Tier 3	
prednisolone oral solution 15 mg/5 ml	Tier 1	
prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	Tier 1	
prednisolone sodium phosphate oral tablet,disintegrating 10 mg, 15 mg, 30 mg	Tier 1	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	Tier 2	
prednisone oral solution 5 mg/5 ml	Tier 1	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	Tier 1	
prednisone oral tablets,dose pack 10 mg, 5 mg	Tier 1	
RAYOS ORAL TABLET,DELAYED RELEASE (DR/EC) 1 MG, 2 MG, 5 MG	Tier 3	PA
Gonadotropin Inhibitor Pituitary Suppressants		
danazol oral capsule 100 mg, 200 mg, 50 mg	Tier 1	
Growth Hormone Receptor Antagonists		
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	Tier 8	PA; Specialty; 30D; Specialty
Growth Hormone Releasing Hormones (Ghrh)		
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG, 2 MG	Tier 8	PA; Specialty; 30D

Drug Name	Drug Tier	Notes
Growth Hormones		
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML, 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	Tier 8	PA; Specialty; 30D; Specialty
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML), 5 MG/ML (15 UNIT/ML)	Tier 8	PA; Specialty; 30D; Specialty
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT), 6 MG (18 UNIT)	Tier 8	PA; Specialty; 30D; Specialty
HUMATROPE INJECTION RECON SOLN 5 (15 UNIT) MG	Tier 8	PA; Specialty; 30D; Specialty
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	Tier 4	PA; Specialty; 30D; Specialty
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 20 MG/2 ML (10 MG/ML), 5 MG/2 ML (2.5 MG/ML)	Tier 8	PA; Specialty; 30D; Specialty
NUTROPIN AQ SUBCUTANEOUS CARTRIDGE 10 MG/2 ML (5 MG/ML)	Tier 8	PA; Specialty; 30D; Specialty
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	Tier 8	PA; Specialty; 30D; Specialty
OMNITROPE SUBCUTANEOUS RECON SOLN 5.8 MG	Tier 8	PA; Specialty; 30D; Specialty
SAIZEN CLICK.EASY SUBCUTANEOUS CARTRIDGE 8.8 MG/1.5 ML (FNL)	Tier 8	PA; Specialty
SAIZEN SUBCUTANEOUS RECON SOLN 5 MG, 8.8 MG	Tier 8	PA; Specialty
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	Tier 8	PA; Specialty; 30D; Specialty
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG, 5 MG	Tier 8	PA; Specialty; 30D; Specialty
ZORBTIVE SUBCUTANEOUS RECON SOLN 8.8 MG	Tier 8	PA; Specialty; 30D; Specialty
Human Chorionic Gonadotropin (Hcg)		
CHORIONIC GONADOTROPIN, HUMAN INTRAMUSCULAR RECON SOLN 10,000 UNIT	Tier 8	PA; Specialty; 30D; Specialty; Infert.

Drug Name	Drug Tier	Notes
NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT	Tier 8	PA; Specialty; 30D; Specialty; Infert.
OVIDREL SUBCUTANEOUS SYRINGE 250 MCG/0.5 ML	Tier 8	PA; Specialty; 30D; Specialty; Infert.
PREGNYL INTRAMUSCULAR RECON SOLN 10,000 UNIT	Tier 8	PA; Specialty; 30D; Specialty; Infert.
Human Insulins - Fixed Combinations		
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	Tier 2	Mand 90
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	Tier 2	Mand 90
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	Tier 3	PA
Human Insulins - Intermediate Acting		
HUMULIN N KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Tier 2	Mand 90
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	Tier 2	Mand 90
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	Tier 3	PA
Human Insulins - Short Acting		
AFREZZA INHALATION CARTRIDGE WITH INHALER 4 UNIT, 4 UNIT (30)/ 8 UNIT (60), 4 UNIT (60)/ 8 UNIT (30), 8 UNIT (60)/ 12 UNIT (30)	Tier 3	PA; QL/DS (4 unit cartridges: limited to 3 per day; 90 cartridges per 30 days 8 unit cartridges: limited to 9 per day; 270 cartridges per 30 days)
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	Tier 2	Mand 90
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML)	Tier 2	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML	Tier 2	
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	Tier 3	PA
Insulin Analogs - Fixed Combinations		
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (50-50)	Tier 2	
HUMALOG MIX 50-50 SUBCUTANEOUS SUSPENSION 100 UNIT/ML (50-50)	Tier 2	

Drug Name	Drug Tier	Notes
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (75-25)	Tier 2	
HUMALOG MIX 75-25 SUBCUTANEOUS SUSPENSION 100 UNIT/ML (75-25)	Tier 2	
NOVOLOG MIX 70-30 FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	Tier 3	PA
NOVOLOG MIX 70-30 SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	Tier 3	PA
Insulin Analogs - Long Acting		
BASAGLAR KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Tier 3	
LANTUS SOLOSTAR SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Tier 1	Mand 90
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	Tier 1	Mand 90
LEVEMIR FLEXTOUCH SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Tier 7	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	Tier 7	
TOUJEO SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)	Tier 2	Mand 90
TRESIBA FLEXTOUCH U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	Tier 3	
TRESIBA FLEXTOUCH U-200 SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Tier 3	
Insulin Analogs - Rapid Acting		
APIDRA SOLOSTAR SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 3	PA
APIDRA SUBCUTANEOUS SOLUTION 100 UNIT/ML	Tier 3	PA
HUMALOG KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 2	Mand 90
HUMALOG KWIKPEN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML)	Tier 2	
HUMALOG SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	Tier 2	Mand 90
HUMALOG SUBCUTANEOUS SOLUTION 100 UNIT/ML	Tier 2	Mand 90
NOVOLOG FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML	Tier 3	PA

Drug Name	Drug Tier	Notes
NOVOLOG PENFILL SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	Tier 3	PA
NOVOLOG SUBCUTANEOUS SOLUTION 100 UNIT/ML	Tier 3	PA
Insulin Response Enhancers - Biguanides		
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 1,000 MG, 500 MG	Tier 3	
GLUCOPHAGE ORAL TABLET 1,000 MG, 500 MG, 850 MG	Tier 3	
GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG, 750 MG	Tier 3	
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 1,000 MG, 500 MG	Tier 3	PA
metformin oral tablet 1,000 mg, 500 mg, 850 mg	Tier 1	Mand 90
metformin oral tablet extended release 24 hr 500 mg, 750 mg	Tier 1	Mand 90
metformin oral tablet extended release 24hr 1,000 mg, 500 mg	Tier 1	PA; Mand 90
RIOMET ORAL SOLUTION 500 MG/5 ML	Tier 3	
Insulin Response Enhancers - Thiazolidinediones (Ppar-Gamma Agonists)		
ACTOS ORAL TABLET 15 MG, 30 MG, 45 MG	Tier 3	
AVANDIA ORAL TABLET 2 MG, 4 MG	Tier 3	Mand 90
pioglitazone oral tablet 15 mg, 30 mg, 45 mg	Tier 1	Mand 90
Insulin-Like Growth Factor-1 (Igf-1)		
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
Leptin Hormone Analogs		
MYALEPT SUBCUTANEOUS RECON SOLN 5 MG/ML (FINAL CONC.)	Tier 8	30D; Specialty
Lhrh (Gnrh) Agonist Analog Pituitary Suppressants		
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG	Tier 8	PA; Specialty; 30D; Specialty
SYNAREL NASAL SPRAY,NON-AEROSOL 2 MG/ML	Tier 3	

Drug Name	Drug Tier	Notes
Lhrh (Gnrh) Antagonists		
CETROTIDE SUBCUTANEOUS KIT 0.25 MG	Tier 4	PA; Specialty; Specialty; Infert.
ganirelix subcutaneous syringe 250 mcg/0.5 ml	Tier 4	PA; Specialty; Infert.
Menopausal Symptoms Suppressant-Selective Estrogen Receptor Modulators		
OSPHENA ORAL TABLET 60 MG	Tier 3	
Menopausal Symptoms Suppressant-Ssri Antidepressant Type		
BRISDELLE ORAL CAPSULE 7.5 MG	Tier 3	PA
Mineralocorticoids		
fludrocortisone oral tablet 0.1 mg	Tier 1	
Parathyroid Hormones		
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG/DOSE, 25 MCG/DOSE, 50 MCG/DOSE, 75 MCG/DOSE	Tier 8	PA; Specialty; QL/DS (Limited to a 14 day supply per prescription.); Specialty; QL (1 cartridge per 1 day)
Progestins		
AYGESTIN ORAL TABLET 5 MG	Tier 3	
hydroxyprogesterone caproate intramuscular oil 250 mg/ml	Tier 6	
medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1	Mand 90
norethindrone acetate oral tablet 5 mg	Tier 1	Mand 90
progesterone micronized oral capsule 100 mg, 200 mg	Tier 1	Mand 90
PROMETRIUM ORAL CAPSULE 100 MG, 200 MG	Tier 3	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG	Tier 3	
Prolactin Inhibitor - Ergot Derivative Dopamine Receptor Agonists		
cabergoline oral tablet 0.5 mg	Tier 1	
Selective Estrogen Receptor Modulators (Serms)		
EVISTA ORAL TABLET 60 MG	Tier 5	
raloxifene oral tablet 60 mg	Tier 5	Mand 90

Drug Name	Drug Tier	Notes
Somatostatic Agents		
octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	Tier 4	30D; Specialty
octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)	Tier 4	30D; Specialty
SANDOSTATIN INJECTION SOLUTION 1,000 MCG/ML, 100 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML	Tier 8	30D; Specialty
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML), 0.9 MG/ML (1 ML)	Tier 8	
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML	Tier 8	PA; 30D; Specialty
Thyroid Hormone Combinations - Synthetic T3 And T4		
THYROLAR-1 ORAL TABLET 12.5-50 MCG	Tier 2	Mand 90
THYROLAR-1/2 ORAL TABLET 6.25-25 MCG	Tier 2	Mand 90
THYROLAR-1/4 ORAL TABLET 3.1-12.5 MCG	Tier 2	Mand 90
THYROLAR-2 ORAL TABLET 25-100 MCG	Tier 2	Mand 90
THYROLAR-3 ORAL TABLET 37.5-150 MCG	Tier 2	Mand 90
Thyroid Hormones - Animal Source (Porcine)		
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG	Tier 2	AR; AR
NATURE-THROID ORAL TABLET 113.75 MG, 130 MG, 146.25 MG, 16.25 MG, 162.5 MG, 195 MG, 260 MG, 32.5 MG, 325 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG	Tier 1	AR; AR
np thyroid oral tablet 15 mg	Tier 1	AR; Mand 90
np thyroid oral tablet 30 mg, 60 mg, 90 mg	Tier 1	AR; Mand 90; AR
WESTHROID ORAL TABLET 130 MG, 195 MG, 32.5 MG, 65 MG, 97.5 MG	Tier 1	
WP THYROID ORAL TABLET 113.75 MG, 130 MG, 16.25 MG, 32.5 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG	Tier 1	

Drug Name	Drug Tier	Notes
Thyroid Hormones - Synthetic T3 (Triiodothyronine)		
CYTOMEL ORAL TABLET 25 MCG, 5 MCG, 50 MCG	Tier 3	
liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg	Tier 1	Mand 90
Thyroid Hormones - Synthetic T4 (Thyroxine)		
levothyroxine oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	Tier 1	Mand 90
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 1	
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 2	
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 3	
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	Tier 1	
Gastrointestinal Therapy Agents		
Antidiarrheal - Antiperistaltic Agents		
loperamide oral capsule 2 mg	Tier 1	
opium tincture oral tincture 10 mg/ml (morphine)	Tier 1	
paregoric oral liquid 2 mg/5 ml	Tier 1	
Antidiarrheal - Gastrointestinal Chloride Channel Inhibitors		
MYTESI ORAL TABLET,DELAYED RELEASE (DR/EC) 125 MG	Tier 3	
Antidiarrheal Antiperistaltic-Anticholinergic Combinations		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml	Tier 1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	Tier 1	
LOMOTIL ORAL TABLET 2.5-0.025 MG	Tier 3	
MOTOFEN ORAL TABLET 1-0.025 MG	Tier 3	

Drug Name	Drug Tier	Notes
Antiemetic - Anticholinergics		
TRANSDERM-SCOP TRANSDERMAL PATCH 3 DAY 1.5 MG (1 MG OVER 3 DAYS)	Tier 2	
Antiemetic - Antihistamines		
ANTIVERT ORAL TABLET 12.5 MG, 25 MG	Tier 3	
meclizine oral tablet 12.5 mg, 25 mg	Tier 1	
Antiemetic - Antihistamine-Vitamin Combinations		
DICLEGIS ORAL TABLET,DELAYED RELEASE (DR/EC) 10-10 MG	Tier 3	PA; QL (4 tabs per 1 day)
Antiemetic - Cannabinoids		
CESAMET ORAL CAPSULE 1 MG	Tier 3	
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	Tier 1	
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG	Tier 3	
Antiemetic - Dopamine (D2)/5-Ht3 Antagonists		
TIGAN ORAL CAPSULE 300 MG	Tier 3	AR; AR
trimethobenzamide oral capsule 300 mg	Tier 1	AR; AR
Antiemetic - Phenothiazines		
COMPAZINE ORAL TABLET 10 MG, 5 MG	Tier 3	
COMPAZINE RECTAL SUPPOSITORY 25 MG	Tier 3	
COMPRO RECTAL SUPPOSITORY 25 MG	Tier 1	
PHENADOZ RECTAL SUPPOSITORY 12.5 MG, 25 MG	Tier 1	AR; AR
PHENERGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG	Tier 3	AR; AR
prochlorperazine maleate oral tablet 10 mg, 5 mg	Tier 1	
prochlorperazine rectal suppository 25 mg	Tier 1	
promethazine rectal suppository 12.5 mg, 25 mg	Tier 1	AR; AR
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG	Tier 1	AR; AR
Antiemetic - Selective Serotonin 5-Ht3 Antagonists		
ANZEMET ORAL TABLET 100 MG, 50 MG	Tier 8	30D
granisetron hcl oral tablet 1 mg	Tier 1	
ondansetron hcl oral solution 4 mg/5 ml	Tier 1	

Drug Name	Drug Tier	Notes
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	Tier 1	
ondansetron oral tablet,disintegrating 4 mg, 8 mg	Tier 1	
SANCUSO TRANSDERMAL PATCH WEEKLY 3.1 MG/24 HOUR	Tier 3	
SUSTOL SUBCUTANEOUS LIQUID,EXTENDED RELEASE SYRING 10 MG/0.4 ML	Tier 6	
ZOFRAN (AS HYDROCHLORIDE) ORAL SOLUTION 4 MG/5 ML	Tier 3	
ZOFRAN (AS HYDROCHLORIDE) ORAL TABLET 4 MG, 8 MG	Tier 3	
ZOFRAN ODT ORAL TABLET,DISINTEGRATING 4 MG, 8 MG	Tier 3	
ZUPLENZ ORAL FILM 4 MG, 8 MG	Tier 3	PA
Antiemetic - Substance P-Neurokinin 1 (Nk1) Receptor Antagonists		
EMEND ORAL CAPSULE 125 MG, 40 MG, 80 MG	Tier 2	
EMEND ORAL CAPSULE,DOSE PACK 125 MG (1)- 80 MG (2)	Tier 2	
EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ ML FINAL CONC.)	Tier 3	
VARUBI ORAL TABLET 90 MG	Tier 3	
Antiemetic - Substance P-Neurokinin 1 And 5-Ht3 Recept Antagonist Comb		
AKYNZEO ORAL CAPSULE 300-0.5 MG	Tier 3	PA; QL (4 capsules per 30 days)
Bile Acids		
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	Tier 8	Specialty; 30D; Specialty
Colonic Acidifier (Ammonia Inhibitor)		
ENULOSE ORAL SOLUTION 10 GRAM/15 ML	Tier 1	
GENERLAC ORAL SOLUTION 10 GRAM/15 ML	Tier 1	
lactulose oral solution 10 gram/15 ml	Tier 1	
Digestive Enzyme Mixtures		
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000-180,000 UNIT, 6,000-19,000 -30,000 UNIT	Tier 2	

Drug Name	Drug Tier	Notes
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 2,600-6,200- 10,850 UNIT	Tier 3	
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 16,000-57,500- 60,500 UNIT, 4,000-14,375- 15,125 UNIT, 8,000-28,750- 30,250 UNIT	Tier 3	
VIOKACE ORAL TABLET 10,440-39,150-39,150 UNIT, 20,880-78,300- 78,300 UNIT	Tier 3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-34,000 -55,000 UNIT, 15,000-51,000 -82,000 UNIT, 20,000-68,000 -109,000 UNIT, 25,000-85,000-136,000 UNIT, 3,000-10,000- 16,000 UNIT, 40,000-136,000- 218,000 UNIT, 5,000-17,000 -27,000 UNIT	Tier 3	
Digestive Enzymes		
SUCRAID ORAL SOLUTION 8,500 UNIT/ML	Tier 8	30D; Specialty
Gallstone Solubilizing (Litholysis) Agents		
ACTIGALL ORAL CAPSULE 300 MG	Tier 3	
CHENODAL ORAL TABLET 250 MG	Tier 8	30D; Specialty
URSO 250 ORAL TABLET 250 MG	Tier 3	
URSO FORTE ORAL TABLET 500 MG	Tier 3	
ursodiol oral capsule 300 mg	Tier 1	
ursodiol oral tablet 250 mg, 500 mg	Tier 1	
Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists		
cimetidine hcl oral solution 300 mg/5 ml	Tier 1	
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	Tier 1	
famotidine oral suspension 40 mg/5 ml (8 mg/ml)	Tier 1	
famotidine oral tablet 20 mg, 40 mg	Tier 1	
nizatidine oral capsule 150 mg, 300 mg	Tier 1	
nizatidine oral solution 150 mg/10 ml	Tier 1	
PEPCID ORAL SUSPENSION 40 MG/5 ML (8 MG/ML)	Tier 3	
ranitidine hcl oral capsule 150 mg, 300 mg	Tier 1	
ranitidine hcl oral syrup 15 mg/ml	Tier 1	
ranitidine hcl oral tablet 150 mg, 300 mg	Tier 1	
ZANTAC ORAL TABLET 150 MG, 300 MG	Tier 3	

Drug Name	Drug Tier	Notes
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (Ppis)		
ACIPHEX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG	Tier 3	
ACIPHEX SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 10 MG, 5 MG	Tier 3	PA
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 30 MG, 60 MG	Tier 3	PA; QL (1 capsule per 1 day)
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg, 40 mg	Tier 1	PA
lansoprazole oral capsule,delayed release(dr/ec) 15 mg, 30 mg	Tier 1	
NEXIUM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG, 40 MG	Tier 3	PA; QL (1 capsule per 1 day)
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 40 MG, 5 MG	Tier 3	PA; QL (1 packet per 1 day)
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg	Tier 1	
pantoprazole oral tablet,delayed release (dr/ec) 20 mg, 40 mg	Tier 1	
PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 15 MG, 30 MG	Tier 3	
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG, 30 MG	Tier 3	PA; QL (1 tablet per 1 day)
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON 10 MG, 2.5 MG	Tier 3	PA; QL (1 packet per 1 day)
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	Tier 3	PA; QL (1 packet per 1 day)
PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG, 40 MG	Tier 3	
rabeprazole oral tablet,delayed release (dr/ec) 20 mg	Tier 1	
Gastric Acid Secretion Reducing-Proton Pump Inhibitor And Antacid Comb		
omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram, 40-1.1 mg-gram	Tier 1	
omeprazole-sodium bicarbonate oral packet 20-1,680 mg, 40-1,680 mg	Tier 1	PA
ZEGERID ORAL CAPSULE 20-1.1 MG-GRAM, 40-1.1 MG-GRAM	Tier 3	

Drug Name	Drug Tier	Notes
ZEGERID ORAL PACKET 20-1,680 MG, 40-1,680 MG	Tier 3	PA
Gastric Mucosa - Cytoprotective Prostaglandin Analogs		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG	Tier 3	
misoprostol oral tablet 100 mcg, 200 mcg	Tier 1	
Gastrointestinal Prokinetic Agents - D2 Antagonist/5-Ht4 Agonists		
metoclopramide hcl oral solution 5 mg/5 ml	Tier 1	
metoclopramide hcl oral tablet 10 mg, 5 mg	Tier 1	
metoclopramide hcl oral tablet,disintegrating 5 mg	Tier 1	
REGLAN ORAL TABLET 10 MG, 5 MG	Tier 3	
Gi Antispasmodic - Belladonna Alkaloids		
ANASPAZ ORAL TABLET,DISINTEGRATING 0.125 MG	Tier 3	
ED-SPAZ ORAL TABLET,DISINTEGRATING 0.125 MG	Tier 1	
hyoscyamine sulfate oral drops 0.125 mg/ml	Tier 1	
hyoscyamine sulfate oral elixir 0.125 mg/5 ml	Tier 1	
hyoscyamine sulfate oral tablet 0.125 mg	Tier 1	
hyoscyamine sulfate oral tablet extended release 12 hr 0.375 mg	Tier 1	
hyoscyamine sulfate oral tablet,disintegrating 0.125 mg	Tier 1	
hyoscyamine sulfate sublingual tablet 0.125 mg	Tier 1	
HYOSYNE ORAL ELIXIR 0.125 MG/5 ML	Tier 1	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG	Tier 3	
LEVSIN ORAL TABLET 0.125 MG	Tier 3	
LEVSIN/SL SUBLINGUAL TABLET 0.125 MG	Tier 3	
methscopolamine oral tablet 2.5 mg, 5 mg	Tier 1	
NULEV ORAL TABLET,DISINTEGRATING 0.125 MG	Tier 3	
OSCIMIN ORAL TABLET 0.125 MG	Tier 1	
OSCIMIN SL SUBLINGUAL TABLET 0.125 MG	Tier 1	

Drug Name	Drug Tier	Notes
OSCIMIN SR ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG	Tier 1	
SYMAX FASTABS ORAL TABLET,DISINTEGRATING 0.125 MG	Tier 1	
SYMAX-SL SUBLINGUAL TABLET 0.125 MG	Tier 3	
SYMAX-SR ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG	Tier 3	
Gi Antispasmodic - Quaternary Ammonium Compounds		
glycopyrrolate oral tablet 1 mg, 2 mg	Tier 1	
propantheline oral tablet 15 mg	Tier 1	
ROBINUL FORTE ORAL TABLET 2 MG	Tier 3	
ROBINUL ORAL TABLET 1 MG	Tier 3	
Gi Antispasmodic - Synthetic Tertiary Amines		
BENTYL ORAL CAPSULE 10 MG	Tier 3	
BENTYL ORAL TABLET 20 MG	Tier 3	
dicyclomine oral capsule 10 mg	Tier 1	
dicyclomine oral solution 10 mg/5 ml	Tier 1	
dicyclomine oral tablet 20 mg	Tier 1	
Gi Antispasmodic And Benzodiazepine Combinations		
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	Tier 1	
LIBRAX (WITH CLIDINIUM) ORAL CAPSULE 5-2.5 MG	Tier 3	
Gi Antispasmodic Combinations Other		
belladonna alkaloids-opium rectal suppository 16.2-60 mg	Tier 1	
BELLADONNA-OPIUM RECTAL SUPPOSITORY 16.2-30 MG	Tier 1	
chlordiazepoxide-clidinium oral capsule 5-2.5 mg	Tier 1	
DONNATAL ORAL ELIXIR 16.2-0.1037 -0.0194 MG/5 ML	Tier 3	
DONNATAL ORAL TABLET 16.2-0.1037 -0.0194 MG	Tier 3	
LIBRAX (WITH CLIDINIUM) ORAL CAPSULE 5-2.5 MG	Tier 3	

Drug Name	Drug Tier	Notes
Ibs Agent - Gastrointestinal Chloride Channel Activator Agents		
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG	Tier 2	PA
Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG	Tier 3	
Ibs Agent - Mixed Opioid Receptor Agonist And Antagonist		
VIBERZI ORAL TABLET 100 MG, 75 MG	Tier 4	Specialty; 30D; Specialty
Ibs Agent - Selective 5-Ht3 Receptor Antagonists		
alosetron oral tablet 0.5 mg, 1 mg	Tier 4	Specialty; Specialty
LOTRONEX ORAL TABLET 0.5 MG, 1 MG	Tier 8	Specialty; 30D; Specialty
Inflammatory Bowel Agent - Interleukin-12 And Il-23 Inhibitors, Mc Ab		
STELARA INTRAVENOUS SOLUTION 130 MG/26 ML	Tier 6	
Inflammatory Bowel Agent - Aminosalicylates And Related Agents		
APRISO ORAL CAPSULE,EXTENDED RELEASE 24HR 0.375 GRAM	Tier 2	Mand 90
ASACOL HD ORAL TABLET,DELAYED RELEASE (DR/EC) 800 MG	Tier 3	Mand 90
AZULFIDINE EN-TABS ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	Tier 3	
AZULFIDINE ORAL TABLET 500 MG	Tier 3	
balsalazide oral capsule 750 mg	Tier 1	
CANASA RECTAL SUPPOSITORY 1,000 MG	Tier 2	Mand 90; QL (1 suppository per 1 day)
COLAZAL ORAL CAPSULE 750 MG	Tier 3	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS) 400 MG	Tier 3	
DIPENTUM ORAL CAPSULE 250 MG	Tier 3	PA (New); Mand 90
GIAZO ORAL TABLET 1.1 GRAM	Tier 3	PA (New)
LIALDA ORAL TABLET,DELAYED RELEASE (DR/EC) 1.2 GRAM	Tier 3	PA (New); Mand 90

Drug Name	Drug Tier	Notes
mesalamine oral tablet,delayed release (dr/ec) 800 mg	Tier 1	
mesalamine rectal enema 4 gram/60 ml	Tier 1	Mand 90
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG, 500 MG	Tier 2	Mand 90
ROWASA RECTAL ENEMA KIT 4 GRAM/60 ML	Tier 3	
sulfasalazine oral tablet 500 mg	Tier 1	Mand 90
sulfasalazine oral tablet,delayed release (dr/ec) 500 mg	Tier 1	Mand 90
sulfazine oral tablet 500 mg	Tier 1	Mand 90
Inflammatory Bowel Agent - Glucocorticoids		
budesonide oral capsule,delayed,extend.release 3 mg	Tier 1	
COLOCORT RECTAL ENEMA 100 MG/60 ML	Tier 1	
CORTENEMA RECTAL ENEMA 100 MG/60 ML	Tier 3	
CORTIFOAM RECTAL FOAM 10 % (80 MG)	Tier 3	
ENTOCORT EC ORAL CAPSULE,DELAYED,EXTEND.RELEASE 3 MG	Tier 3	
hydrocortisone rectal enema 100 mg/60 ml	Tier 1	
UCERIS ORAL TABLET,DELAYED AND EXT.RELEASE 9 MG	Tier 8	PA (New); 30D; Specialty
Inflammatory Bowel Agent - Tumor Necrosis Factor Alpha Blockers		
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	Tier 8	PA; 30D; Specialty
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	Tier 8	PA; 30D; Specialty
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML	Tier 4	PA; Specialty; Specialty
Irritable Bowel Syndrome (Ibs) Agents		
alosetron oral tablet 0.5 mg, 1 mg	Tier 4	Specialty; Specialty

Drug Name	Drug Tier	Notes
LINZESS ORAL CAPSULE 145 MCG, 290 MCG	Tier 3	
LOTRONEX ORAL TABLET 0.5 MG, 1 MG	Tier 8	Specialty; 30D; Specialty
Laxative - Saline And Osmotic		
CONSTULOSE ORAL SOLUTION 10 GRAM/15 ML	Tier 1	
KRISTALOSE ORAL PACKET 10 GRAM, 20 GRAM	Tier 3	
lactulose oral solution 10 gram/15 ml	Tier 1	
polyethylene glycol 3350 oral powder 17 gram/dose	Tier 1	
polyethylene glycol 3350 oral powder in packet 17 gram	Tier 1	
Laxative - Saline/Osmotic Mixtures		
COLYTE WITH FLAVOR PACKS ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM	Tier 3	
GAVILYTE-C ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM	Tier 1	
GAVILYTE-G ORAL RECON SOLN 236-22.74-6.74 -5.86 GRAM	Tier 1	
GAVILYTE-N ORAL RECON SOLN 420 GRAM	Tier 1	
GOLYTELY ORAL POWDER IN PACKET 227.1-21.5-6.36 GRAM	Tier 2	
GOLYTELY ORAL RECON SOLN 236-22.74-6.74 -5.86 GRAM	Tier 3	
MOVIPREP ORAL POWDER IN PACKET 100-7.5-2.691 GRAM	Tier 3	
NULYTELY WITH FLAVOR PACKS ORAL RECON SOLN 420 GRAM	Tier 3	
OSMOPREP ORAL TABLET 1.5 GRAM	Tier 3	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram, 240-22.72-6.72 -5.84 gram	Tier 1	
PEG-3350 WITH FLAVOR PACKS ORAL RECON SOLN 420 GRAM	Tier 1	
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM	Tier 3	
TRILYTE WITH FLAVOR PACKETS ORAL RECON SOLN 420 GRAM	Tier 1	

Drug Name	Drug Tier	Notes
Laxative - Stimulant And Saline/Osmotic Combinations		
gavilyte-h and bisacodyl oral kit 5-210 mg-gram	Tier 1	
PEG-PREP ORAL KIT 5-210 MG-GRAM	Tier 3	
PREPOPIK ORAL POWDER IN PACKET 10 MG-3.5 GRAM-12 GRAM	Tier 3	
Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives		
CARAFATE ORAL SUSPENSION 100 MG/ML	Tier 2	
CARAFATE ORAL TABLET 1 GRAM	Tier 3	
sucralfate oral suspension 100 mg/ml	Tier 1	
sucralfate oral tablet 1 gram	Tier 1	
Peptic Ulcer - Treatment Of H. Pylori: Antibiotic-Bismuth Combinations		
PYLERA ORAL CAPSULE 140-125-125 MG	Tier 3	
Peptic Ulcer-Treatment H. Pylori-Proton Pump Inhibitor And Antibiotics		
amoxicil-clarithromy-lansopraz oral combo pack 500-500-30 mg	Tier 1	
OMECLAMOX-PAK ORAL COMBO PACK 20 MG-500 MG- 500 MG (40)	Tier 3	
PREVPAC ORAL COMBO PACK 500-500-30 MG	Tier 3	
Short Bowel Syndrome (Sbs) - Glucagon-Like Peptide-2 (Glp-2) Analog		
GATTEX 30-VIAL SUBCUTANEOUS KIT 5 MG	Tier 8	30D; Specialty
GATTEX ONE-VIAL SUBCUTANEOUS KIT 5 MG	Tier 8	30D; Specialty
Short Bowel Syndrome (Sbs) Agents		
NUTRESTORE ORAL POWDER IN PACKET 5 GRAM	Tier 3	
octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	Tier 4	30D; Specialty
octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)	Tier 4	30D; Specialty

Drug Name	Drug Tier	Notes
SAIZEN SUBCUTANEOUS RECON SOLN 8.8 MG	Tier 8	PA; Specialty
SANDOSTATIN INJECTION SOLUTION 1,000 MCG/ML, 100 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML	Tier 8	30D; Specialty
ZORBTIVE SUBCUTANEOUS RECON SOLN 8.8 MG	Tier 8	PA; Specialty; 30D; Specialty
Genitourinary Therapy		
Bph Agent- 5-Alpha Reductase Inhib And Alpha-1 Adrenoceptor Antag Comb		
JALYN ORAL CAPSULE, ER MULTIPHASE 24 HR 0.5-0.4 MG	Tier 2	
Cystinosis Therapy (Cystine Depleting Agents)		
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	Tier 3	
PROCYSBI ORAL CAPSULE, DELAYED REL SPRINKLE 25 MG, 75 MG	Tier 8	30D; Specialty
G.U. Irrigants - Anti-Infective		
NEOSPORIN GU IRRIGANT IRRIGATION SOLUTION 40 MG-200,000 UNIT/ML	Tier 3	
Interstitial Cystitis Agents		
ELMIRON ORAL CAPSULE 100 MG	Tier 2	
Kidney Stone Agents		
THIOLA ORAL TABLET 100 MG	Tier 3	
Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist		
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG, 50 MG	Tier 3	PA; Mand 90; QL (1 tablet per 1 day)
Phosphate Binders		
AURYXIA ORAL TABLET 210 MG IRON	Tier 3	
calcium acetate oral capsule 667 mg	Tier 1	
calcium acetate oral tablet 667 mg	Tier 1	
ELIPHOS ORAL TABLET 667 MG	Tier 3	PA
FOSRENOL ORAL POWDER IN PACKET 1,000 MG, 750 MG	Tier 4	Specialty; 30D; Specialty
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 500 MG, 750 MG	Tier 4	Specialty; 30D; Specialty
MAGNEBIND 400 ORAL TABLET 400-200-1 MG	Tier 3	

Drug Name	Drug Tier	Notes
PHOSLYRA ORAL SOLUTION 667 MG (169 MG CALCIUM)/5 ML	Tier 3	
RENAGEL ORAL TABLET 400 MG, 800 MG	Tier 4	30D; Specialty
RENVELA ORAL POWDER IN PACKET 0.8 GRAM, 2.4 GRAM	Tier 2	
RENVELA ORAL TABLET 800 MG	Tier 4	Specialty; 30D; Specialty
VELPHORO ORAL TABLET,CHEWABLE 500 MG	Tier 8	30D; Specialty
Phosphate Binders - Iron-Based		
AURYXIA ORAL TABLET 210 MG IRON	Tier 3	
VELPHORO ORAL TABLET,CHEWABLE 500 MG	Tier 8	30D; Specialty
Prostatic Hypertrophy Agent - Alpha-1-Adrenoceptor Antagonists		
alfuzosin oral tablet extended release 24 hr 10 mg	Tier 1	Mand 90
FLOMAX ORAL CAPSULE,EXTENDED RELEASE 24HR 0.4 MG	Tier 3	
RAPAFLO ORAL CAPSULE 4 MG, 8 MG	Tier 3	PA; Mand 90
tamsulosin oral capsule,extended release 24hr 0.4 mg	Tier 1	Mand 90
UROXATRAL ORAL TABLET EXTENDED RELEASE 24 HR 10 MG	Tier 3	
Prostatic Hypertrophy Agent - Type Ii 5-Alpha Reductase Inhibitors		
finasteride oral tablet 5 mg	Tier 1	Mand 90
PROSCAR ORAL TABLET 5 MG	Tier 3	
Prostatic Hypertrophy Agent-Sel.Cgmp Phosphodiesterase Type5 Inhibitor		
CIALIS ORAL TABLET 2.5 MG, 5 MG	Tier 2	PA; QL/DS (QL (limited to 30 tablets per month for indication of BPH) * No addtl qty of drugs for ED when receiving Cialis daily for BPH)
Prostatic Hypertrophy Agent-Type I And Ii 5-Alpha Reductase Inhibitors		
AVODART ORAL CAPSULE 0.5 MG	Tier 3	Mand 90
dutasteride oral capsule 0.5 mg	Tier 1	
Urinary Acidifier - Bacterial Urease Inhibitor		
LITHOSTAT ORAL TABLET 250 MG	Tier 3	

Drug Name	Drug Tier	Notes
Urinary Acidifier - Phosphates		
K-PHOS NO 2 ORAL TABLET 305-700 MG	Tier 2	
K-PHOS ORIGINAL ORAL TABLET,SOLUBLE 500 MG	Tier 2	
K-PHOS-NEUTRAL ORAL TABLET 250 MG	Tier 3	
PHOSPHA 250 NEUTRAL ORAL TABLET 250 MG	Tier 1	
Urinary Alkalinizer - Citrates		
potassium citrate oral tablet extended release 10 meq (1,080 mg), 5 meq (540 mg)	Tier 1	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1,080 MG)	Tier 3	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ	Tier 3	
UROCIT-K 5 ORAL TABLET EXTENDED RELEASE 5 MEQ (540 MG)	Tier 3	
Urinary Analgesics		
phenazopyridine oral tablet 100 mg, 200 mg	Tier 1	
PYRIDIUM ORAL TABLET 100 MG, 200 MG	Tier 3	
Urinary Antibacterial - Methenamine And Salts		
HIPREX ORAL TABLET 1 GRAM	Tier 3	
methenamine hippurate oral tablet 1 gram	Tier 1	
methenamine mandelate oral tablet 0.5 g, 1 gram	Tier 1	
UROQID-ACID NO.2 ORAL TABLET 500-500 MG	Tier 3	
Urinary Antibacterial - Nitrofuran Derivatives		
FURADANTIN ORAL SUSPENSION 25 MG/5 ML	Tier 3	AR
MACROBID ORAL CAPSULE 100 MG	Tier 3	AR; AR
MACRODANTIN ORAL CAPSULE 100 MG, 50 MG	Tier 3	AR; AR
MACRODANTIN ORAL CAPSULE 25 MG	Tier 2	AR; AR
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	Tier 1	AR; AR
nitrofurantoin monohyd/m-cryst oral capsule 100 mg	Tier 1	AR; AR
nitrofurantoin oral suspension 25 mg/5 ml	Tier 1	AR; AR

Drug Name	Drug Tier	Notes
Urinary Antibacterial - Quinolones		
CIPRO XR ORAL TABLET, ER MULTIPHASE 24 HR 1,000 MG, 500 MG	Tier 3	
ciprofloxacin (mixture) oral tablet, er multiphase 24 hr 1,000 mg, 500 mg	Tier 1	
Urinary Antibacterials Other		
MONUROL ORAL PACKET 3 GRAM	Tier 3	
Urinary Anti-Infective Methenamine-Antispas-Analg Combinations		
hyolev mb oral tablet 81-10.8-40.8 mg	Tier 1	
HYOPHEN ORAL TABLET 81.6-0.12-10.8 MG	Tier 1	
PHOSPHASAL ORAL TABLET 81.6-10.8-40.8 MG	Tier 2	
UR N-C ORAL TABLET 81.6-10.8-40.8 MG	Tier 1	
uramit mb oral capsule 118-10-40.8-36 mg	Tier 1	
URELLE ORAL TABLET 81-10.8-40.8 MG	Tier 3	
URETRON D-S ORAL TABLET 81.6-10.8-40.8 MG	Tier 2	
URIBEL ORAL CAPSULE 118-10-40.8-36 MG	Tier 3	
URIMAR-T ORAL TABLET 120-0.12-10.8 MG	Tier 3	
URIN DS ORAL TABLET 81.6-10.8-40.8 MG	Tier 2	
URO-MP ORAL CAPSULE 118-10-40.8-36 MG	Tier 1	
USTELL ORAL CAPSULE 120-0.12 MG	Tier 1	
Urinary Anti-Infective Methenamine-Antispasmodic Combinations		
methen-sod phos-meth blue-hyos oral tablet 81.6-40.8-0.12 mg	Tier 1	
UROGESIC-BLUE ORAL TABLET 81.6-40.8-0.12 MG	Tier 1	PA
urolet mb oral tablet 81.6-40.8-0.12 mg	Tier 1	
URYL ORAL TABLET 81.6-40.8-0.12 MG	Tier 3	
UTA ORAL CAPSULE 120-40.8-10 MG	Tier 3	

Drug Name	Drug Tier	Notes
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)		
darifenacin oral tablet extended release 24 hr 15 mg, 7.5 mg	Tier 1	QL (1 tablet per 1 day)
ENABLEX ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 7.5 MG	Tier 3	Mand 90; QL (1 tablet per 1 day)
VESICARE ORAL TABLET 10 MG, 5 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
Urinary Antispasmodic - Smooth Muscle Relaxants		
DETROL LA ORAL CAPSULE,EXTENDED RELEASE 24HR 2 MG, 4 MG	Tier 3	QL (1 capsule per 1 day)
DETROL ORAL TABLET 1 MG, 2 MG	Tier 3	
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 15 MG, 5 MG	Tier 3	QL (1 tablet per 1 day)
flavoxate oral tablet 100 mg	Tier 1	
GELNIQUE TRANSDERMAL GEL IN PACKET 10 % (100 MG/GRAM)	Tier 3	
oxybutynin chloride oral syrup 5 mg/5 ml	Tier 1	Mand 90
oxybutynin chloride oral tablet 5 mg	Tier 1	Mand 90
oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg	Tier 1	Mand 90; QL (1 tablet per 1 day)
OXYTROL TRANSDERMAL PATCH SEMIWEEKLY 3.9 MG/24 HR	Tier 3	
tolterodine oral capsule,extended release 24hr 2 mg, 4 mg	Tier 1	Mand 90; QL (1 capsule per 1 day)
tolterodine oral tablet 1 mg, 2 mg	Tier 1	Mand 90
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG	Tier 2	Mand 90; QL (1 tablet per 1 day)
trospium oral capsule,extended release 24hr 60 mg	Tier 1	Mand 90
trospium oral tablet 20 mg	Tier 1	Mand 90
Urinary Retention Therapy - Parasympathomimetic Agents		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	Tier 1	
URECHOLINE ORAL TABLET 10 MG, 25 MG, 5 MG, 50 MG	Tier 3	
Gout And Hyperuricemia Therapy		
Gout Acute Therapy - Antimitotics		
colchicine oral capsule 0.6 mg	Tier 1	

Drug Name	Drug Tier	Notes
colchicine oral tablet 0.6 mg	Tier 1	
COLCRYS ORAL TABLET 0.6 MG	Tier 3	
MITIGARE ORAL CAPSULE 0.6 MG	Tier 3	
Gout And Hyperuricemia - Antimitotic-Uricosuric Combinations		
probenecid-colchicine oral tablet 500-0.5 mg	Tier 1	
Hyperuricemia Therapy - Uric Acid Transporter 1 (Urat1) Inhibitors		
ZURAMPIC ORAL TABLET 200 MG	Tier 3	
Hyperuricemia Therapy - Uricosurics		
probenecid oral tablet 500 mg	Tier 1	Mand 90
Hyperuricemia Therapy - Xanthine Oxidase Inhibitors		
allopurinol oral tablet 100 mg, 300 mg	Tier 1	Mand 90
ALOPRIM INTRAVENOUS RECON SOLN 500 MG	Tier 3	
ULORIC ORAL TABLET 40 MG, 80 MG	Tier 2	PA; QL (1 tablet per 1 day)
ZYLOPRIM ORAL TABLET 100 MG, 300 MG	Tier 3	
Hematological Agents		
Anticoagulants - Citrate-Based		
ACD-A SOLUTION	Tier 3	
Anticoagulants - Coumarin		
COUMADIN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	Tier 2	
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	Tier 1	
warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg	Tier 1	
Direct Factor Xa Inhibitors		
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	Tier 2	QL (74 tablets per 31 days)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG	Tier 3	QL (1 tablet per 1 day)
XARELTO ORAL TABLET 10 MG	Tier 2	QL (35 tablets per 1 episode)
XARELTO ORAL TABLET 15 MG	Tier 2	
XARELTO ORAL TABLET 20 MG	Tier 2	QL (1 tablet per 1 day)
XARELTO ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9)	Tier 2	

Drug Name	Drug Tier	Notes
Erythropoietins		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 150 MCG/0.75 ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	Tier 8	PA; Specialty; 30D; Specialty
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML	Tier 8	PA; Specialty; 30D; Specialty
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	Tier 4	PA; Specialty; 30D; Specialty
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML	Tier 8	30D; Specialty
MIRCERA INJECTION SYRINGE 200 MCG/0.3 ML	Tier 8	Specialty; Specialty
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML	Tier 4	PA; Specialty; Specialty
Factor Ix Preparations		
ALPHANINE SD INTRAVENOUS RECON SOLN 1,500 (+/-) UNIT	Tier 6	30D
Granulocyte Colony-Stimulating Factor (G-Csf)		
GRANIX SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	Tier 8	Specialty; Specialty
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6ML	Tier 8	Specialty; 30D; Specialty
NEULASTA SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML	Tier 8	Specialty; 30D; Specialty
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	Tier 4	Specialty; 30D; Specialty
NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	Tier 4	Specialty; 30D; Specialty
Granulocyte-Macrophage Colony-Stimulating Factor (Gm-Csf)		
LEUKINE INJECTION RECON SOLN 250 MCG	Tier 4	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
Hematorheologic Agents		
pentoxifylline oral tablet extended release 400 mg	Tier 1	
Hemostatic Systemic - Antifibrinolytic Agents		
AMICAR ORAL TABLET 500 MG	Tier 3	
LYSTEDA ORAL TABLET 650 MG	Tier 3	
tranexamic acid oral tablet 650 mg	Tier 1	
Human Monoclonal Antibody Complement (C5) Inhibitors		
SOLIRIS INTRAVENOUS SOLUTION 300 MG/30 ML	Tier 6	30D
Indirect Factor Xa Inhibitors		
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 2.5 MG/0.5 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	Tier 3	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 2.5 mg/0.5 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	Tier 1	
Low Molecular Weight Heparins		
enoxaparin subcutaneous solution 300 mg/3 ml	Tier 1	
enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml	Tier 1	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	Tier 8	Specialty; 30D; Specialty
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML, 7,500 ANTI-XA UNIT/0.3 ML	Tier 8	Specialty; 30D; Specialty
LOVENOX SUBCUTANEOUS SOLUTION 300 MG/3 ML	Tier 3	
LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML, 120 MG/0.8 ML, 150 MG/ML, 30 MG/0.3 ML, 40 MG/0.4 ML, 60 MG/0.6 ML, 80 MG/0.8 ML	Tier 3	
Platelet Aggregation Inhib - Cyclopentyl-Triazolo-Pyrimidines (Cptps)		
BRILINTA ORAL TABLET 60 MG, 90 MG	Tier 3	QL (2 tablets per 1 day)

Drug Name	Drug Tier	Notes
Platelet Aggregation Inhibitor Combinations		
AGGRENOX ORAL CAPSULE, ER MULTIPHASE 12 HR 25-200 MG	Tier 3	Mand 90
aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg	Tier 1	Mand 90
Platelet Aggregation Inhibitors - Phosphodiesterase Iii Inhibitors		
cilostazol oral tablet 100 mg, 50 mg	Tier 1	Mand 90
Platelet Aggregation Inhibitors - Quinazoline Agents		
AGRYLIN ORAL CAPSULE 0.5 MG	Tier 3	
anagrelide oral capsule 0.5 mg, 1 mg	Tier 1	Mand 90
Platelet Aggregation Inhibitors - Salicylates		
ADULT LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR
aspirin oral tablet 325 mg	Tier 5	AR; AR
aspirin oral tablet,chewable 81 mg	Tier 5	AR; AR
aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg	Tier 5	AR; AR
ASPIR-LOW ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR; AR
BAYER CHEWABLE ASPIRIN ORAL TABLET,CHEWABLE 81 MG	Tier 5	AR; AR
DURLAZA ORAL CAPSULE,EXTENDED RELEASE 24HR 162.5 MG	Tier 3	
E.C. PRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG	Tier 5	AR
ECOTRIN LOW STRENGTH ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR; AR
ECOTRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG	Tier 5	AR; AR
ST JOSEPH ASPIRIN ORAL TABLET,CHEWABLE 81 MG	Tier 5	AR; AR
ST. JOSEPH ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG	Tier 5	AR; AR

Drug Name	Drug Tier	Notes
Platelet Aggregation Inhibitors - Thienopyridine Agents		
clopidogrel oral tablet 300 mg, 75 mg	Tier 1	
EFFIENT ORAL TABLET 10 MG, 5 MG	Tier 2	QL (1 tablet per 1 day)
PLAVIX ORAL TABLET 300 MG, 75 MG	Tier 3	
ticlopidine oral tablet 250 mg	Tier 1	
Platelet Aggregation Inhibitors-Salicylates And Proton Pump Inhib Comb		
YOSPRALA ORAL TABLET,IR,DELAYED REL,BIPHASIC 325-40 MG, 81-40 MG	Tier 3	
Platelet Aggregation Inhib-Pdesterase And Adenosine Deaminase Inhibitr		
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	Tier 1	AR; Mand 90; AR
Platelet Aggregation Inhib-Protease-Activ.Receptor-1(Par-1) Antagonist		
ZONTIVITY ORAL TABLET 2.08 MG	Tier 3	PA; QL (1 tablet per 1 day)
Sickle Cell Anemia Agents		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	Tier 2	
Thrombin Inhibitor - Selective Direct And Reversible		
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG	Tier 2	QL (2 capsules per 1 day)
Thrombin Inhibitor - Selective Direct And Reversible - Hirudin Type		
IPRIVASK SUBCUTANEOUS RECON SOLN 15 MG	Tier 8	30D; Specialty
Thrombopoietin Receptor Agonists		
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG	Tier 8	Specialty; 30D; Specialty
Hepatobiliary System Treatment Agents		
Farnesoid X Receptor (Fxr) Agonist, Bile Acid Analog		
OCALIVA ORAL TABLET 10 MG, 5 MG	Tier 8	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
Immunosuppressive Agents		
Immunosuppressive - Calcineurin Inhibitors		
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG, 5 MG	Tier 8	30D; Specialty
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	Tier 1	Mand 90
cyclosporine modified oral solution 100 mg/ml	Tier 1	Mand 90
cyclosporine oral capsule 100 mg, 25 mg	Tier 1	Mand 90
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG	Tier 3	
gengraf oral capsule 100 mg, 25 mg	Tier 1	Mand 90
GENGRAF ORAL CAPSULE 50 MG	Tier 3	
gengraf oral solution 100 mg/ml	Tier 1	Mand 90
NEORAL ORAL CAPSULE 100 MG, 25 MG	Tier 3	
NEORAL ORAL SOLUTION 100 MG/ML	Tier 3	
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML	Tier 6	30D
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG	Tier 8	30D
SANDIMMUNE INTRAVENOUS SOLUTION 250 MG/5 ML	Tier 3	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG	Tier 3	
SANDIMMUNE ORAL SOLUTION 100 MG/ML	Tier 2	
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	Tier 1	
Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors		
CELLCEPT ORAL CAPSULE 250 MG	Tier 3	
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION 200 MG/ML	Tier 8	30D; Specialty
CELLCEPT ORAL TABLET 500 MG	Tier 3	
mycophenolate mofetil oral capsule 250 mg	Tier 1	Mand 90
mycophenolate mofetil oral suspension for reconstitution 200 mg/ml	Tier 1	Mand 90
mycophenolate mofetil oral tablet 500 mg	Tier 1	Mand 90

Drug Name	Drug Tier	Notes
mycophenolate sodium oral tablet,delayed release (dr/ec) 180 mg, 360 mg	Tier 1	
MYFORTIC ORAL TABLET,DELAYED RELEASE (DR/EC) 180 MG, 360 MG	Tier 3	
Immunosuppressive - Mammalian Target Of Rapamycin (Mtor) Inhibitors		
RAPAMUNE ORAL SOLUTION 1 MG/ML	Tier 8	30D; Specialty
RAPAMUNE ORAL TABLET 0.5 MG, 1 MG, 2 MG	Tier 8	30D; Specialty
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	Tier 1	Mand 90
ZORTRESS ORAL TABLET 0.25 MG	Tier 2	Mand 90
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG	Tier 4	30D; Specialty
Immunosuppressive - Purine Analogs		
AZASAN ORAL TABLET 100 MG, 75 MG	Tier 2	Mand 90
azathioprine oral tablet 50 mg	Tier 1	Mand 90
IMURAN ORAL TABLET 50 MG	Tier 3	Mand 90
Locomotor System		
Als Agent - Benzathiazoles		
RILUTEK ORAL TABLET 50 MG	Tier 8	30D; Specialty
riluzole oral tablet 50 mg	Tier 4	30D; Specialty
Antimyasthenic Agent - Reversible Cholinesterase Inhibitors		
MESTINON ORAL SYRUP 60 MG/5 ML	Tier 3	
MESTINON ORAL TABLET 60 MG	Tier 3	
MESTINON TIMESPAN ORAL TABLET EXTENDED RELEASE 180 MG	Tier 3	
pyridostigmine bromide oral tablet 60 mg	Tier 1	
pyridostigmine bromide oral tablet extended release 180 mg	Tier 1	
Antimyasthenic Agents Other		
guanidine oral tablet 125 mg	Tier 1	
Skeletal Muscle Relaxant - Analgesic Salicylate Combinations		
carisoprodol-aspirin oral tablet 200-325 mg	Tier 1	
Skeletal Muscle Relaxant - Central Muscle Relaxants		
AMRIX ORAL CAPSULE,EXTENDED RELEASE 24HR 15 MG, 30 MG	Tier 8	PA; 30D; AR; AR

Drug Name	Drug Tier	Notes
baclofen oral tablet 10 mg, 20 mg	Tier 1	
carisoprodol oral tablet 250 mg, 350 mg	Tier 1	AR; AR
chlorzoxazone oral tablet 500 mg	Tier 1	AR; AR
cyclobenzaprine oral tablet 10 mg, 5 mg, 7.5 mg	Tier 1	AR; AR
FEXMID ORAL TABLET 7.5 MG	Tier 3	
LORZONE ORAL TABLET 375 MG, 750 MG	Tier 3	AR; AR
metaxall oral tablet 800 mg	Tier 1	
metaxalone oral tablet 400 mg	Tier 1	AR
metaxalone oral tablet 800 mg	Tier 1	AR; AR
methocarbamol oral tablet 500 mg, 750 mg	Tier 1	AR; AR
orphenadrine citrate oral tablet extended release 100 mg	Tier 1	AR; AR
PARAFON FORTE DSC ORAL TABLET 500 MG	Tier 3	AR; AR
ROBAXIN ORAL TABLET 500 MG	Tier 3	AR; AR
ROBAXIN-750 ORAL TABLET 750 MG	Tier 3	AR; AR
SKELAXIN ORAL TABLET 800 MG	Tier 3	AR; AR
SOMA ORAL TABLET 250 MG, 350 MG	Tier 3	AR; AR
tizanidine oral capsule 2 mg, 4 mg, 6 mg	Tier 1	PA
tizanidine oral tablet 2 mg, 4 mg	Tier 1	
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG	Tier 3	PA
ZANAFLEX ORAL TABLET 4 MG	Tier 3	
Skeletal Muscle Relaxant - Direct Muscle Relaxants		
DANTRIUM INTRAVENOUS RECON SOLN 20 MG	Tier 6	
DANTRIUM ORAL CAPSULE 25 MG, 50 MG	Tier 3	
dantrolene oral capsule 100 mg, 25 mg, 50 mg	Tier 1	
Skeletal Muscle Relaxant - Narcotic Analgesic Combinations		
carisoprodol-asa-codeine oral tablet 200-325-16 mg	Tier 1	
Skeletal Muscle Relaxant, Salicylate, And Narcotic Analgesic Comb.		
carisoprodol-asa-codeine oral tablet 200-325-16 mg	Tier 1	

Drug Name	Drug Tier	Notes
Medical Supplies And Durable Medical Equipment (Dme)		
Medical Supplies And Dme - Blood Glucose Tests		
FREESTYLE INSULINX TEST STRIPS STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
FREESTYLE LITE STRIPS STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
FREESTYLE PRECISION NEO STRIPS STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
FREESTYLE TEST STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
PRECISION XTRA TEST STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
Medical Supplies And Dme - Diaphragms		
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM	Tier 5	
Medical Supplies And Dme - Glucose Monitoring Test Supplies		
FREESTYLE CONTROL SOLUTION	Tier 5	
FREESTYLE FREEDOM KIT	Tier 5	QL (1 meter per 1 year)
FREESTYLE FREEDOM LITE KIT	Tier 5	QL (1 meter per 1 year)
FREESTYLE INSULINX	Tier 5	QL (1 meter per 1 year)

Drug Name	Drug Tier	Notes
FREESTYLE LITE METER KIT	Tier 5	QL (1 meter per 1 year)
FREESTYLE PRECISION NEO METER	Tier 5	QL (1 meter per 1 year)
lancing device with lancets kit	Tier 1	
MEDISENSE MID CONTROL SOLUTION	Tier 5	
PRECISION XTRA MONITOR	Tier 5	QL (1 meter per 1 year)
Medical Supplies And Dme - Insulin Needles-Syringes And Admin Supplies		
BD AUTOSHIELD PEN NEEDLE NEEDLE 29 GAUGE X 5/16"	Tier 1	
BD INSULIN PEN NEEDLE UF SHORT NEEDLE 31 GAUGE X 5/16"	Tier 1	Mand 90
BD INSULIN SYRINGE ULTRA-FINE SYRINGE 0.3 ML 31 GAUGE X 5/16, 0.5 ML 31 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	Tier 1	Mand 90
novofine 30 needle 30 gauge x 1/3"	Tier 1	
novofine 32 needle 32 gauge x 1/4"	Tier 1	
novofine autocover needle 30 gauge x 1/3"	Tier 1	
novofine plus needle 32 gauge x 1/6"	Tier 1	
novotwist needle 32 gauge x 1/5"	Tier 1	
Medical Supplies And Dme - Needles And Syringes		
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2"	Tier 1	
Medical Supply, Fdb Superset		
Medical Supply, Fdb Superset		
BD AUTOSHIELD PEN NEEDLE NEEDLE 29 GAUGE X 5/16"	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2"	Tier 1	
BD INSULIN PEN NEEDLE UF SHORT NEEDLE 31 GAUGE X 5/16"	Tier 1	Mand 90
BD INSULIN SYRINGE ULTRA-FINE SYRINGE 0.3 ML 31 GAUGE X 5/16, 0.5 ML 31 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	Tier 1	Mand 90
FREESTYLE CONTROL SOLUTION	Tier 5	
FREESTYLE FREEDOM KIT	Tier 5	QL (1 meter per 1 year)
FREESTYLE FREEDOM LITE KIT	Tier 5	QL (1 meter per 1 year)
FREESTYLE INSULINX	Tier 5	QL (1 meter per 1 year)
FREESTYLE INSULINX TEST STRIPS STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)

Drug Name	Drug Tier	Notes
FREESTYLE LANCETS 28 GAUGE	Tier 1	Mand 90
FREESTYLE LITE METER KIT	Tier 5	QL (1 meter per 1 year)
FREESTYLE LITE STRIPS STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
FREESTYLE PRECISION NEO METER	Tier 5	QL (1 meter per 1 year)
FREESTYLE PRECISION NEO STRIPS STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
FREESTYLE TEST STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
lancing device with lancets kit	Tier 1	
MEDISENSE MID CONTROL SOLUTION	Tier 5	
NOVOFINE 30 NEEDLE 30 GAUGE X 1/3"	Tier 1	
NOVOFINE 32 NEEDLE 32 GAUGE X 1/4"	Tier 1	
NOVOFINE AUTOCOVER NEEDLE 30 GAUGE X 1/3"	Tier 1	
NOVOFINE PLUS NEEDLE 32 GAUGE X 1/6"	Tier 1	
novotwist needle 32 gauge x 1/5"	Tier 1	
PRECISION XTRA B-KETONE STRIP	Tier 5	QL (10 strips per 30 days)
PRECISION XTRA MONITOR	Tier 5	QL (1 meter per 1 year)
PRECISION XTRA TEST STRIP	Tier 5	QL/DS (No copay at the pharmacy- QL of 150 units per 30 days or 450 units per 90 days)
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM	Tier 5	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM	Tier 5	

Drug Name	Drug Tier	Notes
Metabolic Disease Enzyme Replacement Agents		
Metabolic Disease Enzyme Replacement, Hypophosphatasia		
STRENSIQ SUBCUTANEOUS SOLUTION 100 MG/ML, 40 MG/ML	Tier 8	Specialty; 30D; Specialty
Metabolic Dx Enzyme Replacement, Severe Combined Immune Deficiency		
ADAGEN INTRAMUSCULAR SOLUTION 250 UNIT/ML	Tier 8	Specialty
Metabolic Modifiers		
Hyperparathyroid Treatment Agents - Vitamin D Analog-Type		
doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg	Tier 1	
HECTOROL ORAL CAPSULE 0.5 MCG, 1 MCG, 2.5 MCG	Tier 3	
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	Tier 1	
RAYALDEE ORAL CAPSULE,EXTENDED RELEASE 24 HR 30 MCG	Tier 3	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	Tier 3	
Metabolic Modifier - Carnitine Replenisher Agents		
CARNITOR INTRAVENOUS SOLUTION 200 MG/ML	Tier 6	
CARNITOR ORAL SOLUTION 100 MG/ML	Tier 3	
CARNITOR ORAL TABLET 330 MG	Tier 3	
levocarnitine (with sugar) oral solution 100 mg/ml	Tier 1	
levocarnitine oral tablet 330 mg	Tier 1	
Metabolic Modifier - Gaucher's Disease, Type-1, Substrate Reduction Tx		
CERDELGA ORAL CAPSULE 84 MG	Tier 8	30D; Specialty
ZAVESCA ORAL CAPSULE 100 MG	Tier 8	Specialty; 30D; Specialty
Metabolic Modifier - Hereditary Tyrosinemia Treatment Agents		
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG	Tier 8	30D; Specialty
ORFADIN ORAL SUSPENSION 4 MG/ML	Tier 3	

Drug Name	Drug Tier	Notes
Metabolic Modifier - Homocystinuria Treatment Agents		
CYSTADANE ORAL POWDER 1 GRAM/1.7 ML	Tier 3	
Metabolic Modifier - Urea Cycle Disorder Agents-Conjugating Agents		
BUPHENYL ORAL POWDER 0.94 GRAM/GRAM	Tier 3	
BUPHENYL ORAL TABLET 500 MG	Tier 3	
RAVICTI ORAL LIQUID 1.1 GRAM/ML	Tier 8	30D; Specialty
sodium phenylbutyrate oral powder 0.94 gram/gram	Tier 1	
Metabolic Modifier-Carbamoyl Phosphate Synthetase 1 (Cps 1) Activator		
CARBAGLU ORAL TABLET, DISPERSIBLE 200 MG	Tier 3	
Pharmacoenhancer - Cytochrome P450 Inhibitors		
TYBOST ORAL TABLET 150 MG	Tier 2	PA; QL (1 tablet per 1 day)
Phenylketonuria(Pku) Tx Agents - Cofactor Of Phenylalanine Hydroxylase		
KUVAN ORAL POWDER IN PACKET 100 MG, 500 MG	Tier 8	Specialty; 30D; Specialty
KUVAN ORAL TABLET,SOLUBLE 100 MG	Tier 8	Specialty; 30D; Specialty
Mouth-Throat-Dental - Preparations		
Dental Product - Fluoride Preparations		
CLINPRO 5000 DENTAL PASTE 1.1 %	Tier 3	
DENTA 5000 PLUS DENTAL CREAM 1.1 %	Tier 1	
DENTAGEL DENTAL GEL 1.1 %	Tier 1	
FLUORIDEX DAILY DEFENSE DENTAL GEL 1.1 %	Tier 3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 %	Tier 3	
PREVIDENT 5000 SENSITIVE DENTAL PASTE 1.1-5 %	Tier 3	
PREVIDENT DENTAL SOLUTION 0.2 %	Tier 3	
SF 5000 PLUS DENTAL CREAM 1.1 %	Tier 1	
sodium fluoride dental solution 0.2 %	Tier 1	

Drug Name	Drug Tier	Notes
sodium fluoride oral drops 0.5 mg fluoride (1.1 mg)/ml	Tier 5	
sodium fluoride oral tablet,chewable 0.25 mg fluorid (0.55 mg)	Tier 5	
Mouth And Throat - Antifungals		
clotrimazole mucous membrane troche 10 mg	Tier 1	
nystatin oral suspension 100,000 unit/ml	Tier 1	DDS
Mouth And Throat - Anti-Infective Mixtures		
DEBACTEROL MUCOUS MEMBRANE SWAB 30-50 %	Tier 3	
Mouth And Throat - Anti-Infective-Local Anesthetic Combinations		
BUCALSEP MUCOUS MEMBRANE SOLUTION	Tier 3	
Mouth And Throat - Antiseptics		
chlorhexidine gluconate mucous membrane mouthwash 0.12 %	Tier 1	DDS
PERIDEX MUCOUS MEMBRANE MOUTHWASH 0.12 %	Tier 3	
PERIOGARD MUCOUS MEMBRANE MOUTHWASH 0.12 %	Tier 1	
Mouth And Throat - Glucocorticoids		
ORALONE DENTAL PASTE 0.1 %	Tier 1	
triamcinolone acetonide dental paste 0.1 %	Tier 1	
Mouth And Throat - Local Anesthetic Amides		
lidocaine hcl mucous membrane jelly 2 %	Tier 1	DDS
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	Tier 1	DDS
LIDOCAINE VISCOUS MUCOUS MEMBRANE SOLUTION 2 %	Tier 1	DDS
Mouth And Throat - Saliva Stimulants		
cevimeline oral capsule 30 mg	Tier 1	
EVOXAC ORAL CAPSULE 30 MG	Tier 3	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	Tier 1	Mand 90
SALAGEN ORAL TABLET 5 MG, 7.5 MG	Tier 3	Mand 90

Drug Name	Drug Tier	Notes
Periodontal Product - Tetracycline Antiinfective, Local		
ARESTIN DENTAL CARTRIDGE 1 MG	Tier 3	
Periodontal Product - Tetracycline-Type, Collagenase Inhibitors		
doxycycline hyclate oral tablet 20 mg	Tier 1	
Therapy For Drooling- Primary Or Secondary Sialorrhea-Anticholinergic		
CUVPOSA ORAL SOLUTION 1 MG/5 ML (0.2 MG/ML)	Tier 3	
Multiple Sclerosis Agents		
Multiple Sclerosis Agent - Interferons		
AVONEX (WITH ALBUMIN) INTRAMUSCULAR KIT 30 MCG	Tier 4	PA; Specialty; Specialty
AVONEX INTRAMUSCULAR PEN INJECTOR 30 MCG/0.5 ML	Tier 4	PA; Specialty; Specialty
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML	Tier 4	PA; Specialty; Specialty
AVONEX INTRAMUSCULAR SYRINGE 30 MCG/0.5 ML	Tier 4	PA; Specialty; Specialty
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML	Tier 4	PA; Specialty; Specialty
BETASERON SUBCUTANEOUS KIT 0.3 MG	Tier 8	PA; 30D; Specialty
BETASERON SUBCUTANEOUS RECON SOLN 0.3 MG	Tier 8	PA; Specialty; 30D
EXTAVIA SUBCUTANEOUS KIT 0.3 MG	Tier 8	PA; Specialty; 30D; Specialty
EXTAVIA SUBCUTANEOUS RECON SOLN 0.3 MG	Tier 8	PA; Specialty; 30D; Specialty
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML	Tier 8	PA; Specialty; 30D; Specialty
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML	Tier 8	PA; Specialty; 30D; Specialty
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 22 MCG/0.5 ML, 44 MCG/0.5 ML	Tier 4	PA; Specialty; 30D; Specialty
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)	Tier 4	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE 8.8MCG/0.2ML-22 MCG/0.5ML (6)	Tier 4	PA; Specialty; 30D; Specialty
Multiple Sclerosis Agent - Others		
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML	Tier 4	PA; Specialty; 30D; Specialty
glatopa subcutaneous syringe 20 mg/ml	Tier 4	PA; Specialty; 30D; Specialty
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG	Tier 8	PA; Specialty; 30D; Specialty
Multiple Sclerosis Agent - Potassium Channel Blocker		
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HR 10 MG	Tier 8	PA; Specialty; 30D; Specialty
Multiple Sclerosis Agent - Pyrimidine Synthesis Inhibitors		
AUBAGIO ORAL TABLET 14 MG, 7 MG	Tier 8	PA; Specialty; 30D; Specialty
Multiple Sclerosis Agent - Sphingosine 1-Phosphate Receptor Modulator		
GILENYA ORAL CAPSULE 0.5 MG	Tier 8	PA; Specialty; 30D; Specialty; QL (1 capsule per 1 day)
Multiple Sclerosis Agent-Interleukin-2 Receptor Modulator, Mc Antibody		
ZINBRYTA SUBCUTANEOUS SYRINGE 150 MG/ML	Tier 8	PA; Specialty; 30D; Specialty
Ophthalmic Agents		
Artificial Tears And Lubricant Single Agents		
LACRISERT OPHTHALMIC INSERT 5 MG	Tier 3	
Miotics - Cholinesterase Inhibitors		
PHOSPHOLINE IODIDE OPHTHALMIC DROPS 0.125 %	Tier 2	Mand 90
Miotics - Direct Acting		
ISOPTO CARPINE OPHTHALMIC DROPS 1 %, 2 %, 4 %	Tier 3	Mand 90
pilocarpine hcl ophthalmic drops 1 %, 2 %, 4 %	Tier 1	Mand 90
Mydriatic And Cycloplegic Combinations		
CYCLOMYDRIL OPHTHALMIC DROPS 0.2-1 %	Tier 3	

Drug Name	Drug Tier	Notes
Ophthalmic - Adrenergic-Carbonic Anhydrase Inhibitor Combinations		
SIMBRINZA OPHTHALMIC DROPS,SUSPENSION 1-0.2 %	Tier 3	Mand 90
Ophthalmic - Antibacterial-Glucocorticoid Combinations		
BLEPHAMIDE OPHTHALMIC DROPS,SUSPENSION 10-0.2 %	Tier 2	
BLEPHAMIDE S.O.P. OPHTHALMIC OINTMENT 10-0.2 %	Tier 2	
MAXITROL OPHTHALMIC DROPS,SUSPENSION 3.5MG/ML-10,000 UNIT/ML-0.1 %	Tier 3	
MAXITROL OPHTHALMIC OINTMENT 3.5 MG/G-10,000 UNIT/G-0.1 %	Tier 3	
neomycin-bacitracin-poly-hc ophthalmic ointment 3.5-400-10,000 mg-unit/g-1%	Tier 1	
neomycin-polymyxin b-dexameth ophthalmic drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %	Tier 1	
neomycin-polymyxin b-dexameth ophthalmic ointment 3.5 mg/g-10,000 unit/g-0.1 %	Tier 1	
neomycin-polymyxin-hc ophthalmic drops,suspension 3.5-10,000-10 mg-unit-mg/ml	Tier 1	
PRED-G OPHTHALMIC DROPS,SUSPENSION 0.3-1 %	Tier 3	
PRED-G S.O.P. OPHTHALMIC OINTMENT 0.3-0.6 %	Tier 3	
sulfacetamide-prednisolone ophthalmic drops 10 %-0.23 % (0.25 %)	Tier 1	
TOBRADEX OPHTHALMIC DROPS,SUSPENSION 0.3-0.1 %	Tier 3	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	Tier 2	
TOBRADEX ST OPHTHALMIC DROPS,SUSPENSION 0.3-0.05 %	Tier 3	
tobramycin-dexamethasone ophthalmic drops,suspension 0.3-0.1 %	Tier 1	
ZYLET OPHTHALMIC DROPS,SUSPENSION 0.3-0.5 %	Tier 3	
Ophthalmic - Anticholinergics		
atropine ophthalmic drops 1 %	Tier 1	
atropine ophthalmic ointment 1 %	Tier 1	

Drug Name	Drug Tier	Notes
CYCLOGYL OPHTHALMIC DROPS 0.5 %, 1 %, 2 %	Tier 3	
cyclopentolate ophthalmic drops 0.5 %, 1 %, 2 %	Tier 1	
HOMATROPAIRE OPHTHALMIC DROPS 5 %	Tier 1	
homatropine hbr ophthalmic drops 5 %	Tier 1	
ISOPTO ATROPINE OPHTHALMIC DROPS 1 %	Tier 3	
MYDRIACYL OPHTHALMIC DROPS 1 %	Tier 3	
tropicamide ophthalmic drops 0.5 %, 1 %	Tier 1	
Ophthalmic - Antihistamines		
ALAWAY OPHTHALMIC DROPS 0.025 % (0.035 %)	Tier 1	
azelastine ophthalmic drops 0.05 %	Tier 1	
BEPREVE OPHTHALMIC DROPS 1.5 %	Tier 3	PA
ELESTAT OPHTHALMIC DROPS 0.05 %	Tier 3	
EMADINE OPHTHALMIC DROPS 0.05 %	Tier 3	PA
epinastine ophthalmic drops 0.05 %	Tier 1	
ketotifen fumarate ophthalmic drops 0.025 % (0.035 %)	Tier 1	
LASTACAFT OPHTHALMIC DROPS 0.25 %	Tier 3	PA
olopatadine ophthalmic drops 0.1 %	Tier 1	PA
PATADAY OPHTHALMIC DROPS 0.2 %	Tier 3	PA
PATANOL OPHTHALMIC DROPS 0.1 %	Tier 3	
PAZEO OPHTHALMIC DROPS 0.7 %	Tier 3	PA
WAL-ZYR (KETOTIFEN) OPHTHALMIC DROPS 0.025 % (0.035 %)	Tier 1	
ZADITOR OPHTHALMIC DROPS 0.025 % (0.035 %)	Tier 3	
Ophthalmic - Anti-Inflammatory, Glucocorticoids		
ALREX OPHTHALMIC DROPS,SUSPENSION 0.2 %	Tier 3	
dexamethasone sodium phosphate ophthalmic drops 0.1 %	Tier 1	
DUREZOL OPHTHALMIC DROPS 0.05 %	Tier 3	
FLAREX OPHTHALMIC DROPS,SUSPENSION 0.1 %	Tier 3	
fluorometholone ophthalmic drops,suspension 0.1 %	Tier 1	

Drug Name	Drug Tier	Notes
FML FORTE OPHTHALMIC DROPS,SUSPENSION 0.25 %	Tier 3	
FML LIQUIFILM OPHTHALMIC DROPS,SUSPENSION 0.1 %	Tier 3	
FML S.O.P. OPHTHALMIC OINTMENT 0.1 %	Tier 3	
LOTEMAX OPHTHALMIC DROPS,GEL 0.5 %	Tier 3	
LOTEMAX OPHTHALMIC DROPS,SUSPENSION 0.5 %	Tier 3	
LOTEMAX OPHTHALMIC OINTMENT 0.5 %	Tier 3	
MAXIDEX OPHTHALMIC DROPS,SUSPENSION 0.1 %	Tier 2	
OMNIPRED OPHTHALMIC DROPS,SUSPENSION 1 %	Tier 3	
PRED FORTE OPHTHALMIC DROPS,SUSPENSION 1 %	Tier 3	
PRED MILD OPHTHALMIC DROPS,SUSPENSION 0.12 %	Tier 2	
prednisolone acetate ophthalmic drops,suspension 1 %	Tier 1	
prednisolone sodium phosphate ophthalmic drops 1 %	Tier 1	
Ophthalmic - Anti-Inflammatory, Immunomodulators		
RESTASIS OPHTHALMIC DROPPERETTE 0.05 %	Tier 2	PA; QL (2 drops per 1 day)
XIIDRA OPHTHALMIC DROPPERETTE 5 %	Tier 3	
Ophthalmic - Anti-Inflammatory, Lfa-1 Antagonists		
XIIDRA OPHTHALMIC DROPPERETTE 5 %	Tier 3	
Ophthalmic - Anti-Inflammatory, Nsaids		
ACULAR LS OPHTHALMIC DROPS 0.4 %	Tier 3	
ACULAR OPHTHALMIC DROPS 0.5 %	Tier 3	
ACUVAIL (PF) OPHTHALMIC DROPPERETTE 0.45 %	Tier 3	
bromfenac ophthalmic drops 0.09 %	Tier 1	
BROMSITE OPHTHALMIC DROPS 0.075 %	Tier 3	

Drug Name	Drug Tier	Notes
diclofenac sodium ophthalmic drops 0.1 %	Tier 1	
flurbiprofen sodium ophthalmic drops 0.03 %	Tier 1	
ILEVRO OPHTHALMIC DROPS,SUSPENSION 0.3 %	Tier 3	
ketorolac ophthalmic drops 0.4 %, 0.5 %	Tier 1	
NEVANAC OPHTHALMIC DROPS,SUSPENSION 0.1 %	Tier 2	
OCUFEN OPHTHALMIC DROPS 0.03 %	Tier 3	
PROLENSA OPHTHALMIC DROPS 0.07 %	Tier 3	
Ophthalmic - Beta Blockers-Adrenergic Combinations		
COMBIGAN OPHTHALMIC DROPS 0.2-0.5 %	Tier 3	
Ophthalmic - Beta Blockers-Carbonic Anhydrase Inhibitor Combinations		
COSOPT (PF) OPHTHALMIC DROPPERETTE 2-0.5 %	Tier 3	
COSOPT OPHTHALMIC DROPS 22.3-6.8 MG/ML	Tier 3	
dorzolamide-timolol ophthalmic drops 22.3-6.8 mg/ml	Tier 1	Mand 90
Ophthalmic - Carbonic Anhydrase Inhibitors		
AZOPT OPHTHALMIC DROPS,SUSPENSION 1 %	Tier 2	Mand 90
dorzolamide ophthalmic drops 2 %	Tier 1	Mand 90
TRUSOPT OPHTHALMIC DROPS 2 %	Tier 3	
Ophthalmic - Cystine Depleting Agents		
CYSTARAN OPHTHALMIC DROPS 0.44 %	Tier 8	30D; Specialty
Ophthalmic - Decongestants		
phenylephrine hcl ophthalmic drops 10 %, 2.5 %	Tier 1	
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-Blockers		
BETAGAN OPHTHALMIC DROPS 0.5 %	Tier 3	
betaxolol ophthalmic drops 0.5 %	Tier 1	Mand 90
BETIMOL OPHTHALMIC DROPS 0.25 %, 0.5 %	Tier 3	PA; Mand 90
BETOPTIC S OPHTHALMIC DROPS,SUSPENSION 0.25 %	Tier 3	
carteolol ophthalmic drops 1 %	Tier 1	

Drug Name	Drug Tier	Notes
ISTALOL OPHTHALMIC DROPS, ONCE DAILY 0.5 %	Tier 3	PA
levobunolol ophthalmic drops 0.5 %	Tier 1	Mand 90
metipranolol ophthalmic drops 0.3 %	Tier 1	Mand 90
timolol maleate ophthalmic drops 0.25 %, 0.5 %	Tier 1	Mand 90
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	Tier 1	Mand 90
TIMOPTIC OCUDOSE (PF) OPHTHALMIC DROPPERETTE 0.25 %, 0.5 %	Tier 2	
TIMOPTIC OPHTHALMIC DROPS 0.25 %, 0.5 %	Tier 3	
TIMOPTIC-XE OPHTHALMIC GEL FORMING SOLUTION 0.25 %, 0.5 %	Tier 3	
Ophthalmic - Local Anesthetic Esters		
TETCAINE OPHTHALMIC DROPS 0.5 %	Tier 3	
tetracaine hcl (pf) ophthalmic drops 0.5 %	Tier 1	
Ophthalmic - Mast Cell Stabilizers		
ALOCRIL OPHTHALMIC DROPS 2 %	Tier 3	PA
ALOMIDE OPHTHALMIC DROPS 0.1 %	Tier 3	PA
cromolyn ophthalmic drops 4 %	Tier 1	
Ophthalmic Antibacterial Mixtures		
bacitracin-polymyxin b ophthalmic ointment 500-10,000 unit/gram	Tier 1	
neomycin-bacitracin-polymyxin ophthalmic ointment 3.5-400-10,000 mg-unit-unit/g	Tier 1	
neomycin-polymyxin-gramicidin ophthalmic drops 1.75 mg-10,000 unit-0.025mg/ml	Tier 1	
NEO-POLYCIN OPHTHALMIC OINTMENT 3.5-400-10,000 MG-UNIT-UNIT/G	Tier 3	
NEOSPORIN (NEO-POLYM-GRAMICID) OPHTHALMIC DROPS 1.75 MG-10,000 UNIT-0.025MG/ML	Tier 3	
polymyxin b sulf-trimethoprim ophthalmic drops 10,000 unit- 1 mg/ml	Tier 1	
POLYTRIM OPHTHALMIC DROPS 10,000 UNIT- 1 MG/ML	Tier 3	
Ophthalmic Antibiotic - Aminoglycosides		
GENTAK OPHTHALMIC OINTMENT 0.3 % (3 MG/GRAM)	Tier 1	

Drug Name	Drug Tier	Notes
gentamicin ophthalmic drops 0.3 %	Tier 1	
gentamicin ophthalmic ointment 0.3 % (3 mg/gram)	Tier 1	
tobramycin ophthalmic drops 0.3 %	Tier 1	
TOBREX OPHTHALMIC DROPS 0.3 %	Tier 3	
TOBREX OPHTHALMIC OINTMENT 0.3 %	Tier 2	
Ophthalmic Antibiotic - Dehydropeptidase Inhibitors		
bacitracin ophthalmic ointment 500 unit/gram	Tier 1	
Ophthalmic Antibiotic - Fluoroquinolones		
BESIVANCE OPHTHALMIC DROPS,SUSPENSION 0.6 %	Tier 3	
CILOXAN OPHTHALMIC DROPS 0.3 %	Tier 3	
CILOXAN OPHTHALMIC OINTMENT 0.3 %	Tier 3	
ciprofloxacin hcl ophthalmic drops 0.3 %	Tier 1	
gatifloxacin ophthalmic drops 0.5 %	Tier 1	
levofloxacin ophthalmic drops 0.5 %	Tier 1	
MOXEZA OPHTHALMIC DROPS, VISCOUS 0.5 %	Tier 3	
OCUFLOX OPHTHALMIC DROPS 0.3 %	Tier 3	
ofloxacin ophthalmic drops 0.3 %	Tier 1	
VIGAMOX OPHTHALMIC DROPS 0.5 %	Tier 2	
ZYMAXID OPHTHALMIC DROPS 0.5 %	Tier 3	
Ophthalmic Antibiotic - Macrolides		
AZASITE OPHTHALMIC DROPS 1 %	Tier 3	
erythromycin ophthalmic ointment 5 mg/gram (0.5 %)	Tier 1	
ILOTYCIN OPHTHALMIC OINTMENT 5 MG/GRAM (0.5 %)	Tier 3	
Ophthalmic Antibiotic - Sulfonamides		
BLEPH-10 OPHTHALMIC DROPS 10 %	Tier 3	PA
sulfacetamide sodium ophthalmic drops 10 %	Tier 1	
Ophthalmic Antifungals		
NATACYN OPHTHALMIC DROPS,SUSPENSION 5 %	Tier 3	
Ophthalmic Antiseptics		
BETADINE OPHTHALMIC PREP OPHTHALMIC SOLUTION 5 %	Tier 3	

Drug Name	Drug Tier	Notes
Ophthalmic Antivirals		
trifluridine ophthalmic drops 1 %	Tier 1	
VIROPTIC OPHTHALMIC DROPS 1 %	Tier 3	
ZIRGAN OPHTHALMIC GEL 0.15 %	Tier 3	
Ophthalmic-Intraocular Press. Reducing, Sel. Alpha Adrenergic Agonists		
ALPHAGAN P OPHTHALMIC DROPS 0.1 %, 0.15 %	Tier 3	
apraclonidine ophthalmic drops 0.5 %	Tier 1	Mand 90
brimonidine ophthalmic drops 0.15 %, 0.2 %	Tier 1	Mand 90
IOPIDINE OPHTHALMIC DROPPERETTE 1 %	Tier 3	
IOPIDINE OPHTHALMIC DROPS 0.5 %	Tier 3	
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs		
bimatoprost ophthalmic drops 0.03 %	Tier 1	
latanoprost ophthalmic drops 0.005 %	Tier 1	Mand 90
LUMIGAN OPHTHALMIC DROPS 0.01 %	Tier 2	PA; Mand 90
TRAVATAN Z OPHTHALMIC DROPS 0.004 %	Tier 3	PA; Mand 90
XALATAN OPHTHALMIC DROPS 0.005 %	Tier 3	
ZIOPTAN (PF) OPHTHALMIC DROPPERETTE 0.0015 %	Tier 3	PA; Mand 90; QL (1 unit per 1 day)
Otic		
Otic - Anti-Infective-Glucocorticoid Combinations		
CIPRO HC OTIC DROPS,SUSPENSION 0.2-1 %	Tier 3	
CIPRODEX OTIC DROPS,SUSPENSION 0.3-0.1 %	Tier 2	
neomycin-polymyxin-hc otic drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%	Tier 1	
neomycin-polymyxin-hc otic solution 3.5-10,000-1 mg/ml-unit/ml-%	Tier 1	
OTOVEL OTIC SOLUTION 0.3-0.025 % (0.25 ML)	Tier 3	
Otic - Anti-Infectives Other		
acetic acid otic solution 2 %	Tier 1	

Drug Name	Drug Tier	Notes
Otic - Fluoroquinolones		
CETRAXAL OTIC DROPPERETTE 0.2 %	Tier 3	
ciprofloxacin hcl otic dropperette 0.2 %	Tier 1	
FLOXIN OTIC DROPS 0.3 %	Tier 3	
ofloxacin otic drops 0.3 %	Tier 1	
Otic - Glucocorticoids		
ACETASOL HC OTIC DROPS 1-2 %	Tier 1	
DERMOTIC OIL OTIC DROPS 0.01 %	Tier 3	
fluocinolone acetonide oil otic drops 0.01 %	Tier 1	
hydrocortisone-acetic acid otic drops 1-2 %	Tier 1	
Otic - Pinna Combinations		
CORTANE-B TOPICAL LOTION 1-1-0.1 %	Tier 3	
Respiratory Therapy Agents		
1St Generation Antihistamine-Decongestant Combinations		
PROMETHAZINE VC ORAL SYRUP 6.25-5 MG/5 ML	Tier 1	AR; AR
2Nd Generation Antihistamine-Decongestant Combinations		
alavert d-12 allergy-sinus oral tablet extended release 12 hr 5-120 mg	Tier 1	
allerclear d-12hr oral tablet extended release 12 hr 5-120 mg	Tier 1	
allergy and congestion relief oral tablet extended release 12 hr 5-120 mg	Tier 1	
allergy relief-d (loratadine) oral tablet extended release 12 hr 5-120 mg	Tier 1	
CLARINEX-D 12 HOUR ORAL TABLET, ER MULTIPHASE 12 HR 2.5-120 MG	Tier 3	PA
CLARITIN-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HR 5-120 MG	Tier 3	
loratadine-d oral tablet extended release 12 hr 5-120 mg	Tier 1	
SEMPREX-D ORAL CAPSULE 8-60 MG	Tier 3	
wal-itin d 12 hour oral tablet extended release 12 hr 5-120 mg	Tier 1	

Drug Name	Drug Tier	Notes
Antihistamine - 1St Generation - Ethanolamines		
ARBINOXA ORAL TABLET 4 MG	Tier 1	
carbinoxamine maleate oral liquid 4 mg/5 ml	Tier 1	
carbinoxamine maleate oral tablet 4 mg	Tier 1	
clemastine oral tablet 2.68 mg	Tier 1	
diphenhydramine hcl oral capsule 50 mg	Tier 1	
diphenhydramine hcl oral elixir 12.5 mg/5 ml	Tier 1	
KARBINAL ER ORAL SUSPENSION,EXTENDED REL 12 HR 4 MG/5 ML	Tier 3	
Antihistamine - 1St Generation - Phenothiazines		
promethazine oral syrup 6.25 mg/5 ml	Tier 1	AR; AR
promethazine oral tablet 12.5 mg, 25 mg, 50 mg	Tier 1	AR; AR
Antihistamine - 1St Generation - Piperidines		
cyproheptadine oral syrup 2 mg/5 ml	Tier 1	
cyproheptadine oral tablet 4 mg	Tier 1	
Antihistamines - 1St Generation		
ARBINOXA ORAL TABLET 4 MG	Tier 1	
carbinoxamine maleate oral liquid 4 mg/5 ml	Tier 1	
carbinoxamine maleate oral tablet 4 mg	Tier 1	
clemastine oral tablet 2.68 mg	Tier 1	
cyproheptadine oral syrup 2 mg/5 ml	Tier 1	
cyproheptadine oral tablet 4 mg	Tier 1	
diphenhydramine hcl oral capsule 50 mg	Tier 1	
diphenhydramine hcl oral elixir 12.5 mg/5 ml	Tier 1	
KARBINAL ER ORAL SUSPENSION,EXTENDED REL 12 HR 4 MG/5 ML	Tier 3	
promethazine oral syrup 6.25 mg/5 ml	Tier 1	AR; AR
promethazine oral tablet 12.5 mg, 25 mg, 50 mg	Tier 1	AR; AR
Antihistamines - 2Nd Generation		
CLARINEX ORAL SYRUP 2.5 MG/5 ML (0.5 MG/ML)	Tier 3	
CLARINEX ORAL TABLET 5 MG	Tier 3	QL (1 tablet per 1 day)
XYZAL ORAL SOLUTION 2.5 MG/5 ML	Tier 3	
XYZAL ORAL TABLET 5 MG	Tier 3	

Drug Name	Drug Tier	Notes
Antihistamines - 2Nd Generation - Piperazines		
XYZAL ORAL SOLUTION 2.5 MG/5 ML	Tier 3	
XYZAL ORAL TABLET 5 MG	Tier 3	
Antihistamines - 2Nd Generation - Piperidines		
CLARINEX ORAL SYRUP 2.5 MG/5 ML (0.5 MG/ML)	Tier 3	
CLARINEX ORAL TABLET 5 MG	Tier 3	QL (1 tablet per 1 day)
Antitussives - Nonnarcotic		
benzonatate oral capsule 100 mg, 150 mg, 200 mg	Tier 1	
TESSALON PERLES ORAL CAPSULE 100 MG	Tier 3	
ZONATUSS ORAL CAPSULE 150 MG	Tier 3	
Asthma Therapy - 5-Lipoxygenase Inhibitors		
ZYFLO CR ORAL TABLET, ER MULTIPHASE 12 HR 600 MG	Tier 3	PA
ZYFLO ORAL TABLET 600 MG	Tier 3	PA
Asthma Therapy - Glucocorticoids		
AEROSPAN INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	Tier 3	PA
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION, 80 MCG/ACTUATION	Tier 3	PA
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION	Tier 3	PA
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION	Tier 3	PA
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 110 MCG (7 DOSES), 220 MCG (120 DOSES), 220 MCG (14 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	Tier 3	PA
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml	Tier 1	

Drug Name	Drug Tier	Notes
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION	Tier 3	PA
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION, 220 MCG/ACTUATION, 44 MCG/ACTUATION	Tier 3	PA
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION, 90 MCG/ACTUATION	Tier 2	
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2 ML	Tier 3	
QVAR INHALATION AEROSOL 40 MCG/ACTUATION, 80 MCG/ACTUATION	Tier 2	
Asthma Therapy - Leukotriene Receptor Antagonists		
ACCOLATE ORAL TABLET 10 MG, 20 MG	Tier 3	
montelukast oral granules in packet 4 mg	Tier 1	Mand 90
montelukast oral tablet 10 mg	Tier 1	Mand 90
montelukast oral tablet,chewable 4 mg, 5 mg	Tier 1	Mand 90
SINGULAIR ORAL GRANULES IN PACKET 4 MG	Tier 3	
SINGULAIR ORAL TABLET 10 MG	Tier 3	
SINGULAIR ORAL TABLET,CHEWABLE 4 MG, 5 MG	Tier 3	
zafirlukast oral tablet 10 mg, 20 mg	Tier 1	Mand 90
Asthma Therapy - Xanthines		
ELIXOPHYLLIN ORAL ELIXIR 80 MG/15 ML	Tier 2	Mand 90
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG	Tier 2	Mand 90
THEOCHRON ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 200 MG, 300 MG	Tier 1	Mand 90
theophylline oral elixir 80 mg/15 ml	Tier 1	
theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg, 450 mg	Tier 1	Mand 90
Asthma/Copd - Phosphodiesterase-4 (Pde4) Inhibitors		
DALIRESP ORAL TABLET 500 MCG	Tier 2	

Drug Name	Drug Tier	Notes
Asthma/Copd - Anticholinergic Agents, Inhaled Long Acting		
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE 62.5 MCG/ACTUATION	Tier 3	
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION	Tier 2	
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG	Tier 2	
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATION	Tier 2	
Asthma/Copd - Anticholinergic Agents, Inhaled Short Acting		
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION	Tier 2	
ipratropium bromide inhalation solution 0.02 %	Tier 1	
Asthma/Copd - Beta 2-Adrenergic Agents, Inhaled, Ultra-Long Acting		
ARCAPTA NEOHALER INHALATION CAPSULE, W/INHALATION DEVICE 75 MCG	Tier 2	
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION	Tier 3	
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Long Acting		
BROVANA INHALATION SOLUTION FOR NEBULIZATION 15 MCG/2 ML	Tier 2	
PERFOROMIST INHALATION SOLUTION FOR NEBULIZATION 20 MCG/2 ML	Tier 3	
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE	Tier 2	
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting		
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml	Tier 1	

Drug Name	Drug Tier	Notes
levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml	Tier 1	
levalbuterol tartrate inhalation hfa aerosol inhaler 45 mcg/actuation	Tier 1	PA
PROAIR HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	Tier 3	PA
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	Tier 3	PA
PROVENTIL HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	Tier 3	PA
VENTOLIN HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION	Tier 2	
XOPENEX HFA INHALATION HFA AEROSOL INHALER 45 MCG/ACTUATION	Tier 3	PA
XOPENEX INHALATION SOLUTION FOR NEBULIZATION 0.31 MG/3 ML, 0.63 MG/3 ML, 1.25 MG/3 ML	Tier 3	
Asthma/Copd Therapy - Beta Adrenergic Agents		
albuterol sulfate oral syrup 2 mg/5 ml	Tier 1	
albuterol sulfate oral tablet 2 mg, 4 mg	Tier 1	
albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg	Tier 1	
metaproterenol oral syrup 10 mg/5 ml	Tier 1	
metaproterenol oral tablet 10 mg, 20 mg	Tier 1	
terbutaline oral tablet 2.5 mg, 5 mg	Tier 1	
VOSPIRE ER ORAL TABLET EXTENDED RELEASE 12 HR 4 MG, 8 MG	Tier 3	
Asthma/Copd Therapy - Beta Adrenergic-Anticholinergic Combinations		
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	Tier 3	
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG	Tier 3	
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	Tier 2	QL (6 doses per 1 day)
ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml	Tier 1	
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	Tier 2	

Drug Name	Drug Tier	Notes
Asthma/Copd Therapy - Beta Adrenergic-Glucocorticoid Combinations		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	Tier 3	PA
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION	Tier 3	PA
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	Tier 3	PA
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 200-5 MCG/ACTUATION	Tier 2	
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	Tier 2	
Cystic Fibrosis - Inhaled Aminoglycosides		
BETHKIS INHALATION SOLUTION FOR NEBULIZATION 300 MG/4 ML	Tier 8	PA; Specialty; 30D; Specialty
TOBI INHALATION SOLUTION FOR NEBULIZATION 300 MG/5 ML	Tier 8	PA; 30D; Specialty
TOBI PODHALER INHALATION CAPSULE 28 MG	Tier 8	PA; 30D; Specialty
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG	Tier 8	PA; 30D; Specialty
tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml	Tier 4	PA; 30D; Specialty
Cystic Fibrosis - Inhaled Monobactams		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML	Tier 8	PA; Specialty; 30D
Cystic Fibrosis-Transmembrane Conductance Regulator (Cftr) Potentiator		
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	Tier 8	PA; Specialty; 30D; Specialty; QL (60 packets per 30 days)
KALYDECO ORAL TABLET 150 MG	Tier 8	PA; Specialty; 30D; Specialty; QL (1 tablet per 1 day)

Drug Name	Drug Tier	Notes
Cystic Fib-Transmemb Conduct. Reg.(Cftr) Potentiator And Corrector Cmb		
ORKAMBI ORAL TABLET 100-125 MG	Tier 2	PA; QL/DS (Limited to a 14 day supply per prescription.); QL (56 capsules per 14 days)
ORKAMBI ORAL TABLET 200-125 MG	Tier 2	PA; QL/DS (Limited to a 14 day supply per prescription.); QL (56 capsues per 14 days)
Mucolytics		
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)	Tier 1	
PULMOZYME INHALATION SOLUTION 1 MG/ML	Tier 4	30D; Specialty
Narcotic Antitussive-1St Gen. Antihistamine-Decongestant Combinations		
hydrocodone-cpm-pseudoephed oral solution 5-4-60 mg/5 ml	Tier 3	
PROMETHAZINE VC-CODEINE ORAL SYRUP 6.25-5-10 MG/5 ML	Tier 3	AR; AR
ZUTRIPRO ORAL SOLUTION 5-4-60 MG/5 ML	Tier 3	
Narcotic Antitussive-1St Generation Antihistamine Combinations		
hydrocodone-chlorpheniramine oral suspension,extended rel 12 hr 10-8 mg/5 ml	Tier 1	
promethazine-codeine oral syrup 6.25-10 mg/5 ml	Tier 1	AR; AR
TUSSICAPS ORAL CAPSULE,EXTENDED RELEASE 12 HR 10-8 MG, 5-4 MG	Tier 3	
TUSSIONEX PENNKINETIC ER ORAL SUSPENSION,EXTENDED REL 12 HR 10-8 MG/5 ML	Tier 3	
VITUZ ORAL SOLUTION 5-4 MG/5 ML	Tier 3	PA
Narcotic Antitussive-Anticholinergic Combinations		
hydrocodone-homatropine oral syrup 5-1.5 mg/5 ml	Tier 1	
hydrocodone-homatropine oral tablet 5-1.5 mg	Tier 1	
HYDROMET ORAL SYRUP 5-1.5 MG/5 ML	Tier 1	

Drug Name	Drug Tier	Notes
Narcotic Antitussive-Decongestant Combinations		
REZIRA ORAL SOLUTION 60-5 MG/5 ML	Tier 3	
Narcotic Antitussive-Expectorant Combinations		
codeine-guaifenesin oral liquid 10-100 mg/5 ml	Tier 1	
Nasal Antibiotics		
BACTROBAN NASAL NASAL OINTMENT 2 %	Tier 2	PA; QL (10 GMs per 1 month)
Nasal Anticholinergics		
ipratropium bromide nasal spray,non-aerosol 0.03 %, 0.06 %	Tier 1	
Nasal Antihistamine And Anti-Inflammatory Steroid Combinations		
DYMISTA NASAL SPRAY,NON-AEROSOL 137-50 MCG/SPRAY	Tier 3	PA
Nasal Antihistamines		
ASTEPRO NASAL SPRAY,NON-AEROSOL 0.15 % (205.5 MCG)	Tier 3	
azelastine nasal aerosol,spray 137 mcg (0.1 %)	Tier 1	
azelastine nasal spray,non-aerosol 0.15 % (205.5 mcg)	Tier 1	
olopatadine nasal spray,non-aerosol 0.6 %	Tier 1	
PATANASE NASAL SPRAY,NON-AEROSOL 0.6 %	Tier 3	
Nasal Corticosteroids		
BECONASE AQ NASAL SPRAY,NON-AEROSOL 42 MCG (0.042 %)	Tier 3	PA
budesonide nasal spray,non-aerosol 32 mcg/actuation	Tier 1	
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	Tier 1	
fluticasone nasal spray,suspension 50 mcg/actuation	Tier 1	
mometasone nasal spray,non-aerosol 50 mcg/actuation	Tier 1	
NASONEX NASAL SPRAY,NON-AEROSOL 50 MCG/ACTUATION	Tier 3	PA
OMNARIS NASAL SPRAY,NON-AEROSOL 50 MCG	Tier 3	PA

Drug Name	Drug Tier	Notes
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION, 80 MCG/ACTUATION	Tier 3	PA
RHINOCORT ALLERGY NASAL SPRAY,NON-AEROSOL 32 MCG/ACTUATION	Tier 3	
VERAMYST NASAL SPRAY,SUSPENSION 27.5 MCG/ACTUATION	Tier 3	PA
ZETONNA NASAL HFA AEROSOL INHALER 37 MCG/ACTUATION	Tier 3	PA
Nasal Sympathomimetic Decongestants (Intranasal)		
TYZINE NASAL DROPS 0.05 %, 0.1 %	Tier 3	
TYZINE NASAL SPRAY,NON-AEROSOL 0.1 %	Tier 3	
Non-Narc Antitussive-1St Gen. Antihistamine-Decongestant Combinations		
BROMFED DM ORAL SYRUP 2-30-10 MG/5 ML	Tier 1	
Non-Narcotic Antitus-Decongestant-Analgesic,Non-Salicylate-Expectorant		
DURAFLU ORAL TABLET 60-20-200-500 MG	Tier 3	
Non-Narcotic Antitussive-Antihistamine Combinations		
promethazine-dm oral syrup 6.25-15 mg/5 ml	Tier 1	AR; AR
Pulmonary Fibrosis Treatment Agents - Antifibrotic Therapy		
ESBRIET ORAL CAPSULE 267 MG	Tier 8	30D; Specialty
Pulmonary Fibrosis Treatment Agents - Multikinase Inhibitors		
OFEV ORAL CAPSULE 100 MG, 150 MG	Tier 4	30D; Specialty
Vaginal Products		
Vaginal Antibacterial - Lincosamides		
CLEOCIN VAGINAL CREAM 2 %	Tier 3	
CLEOCIN VAGINAL SUPPOSITORY 100 MG	Tier 3	
clindamycin phosphate vaginal cream 2 %	Tier 1	

Drug Name	Drug Tier	Notes
CLINDESSE VAGINAL CREAM,EXTENDED RELEASE 2 %	Tier 3	
Vaginal Antibacterial - Sulfonamides		
AVC VAGINAL VAGINAL CREAM 15 %	Tier 2	
Vaginal Antifungal - Imidazoles		
GYNAZOLE-1 VAGINAL CREAM 2 %	Tier 3	
MICONAZOLE-3 VAGINAL SUPPOSITORY 200 MG	Tier 1	
Vaginal Antifungal - Triazoles		
TERAZOL 7 VAGINAL CREAM 0.4 %	Tier 3	
terconazole vaginal cream 0.4 %, 0.8 %	Tier 1	
terconazole vaginal suppository 80 mg	Tier 1	
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives		
METROGEL VAGINAL VAGINAL GEL 0.75 %	Tier 3	
metronidazole vaginal gel 0.75 %	Tier 1	
NUVESSA VAGINAL GEL 1.3 %	Tier 3	
VANDAZOLE VAGINAL GEL 0.75 %	Tier 2	
Vaginal Antiseptic Mixtures		
FEM PH VAGINAL GEL 0.9-0.025 %	Tier 3	
RELAGARD VAGINAL GEL 0.9-0.025 %	Tier 3	
Vaginal Estrogens		
ESTRACE VAGINAL CREAM 0.01 % (0.1 MG/GRAM)	Tier 2	
ESTRING VAGINAL RING 2 MG	Tier 3	
FEMRING VAGINAL RING 0.05 MG/24 HR, 0.1 MG/24 HR	Tier 3	Mand 90
PREMARIN VAGINAL CREAM 0.625 MG/GRAM	Tier 2	Mand 90
VAGIFEM VAGINAL TABLET 10 MCG	Tier 3	
yuvafem vaginal tablet 10 mcg	Tier 1	
Vaginal Progestins		
CRINONE VAGINAL GEL 4 %	Tier 3	

Drug Name	Drug Tier	Notes
ABRAXANE INTRAVENOUS SUSPENSION FOR RECONSTITUTION 100 MG	Tier 6	Specialty; 30D; Specialty
ACETADOTE INTRAVENOUS SOLUTION 200 MG/ML (20 %)	Tier 6	Specialty; Specialty
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML)	Tier 6	PA; Specialty; 30D; Specialty
ACTEMRA INTRAVENOUS SOLUTION 400 MG/20 ML (20 MG/ML), 80 MG/4 ML (20 MG/ML)	Tier 6	PA; Specialty; Specialty
acyclovir sodium intravenous recon soln 1,000 mg, 500 mg	Tier 6	Specialty; Specialty
acyclovir sodium intravenous solution 50 mg/ml	Tier 6	Specialty; Specialty
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	Tier 6	Specialty; Specialty
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	Tier 6	Specialty; 30D; Specialty
ADCETRIS INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; 30D; Specialty
ADRUCIL INTRAVENOUS SOLUTION 2.5 GRAM/50 ML, 5 GRAM/100 ML	Tier 6	Specialty; Specialty
ADRUCIL INTRAVENOUS SOLUTION 500 MG/10 ML	Tier 6	Specialty; 30D; Specialty
ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5 ML	Tier 6	Specialty; 30D; Specialty
ALFERON N INJECTION SOLUTION 5 MILLION UNIT/ML	Tier 6	Specialty; 30D; Specialty
ALIMTA INTRAVENOUS RECON SOLN 100 MG	Tier 6	Specialty; Specialty
ALIMTA INTRAVENOUS RECON SOLN 500 MG	Tier 6	Specialty; 30D; Specialty
ALKERAN INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; 30D; Specialty
ALOXI INTRAVENOUS SOLUTION 0.25 MG/5 ML	Tier 6	Specialty; 30D; Specialty
AMBISOME INTRAVENOUS SUSPENSION FOR RECONSTITUTION 50 MG	Tier 6	Specialty; 30D; Specialty
amifostine crystalline intravenous recon soln 500 mg	Tier 6	Specialty; 30D; Specialty
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG, 500 MG	Tier 6	Specialty; Specialty

Drug Name	Drug Tier	Notes
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG	Tier 6	PA; Specialty; 30D; Specialty
ARZERRA INTRAVENOUS SOLUTION 1,000 MG/50 ML	Tier 6	Specialty; 30D; Specialty
ARZERRA INTRAVENOUS SOLUTION 100 MG/5 ML	Tier 6	Specialty; Specialty
ATGAM INTRAVENOUS SOLUTION 50 MG/ML	Tier 6	Specialty; 30D; Specialty
AVASTIN INTRAVENOUS SOLUTION 25 MG/ML	Tier 6	Specialty; 30D; Specialty
AVEED INTRAMUSCULAR SOLUTION 750 MG/3 ML (250 MG/ML)	Tier 6	PA; Specialty; Specialty
AZACITIDINE INJECTION RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTION 50 MG	Tier 5	Specialty; Specialty
BELEODAQ INTRAVENOUS RECON SOLN 500 MG	Tier 6	Specialty; 30D; Specialty
BENLYSTA INTRAVENOUS RECON SOLN 120 MG	Tier 6	Specialty; 30D; Specialty
BENLYSTA INTRAVENOUS RECON SOLN 400 MG	Tier 6	Specialty; Specialty
BERINERT INTRAVENOUS KIT 500 UNIT (10 ML)	Tier 6	PA; Specialty; 30D; Specialty
BERINERT INTRAVENOUS RECON SOLN 500 UNIT (10 ML)	Tier 6	PA; Specialty; Specialty
BEXSERO (PF) INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
BICNU INTRAVENOUS RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
BIOTHRAX INTRAMUSCULAR SUSPENSION 0.5 ML/DOSE	Tier 6	Specialty; 30D; Specialty
BIVIGAM INTRAVENOUS SOLUTION 10 %	Tier 6	PA; Specialty; 30D; Specialty
bleomycin injection recon soln 15 unit	Tier 6	Specialty; 30D; Specialty
bleomycin injection recon soln 30 unit	Tier 6	Specialty; Specialty
BONIVA INTRAVENOUS SYRINGE 3 MG/3 ML	Tier 6	Specialty; 30D; Specialty
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML	Tier 6	Specialty; Specialty
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	Tier 6	Specialty; Specialty

Drug Name	Drug Tier	Notes
BOTOX INJECTION RECON SOLN 100 UNIT, 200 UNIT	Tier 6	PA; Specialty; 30D; Specialty
BUSULFEX INTRAVENOUS SOLUTION 60 MG/10 ML	Tier 6	Specialty; 30D; Specialty
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	Tier 6	PA; Specialty; Specialty
CERVARIX VACCINE (PF) INTRAMUSCULAR SYRINGE 20-20 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
cidofovir intravenous solution 75 mg/ml	Tier 6	Specialty; 30D; Specialty
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS)	Tier 6	PA; Specialty; 30D; Specialty
CINRYZE INTRAVENOUS RECON SOLN 500 UNIT (5 ML)	Tier 6	PA; Specialty; 30D; Specialty
cisplatin intravenous solution 1 mg/ml	Tier 6	Specialty; 30D; Specialty
cladribine intravenous solution 10 mg/10 ml	Tier 6	Specialty; 30D; Specialty
CLEVIPREX INTRAVENOUS EMULSION 25 MG/50 ML, 50 MG/100 ML	Tier 6	Specialty; 30D; Specialty
COSMEGEN INTRAVENOUS RECON SOLN 0.5 MG	Tier 6	Specialty; 30D; Specialty
CYANOCOBALAMIN (VITAMIN B-12) INJECTION SOLUTION 1,000 MCG/ML	Tier 6	Specialty; 30D; Specialty
CYKLOKAPRON INTRAVENOUS SOLUTION 1,000 MG/10 ML (100 MG/ML)	Tier 6	Specialty; Specialty
CYRAMZA INTRAVENOUS SOLUTION 10 MG/ML	Tier 6	Specialty; 30D; Specialty
cytarabine (pf) injection solution 100 mg/5 ml (20 mg/ml), 2 gram/20 ml (100 mg/ml), 20 mg/ml	Tier 6	Specialty; Specialty
cytarabine injection solution 20 mg/ml	Tier 6	Specialty; Specialty
CYTOGAM INTRAVENOUS SOLUTION 50 MG/ML	Tier 6	Specialty; 30D; Specialty
CYTOVENE INTRAVENOUS RECON SOLN 500 MG	Tier 6	Specialty; 30D; Specialty
dacarbazine intravenous recon soln 100 mg, 200 mg	Tier 6	Specialty; 30D; Specialty
DACOGEN INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; 30D; Specialty
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION 15-10-5 LF-MCG-LF/0.5ML	Tier 6	Specialty; 30D; Specialty
daunorubicin intravenous recon soln 20 mg	Tier 6	Specialty; 30D; Specialty
daunorubicin intravenous solution 5 mg/ml	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
decitabine intravenous recon soln 50 mg	Tier 6	Specialty; 30D; Specialty
deferoxamine injection recon soln 2 gram	Tier 6	Specialty; 30D; Specialty
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML, 40 MG/ML	Tier 6	Specialty; 30D; Specialty
DEPOCYT (PF) INTRATHECAL SUSPENSION 50 MG/5 ML (10 MG/ML)	Tier 6	Specialty; 30D; Specialty
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML	Tier 6	Specialty; 30D; Specialty
DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML, 40 MG/ML, 80 MG/ML	Tier 6	Specialty; 30D; Specialty
DEPO-PROVERA INTRAMUSCULAR SOLUTION 400 MG/ML	Tier 6	Specialty; 30D; Specialty
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	Tier 6	Specialty; 30D; Specialty
DEPO-PROVERA INTRAMUSCULAR SYRINGE 150 MG/ML	Tier 6	Specialty; 30D; Specialty
DESFERAL INJECTION RECON SOLN 2 GRAM	Tier 6	Specialty; 30D; Specialty
dexamethasone sodium phos (pf) injection solution 10 mg/ml	Tier 6	Specialty; 30D; Specialty
dexamethasone sodium phosphate injection solution 10 mg/ml, 4 mg/ml	Tier 6	Specialty; 30D; Specialty
dexrazoxane hcl intravenous recon soln 250 mg	Tier 6	Specialty; 30D; Specialty
dexrazoxane hcl intravenous recon soln 500 mg	Tier 6	Specialty; Specialty
DIPHENHYDRAMINE HCL INJECTION SYRINGE 50 MG/ML	Tier 6	Specialty; 30D; Specialty
DOCEFREZ INTRAVENOUS RECON SOLN 20 MG, 80 MG	Tier 6	Specialty; 30D; Specialty
DOCETAXEL INTRAVENOUS SOLUTION 10 MG/ML	Tier 6	Specialty; Specialty
docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 160 mg/8 ml (20 mg/ml), 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)	Tier 6	Specialty; Specialty
docetaxel intravenous solution 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml)	Tier 6	Specialty; 30D; Specialty
doxercalciferol intravenous solution 4 mcg/2 ml	Tier 6	Specialty; 30D; Specialty
DOXIL INTRAVENOUS SUSPENSION 2 MG/ML	Tier 6	Specialty; 30D; Specialty
doxorubicin intravenous recon soln 10 mg, 50 mg	Tier 6	Specialty; Specialty
doxorubicin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml	Tier 6	Specialty; Specialty
doxorubicin, peg-liposomal intravenous suspension 2 mg/ml	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
DYSPORT INTRAMUSCULAR RECON SOLN 300 UNIT	Tier 6	PA; Specialty; Specialty
DYSPORT INTRAMUSCULAR RECON SOLN 500 UNIT	Tier 6	PA; Specialty; 30D; Specialty
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3 ML	Tier 6	PA; Specialty; 30D; Specialty
ELELYSO INTRAVENOUS RECON SOLN 200 UNIT	Tier 6	Specialty; 30D; Specialty
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	Tier 6	Specialty; 30D; Specialty
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	Tier 6	Specialty; 30D; Specialty
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	Tier 6	Specialty; 30D; Specialty
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	Tier 6	Specialty; 30D; Specialty
ELITEK INTRAVENOUS RECON SOLN 1.5 MG, 7.5 MG	Tier 6	Specialty; 30D; Specialty
ELLENCE INTRAVENOUS SOLUTION 200 MG/100 ML	Tier 6	Specialty; Specialty
ELLENCE INTRAVENOUS SOLUTION 50 MG/25 ML	Tier 6	Specialty; 30D; Specialty
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML	Tier 6	Specialty; Specialty
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	Tier 6	Specialty; 30D; Specialty
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SUSPENSION 10 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	Tier 6	Specialty; Specialty
ENTYVIO INTRAVENOUS RECON SOLN 300 MG	Tier 6	PA; Specialty; 30D; Specialty
epirubicin intravenous recon soln 200 mg, 50 mg	Tier 6	Specialty; Specialty
epirubicin intravenous solution 200 mg/100 ml	Tier 6	Specialty; Specialty
epirubicin intravenous solution 50 mg/25 ml	Tier 6	Specialty; 30D; Specialty
epoprostenol (glycine) intravenous recon soln 0.5 mg, 1.5 mg	Tier 6	Specialty; 30D; Specialty
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, 200 MG/100 ML	Tier 6	Specialty; 30D; Specialty
ERWINAZE INJECTION RECON SOLN 10,000 UNIT	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
ESTRADIOL VALERATE INTRAMUSCULAR OIL 20 MG/ML, 40 MG/ML	Tier 6	Specialty; 30D; Specialty
ETOPOPHOS INTRAVENOUS RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
etoposide intravenous solution 20 mg/ml	Tier 6	Specialty; 30D; Specialty
EUFLEXXA INTRA-ARTICULAR SYRINGE 10 MG/ML(MW 2.4 -3.6 MILLION)	Tier 6	Specialty; 30D; Specialty
EVZIO INJECTION AUTO-INJECTOR 0.4 MG/0.4 ML	Tier 6	Specialty; 30D; Specialty
FABRAZYME INTRAVENOUS RECON SOLN 35 MG, 5 MG	Tier 6	PA; Specialty; 30D; Specialty
FASLODEX INTRAMUSCULAR SYRINGE 250 MG/5 ML	Tier 6	Specialty; 30D; Specialty
FERAHEME INTRAVENOUS SOLUTION 510 MG/17 ML (30 MG/ML)	Tier 6	Specialty; 30D; Specialty
FERRLECIT INTRAVENOUS SOLUTION 62.5 MG/5 ML	Tier 6	Specialty; 30D; Specialty
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %, 5 %	Tier 6	PA; Specialty; 30D; Specialty
FLOLAN INTRAVENOUS RECON SOLN 0.5 MG, 1.5 MG	Tier 6	Specialty; 30D; Specialty
floxuridine injection recon soln 0.5 gram	Tier 6	Specialty; 30D; Specialty
fludarabine intravenous solution 50 mg/2 ml	Tier 6	Specialty; 30D; Specialty
fluorouracil intravenous solution 1 gram/20 ml, 2.5 gram/50 ml, 5 gram/100 ml	Tier 6	Specialty; Specialty
fluorouracil intravenous solution 500 mg/10 ml	Tier 6	Specialty; 30D; Specialty
fluphenazine decanoate injection solution 25 mg/ml	Tier 6	Specialty; Specialty
fluphenazine hcl injection solution 2.5 mg/ml	Tier 6	Specialty; 30D; Specialty
FOLOTYN INTRAVENOUS SOLUTION 20 MG/ML (1 ML), 40 MG/2 ML (20 MG/ML)	Tier 6	Specialty; 30D; Specialty
fomepizole intravenous solution 1 gram/ml	Tier 6	Specialty; 30D; Specialty
foscarnet intravenous solution 24 mg/ml	Tier 6	Specialty; 30D; Specialty
FOSCAVIR INTRAVENOUS SOLUTION 24 MG/ML	Tier 6	Specialty; 30D; Specialty
FUSILEV INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; 30D; Specialty
GAMASTAN S/D INTRAMUSCULAR SOLUTION 15-18 % RANGE	Tier 6	PA; Specialty; 30D; Specialty
GAMMAGARD LIQUID INJECTION SOLUTION 10 %	Tier 6	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN 10 GRAM, 5 GRAM	Tier 6	PA; Specialty; 30D; Specialty
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 5 GRAM/50 ML (10 %)	Tier 6	PA; Specialty; 30D; Specialty
GAMMAPLEX INTRAVENOUS SOLUTION 5 %	Tier 6	PA; Specialty; 30D; Specialty
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %)	Tier 6	PA; Specialty; 30D; Specialty
ganciclovir sodium intravenous recon soln 500 mg	Tier 6	Specialty; 30D; Specialty
GARDASIL (PF) INTRAMUSCULAR SUSPENSION 20-40-40-20 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
GARDASIL (PF) INTRAMUSCULAR SYRINGE 20-40-40-20 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML	Tier 6	Specialty; 30D; Specialty
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	Tier 6	Specialty; 30D; Specialty
GAZYVA INTRAVENOUS SOLUTION 1,000 MG/40 ML	Tier 6	Specialty; 30D; Specialty
GEL-ONE INTRA-ARTICULAR SYRINGE 30 MG/3 ML	Tier 6	Specialty; 30D; Specialty
gemcitabine intravenous recon soln 1 gram	Tier 6	Specialty; 30D; Specialty
gemcitabine intravenous recon soln 2 gram, 200 mg	Tier 6	Specialty; Specialty
gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)	Tier 6	Specialty; Specialty
GEMZAR INTRAVENOUS RECON SOLN 1 GRAM	Tier 6	Specialty; Specialty
GEMZAR INTRAVENOUS RECON SOLN 200 MG	Tier 6	Specialty; 30D; Specialty
GEODON INTRAMUSCULAR RECON SOLN 20 MG/ML (FINAL CONC.)	Tier 6	Specialty; Specialty
GLASSIA INTRAVENOUS SOLUTION 1 GRAM/50 ML (2 %)	Tier 6	Specialty; 30D; Specialty
GLIADEL WAFER IMPLANT WAFER 7.7 MG	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
granisetron (pf) intravenous solution 1 mg/ml (1 ml), 100 mcg/ml	Tier 6	Specialty
granisetron hcl intravenous solution 1 mg/ml	Tier 6	Specialty; 30D; Specialty
granisetron hcl intravenous solution 1 mg/ml (1 ml)	Tier 6	Specialty
HALAVEN INTRAVENOUS SOLUTION 1 MG/2 ML (0.5 MG/ML)	Tier 6	Specialty; 30D; Specialty
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/ML	Tier 6	Specialty; Specialty
HALDOL INJECTION SOLUTION 5 MG/ML	Tier 6	Specialty; Specialty
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml	Tier 6	Specialty; Specialty
haloperidol lactate injection solution 5 mg/ml	Tier 6	Specialty; Specialty
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	Tier 6	Specialty; 30D; Specialty
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 720 ELISA UNIT/0.5 ML	Tier 6	Specialty; Specialty
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	Tier 6	Specialty; 30D; Specialty
HECTOROL INTRAVENOUS SOLUTION 2 MCG/ML (1 ML)	Tier 6	Specialty; Specialty
HECTOROL INTRAVENOUS SOLUTION 4 MCG/2 ML	Tier 6	Specialty; 30D; Specialty
HEPAGAM B INJECTION SOLUTION >312 UNIT/ML, GREATR THAN 312 UNIT/ML (5 ML)	Tier 6	Specialty; Specialty
HERCEPTIN INTRAVENOUS RECON SOLN 440 MG	Tier 6	Specialty; 30D; Specialty
HIZENTRA SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %)	Tier 6	PA; Specialty; 30D; Specialty
HIZENTRA SUBCUTANEOUS SOLUTION 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %)	Tier 6	PA; Specialty; Specialty
HYALGAN INTRA-ARTICULAR SOLUTION 10 MG/ML	Tier 6	Specialty; 30D; Specialty
HYALGAN INTRA-ARTICULAR SYRINGE 10 MG/ML	Tier 6	Specialty; Specialty
HYCAMTIN INTRAVENOUS RECON SOLN 4 MG	Tier 6	Specialty; 30D; Specialty
HYPERHEP B S/D INTRAMUSCULAR SOLUTION 220 UNIT/ML	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
HYPERHEP B S/D INTRAMUSCULAR SOLUTION 220 UNIT/ML (5 ML)	Tier 6	Specialty; Specialty
HYPERHEP B S/D INTRAMUSCULAR SYRINGE 220 UNIT/ML	Tier 6	Specialty; 30D; Specialty
HYPERHEP B S-D NEONATAL INTRAMUSCULAR SYRINGE 110 UNIT/0.5 ML	Tier 6	Specialty; 30D; Specialty
HYPERRHO S/D INTRAMUSCULAR SYRINGE 1,500 UNIT (300 MCG), 250 UNIT (50 MCG)	Tier 6	Specialty; 30D; Specialty
HYPERTET S/D (PF) INTRAMUSCULAR SYRINGE 250 UNIT	Tier 6	Specialty; Specialty
HYQVIA SUBCUTANEOUS SOLUTION 10 GRAM /100 ML (10 %), 2.5 GRAM /25 ML (10 %), 20 GRAM /200 ML (10 %), 30 GRAM /300 ML (10 %), 5 GRAM /50 ML (10 %)	Tier 6	PA; Specialty; 30D; Specialty
ibandronate intravenous solution 3 mg/3 ml	Tier 6	Specialty; 30D; Specialty
ibandronate intravenous syringe 3 mg/3 ml	Tier 6	Specialty; 30D; Specialty
IC GREEN INJECTION RECON SOLN 25 MG	Tier 6	Specialty; 30D; Specialty
IDAMYCIN PFS INTRAVENOUS SOLUTION 1 MG/ML	Tier 6	Specialty; 30D; Specialty
idarubicin intravenous solution 1 mg/ml	Tier 6	Specialty; 30D; Specialty
IFEX INTRAVENOUS RECON SOLN 1 GRAM	Tier 6	Specialty; 30D; Specialty
ifosfamide-mesna intravenous kit 1-1 gram, 3,000-1,000 mg	Tier 6	Specialty; 30D; Specialty
ILARIS (PF) SUBCUTANEOUS RECON SOLN 180 MG/1.2 ML (150 MG/ML)	Tier 6	PA; Specialty; 30D; Specialty
IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML, 10EXP8 (100 MILLION) PFU/ML	Tier 6	Specialty; 30D; Specialty
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN 2.5 UNIT	Tier 6	Specialty; Specialty
indocyanine green injection recon soln 25 mg	Tier 6	Specialty; 30D; Specialty
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION 25-58-10 LF-MCG-LF/0.5ML	Tier 6	Specialty; 30D; Specialty
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE 25-58-10 LF-MCG-LF/0.5ML	Tier 6	Specialty; Specialty
INFED INJECTION SOLUTION 100 MG/2 ML (50 MG/ML)	Tier 6	Specialty; 30D; Specialty
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 39 MG/0.25 ML, 78 MG/0.5 ML	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML, 410 MG/1.315 ML, 546 MG/1.75 ML, 819 MG/2.625 ML	Tier 6	Specialty; 30D; Specialty
IPOL INJECTION SUSPENSION 40-8-32 UNIT/0.5 ML	Tier 6	Specialty; Specialty
irinotecan intravenous solution 100 mg/5 ml, 40 mg/2 ml, 500 mg/25 ml	Tier 6	Specialty; 30D; Specialty
ISTODAX INTRAVENOUS RECON SOLN 10 MG/2 ML	Tier 6	Specialty; 30D; Specialty
IXIARO (PF) INTRAMUSCULAR SYRINGE 6 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
JEVTANA INTRAVENOUS SOLUTION 10 MG/ML (FIRST DILUTION)	Tier 6	Specialty; 30D; Specialty
KADCYLA INTRAVENOUS RECON SOLN 100 MG, 160 MG	Tier 6	Specialty; 30D; Specialty
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML (1 ML)	Tier 6	Specialty; 30D; Specialty
KENALOG INJECTION SUSPENSION 10 MG/ML, 40 MG/ML	Tier 6	Specialty; 30D; Specialty
KEYTRUDA INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; 30D; Specialty
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	Tier 6	Specialty; 30D; Specialty
KINRIX (PF) INTRAMUSCULAR SUSPENSION 25 LF-58 MCG-10 LF/0.5 ML	Tier 6	Specialty; 30D; Specialty
KINRIX (PF) INTRAMUSCULAR SYRINGE 25 LF-58 MCG-10 LF/0.5 ML	Tier 6	Specialty; 30D; Specialty
KRYSTEXXA INTRAVENOUS SOLUTION 8 MG/ML	Tier 6	Specialty; 30D; Specialty
KYPROLIS INTRAVENOUS RECON SOLN 30 MG, 60 MG	Tier 6	Specialty; 30D; Specialty
LEMTRADA INTRAVENOUS SOLUTION 12 MG/1.2 ML	Tier 6	PA; Specialty; Specialty
leucovorin calcium injection recon soln 100 mg, 200 mg, 350 mg, 50 mg, 500 mg	Tier 6	Specialty; 30D; Specialty
leuprolide subcutaneous kit 1 mg/0.2 ml	Tier 6	Specialty; 30D; Specialty
levoleucovorin intravenous recon soln 50 mg	Tier 6	Specialty; 30D
levoleucovorin intravenous recon soln 50 mg	Tier 6	Specialty; 30D; Specialty
levoleucovorin intravenous solution 10 mg/ml	Tier 6	Specialty; Specialty
LIPODOX INTRAVENOUS SUSPENSION 2 MG/ML	Tier 6	Specialty; 30D; Specialty
LUMIZYME INTRAVENOUS RECON SOLN 50 MG	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
LUPANETA PACK (1 MONTH) KIT. SYRINGE AND TABLET 3.75 MG -5 MG (30)	Tier 6	Specialty; Specialty
LUPANETA PACK (3 MONTH) KIT. SYRINGE AND TABLET 11.25 MG -5 MG (90)	Tier 6	Specialty; Specialty
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 22.5 MG	Tier 6	PA; Specialty; 30D; Specialty
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	Tier 6	PA; Specialty; 30D; Specialty
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG	Tier 6	PA; Specialty; 30D; Specialty
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 7.5 MG	Tier 6	PA; Specialty; 30D; Specialty
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG	Tier 6	Specialty; Specialty
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	Tier 6	Specialty; 30D; Specialty
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	Tier 6	Specialty; Specialty
MAKENA INTRAMUSCULAR OIL 250 MG/ML	Tier 6	Specialty; 30D; Specialty
MARQIBO INTRAVENOUS KIT 5 MG/31 ML(0.16 MG/ML) FINAL	Tier 6	Specialty; 30D; Specialty
medroxyprogesterone intramuscular suspension 150 mg/ml	Tier 6	Specialty; Specialty
medroxyprogesterone intramuscular syringe 150 mg/ml	Tier 6	Specialty; Specialty
melphalan hcl intravenous recon soln 50 mg	Tier 6	Specialty; 30D; Specialty
MENACTRA (PF) INTRAMUSCULAR SOLUTION 4 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
MENOMUNE - A/C/Y/W-135 (PF) SUBCUTANEOUS RECON SOLN 50 MCG	Tier 6	Specialty; Specialty
MENOMUNE - A/C/Y/W-135 SUBCUTANEOUS RECON SOLN 50 MCG	Tier 6	Specialty; 30D; Specialty
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
mesna intravenous solution 100 mg/ml	Tier 6	Specialty; 30D; Specialty
MESNEX INTRAVENOUS SOLUTION 100 MG/ML	Tier 6	Specialty; 30D; Specialty
methotrexate sodium (pf) injection recon soln 1 gram	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
methotrexate sodium (pf) injection solution 25 mg/ml	Tier 6	Specialty
methotrexate sodium injection solution 25 mg/ml	Tier 6	Specialty; 30D; Specialty
methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml	Tier 6	Specialty; 30D; Specialty
methylprednisolone sodium succ injection recon soln 125 mg, 40 mg	Tier 6	Specialty; Specialty
MICRHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SYRINGE 250 UNIT (50 MCG)	Tier 6	Specialty; 30D; Specialty
mitomycin intravenous recon soln 20 mg	Tier 6	Specialty; 30D; Specialty
mitomycin intravenous recon soln 40 mg, 5 mg	Tier 6	Specialty; Specialty
mitoxantrone intravenous concentrate 2 mg/ml	Tier 6	Specialty; 30D; Specialty
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML	Tier 6	Specialty; Specialty
MONOVISC INTRA-ARTICULAR SYRINGE 88 MG/4 ML	Tier 6	Specialty; Specialty
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2 ML (20 MG/ML)	Tier 6	Specialty; 30D; Specialty
MUSTARGEN INJECTION RECON SOLN 10 MG	Tier 6	Specialty; 30D; Specialty
MYOBLOC INTRAMUSCULAR SOLUTION 10,000 UNIT/2 ML, 5,000 UNIT/ML	Tier 6	PA; Specialty; Specialty
MYOBLOC INTRAMUSCULAR SOLUTION 2,500 UNIT/0.5 ML	Tier 6	PA; Specialty; 30D; Specialty
NABI-HB INTRAMUSCULAR SOLUTION GREATER THAN 1,560 UNIT/5 ML	Tier 6	Specialty; Specialty
NABI-HB INTRAMUSCULAR SOLUTION GREATR THAN 312 UNIT/ML	Tier 6	Specialty; 30D; Specialty
NAGLAZYME INTRAVENOUS SOLUTION 5 MG/5 ML	Tier 6	Specialty; 30D; Specialty
NAVELBINE INTRAVENOUS SOLUTION 10 MG/ML	Tier 6	Specialty; 30D; Specialty
NAVELBINE INTRAVENOUS SOLUTION 50 MG/5 ML	Tier 6	Specialty; Specialty
NEXPLANON SUBDERMAL IMPLANT 68 MG	Tier 6	Specialty; 30D; Specialty
NIPENT INTRAVENOUS RECON SOLN 10 MG	Tier 6	Specialty; 30D; Specialty
NPLATE SUBCUTANEOUS RECON SOLN 250 MCG	Tier 6	Specialty; 30D; Specialty
NPLATE SUBCUTANEOUS RECON SOLN 500 MCG	Tier 6	Specialty; Specialty

Drug Name	Drug Tier	Notes
NUCALA SUBCUTANEOUS RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
NULOJIX INTRAVENOUS RECON SOLN 250 MG	Tier 6	Specialty; 30D; Specialty
OCTAGAM INTRAVENOUS SOLUTION 10 %	Tier 6	PA; Specialty; Specialty
OCTAGAM INTRAVENOUS SOLUTION 5 %	Tier 6	PA; Specialty; 30D; Specialty
olanzapine intramuscular recon soln 10 mg	Tier 6	Specialty; 30D; Specialty
ondansetron hcl (pf) injection solution 4 mg/2 ml	Tier 6	Specialty; 30D; Specialty
ondansetron hcl (pf) injection syringe 4 mg/2 ml	Tier 6	Specialty; Specialty
ondansetron hcl intravenous solution 2 mg/ml	Tier 6	Specialty; Specialty
OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 40 MG/4 ML	Tier 6	Specialty; Specialty
ORENCIA (WITH MALTOSE) INTRAVENOUS RECON SOLN 250 MG	Tier 6	PA; Specialty; 30D; Specialty
ORTHOVISC INTRA-ARTICULAR SYRINGE 30 MG/2 ML	Tier 6	Specialty; 30D; Specialty
oxaliplatin intravenous recon soln 100 mg	Tier 6	Specialty; Specialty
oxaliplatin intravenous recon soln 50 mg	Tier 6	Specialty; 30D; Specialty
oxaliplatin intravenous solution 100 mg/20 ml, 50 mg/10 ml (5 mg/ml)	Tier 6	Specialty; Specialty
paclitaxel intravenous concentrate 6 mg/ml	Tier 6	Specialty; 30D; Specialty
pamidronate intravenous recon soln 30 mg	Tier 6	Specialty; Specialty
pamidronate intravenous recon soln 90 mg	Tier 6	Specialty; 30D; Specialty
pamidronate intravenous solution 30 mg/10 ml (3 mg/ml), 60 mg/10 ml (6 mg/ml)	Tier 6	Specialty; 30D; Specialty
pamidronate intravenous solution 90 mg/10 ml (9 mg/ml)	Tier 6	Specialty; Specialty
PEDIARIX (PF) INTRAMUSCULAR SYRINGE 10 MCG-25LF-25 MCG-10LF/0.5 ML	Tier 6	Specialty; 30D; Specialty
PENTACEL (PF) INTRAMUSCULAR KIT 15 LF UNIT-20 MCG-5 LF/0.5 ML	Tier 6	Specialty; 30D; Specialty
PENTACEL ACTHIB COMPONENT (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
PENTACEL DTAP-IPV COMPNT (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML	Tier 6	Specialty; 30D; Specialty
PENTAM INJECTION RECON SOLN 300 MG	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
PNEUMOVAX 23 INJECTION SOLUTION 25 MCG/0.5 ML	Tier 6	Specialty; 30D; Specialty
PNEUMOVAX 23 INJECTION SYRINGE 25 MCG/0.5 ML	Tier 6	Specialty; Specialty
PREVNAR 13 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	Tier 6	Specialty; 30D; Specialty
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 25 MCG/ML	Tier 6	Specialty; 30D; Specialty
PRIVIGEN INTRAVENOUS SOLUTION 10 %	Tier 6	PA; Specialty; 30D; Specialty
PROGESTERONE IN OIL INTRAMUSCULAR OIL 50 MG/ML	Tier 6	Specialty; Specialty
progesterone intramuscular oil 50 mg/ml	Tier 6	Specialty; Specialty
PROLASTIN-C INTRAVENOUS RECON SOLN 1,000 MG	Tier 6	Specialty; 30D; Specialty
PROLEUKIN INTRAVENOUS RECON SOLN 22 MILLION UNIT	Tier 6	Specialty; 30D; Specialty
PROLIA SUBCUTANEOUS SYRINGE 60 MG/ML	Tier 6	Specialty; 30D; Specialty
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3-4.3-3- 3.99 TCID50/0.5	Tier 6	Specialty; Specialty
PROVENGE INTRAVENOUS SUSPENSION 50 MILLION CELL/250 ML	Tier 6	Specialty; 30D; Specialty
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML	Tier 6	Specialty; 30D; Specialty
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 2.5 UNIT	Tier 6	Specialty; Specialty
RECLAST INTRAVENOUS SOLUTION 5 MG/100 ML	Tier 6	PA; Specialty; 30D; Specialty
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	Tier 6	Specialty; Specialty
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	Tier 6	Specialty; Specialty
REMICADE INTRAVENOUS RECON SOLN 100 MG	Tier 6	PA; Specialty; 30D; Specialty
REMODULIN INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2.5 MG/ML, 5 MG/ML	Tier 6	Specialty; 30D; Specialty
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML	Tier 6	Specialty; Specialty

Drug Name	Drug Tier	Notes
RHOGAM ULTRA-FILTERED PLUS INTRAMUSCULAR SYRINGE 1,500 UNIT (300 MCG)	Tier 6	Specialty; 30D; Specialty
RHOPHYLAC INJECTION SYRINGE 1,500 UNIT (300 MCG)/2 ML	Tier 6	Specialty; Specialty
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML, 50 MG/2 ML	Tier 6	Specialty; 30D; Specialty
RITUXAN INTRAVENOUS CONCENTRATE 10 MG/ML	Tier 6	PA; Specialty; 30D; Specialty
rocuronium intravenous solution 10 mg/ml	Tier 6	Specialty; 30D; Specialty
rocuronium intravenous syringe 100 mg/10 ml (10 mg/ml), 50 mg/5 ml (10 mg/ml)	Tier 6	Specialty; Specialty
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION 10EXP6 CCID50/ML	Tier 6	Specialty; Specialty
ROTATEQ VACCINE ORAL SUSPENSION 2 ML	Tier 6	Specialty; Specialty
RUCONEST INTRAVENOUS RECON SOLN 2,100 UNIT	Tier 6	Specialty; Specialty
SIGNIFOR LAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 20 MG, 40 MG, 60 MG	Tier 6	Specialty; Specialty
SOLU-CORTEF (PF) INJECTION RECON SOLN 1,000 MG/8 ML, 100 MG/2 ML, 250 MG/2 ML, 500 MG/4 ML	Tier 6	Specialty; 30D; Specialty
SOLU-CORTEF INJECTION RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
SOLU-MEDROL (PF) INJECTION RECON SOLN 125 MG/2 ML, 40 MG/ML	Tier 6	Specialty; 30D; Specialty
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML	Tier 6	PA; Specialty; 30D; Specialty
SUPPRELIN LA IMPLANT KIT 50 MG (65 MCG/DAY)	Tier 6	Specialty; Specialty
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5 ML	Tier 6	PA; Specialty; 30D; Specialty
SYNRIBO SUBCUTANEOUS RECON SOLN 3.5 MG	Tier 6	Specialty; 30D; Specialty
SYNVISC INTRA-ARTICULAR SYRINGE 16 MG/2 ML	Tier 6	Specialty; 30D; Specialty
SYNVISC-ONE INTRA-ARTICULAR SYRINGE 48 MG/6 ML	Tier 6	Specialty; 30D; Specialty
TAXOTERE INTRAVENOUS SOLUTION 20 MG/ML (1 ML)	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
TAXOTERE INTRAVENOUS SOLUTION 80 MG/4 ML (20 MG/ML)	Tier 6	Specialty; Specialty
TEFLARO INTRAVENOUS RECON SOLN 400 MG, 600 MG	Tier 6	Specialty; 30D; Specialty
TEMODAR INTRAVENOUS RECON SOLN 100 MG	Tier 6	Specialty; Specialty
teniposide intravenous solution 50 mg/5 ml	Tier 6	Specialty; Specialty
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML	Tier 6	Specialty; 30D; Specialty
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML	Tier 6	Specialty; Specialty
TESTOPEL IMPLANT PELLET 75 MG	Tier 6	PA; Specialty; 30D; Specialty
tetanus,diphtheria tox ped(pf) intramuscular suspension 5-25 lf unit/0.5 ml	Tier 6	Specialty; Specialty
tetanus-diphtheria toxoids-td intramuscular suspension 2-2 lf unit/0.5 ml	Tier 6	Specialty; Specialty
THERACYS INTRAVESICAL SUSPENSION FOR RECONSTITUTION 81 MG	Tier 6	Specialty; 30D; Specialty
THYMOGLOBULIN INTRAVENOUS RECON SOLN 25 MG	Tier 6	Specialty; Specialty
THYROGEN INTRAMUSCULAR RECON SOLN 1.1 MG	Tier 6	Specialty; 30D; Specialty
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION 50 MG	Tier 6	Specialty; 30D; Specialty
TOPOSAR INTRAVENOUS SOLUTION 20 MG/ML	Tier 6	Specialty; 30D; Specialty
topotecan intravenous recon soln 4 mg	Tier 6	Specialty; Specialty
topotecan intravenous solution 4 mg/4 ml (1 mg/ml)	Tier 6	Specialty; 30D; Specialty
TORISEL INTRAVENOUS RECON SOLN 30 MG/3 ML (10 MG/ML) (FIRST)	Tier 6	Specialty; Specialty
TREANDA INTRAVENOUS RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
TREANDA INTRAVENOUS RECON SOLN 25 MG	Tier 6	Specialty; Specialty
TRELSTAR INTRAMUSCULAR SYRINGE 11.25 MG/2 ML, 22.5 MG/2 ML, 3.75 MG/2 ML	Tier 6	Specialty; 30D; Specialty
triamcinolone acetonide injection suspension 10 mg/ml, 40 mg/ml	Tier 6	Specialty; Specialty
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML	Tier 6	Specialty; Specialty

Drug Name	Drug Tier	Notes
TWINRIX (PF) INTRAMUSCULAR SUSPENSION 720 ELISA UNIT -20 MCG/ML	Tier 6	Specialty; Specialty
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT -20 MCG/ML	Tier 6	Specialty; Specialty
TYSABRI INTRAVENOUS SOLUTION 300 MG/15 ML	Tier 6	PA; Specialty; 30D; Specialty
VALSTAR INTRAVESICAL SOLUTION 40 MG/ML	Tier 6	Specialty; Specialty
VANTAS IMPLANT KIT 50 MG (50 MCG/DAY)	Tier 6	Specialty; Specialty
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 50 UNIT/ML	Tier 6	Specialty; Specialty
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML	Tier 6	Specialty; 30D; Specialty
VARIZIG INTRAMUSCULAR RECON SOLN 125 UNIT	Tier 6	Specialty; 30D; Specialty
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)	Tier 6	Specialty; 30D; Specialty
VECTIBIX INTRAVENOUS SOLUTION 400 MG/20 ML (20 MG/ML)	Tier 6	Specialty; Specialty
VELCADE INJECTION RECON SOLN 3.5 MG	Tier 6	Specialty; 30D; Specialty
VELETRI INTRAVENOUS RECON SOLN 0.5 MG, 1.5 MG	Tier 6	Specialty; 30D; Specialty
VIDAZA INJECTION RECON SOLN 100 MG	Tier 6	Specialty; 30D; Specialty
VIMIZIM INTRAVENOUS SOLUTION 5 MG/5 ML (1 MG/ML)	Tier 6	Specialty; Specialty
vinblastine intravenous solution 1 mg/ml	Tier 6	Specialty; Specialty
VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML, 2 MG/2 ML	Tier 6	Specialty; Specialty
vincristine intravenous solution 1 mg/ml, 2 mg/2 ml	Tier 6	Specialty; Specialty
vinorelbine intravenous solution 10 mg/ml	Tier 6	Specialty; 30D; Specialty
vinorelbine intravenous solution 50 mg/5 ml	Tier 6	Specialty; Specialty
VISUDYNE INTRAVENOUS RECON SOLN 15 MG	Tier 6	Specialty; 30D; Specialty
VIVITROL INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 380 MG	Tier 6	Specialty; 30D; Specialty
VPRIV INTRAVENOUS RECON SOLN 400 UNIT	Tier 6	PA; Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
WINRHO SDF INJECTION SOLUTION 1,500 UNIT/1.3 ML, 15,000 UNIT/13 ML, 2,500 UNIT/2.2 ML, 5,000 UNIT/4.4 ML	Tier 6	Specialty; Specialty
XEOMIN INTRAMUSCULAR RECON SOLN 100 UNIT, 50 UNIT	Tier 6	PA; Specialty; 30D; Specialty
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7 ML (70 MG/ML)	Tier 6	PA; Specialty; 30D; Specialty
XIAFLEX INJECTION RECON SOLN 0.9 MG	Tier 6	Specialty; 30D; Specialty
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	Tier 6	PA; Specialty; 30D; Specialty
YERVOY INTRAVENOUS SOLUTION 200 MG/40 ML (5 MG/ML)	Tier 6	Specialty; Specialty
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	Tier 6	Specialty; 30D; Specialty
ZANOSAR INTRAVENOUS RECON SOLN 1 GRAM	Tier 6	Specialty; 30D; Specialty
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	Tier 6	Specialty; Specialty
ZEMPLAR INTRAVENOUS SOLUTION 2 MCG/ML, 5 MCG/ML	Tier 6	Specialty; Specialty
ZEVALIN (Y-90) INTRAVENOUS KIT 3.2 MG/2 ML	Tier 6	Specialty; 30D; Specialty
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 250 MG	Tier 6	Specialty; 30D; Specialty
ZINECARD (AS HCL) INTRAVENOUS RECON SOLN 500 MG	Tier 6	Specialty; Specialty
ZOFRAN (AS HYDROCHLORIDE) INTRAVENOUS SOLUTION 2 MG/ML	Tier 6	Specialty; 30D; Specialty
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG	Tier 6	Specialty; 30D; Specialty
zoledronic acid intravenous recon soln 4 mg	Tier 6	Specialty; Specialty
ZOLEDRONIC ACID INTRAVENOUS SOLUTION 4 MG/5 ML	Tier 6	Specialty; 30D; Specialty
zoledronic acid-mannitol-water intravenous piggyback 4 mg/100 ml	Tier 6	Specialty; Specialty
ZOLEDRONIC ACID-MANNITOL-WATER INTRAVENOUS SOLUTION 5 MG/100 ML	Tier 6	PA; Specialty; 30D; Specialty
ZOMETA INTRAVENOUS SOLUTION 4 MG/100 ML	Tier 6	Specialty; Specialty
ZOMETA INTRAVENOUS SOLUTION 4 MG/5 ML	Tier 6	Specialty; 30D; Specialty

Drug Name	Drug Tier	Notes
ZOSTAVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 19,400 UNIT/0.65 ML	Tier 6	Specialty; 30D; Specialty
ZYPREXA INTRAMUSCULAR RECON SOLN 10 MG	Tier 6	Specialty; 30D; Specialty
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG, 300 MG, 405 MG	Tier 6	Specialty; Specialty

APPENDIX D

DRUG/CATEGORY	QTY LIMIT	CRITERIA
ADD Medications Vyvanse® (lisdexamfetamine dimesylate)	Limited to 1 unit per day	1. The patient must have a chart documented trial or Rx claims for generic Adderall or Adderall XR in the past 120 days, **OR** 2. Patient is 18 years of age or older with a documented diagnosis or moderate to severe binge eating disorder.
Strattera® (atomoxetine)	10mg, 18mg, 25mg, and 40mg: Limited to a qty of 60 units per month 60mg, 80mg and 100mg: Limited to a qty of 30 units per month	1. The patient must have a documented diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD); **AND** 2. The patient must have documented failure based on chart documentation or prescription claims with a generic methylphenidate (i.e., Ritalin, Concerta) **AND** generic Adderall; **OR** 3. The patient must have a documented history or risk of substance abuse; **OR** 4. The patient must have a documented diagnosis of anxiety or tics.
Focalin XR® (dexmethylphenidate)		1. The patient must have chart documented trial or Rx claims for a generic methylphenidate in the past 120 days.
Aptensio XR® (methylphenidate extended-release capsules) Daytrana® (methylphenidate patch) Quillivant XR® (methylphenidate suspension)		1. The patient is at least six years of age and has a documented diagnosis of ADD/ADHD; **AND** 2. The patient must have a chart documented trial or Rx claims for a generic methylphenidate in the past 120 days; **OR** **For Daytrana only:** If the patient has a chart documented inability to swallow, a trial of oral methylphenidate is not required.
Intuniv® (guanfacine)	Limited to a qty of 30 units per month	1. The patient must have a documented diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD); **AND** 2. The patient must have documented failure based on chart documentation or prescription claims with a generic methylphenidate (i.e., Ritalin, Concerta) **AND** generic Adderall; **OR** 3. The patient must have a documented history or risk of substance abuse; **OR** 4. The patient must have a documented diagnosis of anxiety or tics.
Zenzedi® (dextroamphetamine) 2.5mg, 7.5mg, 15mg, 20mg, 30mg		1. The patient is being treated for ADHD or Narcolepsy; **AND** 2. The patient has chart documented treatment failure or intolerance to 2 generic formulary alternatives (i.e., mixed amphetamine salts, dextroamphetamine, methylphenidate).
Allergy Medications Clarinex® (desloratadine)	Limited to a qty of 30 units per month	

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Allergy Medications, continued Clarinex-D® (desloratadine/pseudoephedrine)		1. The patient must have documented failure or Rx claims for generic OTC Claritin D or OTC generic Claritin in combination with OTC generic pseudoephedrine in the past year. **NOTE:** For Clarinex-D, prior authorization is only required for patients over 12 years of age. Generic Claritin and Claritin-D OTC products are covered with a prescription; OTC pseudoephedrine is not a covered benefit.
All Brand Nasal Steroids Beconase AQ® (beclomethasone dipropionate) Nasonex® (mometasone furoate) Omnaris® (ciclesonide) Qnasl® (beclomethasone dipropionate) Veramyst® (fluticasone furoate) Zetonna® (ciclesonide)		1. The patient must have documented failure or Rx claims for two generic nasal steroids (i.e., Flonase, flunisolide, Nasacort AQ, Rhinocort Aqua) in the past year.
All Brand Nasal Steroids, Combination Products Dymista® (azelastine/fluticasone propionate)		1. The patient must have documented failure or Rx claims for a generic nasal steroid (i.e., Flonase, flunisolide, Nasacort AQ) in the past year.
Alzheimers Namzaric® (memantine ext rel./donepezil)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 1 unit per day
Analgesics **On Formulary with PA:** Actiq® (fentanyl citrate oral transmucosal) **Non-Formulary with PA:** Abstral® (fentanyl sl) Fentora® (fentanyl citrate buccal tablet) Lazanda® (fentanyl nasal spray) Subsys® (fentanyl sublingual spray)	Abstral, Fentora, Subsys qty-4 units/day Actiq qty- 4 units/ day Lazanda qty-1 bottle (5ml)/day	1. The patient has a documented current diagnosis of cancer. 2. The patient is already receiving and is tolerant to opioid therapy for underlying persistent cancer pain. **NOTE:** System will automatically approve if written by an oncologist (or if there are prescription claims for chemotherapy-related medications) and the patient is receiving opioid pain medications. Abstral, Lazanda and Subsys– New Starts Only
Embeda® (morphine/naltrexone)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 2 units per day
MS Contin® (morphine ext. release)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 3 units per day
Nucynta® (tapentadol)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 6 units per day
Nucynta ER® (tapentadol)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 2 units per day
Opana® (oxymorphone)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 8 units per day

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Analgesics, continued Opana ER (Crush Resistant)® (oxymorphone) Oxymorphone ER (Non-Crush Resistant) (oxymorphone)	Qty is limited to 3 units per day	1. The patient has a documented current diagnosis of active cancer. **NOTE:** System will automatically approve if written by an oncologist or if there are previous claims for chemotherapy-related medications.
Oxycodone/Ibuprofen		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 28 units per 30 days
Stadol NS® (butorphanol)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 2 bottles (5ml) per 30 days
Ultracet® (tramadol/acetaminophen) Ultram® (tramadol)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 8 units per day
Ultram ER® (tramadol)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 1 unit per day
Butrans® (buprenorphine patch)	Qty is limited to 4 units per 28 days	For indications other than cancer: 1. The patient must have documented failure or prescription claims for at least two formulary alternatives (i.e., morphine ER, tramadol, APAP/codeine, hydrocodone/APAP) within the last 3 months; **OR** 2. Based on chart documentation, all formulary alternatives are inappropriate, **AND** 3. The patient is not being treated for opioid dependence. **NOTE:** System will automatically approve if written by an oncologist or if there are prescription claims for chemotherapy-related medications.
Conzip® (tramadol)	Limited to 1 unit per day	1. The patient must have documented failure or Rx claims with generic Ultram or Ultram ER in the past 60 days.
Kadian® (morphine ext. release)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 2 units per day
Avinza® (morphine sulfate, sustained release)	Qty is limited to 30 units per 30 days	1. The patient has a documented current diagnosis of active cancer. 2. System will automatically approve if written by an oncologist or if there are previous claims for chemotherapy-related medications.
Rybix ODT® (tramadol)		1. The patient must have documented failure or Rx claims with generic Ultram in the past 60 days, or 2. The patient must have documented inability to swallow or absorb oral medications.
Ryzolt® (tramadol ER)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 1 unit per day
All acetaminophen-containing narcotic analgesics		**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims with a monthly quantity that exceeds the MAX recommended dose of 4gm/day of acetaminophen. Physician must submit signed request stating he/she is allowing the patient to exceed the MAX recommended dose of acetaminophen.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Analgesics, continued Duragesic Patches® (fentanyl)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 15 units per 30 days
Oxycontin® (oxycodone)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 3 units per day
Exalgo® (extended release hydromorphone)	8mg, 12mg, 16mg-qty limited to 1 unit per day 32mg-qty limited to 2 units per day	Requires prior authorization for indications other than cancer. System will automatically approve if written by an oncologist or if there are previous claims for chemotherapy-related medications. 1. The patient must have documented failure or Rx claims with generic Dilaudid (hydromorphone) and generic Duragesic (fentanyl).
Vicodin 5/300® (hydrocodone/acetaminophen) Vicodin ES 7.5/300® (hydrocodone/acetaminophen) Vicodin HP 10/300® (hydrocodone/acetaminophen)	Vicodin 5/300 limit 8 tabs/day Vicodin ES 7.5/300 & Vicodin HP 10/300 limit 6 tabs/day	1. Physician must provide chart documentation that shows that a product with 325mg acetaminophen (i.e. generic Norco) is contraindicated in this patient but that a product with 300mg acetaminophen is not contraindicated **Note:** Acetaminophen is not recommended for patients with liver disease.
Xartemis XR® (oxycodone/APAP CR)	120 tablets per 30 days	1. Patient must have documented failure or Rx claims for both generic Percocet and generic MS Contin in the past 6 months; **AND** 2. The prescriber must submit a current MAPS report (or similar report) which shows no sign of substance abuse or multiple prescribers of narcotics in the past 6 months; **AND** 3. The authorization will be approved for 6 months. Renewals require submission of an updated MAPS report confirming no evidence of substance abuse.
All Brand Combination Butalbital/Acetaminophen Products Bupap® (butalbital/acetaminophen) Phrenilin/Phrenilin Forte® (butalbital/acetaminophen) Allzital® (butalbital/acetaminophen)		1. The patient must have chart documented failure or prescription claims for an oral generic butalbital/acetaminophen product in the past 6 months.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Analgesics, continued **All Single Ingredient Hydrocodone Products** Hysingla ER® (hydrocodone) Zohydro ER® (hydrocodone)	Zohydro ER Qty is limited to 2 units per day Hysingla ER Qty is limited to 1 unit per day	1. The patient must have documented failure or Rx claims for both generic MS Contin and generic Duragesic patches in the past 6 months; **AND** 2. The prescriber must submit a current MAPS report (or similar report) which shows no sign of substance abuse or multiple prescribers of narcotics in the past 6 months; **AND** 3. The authorization will be approved for 6 months. Renewals require submission of an updated MAPS report confirming no evidence of substance abuse.
Androgens **All Non-Formulary Testosterone Products** Androderm® (testosterone patch) Axiron® (testosterone solution) Aveed® (testosterone undecanoate) Natesto® (testosterone) Striant® (testosterone buccal)		1. The patient has a documented diagnosis of hypogonadism; **AND** 2. The patient has a morning (before 11AM) serum total testosterone concentration of less than 300 ng/dL documented on 2 separate occasions in the past year; **AND** 3. The patient must have documented failure or Rx claims with a preferred formulary testosterone replacement product (i.e., testosterone cypionate/enanthate, AndroGel).
Non-Formulary Oral Methyltestosterone and Fluoxymesterone Products Methitest® (methyltestosterone) Testred® (methyltestosterone)		1. The patient has a documented diagnosis of hypogonadism; **AND** 2. The patient has a morning (before 11AM) serum total testosterone concentration of less than 300 ng/dL documented on 2 separate occasions in the past year; **AND** 3. The patient must have documented failure or Rx claims with a preferred formulary testosterone replacement product (i.e., testosterone cypionate/enanthate, AndroGel, Android); **OR** 1. The patient has a documented diagnosis of delayed puberty; **AND** 2. The patient must have documented failure or RX claims with testosterone cypionate/enanthate or Android; **OR** 1. The patient has a documented diagnosis of breast cancer.
All Non-Formulary Angiotensin II Receptor Blockers Teveten HCT® (eprosartan mesylate)	All ARBs except Cozaar (not combos) are limited to a qty of 30 units per month	1. The patient must have documented failure or Rx claims for all formulary ARBs or ARB combination products (i.e., Benicar/HCT, or Diovan/HCT). **NOTE:** If patient is a first time ARB user, patient should have documented failure or Rx claims for at least one generically available ACE inhibitor previous to ARB therapy.
Edarbi® (azilsartan medoxomil) Edarbyclor® (azilsartan medoxomil/chlorthalidone)	Qty is limited to 30 units per 30 days	1. The patient must have documented failure or Rx claim(s) for at least one formulary ARB or ARB combination product (i.e., generic Cozaar/Hyzaar, Benicar/HCT or Diovan/HCT).
Entresto® (sacubitril/ valsartan)		1. Patient has a diagnosis of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction (HFrEF with EF ≤40%); **AND** 2. Prescription must be written by a cardiologist; **AND** 3. Patient must not have advanced liver disease (Child-Pugh Class C); **AND** 4. Patient is not concomitantly receiving an ACE or ARB; **AND** 5. Patient is not a diabetic using Tekturna (aliskiren).

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Antibiotics **All Brand Doxycycline Products** Acticlate® (doxycycline hyclate) Avidoxy DK Kit® (doxycycline/salicy/oct/zinc ox Doryx® (doxycycline hyclate) Morgidox Kit® (doxycycline/skin cleanser #19) Vibramycin Syrup® (doxycycline calcium) Targadox® (doxycycline)		1. The patient must have documented failure or Rx claim for generic doxycycline in the past 60 days.
Oracea® (doxycycline monohydrate)		1. The patient must have documented failure or Rx claim for generic Vibramycin.
Dificid® (fidaxomicin)		1. Patient has documented diagnosis of C. difficile associated diarrhea, **AND** 2. Patient has tried and failed an adequate trial of vancomycin, **OR** 3. Patient has a contraindication or intolerance to vancomycin, **OR** 4. Patient has been recently discharged from a hospital or a medical facility and has had documented treatment with Dificid or vancomycin. New Starts Only
All Brand Minocycline Products Minocin PAC® (minocycline kit) Solodyn® (minocycline ER)		1. The patient must have documented failure or Rx claims for a generic topical acne product **AND** minocycline in the past 60 days.
Factive® (gemifloxacin mesylate)		1. The patient must have documented failure or Rx claim for a formulary fluoroquinolone (e.g., generic Cipro, Levaquin or Avelox) in the past 60 days. **NOTE:** Individual requests are reviewed to include consideration of the diagnosis, culture and sensitivity, and other documentation.
Tobi Solution/Podhaler Bethkis® (tobramycin)		1. The patient must have a diagnosis of Cystic Fibrosis; **AND** 2. The drug is given for 28 days followed by 28 days off, in repeat cycles.
Anticoagulants Brilinta® (ticagrelor)	Qty is limited to 2 units per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than twice daily dosing.
Effient® (prasugrel hydrochloride)	Qty is limited to 1 unit per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing
Eliquis® (apixaban)	Qty is limited to 74 units per 31 days	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than 74 units in 31 days.
Pradaxa® (dabigatran)	Qty is limited to 2 units per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than twice daily dosing.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Anticoagulants, continued Savaysa® (edoxaban tosylate)	Qty is limited to 1 unit per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.
Xarelto® 10 mg (rivaroxaban)	Qty for 10mg is limited to 35 units	
Xarelto® 20mg (rivaroxaban)	Qty is limited to 1 unit per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.
Zontivity® (vorapaxar)	Qty is limited to 1 unit per day	1. Prescription is written by a cardiologist or vascular surgeon, **AND** 2. Patient has a diagnosis of myocardial infarction (MI) or peripheral artery disease (PAD), **AND** 3. Patient does not have a history of stroke, TIA, ACS, GI bleed, or peptic ulcer, **AND** 4. Prescriptions are written for concomitant aspirin and/or clopidogrel.
Anticonvulsants Aptiom® (eslicarbazepine)		1. The patient must be 18 years of age or older; **AND** 2. Patient has a documented diagnosis of partial-onset seizures; **AND** 3. The patient must have documented insufficient response, intolerable side effects, or Rx claims for at least 2 generic anti-epileptic drugs (i.e., lamotrigine, topiramate, oxcarbazepine, carbamazepine, levetiracetam, divalproex, gabapentin, zonisamide).
Oxtellar XR® (oxcarbazepine)		1. Patient has a documented diagnosis of partial onset seizures; **AND** 2. The patient must have documented insufficient response, intolerable side effects, or Rx claims for at least 2 generic anti-epileptic drugs (i.e., carbamazepine, oxcarbazepine, valproate, levetiracetam); **AND** 3. Must be used as adjunctive therapy.
Trokendi XR® (topiramate)		1. Patient has a documented diagnosis of partial onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome; **AND** 2. The patient must have documented insufficient response, intolerable side effects, or Rx claims for at least 2 generic anti-epileptic drugs (i.e., carbamazepine, oxcarbazepine, valproate, levetiracetam).
Antidepressants Luvox CR® (fluvoxamine ext. release) Pexeva® (paroxetine mesylate) Viibryd® (vilazodone)	Qty is limited to 1 unit per day	1. The patient must have documented failure with dose titration and Rx claims for at least two generic SSRI medications (i.e., Prozac, Celexa, Paxil and Zoloft).
Brintellix® (vortioxetine) Trintellix® (vortioxetine)		1. The patient must have documented failure with dose titration and Rx claims for at least 3 generic antidepressant medications (i.e., Prozac, Paxil, Effexor, Wellbutrin). New Starts Only
Prozac Weekly® (fluoxetine)		1. The patient has a diagnosis of depression, **AND** 2. The patient has been treated with fluoxetine 20mg daily for at least 13 weeks, based on Rx claims, and has responded to treatment with symptom control.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Antidepressants, continued **On Formulary with PA:** Sarafem® (fluoxetine)		1. The patient must have documented failure or Rx claim for generic Prozac.
Effexor XR® (venlafaxine, ext. release) Lexapro® (escitalopram oxalate) Pristiq® (desvenlafaxine succinate)	Qty is limited to 1 unit per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.
Fetzima® (levomilnacipran)		1. Patient has a documented diagnosis of Major Depressive Disorder (MDD); **AND** 2. The patient must have documented insufficient response, intolerable side effects, or Rx claims for at least 2 generic antidepressant drugs (i.e., fluoxetine, sertraline, bupropion, venlafaxine, duloxetine, amitriptyline).
Oleptro ER® (trazodone hydrochloride extended release)		1. The patient must have documented failure or Rx claims with generic Desyrel (trazodone).
Aplenzin® (bupropion hbr)		1. The patient must have documented failure or prescription claims at an equivalent dosage of bupropion HCl extended-release (24hr) in the past year.
Wellbutrin XL® (bupropion, ext. release)		**DOSE OPTIMIZATION ONLY** 1. For Wellbutrin XL 150mg tablets are limited to Once Daily 2. Dosing. Wellbutrin XL 300mg requires the physician to prescribe a 300mg tablet (not 2 of the 150mg tablets) once daily to optimize the dose. 3. Dosages greater than 450mg per day will require the physician to submit medical necessity for that dosing regimen.
Antiemetic Akynzeo® (netupitant/ palonosetron)	Limited to a qty of 4 units per 30 days	1. Patient is receiving highly emetogenic chemotherapy (see HEC list below), **OR** 2. Patient has previously failed (see definition below) with other 5HT3 agent (Zofran or Kytril) while on the current regimen.(Failure is defined as 2 or more documented episodes of vomiting attributed to the current chemotherapy regimen) Note: Highly emetogenic chemotherapy (HEC) includes: Cisplatin, Mechlorethamine, Streptomycin, Cyclophosphamide, Carmustine, Dacarbazine, Dactinomycin, Doxorubicin, Epirubicin, Ifosfamide.
Diclegis® (doxylamine/pyridoxine)	Qty is limited to 120 units per 30 days	1. The patient must have a documented diagnosis of pregnancy; **AND** 2. The patient must have a chart documented trial and failure or Rx claims for generic Zofran; **AND** 3. The patient must have a chart documented trial and failure of the individual agents (doxylamine and pyridoxine) in combination. New Starts Only
Zuplenz® (ondansetron)		1. The patient must try and fail an adequate course of therapy with generic Zofran ODT.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Antipsychotics, Atypical Latuda® (lurasidone)		1. The patient must have documented failure or prescription claims for at least two formulary atypical antipsychotic alternatives (e.g., geq Risperdal, geq Clozaril, geq Geodon or geq Seroquel). **OR** 2. The patient must have documented failure or prescription claims for at least 1 formulary atypical antipsychotic and 1 formulary mood stabilizer (e.g., lithium, divalproex sodium, valproate) if prescribed for Bipolar Depression
Abilify® (aripiprazole) Zyprexa/Zydis® (olanzapine)	Qty is limited to 1 unit per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.
Asthma/COPD **All Brand Non-Formulary Corticosteroid/Long Acting Beta Agonist Inhalers** Advair Diskus® (fluticasone/ salmeterol) Advair HFA® (fluticasone/ salmeterol) Breo Ellipta® (fluticasone/ vilanterol)		1. Patient has a documented contraindication to the preferred formulary corticosteroid/long acting beta agonist inhalers (i.e., Dulera and Symbicort for Asthma or Symbicort for COPD), **OR** 2. The patient is <12 years of age.
All Brand Non-Formulary Single Ingredient Corticosteroid Inhalers Arnuity Ellipta® (fluticasone) Asmanex Twisthaler® (mometasone furoate) Asmanex HFA® (mometasone furoate) Flovent Diskus® (fluticasone) Flovent HFA® (fluticasone) Alvesco® (ciclesonide) Aerospan® (flunisolide)		1. Patient has a documented contraindication to all preferred formulary corticosteroid inhalers (i.e., Pulmicort and QVAR).
Combivent Respimat® (albuterol/ ipratropium)	Limited to 6 doses per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than 6 doses a day.
Proventil HFA® (albuterol) ProAir HFA® (albuterol) ProAir RespiClick® (albuterol)		1. Patient has a documented contraindication to the preferred formulary albuterol inhaler (i.e. Ventolin HFA)
Xopenex/HFA® (levalbuterol)		1. The patient must have documented intolerant side effects to albuterol (e.g., palpitations, tremors and tachycardia).
Zyflo/CR® (zileuton)		1. The patient must have a diagnosis of asthma; **AND** 2. The patient must be 12 years of age or older; **AND** 3. The patient must have chart documented failure or prescription claims for generic Singulair or Accolate.
Beta Blockers Bystolic® (nebivolol)	Limited to a qty of 1 unit per day	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Beta Blockers, continued Coreg CR® (carvedilol phosphate controlled release)		1. The patient must have documented failure on immediate release carvedilol of equivalent dose and attempted at least one dose increase (6.25mg/day IR = 10mg/day ER when converting).
Calcium Channel Blockers Cardizem LA® (diltiazem, long-acting)		1. The patient must have documented failure or Rx claims for at least two generically available formulary alternatives (e.g., Cardizem CD, Cardizem SR and Dilacor XR).
Cardiovascular Agents Corlanor® (ivabradine)	Limited to a qty of 2 units per day	1. Prescription is written by a cardiologist; **AND** 2. Patient is at least 18 years of age; **AND** 3. Patient has a diagnosis of symptomatic (dyspnea, fatigue, fluid retention) chronic heart failure (HFrEF); **AND** 4. Patient does not have acute decompensated heart failure, **AND** 5. Documentation is submitted demonstrating HFrEF with echocardiogram LVEF ≤ 35 percent AND heart rate ≥ 70bpm; **AND** 6. Patient is receiving maximally-tolerated doses of a beta-blocker OR patient has a documented contraindication to beta blocker therapy; **AND** 7. Patient does not have severe hepatic impairment (Child-Pugh C); **AND** 8. Patient's current medications have been reviewed for potential interactions: a. Patient must not be taking any medication that significantly reduces the concentration of Corlanor (e.g., strong CYP3A4 inhibitors such as itraconazole, clarithromycin, telithromycin, nelfinavir, and nefazodone), **AND** b. Patient is not taking any moderate CYP3A4 inhibitors (diltiazem, verapamil, and grapefruit juice) or CYP3A4 inducers (rifampicin, barbiturates, St. John's wort, and phenytoin).
Cholesterol Medications **On Formulary with PA:** Crestor® (rosuvastatin) **Non-Formulary with PA:** Advicor® (lovastatin/niacin) Altoprev® (lovastatinSR) Lescol XL® (fluvastatin) Livalo® (pitavastatin calcium)	All HMGs are limited to a qty of 30 units per month	1. The patient must have documented failure or Rx claim(s) for generic Zocor, **OR** 2. The patient is currently receiving a medication that potentiates simvastatin levels (i.e., itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, gemfibrozil, cyclosporine, amiodarone, verapamil, diltiazem, amlodipine, ranolazine).
Liptruzet® (ezetimibe/atorvastatin)	Qty is limited to 1 unit per day	1. **DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.
All Brand Omega-3 Fatty Acid Products Lovaza® (omega-3-acid ethyl esters) Vascepa® (icosapent ethyl)		1. The patient's triglyceride (TG) levels are >500mg/dL (with chart documentation provided) **OR** 2. The patient must have documented failure or Rx claims in the past six months for at least two or more lipid-lowering agents, with at least one being a generic product (e.g., statins, fenofibrate, nicotinic acid).

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Cholesterol Medications, continued Antara® (fenofibrate, micronized) Fenoglide® (fenofibrate) Triglide® (fenofibrate)		1. The patient must have documented failure or Rx claim for a formulary fenofibrate (i.e., generic Lofibra) in the past year with at least one documented dosage increase.
On Formulary with PA: Zetia® (ezetimibe)		**AUTHORIZATION IS ONLY REQUIRED FOR THE FOLLOWING:** 1. If the patient has not had an Rx claim for an HMG statin medication in the previous year. Criteria for authorization for monotherapy include a documented contraindication for both hydrophilic (Pravachol, Lescol) and lipophilic (Zocor, Lipitor) statins, elevated liver enzymes, etc. 2. A dose >10mg per day requires documentation to support safety and efficacy.
Contraceptives **All Brand Contraceptives** Beyaz® Lo Minastrin FE® Natazia® Ortho Tri-Cyclen Lo® Ovcon-50® Safyral®		1. The patient must have a documented trial or Rx claims for at least two generically available oral contraceptives in the past year before any brand product will be covered. **NOTE:** Injectable generic Depo-Provera is an alternative if compliance is a potential issue.
Cough and Cold Vituz®		1. The patient must have documented failure or Rx claims for 2 generically available cough suppressants in the past month.
Dermatologicals Absorica® (isotretinoin)		1. The patient has a documented diagnosis of severe recalcitrant nodular or refractory acne **OR** severe refractory rosacea; **AND** 2. The patient has tried and failed treatment with at least 2 generic topical acne products **AND** one oral generic antibiotic; **AND** 3. The patient must have chart documented failure or Rx claims for generic isotretinoin (i.e., Amnesteem, Claravis, Myorisan, Zenatane) in the past 120 days.
Altabax® (retapamulin)		4. The patient must have a documented treatment failure with generic Bactroban ointment for each instance of impetigo **AND** 5. A diagnosis of impetigo.
Bactroban Nasal Ointment® (mupirocin)	10 grams (10, 1gm) tubes per month	1. The patient must have a chart documented nasal colonization with methicillin-resistant S. aureus (MRSA); **AND** 2. The patient must have Rx claims for generic mupirocin ointment in the past 7 days. **Criteria for more than 10 grams per month** 1. The patient must have chart documented nasal recolonization of MRSA.
Carac® 0.5% cream, including generic (fluorouracil) Fluoroplex® 1% cream (fluorouracil)		1. The patient has a chart documented diagnosis of actinic ketotosis; **AND** 2. The patient has chart documented failure, intolerance, or Rx claims for generic Efudex (fluorouracil 2% solution or 5% cream or solution).

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Dermatologicals, continued **Clobetasol Propionate Cream and Ointment -generics** Cormax® (clobetasol propionate) Temovate® (clobetasol propionate) Temovate E® (clobetasol propionate)		1. The patient must have documented failure or Rx claims for generic Diprolene/AF (augmented betamethasone) or generic Ultravate (halobetsol) cream or ointment in the past 60 days.
Finacea® 15% gel (azelaic acid) metronidazole 1% gel Soolantra® 1% cream (ivermectin)		1. The patient has a chart documented diagnosis of rosacea; **AND** 2. The patient has chart documented failure, intolerance, or Rx claims for generic metronidazole 0.75% gel, cream, or lotion.
Trianex® (triamcinolone)	Limited to 90 grams per 30 days	1. The patient must have documented failure or Rx claims for at least 2 alternative generic topical steroid ointments (i.e., triamcinolone 0.025%, 0.1%, 0.025% ointment or mometasone 0.1% ointment) in the past 60 days.
Veregen® (sinecatechins)		1. Patient must be 18 years or older, **AND** 2. Patient must have documented diagnosis of external genital or perianal warts, **AND** 3. Patient has documented failure with both generic Aldara and generic Condylox.
Vusion® (miconazole nitrate/zinc oxide)		1. The patient must be an infant greater than 4 weeks old with a diagnosis of candidal diaper dermatitis or candidal infection.
Zovirax® Ointment/Cream (acyclovir)	Limited to 5 grams per 7 days	**QUANTITY LIMITS** Prescription fills are limited to a 7 day supply at one time.
Zyclara® (imiquimod)		1. The patient must have a diagnosis of actinic keratosis and documented treatment failure or Rx claims for geq Aldara; **OR** 2. The patient must have a diagnosis of condyloma acuminate and documented treatment failure or Rx claims for geq Condylox or geq Aldara. New Starts Only

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Dermatologicals, continued **All Branded Topical Antifungal Agents** Ciclodan Kit® (ciclopirox olamine cream/cleanser) CNL Nail Kit® (ciclopirox/lacquer removal pads) Dermasorb AF Kit® (clioquinol-hc /emollient) Ecoza® (econazole nitrate) Ertaczo® (sertaconazole nitrate) Exelderm® (sulconazole nitrate) Jublia® (efinaconazole) Kerydin® (tavaborole) Ketodan Kit® (ketoconazole foam/cleanser) Mentax® (butenafine) Naftin® (naftifine) Oxistat® (oxiconazole nitrate) Pediaderm AF® (nystatin/emollient) Terbinex® (terbinafine/hydroxychitosan) Tersi® (selenium sulfide) Xolegel® (ketoconazole)		1. The patient must have documented failure and Rx claims for four generic antifungals (e.g., Loprox, Nizoral, Spectazole and Grifulvin V).
Luzu® (luliconazole)		1. The patient must have documented failure or Rx claims for at least 2 generic antifungal products (i.e., clotrimazole, miconazole, tolnaftate, terbinafine).
All Branded Topical Clindamycin Products Clindagel 1% Gel® (clindamycin)		1. Patient must have documented failure or Rx claim(s) for topical generic clindamycin product in the past 90 days (e.g., GEQ Cleocin T).
All Brand Benzoyl Peroxide/Antibiotic Combination Products Acanya 1.2%-2.5%® (clindamycin/benzoyl peroxide) Benzamycin Pak 3%-5% Gel® (erythromycin base/benzoyl peroxide) Onexton 1.2%-3.75%® (clindamycin/benzoyl peroxide)		1. Patient must have documented failure or Rx claim(s) for a generic combination product in the past 90 days (i.e., GEQ Benzaclin, GEQ Benzamycin.
All Brand Topical Adapalene, Dapsone, and Combination Products Aczone 5% Gel® (dapsone) Aczone 7.5% Gel w/ Pump (dapsone) Epiduo 0.1%-2.5% Gel® (adapalene/benzoyl peroxide)		1. The patient must have documented failure or Rx claim(s) for a generic tretinoin (e.g., Avita, Retin-A) **AND** a generic adapalene (e.g., Differin gel)

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Dermatologicals, continued **All Tretinoin Products**		**Age Restriction**: Patients ≥ 25 years of age must have a documented diagnosis of acne.
All Brand Tretinoin/Combination Products Retin A Micro 0.08%® (tretinoin) Tretin-X® (tretinoin) Veltin® (tretinoin/clindamycin) Ziana® (tretinoin/clindamycin)		1. The patient must have documented failure or Rx claim for a generic tretinoin product (e.g., Retin-A, Avita) in the past 90 days. **NOTE:** Age restriction for all topical tretinoin products for age ≥ 25 based on a diagnosis of acne.
All Brand/Combination Topical Steroids Cordran Tape® (flurandrenolide) Halog 0.1% Cream/Ointment (halcinonide) Synalar TS® (fluocinolone/cleanser) Ultravate PAC Kit® (halobetasol propionate/ammonium lactate) Ultravate X® (halobetasol/lactic acid)		1. The patient must have documented failure or Rx claim with a generic topical steroid in the same potency class (e.g., Ultravate, Diprolene) in the past 60 days.
Pandel Cream® (hydrocortisone probutate) Pediaderm TA® (triamcinolone) Topicort Spray® (desoximetasone)		1. The patient must have documented failure or Rx claim with a generic topical steroid in the same potency class (e.g., Elocon, Westcort and Synalar) in the past 60 days.
Cordran Lotion® (flurandrenolide) Cordran SP Cream® (flurandrenolide) Locoid Lotion ® (hydrocortisone butyrate)		1. The patient must have documented failure or Rx claim with a generic topical steroid in the same potency class (e.g., Beta-Val Cr, Cutivate Cr, Dermatop Cr) in the past 60 days.
Desonate Gel® (desonide) Pediaderm HC® (hydrocortisone) Pramosone® (hydrocortisone/ pramoxine) Vanoxide-HC Lotion® (hydrocortisone/benzoyl peroxide) Verdeso Foam® (desonide)		1. The patient must have documented failure or Rx claim with a generic topical steroid in the same potency class (e.g., Aclovate, Desowen and Synalar) in the past 60 days.
Elidel® (pimecrolimus)		1. The patient must have documented failure or Rx claims with at least two generically available topical steroids **AND** generic topical tacrolimus in the past 180 days.
Solaraze® (diclofenac 3% gel)-including generics		1. The patient must have a chart documented diagnosis of actinic keratosis.
Dovonex® (calcipotriene) Taclonex® (betamethasone/calcipotriene)	Safety limited to a qty of ≤ 100g per 7 days	**QUANTITY LIMITS ONLY**

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Dermatologicals, continued Vectical® (calcitriol)	Safety limited to a qty of ≤ 200g per 7 days	**QUANTITY LIMITS ONLY**
All Branded Topical Sulfonamide and Sulfonamide/Sulfur Products Avar® (sulfacetamide sodium/sulfur) Avar-E® (sulfacetamide sodium/sulfur) Avar LS® (sulfacetamide sodium/sulfur) Plexion® (sulfacetamide sodium/sulfur) Rosanil® (sulfacetamide sodium/sulfur) Rosula® (sulfacetamide sodium/sulfur) Sumadan® (sulfacetamide sodium/sulfur)		1. The patient must have documented failure and Rx claims for at least 2 generic sulfonamide/sulfur products in the past year.
Diabetes Farxiga® (dapagliflozin) Glyxambi® (empagliflozin/ linagliptin) Jardiance® (empagliflozin) Xigduo® (dapagliflozin/ metformin ER)	Limited to a qty of 1 unit per day	1. The patient has a documented insufficient response to, or intolerable side effects from, Invokana or Invokamet.
Fortamet® (metformin ER) Glumetza® (metformin)		1. The patient must have documented failure or Rx claims in the past year for generic Glucophage **AND** generic Glucophage XR.
Janumet, XR® (sitagliptin/metformin) Kazano® (alogliptin/metformin) Kombiglyze XR® (saxagliptin/metformin) Oseni® (alogliptin/pioglitazone)		1. The patient must have documented failure or Rx claims with a preferred formulary DPP-4 inhibitor (i.e. Tradjenta, Jentadueto).
Januvia® (sitagliptin) Nesina® (alogliptin benzoate) Onglyza® (saxagliptin)	Limited to a qty of 30 units per month	1. The patient must have documented failure or Rx claims with a preferred formulary DPP-4 inhibitor (i.e. Tradjenta, Jentadueto).
Synjardy® (empagliflozin/ metformin)	Limited to a qty of 2 units per day	1. The patient has a documented insufficient response to, or intolerable side effects from, Invokana or Invokamet.
Tradjenta® (linagliptin) Invokana® (canagliflozin)	Limited to a qty of 30 units per month	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Diabetes, continued Afrezza® (insulin human inhalation powder)	4 unit cartridges limited to 3 per day; 90 cartridges per 30 days 8 unit cartridges limited to 9 per day; 270 cartridges per 30 days	1. Patient has a documented contraindication to a comparable preferred formulary insulin (i.e., Humulin and Humalog products) 2. Patient has no history of: a. Smoking in the previous 6 months, **OR** b. Chronic lung disease, such as asthma or COPD 3. For patients with type 1 diabetes, documentation must be provided that patient is using concurrent long-acting insulin.
Apidra® Novolin® Insulins (insulin) Novolog® Insulins (insulin aspart) Novolog Mix® (insulin)		1. Patient has a documented contraindication to a comparable preferred formulary insulin (i.e. Humulin and Humalog products),
Glucose Test Strips Freestyle Lite® Freestyle Insulinx® Precision Xtra®	Limited qty of 150 units per 30 days or 450 units per 90 days	**DOSE OPTIMIZATION ONLY**
Erectile Dysfunction/Lifestyle Medications **ALL Oral Formulary:** Sildenafil 20mg **ALL Non-Oral Non-Formulary:** Caverject®, Edex®, Muse® (alprostadil) ED meds are covered when written by PCP or in-plan urologist.	**Oral Sildenafil 20mg**: 30 tablets per 30 days **Non-Oral**: 6 units per 30 days **All other ED products**: 6 units per 30 days	**PRIOR AUTHORIZATION IS ONLY REQUIRED IN THE FOLLOWING INSTANCES:** 1. If the patient <35, the patient must have a documented diagnosis of ED **OR** a history of ED with contributing **OR** concomitant disease state. 2. If the patient has a history of nitrate use and the physician is prescribing Sildenafil: **Criteria:** a. The physician must submit a written request stating that the patient is no longer using nitrates. ****Request must be on physician letterhead with physician's signature****

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Erectile Dysfunction/Lifestyle Medications, continued Addyi® (flibanserin)	Limited to a qty of 30 units per 30 days	1. The patient is a premenopausal woman with a diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). [chart documentation is required]; **AND** 2. The patient's low sexual desire is not caused by ANY of the following: • A co-existing medical or psychiatric condition • Problems within the relationship • The effects of a medication or other drug substance; **AND** 3. Addyi is not being used to enhance sexual performance; **AND** 4. Prescriber is certified in the Addyi Risk Evaluation and Mitigation Strategy (REMS) program as required by the FDA and agrees to counsel and monitor the patient regarding the increased risk of hypotension and syncope, as well as the importance of not consuming alcohol while taking Addyi; **AND** 5. Pharmacy is certified and currently identified in the Addyi Certified Pharmacy Network (https://www.addyirems.com/AddyiUI/rems/home.action) for the Addyi Risk Evaluation and Mitigation Strategy (REMS) program as required by the FDA and agrees to counsel the patient regarding the increased risk of hypotension and syncope, as well as the importance of not consuming alcohol while taking Addyi; **AND** 6. The patient does not have hepatic impairment; **AND** 7. Based on a review of prescription claims, the patient is not taking Addyi concurrently with moderate or strong CYP3A4 inhibitors (e.g. ketoconazole, clarithromycin, ciprofloxacin, fluconazole, etc.) or other medications that are contraindicated with Addyi; **AND** **Initial Approval Period: 2 Months (60 days)** Chart documentation of a positive response will be required for continuation of therapy beyond 2 months. If no improvement is identified, treatment is to be discontinued and no subsequent claims will be approved. **Re-Authorization Approval Period: 6 Months (180 days)**

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Genitourinary Medications Detrol LA® (tolterodine, long-acting) Ditropan XL® (oxybutynin, sust. release) Enablex® (darifenacin) Toviaz® (fesoterodine) Vesicare® (solifenacin)	Limited to a qty of 30 units per month	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.
Cialis 2.5, 5MG® (tadalafil)	Limited to 30 tablets per month for indication of BPH **No addl qty of drugs for ED approved when receiving Cialis daily for BPH	1. The patient must have a chart documented diagnosis of benign prostatic hyperplasia (BPH); **AND** 2. The patient must have documented failure or contraindication to at least one formulary alternative from either of the following classes of medication: a. Alpha-1 Adrenergic Blockers (i.e., alfuzosin, doxazosin, tamsulosin, or terazosin) b. 5-Alpha Reductase Inhibitors (i.e., finasteride or Avodart); **AND** 3. If the patient has a history of nitrate use a. The physician must submit a written request on physician letterhead stating that the patient is no longer using nitrates; **AND** b. The physician must hand-sign the request.
Myrbetriq® (mirabegron)	Limited to a qty of 30 units per month	1. Patient must have chart documented treatment failure or intolerance to at least 2 generic formulary alternatives for overactive bladder (i.e., oxybutynin, tolterodine, trospium chloride).
Rapaflo® (silodosin)		1. The patient must have documented failure based on chart documentation or Rx claims for a generically available alpha1-blocker indicated for BPH (i.e., generic Cardura, Hytrin or Flomax).
Infertility All medications for infertility (subject to the member's benefit).		**Confirmation of Coverage:** 1. The patient's benefit includes coverage for infertility, **AND** 2. There is an appropriate referral, if applicable, **AND** 3. The service/procedure is a covered benefit.
All Human Chorionic Gonadotropin Products Novarel® (chorionic gonadotropin) Ovidrel® (choriogonadotropin alfa) Pregnyl® (chorionic gonadotropin)		1. Patient must have documentation of an FDA-approved indication (i.e., prepubertal cryptorchidism, hypogonadotropic hypogonadism, or anovulation with infertility). **Note:** All Human Chorionic Gonadotropin products are included in the Mandatory Specialty Program.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Migraine Medications Frova® (frovatriptan) Treximet® (sumatriptan/naproxen)	All triptans combined are limited to a qty of 9 tablets per month	1. The patient must have documented failure or Rx claims for all formulary alternatives (i.e., Relpax, and generic Amerge, Axert, Imitrex, Maxalt and Zomig), or formulary alternatives must be inappropriate with chart documentation provided. **NOTE:** Formulary triptans are limited to nine tablets (cumulative with all oral products) **CRITERIA FOR MORE THAN NINE TABLETS PER MONTH** 1. Patient is currently receiving medication therapy for the prophylaxis of migraines based on Rx claims in the past 120 days and still requires more than nine tablets per month, **OR** 2. Patient has had documented failure of all options for migraine prophylaxis and still requires more than nine tablets per month.
Cambia® (diclofenac potassium)		1. The patient must have a diagnosis of migraine headaches; **AND** 2. The patient must have documented failure or Rx claims for generic diclofenac; **AND** 3. The patient must have documented failure or Rx claims for at least one additional non-steroidal anti-inflammatory drug (i.e., ibuprofen, naproxen sodium).
Imitrex Injection® (sumatriptan injection)	All injectable sumatriptan products limited to 6 injections for 30 days	**Criteria for more than 6 injections per month** 1. Patient is currently receiving medication therapy for the prophylaxis of migraines based on Rx claims in the past 120 days and still requires more than 6 injections per month, **OR** 2. Patient has had documented failure or contraindication to all options for migraine prophylaxis and requires more than 6 injections per month.
Sumavel® (sumatriptan injection)	All injectable sumatriptan products limited to 6 injections for 30 days	1. The patient must have documented failure or prescription claims for generic Imitrex injection. **Criteria for more than 6 injections per month** 1. Patient is currently receiving medication therapy for the prophylaxis of migraines based on Rx claims in the past 120 days and still requires more than 6 injections per month, **OR** 2. Patient has had documented failure or contraindication to all options for migraine prophylaxis and requires more than 6 injections per month.
Imitrex Nasal Spray® (sumatriptan) Zomig Nasal Spray® (zolmitriptan)	All nasal triptan products are limited to a quantity of 6 per month	**Criteria for more than 6 units per month** 1. Patient is currently receiving medication therapy for the prophylaxis of migraines based on Rx claims in the past 120 days and still requires more than 6 units per month, **OR** 2. Patient has had documented failure or contraindication to all options for migraine prophylaxis and requires more than 6 units per month.
Zecuity® (sumatriptan succinate)	Limited to 4 patches for 30 days	1. The patient must have chart documented failure of, and prescription claims for each of the currently available formulary generic oral triptan medications (i.e. generic Imitrex, Maxalt, Zomig, Amerge); **AND** 2. The patient must have chart documented failure and prescription claims for Sumatriptan nasal spray and injection.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Migraine Medications, continued **All Non-Injectable Dihydroergotamine Products** Migranal® (dihydroergotamine) – including generics	8 units (ml) per month	1. The patient must have a diagnosis of migraine headaches; **AND** 2. The patient must have chart documented failure or prescription claims for an oral generic triptan medication (i.e. generic Imitrex, Maxalt, Zomig, Amerge); **AND** 3. The patient must have chart documented failure or prescription claims for generic Imitrex nasal spray or injection; **OR** 4. The patient has a chart documented contraindication or intolerance to triptan medications. **Criteria for more than 8 units per month** 1. Patient is currently receiving medication therapy for the prophylaxis of migraines based on Rx claims in the past 120 days and still requires more 8 units per month. 2. Patient has had documented failure of all options for migraine prophylaxis and still requires more than 8 units per month.
All Brand Ergotamine Products Cafergot® (ergotamine/caffeine tablets) Migergot® (ergotamine/caffeine rectal suppositories)	40 tabs per 30 days **OR** 20 supps per 30 days	1. The patient must have a diagnosis of migraine headaches; **AND** 2. The patient must have chart documented failure or prescription claims for an oral generic triptan medication (i.e. generic Imitrex, generic Amerge); **OR** 3. The patient has a chart documented contraindication or intolerance to triptan medications.
Muscle Relaxants Amrix® (cyclobenzaprine ext release)		1. The patient must try and fail an adequate course of therapy with at least two generic prescription muscle relaxants (i.e., Flexeril, Norflex, Robaxin, Skelaxin).
Zanaflex capsules® (tizanidine), including generic capsules		1. The member has a documented contraindication to generic tizanidine tablets.
Miscellaneous Amitiza® (lubiprostone)		1. The patient must have documented treatment failure with at least 3 generic/OTC cathartics (e.g.,bisacodyl, docusate sodium, lactulose, mineral oil, etc)
Brisdelle® (paroxetine)		1. The patient must have documented failure and Rx claims for generic paroxetine; **AND** 2. The patient is not currently taking any other serotonin modulating antidepressant (i.e., SSRIs or SNRIs)
Cardura XL® (doxazosin mesylate ext. release)		1. The patient must have documented failure or Rx claim in the past year for a generically available alpha 1-adrenergic antagonist (i.e., Cardura, Flomax or Hytrin).

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Miscellaneous, continued Grastek® (timothy grass pollen allergen extract) Oralair® (mixed pollens allergen extract) Ragwitek® (short ragweed pollen allergen extract)	Limited to a qty of 1 unit per day	1. The prescriber must be an allergist and administer the first dose under supervision; **AND** 2. The patient must have chart documentation of a positive skin test or in-vitro testing for pollen-specific IgE antibodies for the allergens containedin the product; **AND** 3. Patient must have a chart documented trial of at least one nasal steroid (i.e., Flonase, flunisolide, Nasacort AQ) and one non-sedating antihistamine (i.e., Claritin, Zyrtec, Allegra); **AND** 4. There are claims for an epinephrine auto-injector within the past 6 months; **AND** 5. For Ragwitek and Grastek, treatment will be initiated 12 weeks prior to the expected onset of the allergen season and continued throughout the season; **OR** 6. For Oralair, treatment will be initiated 16 weeks prior to the expected onset of the allergen season and continued throughout the season. Ragwitek and Grastek: authorization will approved for 24 weeks per calendar year. Oralair: authorization will be approved for 28 weeks per calendar year. Note: The authorization approvals are based on a 12 week allergy season.
Lyrica® (pregabalin)		**DOSE OPTIMIZATION ONLY** Quantity limits/dose optimization: 1. The 25, 50, 75, 100, 150 and 200mg capsules are limited to a quantity of 90 per month. 2. The 225 and 300mg capsules are limited to a quantity of 60 per month.
Movantik® (naloxegol)	Limited to a qty of 30 units per 30 days	1. The patient must be on a stable opioid regimen, **AND** 2. The patient has documented opioid constipation, **AND** 3. The patient must have documented treatment failure with at least 3 generic/OTC cathartics (e.g., bisacodyl, docusate sodium, lactulose, mineral oil, polyethylene glycol, phosphasoda enema, etc.) and Amitiza.
Northera® (droxidopa)		1. Patient has symptomatic neurogenic orthostatic hypotension (NOH) caused by: • Primary autonomic failure (i.e., Parkinson's disease, multiple system atrophy, or pure autonomic failure; OR • Dopamine beta-hydroxylase deficiency; OR • Non-diabetic autonomic neuropathy; AND 2. The patient has failed or has clinically significant adverse effects to midodrine OR fludrocortisone. NOTE: Effectiveness beyond two weeks of treatment has not been established. Authorization will be given for 21 days. Renewal and duration of authorization requires documentation that the patient's condition has improved

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Miscellaneous, continued Nuvigil® (armodafinil)	Qty is limited to 30 units per 30 days	1. The patient has a documented diagnosis of narcolepsy, or excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS) or shift work sleep disorder (SWSD).
Xyrem® (sodium oxybate)	Quantity limit of 540mls every 30 days	1. The patient is 16 years of age or older **AND** 2. The patient has documented sleep study results resulting in a diagnosis of narcolepsy and has one of the following: a. Episodes of cataplexy demonstrated by chart documentation, **OR** b. Excessive daytime sleepiness with symptoms that limit the ability to perform normal daily activities demonstrated by chart documentation and: i. Provigil or Nuvigil therapy has been ineffective or contraindicated **AND** ii. Methylphenidate, amphetamine salts, or dextroamphetamine therapy has been ineffective or contraindicated **AND** 3. The patient is not being treated with a sedative hypnotic agent **AND** 4. The patient does not have a succinic semialdehyde dehydrogenase deficiency **AND** 5. The patient does not have a history of substance abuse.
Rayos® (prednisone delayed release tablets)		1. The patient must have a documented diagnosis of rheumatoid arthritis; **AND** 2. The patient must have documented failure and Rx claims for 2 generically available oral corticosteroids (i.e., prednisone, methylprednisolone).
Relistor® (methylnaltrexone)		1. The patient must have a diagnosis of opioid-induced constipation; **AND** 2. The patient has advanced illness and receiving palliative care with a life expectancy of less than 6 months; **AND** 3. The patient has documented failure or contraindication of 3 other laxative drugs.
Revatio® (sildenafil)	Limited to a qty of 30 units per 30 days.	**DOSE OPTIMIZATION ONLY** Only quantities greater than 1 per day will require prior authorization for pulmonary hypertension.
Non-Formulary with PA: Adcirca® (tadalafil)		1. The patient must have a documented diagnosis of pulmonary arterial hypertension. 2. If the patient has a history of nitrate use, the physician must submit a written request on his/her letterhead stating that the patient is no longer using nitrates.
On Formulary with PA: Savella® (milnacipran)		1. The patient must have a documented diagnosis of fibromyalgia, **OR** 2. Documentation of all of the following: a. Widespread pain for at least 3 months, **AND** b. Pain on both sides of the body, above and below the waist, **AND** c. Abnormal tenderness in at least 11 of the 18 anatomically-defined body sites.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Miscellaneous, continued Uloric® (febuxostat)	Limited to a qty of 30 units per month	1. Patient must have documented failure or prescription claims with allopurinol, **OR** 2. The patient cannot tolerate therapeutic doses or is not an appropriate candidate for allopurinol based on documentation provided.
Neurological Miscellaneous Horizant® (gabapentin enacarbil)	Limited to a qty of 30 units per 30 days.	1. The patient must have a diagnosis of restless legs syndrome, **AND** 2. The patient must have documented failure and Rx claims with generic Neurontin, **AND** 3. The patient must have documented failure or Rx claims with generic Requip or generic Mirapex.
Gralise® (gabapentin)		1. The patient must have a documented diagnosis of postherpetic neuralgia, **AND** 2. The patient must have documented failure and Rx claims with generic Neurontin, **AND** 3. The patient must have documented failure or Rx claims with a generic tricyclic antidepressant.
Nuedexta® (dextromethorphan/quinidine)	Limited to a qty of 60 units per 30 days.	1. The patient must have a documented diagnosis of pseudobulbar affect; **AND** 2. The patient must be 18 years or older; **AND** 3. Patient is not currently receiving quinidine, quinine, mefloquine, an MAOI, or any drug that prolongs QT interval and is metabolized by CYP2D6 (e.g., thioridazine or pimozide); **AND** 4. Patient must have recent (within the past three months) platelet count, liver function panel, and ECG if patient has left ventricular dysfunction/hypertrophy. Prior authorization requests are approved for a 6 month duration.
NSAIDs Arthrotec® (diclofenac/misoprostol) Naprelan CR® (naproxen sodium)	All Cox-2 drugs are limited to a qty of 30 units per month	1. Documented indication for acute or chronic treatment of the signs and symptoms of osteoarthritis or rheumatoid arthritis, **AND** 2. The patient must have documented failure or Rx claims for an adequate course of therapy with at least two generic prescription NSAID agents (e.g., ibuprofen, naproxen, piroxicam, ketoprofen, diclofenac, etc.). Adequate course of therapy is defined as a full therapeutic dose on a scheduled basis for at least 1-2 weeks; **OR** 3. The patient is identified as "high risk" for developing GI complications: a. Age over 60 years old **AND** any one of the following risks: b. Requiring prolonged use of max dose of traditional NSAIDS **OR** c. Concomitant use of steroids **OR** d. Documented history of ulcer/bleed/perforation, **OR** 4. Active ulcer or recent documented history of ulcer (within months) on history of GI bleed/perforation.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
NSAIDs, continued Duexis® (ibuprofen/famotidine)		1. The patient must have a documented diagnosis of arthritis; **AND** 2. The patient must be high risk for developing GI complications: a. Documentation or Rx claims for concomitant use of steroids, DMARDs, or anticoagulants b. Documentation of active or previous ulcer/bleed/perforation c. Documentation of platelet dysfunction or coagulopathy; **AND** 3. The patient must have chart documented failure or Rx claims for both ibuprofen 800 mg and famotidine 20 mg in the past month.
Indocin Suspension® (indomethacin) Tivorbex® (indomethacin)		1. The patient must have documented failure or Rx claims for an adequate course of therapy with at least two generic prescription NSAID agents (e.g., ibuprofen, naproxen, piroxicam, ketoprofen, diclofenac, etc.), and one must be generic Indocin. Adequate course of therapy is defined as a full therapeutic dose on a scheduled basis for at least 1-2 weeks
Sprix® (ketorolac tromethamine)	Limit of 5 bottles per 30 days	1. The patient is being treated for acute pain; **AND** 2. The patient has chart documented treatment failure or intolerance to an oral generic ketorolac product; **AND** 3. The patient will be treated for less than or equal to 5 days.
Vimovo® (esomeprazole/naproxen)		1. The patient must have a documented diagnosis of arthritis, **AND** 2. The patient must be high risk for developing GI complications: a. Documentation or Rx claims for concomitant use of steroids, DMARDs, or anticoagulants b. Documentation of active or previous ulcer/bleed/perforation c. Documentation of platelet dysfunction or coagulopathy 3. The patient must fail all formulary proton pump inhibitor alternatives (i.e., Omeprazole, generic Aciphex, generic Prevacid, generic Protonix) in combination with generic naproxen.
Flector® (diclofenac epolamine transdermal patch)		1. The patient must have documented failure or Rx claims for an adequate course of therapy with at least two generic prescription NSAID agents (e.g., ibuprofen, naproxen, piroxicam, ketoprofen, diclofenac, etc.). Adequate course of therapy is defined as a full therapeutic dose on a scheduled basis for at least 1-2 weeks; **OR** 2. The patient is identified as "high risk" for developing GI complications: a. Age over 60 years old **AND** any one of the following risks: b. Requiring prolonged use of max dose of traditional NSAIDS **OR** c. Concomitant use of steroids **OR** d. Documented history of ulcer/bleed/perforation, **OR** 3. Active ulcer or recent documented history of ulcer (within 6 months) or history of GI bleed/perforation.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
NSAIDs, continued Voltaren Gel® (diclofenac sodium)		1. The patient must have documented failure or Rx claims for an adequate course of therapy with at least two generic prescription NSAID agents (e.g., ibuprofen, naproxen, piroxicam, ketoprofen, diclofenac, etc.).
All Oral Brand Diclofenac Products Zipsor® (diclofenac potassium) Zorvolex® (diclofenac)		1. The patient must have documented failure or Rx claims for an adequate course of therapy with at least two generic prescription NSAID agents (e.g., ibuprofen, naproxen, piroxicam, ketoprofen, diclofenac, etc.), and one must be generic Voltaren. Adequate course of therapy is defined as a full therapeutic dose on a scheduled basis for at least 1-2 weeks.
Ophthalmic Products **All Brand Topical Ophthalmic Antihistamines** **On Formulary with PA:** Patanol® (olopatadine) **Non-Formulary with PA:** Alocril® (nedocromil sodium) Alomide® (lodoxamide tromethamide) Bepreve® (bepotastine besilate) Emadine® (emedastine difumarate) Lastacaft® (alcaftadine) Pataday® (olopatadine) Pazeo® (olopatadine)		1. The patient must have documented failure or Rx claim for generic OTC Zaditor in the past 90 days (covered with written prescription). 2. If the patient fails treatment with generic OTC Zaditor, then Patanol is the second-line formulary alternative with prior authorization required. 3. The patient must have documented failure or Rx claims for the formulary alternatives (OTC Zaditor and Patanol) before a non-formulary drug will be approved.
Restasis® (cyclosporine)	Qty is limited to 2 units per day	1. Patient has a diagnosis of tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca (chronic dry eye disease), Sjogren's Syndrome, or is being treated for Graft vs. Host Disease or Corneal Transplant Rejection **AND** all of the following: 2. Patient must have a functioning lacrimal gland; **AND** 3. Member has failed at least two separate 30-day trials using two different OTC ocular lubricants / artificial tear solutions 4x/day during each trial; **AND** 4. Must be prescribed by an ophthalmologist or optometrist; **AND** 5. Patient is not less than 16; **AND** 6. Patient has not had an ocular infection, surgery, or injury in the last 6 months; **AND** 7. Patient is not using daily contacts; **AND** Authorization is limited to 3 months. Extended authorizations are dependent on response and use.
Betimol® (timolol) Istalol® (timolol maleate)		1. The patient must have documented failure or Rx claim for generic Timolol (i.e., Timoptic).

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Ophthalmic Products, continued **All Brand Topical Ophthalmic Prostaglandin Analogs** **On Formulary with PA:** Lumigan 0.01%® (bimatoprost) **Non-Formulary with PA:** Travatan Z® (travoprost) Zioptan® (tafluprost)	Zioptan is limited to a qty of 1 unit per day	1. The patient must have documented failure or prescription claims for a generic prostaglandin analog (i.e., generic Xalatan). 2. If the patient fails treatment with all generic prostaglandin analogs, then Lumigan 0.01% is the second-line formulary alternative with prior authorization required. 3. The patient must have documented failure or prescription claims for all formulary alternatives (generic Xalatan **AND** branded Lumigan 0.01%) before a non-formulary brand drug will be approved.
Parkinson's Duopa® (carbidopa/levodopa)	Limited to a qty of 100mls per day	1. Patient must have diagnosis of advanced Parkinson's disease, **AND** 2. Patient must have complicated motor fluctuations that have not been adequately controlled with optimal therapy including: a. Oral levodopa-carbidopa; **AND** b. Dopamine agonist (bromocriptine, pramipexole, ropinirole), **OR** c. Catechol-O-methyltransferase (COMT) inhibitor (entacapone).
Rytary ER® (carbidopa/levodopa)		1. Patient must have chart documented trial and failure of a similar strength of carbidopa and levodopa ER (geq Sinemet CR).
Proton Pump Inhibitors **On Formulary with PA:** Esomeprazole Strontium® (esomeprazole strontium) **Non-Formulary with PA:** Aciphex Sprinkle® (rabeprazole) Dexilant® (dexlansoprazole) First-Lansoprazole® (lansoprazole) First-Omeprazole® (omeprazole) Nexium® (esomeprazole) Prevacid Solutab® (lansoprazole) Prilosec DR Susp® (omeprazole magnesium) Protonix Pak® (pantoprazole) Zegerid Susp® (omeprazole/sodium bicarbonate)	Brand PPIs are limited to a qty of 30 tabs/caps per month	1. The patient must have documented failure or Rx claims for 4 generic proton pump inhibitors (PPI) before a non-formulary PPI will be approved, **AND** 2. Specifically for Nexium and esomeprazole strontium, the patient must have a current documented diagnosis of Barrett's Esophagus, Zollinger-Ellison or Erosive Esophagitis. Approved automatically for children under 2 years of age. 3. Specifically for Dexilant, the patient must have a current documented diagnosis of Erosive Esophagitis; **OR** if the patient is currently taking clopidogrel, they must have documented failure or Rx claims for both pantoprazole and lansoprazole. **Specifically for liquid or soluble preparations:** 1. The patient must have a documented inability to swallow a solid dosage form.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Sleeping Aids **All Branded Sleeping Aid Products** Belsomra® (suvorexant) Edluar SL® (zolpidem) Hetlioz® (tasimelteon) Intermezzo® (zolpidem) Rozerem® (ramelteon) Silenor® (doxepin) Zolpimist® (zolpidem)	Quantity is limited to 30 per month	1. If there is no contraindication present, the patient must have documented failure or Rx claim(s) for three generically available sleeping agents (e.g., Ambien, Desyrel, Halcion, Prosom, Restoril or Sonata). 2. If a contraindication to benzodiazepines is present, the patient must try and fail an adequate course of therapy with generic Ambien **AND** Sonata. **NOTE:** Limited to1 unit per day. Prior Authorization for more than 1 unit per day is based on a specific review of medical necessity.
Ambien/CR® (zolpidem) Restoril® (temazepam) Sonata® (zaleplon)		**QUANTITY LIMITS ONLY** **NOTE:** Limited to 1 unit per day. Prior Authorization is only required for quantities that exceed the limit, and is based on a specific review of medical necessity.
Opioid Dependency Agents **All Buprenorphine and Buprenorphine/Naloxone Products** Bunavail® (buprenorphine/ naloxone) Suboxone® Film (buprenorphine/naloxone) Suboxone® SL Tablet (buprenorphine/naloxone) Subutex® (buprenorphine) Zubsolv® (buprenorphine/ naloxone)	Bunavail, Suboxone 12-3mg, 4-1mg films limited to 2 units per day Suboxone 2-0.5mg, 8-2mg, Subutex, Zubsolv limited to 3 units per day	1. The patient must have a chart documented diagnosis of opioid addiction/dependence (Opioid Dependency Agents are not indicated or covered for the treatment of pain); **AND** 2. The patient must not be using short or long acting opioids concurrently, verified by current MAPS report; **AND** 3. The prescriber must be certified to prescribe buprenorphine for opioid dependence and provide their Drug Addiction Treatment (DATA) 2000 waiver identification number (X DEA number); **AND** 4. For Subutex, if used for maintenance therapy, the patient must have a contraindication to or unable to tolerate naloxone in combination with buprenorphine 5. If approved, all opioid analgesics claims will be blocked 6. If during treatment, opioid use is discovered, the authorization may be terminated. Duration of approval is for 6 months Renewal Criteria 1. The patient must have evidence of a dosage taper, **AND** 2. The patient's MAPS report does not contain evidence of opioid use during treatment.
All Opioid Agents when the patient has current approval for an opioid dependency medication		1. If the patient has current approval for an opioid dependency medication, any/all opioid products will not be covered during the same timeframe.
Inflammatory Bowel Disease **All Branded Non-Formulary Oral Agents** Dipentum® (olsalazine sodium) Giazo® (balsalazide) Lialda® (mesalamine) Uceris® (budesonide)		1. The patient must have documented failure or Rx claims for at least two formulary agents (e.g., generic Azulfidine, Colazal, or Asacol) in the past year. New Starts Only
Canasa® (mesalamine)	Limited to a qty of 30 units per month	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Weight Management All medications for the treatment of obesity Examples: Adipex® (phentermine) Belviq® (lorcaserin) Belviq XR® (lorcaserin) Bontril 105mg® (phendimetrazine tartrate) Bontril PDM 35mg® (phendimetrazine tartrate) Contrave® (naltrexone/ bupropion) Didrex® (benzphetamine) Diethylpropion® (diethylpropion) Evekeo® (amphetamine sulfate) Lomaira® (phentermine) Qsymia® (phentermine/ topiramate) Saxenda® (liraglutide) Suprenza® (phentermine) Xenical® (orlistat)		1. The patient is an adult ≥ 18 years of age; **AND** 2. The patient has a body mass index (BMI) of ≥30kg/m^2, **OR** 3. The patient has a body mass index (BMI) of ≥27kg/m^2 with any of the following co-morbidities: -established coronary heart disease -atherosclerotic disease -type 2 diabetes -sleep apnea, **OR** 4. The patient has a body mass index (BMI) of ≥27kg/m^2, A. With at least three of the following risk factors: -hypertension -high LDL cholesterol -low HDL cholesterol -impaired fasting glucose -smoking -family history of early cardiovascular disease -age ≥45 years for men or age ≥55 years for women, **AND** B. The patient has undergone evaluation to rule out other treatable causes of obesity, not presence of malabsorption syndrome, thyroid conditions, cholestasis, pregnancy, and/or lactation, **AND** C. There has been a previous weight loss attempt for at least 6-12 months within one (1) year through a physician-supervised diet and exercise program consisting of low calorie diet, **AND** D. The patient has a strong desire, willingness and cognitive ability to make changes in diet and activity level, **AND** E. The medication is part of a continued treatment plan, which includes a calorie and fat reduced diet and a regular exercise program. **AND** 5. The patient is not pregnant or breastfeeding, **AND** 6. If the medication is a brand name product, the patient must have tried a generically available product (i.e. phentermine, diethylpropion) in the past year **AND** meet drug specific criteria if applicable. **Belviq:** 1. The patient must not be taking a serotonergic drug (i.e. SSRIs, SNRIs, MAOIs, triptans, bupropion, dextromethorphan, St. John's Wort, **AND** 2. The dose doesn't exceed 10 mg twice daily. **Contrave:** 1. The patient must not be taking bupropion, AND 2. The patient is not currently on long-term opioid analgesic therapy, **AND** 3. The patient doesn't have a history of seizures.

APPENDIX D

DRUG/CATEGORY	QTY LIMIT	CRITERIA
Weight Management, continued All medications for the treatment of obesity Examples: Adipex® (phentermine) Belviq® (lorcaserin) Belviq XR® (lorcaserin) Bontril 105mg® (phendimetrazine tartrate) Bontril PDM 35mg® (phendimetrazine tartrate) Contrave® (naltrexone/ bupropion) Didrex® (benzphetamine) Diethylpropion® (diethylpropion) Evekeo® (amphetamine sulfate) Lomaira® (phentermine) Qsymia® (phentermine/ topiramate) Saxenda® (liraglutide) Suprenza® (phentermine) Xenical® (orlistat)		**Qsymia:** 1. The patient must not be intolerant to phentermine or topiramate, **AND** 2. The patient has not taken a MAOI in the past 14 days (i.e., isocarboxazid, linezolid, phenelzine, rasagiline, selegiline, tranylcypromine). **Saxenda:** 1. The patient must not be using insulin or another GLP-1 agonist. **Xenical:** 1. The patient must not have a history of cholestasis or chronic intestinal malabsorption. If the preceding criteria are met, the request for a weight loss medication will be approved for 1 year (365 days) of total coverage.

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Non-Sterile Compounded Prescriptions **Non-Formulary with PA**		1. The compounded product contains at least one FDA-approved prescription ingredient; **AND** 2. Each prescription drug or active ingredient in the compounded product is approved by the Food & Drug Administration (FDA) for medical use in the United States; **AND** 3. The active prescription medication component(s) are in therapeutic amounts; **AND** 4. The compounded product is not a copy of any commercially available FDA-approved drug product; **AND** 5. The use for which the compounded product is being prescribed is supported by FDA approval of the active ingredient(s), or is supported by two or more articles from peer reviewed journals demonstrating the safety and efficacy of the prescribed therapy for that diagnosis and method or route of delivery; **AND** 6. If any prescription ingredient in the compounded product is included in the HealthPlus Prior Authorization program, the patient must meet the criteria designated for that prescription ingredient. **Based on limitations or exclusions in the subscriber certificate, coverage will NOT be provided for compounds under the following circumstances:** 1. Any compound that does not contain a FDA-approved prescription ingredient otherwise covered by the plan; **OR** 2. Any compound that contains a non-FDA approved or non-HealthPlus covered prescription ingredient. 3. Compounded formulations that contain any bulk powders that are not FDA approved or HealthPlus approved; **OR** 4. Compounded formulations that are being used for cosmetic purposes; **OR** 5. Compounded formulations that are using prescription ingredients for non-FDA approved indications or purposes that are not supported by peer-reviewed literature; **OR** 6. Compounded formulations that may be considered investigational or experimental; **OR** 7. Compounded formulations that use drugs withdrawn or removed from the market for safety reasons; **OR** 8. Prescription ingredient(s) compounded for the purpose of convenience only. a. Exceptions include: i. Compounded medications for those patients that cannot swallow or have trouble swallowing and require administration with an oral liquid, or administration by topical, rectal or other appropriate non-oral routes; ii. Compounded medications for those patients who have sensitivity to dyes, preservatives, or fillers in commercial products and require allergy-free medications as documented in the medical record; iii. Compounded medications for children who require prescription medications for which there are no liquid formulations available**.**

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DRUG/CATEGORY	QTY LIMIT	CRITERIA
Dispense as Written DAW Specific request for a brand name product when a generic is available		1. The benefit covers generic products when a generically equivalent product is available. 2. In general, prior authorization is required for all brand name drugs (when the drug is available and covered as a generic medication). The physician may submit a prior authorization request form for the brand name drug (when a generic equivalent is available), but this must be substantiated by medical necessity. If medical necessity is based on a trial and failure of the generic medication, a prescription claim for the generic drug must be present or chart notes documenting the failure must be provided. 3. If a physician submits a prior authorization request form for coverage of a brand name drug (when a generic equivalent is available), the request is reviewed through the same process as all other drugs that require prior authorization. 4. The member may still choose to receive a brand product without medical necessity, but would be responsible for additional costs based on their benefit (i.e., the difference in cost between the brand and generic product plus their usual copayment; or, a higher copayment).
Quantity Limit QL Specific request for a dose, quantity, day supply or duration that exceeds the established limits		1. The physician must provide documentation of the clinical rationale for requesting a dosage, quantity, day supply or duration of medication greater than the criteria specified in the formulary. 2. If the dosage exceeds the manufacturer product labeling/prescribing information, the physician must submit documentation of two articles from peer reviewed journals demonstrating the safety and efficacy of the prescribed therapy.

High Risk Medications in the Elderly (≥66 years old)

Based on the availability of safer alternatives, the following medications require prior authorization for members 66 years of age and older with the following criteria:

1) The recommended alternative treatment(s) are not appropriate, are contraindicated or are unsafe for the patient based on specific documented patient circumstances, **OR**
2) The patient has a documented trial and failure (or prescription claims) for the recommended alternative treatment(s).

Name	Concern	Alternative Treatment
Estrogens – all oral and topical patches only (Premarin, estradiol, Estratest, Vivelle-Dot, etc.)	Evidence of breast/Endometrial cancer; No cardio or cognitive protection in older women	**Hot flashes:** non-pharmacological therapy, Zoloft, Paxil, Effexor **Bone density:** Calcium with vitamin D[2], Fosamax, Boniva[1], Evista[1]
Promethazine (Phenergan) – including all combinations **Promethazine w/ Codeine**	Anticholinergic effects (i.e., urinary retention, confusion, sedation)	**Antihistamine:** Claritin[1,2], Zytrec[2] **Antiemetic:** Antivert, Zofran[1] **Cough:** Dextromethorphan
Nitrofurantoin (Macrodantin)	Nephrotoxicity	**Depends on site of infection, culture, and sensitivity.** Bactrim, Vibramycin, Azithromycin, Fluoroquinolone[1]
Thyroid USP (Armour Thyroid, Desiccated)	Cardiac adverse effects	**Levothyroxine (LT4):** Synthroid, Levoxyl
Glyburide (Micronase) **Glyburide-Metformin (Glucovance)** **Chlorpropamide (Diabinese)**	Associated with an increased risk of hypoglycemia compared to other agents	**Diabetes:** Glucotrol, Amaryl, Metaglip
Hydroxyzine (Vistaril, Atarax)	Anticholinergic effects, urinary retention, confusion, sedation	**Antihistamine:** Claritin[2], Zyrtec[2]
Carisoprodol (Soma) **Cyclobenzaprine (Flexeril)** **Orphenadrine (Norflex)** **Chlorzoxazone (Parafon Forte)** **Methocarbamol (Robaxin)** **Skelaxin (Metaxalone)**	Anticholinergic effects, sedation, cognitive impairment, weakness, urinary retention	**Physiotherapy:** correct seating & footwear **Spasticity:** Baclofen, Zanaflex tablets. Treat underlying problems

Name	Concern	Alternative Treatment
Amitriptyline (Elavil)	Highly anticholinergic, sedating, and causes orthostatic hypotension	**Depression:** Zoloft, Paxil, Effexor
Imipramine (Tofranil)		
Trimethobenzamide (Tigan)	Extrapyramidal side effects, poor efficacy	**Nausea:** Zofran, Compazine, or Reglan
Ketorolac (Toradol)	GI bleeding	**Pain:** Tylenol[2], Motrin[2], Norco
Indomethacin		
Dipyridamole (Persantine)	Orthostatic hypotension, poor efficacy	**For secondary prevention of non-cardioembolic stroke or TIA:** Plavix, Aggrenox, Aspirin

[1] Drug may require prior authorization or may have limited coverage depending on member's benefit plan
[2] Available OTC

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Adrenocorticotropic Hormones H.P. Acthar Gel® (repository corticotropin injection)	1. Patient has a chart documented diagnosis of infantile spasms (West Syndrome); **AND** 2. The patient age is less than 2 years old; **OR** 1. Patient has diagnosis of acute exacerbation of Multiple Sclerosis; **AND** 2. Patient has severe and unmanageable intolerance or contraindication to corticosteroids (i.e., dexamethasone, betamethasone, prednisolone, and methylprednisolone); **AND** 3. Patient is currently treated with an immunomodulatory drug to control MS progression i.e. (interferon beta-1b (Betaseron, Extavia), interferon Beta-1a (Avonex, Rebif), natalizumab (Tysabri), fingolimod (Gilenya), teriflunomide (Aubagio), dimethyl fumerate (Tecfidera), or glatiramer acetate (Copaxone)).		H.P. Acthar Gel is in the Medical Prior Authorization Program Quantity is limited as follows: Infantile spasms 63 billable units per 28 days Acute exacerbation of Multiple Sclerosis (MS) 63 billable units per 21 days Note: 1 billable unit equals up to 40 units of H.P. Acthar Gel (80u/ml) for J code J0800.
Androgens Testopel® (testosterone implant pellets)	1. The patient has a documented diagnosis of hypogonadism; **AND** 2. The patient has a morning (before 11AM) serum total testosterone concentration of less than 300 ng/dL documented on 2 separate occasions in the past year; **AND** 3. The patient has a morning free serum testosterone level less than the lower limit of the lab reference range of normal based on age; **AND** 4. The patient must have documented failure or Rx claims with testosterone cypionate or enanthate for a minimum of 2 months; **OR** 1. The patient has a documented diagnosis of delayed puberty; **AND** 2. The patient must have documented failure or Rx claims with testosterone cypionate or enanthate.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antifungals Cresemba® (isavuconazonium)	1. Patient must be 18 years or older; **AND** 2. Patient has a diagnosis of invasive aspergillosis or mucormycosis; **AND** 3. If being used for invasive aspergillosis, documentation must be submitted that the patient cannot tolerate voriconazole or amphotericin B; **AND** 4. Patient is not receiving co-administration of strong CYP3A4 inhibitors (e.g., ketoconazole or high-dose ritonavir [400 mg every 12 hours] or strong CYP3A4 inducers (e.g., rifampin, carbamazepine, St. John's wart, or long acting barbiturates).		
Antihyperlipidemics Juxtapid® (lomitapide mesylate)	1. The patient must be over 18 years old; **AND** 2. The patient must have a previous Rx claim for a HMG-CoA reductase inhibitor (i.e. statin); **AND** 3. The patient must have clinical and/or laboratory determined presence of homozygous familial hypercholesterolemia. Acceptable documentation includes*: a. Chart documentation confirming the presence of xanthomas before the age of 10, an untreated LDL of >500mg/dL, a treated LDL of ≥300mg/dL, or a treated non-HDL ≥330mg/dL; **OR** b. Genetic testing showing 2 mutated alleles at the LDL-Receptor, ApoB, PCSK9, or ARH adaptor protein gene locus; **AND** 4. A negative pregnancy test must be completed just prior to initiating therapy; **AND** 5. The patient must have ALT, AST, alkaline phosphate, total bilirubin, INR, and SCr testing obtained just prior to initiating therapy; **AND** 6. The results from liver function tests must be normal (no clinically significant or unexplainable abnormalities); **AND** 7. The dose must be appropriate based on manufacturer recommendations.	Approval of prior authorization requests is limited to 12 months.	Recent lab results (within 3 months) are required for each renewal.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antihyperlipidemics, continued Kynamro® (mipomersen)	1. The patient must be over 18 years old; **AND** 2. The patient must have a previous Rx claim for a HMG-CoA reductase inhibitor (i.e. statin); **AND** 3. The patient must have clinical and/or laboratory determined presence of homozygous familial hypercholesterolemia. Acceptable documentation includes*: a. Chart documentation confirming the presence of xanthomas before the age of 10, an untreated LDL of >500mg/dL, a treated LDL of ≥300mg/dL, or a treated non-HDL ≥330mg/dL; **OR** b. Genetic testing showing 2 mutated alleles LDL-Receptor, ApoB, PCSK9, or ARH adaptor protein gene locus; **AND** 4. The patient must have ALT, AST, alkaline phosphate, total bilirubin, INR, and SCr testing obtained just prior to initiating therapy; **AND** 5. The results from liver function tests must be normal (no clinically significant or unexplainable abnormalities); **AND** 6. The dose must be appropriate based on manufacture recommendations	Approval of prior authorization requests is limited to 12 months.	Recent lab values (within 3 months) are required for each renewal. Discontinuation of treatment should be considered if patient does not have a sufficient response to warrant the potential risk of liver toxicity after 6 months.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antihyperlipidemics, continued Praluent® (alirocumab) Repatha® (evolocumab) Repatha Pushtronex® (evolocumab)	1. For the management of hyperlipidemia as ADJUNCT to diet and maximally tolerated statin therapy in the following patient populations: a. Familial Hypercholesterolemia (FH) I. Homozygous (HoFH) or Heterozygous (HeFH) II. Evidence in the medical record of established HoFH or HeFH with diagnostic criteria for clinical diagnosis of FH or positive results of genetic testing **- OR -** b. Clinical ASCVD I. Clinical diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD), defined as evidence in medical record on history of ONE of the following: ▪ Myocardial infarction (MI) **-OR-** ▪ Acute Coronary Syndrome (ACS) **-OR-** ▪ Stable or unstable angina **-OR-** ▪ Thromboebmolic stroke **-OR-** ▪ Transient ischemic attack (TIA) **-OR-** ▪ Peripheral arterial disease (PAD) -**OR-** ▪ Coronary or other arterial revascularization **-AND -** II . Documented adherence to 2013 ACC/AHA Lifestyle Management guidelines (e.g. heart healthy diet, aerobic exercises 3 to 4 times weekly, active weight loss) **-AND-** III . Documented non-smoker **-AND-** IV . Failure to attain LDL-C reduction in accordance with the 2013 ACC/AHA cholesterol guidelines defined as < 50% reduction in LDL-C compared to baseline LDL-C level with the ~ 12 weeks use of high-intensity statin therapy (must include trial of rosuvastatin 40 mg daily or equivalent) plus ezetimibe i . Adherence to statin therapy and ezetimibe (with evidence of ≥ 75% adherence to prescribed regimen via claims processing) **-OR-** (continued on next page…)	Duration of initial approval is for 3 months.	**Praluent:** QL 1 injection per 14 days. Prescriptions are limited to 14 day supplies to monitor adherence to therapy. Renewal requires documentation of the following: a. LDL levels have dropped by 40% since initiating therapy; **-- AND** b. Liver transaminases are less than 3X normal limit. **Repatha:** Prescriptions are limited to: • 1 (140mg/ml) injection per 14 days for patients with HeFH or clinical atherosclerotic cardiovascular disease • 3 (140mg/ml) injections per 28 days for patients with HoFH Renewal requires documentation of the following: a. LDL levels have dropped by 40% since initiating therapy

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antihyperlipidemics, continued Praluent® (alirocumab) Repatha® (evolocumab) Repatha Pushtronex® (evolocumab)	V . Intolerance to statin therapy, where medical records containing objective data (e.g. elevated LFTs or elevated creatinine kinase levels) must be submitted for review to support statin intolerance i. Must demonstrate evidence of statin intolerance via objective data on ≥ 3 statin regimens (refer to figure on page 39 for required trials of statin therapy) and demonstrate adherence through pharmacy claims data (See page 39 for workflow process) ▪ Reference: Moriarty PM, Thompson PD, Cannon CP, et al. ODYSSEY ALTERNATIVE: efficacy and safety of alirocumab versus ezetimibe, in patients with statin intolerance defined by placebo run-in and statin rechallenge arm. Presented at: American Heart Association 2014 Scientific Sessions; November 15-19, 2014a; Chicago, IL, USA. http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@scon/documents/downloadable/ucm_469684.pdf 2. Initially prescribed by cardiologist or lipid specialist for hyperlipidemia. [Requests for renewal may be submitted by cardiologist, lipid specialist, or primary care physician (PCP). If renewal completed by PCP, member is adherent to annual follow-up with specialist (i.e. cardiology). 3. Concurrent use of high intensity statin with PCSK9 inhibitor (adherence). 4. Medical records and labs are required to be submitted for review of appropriateness based on listed criteria for use -PCSK9 medication will not be approved for use with another PCSK9 inhibitor, Kynamro, or Juxtapid		

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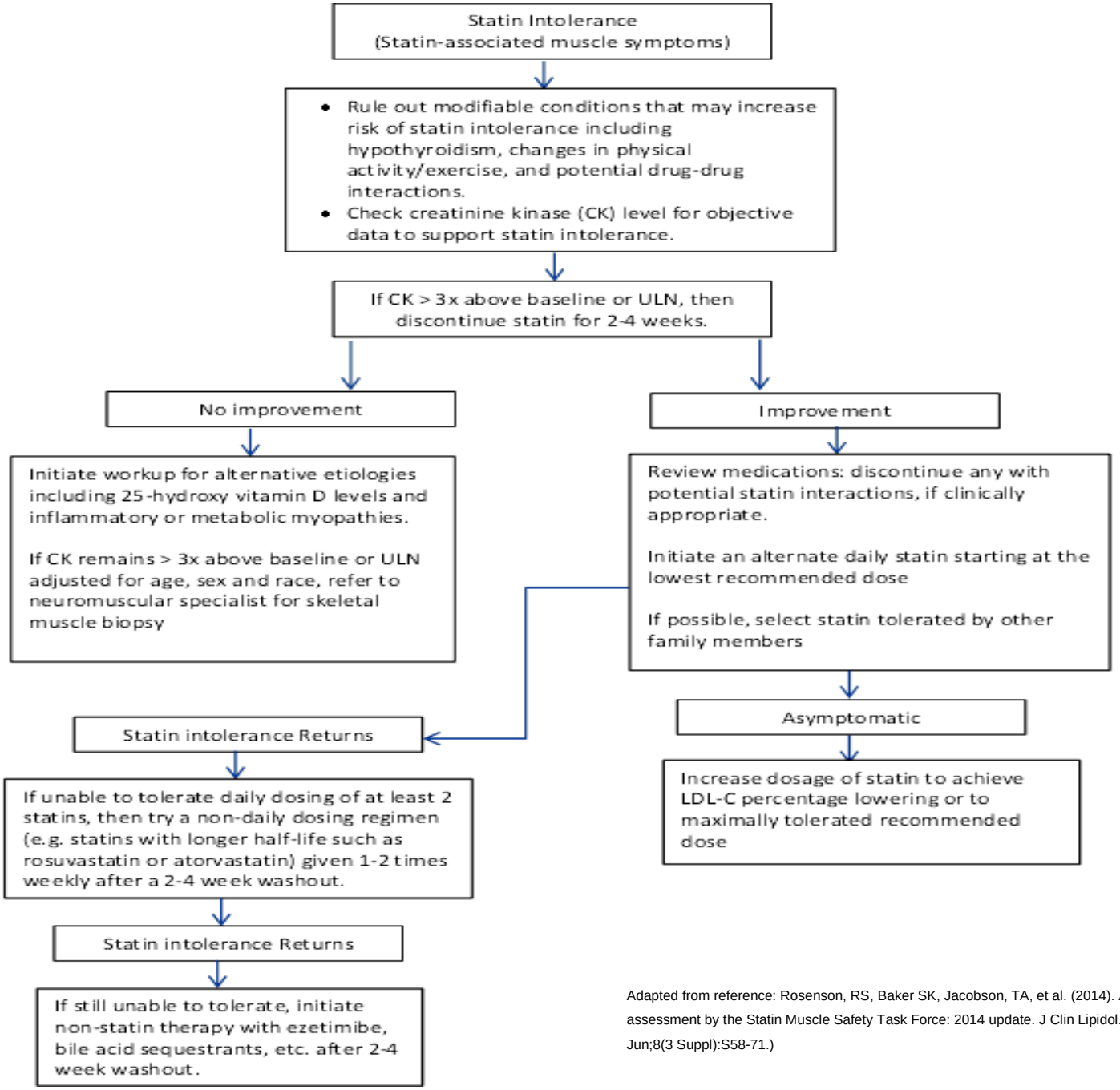

Adapted from reference: Rosenson, RS, Baker SK, Jacobson, TA, et al. (2014). An assessment by the Statin Muscle Safety Task Force: 2014 update. J Clin Lipidol. 2014 May-Jun;8(3 Suppl):S58-71.)

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antineoplastic Lenvima® (lenvatinib)	1. Patient must be 18 years or older, **AND** 2. Patient must have a diagnosis of differentiated thyroid cancer (DTC) that is locally recurrent or metastatic, progressive, radio-active iodine (RAI)-refractory. RAI-refractory disease can be confirmed by any of the following: o At least one measurable lesion without iodine uptake o At least one measurable lesion that had progressed within 12 months after RAI therapy o No improvement or disease progression despite receiving RAI equivalent to cumulative activity of >600 mCi 3. Patient must be concomitantly receiving levothyroxine, or document trial and failure.	Duration of coverage should be for 6 months. Coverage is renewable for additional 6 months intervals if there is no evidence of disease progression or unacceptable toxicity while on Lenvima therapy.	Prescriptions are limited to 14 day supplies to monitor adherence to therapy. Quantity is limited to: 24mg = 14 capsules per 14 days. Mandatory Specialty Program.
Lynparza® (olaparib)	1. Pt must have diagnosis of deleterious or suspected deleterious germline BRCA mutated advanced ovarian cancer a. Mutation status must be confirmed by an FDA-approved test (BRACAnalysis test), **AND** 2. There is chart documentation of treatment with three or more prior lines of chemotherapy, including carboplatin and paclitaxel, **AND** Authorization is limited to 6 months. Recertification requires documentation that patient's disease has not progressed while on therapy.	Authorization is limited to 6 months. Recertification requires documentation that patient's disease has not progressed while on therapy	Prescriptions are limited to 14 day supplies to monitor adherence to therapy. Quantity is limited to 224 tablets per 14 days. Mandatory Specialty Program.
Sylatron® (peg-interferon alfa 2b)	1. Consideration of FDA-approved labeled indications, appropriate dosing and therapies tried and failed. Prescribed by a contracted oncologist. 2. Adjuvant treatment of malignant melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy. Previous failure with other therapies.	Initial starts – 3 month approval Continuations – up to 6 months depending on tolerability to regimen, compliance, evidence of benefit	Requires laboratory test and or diagnostic test to show applicability for initial request and evidence of benefit for renewal requests Mandatory Specialty Program.

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Brand (generic) Name	Criteria	Notes
Antineoplastic, continued Afinitor® Bosulif® Capecitabine (Xeloda) ® Erivedge® Farydak® Gilotrif® Gleevec® Ibrance® Imbruvica® Inlyta® Iressa® Jakafi® Lonsurf® Mekinist® Nexavar® Ninlaro® Odomzo® Pomalyst® Revlimid® Sprycel® Stivarga® Sutent® Tarceva® Tasigna® Temodar® temozolomide® Thalomid® Tykerb® Vandetanib® Votrient® Xalkori® Xtandi® Zelboraf® Zolinza® Zydelig® Zykadia® Zytiga®	**• All oral oncology requests [general]: Consideration for coverage is given for FDA-approved labeled indications, with FDA-approved dosing, and previous therapies tried and failed (some oncology therapies have listed treatments which should be attempted prior to a specific oncology agent). HealthPlus may have preferred agents for specific oncology indications for which a trial of preferred agent(s) is required, documentation of therapeutic failure on preferred agent(s) or documentation of a medical contraindication to preferred agent(s) must be provided.** **• Prescribed by a contracted oncologist.** **• For medications with multiple dosage strengths; minimizing the number of pills used to achieve total daily dose will be enforced** Breast Cancer Medical Information may include (where applicable): • CBC, LFTs, serum bilirubin, serum creatinine • HER2 testing in patients with invasive (early stage or recurrence) breast cancer on the basis of one or more HER2 test results (negative, equivocal or positive) • ER/PR status • mammogram, ultrasound, or MRI Other criteria/notes: • *Afinitor*: (1) post-menopausal women with advanced, hormone receptor +, HER2 negative; (2) previous use of letrozole or anastrozole; (3) a combination of exemestane with everolimus can be considered for patients who progressed within 12 months or on non-steroidal AI, or any time on tamoxifen for endocrine therapy for recurrent or stage IV disease • *Tykerb*: (1) used in combination with capecitabine, traztuzumab, or letrozole; (2) if used with trastuzumab, patient must first try trastuzumab without Tykerb (lapatinib) • *Ibrance*: (1) ER+, HER2- advanced breast cancer; (2) post-menopausal; (3) locally recurrent disease not amendable to surgery or evidence of metastatic disease; (4) no evidence of brain metastases; (5) not received letrozole as either neoadjuvant or adjuvant treatment within the last 12 months; (6) not received previous treatment for advanced breast cancer (Stage III or IV) * consideration may be made on a case-by-case basis	Oncology requests in general: • Medical records (including prior and current therapies), laboratory tests and/or diagnostic tests are required to show applicability for requested indication and evidence of benefit, tolerability, safety and lack of disease progression for renewal requests. • For medications with multiple dosage strengths; minimizing the number of pills used to achieve total daily dose will be enforced Initial starts – 0 to 3 months Continuations – 1 to 6 months depending on tolerability to regimen, compliance, evidence of benefit, and lack of disease progression All off-label, non-FDA-approved indications require submission of supportive documentation in peer-reviewed journals outlining efficacy and safety for the requested indication. Support in NCCN will be taken into consideration. However, HealthPlus may have preferred agents for specific oncology indications for which a trial of preferred agent(s) is required, documentation of therapeutic failure on preferred agent(s) or documentation of a medical contraindication to preferred agent(s) must be provided. Requests are reviewed on a case-by-case basis. NOTE: Scenarios described to the left do not include all approved indications for specific oral oncology agents, or all oral oncology agents. All listed drugs are mandatory specialty

Brand (generic) Name	Criteria	Notes
Antineoplastic, continued Afinitor® Bosulif® Capecitabine (Xeloda) ® Erivedge® Farydak® Gilotrif® Gleevec® Ibrance® Imbruvica® Inlyta® Iressa® Jakafi® Lonsurf® Mekinist® Nexavar® Ninlaro® Odomzo® Pomalyst® Revlimid® Sprycel® Stivarga® Sutent® Tarceva® Tasigna® Temodar® temozolomide® Thalomid® Tykerb® Vandetanib® Votrient® Xalkori® Xtandi® Zelboraf® Zolinza® Zydelig® Zykadia® Zytiga®	CML Medical Information may include (where applicable): • CBC, LFTs • cytogenetic tests (Philidelphia chromosome positive), GIST, C-kit • evidence of T315I mutation (if applicable) Other criteria/notes: • Consideration for Gleevec (first-line); Sprycel (second-line): Based upon overall survival and safety data collected for the three second-line agents available for the management of CML in patients resistant or intolerant to *Gleevec* (imatinib), HealthPlus recommends *Sprycel* (dasatinib) as the preferred second line agent. Tasigna (nilotinib) and Bosulif (bosutinib) will be available for patients who cannot tolerate Sprycel (dasatinib) or progress on Sprycel (dasatinib). NSCLC: Medical Information may include (where applicable): • CBC, LFTs • EGFR testing Other criteria/notes: • *Tarceva*: (1) First-line must be EGFR+ exon 19 deletions or exon 21 (L858R) substitution mutations; (2) second-line if EGFR mutational status unknown or EGFR- after failure of doublet chemotherapy or bevacizumab + chemotherapy or bevacizumab/vinorelibine/cisplatin • *Gilotrif*: (1) Failure or contraindication with Tarceva; (2) For first-line use (if Tarceva is contraindicated) must have EGFR mutation; (3) if member is taking warfarin and cannot take Tarceva – physician may consider Xarelto or Eliquis (to replace warfarin if feasible) and proceed with Tarceva • *Xalkori*: (1) Metastatic ALK + NSCLC • *Zykadia*: (1) Metastatic ALK + NSCLC; (2) Failure or contraindication to Xalkori (crizotinib)	

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Antineoplastic, continued Afinitor® Bosulif® Capecitabine (Xeloda) ® Erivedge® Farydak® Gilotrif® Gleevec® Ibrance® Imbruvica® Inlyta® Iressa® Jakafi® Lonsurf® Mekinist® Nexavar® Ninlaro® Odomzo® Pomalyst® Revlimid® Sprycel® Stivarga® Sutent® Tarceva® Tasigna® Temodar® temozolomide® Thalomid® Tykerb® Vandetanib® Votrient® Xalkori® Xtandi® Zelboraf® Zolinza® Zydelig® Zykadia® Zytiga®	Multiple Myeloma: Medical Information may include (where applicable): • CBC, SCr, pregnancy test, Celgene authorized • May require anticoagulation • Ninlaro – consideration should be given to use of bortezomib (Velcade) for proteasome inhibitor Other criteria/notes: *Farydak (panobinostat):* Reviewed for FDA-approved indication for the treatment of patients with multiple myeloma who have received at least 2 prior regimens, including bortezomib and an immunomodulatory agent • Documented diagnosis of multiple myeloma • Taken in combination with bortezomib and dexamethasone • Inadequate response to at least two (2) prior regimens, including bortezomib and an immunomodulatory agent • Prescribed by oncologist or hematologist [Cautions- cardiac arrhythmia, severe diarrhea, drug interactions] Required labs • CBC with differential • ECG • LFTs • Pregnancy testing • Serum electrolytes • Cytogenetic tests • FISH results • MRI, CT, or PET Limitations: Maximum 16 cycles	

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Antineoplastic, continued Afinitor® Bosulif® Capecitabine (Xeloda)® Erivedge® Farydak® Gilotrif® Gleevec® Ibrance® Imbruvica® Inlyta® Iressa® Jakafi® Lonsurf® Mekinist® Nexavar® Ninlaro® Odomzo® Pomalyst® Revlimid® Sprycel® Stivarga® Sutent® Tafinlar® Tarceva® Tasigna® Temodar® temozolomide® Thalomid® Tykerb® Vandetanib® Votrient® Xalkori® Xtandi® Zelboraf® Zolinza® Zydelig® Zykadia® Zytiga®	Prostate Cancer: Medical Information may include (where applicable): • Gleason score, PSA CLL/SLL: Medical Information may include (where applicable): • SCr, BUN Other criteria/notes: • Imbruvica is preferred • Zydelig may be considered for patients that fail or contraindications to Imbruvica Melanoma: Medical Information may include (where applicable): • LFTs, SCr, ejection fraction, echocardiogram • BRAF mutational testing Other criteria/notes: • Vemurafenib, dabrafenib, and trametinib are only to be used in BRAF-mutated tumors. ***Trametinib*** is not to be used in a patient who has already received BRAF inhibitor therapy. • Note that combination therapy with Tafinlar and Mekinist will be considered on a case by case basis. Tafinlar - Indicated for unresectable or metastatic melanoma possessing a V600E mutant BRAF kinase Criteria V600E BRAF mutation • Dabrafenib has some evidence for efficacy in patients with brain metastases • Mekinist - Indicated for unresectable or metastatic melanoma containing a V600E or V600K mutated BRAF Criteria V600E or V600K BRAF mutation Has not previously received BRAF inhibitor therapy (vemurafenib or trametinib) Basal Cell Carcinoma Erivedge or Odomzo – consideration for dermatology as specialist	

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Brand (generic) Name	Criteria	Notes
Antineoplastic, continued Targretin® (Oral) (bexarotene)	1. Consideration of FDA-approved labeled indications, appropriate dosing and therapies tried and failed. 2. Prescribed by a contracted dermatologist or oncologist. 3. 18 years and older. 4. FDA-approved for the treatment of cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) (aka Mycosis Fungoides/Sezary Syndrome), for patients who are refractory to at least one prior systemic therapy for CTCL. 5. Documented prior treatment failure (refractory or persistent disease) after failure of ONE of the following systemic treatment regimens: a) Chemotherapy (Examples: methotrexate, doxorubicin, gemcitabine, cyclophosphamide, etopiside, etc.) b) Interferon alfa and gamma 6. Pregnancy must be excluded prior to administration; appropriate contraceptive methods must be used.	Targretin capsules and gel are category X and may cause fetal harm when administered to pregnant women. Baseline LFTs should be obtained, and carefully monitored after one, two, four weeks of treatment initiation; then every eight weeks during treatment. Monitoring involves liver function tests, fasting lipid panel, WBC, thyroid function tests. Oral capsule is available in generic formulation. Mandatory Specialty Program

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals **HIV Medications** **All Products Containing Abacavir** Epzicom® (abacavir sulfate/lamivudine) Triumeq® (abacavir/ dolutegravir/lamivudi) Trizivir® (abacavir sulfate/ lamivudine/zidovudine) Ziagen® (abacavir)	1. The patient has been screened for the HLA-B*5701 allele with a negative test result. New Starts Only		
All Products Containing Rilpivirine Complera® (emtricitabine/rilpivirine/ tenofovir) Edurant® (rilpivirine**)** Odefsey® (emtricitabine/rilpivirine/tenofovir AF)	1. The patient has a HIV-1 RNA level less than or equal to 100,000 copies/mL; AND 2. The patient has a confirmed CD4+ count greater than or equal to 200 cells/mm3. New Starts Only	Approval is limited to 12 months	
Evotaz® (atazanavir/cobicistat) Prezcobix® (darunavir/cobicistat)	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing		Limited to a quantity of 1 unit per day
Fuzeon® (enfuvirtide)	1. For new starts, patient must have a diagnosis of HIV-1; **AND** 2. Fuzeon must be used in combination with other anti-retroviral agents; **AND** 3. Patient must be anti-retroviral treatment-experienced; **AND** 4. Evidence of HIV-1 replication despite ongoing anti-retroviral therapy; **AND** 5. Patient or caregiver is able to demonstrate appropriate techniques for administration of Fuzeon.	Long-term	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals **HIV Medications, continued** **Protease Inhibitors** saquinavir® (Invirase) tipranavir® (Aptivus)	1. Patient is concomitantly receiving the boosting agent ritonavir (Norvir tablets or capsules), **AND** 2. Pharmacy submits the claims for the boosting agent and the protease inhibitor on the same day according to the required protocol. New Starts Only		1. A pharmacy must first submit, and receive, an adjudicated claim for the boosting agent ritonavir (Norvir Tablets or Capsules). 2. Once the ritonavir claim is accepted, the pharmacy may then submit a claim for the prescribed protease inhibitor. 3. Claims must be submitted on the same day. If Norvir is reversed, accompanying PI must also be reversed. If submitted out of order, the pharmacy will receive a message stating "Norvir boosting required for his agent. Please submit ritonavir (Norvir) prior to adjudicating the primary protease inhibitor".

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals **HIV Medications, continued** Prezista® (darunavir)	1. Patient is concomitantly receiving the boosting agent Norvir or Tybost, **AND** 2. Pharmacy submits the claims for the boosting agent and the protease inhibitor on the same day according to the required protocol.		1. A pharmacy must first submit, and receive, an adjudicated claim for the boosting agent Norvir or Tybost. 2. Once the Norvir or Tybost claim is accepted, the pharmacy may then submit a claim for the prescribed protease inhibitor. 3. Claims must be submitted on the same day. If the boosting agent is reversed, accompanying PI must also be reversed. If submitted out of order, the pharmacy will receive a message stating "Boosting required for his agent. Please submit Norvir or Tybost prior to adjudicating the primary protease inhibitor".
Selzentry® (maraviroc)	1. The patient has had a coreceptor tropism assay confirming the presence of only CCR5 tropic HIV-1 virus. New Starts Only		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals **HIV Medications, continued** Tivicay® (dolutegravir)	1. A dose exceeding one per day, up to a maximum of two per day, will only be authorized under the following circumstances: a. For pediatric patients 12 years of age and < 18 years of age, weighing at least 40kg, documentation of the following is required: i. Concurrent therapy with efavirenz, fosamprenavir/ritonavir, tipranavir/ritonavir or rifampin (due to induction of UGT1A1 and CYP3A mediated dolutegravir metabolism which may result in decreased dolutegravir serum concentrations, treatment failure, and the development of drug resistance). b. For patients ≥ 18 years of age, documentation of one of the following is required: i. Concurrent therapy with efavirenz, fosamprenavir/ritonavir, tipranavir/ritonavir or rifampin (due to induction of UGT1A1 and CYP3A mediated dolutegravir metabolism which may result in decreased dolutegravir serum concentrations, treatment failure, and the development of drug resistance); **OR** ii. Integrase strand transfer inhibitor (INSTI)-associated resistance substitutions or clinically suspected INSTI-resistance as outlined in section 12.4 (Microbiology/Resistance) of the FDA approved prescribing information document for Tivicay.		Limited to a quantity of 1 unit per day
Truvada® (emtricitabine/tenofovir disoproxil fumarate)	**DOSE OPTIMIZATION ONLY** **NOTE:** System edits apply for prescription claims submitted for more than once daily dosing		Limited to a quantity of 1 unit per day
Tybost® (cobicistat)	1. Member is concurrently receiving Reyataz (atazanavir) 300 mg once daily; **OR** 2. Member is concurrently receiving Prezista (darunavir) 800 mg once daily.		Limited to a quantity of 1 unit per day

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals **HIV Medications, continued** Vitekta (elvitegravir)	1. Patient is concomitantly receiving the appropriate dose of the boosting agent ritonavir (Norvir tablets or capsules) a. If being used concomitantly with ritonavir 100 mg once daily in combination with atazanavir 300 mg once daily (Norvir+Reyataz), the recommended Vitekta dose is 85 mg once daily. b. If being used concomitantly with ritonavir 100 mg twice daily in combination with lopinavir 400 mg twice daily (Kaletra), the recommended Vitekta dose is 85 mg once daily. c. If being used concomitantly with ritonavir 100 mg twice daily in combination with either darunavir 600 mg twice daily (Norvir+Prezista) or fosamprenavir 700 mg twice daily (Norvir+Lexiva), the recommended dose is 150 mg once daily. d. If being used concomitantly with ritonavir 200 mg twice daily in combination with tipranavir 500 mg twice daily (Norvir+Aptivus), the recommended Vitekta dose is 150 mg once daily. 2. Pharmacy submits the claims for the boosting agent and the Vitekta on the same day according to the required protocol.		Limited to a quantity of 1 unit per day 1. A pharmacy must first submit, and receive, an adjudicated claim for the boosting agent ritonavir (Norvir Tablets or Capsules). 2. Once the ritonavir claim is accepted, the pharmacy may then submit a claim for Vitekta. 3. Claims must be submitted on the same day. If Norvir is reversed, Vitekta must also be reversed. If submitted out of order, the pharmacy will receive a message stating “Norvir boosting required for his agent. Please submit ritonavir (Norvir) prior to adjudicating Vitekta”.

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Brand (generic) Name	Criteria	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**General Coverage Criteria (for all Genotypes)** 1. Therapy is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist; **AND** 2. Patient must have compensated liver disease (CPT A {CPT score <6}; not CPT B or C); **AND** 3. Patient has advanced fibrosis as documented by a. Liver biopsy-proven fibrosis staging score of F3 or F4 on the IASL, Batts-Ludwig, or Metavir fibrosis staging scales; **OR** b. Liver biopsy fibrosis staging score greater than or equal to F4 on the Ishak fibrosis staging scale; **OR** c. If documentation contraindicating a liver biopsy is provided, medical imaging-proven fibrosis staging score of F3 or F4 on IASL, Batt-Ludwig, or Metavir scales or greater than or equal to F4 on Ishak scale; **AND** 4. Patient has abstained from the use of unauthorized or illicit drugs and alcohol for a minimum of 3 months immediately prior to therapy as evidenced by a MAPS report and blood serum testing (results must be submitted with request and include COC, THC, OPI, AMP, BZO, BAR, BUP, MDMA, MTD, OXY); **AND** 5. Patient has not initiated treatment to facilitate cessation of drug and/or alcohol abuse in the last 6 months; **AND** 6. If patient has a history of substance abuse, patient must be enrolled in HealthPlus case management for the duration of treatment as deemed appropriate by HealthPlus case management; **AND** 7. Patient must not have received a liver transplant; **AND** 8. Member does not have severe renal impairment (eGFR <30ml/min/1.73m^2) or end stage renal disease requiring hemodialysis; **AND** 9. Patient does not have significant or unstable heart disease (indicated by NYHA Functional Class III-IV or Objective Assessment Class C-D); **AND** 10. A quantitative HCV-RNA test must be drawn at week 4 to evaluate patient response, adherence to therapy, and/or treatment futility if applicable; **AND** 11. Authorization of primary oral Hepatitis C agents is limited to one treatment course per lifetime; 12. Patient must sign an acknowledgment of criteria prior to initiation of therapy; **AND** drug specific criteria are met.	**Limitations:** 1. For all members, a one-time approval for any direct-acting antiviral (DAA) will be granted if criteria are met. Due to lack of evidence in peer reviewed literature regarding outcomes with repeated courses of therapy after failure of novel direct acting antiviral agents, additional courses of therapy will not be approved based on medical necessity. 2. Regimens for which clinical evidence supports interferon concomitant therapy use, interferon must be used. The only exceptions for NOT using interferon: a. Previous adverse reaction with interferon that led to discontinuation of treatment: i. Hematologic toxicity: ANC <500/mm3 or platelets < 25,000/mm3 ii. Hypersensitivity reaction (acute, serious), ophthalmic disorders (new or worsening), thyroid abnormality development (which cannot be normalized with medication), signs or symptoms of liver failure. iii. Liver function abnormality, pulmonary infiltrate development, evidence of pulmonary function impairment, or autoimmune disorder development, triglycerides >1000 mg/dL. **(Continued on next page)**

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Brand (generic) Name	Criteria	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Harvoni:** 1. Consideration for coverage of dosing and duration in **HCV mono-infected Genotype 1:** a. Treatment naïve, without cirrhosis (and Metavir F3), with baseline HCV RNA < 6million IU/mL i. Once daily therapy of ledipasvir/sofosbuvir for 8 weeks b. Treatment naïve; with cirrhosis or without cirrhosis (and Metavir F3), with baseline HCV RNA > 6 million IU/mL: i. Once daily therapy of ledipasvir/sofosbuvir for 12 weeks c. Treatment experienced, without cirrhosis (and Metavir F3) i. Once daily therapy of ledipasvir/sofosbuvir for 12 weeks d. Treatment experienced, with cirrhosis i. Once daily therapy of ledipasvir/sofosbuvir + weight-based ribavirin for 12 weeks ii. Exception to receive Harvoni monotherapy for 24 weeks if medical documentation supports an intolerance to ribavirin (see Limitations)	**Limitations Cont:** iv.Major neuropsychiatric disorders (uncontrolled depression during treatment) b.Member has not tried interferon, but has the following: i. autoimmune hepatitis, hepatic decompensation; CrCl<50; hemoglobinopathies (e.g. ITP); didanosine therapy; demonstrated psychiatric disease with recent suicide attempt and/or treatment resistant depression (patient is on active therapy). 3. Regimens for which clinical evidence supports ribavirin concomitant therapy use, ribavirin must be used. The only exceptions for NOT using ribavirin: a. Previous adverse reaction with ribavirin that led to discontinuation of treatment, or CBC results within the past month i. Hematologic toxicity: ANC <750/mm3 or platelets <50,000/mm3 ii. Hemoglobin <10g/dL iii. Hypersensitivity reaction (acute, serious) **(Continued on next page)**

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Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Harvoni Cont…:** 2. Consideration for coverage of dosing and duration in **HCV mono-infected Genotype 4, Genotype 5, or Genotype 6:** a. Treatment naïve or treatment experienced with cirrhosis or without cirrhosis (and Metavir F3) i. Once daily therapy of ledipasvir/sofosbuvir for 12 weeks 3. Consideration for treatment experienced patients are for those who have tried and failed prior therapy with peginterferon/ribavirin or peg-interferon/ribavirin + protease inhibitor (PI: telaprevir, boceprevir, simeprevir) 4. Ledipasvir/sofosbuvir (Harvoni) is NOT covered in the following clinical scenarios due to lack of published literature in peer-reviewed journals demonstrating established safety and/or efficacy for use: a. Hepatocellular carcinoma b. Co-infection with Hepatitis B c. Concomitant use of telaprevir, boceprevir, or simeprevir therapy d. Previous treatment history with sofosbuvir and/or ledipasvir/sofosbuvir **Sovaldi:** ***Sovaldi may be considered (once all general coverage criteria are satisfied) for Genotype 2, and Genotype 3 (specific criteria for use of Sovaldi may be required).*** *Sofosbuvir* is **NOT** covered in the following clinical scenarios due to lack of published literature in peer-reviewed journals demonstrating established safety and/or efficacy for use: a. Genotype 1 (refer to *Ledipasvir/sofosbuvir* (Harvoni©)) b. Pre- and Post-liver transplant [c] c. Monotherapy use of *sofosbuvir* [c] d. Member is treatment experienced with regimens that include prior history with protease inhibitors (telaprevir, boceprevir, simeprevir), or *sofosbuvir* [c] e. Genotype 5 and Genotype 6 [c]	b. Member has not tried ribavirin, but has the following: i. autoimmune hepatitis or other autoimmune condition known to be exacerbated by ribavirin, hepatic decompensation (Child Pugh score > 6; class B); pregnant or partner is pregnant, hemoglobinopathies (e.g. thalassemia major, sickle cell disease); documented history of significant or unstable cardiac disease; hemolytic anemia; pancreatitis; CrCl<50 In general coverage criteria, the statement regarding renal insufficiency, "Member does not have severe renal impairment (eGFR < 30 ml/min/1.73m2) or end stage renal disease requiring hemodialysis" is not applicable for requests for Zepatier. All other general coverage criteria apply. All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. [c]*HealthPlus/HAP clinical criteria used to determine coverage are based upon FDA-approved indications supported with publication of at least one completed study in peer-reviewed journal.*

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Brand (generic) Name	Criteria	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Zepatier:** **Note: All general coverage criteria MUST BE SATISFIED prior to drug specific coverage criteria being reviewed for all scenarios outlined EXCEPT for use of Zepatier in HCV/HIV-1 co-infected Genotype 1 or Genotype 4.** 1. Consideration for coverage of dosing and duration in **HCV mono-infected and HCV/HIV-1 co-infected Genotype 1a:** a.Treatment naïve or PegIFN/RBV-experienced without baseline NS5A polymorphisms, with or without cirrhosis (and Metavir F3) i. 12 weeks b. Treatment naïve or PegIFN/RBV-experienced with baseline NS5A polymorphisms, with or without cirrhosis (and Metavir F3) i. 16 weeks + weight-based ribavirin 2. Consideration for coverage of dosing and duration in **HCV mono-infected and HCV/HIV-1 co-infected Genotype 1b:** a. Treatment naïve or PegIFN/RBV-experienced (regardless of NS5A polymorphisms), with or without cirrhosis (and Metavir F3) i. 12 weeks 3. Consideration for coverage of dosing and duration in **HCV mono-infected and HCV/HIV-1 co-infected Genotype 1a or 1b:** a. PegIFN/RBV/HCVNS3/4A Protease inhibitor-experienced (e.g. boceprevir, telaprevir, simeprevir), with or without cirrhosis (and Metavir F3) i. 12 weeks + weight-based ribavirin	All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. **See Limitations Above (Starts on Page 52)**

Brand (generic) Name	Criteria	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Zepatier Cont.:** 4. Consideration for coverage of dosing and duration in **HCV mono-infected and HCV/HIV-1 co-infected Genotype 4:** a. Treatment naïve (regardless of NS5A polymorphisms), with or without cirrhosis (and Metavir F3) i. 12 weeks b. PegIFN/RBV-experienced (regardless of NS5A polymorphisms), with or without cirrhosis (and Metavir F3) i. 16 weeks + weight-based ribavirin 5. General coverage criteria in the setting of renal impairment (CKD 4/5), including hemodialysis, must be satisfied for use of Zepatier in Genotype 1.	All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. **See Limitations Above** **(Starts on Page 52)**

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Brand (generic) Name	Criteria	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Technivie:** 1. Patient is ≥18 yo and must have a documented diagnosis of Hepatitis C genotype 4; **AND** 2. Patient does not have mild hepatic impairment (Child-Pugh B) or cirrhosis (compensated or decompensated); **AND** 3. Due to the potential for cross resistance, patient has not received treatment with any NS5A inhibitors in the past; **AND** 4. Technivie is coadministered with ribavirin unless patient is treatment naïve and documentation is submitted that patient is intolerant of ribavirin; **AND** 5. Liver function tests are performed at prior to starting Technivie (within 3 months) and during the first 4 weeks of treatment; **AND** 6. Patient is not taking any ethinyl estradiol-containing medications; **AND** 7. Patient's current medications have been reviewed for potential interactions. Patient is not receiving any medications that are not recommended for use with Technivie; 8. Patient is not nursing or pregnant; **AND** 9. Baseline HCV-RNA level is submitted; **AND** 10. Patient has met all class criteria for oral hepatitis C therapy agents.	Limit of 28 tablets per 14 days All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. *Due to the risk of ALT elevations associated with ethinyl estradiol-containing medications, alternative methods of contraception (e.g., progestin only or non-hormonal methods) are recommended while on Technivie. **See Limitations Above** **(Starts on Page 52)**

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Brand (generic) Name	Criteria	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Victrelis:** 1. The patient has not previously been treated with a primary oral Hepatitis C drug, and has a documented contraindication to the preferred formulary agent for treatment of Genotype 1 Hepatitis C. 2. Patient must have a documented diagnosis of Hepatitis C (HCV) genotype 1, **AND** 3. Patient has concurrent therapy with both ribavirin and pegylated interferon, **AND** 4. Patient has not received HCV treatment with a protease inhibitor in the past, **AND** 5. Viral loads (HCV-RNA test) must be drawn at 8, 12, and 24, weeks after starting therapy. Treatment is considered futile and prior authorization will be rescinded if HCV-RNA level is ≥1000 IU/ml at week 8, ≥100 IU/ml at week 12, or detectable at week 24; **AND** 6. Initial duration of approval is for 10 weeks; **AND** 7. Authorization is renewed for an additional 4 weeks provided HCV-RNA levels at week 8 are not indicative of treatment futility; **AND** 8. Authorization is renewed for an additional 12 weeks if HCV-RNA levels at week 12 are not indicative of treatment futility; **AND** 9. Authorization can be approved for up to a total of 48 weeks, in accordance with prescribing guidelines, if HCV-RNA is undetectable at week 24.	All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. **See Limitations Above (Starts on Page 52)**

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Viekira Pak:** 1. The patient has not previously been treated with a primary oral Hepatitis C drug, and has a documented contraindication to the preferred formulary agent for treatment of Genotype 1 Hepatitis C. 2. Patient is ≥18 yo and must have a documented diagnosis of Hepatitis C genotype 1; **AND** 3. Patient does not have decompensated liver disease or severe hepatic impairment as evidenced by a recent liver panel drawn in the last month; 4. Patient's current medications have been reviewed for potential interactions. a. Patient is not taking any medication that is contraindicated with Viekira Pak (e.g., ethinyl estradiol containing contraceptives, lovastatin, simvastatin, St. John's wort, gemfibrozil, carbamazepine, phenytoin, ergotamine, triazolam, etc.); **AND** b. Patient is not receiving any medications that could potentially interact significantly with Viekira Pak; if so, dosages have been adjusted as recommended (e.g., selected antiarrhythmic agents, selected antifungals, amlodipine, furosemide, rosuvastatin, pravastatin, cyclosporine, tacrolimus, antiviral agents, omeprazole, alprazolam, etc.,); **AND** **c.** Patient is not taking any other drug which could increase or decrease the level of any of the components of Viekira Pak; **AND** 5. Patient is not nursing or pregnant; **AND** 6. Baseline HCV-RNA level is submitted; **AND** 7. Patient has met all class criteria for oral hepatitis C therapy agents.	Duration of approval is for 12 weeks unless documentation is provided where 24 weeks is indicated for 1) genotype 1a, 2) cirrhosis, and 3) null response to previous therapy.	Limit of 1 daily dose pak per day. All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. **See Limitations Above** **(Starts on Page 52)**

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Olysio:** 1. The patient has not previously been treated with a primary oral Hepatitis C drug, and has a documented contraindication to the preferred formulary agent for treatment of Genotype 1 Hepatitis C. 2. Patient must have a documented diagnosis of Hepatitis C genotype 1 without an NS3 Q80K polymorphism; **AND** 3. Patient has concurrent therapy with both ribavirin and pegylated interferon; **AND** 4. Patient has not received HCV treatment with a protease inhibitor in the past; **AND** 5. Patient does not have an allergy to sulfonamides; **AND** 6. Patient's current medications have been reviewed for potential interactions. Patient is not receiving any medications that are not recommended for use with Olysio (simeprevir); **AND** 7. Viral loads (HCV-RNA test) must be drawn at 4 weeks after starting therapy. Treatment is considered futile and prior authorization will be rescinded if HCV-RNA level is >25 IU/mL after 4 weeks.	**Olysio:** Initial duration of approval is for 6 weeks. Authorization is renewed for an additional 6 weeks provided HCV-RNA levels at week 4 are not indicative of treatment futility	All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. **See Limitations Above (Starts on Page 52)**

Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals, continued **All Primary Oral Hepatitis C Treatments** **Formulary** Harvoni® (ledipasvir/sofosbuvir) Sovaldi® (sofosbuvir) Zepatier® (elbasvir/ grazoprevir) **Non-Formulary** Technivie® (ombitasvir/ paritaprev/ ritonav) Victrelis® (boceprevir) Viekira Pak/Viekira XR® (ombitasvir/ paritaprevir/ritonavir/ dasabuvir) Olysio® (simeprevir) Daklinza® (daclatasvir) Epclusa® (sofosbuvir/velpatasvir)	**Daklinza:** 1. Patient is ≥18 yo and must have a documented diagnosis of Hepatitis C genotype 3; **AND** 2. Patient does not have cirrhosis (compensated or decompensated); **AND** 3. Due to the potential for cross resistance, patient has not received treatment with any NS5A inhibitors in the past; **AND** 4. Daklinza is coadministered with Sovaldi (sofosbuvir); **AND** 5. Patient's current medications have been reviewed for potential interactions. Patient is not taking any medication that significantly interacts with Daklinza. a. Patient is not taking amiodarone, digoxin, or dabigatran (Pradaxa); **AND** b. Patient is not receiving strong CYP3A inducers (e.g., phenytoin, carbamazepine, rifampin, St. John's wort) or any other any medications that would reduce the concentration of daclatasvir or sofosbuvir; **AND** c. The dosage of Daklinza is increased as recommended by the manufacturer for patients taking moderate CYP3A inducers (e.g., dexamethasone, etravirine, modafinil, efavirenz, nafcillin); **AND** d. The dosage of Daklinza is reduced as recommended by the manufacturer for patients taking strong CYP3A inhibitors (e.g. ritonavir, ketoconazole, voriconazole); **AND** 6. Patient is not nursing or pregnant; **AND** 7. Baseline HCV-RNA level is submitted; **AND** 8. Patient has met all class criteria for oral hepatitis therapy agents.	Duration of approval is dependent on treatment experience, presence of cirrhosis and viral load prior to therapy initiation. • Treatment-naïve patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL: 8 weeks • Treatment-naïve with or without cirrhosis: 12 weeks • Treatment-experienced without cirrhosis: 12 weeks • Treatment-experienced with cirrhosis: 24 weeks	Quantity is limited to 14 tablets per 14 days. All Hepatitis C treatments (primary/adjunctive/oral/injectable) are included in the mandatory specialty program. Prescriptions are limited to 14 day supplies for all Hepatitis-C products to monitor adherence to therapy. Viral loads (HCV-RNA test) should be drawn at 4 weeks to monitor patient response and adherence to therapy. Viral loads will be requested 12 weeks after therapy completion to document patient response. **See Limitations Above (Starts on Page 52)**

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals, continued Intron A® (interferon alpha-2b)	1. For diagnosis of hairy cell leukemia, malignant melanoma, follicular lymphoma, AIDS related Kaposi's Sarcoma and CML, patients must be >18 years of age; **OR** 2. For the diagnosis of condylomata acuminata, documented failure of, or intolerance to**,** traditional treatment modalities (e.g., podofilox, imiquimod, acid-therapy, or surgical options); **OR** 3. For the diagnosis of chronic hepatitis B, patients must have documented liver disease and hepatitis B viral replication; **OR** 4. For the diagnosis of chronic hepatitis C, allow 6-month initial authorization and 6-month renewal permitted if the patient has Genotype 1 HCV; or has initial viral load >2 million copies/mL.	Approvals for diagnosis of condylomata acuminata should be approved for 4 months. Approvals for all other diagnoses should be approved for 6 months.	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
<u>Antivirals,</u> continued **On Formulary with PA:** Pegasys, Proclick® (pegylated interferon alfa-2a) **Non-Formulary with PA:** Peg-Intron® (pegylated interferon alfa-2b)	1. Patient has diagnosis of Hepatitis B or C, **AND** 2. Peg-Intron requires prior authorization for documented failure of or intolerance to Pegasys, **AND** 3. Approval is for 48 weeks provided that HCV-RNA levels are not indicative of treatment futility. Viral loads (HCV RNA test) must be drawn to evaluate treatment futility. a. For pegylated interferon in combination with ribavirin, prior authorization will be rescinded if HCV-RNA is detectable after 24 weeks. b. For combination therapy involving a protease inhibitor, patient must meet criteria associated with the protease inhibitor. Prior authorization will be rescinded if: 1. HCV-RNA level is >100 IU/ml after 12 or 24 weeks of combination therapy with Victrelis New Starts Only	Initial authorization approved for 6 months. Renewal approved for 6 months. -renewal permitted if the patient has Genotype 1 HCV; or has initial viral load >2 million copies/mL.	
RibaPak® (ribavirin) RibaTab® (ribavirin)	1. Patient must have a chart documented trial or Rx claims for generic ribavirin 200 mg tablets or capsules.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Antivirals, continued Synagis® (palivizumab)	1. Infants and children younger than 2 years of age with documented chronic lung disease (CLD), born less than 32 weeks gestation, who have required medical therapy (e.g., supplemental oxygen, bronchodilator, diuretics, or corticosteroid therapy) for their CLD within 6 months before the anticipated RSV season may receive a maximum of 5 monthly doses; **OR** 2. Infants born at 28 weeks gestation (up to and including 28 weeks, 6 days) or earlier without CLD and who are 12 months of age or younger may receive a maximum of 5 monthly doses; **OR** 3. Infants and children who are 12 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD) or severe immunodeficiencies may receive a maximum of 5 doses. 4. Infants and children who have either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions may receive a maximum of 5 doses during the first year of life. 5. Infants and children less than 24 months of age who undergo cardiac transplantation during the RSV season. 6. Infants and children less than 24 months of age who are profoundly immunocompromised (e.g., solid organ or hematopoietic stem cell transplantation or receiving chemotherapy) during the RSV season.	Approved for 5 months interval, during the region's RSV season, beginning as soon as October and ending as late as April.	Monthly prophylaxis should be discontinued for any child who is hospitalized for RSV.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Bisphosphonates Reclast® (zoledronic acid)	1. Creatinine clearance is > 35 ml/min; **AND** 2. Documented failure of, or intolerance to, an oral bisphosphonate agent; **AND** 3. Patient has a diagnosis of osteoporosis or is postmenopausal with osteopenia as indicated by a t-score <-1; **OR** 4. Diagnosis of Paget's disease; **OR** 5. Patient is considered high-risk (e.g., recent low-trauma hip fracture) and Reclast® is indicated for secondary fracture prophylaxis.	Approved for 1 year Dose optimization not to exceed 5mg once a year (with the exception of Paget's disease)	Retreatment may be necessary for patients with Paget's disease who have relapsed, so there is no defined dosing frequency. When treating Paget's disease, patients should receive 1500 mg elemental calcium daily in divided doses (750 mg two times a day, or 500 mg three times a day) and 800 IU vitamin D daily, particularly in the 2 weeks following administration to prevent hypocalcemia. For osteoporosis treatment (postmenopausal, in men, and glucocorticoid induced), concomitant treatment with an average of at least 1200 mg calcium and 800-1000 IU vitamin D daily is recommended (dietary + supplemental).

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Chelating Agents Jadenu® (deferasirox)	1. Patient must have diagnosis of chronic iron overload due to blood transfusions demonstrated by transfusion of at least 100 mL/kg of packed red blood cells and a serum ferritin consistently greater than 1,000 mcg/L; **AND** 2. Patient must be 2 years of age or older; **AND** 3. Patient must have a creatinine clearance ≥ 40 mL/min and a platelet count of ≥ 50 x 10^9/L. **OR** 1. Patient must have diagnosis of chronic iron overload in patients with non-transfusion-dependent thalassemia (NTDT) syndromes; **AND** 2. Patient must be 10 years of age or older; **AND** 3. Serum ferritin greater than 300 mcg/L; **AND** 4. Patient must have a creatinine clearance ≥ 40 mL/min and a platelet count of ≥ 50 x 10^9/L.		Prescriptions are limited to 14 day supplies to monitor adherence to therapy. Jadenu® is considered a specialty drug and will be included in the Mandatory Specialty Program.
Syprine® (trientine)	1. The patient must be ≥ 2 years of age; **AND** 2. The patient must have a diagnosis of Wilson's disease; **AND** 3. The patient must have intolerable or life endangering side effects to penicillamine.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Cystic Fibrosis Treatments Kalydeco® (ivacaftor)	1. Patient has a diagnosis of cystic fibrosis with documentation of a G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H mutation in the CFTR gene; **AND** 2. Patient must be 2 years of age or older; **AND** 3. Patient must have a recent (within the last 3 months) liver function panel, **AND** 4. The patient is not homozygous for the F508del mutation in the CFTR gene.	Approved for 1 year	Quantity is limited to 60 units per 30 days.
Orkambi® (lumacaftor/ ivacaftor)	1. Patient has a diagnosis of cystic fibrosis with documentation of the F508del mutation on both alleles of the CFTR gene (homozygous); **AND** 2. Patient must be 12 years of age or older; **AND** 3. Patient must not have advanced liver disease (Child-Pugh Class C); **AND** 4. Baseline (within the last 3 months) liver function panel and ophthalmic evaluation must be submitted; **AND** 5. Patient's current medications have been reviewed for potential interactions. a. Patient must not be taking any medication that significantly reduces the concentration of Orkambi (e.g., CYP3A inducers such as rifampin, phenobarbital, carbamezapine, phenytoin or St. John's wort); **AND** b. Patient is not taking any sensitive CYP3A substrates or CYP3a substrates with a narrow therapeutic range (e.g., midazolam, triazolam, cyclosporine, everolimus, sirolimus, or tacrolimus).	Authorization is limited to 1 year. Recertification requires documentation that a. Patient's disease has not progressed while on therapy; **AND** b. Serum transaminases and bilirubin are not elevated beyond what is recommended in package insert; **AND** c. Any development of lens opacities/ cataracts has been evaluated for risk vs. benefit of patient.	Prescriptions are limited to 14 day supplies to monitor adherence to therapy. Quantity is limited to 56 capsules per 14 days. Orkambi is considered a specialty drug and will be included in the Mandatory Specialty Program. **NOTE:** Patients should be educated that Orkambi may substantially decrease hormonal contraceptive exposure, reducing their effectiveness and increasing the incidence of menstruation-associated adverse reactions. Hormonal contraceptives, including oral, injectable, transdermal, and implantable, should not be relied upon as an effective method of contraception when co-administered with Orkambi.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Enzymes Cerezyme® (imiglucerase) VPRIV™ (velaglucerase alfa)	1. The patient must have a diagnosis of Type 1 (non-neuronopathic or adult) Gaucher's disease with evidence of at least 1 of the following: - Moderate to severe anemia **OR** - Thrombocytopenia **OR** - Bone disease **OR** - Hepatomegaly **OR** - Splenomegaly	Long-term Evaluate initially at 3 month intervals for maintenance dose reductions/ development of sensitivity	Recommended dose: **Cerezyme** Initial dosage may begin at 2.5 units/kg of body weight infused 3 times a week up to as much as 60 units/kg administered as frequently as once a week or as infrequently as every 4 weeks. **VPRIV** Dose 60units/kg IVPB every other week.
Fabrazyme® (agalsidase)	1. The patient must have diagnosis of Fabry disease	Evaluate in 3 months for response/development of sensitivity	Recommended dose: 1mg/kg infused once every 2 weeks Pt should receive antipyretics prior to infusion Precaution: Most patients will develop IgG antibodies to Fabrazyme; physicians should periodically monitor IgE levels/Fabrazyme sensitivity
Myozyme® (alglucosidase alfa)	1. The patient must have diagnosis of Pompe disease (GAA deficiency)	Evaluate in 3 months for response/development of sensitivity	Recommended dose: 20 mg/kg body weight infused every 2 weeks Precaution: Risk of hypersensitivity and sudden cardiac death

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Erythrocyte Stimulating Agents Aranesp® (darbepoetin alfa) Epogen® (epoetin alfa) Procrit® (epoetin alfa)	1. The patient must have a diagnosis of anemia associated with a. chronic renal failure, **OR** b. cancer treated with chemotherapy, **OR** c. zidovudine-treated HIV infection, **OR** d. hepatitis C, **OR** e. chronic disease, **OR** f. prematurity, **OR** g. myelodysplastic syndrome, **OR** h. rheumatoid arthritis, **AND** 2. Hgb level is < 11g/dL or < 10g/dL if on cancer chemotherapy; **OR** 1. Treatment is needed to reduce the need for allogenic blood transfusion prior to surgery for anemic patients (Hgb >10 to ≤ 13g/dL) who are at high risk for perioperative blood loss from elective, non-cardiac, non-vascular surgery.		For each of the conditions listed (except for allogenic blood transfusion), therapy is to be discontinued when Hgb level > 11g/dL OR after 8 weeks of therapy if there has been no response as measured by hemoglobin levels.
Growth Factor, Recombinant Insulin-like Increlex® (mecasermin [rDNA origin] injection)	1. Patient has a diagnosis of primary IGF-1 deficiency or GH gene deletion, **AND** 2. Increlex is prescribed by or after consultation with a pediatric endocrinologist, **AND** 3. Patient is 2 years to 18 years of age, **AND** 4. Epiphyses are open, **AND** 5. Patient's bone age is < 16 years for males or < 14 years for females	1 year	Starting dose: 0.04 to 0.08 mg/kg (40 to 80 mcg/kg) subcutaneously twice daily. If well-tolerated for at least one week, the dose may be increased by 0.04 mg/kg per dose, to the maximum dose of 0.12 mg/kg given twice daily. Funduscopic exam is recommended at the initiation Limitations of use: Increlex® is not a substitute to GH for approved GH indications.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Growth Hormones **On Formulary with PA:** Norditropin® Products (somatropin) **Non-Formulary with PA:** All other somatropin products Egrifta® Genotropin® Humatrope® Omnitrope® Nutropin® Nutropin AQ® Nutropin AQ NuSpin® Saizen® Serostim® Tev-Tropin™ Zorbtive® Zomacton®	**Pediatric patients:** 1. Diagnosis of chronic renal failure and growth retardation; **OR** 2. Diagnosis of hypothalamic-pituitary lesions or panhypopituitarism; **OR** 3. Diagnosis of growth hormone (GH) deficiency; **AND** Patient must meet 3 of the 4 following criteria for documentation of growth failure: a. Height is >2 standard deviations below the mean for age and sex (less than 5th percentile for age); **AND** b. Growth velocity is subnormal (age specific growth rate at less than the 25th percentile); **AND** c. Bone age is delayed; **AND** d. Documented failure of at least one GH stimulation tests (defined as a peak growth hormone level of less than 10mcg/L after GH stimulation by insulin, arginine, clonidine, glucagon, or levodopa). GH stimulation tests not required with diagnosis of Turner Syndrome, Noonan Syndrome, or Prader-Willi Syndrome; **OR** 4. Diagnosis of Idiopathic Short Stature (ISS); **AND** a. Height is >2 standard deviations below the mean for age and sex (less than 5th percentile for age); **AND** b. Documentation that epiphyses are not closed. **Adult patients:** 1. Diagnosis of HIV and an unintentional weight loss of 10% over 12 months, 7.5% over 6 months or a BMI <20mg/kg; **OR** 2. Diagnosis of hypothalamic-pituitary lesions or panhypopituitarism; **OR** 3. Documented GH deficiency; **OR** 4. Diagnosis of Short Bowel Syndrome; **AND** 5. Patient is currently receiving specialized nutrition support directed by a healthcare professional (Total Parenteral Nutrition (TPN), Peripheral Parenteral Nutrition (PPN), or high-complex carbohydrate, low-fat diet) **Both Pediatric and Adult patients:** 1. Patient must have documented failure of, or intolerance to Norditropin® before a non-preferred recombinant human growth hormone product will be approved.	Approved for 1 year Documentation required for pediatric renewal: 1. Growth rate has exceeded 2.5cm/year 2. Epiphyses remain open	Contraindicated for: -Diabetic retinopathy -Epiphyseal closure -Respiratory insufficiency -Sleep Apnea -Product specific hypersensitivities (Cresol, Benzyl Alcohol,Glycerin) -Active neoplastic disease -Intracranial hypertension -Acute critical illness -Prader-Willi Syndrome in Children

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Hormones Lupron Depot® (leuprolide)	1. The patient must have a diagnosis of uterine fibroid tumors, endometriosis, ovarian cancer or prostate cancer; **AND** 2. The patient must be 18 years of age or older.		
Lupron Depot-Ped® (leuprolide)	1. The patient has Central Precocious Puberty (CPP) and displays onset of secondary sexual characteristics earlier than age 8 for girls and 9 for boys; **AND** 2. The patient is less than 13 years old; **AND** 3. Diagnosis is confirmed by a pubertal gonadal sex steroid level or a pubertal LH response to stimulation by native GnRH; **AND** 4. Tumor has been ruled out by lab tests, CT, MRI or ultrasound.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators Actemra® (tocilizumab)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Actemra; **AND** 3. Patient has no active infection (including bacterial sepsis, tuberculosis, invasive fungal and other opportunistic infections; **AND** 4. Patient has ANC >2000/mm^3 AND Platelets >100,000/mm^3 AND ALT or AST <1.5x upper limits of normal; **AND** 5. Patient is not also receiving TNF antagonists, or other biologics (Enbrel, Humira, Remicade, Simponi, Cimzia, Kineret, Rituxan, Orencia), or live vaccines and diagnostic specific criteria are met. **Rheumatoid Arthritis:** 6. Diagnosis of moderate to severe rheumatoid arthritis; **AND** 7. Patient has documented failure of, or intolerance to, both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 8. The patient is not physically able to administer or is not an appropriate candidate for a subcutaneously administered biologic agent (e.g., Humira, Enbrel); **AND** 9. Documented failure of, intolerance or contraindication to, two other disease modifying antirheumatic drugs (DMARDS) (e.g., methotrexate, sulfasalazine, azathioprine, or hydroxychloroquine). **Juvenile Idiopathic Arthritis (JIA)/Juvenile Rheumatoid Arthritis (JRA) / polyarticular juvenile idiopathic arthritis (PJIA):** 6. Patient is ≥ 2 years old; **AND** 7. Patient has a diagnosis of active systemic JIA/JRA/PJIA. **AND** 8. Patient has documented failure of, or intolerance to, both formulary subcutaneous biologic agents (e.g., Humira and Enbrel).		The dose of Actemra is 4mg/kg IV every 4 weeks; may increase to 8 mg/kg IV based on clinical response (Max: 800mg per infusion). Infuse over 60 minutes with infusion set.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Berinert® (C1 esterase inhibitor) Cinryze® (C1 esterase inhibitor) Firazyr® (icatibant)	1. The patient must have a diagnosis of hereditary angiodema or C1 inhibitor deficiency 2. The prescription must be written by an allergist, immunologist, or hematologist 3. For Firazyr, the patient must be 18 years of age or older.		
Cimzia® (certolizumab pegol)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Cimzia; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Orencia, Kineret, Enbrel, Remicade or other anti-TNF therapy; **AND** diagnosis specific criteria are met. **Crohn's Disease:** 5. Diagnosis of moderate to severe active Crohn's disease with documented failure of, intolerance or contraindication to, conventional therapy (azathioprine, mesalamine, mercaptopurine, sulfasalazine, methotrexate, corticosteroids); **AND** 6. Patient has documented failure of, or intolerance to, Humira; **AND** 7. Dose is 400 mg at week 0, 2, and 4 weeks. If response, dose is 400 mg every 4 weeks. **Rheumatoid Arthritis:** 5. Diagnosis of moderately to severely active rheumatoid arthritis. **AND** 6. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 7. Dose is 400 mg at week 0, 2, and 4, followed by 200 mg every other week. May consider 400 mg every 4 weeks for maintenance.	Approved for 1 year	.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Cimzia® (certolizumab pegol), continued	**Psoriatic Arthritis:** 5. Diagnosis of active psoriatic arthritis; **AND** 6. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 7. Dose is 400 mg at week 0, 2, and 4, followed by 200 mg every other week. May consider 400 mg every 4 weeks for maintenance. **Ankylosing Spondylitis:** 5. Diagnosis of active ankylosing spondylitis; **AND** 6. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 7. Dose is 400 mg at week 0, 2, and 4, followed by 200 mg every other week or 400 mg every 4 weeks.		
Cosentyx® (secukinumab)	1. A negative TB test before initiating therapy; **OR** treatment for latent TB infections must be initiated before treatment with Cosentyx; **AND** 2. Patient has no active infection (including bacterial, fungal or viral); **AND** 3. Patient does not have Crohn's disease; **AND** 4. Specific criteria for diagnosis are met. **For Psoriasis:** 1. Diagnosis of moderate to severe plaque psoriasis; **AND** 2. Prescription is written by a dermatologist; **AND** 3. There is documented failure of, intolerance or contraindication to, at least two traditional therapies (e.g., PUVA, UVB, methotrexate, or cyclosporine); **AND** 4. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 5. The dose is no more than 300 mg at weeks 0, 1, 2, 3, and 4 and then every 4 weeks.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators , continued Enbrel® (etanercept)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Enbrel; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Orencia, Kineret, Humira, Remicade or other anti-TNF therapy; **AND** diagnosis specific criteria are met. **Arthritis:** 5. Diagnosis of rheumatoid arthritis (RA), juvenile RA (JRA), juvenile idiopathic arthritis (JIA), or psoriatic arthritis (JRA/JIA approved for ages 2-17). **Psoriasis:** 5. Diagnosis of plaque psoriasis; **AND** 6. Prescription is written by a dermatologist; **AND** 7. Documented failure of, intolerance or contraindication to, at least 2 traditional therapies (e.g., PUVA, UVB, methotrexate, or cyclosporine). **Spondylitis:** 5. Diagnosis of ankylosing spondylitis or juvenile spondyloarthropathy.	Approved for 1 year Dose Optimization not to exceed 50mg twice a week	Patients with a latex allergy or sensitivity should not handle the prefilled syringe or autoinjector syringe since the needle cap(s) contain latex.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators , continued Entyvio® (vedolizumab)	1. Diagnosis of moderately to severely active ulcerative colitis or Crohn's disease; **AND** 2. Documented failure of, intolerance or contraindication to conventional therapy (azathioprine, mesalamine, mercaptopurine, sulfasalazine, methotrexate, corticosteroids); **AND** 3. Patient has documented failure of, or intolerance to Humira; **OR** 4. The patient is not physically able to administer or is not an appropriate candidate for a subcutaneously administered biologic agent (e.g., Humira) New Starts Only	Initial duration of approval is for 4 months. Authorization will be renewed with documentation of therapy response. Patients not responding by week 14 are unlikely to respond and therapy should be discontinued.	

Brand (generic) Name	Criteria	Duration of Approval	Notes
<u>Immunomodulators</u>, continued Humira® (adalimumab)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Humira; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Orencia, Kineret, Enbrel, Remicade or other anti-TNF therapy; AND diagnosis specific criteria are met. **Ankylosing Spondylitis OR Psoriatic Arthritis:** 5. Diagnosis of ankylosing spondylitis or psoriatic arthritis. 6. The dose of Humira is 40mg administered subcutaneously every other week. **Crohn's Disease:** 5. Diagnosis of moderate to severe Crohn's disease; **AND** 6. Documented failure of, intolerance or contraindication to, conventional therapy (azathioprine, mesalamine, mercaptopurine, sulfasalazine, methotrexate, corticosteroids); **AND** 7. The dose of Humira is 160mg on day 1, 80mg on day 15 and then 40mg every other week starting on day 28. **Juvenile Idiopathic Arthritis (JIA)/Juvenile Rheumatoid Arthritis (JRA):** 5. Patient is 4 years of age and older; **AND** 6. Patient has moderately to severely active polyarticular JIA/JRA. 7. The dose of Humira for patients: - 15 kg (33 lbs) to <30 kg (66 lbs) is 20 mg administered subcutaneously every other week. - ≥30 kg (66 lbs) is 40 mg administered subcutaneously every other week.	Approved for 1 year	Patients with a latex allergy or sensitivity should not handle the needle cover of the syringe as it contains latex.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Humira® (adalimumab), continued	**Psoriasis:** 5. Diagnosis of chronic moderate to severe plaque psoriasis; **AND** 6. Documented failure of, intolerance or contraindication to, at least 2 traditional therapies (e.g. PUVA, UVB, methotrexate, or cyclosporine); **AND** 7. Prescription is written by a dermatologist. 8. The dose of Humira is 80 mg subcutaneously followed by 40 mg every other week starting 1 week after the initial dose. **Rheumatoid Arthritis:** 5. Diagnosis of rheumatoid arthritis; **AND** 6. The dose of Humira is 40mg every other week. **Ulcerative Colitis:** 5. Diagnosis of moderate-to-severe ulcerative colitis; **AND** 6. Documented failure of, intolerance or contraindication to, conventional therapy (azathioprine, mesalamine, mercaptopurine, sulfasalazine, methotrexate, corticosteroids); **AND** 7. The dose of Humira is 160mg on day 1, 80mg on day 15 and then 40mg every other week thereafter. Documentation of clinical remission must be submitted to continue therapy beyond 12 weeks. **Uveitis:** For the treatment of non-infectious uveitis (including intermediate, posterior, and panuveitis): 1. Evidence of chronic, recurrent, treatment-refractory or vision-threatening disease 2. Prior failure of periocular, intraocular, or systemic corticosteroids 3. Prior failure of TWO immunosuppressive agents (e.g. methotrexate, mycophenolate, azathioprine, cyclophosphamide, or cyclosporine) 4. Negative TB test 5. Prescribed by ophthalmology specialist Limitations: (1) Therapy will be discontinued if evidence of treatment failure defined as: (a) development of new inflammatory chorioretinal and/or inflammatory retinal vascular lesions; (b) an increase in anterior chamber cell grade or vitreous haze grade; (c) a decrease in best corrected visual acuity		

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Immunomodulators, continued Taltz Autoinjector® (ixekizumab) Taltz Syringe® (ixekizumab)	Based on specific documented patient circumstances, each/all of the formulary drugs/alternatives are not appropriate because: 1. Medication(s) are contraindicated or unsafe, **OR** 2. Patient is intolerant or allergic, **OR** 3. Patient had an inadequate or inappropriate response; **AND** 4. Chart documentation to support this medical necessity has been provided; **AND** 5. The requested drug and dosage is FDA-approved for the patient's diagnosis. **Formulary alternatives for psoriasis include Enbrel and Humira. Patient must have documented failure or intolerance to Enbrel and Humira.**		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV)** Carimune NF® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra® Cuvitru®	Primary Immunodeficiencies [X-linked (congenital) agamma-globulinemia, X-linked (congenital) immunodeficiency with hyper-IgM, Hypogammaglobulinemia, Common variable immunodeficiency, and Combined immunodeficiency syndromes including: Wiskott-aldrich syndrome; severe combined immunodeficiency syndrome (SCIDs)] 1. A serum trough IgG of ≤400 mg/dl. (In rare circumstances where serum trough level is recommended >600 mg/dl, documentation should support rationale)	1 year	
	Selective IgG subclass deficiencies with severe infection including Specific Antibody Deficiency (SAD) 1. Documentation of IgG subclass deficiency (Appendix 1), **-or-** 2. Documentation of severe polysaccharide non-responsiveness (inability to make IgG antibody against diphtheria and tetanus toxoids, pneumococcal polysaccharide vaccine, or both), **-or-** 3. Documentation of antigen testing with less than 4 fold increase in specific antibody titer and lack of protective antibody titer (specific IgG antibody titer <1.3 mcg/ml), **-and-** 4. Documented trial and failure of an antibiotic within the last year (for initial authorization only).	1 year	

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Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV)** Carimune NF® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra®	Primary Immunodeficiencies [X-linked (congenital) agamma-globulinemia, X-linked (congenital) immunodeficiency with hyper-IgM, Hypogammaglobulinemia, Common variable immunodeficiency, and Combined immunodeficiency syndromes including: Wiskott-aldrich syndrome; severe combined immunodeficiency syndrome (SCIDs)] 1. A serum trough IgG of ≤400 mg/dl. (In rare circumstances where serum trough level is recommended >600 mg/dl, documentation should support rationale)	1 year	
	Selective IgG subclass deficiencies with severe infection including Specific Antibody Deficiency (SAD) 1. Documentation of IgG subclass deficiency (Appendix 1), **-or-** 2. Documentation of severe polysaccharide non-responsiveness (inability to make IgG antibody against diphtheria and tetanus toxoids, pneumococcal polysaccharide vaccine, or both), **-or-** 3. Documentation of antigen testing with less than 4 fold increase in specific antibody titer and lack of protective antibody titer (specific IgG antibody titer <1.3 mcg/ml), **-and-** 4. Documented trial and failure of an antibiotic within the last year (for initial authorization only).	1 year	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV), continued** Carimune NF ® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra®	**Idiopathic Thrombocytopenia Purpura (ITP)** **Acute ITP** 1. Platelet count <50,000/ul and rapid rise in platelet count is necessary prior to surgery, or to avoid/defer splenectomy, or patient is at risk for acute bleeding. **Chronic ITP** 1. Platelet count is low < 30,000/ul, **-and-** 2. Age ≥10 years of age, **-and-** 3. Duration of illness > 6 months, **-and-** 4. Documented failure of, intolerance, or contraindication to at least 3 of the following: corticosteroids, rituximab, danazol, colchicine, dapsone, cyclophosphamide, azathioprine, mycophenolate, cyclosporine, chemotherapy **-or-** 5. Splenectomy **ITP in pregnancy** 1. Platelets <30,000/ul in 3rd trimester, **-or-** 2. Previously delivered infants with autoimmune thrombocytopenia and platelet counts <75,000/ul during current pregnancy, **-and-** 3. Documented failure of, intolerance, or contraindication to corticosteroids, **-or-** 4. Splenectomy	**Acute ITP** 1 week **Chronic ITP** 1 year **ITP in pregnancy** 1year	
	Kawasaki syndrome/Mucocutaneous Lymph Node Syndrome (MCLS) 1. Therapy is started within 10 days of fever, **-and-** 2. Concurrent aspirin administration.	1 week	

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Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV), continued** Carimune NF ® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra®	**Allogeneic (genetically similar donor) bone marrow transplant** 1. Therapy is started within the first 100 days post transplant, **-or-** 2. Patient is 100 days post transplant, **-and-** 3. IgG levels < 400 mg/dl (exception made for patients who underwent transplantation for multiple myeloma or malignant macroglobulinemia because total IgG concentration is affected by their underlying paraproteinemia, **-or-** 4. Patient has history of CMV or RSV.	4 months	
	Chronic Lymphocytic Leukemia (CLL) 1. Immunoglobulin (IgG) level of < 600 mg/dl, **-and-** 2. Documented trial and failure of an antibiotic within the last year (for initial authorization only)	1 year	
	Pediatric HIV infection 1. Documentation of ≥2 bacterial infections in a 1 year period, **-or-** 2. Patient has HIV-associated thrombocytopenia, **-or-** 3. Patient has bronchiectasis, **-or-** 4. Documentation of T4 cell count ≥200 /mm^3	1 year	

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Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV), continued** Carimune NF ® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra®	**Acute and Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)/Guillian-Barre Syndrome (GBS)** For Chronic CIDP: 1. Documented failure of, intolerance, or contraindication to prednisone or azathioprine, **-or-** 2. Documented plasma exchange. For GBS 1. Patient must initiate within first four weeks of illness.	Not limited	
	Post transfusion purpura 1. Platelet count less than 10,000/ul, **-and-** 2. Infusion must be within 14 days of bleeding post transfusion, **-and-** 3. Documented failure of, intolerance, or contraindication to corticosteroids, **-or-** 4. Documented plasma exchange.	1 month (to account for relapse)	
	Multiple Sclerosis (MS) 1. Patient must have relapse-remitting MS only (not primary or secondary progressive MS), **-and-** 2. Documented treatment with, intolerance, or contraindication to any interferon therapy (Betaseron, Avonex, or Rebif).	1 year	

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Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV), continued** Carimune NF ® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra®	**Myasthenia Gravis (MG) and Lambert-Eaton (LE) Myasthenia** *MG:* 1. Documented failure of, intolerance, or contraindication to at least 2 of the following: anticholinesterases (eg., Mestinon, Prostigmin), corticosteroids, cyclosporine, cyclophosphamide, or azathioprine. *LE :* 1. Documented failure of, intolerance, or contraindication to anticholinesterases (eg. Mestinon,Prostigmin), **-or-** 2. Documented plasma exchange.	1 week	
	Dermatomyositis and Polymyositis 1. Documented failure of, intolerance, or contraindication to at least 2 of the following: corticosteroids, methotrexate, azathioprine, cyclophosphamide, or cyclosporine.	6 months	
	Systemic Lupus Erythematosus (SLE) 1. Documentation of severe (solid organ involvement), active SLE, -**and-** 2. Documented failure of, intolerance, or contraindication to at least 2 of the following: corticosteroids. methotrexate, azathioprine, or cyclophosphamide	Not limited	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued **(FDA approved indications vary by product)** **Immune Globulin (IM)** GamaSTAN™ **Immune Globulin (IV), continued** Carimune NF ® Flebogamma® Gammagard® Gammagard S/D® Gammaked® Gammaplex® Gamunex® Privigen® Hyqvia® **Immune Globulin (SQ)** Gamunex-C® Hizentra®	**Autoimmune mucocutaneous blistering diseases, including Pemphigus vulgaris, Pemphigus foliaceus, Bullous pemphigoid, Mucous membrane pemphigoid, Epidermyolysis bullosa** 1. Documented failure of, intolerance, or contraindication to atleast 2 of the following: corticosteroids. methotrexate, azathioprine, or cyclophosphamide, **-or-** 2. Documentation of rapidly progressive disease in which a clinical response could not be affected quickly enough using prerequisite therapies.	6 months	
	Multifocal Motor Neuropathy 1. Diagnosis is required	Not limited	
	Stiff Person Syndrome 1. Diagnosis is required	Not limited	
	Fetal/neonatal alloimmune thrombocytopenia (FAIT/NAIT) 1. Diagnosis is required	Not limited	
	Hemolytic disease of the newborn 1. Diagnosis is required	Not limited	
	Hemolytic Uremic Syndrome 1. Diagnosis is required	Not limited	
	Complications of transplanted organs (including solid organ and bone marrow) 1. Diagnosis is required	Not limited	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Kineret® (anakinra)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Kineret; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Orencia, Enbrel, Remicade or other anti-TNF therapy; **AND** diagnosis specific criteria are met. **Rheumatoid Arthritis:** 5. The patient must be >18 years of age; **AND** 6. Diagnosis of rheumatoid arthritis; **AND** 7. Documented failure of, or intolerance to, methotrexate; **AND** 8. Documented failure of, or intolerance to, another disease modifying antirheumatic drug (DMARD) (e.g., azathioprine, leflunomide, cyclosporine, penicillamine, sulfasalazine); **AND** 9. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 10. The dose of Kineret is 100mg administered subcutaneously once daily. **Cryopyrin-Associated Periodic Syndromes** 5. The patient must be diagnosed with Neonatal-Onset Multisystem Inflammatory Disease (NOMID); **AND** 6. The max dose is 8mg/kg per day	Approved for 1 year	Patients with a latex allergy or sensitivity should not handle the Kineret needle cover as it contains latex. Kineret should not be given by intravenous administration or intramuscular administration.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Orencia® (abatacept)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Orencia; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Cimzia, Kineret, Enbrel, or Remicade or other anti-TNF therapy; **AND** 5. For infused Orencia, the patient has documented failure of, intolerance to, or is not physically able to administer the subcutaneous formulation of Orencia; **AND** diagnosis specific criteria are met. **Arthritis:** 6. Diagnosis of moderate to severe rheumatoid arthritis; **OR** 7. Diagnosis of moderate to severe polyarticular juvenile rheumatoid arthritis (JRA)/juvenile idiopathic arthritis (JIA); (JRA/JIA approved for > 6 years of age). 8. Patient has documented failure of, intolerance or contraindication to, two other disease modifying antirheumatic drugs (DMARDS) (e.g., methotrexate, sulfasalazine, azathioprine, or hydroxychloroquine); **AND** 9. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel).	Approved for 1 year	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Otezla® (apremilast)	**Psoriatic Arthritis:** 1. Diagnosis of active psoriatic arthritis**; AND** 2. Documented failure of, intolerance or contraindication to, NSAID therapy; **AND** 3. Documented failure of, or intolerance to, one other disease modifying antirheumatic drug (DMARDS) (e.g., methotrexate, sulfasalazine, leflunomide); **AND** 4. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 5. The patient is not physically able to administer or is not an appropriate candidate for a subcutaneously administered biologic agent (e.g., Humira, Enbrel) **Psoriasis:** 1. Diagnosis of chronic moderate to severe plaque psoriasis**; AND** 2. Documented failure of, intolerance or contraindication to, at least 2 traditional therapies (e.g. PUVA, UVB, methotrexate, or cyclosporine)**; AND** 3. Prescription is written by a dermatologist**; AND** 4. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel)**; OR** 5. The patient is not physically able to administer or is not an appropriate candidate for a subcutaneously administered biologic agent (e.g., Humira, Enbrel)		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Remicade® (infliximab)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Remicade; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Orencia, Kineret, Enbrel, or Humira or other anti-TNF therapy; **AND** 5. Diagnosis specific criteria are met. **Ankylosing Spondylitis OR Psoriatic Arthritis:** 6. Diagnosis of ankylosing spondylitis or psoriatic arthritis; **AND** 7. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 8. Patient has documented failure of, or intolerance to, or inability to inject a formulary subcutaneously administered anti-TNF agent (e.g., Humira, Enbrel); **AND** 9. The maintenance dose is a maximum of 5 mg/kg every 6 weeks (Ankylosing Spondylitis) or every 8 weeks (Psoriatic Arthritis). **Crohn's Disease:** 6. Patient is ≥ 6 years old; **AND** 7. Patient has a diagnosis of moderate to severe Crohn's disease; **OR** 8. Diagnosis of Crohn's disease with draining enterocutaneous fistulae; **AND** 9. Documented failure of, or intolerance to, mesalamine and corticosteroids and 6-mercaptopurine or azathioprine; **AND** 10. Patient has documented failure of, or intolerance to, or inability to inject a formulary subcutaneously administered anti-TNF agent (e.g., Humira); **AND** 11. The maintenance dose is a maximum of 10mg/kg every 8 weeks.	Approved for 1 year	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
<u>Immunomodulators</u>, continued Remicade® (infliximab) continued	**Psoriasis:** 6. Prescription is written by a dermatologist; **AND** 7. Patient has diagnosis of chronic, severe (i.e., extensive and/or disabling) plaque psoriasis; **AND** 8. Documented failure of, or intolerance to, at least 2 traditional therapies (e.g., PUVA, UVB, methotrexate, or cyclosporine); **AND** 9. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 10. The patient is not physically able to administer or is not an appropriate candidate for a formulary subcutaneously administered biologic agent (e.g., Humira, Enbrel); **AND** 11. The maintenance dose is a maximum of 5 mg/kg every 8 weeks. **Rheumatoid Arthritis:** 6. Diagnosis of rheumatoid arthritis; **AND** 7. Patient has documented failure of, or intolerance to, two other disease modifying antirheumatic drugs(DMARDS) (e.g., methotrexate, sulfasalazine, azathioprine, or hydroxychloroquine); **AND** 8. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 9. The patient is not physically able to administer or is not an appropriate candidate for a formulary subcutaneously administered biologic agent (e.g., Humira, Enbrel); **AND** 10. The maintenance dose is a maximum of 10mg/kg every 4 weeks.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
<u>Immunomodulators</u>, continued Remicade® (infliximab), continued	**Ulcerative Colitis:** 6. Patient has moderately to severely active ulcerative colitis and required high dose systemic corticosteroid use; **OR** 7. Patient has documented inadequate response to conventional therapy (e.g., mesalamine (5-ASA), azathioprine, mercaptopurine); **AND** 8. Patient has documented failure of, or intolerance to formulary subcutaneous biologic agents (e.g., Humira); **OR** 9. The patient is not physically able to administer or is not an appropriate candidate for a formulary subcutaneously administered biologic agent (e.g., Humira); **AND** 10. The maintenance dose is a maximum of 5 mg/kg every 8 weeks.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Rituxan® (rituximab)	1. Prescription is written by an oncologist or hematologist; **OR** 2. The patient has a diagnosis of moderate to severe rheumatoid arthritis; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Cimzia, Kineret, Enbrel, or Remicade or other anti-TNF therapy; **AND** 5. Patient has documented failure of, or intolerance to both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 6. The patient is not physically able to administer or is not an appropriate candidate for a formulary subcutaneous biologic agent (e.g., Humira, Enbrel); **AND** 7. Documented failure of, or intolerance to, two other disease modifying antirheumatic drugs (DMARDS) (e.g., methotrexate, sulfasalazine, azathioprine, or hydroxychloroquine).	For a diagnosis of RA: Since safety and efficacy of re-treatment have not been established in controlled trials and a limited number of patients have received two to five courses (two infusions per course) of treatment in an uncontrolled setting, the duration of approval for RA should be limited to 5 courses (3 months) with re-evaluation based on individual response.	The dose for use in RA is 2 x 1000mg IV infusions separated by 2 weeks. Glucocorticoids, administered as methylprednisolone 100mg IV or its equivalent, given 30 minutes prior to each infusion, are recommended to reduce the incidence and severity of infusion reactions.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Simponi® (golimumab)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Simponi; **AND** 3. Patient has no active infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 4. Patient is not also receiving Orencia, Kineret, Enbrel, Remicade or other anti-TNF therapy; **AND** diagnosis specific criteria are met. **Ankylosing Spondylitis OR Psoriatic Arthritis:** 5. Diagnosis of ankylosing spondylitis or psoriatic arthritis; **AND** 6. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 7. The dose of Simponi is 50mg administered subcutaneously once a month. **Rheumatoid Arthritis:** 5. Diagnosis of moderately to severely active rheumatoid arthritis; **AND** 6. Patient is receiving methotrexate concomitantly; **AND** 7. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 8. The dose of Simponi is 50mg administered subcutaneously once a month. **Ulcerative Colitis:** 5. Diagnosis of moderate to severe active ulcerative colitis disease with documented failure of, intolerance or contraindication to, conventional therapy (azathioprine, mesalamine, mercaptopurine, sulfasalazine, methotrexate, corticosteroids). 6. Patient has documented failure of, or intolerance to, Humira. 7. The dose of Simponi is 200 mg administered subcutaneously, followed by 100 mg at week 2, and then 100 mg every 4 weeks, thereafter.	Approved for 1 year	Patients with a latex allergy or sensitivity should not handle the prefilled syringe or autoinjector syringe since the needle cover contains latex.

Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators, continued Stelara® (ustekinumab)	1. A negative TB test before initiating therapy; **OR** 2. Treatment for latent TB infections must be initiated before treatment with Stelara; **AND** 3. Patient has no active infection (including bacterial, fungal or viral); **AND** diagnostic specific criteria are met **Psoriasis:** 4. Diagnosis of moderate to severe plaque psoriasis; **AND** 5. Prescription is written by a dermatologist; **AND** 6. Documented failure of, intolerance or contraindication to, at least two traditional therapies (e.g., PUVA, UVB, methotrexate, or cyclosporine); **AND** 7. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 8. The dose is 45 mg (≤100 kg) or 90 mg (>100 kg) at weeks 0 and 4, followed by 45 mg (≤100 kg) or 90 mg (>100 kg) every 12 weeks. **Psoriatic arthritis:** 4. Diagnosis of active psoriatic arthritis; **AND** 5. Patient has documented failure of, or intolerance to Humira and Enbrel; **AND** 6. The dose is 45 mg at weeks 0 and 4, followed by 45 mg every 12 weeks; **OR** 7. With co-existent moderate to severe plaque psoriasis weighing >100 kg, the dose is 90 mg at week 0 and 4, followed by 90 mg every 12 weeks.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
<u>Immunomodulators</u>, continued Tysabri® (natalizumab)	**For patients with Multiple Sclerosis** 1. Patient must have a diagnosis of a relapsing form of multiple sclerosis; **AND** 2. Patient has had treatment failure, contraindication, or intolerance to Copaxone (glatiramer acetate); **AND** 3. Patient is intolerant to both Avonex (interferon beta 1a) and Rebif (interferon beta 1a) (i.e. severe or intolerable injection site reactions or side effects); **OR** 4. Patient has had treatment failure, contraindication, or allergy to interferon therapy; **AND** 5. Patient must not be currently on combination therapy with Avonex, Rebif, Betaseron, Extavia, Copaxone, or Gilyena; **AND** 6. Patient must not be on concurrent immunosuppressive therapy; **AND** 7. Documentation of an MRI scan must be obtained for each patient with MS to help differentiate potential, future symptoms from progressive multifocal leukoencephalopathy (PML). **For patients with Crohn's Disease** 1. Patient must have a diagnosis of moderate to severe of Crohn's disease; **AND** 2. Patient must have had documented failure of, intolerance or contraindication to, conventional Crohn's disease therapy (i.e. azathioprine, mesalamine, mercaptopurine, sulfasalazine, methotrexate, corticosteroids); **AND** 3. Patient must have had documented failure of, intolerance or contraindication to a, TNF-α inhibitor (i.e. Humira, Cimzia, Remicade); **AND** 4. Patient must not be currently on combination therapy with immunosuppressants or TNF-α inhibitors. New Starts Only		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Immunomodulators Xgeva™ (denosumab)	1. Patient has a diagnosis of bone metastases secondary to solid tumor; **OR** 2. The patient has a diagnosis of giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity.	1 year	Dose: 120 mg every 4 weeks subcutaneously. For giant cell tumor, additional 120 mg doses are given on day 8 and 15 of the first month of therapy. Administer calcium and Vit D PRN to treat or prevent hypocalcemia Not indicated in patients with multiple myeloma.
Immunomodulators, continued **Cryopyrin-Associated Periodic Syndromes** Arcalyst® (rilonacept)	1. Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 years and older.	Evaluate in 3 months for to determine patient response	Recommended dose: Adults 18 yrs or older: Loading dose: 320mg Sub Q Maintenance dose:160mg SubQ once weekly Pediatric patients 12 to 17 yrs old: Loading dose:4.4mg/kg(to max of 320mg) SQ Maintenance dose: 2.2mg/kg SubQ once weekly *Dose should not be given more than once per week Precautions: Arcalyst should not be administered if patient has active or chronic infection. Patient should receive all recommended vaccinations prior to receiving Arcalyst.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Cryopyrin-Associated Periodic Syndromes Ilaris® (canakinumab)	1. Patient has no active or chronic infection (including influenza, systemic fungal or bacterial infections, or acute hepatitis B or C viral infections); **AND** 2. Diagnosis specific criteria are met **Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)** 3. Patient is > 4 years old; **AND** 4. Patient has a diagnosis of CAPS, FCAS, or MWS. **Juvenile Idiopathic Arthritis (JIA)/Juvenile Rheumatoid Arthritis (JRA)/ polyarticular juvenile idiopathic arthritis (PJIA):** 3. Patient is > 2 years old; **AND** 4. Patient has a diagnosis of active systemic JIA/JRA. **AND** 5. Patient has documented failure of, or intolerance to, both formulary subcutaneous biologic agents (e.g., Humira and Enbrel).	Long Term	Recommended dose: Adults, Adolescents, and Children >= 4 years of age and > 40kg: 150mg SC every 8 weeks. Adults, Adolescents, and Children >=4 years of age and 15-40kg: 2mg/kg SC every 8 weeks. Response is inadequate in children in this weight range, may consider dose increase to 3mg/kg SC every 8 weeks.
<u>Miscellaneous</u> Samsca® (tolvaptan)	1. The patient must have clinically significant and euvolemic hyponatremia (serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction); **AND** 2. Therapy will be initiated in an inpatient setting; **AND** 3. Maximum length of therapy is 30 days to minimize the risk of liver injury.	Duration of approval is 30 days	Quantity Limit: 15 mg (30 units per 30 days) 30 mg (60 units per 30 days)

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Multiple Sclerosis, Adjunctive Agents **Non-Formulary** Ampyra® (dalfampridine)	1. The patient must have a diagnosis of Multiple Sclerosis; **AND** 2. The patient is ambulatory; **AND** 3. The patient has no history of a seizure disorder; **AND** 4. The patient must have a CrCl>50mL/min; **AND** 5. The patient must be receiving concurrent therapy with a disease modifying agent (i.e., Avonex, Betaseron, Copaxone); **AND** 6. The prescription is written by a neurologist; **AND** 7. For renewal, the patient has a documented 20% or greater improvement from baseline in a timed 25 foot walk.	6 months	Quantity is limited to 60 units per 30 days.
All Multiple Sclerosis, Disease-Modifying Agents **On Formulary with PA** Avonex® (interferon beta 1a) Copaxone® (glatiramer acetate) Glatopa® (glatiramer acetate) Rebif® (interferon beta 1a)	1. Patient has a diagnosis of multiple sclerosis; **OR** 2. Patient has had signs and symptoms of Clinically Isolated Syndrome (CIS) suggestive of MS	Long-term	
All Multiple Sclerosis, Disease-Modifying Agents **Non-Formulary with PA** Aubagio® (teriflunomide) Betaseron® (interferon beta 1b) Extavia® (interferon beta 1b) Lemtrada® (alemtuzumab) Plegridy® (peginterferon beta 1a) Tecfidera® (dimethyl fumerate) Zinbryta® (daclizumab)	1. Patient has a diagnosis of multiple sclerosis; **OR** 2. Patient has had signs and symptoms of Clinically Isolated Syndrome (CIS) suggestive of MS; **AND** 3. Patient has had treatment failure, contraindication, or intolerance to Copaxone (glatiramer acetate); **AND** 4. Patient is intolerant to both Avonex (interferon beta 1a) and Rebif (interferon beta 1a) (i.e. severe or intolerable injection site reactions or side effects); **OR** 5. Patient has had treatment failure, contraindication, or allergy to interferon therapy.		Lemtrada is in the Medical Prior Authorization Program

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PRIOR AUTHORIZATION CRITERIA FOR SPECIALTY/INJECTABLE DRUGS

APPENDIX D

Brand (generic) Name	Criteria	Duration of Approval	Notes
<u>All Multiple Sclerosis, Disease-Modifying Agents</u> **Non-Formulary with PA, continued** Gilenya® (fingolimod)	1. The patient must have documented diagnosis of a relapsing form of multiple sclerosis; 2. There is documentation of the following within the last 6 months: a. CBC, Liver Function Tests, and b. Ophthalmologic Evaluation; and 3. Physician must submit documentation that the first dose is administered in a setting with resources to appropriately manage symptomatic bradycardia. Setting allows for hourly patient monitoring of pulse and blood pressure for 6 hours for signs and symptoms of bradycardia, including an electrocardiogram prior to dosing, and at the end of the observation period. 4. Patient has not had a recent (within the last six months) occurrence of MI, unstable angina, stroke, TIA, decompensated HF requiring hospitalization, or Class II/IV HF. 5. Patient does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. 6. Patient has a QTc interval >/500ms. 7. Patient is not receiving treatment with a Class 1a or Class III antiarrhythmic drug. 8. Patients receiving concurrent therapy with drugs that slow heart rate (e.g., beta blockers, heart-rate lowering calcium channel blockers such as diltiazem or verapamil, or digoxin) must receive overnight continuous ECG monitoring with administration of first dose. 9. Patient has had treatment failure, contraindication, or intolerance to Copaxone (glatiramer acetate); **AND** 10. Patient is intolerant to both Avonex (interferon beta 1a) and Rebif (interferon beta 1a) (i.e. severe or intolerable injection site reactions or side effects); **OR** 11. Patient has had treatment failure, contraindication, or allergy to interferon therapy**.**		Quantity is limited to 30 units per month. Patient should not receive Gilenya concomitantly with another immunomodulator therapy for multiple sclerosis (e.g. Avonex, Rebif, Betaseron, Extavia, Copaxone, or Tysabri).

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Neurological Xenazine® (tetrabenazine)	1. The patient must have a diagnosis of chorea associated with Huntington's disease; **AND** 2. The patient must have documented failure of, intolerance to, or contraindication to at least two of the following: amantadine, an antipsychotic (fluphenazine, haloperidol, risperidone, ziprasidone, quetiapine or olanzapine), riluzole, or a benzodiazepine, **AND** 3. Prescription must be prescribed by a neurologist, **AND** 4. For doses greater than 50 mg/day, CYP2D6 genotyping is required.	3 months	Patients who do not express CYP2D6 (i.e., poor metabolizers of CYP2D6) require a daily dose of 37.5—50 mg, in 3 divided doses. Patients who do express CYP2D6 (i.e., intermediate or extensive metabolizers of CYP2D6) require a daily dose of at least 50 mg-100mg in 3 divided doses.

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Neuromuscular Blocking Agent Botox® Dysport® Xeomin® (botulism toxin type A)	Patient must have a FDA approved diagnosis and meet the following disease specific criteria: **Cervical dystonia** 1. Patient must be ≥16 years old. **Strabismus** 1. Patient must be ≥12 years old. **Blepharospasm** 1. Patient must be ≥12 years old. **Severe Primary Axillary Hyperhidrosis** 1. Patient must be ≥18 years old, **AND** 2. Patient has chart documented failure or RX claims for prescription strength aluminum chloride (i.e., Drysol). **Upper Limb Spasticity** 1. Patient must be ≥18 years old. **Chronic Migraine** 1. Patient must be ≥18 years old and have chronic migraine, **AND** 2. Patient must have chart documentation showing a headache present for 15 or more days each month, lasting 4 or more hours each day, **AND** 3. Patient has chart documented failure or contraindication to at least one NSAID and butalbital combination product, **AND** 4. Patient has chart documented failure or contraindication to at least 2 triptan medications, **AND** 5. Patient has chart documented failure or contraindication to prophylactic therapies (i.e., beta blocker, tricyclic antidepressant, calcium channel blocker, topiramate)	Approved 3 months	

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Neuromuscular Blocking Agent, continued Botox® Dysport® Xeomin® (botulism toxin type A)	**Overactive Bladder** 1. Patient must be ≥18 years old, **AND** 2. Patient has chart documented failure or contraindication to at least 2 anticholinergic medications (i.e., oxybutynin, tolterodine, trospium). **Urinary Incontinence** 1. Patient's incontinence is due to neurological condition (i.e., spinal cord injury, multiple sclerosis), **AND** 2. Patient has chart documented failure or contraindication to at least 2 anticholinergic medications (i.e., oxybutynin, tolterodine, trospium).		
Myobloc® (botulinum toxin Type B)	1. Patient must be ≥18 years old, **AND** Patient must have a diagnosis of cervical dystonia.		

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Parathyroid Hormones Natpara® (parathyroid hormone)	1. The prescription must be written by an endocrinologist, **AND** 2. The diagnosis of hypoparathyroidism as confirmed by biochemical evidence of hypocalcemia and concomitant serum intact parathyroid hormone levels below the lower limit of normal on at least two test dates at least 21 days apart within the last 12 months, **AND** 3. Hypoparathyroidism is not resulting from an activating mutation in the CaSR gene or impaired responsiveness to PTH (pseudohypoparathyroidism), **AND** 4. Serum calcium level is above 7.5 mg/dL and 25-hydroxyvitamin D levels must be in normal range and, **AND** 5. Documentation is provided that patient is unable to maintain stable serum calcium (8.0 to 8.5 mg/dL) and urinary calcium (<300 mg) with calcium (with at least 1 gram supplement per day) and vitamin D therapy (with either calcitriol ≥0.25 µg per day or alfacalcidol ≥0.50 µg per day). a. Signs and symptoms of unstable control include development of kidney stones and calcium-phosphate product above 55 mg^2/dL^2 b. Alternative causes that may lead to unstable calcium or affect calcium-phosphate homeostasis are under control or have been ruled out. Such causes include active hyperthyroidism, Paget's disease, Type 1 and poorly controlled Type 2 diabetes mellitus (HbA1c>8%), severe and chronic cardiac, liver or renal disease, Cushing's syndrome, neuromuscular disease, myeloma, pancreatitis, malnutrition, rickets, recent prolonged immobility, active malignancy, primary or secondary hyperparathyroidism, a history of parathyroid carcinoma, hypopituitarism, acromegaly, or multiple endocrine neoplasia types I and II.	Duration of approval is 6 months. Recertification requests should document response to therapy, as shown by reduction calcium and or vitamin D dose or stable serum and urinary calcium levels.	Prescriptions are limited to 14 day supplies to monitor adherence to therapy. Quantity is limited to 14 cartridges per 14 days. Natpara® is considered a specialty drug and will be included in the Mandatory Specialty Program

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Brand (generic) Name	Criteria	Duration of Approval	Notes
Parkinson's Apokyn® (apomorphine)	6. Diagnosis of Parkinson's Disease in advanced stages; **AND** 7. Documented two hours or more of "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) despite aggressive oral therapy.	Long-term	
Pulmonary Cayston® (aztreonam for inhalation)	1. Patient must have pseudomonas aeruginosa in the lungs, **AND** 2. Patient must have cystic fibrosis, **AND** 3. Prescription must be written by a pulmonologist, or infectious disease specialist, **AND** 4. Patient must be 7 years of age or older, **AND** 5. FEV1 must be >25% or <75%.		
Uptravi® (selexipag)	1. For the treatment of pulmonary hypertension (PAH, WHO Group I). AND 2. Per P&T, reserved for functional class (FC) II or III, as a second-line and step-wise approach. Add on therapy after prior treatment with PDE5i (e.g. sildenafil) and ERA (e.g. bosentan, ambrisentan, macitentan) AND 3. Prescribed by a PAH specialist. AND 4. Consideration of FDA-approved labeled indications, appropriate dosing and therapies tried and failed.		

Brand (generic) Name	Criteria	Duration of Approval	Notes
Pulmonary, continued Xolair® (omalizumab)	1. Patient is over 12 years of age; **AND** 2. Diagnosis specific criteria are met. **Moderate to severe allergic asthma:** 3. Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen; **AND** 4. Failure of, or intolerance to, maximum dose of oral inhaled steroids (medication compliance should be taken into consideration); **AND/OR** 5. Patient required long-term (>3months) oral steroids previously and had at least 1 ED or hospital admission during the last 6 months; **AND** 6. Maximum dose is 750 mg every 4 weeks. **Chronic idiopathic urticarial:** 3. Patient has chart documented failure or contraindication to H1 antihistamines; **AND** 4. Maximum dose is 300 mg every 4 weeks.	Approved 3 months to determine patient response. Renewals may be authorized long-term.	The warnings for Xolair include malignancy and anaphylaxis.
Rheumatoid Arthritis Misc. Xeljanz® (tofacitinib)	1. Diagnosis of moderate to severe rheumatoid arthritis; **AND** 2. A negative TB test before initiating therapy; **OR** 3. Treatment for latent TB infections must be initiated before treatment with Xeljanz; **AND** 4. Patient has no active infection (including bacterial sepsis, tuberculosis, invasive fungal and other opportunistic infections); **AND** 5. Patient has a lymphocyte count >500 cells/mm^3, ANC > 1000 cells/mm^3, and hemoglobin level >9g/dL; **AND** 6. Patient is not also receiving TNF antagonists, or other biologics (e.g. Enbrel, Humira, Remicade, Simponi, Cimzia, Kineret, Rituxan, Orencia); **AND** 7. Patient has documented failure of, intolerance or contraindication to, two other disease- modifying antirheumatic drugs (DMARDS) (e.g., methotrexate, sulfasalazine, azathioprine, or hydroxychloroquine); **AND** 8. Patient has documented failure of, or intolerance to, both formulary subcutaneous biologic agents (e.g., Humira and Enbrel); **OR** 9. The patient is not physically able to administer or is not an appropriate candidate for a subcutaneously administered biologic agent (e.g., Humira, Enbrel).		

APPENDIX D

Appendix 1 (for Immune Globulin criteria):

Normal Immunoglobulin Levels (mg/dl)				**Normal IgG Subclass Levels (mg/dl)**				
AGE	**IgA**	**IgG**	**IgM**	**AGE**	**IgG1**	**IgG2**	**IgG3**	**IgG4**
1 - 2 mo	1 - 53	251 - 906	20 - 87	cord	435 - 1084	143 - 453	27 - 146	1 - 47
2 - 3 mo	3 - 47	206 - 601	17 - 105	0 - 3 mo	218 - 496	40 - 167	4 - 23	1 - 33
3 - 4 mo	4 - 73	176 - 581	24 - 101	3 - 6 mo	143 - 394	23 - 147	4 - 100	1 - 14
4 - 5 mo	8 - 84	172 - 814	33 - 108	6 - 9 mo	190 - 388	37 - 60	12 - 62	1 - 1
5 - 6 mo	8 - 68	215 - 704	35 - 102	9 mo - 3 yr	286 - 680	30 - 327	13 - 82	1 - 65
6 - 8 mo	11 - 90	217 - 904	34 - 125	3 - 5 yr	381 - 884	70 - 443	17 - 90	1 - 116
8 mo – 1 yr	16 - 84	294 - 1069	41 - 149	5 - 7 yr	292 - 816	83 - 513	8 - 111	1 - 121
1 - 2 yr	14 - 106	345 - 1213	43 - 173	7 - 9 yr	442 - 802	113 - 480	15 - 133	1 - 84
2 - 3 yr	14 - 123	424 - 1051	48 - 168	9 - 11 yr	456 - 938	163 - 513	26 - 113	1 - 121
3 - 4 yr	22 - 159	441 - 1135	47 - 200	11 - 13 yr	456 - 952	147 - 493	12 - 179	1 - 168
4 - 6 yr	25 - 154	463 - 1236	43 - 196	13 - 15 yr	347 - 993	140 - 440	23 - 117	1 - 183
6 - 9 yr	33 - 202	633 - 1280	48 - 207	15 yr & up	422 - 1292	117 - 747	41 - 129	1 - 291
9 - 11 yr	45 - 236	608 - 1572	52 - 242					
11 yr & up	70 - 312	639 - 1349	56 - 352					