

# Community Health Plan of Washington



## 2025 Medicare Advantage (HMO) Prescription Drug Formulary (5 Tier)



**COMMUNITY HEALTH PLAN**  
of Washington™  
**MEDICARE ADVANTAGE**

This formulary was updated on 08/26/2024. For more recent information or other questions, please contact Community Health Plan of Washington Medicare Advantage (HMO) Customer Service at 1-800-942-0247 or for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m. or visit our website at [medicare.chpw.org](http://medicare.chpw.org).

# **Community Health Plan of Washington**

## **Medicare Advantage (HMO)**

### **2025 Formulary**

#### **List of Covered Drugs**

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

HPMS Approved Formulary File Submission ID 00025144, Version Number 7

This formulary was updated on 08/26/2024. For more recent information or other questions, please contact Community Health Plan of Washington (CHPW) Medicare Advantage (MA) Customer Service at 1-800-942-0247 (TTY users should call 711), 7 days a week, 8 a.m. to 8 p.m., or visit medicare.chpw.org.

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Community Health Plan of Washington. When it refers to “plan” or “our plan,” it means Community Health Plan of Washington Medicare Advantage (HMO).

This document includes Drug List (formulary) for our plan which is current as of 08/26/2024. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year.

## **What is the Community Health Plan of Washington Medicare Advantage Formulary?**

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by Community Health Plan of Washington Medicare Advantage in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Community Health Plan of Washington Medicare Advantage network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

### **Can the Formulary change?**

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: medicare.chpw.org.

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Community Health Plan of Washington Medicare Advantage’s Formulary?”

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Community Health Plan of Washington Medicare Advantage’s Formulary?”

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 08/26/2024. To get updated information about the drugs covered by Community Health Plan of Washington Medicare Advantage, please contact us. Our contact information appears on the front and back cover pages.

## **How do I use the Formulary?**

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

### **Medical Condition**

The formulary begins on page 19. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular, Hypertension/Lipids.” If you know what your drug is used for, look for the category name in the list that begins on page 19. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 87. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## **What are generic drugs?**

Our plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

## **What are original biological products and how are they related to biosimilars?**

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, “The ‘Drug List’ tells which Part D drugs are covered.

## **Are there any restrictions on my coverage?**

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

- **Prior Authorization:** Our plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, the plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, the plan provides 30 tablets per prescription for simvastatin. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 19. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Community Health Plan of Washington Medicare Advantage’s formulary?” on page 6 for information about how to request an exception.

## **What if my drug is not on the Formulary?**

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

If you learn that Community Health Plan of Washington Medicare Advantage does not cover your drug, you have two options:

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

## **How do I request an exception to the Community Health Plan of Washington Medicare Advantage Formulary?**

You can ask the Community Health Plan of Washington Medicare Advantage to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

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

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

You or your prescriber should contact us to ask us for a tiering or formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

## **What can I do if my drug is not on the formulary or has a restriction?**

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

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

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

## **Our Policy Regarding Changes in Level of Care**

You may have a change in your treatment setting due to the level of care you require. Such transitions include:

1. Being discharged from a hospital to a home;
2. Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and now needing to use your Part D plan;
3. Giving up Hospice Status and reverting back to standard Medicare Part A and B coverage;
4. Being discharged from chronic psychiatric hospitals with highly individualized drug regimens.

For these unplanned transitions, you may need to request an exception or an appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis if you have had a change in your level of care and are stabilized on drug regimens that if altered, are known to have risks.

Please see the Community Health Plan of Washington Transition Policy ([medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/](http://medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/)) for more information.

Admission or discharge from a long-term care facility should not affect access to your Part D benefits.

## **For more information**

For more detailed information about your Community Health Plan of Washington Medicare Advantage prescription drug coverage, please review your Evidence of Coverage and other plan materials.

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

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

## **Community Health Plan of Washington Medicare Advantage Formulary**

The formulary that begins on page 19 provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 87.

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

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

### **List of Abbreviations**

- **BvD PA:** This prescription may be covered under Medicare Part B or Medicare Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- **LA:** Limited Availability. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Customer Service at 1-800-942-0247, 7 days a week, 8 a.m. to 8 p.m. TTY users should dial 711.
- **MO:** Mail-Order Drug. This prescription is available through our mail-order service, as well as our retail network pharmacies. Consider using mail-order for your long-term (maintenance) medications (such as high blood pressure medications). Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.
- **PA:** Prior Authorization. The plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **ST:** Step Therapy. In some cases, the plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.
- **QL:** Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

## Drug Payment Stages and Drug Tiers

The amount you pay for a covered drug will depend on:

- **Drug payment stage.** There are different stages of drug coverage in your plan. The amount you pay will depend on the coverage stage you're in.
- **Drug tier.** There are five drug tiers. Each tier has a copay and/or coinsurance amount. The table below shows the differences between the tiers.

Please reference your Evidence of Coverage for more information about drug coverage and copay or coinsurance amounts for each tier.

Drug Tier	Includes
Tier 1	Tier 1 is the lowest tier and includes preferred generic drugs.
Tier 2	Tier 2 includes generic drugs.
Tier 3	Tier 3 includes preferred brand drugs and non-preferred generic drugs.
Tier 4	Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.
Tier 5	Tier 5 is the highest tier. It contains very high-cost brand and generic drugs, which may require special handling and/or close monitoring.

## Extra Help

Members who qualify will receive Extra Help for prescription drug, copays, and coinsurance. Please read the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), to learn about your costs. You may also call Customer Service. Our contact information appears on the front and back cover pages.

# **Community Health Plan of Washington**

## **Medicare Advantage**

### **(HMO) Formulario de 2025**

#### **Lista de medicamentos cubiertos**

**LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE  
LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN**

HPMS Approved Formulary File Submission ID 00025144, Version Number 7

Este formulario se actualizó el 26/08/2024. Para obtener información actualizada o hacer alguna pregunta, comuníquese con el Servicio de atención al cliente de Community Health Plan of Washington (CHPW) al 1-800-942-0247 (los usuarios de TTY deben llamar al 711) los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., o visite [medicare.chpw.org](http://medicare.chpw.org).

**Nota para miembros actuales:** Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que todavía incluye los medicamentos que toma.

Cuando esta lista de medicamentos (formulario) dice “nosotros” “nos” o “nuestro”, hace referencia a Community Health Plan of Washington. Cuando menciona “plan” o “nuestro plan”, se refiere a Medicare Advantage de Community Health Plan of Washington (HMO).

Este documento incluye una lista de medicamentos (formulario) para nuestro plan que está vigente desde 26/08/2024. Para obtener un formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Por lo general, debe acudir a las farmacias de la red para usar el beneficio de medicamentos recetados. Los beneficios, el formulario, la red de farmacias, o los copagos/coseguros pueden cambiar el 1 de enero de 2025 y de vez en cuando durante el año.

## ¿Qué es el formulario de los de Community Health Plan of Washington?

Un formulario es una lista de medicamentos cubiertos seleccionados por nuestro plan, en colaboración con un equipo de proveedores de atención médica, que representa las terapias con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Generalmente cubriremos los medicamentos que se mencionan en nuestro formulario, siempre y cuando el medicamento sea médicalemente necesario, la receta se presente en una farmacia de la red del plan y se cumpla con otras normas del plan. Para obtener más información sobre cómo surtir sus recetas, revise su Evidencia de cobertura.

## ¿Puede el Formulario (lista de medicamentos) cambiar?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos añadir o retirar medicamentos de la lista de medicamentos durante el año, pasarlo a diferentes niveles de gastos compartidos o añadir nuevas restricciones. Debemos seguir las normas de Medicare a la hora de hacer estos cambios.

**Los cambios que pueden afectarle este año:** en los siguientes casos, se verá afectado por cambios los de cobertura durante el año:

- **Medicamentos genéricos nuevos.** Podemos retirar de inmediato un medicamento de marca de nuestra Lista de medicamentos si lo reemplazamos por un nuevo medicamento genérico que aparecerá en el mismo nivel de gasto compartido o en uno menor y con las mismas restricciones o menos. Además, al añadir el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero cambiarlo de inmediato a un nivel de gastos compartidos diferente o añadir nuevas restricciones. Si actualmente toma ese medicamento de marca, es posible que no informemos por adelantado que haremos ese cambio, pero luego le brindaremos información sobre los cambios específicos que hemos hecho.
  - Si implementamos dicho cambio, usted u otra persona autorizada a dar recetas pueden solicitarle al plan que realice una excepción y siga cubriendo el medicamento de marca para usted. La notificación que le brindamos también incluirá información sobre cómo solicitar una excepción, además puede encontrar información en la sección a continuación titulada

“¿Cómo solicito una excepción al formulario de Medicare Advantage de Community Health Plan of Washington?”

- **Medicamentos retirados del mercado.** Si la Administración de Drogas y Alimentos (FDA) considera que un medicamento de nuestro formulario no es seguro, o si el fabricante del medicamento lo quita del mercado, eliminaremos inmediatamente dicho medicamento de nuestro formulario y enviaremos un aviso a los miembros que toman ese medicamento.
- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que toman actualmente un medicamento. Por ejemplo, podríamos añadir un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que figure actualmente en el formulario, o añadir nuevas restricciones al medicamento de marca o moverlo a un nivel de gastos compartidos diferente, o ambas opciones. O bien, podemos realizar cambios según nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, o agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, debemos notificar a los miembros afectados sobre el cambio, al menos 30 días antes de que el cambio esté vigente, o cuando el miembro solicite un resurtido del medicamento, en cuyo momento el miembro recibirá un suministro del medicamento para hasta 30 días.
  - Si realizamos estos cambios, usted y su proveedor pueden solicitar al plan que haga una excepción y siga cubriendo el medicamento de marca para usted. La notificación que le brindamos también incluirá información sobre cómo solicitar una excepción, y además puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción al formulario de los planes de Community Health Plan of Washington?”

**Cambios que no le afectarán si actualmente está tomando el medicamento.** Por lo general, si toma un medicamento que se encuentra en nuestro formulario de 2025 que estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2025, excepto en los casos que se describieron anteriormente. Esto significa que estos medicamentos permanecerán disponibles con los mismos gastos compartidos y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. No recibirá un aviso directo sobre los cambios que no le afecten este año. Sin embargo, dichos cambios podrían afectarle a partir del 1 de enero del año siguiente, y es importante que revise la Lista de medicamentos del nuevo año de beneficios para ver los cambios.

El formulario adjunto está vigente desde 26/08/2024. Para obtener información actualizada sobre los medicamentos cubiertos por el plan, comuníquese con nosotros. Nuestra información de contacto aparece en las páginas de portada y contraportada.

## ¿Cómo uso el Formulario?

Existen dos maneras de buscar un medicamento dentro del formulario:

### Afección médica

El formulario comienza en la página 19. En este formulario, los medicamentos se dividen en categorías según el tipo de afección médica que tratan. Por ejemplo, los medicamentos que se utilizan para tratar una afección cardíaca se enumeran bajo la categoría: "Cardiovascular, Hipertensión/Lípidos". Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 19. Luego, busque el nombre del medicamento debajo del nombre de la categoría.

### Orden alfabético

Si no está seguro en qué categoría debe buscar, busque el medicamento en el índice que comienza en la página 87. El índice le proporciona una lista en orden alfabético de todos los medicamentos incluidos en este documento. Allí se enumeran los medicamentos de marca y los medicamentos genéricos. Busque en el índice y encuentre su medicamento. Al lado de medicamento, verá el número de página en donde puede encontrar la información de cobertura. Vaya a la página que figura en el índice y busque el nombre del medicamento en la primera columna de la lista.

## ¿Qué son los medicamentos genéricos?

Nuestro plan cubre medicamentos de marca y genéricos. La Administración de Alimentos y Medicamentos (FDA) aprueba un medicamento genérico cuando considera que contiene el mismo ingrediente activo que el medicamento de marca. En general, los medicamentos genéricos cuestan menos que los medicamentos de marca.

## **¿Existe alguna restricción en mi cobertura?**

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales en la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** Nuestro plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener la aprobación de nuestro plan antes de surtir sus recetas. Si no obtiene la aprobación, es posible que el plan no cubra el medicamento.
- **Límites en la cantidad:** Para ciertos medicamentos, nuestro plan limita la cantidad de medicamento que cubriremos. Por ejemplo, el plan ofrece 30 comprimidos por receta de simvastatina. Esto puede ser adicional a un suministro estándar de uno o tres meses.
- **Tratamiento escalonado:** En algunos casos, nuestro plan requiere que primero pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para su afección. Por ejemplo, si el medicamento A y el medicamento B tratan su afección médica, es posible que nuestro plan no cubra el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le funciona, entonces el plan cubrirá el medicamento B.

Puede averiguar si un medicamento tiene límites o requisitos adicionales al consultar el formulario que comienza en la página 16. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos si visita nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y tratamiento escalonado. También puede solicitar que le envíemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Puede solicitar que hagamos una excepción a estos límites o restricciones, o que le demos una lista de medicamentos similares que puedan utilizarse para tratar su afección médica. Consulte la sección “¿Cómo solicito una excepción al formulario de los Medicare Advantage de Community Health Plan of Washington?” en la página 16 para obtener más información sobre cómo solicitar una excepción.

## **¿Qué pasa si mi medicamento no está en el formulario?**

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicio de atención al cliente y preguntar si su medicamento está cubierto.

Si se le comunica que el plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar a Servicio de atención al cliente una lista de medicamentos similares cubiertos por el plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por nuestro plan.
- Puede solicitar que hagamos una excepción y cubramos su medicamento. Consulte a

continuación para obtener más información sobre cómo solicitar una excepción.

## **¿Cómo solicito una excepción al formulario Medicare Advantage de Community Health Plan of Washington?**

Puede solicitar que hagamos una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede pedirnos que cubramos un medicamento incluso si no figura en nuestro formulario. Si se aprueba, este medicamento se cubrirá a un nivel de costo compartido predeterminado, y no podrá solicitarnos que proporcionemos el medicamento a un nivel de costo compartido menor.
- Puede pedirnos que no apliquemos los límites o restricciones de cobertura de su medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad de medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que no apliquemos el límite y que cubramos un monto mayor.

En general, nuestro plan solo aprobará su solicitud de excepción si el medicamento alternativo incluido en el formulario del plan, o las restricciones de uso adicionales, no son tan efectivos para el tratamiento de su afección o si estos pueden causarle efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión de cobertura inicial sobre una excepción a nuestro formulario o a las restricciones de uso. **Cuando solicita una excepción a nuestro formulario o a las restricciones de uso, debe presentar una declaración de su médico o una persona autorizada a emitir recetas que respalde su solicitud.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de recibir la declaración de apoyo de su recetador. Puede solicitar una excepción acelerada (rápida) si usted o su médico creen que su salud podría ser perjudicada gravemente al esperar 72 horas por una decisión. Si se concede su solicitud de apelación acelerada, debemos comunicarle una decisión en un plazo máximo de 24 horas después de recibir una declaración de apoyo de su médico u otro recetador.

## **¿Qué hago antes de poder hablar con mi médico sobre cambiar de medicamentos o solicitar una excepción?**

Como miembro nuevo o actual de nuestro plan, es posible que esté tomando medicamentos que no estén en nuestro formulario. O bien, puede estar tomando un medicamento que sí está en nuestro formulario, pero su capacidad para obtenerlo es limitada. Por ejemplo, es posible que necesite una autorización previa de nuestra parte antes de que pueda surtir sus medicamentos recetados. Debe hablar con su médico para decidir si debe cambiar a un medicamento adecuado que cubramos o solicitar una excepción para el formulario para que cubramos el medicamento que toma. Mientras habla con su médico para determinar el curso de acción correcto para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días tras convertirse en un miembro del nuestro plan.

Para cada uno de los medicamentos que no estén en nuestro formulario, o si su acceso a estos medicamentos es limitado, cubriremos un suministro temporal de 30 días. Si su receta está indicada para menos días, permitiremos obtener varias veces los medicamentos hasta llegar a un máximo de un

suministro para 30 días del medicamento. Luego de su primer suministro de 30 días, no pagaremos por estos medicamentos, incluso si usted ha sido miembro del plan durante menos de 90 días.

Si es un residente de un centro de atención a largo plazo y necesita un medicamento que no está en nuestro formulario, o si su acceso a estos medicamentos es limitado, pero ya ha superado los primeros 90 días como miembro de nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento mientras intenta obtener una excepción al formulario.

## **Nuestra política con respecto a los cambios en el nivel de atención**

Puede haber cambios en el entorno de su tratamiento debido al nivel de atención que requiere. Dichas transiciones incluyen las siguientes:

1. ser dado de alta de un hospital a su casa;
2. finalizar su estadía en un establecimiento de enfermería especializada de la Parte A (en la que los pagos incluyen todos los cargos farmacéuticos) a raíz de una necesidad de usar su plan de la Parte D;
3. renunciar al Estado de necesidad de cuidados paliativos y volver a la cobertura de la Parte A y B estándar de Medicare;
4. ser dado de alta de hospitales psiquiátricos con regímenes altos de medicamentos individualizados.

Para estas transiciones no planificadas, es posible que necesite solicitar una excepción o apelación para una cobertura continua de su medicamento. Además, revisaremos las solicitudes de continuación del tratamiento sobre una base de caso por caso si ha tenido un cambio en el nivel de atención y si está estable en un régimen de medicamento que, si es alterado, tiene riesgos conocidos.

Lea la política de transición de Community Health Plan of Washington ([medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/](http://medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/)) para obtener más información

La admisión o el alta de un establecimiento de cuidados a largo plazo no debería afectar sus beneficios de la Parte D.

## **Para obtener más información**

Para obtener información más detallada sobre la cobertura de medicamentos recetados de Medicare Advantage de Community Health Plan of Washington, revise su Evidencia de cobertura y otros materiales del plan.

Si tiene alguna pregunta sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, llame al 1-800-MEDICARE (1-800-633-4227), disponible las 24 horas del día, los 7 días de la semana. Los usuarios

de TTY deben llamar al 1-877-486-2048. O visite <http://www.medicare.gov>.

## **Formulario de Medicare Advantage de Community Health Plan of Washington**

El formulario que comienza en la página 19 ofrece información de cobertura sobre los medicamentos cubiertos en nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, diríjase al índice que comienza en la página 87.

En la primera columna de la tabla aparece el nombre del medicamento. Los medicamentos de marca están escritos en mayúscula (por ejemplo, RISPERDAL) y los medicamentos genéricos están escritos en minúscula cursiva (por ejemplo, *risperidona*).

La información en la columna de Requisitos/límites indica si su plan tiene algún requisito especial para la cobertura de su medicamento.

### **Lista de abreviaturas**

- **BvD PA:** esta receta puede estar cubierta por la Parte B o la Parte D de Medicare, según las circunstancias. Es posible que tenga que enviar información describiendo el uso y entorno del medicamento para realizar la determinación.
- **LA (Limited Availability):** disponibilidad limitada. Es posible que este medicamento recetado esté disponible solo en ciertas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame al Servicio de atención al cliente al 1-800-942-0247, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m. Los usuarios de TTY deben llamar al 711.
- **MO (Mail-Order):** medicamento de venta por correo. Esta receta está disponible a través de nuestro servicio de pedido por correo, así como de nuestras farmacias minoristas de la red. Considere utilizar el servicio de pedido por correo para sus medicamentos a largo plazo (medicamentos de mantenimiento), como los medicamentos para la presión arterial alta. Las farmacias minoristas de la red pueden ser más adecuadas para medicamentos recetados a corto plazo, como los antibióticos.
- **PA:** autorización previa. El plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener aprobación antes de surtir sus recetas. Si no obtiene la aprobación, puede que no cubramos el medicamento.
- **ST (Step Therapy):** tratamiento escalonado. En algunos casos, el plan requiere que pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para su afección. Por ejemplo, si el medicamento A y el medicamento B tratan la misma afección médica, es posible que no cubramos el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le funciona, entonces cubriremos el medicamento B.
- **QL (Quantity Limit):** límites en la cantidad. Para ciertos medicamentos, el plan limita la cantidad del medicamento que cubriremos.

## **Etapas del pago de los medicamentos y niveles de los medicamentos**

El monto que paga por un medicamento cubierto dependerá de lo siguiente:

- **Etapa del pago del medicamento.** Hay diferentes etapas de cobertura para los medicamentos de su plan. El monto que pague dependerá de la etapa de cobertura en la que se encuentre.
- **Nivel del medicamento.** Hay cinco niveles de medicamentos. Cada nivel tiene un monto de copago o coseguro. La siguiente tabla muestra las diferencias entre los niveles.

Consulte su Evidencia de cobertura para obtener más información sobre la cobertura de los medicamentos y los montos del copago o coseguro para cada nivel.

<b>Nivel del medicamento</b>	<b>Incluye</b>
Nivel 1	El Nivel 1 es el nivel más bajo e incluye los medicamentos genéricos preferidos.
Nivel 2	El Nivel 2 incluye los medicamentos genéricos.
Nivel 3	El Nivel 3 incluye los medicamentos de marca preferidos y los medicamentos genéricos no preferidos.
Nivel 4	El Nivel 4 incluye los medicamentos de marca no preferidos y los medicamentos genéricos no preferidos.
Nivel 5	El Nivel 5 es el nivel más alto. Contiene medicamentos genéricos y de marca de muy alto costo, que pueden requerir una administración especial o mucha supervisión.

## **Ayuda adicional**

Los miembros que reúnan los requisitos recibirán Ayuda adicional para los medicamentos recetados, los copagos y el coseguro. Lea la “Cláusula de la Evidencia de cobertura para las personas que reciben Ayuda adicional para pagar los medicamentos recetados” (Cláusula LIS) para conocer sus costos. También puede llamar al servicio de atención al cliente. Nuestra información de contacto aparece en las páginas de portada y contraportada.

**COMMUNITY HEALTH PLAN OF  
WASHINGTON**

**2025 PRESCRIPTION DRUG FORMULARY**

( 5 Tier)

**CURRENT AS OF 8/26/2024**

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<b>ANALGESICS</b>		
<b>ANALGESICS</b>		
ENDOCET	3	QL (360 EA per 30 days)
<b>NONSTEROIDAL ANTI-INFLAMMATORY DRUGS</b>		
celecoxib	3	
diclofenac potassium oral tablet 50 mg	2	
diclofenac sodium oral	2	
diflunisal	3	
etodolac oral capsule	3	
etodolac oral tablet	3	
flurbiprofen oral tablet 100 mg	2	
IBU ORAL TABLET 600 MG, 800 MG	1	
ibuprofen oral suspension	2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
meloxicam oral tablet	1	QL (30 EA per 30 days)
nabumetone	2	
naproxen oral tablet	1	
naproxen oral tablet, delayed release (dr/ec)	2	
oxaprozin oral tablet	4	
piroxicam	3	
sulindac	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<b>OPIOID ANALGESICS, LONG-ACTING</b>		
buprenorphine hcl sublingual	2	
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg	5	PA; QL (120 EA per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	4	PA; QL (120 EA per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	4	PA; QL (10 EA per 30 days)
hydromorphone (pf) injection solution 10 mg/ml	4	
hydromorphone oral tablet extended release 24 hr	4	PA; QL (60 EA per 30 days)
methadone oral solution 10 mg/5 ml	3	PA; QL (600 ML per 30 days)
methadone oral solution 5 mg/5 ml	3	PA; QL (1200 ML per 30 days)
methadone oral tablet 10 mg	3	PA; QL (120 EA per 30 days)
methadone oral tablet 5 mg	3	PA; QL (240 EA per 30 days)
morphine concentrate oral solution	3	QL (900 ML per 30 days)
morphine oral solution 10 mg/5 ml	3	QL (900 ML per 30 days)
morphine oral tablet 15 mg	3	QL (180 EA per 30 days)
morphine oral tablet extended release	3	PA; QL (120 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<b>OPIOID ANALGESICS, SHORT-ACTING</b>		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	3	QL (4500 ML per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	3	QL (360 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	3	QL (180 EA per 30 days)
<i>butorphanol nasal</i>	4	QL (10 ML per 28 days)
<b>ENDOCET</b>	3	QL (360 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	5	PA; QL (120 EA per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	4	PA; QL (120 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	4	PA; QL (10 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	3	QL (5550 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	3	QL (360 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	3	QL (50 EA per 30 days)
<i>hydromorphone (pf) injection solution 10 mg/ml</i>	4	
<i>hydromorphone oral liquid</i>	4	QL (2400 ML per 30 days)
<i>hydromorphone oral tablet</i>	3	QL (180 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>morphine concentrate oral solution</i>	3	QL (900 ML per 30 days)
<i>morphine oral solution</i>	3	QL (900 ML per 30 days)
<i>morphine oral tablet</i>	3	QL (180 EA per 30 days)
<i>oxycodone oral capsule</i>	3	QL (360 EA per 30 days)
<i>oxycodone oral concentrate</i>	4	QL (180 ML per 30 days)
<i>oxycodone oral solution</i>	3	QL (1200 ML per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	3	QL (180 EA per 30 days)
<i>oxycodone oral tablet 5 mg</i>	3	QL (360 EA per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	3	QL (360 EA per 30 days)
<i>tramadol oral tablet 50 mg</i>	2	QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	2	QL (240 EA per 30 days)
<b>ANESTHETICS</b>		
<b>LOCAL ANESTHETICS</b>		
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	3	
<i>lidocaine topical adhesive patch,medicated 5 %</i>	4	PA; QL (90 EA per 30 days)
<i>lidocaine topical ointment</i>	4	QL (36 GM per 30 days)
<b>LIDOCAINE VISCOUS</b>	2	
<i>lidocaine-prilocaine topical cream</i>	3	QL (30 GM per 30 days)
<b>LIDOCAN III</b>	4	PA; QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>ANTI- ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS</b>					
<b>ALCOHOL DETERRENTS/AN TI-CRAVING</b>					
<i>acamprosate</i>	4		<i>naloxone nasal</i>	2	
<i>disulfiram</i>	3		<b>SMOKING CESSATION AGENTS</b>		
<i>naltrexone</i>	2		<i>bupropion hcl (smoking deter)</i>	2	
<i>VIVITROL</i>	5		<i>NICOTROL NS</i>	4	
<b>OPIOID DEPENDENCE</b>			<i>varenicline oral tablet 0.5 mg, 1 mg</i>	4	
<i>buprenorphine hcl sublingual</i>	2		<i>varenicline oral tablets,dose pack</i>	4	
<i>buprenorphine- naxalone sublingual film 12-3 mg</i>	3	QL (60 EA per 30 days)	<b>ANTIBACTERIA LS</b>		
<i>buprenorphine- naxalone sublingual film 2-0.5 mg</i>	3	QL (360 EA per 30 days)	<b>AMINOGLYCOSIDES</b>		
<i>buprenorphine- naxalone sublingual film 4-1 mg, 8-2 mg</i>	3	QL (90 EA per 30 days)	<i>amikacin injection solution 500 mg/2 ml</i>	4	PA
<i>buprenorphine- naxalone sublingual tablet 2-0.5 mg</i>	2	QL (360 EA per 30 days)	<i>ARIKAYCE</i>	5	PA; LA
<i>buprenorphine- naxalone sublingual tablet 8-2 mg</i>	2	QL (90 EA per 30 days)	<i>gentamicin in nacl (iso- osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	4	PA
<i>naltrexone</i>	2		<i>gentamicin injection solution 40 mg/ml</i>	4	PA
<i>VIVITROL</i>	5		<i>gentamicin topical cream</i>	4	QL (60 GM per 30 days)
<b>OPIOID REVERSAL AGENTS</b>			<i>gentamicin topical ointment</i>	3	QL (60 GM per 30 days)
<i>naloxone injection solution</i>	2		<i>neomycin</i>	2	
<i>naloxone injection syringe 0.4 mg/ml, 1 mg/ml</i>	2		<i>streptomycin</i>	5	PA; QL (60 EA per 30 days)
<b>ANTIBACTERIALS , OTHER</b>			<i>tobramycin inhalation</i>	5	PA; QL (224 ML per 28 days)
			<i>tobramycin sulfate injection solution</i>	4	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>clindamycin in 5 % dextrose</i>	4	PA
<i>clindamycin phosphate injection</i>	4	PA
<i>clindamycin phosphate vaginal</i>	4	
<i>colistin (colistimethate na)</i>	5	PA; QL (30 EA per 10 days)
<i>daptomycin</i>	5	
<i>linezolid in dextrose 5%</i>	4	PA
<i>linezolid oral suspension for reconstitution</i>	5	
<i>linezolid oral tablet</i>	4	
<i>methenamine hippurate</i>	3	
<i>metronidazole in nacl (iso-os)</i>	4	PA
<i>metronidazole oral tablet</i>	2	
<i>metronidazole topical cream</i>	4	
<i>metronidazole topical gel</i>	4	
<i>metronidazole topical lotion</i>	4	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	3	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	3	
<i>nitrofurantoin monohyd/m-cryst</i>	3	
<i>tigecycline</i>	5	PA
<i>tinidazole</i>	3	
<i>trimethoprim</i>	2	
<i>vancomycin intravenous recon soln 1,000 mg</i>	4	PA; QL (20 EA per 10 days)
<i>vancomycin intravenous recon soln 10 gram</i>	4	PA; QL (2 EA per 10 days)
<i>vancomycin intravenous recon soln 500 mg</i>	4	PA; QL (10 EA per 10 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>vancomycin intravenous recon soln 750 mg</i>	4	PA; QL (27 EA per 10 days)
<i>vancomycin oral capsule 125 mg</i>	4	PA; QL (40 EA per 10 days)
<i>vancomycin oral capsule 250 mg</i>	4	PA; QL (80 EA per 10 days)
<i>XIFAXAN ORAL TABLET 200 MG</i>	3	PA; QL (9 EA per 30 days)
<i>XIFAXAN ORAL TABLET 550 MG</i>	5	PA; QL (90 EA per 30 days)
<b>BETA-LACTAM, CEPHALOSPORIN S</b>		
<i>cefaclor oral capsule</i>	3	
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml</i>	4	
<i>cefadroxil oral capsule</i>	2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	3	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	4	
<i>cefdinir oral capsule</i>	2	
<i>cefdinir oral suspension for reconstitution</i>	3	
<i>cefepime injection</i>	4	
<i>cefixime</i>	4	
<i>cefoxitin</i>	4	PA
<i>cefpodoxime</i>	4	
<i>cefprozil</i>	3	
<i>ceftazidime</i>	4	PA
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	4	
<i>cefuroxime axetil oral tablet</i>	3	
<i>cefuroxime sodium injection recon soln 750 mg</i>	4	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	4	PA
<i>cephalexin oral capsule 250 mg, 500 mg</i>	2	
<i>cephalexin oral suspension for reconstitution</i>	2	
TAZICEF INJECTION	4	PA
TEFLARO	5	PA
<b>BETA-LACTAM, PENICILLINS</b>		
<i>amoxicillin oral capsule</i>	2	
<i>amoxicillin oral suspension for reconstitution</i>	2	
<i>amoxicillin oral tablet</i>	2	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	2	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	2	
<i>amoxicillin-pot clavulanate oral tablet</i>	2	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	4	
<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	2	
<i>ampicillin oral capsule 500 mg</i>	2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	4	PA
<i>ampicillin-sulbactam injection</i>	4	PA
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
BICILLIN L-A	4	PA
<i>dicloxacillin</i>	2	
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	4	PA
<i>nafcillin injection recon soln 10 gram</i>	5	PA
<i>oxacillin</i>	4	PA
<i>oxacillin in dextrose(iso-osm)</i>	4	PA
<i>penicillin g potassium injection recon soln 20 million unit</i>	4	PA
<i>penicillin g sodium</i>	4	PA
<i>penicillin v potassium</i>	2	
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	4	
<b>CARBAPENEMS</b>		
<i>ertapenem</i>	4	PA; QL (14 EA per 14 days)
<i>imipenem-cilastatin</i>	4	PA
<i>meropenem intravenous recon soln 1 gram</i>	4	PA; QL (30 EA per 10 days)
<i>meropenem intravenous recon soln 500 mg</i>	4	PA; QL (10 EA per 10 days)
<b>MACROLIDES</b>		
<i>azithromycin intravenous</i>	4	PA
<i>azithromycin oral packet</i>	3	
<i>azithromycin oral suspension for reconstitution</i>	2	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	2	
<i>clarithromycin oral suspension for reconstitution</i>	4	
<i>clarithromycin oral tablet</i>	3	

Drug Name	Drug Tier	Requirements/ Limits
<i>clarithromycin oral tablet extended release 24 hr</i>	3	
DIFICID ORAL TABLET	5	QL (20 EA per 10 days)
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	4	
<i>erythromycin ethylsuccinate oral tablet</i>	4	
<i>erythromycin oral</i>	4	
<b>QUINOLONES</b>		
<i>ciprofloxacin hcl ophthalmic (eye)</i>	2	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	2	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	4	PA
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	4	PA
<i>levofloxacin oral solution</i>	4	
<i>levofloxacin oral tablet</i>	2	
<i>moxifloxacin oral</i>	3	
<i>moxifloxacin-sod.chloride(iso)</i>	4	PA
<b>SULFONAMIDES</b>		
<i>sulfacetamide sodium (acne)</i>	4	
<i>sulfadiazine</i>	4	
<i>sulfamethoxazole-trimethoprim oral suspension</i>	3	
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<b>TETRACYCLINES</b>		
DOXY-100	4	PA
<i>doxycycline hyclate oral capsule</i>	2	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	2	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	2	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	4	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	2	
<i>minocycline oral capsule</i>	2	
<i>minocycline oral tablet</i>	4	
<i>tetracycline oral capsule</i>	4	
<b>ANTICONVULSANTS</b>		
<b>ANTICONVULSANTS, OTHER</b>		
<i>BRIVIACT ORAL SOLUTION</i>	5	QL (600 ML per 30 days)
<i>BRIVIACT ORAL TABLET</i>	5	QL (60 EA per 30 days)
<i>DIACOMIT</i>	5	PAns; LA
<i>divalproex</i>	2	
<i>EPIDIOLEX</i>	5	PAns; LA
<i>EPRONTIA</i>	4	PAns
<i>felbamate oral suspension</i>	5	
<i>felbamate oral tablet</i>	4	
<i>FYCOMPA ORAL SUSPENSION</i>	5	QL (720 ML per 30 days)
<i>FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG</i>	5	QL (30 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
FYCOMPA ORAL TABLET 2 MG	4	QL (60 EA per 30 days)	XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	QL (28 EA per 180 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG	5	QL (60 EA per 30 days)	ZTALMY	5	PAns; LA; QL (1080 ML per 30 days)
<i>lamotrigine oral tablet</i>	1		<b>CALCIUM CHANNEL MODIFYING AGENTS</b>		
<i>lamotrigine oral tablet, chewable dispersible</i>	2		<i>ethosuximide</i>	3	
<i>lamotrigine oral tablet,disintegrating</i>	4		<i>methsuximide</i>	4	
<i>levetiracetam oral solution 100 mg/ml</i>	2		<i>pregabalin oral capsule</i> 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	3	QL (90 EA per 30 days)
<i>levetiracetam oral tablet</i>	2		<i>pregabalin oral capsule</i> 225 mg, 300 mg	3	QL (60 EA per 30 days)
<i>levetiracetam oral tablet extended release 24 hr</i>	3		<i>pregabalin oral solution</i>	3	QL (900 ML per 30 days)
ROWEPPRA ORAL TABLET 500 MG	2		<i>ZONISADE</i>	5	PAns
SPRITAM	4		<b>GAMMA- AMINOBUTYRIC ACID (GABA) MODULATING AGENTS</b>		
SUBVENITE	1		<i>clobazam oral suspension</i>	4	PAns; QL (480 ML per 30 days)
<i>topiramate oral capsule, sprinkle</i>	2	PAns	<i>clobazam oral tablet</i>	4	PAns; QL (60 EA per 30 days)
<i>topiramate oral tablet</i>	2	PAns	<i>clonazepam oral tablet</i> 0.5 mg, 1 mg	2	QL (90 EA per 30 days)
<i>valproic acid</i>	2		<i>clonazepam oral tablet</i> 2 mg	2	QL (300 EA per 30 days)
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2		<i>clonazepam oral tablet,disintegrating</i> 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	4	QL (90 EA per 30 days)
XCOPRI MAINTENANCE PACK	5	QL (56 EA per 28 days)			
XCOPRI ORAL TABLET 100 MG	5	QL (120 EA per 30 days)			
XCOPRI ORAL TABLET 150 MG, 200 MG	5	QL (60 EA per 30 days)			
XCOPRI ORAL TABLET 50 MG	5	QL (240 EA per 30 days)			
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	QL (28 EA per 180 days)			

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>clonazepam oral tablet,disintegrating 2 mg</i>	4	QL (300 EA per 30 days)	NAYZILAM	5	PAns; QL (10 EA per 30 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	4	PAns; QL (180 EA per 30 days)	<i>phenobarbital oral elixir</i>	4	PAns
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	4	PAns; QL (90 EA per 30 days)	<i>phenobarbital oral tablet</i>	3	PAns
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	4	PAns; QL (360 EA per 30 days)	<i>pregabalin oral capsule 200 mg</i>	3	QL (90 EA per 30 days)
DIAZEPAM INTENSOL	2	PAns; QL (240 ML per 30 days)	<i>pregabalin oral capsule 300 mg</i>	3	QL (60 EA per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	PAns; QL (1200 ML per 30 days)	<i>pregabalin oral solution</i>	3	QL (900 ML per 30 days)
<i>diazepam oral tablet</i>	2	PAns; QL (120 EA per 30 days)	<i>primidone oral tablet 125 mg</i>	4	
<i>diazepam rectal</i>	4		<i>primidone oral tablet 250 mg, 50 mg</i>	2	
<i> gabapentin oral capsule 100 mg, 400 mg</i>	2	QL (270 EA per 30 days)	SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PAns; QL (60 EA per 30 days)
<i> gabapentin oral capsule 300 mg</i>	2	QL (360 EA per 30 days)	SYMPAZAN ORAL FILM 5 MG	4	PAns; QL (60 EA per 30 days)
<i> gabapentin oral solution 250 mg/5 ml</i>	3	QL (2160 ML per 30 days)	<i>tiagabine</i>	4	
<i> gabapentin oral tablet 600 mg</i>	2	QL (180 EA per 30 days)	VALTOCO	5	PAns; QL (10 EA per 30 days)
<i> gabapentin oral tablet 800 mg</i>	2	QL (120 EA per 30 days)	<i>vigabatrin</i>	5	PAns; LA
LIBERVANT	5	PAns; QL (10 EA per 30 days)	VIGADRONE	5	PAns; LA
LORAZEPAM INTENSOL	2	PA; QL (150 ML per 30 days)	VIGPODER	5	PAns; LA
<i> lorazepam oral tablet 0.5 mg, 1 mg</i>	2	PA; QL (90 EA per 30 days)	ZTALMY	5	PAns; LA; QL (1080 ML per 30 days)
<i> lorazepam oral tablet 2 mg</i>	2	PA; QL (150 EA per 30 days)	<b>SODIUM CHANNEL AGENTS</b>		
			APTIOM ORAL TABLET 200 MG	5	QL (180 EA per 30 days)
			APTIOM ORAL TABLET 400 MG	5	QL (90 EA per 30 days)
			APTIOM ORAL TABLET 600 MG, 800 MG	5	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
carbamazepine oral capsule, er multiphase 12 hr	4	
carbamazepine oral suspension 100 mg/5 ml	4	
carbamazepine oral tablet	3	
carbamazepine oral tablet extended release 12 hr	4	
carbamazepine oral tablet, chewable	3	
DILANTIN	4	
EPITOL	3	
lacosamide oral solution	4	QL (1200 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg	4	QL (60 EA per 30 days)
lacosamide oral tablet 50 mg	4	QL (120 EA per 30 days)
oxcarbazepine oral suspension	4	
oxcarbazepine oral tablet	3	
phenytoin oral suspension 125 mg/5 ml	2	
phenytoin oral tablet, chewable	3	
phenytoin sodium extended	2	
rufinamide oral suspension	5	PAns
rufinamide oral tablet 200 mg	4	PAns
rufinamide oral tablet 400 mg	5	PAns
ZONISADE	5	PAns
zonisamide	2	PAns

Drug Name	Drug Tier	Requirements/ Limits
<b>ANTIDEMENTI A AGENTS</b>		
<b>ANTIDEMENTIA AGENTS, OTHER</b>		
donepezil oral tablet 10 mg, 5 mg	2	
donepezil oral tablet,disintegrating	2	
NAMZARIC	3	PA
<b>CHOLINESTERAS E INHIBITORS</b>		
donepezil oral tablet 10 mg, 5 mg	2	
donepezil oral tablet,disintegrating	2	
galantamine oral capsule,ext rel. pellets 24 hr	3	
galantamine oral solution	4	
galantamine oral tablet	3	
rivastigmine	4	
rivastigmine tartrate	3	
<b>N-METHYL-D- ASPARTATE (NMDA) RECEPTOR ANTAGONIST</b>		
memantine oral capsule,sprinkle,er 24hr	4	PA
memantine oral solution	4	PA
memantine oral tablet	3	PA
<b>ANTIDEPRESSA NTS</b>		
<b>ANTIDEPRESSANT S, OTHER</b>		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTEN DED REL SYRING 720 MG/2.4 ML	5	QL (2.4 ML per 56 days)

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	5	QL (3.2 ML per 56 days)	ZURZUVAE ORAL CAPSULE 30 MG	5	PAns; QL (14 EA per 365 days)
ABILIFY MAINTENA	5	QL (1 EA per 28 days)	<b>MONOAMINE OXIDASE INHIBITORS</b>		
<i>aripiprazole oral solution</i>	4	ST	EMSAM	5	
<i>aripiprazole oral tablet</i>	3	ST; QL (30 EA per 30 days)	MARPLAN	4	
<i>aripiprazole oral tablet,disintegrating</i>	4	ST; QL (60 EA per 30 days)	<i>phenelzine</i>	3	
AUVELITY	5	ST; QL (60 EA per 30 days)	<i>tranylcypromine</i>	4	
<i>bupropion hcl oral tablet</i>	2	ST	<b>SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)</b>		
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	2	ST; QL (90 EA per 30 days)	<i>citalopram oral solution</i>	3	ST
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	2	ST; QL (30 EA per 30 days)	<i>citalopram oral tablet</i>	1	ST; QL (30 EA per 30 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	2	ST; QL (60 EA per 30 days)	<i>desvenlafaxine succinate</i>	4	ST; QL (30 EA per 30 days)
<i>mirtazapine oral tablet</i>	2		<i>duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	ST; QL (60 EA per 30 days)
<i>mirtazapine oral tablet,disintegrating</i>	3		<i>escitalopram oxalate oral solution</i>	4	ST
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	ST; QL (90 EA per 30 days)	<i>escitalopram oxalate oral tablet</i>	2	ST; QL (30 EA per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	2	ST; QL (60 EA per 30 days)	FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	4	QL (28 EA per 180 days)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	4	ST; QL (30 EA per 30 days)	FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	4	QL (30 EA per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	4	ST; QL (60 EA per 30 days)	<i>fluoxetine oral capsule 10 mg</i>	1	ST; QL (30 EA per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	5	PAns; QL (28 EA per 365 days)	<i>fluoxetine oral capsule 20 mg</i>	1	ST; QL (90 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>fluoxetine oral capsule 40 mg</i>	1	ST; QL (60 EA per 30 days)
<i>fluoxetine oral solution</i>	2	ST
<i>fluvoxamine oral tablet 100 mg</i>	3	ST; QL (90 EA per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	3	ST; QL (30 EA per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	3	ST; QL (60 EA per 30 days)
<i>nefazodone</i>	4	ST
<i>paroxetine hcl oral suspension</i>	4	ST
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	ST; QL (30 EA per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	2	ST; QL (60 EA per 30 days)
<i>sertraline oral concentrate</i>	4	ST
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	ST; QL (60 EA per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	ST; QL (30 EA per 30 days)
<i>trazodone</i>	1	
<b>TRINTELLIX</b>	3	QL (30 EA per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	2	ST; QL (30 EA per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	2	ST; QL (90 EA per 30 days)
<i>venlafaxine oral tablet</i>	2	ST; QL (90 EA per 30 days)
<i>vilazodone</i>	3	ST; QL (30 EA per 30 days)
<b>TRICYCLICS</b>		
<i>amitriptyline</i>	2	
<i>amoxapine</i>	3	
<i>clomipramine</i>	4	
<i>desipramine</i>	4	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>doxepin oral capsule</i>	4	
<i>doxepin oral concentrate</i>	4	
<i>doxepin oral tablet</i>	3	QL (30 EA per 30 days)
<i>imipramine hcl</i>	4	
<i>nortriptyline oral capsule</i>	2	
<i>nortriptyline oral solution</i>	4	
<i>protriptyline</i>	4	
<i>trimipramine</i>	4	
<b>ANTIEMETICS</b>		
<b>ANTIEMETICS, OTHER</b>		
<i>chlorpromazine oral</i>	4	
<b>COMPRO</b>	4	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	
<i>metoclopramide hcl oral solution</i>	2	
<i>metoclopramide hcl oral tablet</i>	2	
<i>perphenazine</i>	4	
<i>prochlorperazine</i>	4	
<i>prochlorperazine maleate</i>	2	
<i>promethazine oral</i>	4	PA
<i>scopolamine base</i>	4	
<b>EMETOGENIC THERAPY ADJUNCTS</b>		
<i>aprepitant</i>	4	BvD
<i>dronabinol</i>	4	BvD
<i>gransetron hcl oral</i>	4	BvD
<i>ondansetron hcl oral solution</i>	4	BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	2	BvD

Drug Name	Drug Tier	Requirements/ Limits
<i>ondansetron oral tablet,disintegrating 4 mg, 8 mg</i>	2	BvD
VARUBI	3	BvD
<b>ANTIFUNGALS</b>		
<b>ANTIFUNGALS</b>		
ABELCET	4	BvD
<i>amphotericin b</i>	4	BvD
<i>caspofungin intravenous recon soln 50 mg</i>	5	
<i>caspofungin intravenous recon soln 70 mg</i>	4	
<i>ciclopirox topical cream</i>	2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	3	QL (100 GM per 28 days)
<i>ciclopirox topical shampoo</i>	3	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	2	QL (6.6 ML per 28 days)
<i>ciclopirox topical suspension</i>	3	QL (60 ML per 28 days)
<i>clotrimazole mucous membrane</i>	2	
<i>clotrimazole topical cream</i>	2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	2	QL (30 ML per 28 days)
CRESEMBIA ORAL	5	PA
econazole	4	QL (85 GM per 28 days)
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	4	PA
<i>fluconazole oral suspension for reconstitution</i>	3	
<i>fluconazole oral tablet</i>	2	
<i>flucytosine</i>	5	
<i>griseofulvin microsize</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>griseofulvin ultramicrosize</i>	4	
<i>itraconazole oral capsule</i>	4	QL (120 EA per 30 days)
<i>itraconazole oral solution</i>	4	
<i>ketoconazole oral</i>	2	
<i>ketoconazole topical cream</i>	2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	2	QL (120 ML per 28 days)
<i>micafungin</i>	5	
<i>naftifine topical gel 2 %</i>	4	QL (60 GM per 28 days)
NYAMYC	3	QL (180 GM per 30 days)
<i>nystatin oral</i>	2	
<i>nystatin topical cream</i>	2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	3	QL (180 GM per 30 days)
NYSTOP	3	QL (180 GM per 30 days)
<i>posaconazole oral tablet,delayed release (dr/ec)</i>	5	PA; QL (96 EA per 30 days)
<i>terbinafine hcl oral</i>	2	
<i>terconazole</i>	3	
<i>voriconazole intravenous</i>	5	PA
<i>voriconazole oral suspension for reconstitution</i>	5	PA
<i>voriconazole oral tablet</i>	4	PA
<b>ANTIGOUT AGENTS</b>		
<b>ANTIGOUT AGENTS</b>		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	

Drug Name	Drug Tier	Requirements/ Limits
<i>colchicine oral tablet</i>	3	
<i>febuxostat</i>	3	
<i>probenecid</i>	3	
<i>probenecid-colchicine</i>	3	
<b>ANTIMIGRAINE AGENTS</b>		
<b>ANTIMIGRAINE AGENTS</b>		
NURTEC ODT	3	PA; QL (16 EA per 30 days)
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONISTS</b>		
EMGALITY PEN	3	PA; QL (2 ML per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	3	PA; QL (2 ML per 30 days)
NURTEC ODT	3	PA; QL (16 EA per 30 days)
<b>ERGOT ALKALOIDS</b>		
<i>dihydroergotamine nasal</i>	5	QL (8 ML per 28 days)
<i>ergotamine-caffeine</i>	3	
<b>PROPHYLACTIC</b>		
<i>divalproex</i>	2	
EPRONTIA	4	PAns
<i>timolol maleate oral</i>	4	
<i>topiramate oral capsule, sprinkle</i>	2	PAns
<i>topiramate oral tablet</i>	2	PAns
<i>valproic acid</i>	2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2	

Drug Name	Drug Tier	Requirements/ Limits
<b>SEROTONIN (5- HT) RECEPTOR AGONIST</b>		
<i>naratriptan</i>	3	QL (18 EA per 28 days)
<i>rizatriptan oral tablet</i>	2	QL (36 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating</i>	3	QL (36 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	4	QL (18 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	4	QL (36 EA per 28 days)
<i>sumatriptan succinate oral</i>	2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	4	QL (8 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector</i>	4	QL (8 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	4	QL (8 ML per 28 days)
<b>ANTIMYASTHE NIC AGENTS</b>		
<b>PARASYMPATHO MIMETICS</b>		
<i>pyridostigmine bromide oral tablet 60 mg</i>	3	
<i>pyridostigmine bromide oral tablet extended release</i>	3	
<b>ANTIMYCOBAC TERIALS</b>		
<b>ANTIMYCOBACTE RIALS, OTHER</b>		
<i>dapsone oral</i>	3	
<i>PRIFTIN</i>	3	
<i>rifabutin</i>	4	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>ANTITUBERCULARS</b>					
<i>ethambutol</i>	3		XTANDI ORAL TABLET 40 MG	5	PAns; QL (120 EA per 30 days)
<i>isoniazid oral solution</i>	4		XTANDI ORAL TABLET 80 MG	5	PAns; QL (60 EA per 30 days)
<i>isoniazid oral tablet</i>	2		<b>ANTIANGIOGENIC AGENTS</b>		
<b>PRIFTIN</b>	3		<i>lenalidomide</i>	5	PAns; QL (28 EA per 28 days)
<i>pyrazinamide</i>	4		<b>POMALYST</b>	5	PAns; LA
<i>rifampin intravenous</i>	4		THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PAns; QL (28 EA per 28 days)
<i>rifampin oral</i>	3		<b>ANTIESTROGENS/ MODIFIERS</b>		
<b>SIRTURO</b>	5	PA; LA	<b>ORSERDU ORAL TABLET 345 MG</b>	5	PAns; QL (30 EA per 30 days)
<b>TRECATOR</b>	4		<b>ORSERDU ORAL TABLET 86 MG</b>	5	PAns; QL (90 EA per 30 days)
<b>ANTINEOPLASTICS</b>			<b>SOLTAMOX</b>	5	
<b>ALKYLATING AGENTS</b>			<i>tamoxifen</i>	2	
<i>cyclophosphamide oral</i>	3	BvD	<i>toremifene</i>	5	
<b>GLEOSTINE</b>	5		<b>ANTIMETABOLITES</b>		
<b>MATULANE</b>	5		<b>BESREMI</b>	5	PAns; LA
<b>VALCHLOR</b>	5	PAns	<b>DROXIA</b>	3	
<b>ANTIANDROGENS</b>			<i>fluorouracil topical cream 5 %</i>	3	
<i>abiraterone oral tablet 250 mg</i>	5	PAns; QL (120 EA per 30 days)	<i>fluorouracil topical solution</i>	3	
<i>abiraterone oral tablet 500 mg</i>	5	PAns; QL (60 EA per 30 days)	<i>hydroxyurea</i>	2	
<i>bicalutamide</i>	2		<i>mercaptopurine</i>	3	
<b>ERLEADA ORAL TABLET 240 MG</b>	5	PAns; QL (30 EA per 30 days)	<b>ONUREG</b>	5	PAns; QL (14 EA per 28 days)
<b>ERLEADA ORAL TABLET 60 MG</b>	5	PAns; QL (120 EA per 30 days)	<b>PURIXAN</b>	5	
<i>nilutamide</i>	5	PAns			
<b>NUBEQA</b>	5	PAns; LA; QL (120 EA per 30 days)			
<i>toremifene</i>	5				
<b>XTANDI ORAL CAPSULE</b>	5	PAns; QL (120 EA per 30 days)			

Drug Name	Drug Tier	Requirements/ Limits
<b>ANTINEOPLASTIC S, OTHER</b>		
<i>hydroxyurea</i>	2	
IDHIFA	5	PAbs; LA; QL (30 EA per 30 days)
INQOVI	5	PAbs; QL (5 EA per 28 days)
IWILFIN	5	PAbs; LA; QL (240 EA per 30 days)
<i>leucovorin calcium oral</i>	3	
LONSURF	5	PAbs
LYNPARZA	5	PAbs; QL (120 EA per 30 days)
LYSODREN	5	
<i>methotrexate sodium</i>	2	BvD
<i>methotrexate sodium (pf) injection solution</i>	2	BvD
NINLARO	5	PAbs; QL (3 EA per 28 days)
OJJAARA	5	PAbs; QL (30 EA per 30 days)
ORGOVYXX	5	PAbs; LA; QL (30 EA per 28 days)
RETEVMO ORAL CAPSULE 40 MG	5	PAbs; LA; QL (180 EA per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5	PAbs; LA; QL (120 EA per 30 days)
XATMEP	4	BvD
XPOVIO	5	PAbs; LA
ZOLINZA	5	PAbs; QL (120 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<b>AROMATASE INHIBITORS, 3RD GENERATION</b>		
<i>anastrozole</i>	2	
<i>exemestane</i>	4	
<i>letrozole</i>	2	
<b>ENZYME INHIBITORS</b>		
IBRANCE ORAL TABLET	5	PAbs; QL (21 EA per 28 days)
TIBSOVO	5	PAbs
<b>MOLECULAR TARGET INHIBITORS</b>		
AKEEGA	5	PAbs; LA; QL (60 EA per 30 days)
ALECensa	5	PAbs; QL (240 EA per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PAbs; QL (30 EA per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PAbs; QL (60 EA per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	5	PAbs; QL (30 EA per 180 days)
AUGTYRO	5	PAbs; QL (240 EA per 30 days)
AYVAKIT	5	PAbs; LA; QL (30 EA per 30 days)
BALVERSA	5	PAbs; LA
BOSULIF ORAL CAPSULE 100 MG	5	PAbs; QL (90 EA per 30 days)
BOSULIF ORAL CAPSULE 50 MG	5	PAbs; QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
BOSULIF ORAL TABLET 100 MG	5	PAns; QL (90 EA per 30 days)	DAURISMO ORAL TABLET 25 MG	5	PAns; QL (60 EA per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PAns; QL (30 EA per 30 days)	ERIVEDGE	5	PAns; QL (30 EA per 30 days)
BRAFTOVI	5	PAns; LA; QL (180 EA per 30 days)	<i>erlotinib oral tablet 100 mg, 150 mg</i>	5	PAns; QL (30 EA per 30 days)
BRUKINSA	5	PAns; LA; QL (120 EA per 30 days)	<i>erlotinib oral tablet 25 mg</i>	5	PAns; QL (60 EA per 30 days)
CABOMETYX	5	PAns; LA; QL (30 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet</i>	5	PAns; QL (30 EA per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	5	PAns; LA; QL (60 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	5	PAns; QL (330 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG	5	PAns; LA; QL (60 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	5	PAns; QL (240 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PAns; LA; QL (30 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	5	PAns; QL (180 EA per 30 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	5	PAns; QL (56 EA per 28 days)	<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	4	BvD
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	5	PAns; QL (112 EA per 28 days)	<i>everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	5	BvD
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	5	PAns; QL (84 EA per 28 days)	FOTIVDA	5	PAns; LA; QL (21 EA per 28 days)
COPIKTRA	5	PAns; LA; QL (60 EA per 30 days)	FRUZAQLA ORAL CAPSULE 1 MG	5	PAns; QL (84 EA per 28 days)
COTELLIC	5	PAns; LA; QL (63 EA per 28 days)	FRUZAQLA ORAL CAPSULE 5 MG	5	PAns; QL (21 EA per 28 days)
DAURISMO ORAL TABLET 100 MG	5	PAns; QL (30 EA per 30 days)			

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
GAVRETO	5	PAns; LA; QL (120 EA per 30 days)	JAKAFI	5	PAns; QL (60 EA per 30 days)
<i>gefitinib</i>	5	PAns; QL (30 EA per 30 days)	JAYPIRCA ORAL TABLET 100 MG	5	PAns; QL (60 EA per 30 days)
GILOTRIF	5	PAns; QL (30 EA per 30 days)	JAYPIRCA ORAL TABLET 50 MG	5	PAns; QL (30 EA per 30 days)
IBRANCE	5	PAns; QL (21 EA per 28 days)	KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PAns; QL (21 EA per 28 days)
ICLUSIG	5	PAns; QL (30 EA per 30 days)	KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PAns; QL (42 EA per 28 days)
IDHIFA	5	PAns; LA; QL (30 EA per 30 days)	KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PAns; QL (63 EA per 28 days)
<i>imatinib oral tablet 100 mg</i>	5	PAns; QL (180 EA per 30 days)	KOSELUGO	5	PA
<i>imatinib oral tablet 400 mg</i>	5	PAns; QL (60 EA per 30 days)	KRAZATI	5	PAns; QL (180 EA per 30 days)
IMBRUWICA ORAL CAPSULE 140 MG	5	PAns; QL (120 EA per 30 days)	<i>lapatinib</i>	5	PAns; QL (180 EA per 30 days)
IMBRUWICA ORAL CAPSULE 70 MG	5	PAns; QL (30 EA per 30 days)	LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	5	PAns; QL (30 EA per 30 days)
IMBRUWICA ORAL SUSPENSION	5	PAns; QL (324 ML per 30 days)	LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X2), 24 MG/DAY(10 MG X 2-4 MG X 1)	5	PAns; QL (90 EA per 30 days)
IMBRUWICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PAns; QL (30 EA per 30 days)	LENVIMA ORAL CAPSULE 14 MG/DAY(10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	5	PAns; QL (60 EA per 30 days)
INLYTA ORAL TABLET 1 MG	5	PAns; QL (180 EA per 30 days)	LORBRENA ORAL TABLET 100 MG	5	PAns; QL (30 EA per 30 days)
INLYTA ORAL TABLET 5 MG	5	PAns; QL (120 EA per 30 days)			
INREBIC	5	PAns; LA; QL (120 EA per 30 days)			

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
LORBRENA ORAL TABLET 25 MG	5	PAns; QL (90 EA per 30 days)	OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	5	PA; QL (24 EA per 28 days)
LUMAKRAS	5	PAns	OJJAARA	5	PAns; QL (30 EA per 30 days)
LYNPARZA	5	PAns; QL (120 EA per 30 days)	<i>pazopanib</i>	5	PAns; QL (120 EA per 30 days)
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)	5	PAns; LA	PEMAZYRE	5	PAns; LA; QL (28 EA per 28 days)
MEKINIST ORAL RECON SOLN	5	PAns; QL (1200 ML per 30 days)	PIQRAY	5	PAns
MEKINIST ORAL TABLET 0.5 MG	5	PAns; QL (90 EA per 30 days)	QINLOCK	5	PAns; LA; QL (90 EA per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PAns; QL (30 EA per 30 days)	RETEVMO ORAL CAPSULE 40 MG	5	PAns; LA; QL (180 EA per 30 days)
MEKTOVI	5	PAns; LA; QL (180 EA per 30 days)	RETEVMO ORAL CAPSULE 80 MG	5	PAns; LA; QL (120 EA per 30 days)
NERLYNX	5	PAns; LA	REZLIDHIA	5	PAns; QL (60 EA per 30 days)
NINLARO	5	PAns; QL (3 EA per 28 days)	REZUROCK	5	PA; LA; QL (30 EA per 30 days)
ODOMZO	5	PAns; LA; QL (30 EA per 30 days)	ROZLYTREK ORAL CAPSULE 100 MG	5	PAns; QL (150 EA per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	5	PAns; QL (96 ML per 28 days)	ROZLYTREK ORAL CAPSULE 200 MG	5	PAns; QL (90 EA per 30 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	5	PA; QL (16 EA per 28 days)	ROZLYTREK ORAL PELLETS IN PACKET	5	PAns; QL (336 EA per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	5	PAns; QL (20 EA per 28 days)	RUBRACA	5	PAns; LA; QL (120 EA per 30 days)
			RYDAPT	5	PAns; QL (224 EA per 28 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
SCEMBLIX ORAL TABLET 100 MG	5	PAns; QL (120 EA per 30 days)	TEPMETKO	5	PAns; LA
SCEMBLIX ORAL TABLET 20 MG	5	PAns; QL (600 EA per 30 days)	TIBSOVO	5	PAns
SCEMBLIX ORAL TABLET 40 MG	5	PAns; QL (300 EA per 30 days)	TRUQAP	5	PAns; QL (64 EA per 28 days)
<i>sorafenib</i>	5	PAns; QL (120 EA per 30 days)	TUKYSA ORAL TABLET 150 MG	5	PAns; LA; QL (120 EA per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	5	PAns; QL (30 EA per 30 days)	TUKYSA ORAL TABLET 50 MG	5	PAns; LA; QL (300 EA per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	5	PAns; QL (60 EA per 30 days)	TURALIO ORAL CAPSULE 125 MG	5	PA; LA; QL (120 EA per 30 days)
STIVARGA	5	PAns; QL (84 EA per 28 days)	VANFLYTA	5	PAns; QL (56 EA per 28 days)
<i>sunitinib malate</i>	5	PAns; QL (30 EA per 30 days)	VENCLEXTA ORAL TABLET 10 MG	4	PAns; LA; QL (60 EA per 30 days)
TABRECTA	5	PAns	VENCLEXTA ORAL TABLET 100 MG	5	PAns; LA; QL (180 EA per 30 days)
TAFINLAR ORAL CAPSULE	5	PAns; QL (120 EA per 30 days)	VENCLEXTA ORAL TABLET 50 MG	5	PAns; LA; QL (30 EA per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	5	PAns; QL (840 EA per 28 days)	VENCLEXTA STARTING PACK	5	PAns; LA; QL (42 EA per 180 days)
TAGRISSO	5	PAns; LA; QL (30 EA per 30 days)	VERZENIO	5	PAns; LA; QL (60 EA per 30 days)
TALZENNA	5	PAns; QL (30 EA per 30 days)	VITRAKVI ORAL CAPSULE 100 MG	5	PAns; LA; QL (60 EA per 30 days)
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PAns; QL (112 EA per 28 days)	VITRAKVI ORAL CAPSULE 25 MG	5	PAns; LA; QL (180 EA per 30 days)
TASIGNA ORAL CAPSULE 50 MG	5	PAns; QL (120 EA per 30 days)	VITRAKVI ORAL SOLUTION	5	PAns; LA; QL (300 ML per 30 days)
TAZVERIK	5	PAns; LA	VIZIMPRO	5	PAns; QL (30 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
VONJO	5	PAns; QL (120 EA per 30 days)
WELIREG	5	PAns; LA
XALKORI ORAL CAPSULE	5	PAns; QL (60 EA per 30 days)
XALKORI ORAL PELLET 150 MG	5	PAns; QL (180 EA per 30 days)
XALKORI ORAL PELLET 20 MG, 50 MG	5	PAns; QL (120 EA per 30 days)
XOSPATA	5	PAns; LA; QL (90 EA per 30 days)
XPOVIO	5	PAns; LA
ZEJULA ORAL TABLET	5	PAns; LA; QL (30 EA per 30 days)
ZELBORA <small>F</small>	5	PAns; QL (240 EA per 30 days)
ZYDELIG	5	PAns; QL (60 EA per 30 days)
ZYKADIA	5	PAns; QL (90 EA per 30 days)
<b>RETINOIDS</b>		
<i>bexarotene</i>	5	PAns
PANRETIN	5	PAns
<i>tretinoin (antineoplastic)</i>	5	
<b>TREATMENT ADJUNCTS</b>		
<i>leucovorin calcium oral</i>	3	
MESNEX ORAL	5	
<b>ANTIPARASITI CS</b>		
<b>ANTHELMINTICS</b>		
<i>albendazole</i>	5	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
EMVERM	5	
<i>ivermectin oral</i>	3	PA; QL (20 EA per 30 days)
<i>praziquantel</i>	4	
<b>ANTIPROTOZOAL S</b>		
<i>atovaquone</i>	4	
<i>atovaquone-proguanil</i>	4	
<i>chloroquine phosphate</i>	4	
COARTEM	4	
<i>hydroxychloroquine oral tablet 200 mg</i>	2	
<i>mefloquine</i>	2	
<i>nitazoxanide</i>	5	
<i>pentamidine inhalation</i>	4	BvD; QL (1 EA per 28 days)
<i>pentamidine injection</i>	4	
<i>primaquine</i>	4	
<i>pyrimethamine</i>	5	PA
<i>quinine sulfate</i>	4	
<b>ANTIPARKINSON AGENTS</b>		
<b>ANTICHOLINERGICS</b>		
<i>benztropine oral</i>	2	PA
<i>trihexyphenidyl oral tablet</i>	1	
<b>ANTIPARKINSON AGENTS, OTHER</b>		
<i>amantadine hcl oral capsule</i>	3	
<i>amantadine hcl oral solution</i>	3	
<i>carbidopa</i>	4	
<i>carbidopa-levodopa-entacapone</i>	4	
<i>entacapone</i>	4	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>DOPAMINE AGONISTS</b>					
APOKYN	5	PA; LA; QL (90 ML per 30 days)	<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	4	
<i>apomorphine</i>	5	PA; QL (90 ML per 30 days)	<i>haloperidol lactate injection</i>	4	
<i>bromocriptine</i>	4		<i>haloperidol lactate oral</i>	2	
NEUPRO	4		<i>loxapine succinate</i>	2	
<i>pramipexole oral tablet</i>	2		<i>molindone</i>	4	
<i>ropinirole oral tablet</i>	2		<i>perphenazine</i>	4	
<b>DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS</b>					
<i>carbidopa</i>	4		<i>pimozide</i>	4	
<i>carbidopa-levodopa oral tablet</i>	2		<i>prochlorperazine maleate</i>	2	
<i>carbidopa-levodopa oral tablet extended release</i>	2		<i>thioridazine</i>	3	
<i>carbidopa-levodopa oral tablet,disintegrating</i>	4		<i>thiothixene</i>	4	
<b>MONOAMINE OXIDASE B (MAO-B) INHIBITORS</b>			<i>trifluoperazine</i>	3	
<i>rasagiline</i>	4		<b>2ND GENERATION/ATYPICAL</b>		
<i>selegiline hcl</i>	3		ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	5	QL (2.4 ML per 56 days)
<b>ANTIPSYCHOTIC CS</b>			ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	5	QL (3.2 ML per 56 days)
<b>1ST GENERATION/TYPICAL</b>			ABILIFY MAINTENA	5	QL (1 EA per 28 days)
<i>chlorpromazine oral</i>	4		<i>ariPIPrazole oral solution</i>	4	ST
<i>fluphenazine decanoate</i>	4		<i>ariPIPrazole oral tablet</i>	3	ST; QL (30 EA per 30 days)
<i>fluphenazine hcl</i>	4		<i>ariPIPrazole oral tablet,disintegrating</i>	4	ST; QL (60 EA per 30 days)
<i>haloperidol</i>	2		ARISTADA INITIO	5	QL (4.8 ML per 365 days)
			ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	5	QL (3.9 ML per 56 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	5	QL (1.6 ML per 28 days)	INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	QL (0.25 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	5	QL (2.4 ML per 28 days)	INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	QL (0.5 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	5	QL (3.2 ML per 28 days)	INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5	QL (0.88 ML per 90 days)
<i>asenapine maleate</i>	4	ST; QL (60 EA per 30 days)	INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5	QL (1.32 ML per 90 days)
CAPLYTA	4	ST; QL (30 EA per 30 days)	INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	QL (1.75 ML per 90 days)
FANAPT ORAL TABLET	4	ST; QL (60 EA per 30 days)	INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5	QL (2.63 ML per 90 days)
FANAPT ORAL TABLETS,DOSE PACK	4	ST; QL (8 EA per 180 days)	<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	5	ST; QL (30 EA per 30 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5	QL (3.5 ML per 180 days)	<i>lurasidone oral tablet 80 mg</i>	5	ST; QL (60 EA per 30 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5	QL (5 ML per 180 days)	NUPLAZID	4	PAns; QL (30 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	QL (0.75 ML per 28 days)	<i>olanzapine intramuscular</i>	4	
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	QL (1 ML per 28 days)	<i>olanzapine oral tablet</i>	2	ST; QL (30 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	QL (1.5 ML per 28 days)	<i>olanzapine oral tablet,disintegrating</i>	4	ST; QL (30 EA per 30 days)
			<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	4	ST; QL (30 EA per 30 days)
			<i>paliperidone oral tablet extended release 24hr 6 mg</i>	4	ST; QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	ST; QL (90 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 100 MG/0.28 ML	5	QL (0.28 ML per 28 days)
quetiapine oral tablet 300 mg, 400 mg	2	ST; QL (60 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 125 MG/0.35 ML	5	QL (0.35 ML per 28 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	4	ST; QL (30 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 150 MG/0.42 ML	5	QL (0.42 ML per 56 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	4	ST; QL (60 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 200 MG/0.56 ML	5	QL (0.56 ML per 56 days)
REXULTI ORAL TABLET	4	ST; QL (30 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 250 MG/0.7 ML	5	QL (0.7 ML per 56 days)
risperidone microspheres intramuscular suspension, extended rel recon 12.5 mg/2 ml, 25 mg/2 ml	3	QL (2 EA per 28 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 50 MG/0.14 ML	5	QL (0.14 ML per 28 days)
risperidone microspheres intramuscular suspension, extended rel recon 37.5 mg/2 ml, 50 mg/2 ml	5	QL (2 EA per 28 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTEN DED REL SYRING 75 MG/0.21 ML	5	QL (0.21 ML per 28 days)
risperidone oral solution	2	ST	VRAYLAR ORAL CAPSULE	4	ST; QL (30 EA per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	ST; QL (60 EA per 30 days)	ziprasidone hcl	4	ST; QL (60 EA per 30 days)
risperidone oral tablet 4 mg	1	ST; QL (120 EA per 30 days)	ziprasidone mesylate	4	
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	4	ST; QL (60 EA per 30 days)	ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	QL (2 EA per 28 days)
risperidone oral tablet,disintegrating 4 mg	4	ST; QL (120 EA per 30 days)			
SECUADO	5	QL (30 EA per 30 days)			

Drug Name	Drug Tier	Requirements/ Limits
<b>TREATMENT- RESISTANT</b>		
<i>clozapine oral tablet</i>	3	
<i>clozapine oral tablet,disintegrating</i>	4	
VERSACLOZ	5	
<b>ANTISPASTICIT Y AGENTS</b>		
<b>ANTISPASTICITY AGENTS</b>		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	2	
<i>dantrolene oral</i>	4	
<i>tizanidine oral tablet</i>	2	
<b>ANTIVIRALS</b>		
<b>ANTI- CYTOMEGALOVI RUS (CMV) AGENTS</b>		
PREVYMIS ORAL	5	PA; QL (30 EA per 30 days)
<i>valganciclovir oral recon soln</i>	5	
<i>valganciclovir oral tablet</i>	3	
<b>ANTI-HEPATITIS B (HBV) AGENTS</b>		
<i>adefovir</i>	4	
BARACLUDÉ ORAL SOLUTION	5	
<i>entecavir</i>	4	
<i>lamivudine</i>	3	
<i>tenofovir disoproxil fumarate</i>	4	
VEMLIDY	5	
VIREAD ORAL POWDER	5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	4	

Drug Name	Drug Tier	Requirements/ Limits
<b>ANTI-HEPATITIS C (HCV) AGENTS</b>		
<i>ledipasvir-sofosbuvir</i>	5	PA; QL (28 EA per 28 days)
Mavyret Oral Pellets in Packet	5	PA; QL (168 EA per 28 days)
Mavyret Oral Tablet	5	PA; QL (84 EA per 28 days)
<i>ribavirin oral capsule</i>	3	
<i>ribavirin oral tablet 200 mg</i>	3	
<i>sofosbuvir-velpatasvir</i>	5	PA; QL (28 EA per 28 days)
VOSEVI	5	PA; QL (28 EA per 28 days)
<b>ANTIHERPETIC AGENTS</b>		
<i>acyclovir oral capsule</i>	2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	4	
<i>acyclovir oral tablet</i>	2	
<i>acyclovir sodium intravenous solution</i>	4	BvD
<i>famciclovir</i>	3	
<i>trifluridine</i>	3	
<i>valacyclovir oral tablet 1 gram</i>	3	QL (120 EA per 30 days)
<i>valacyclovir oral tablet 500 mg</i>	3	QL (60 EA per 30 days)
<b>ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)</b>		
BIKTARVY	5	
DOVATO	5	
GENVOYA	5	
ISENTRESS HD	5	
ISENTRESS ORAL POWDER IN PACKET	5	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ISENTRESS ORAL TABLET	5		<b>ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)</b>		
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5		<i>abacavir</i>	3	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	3		<i>abacavir-lamivudine</i>	3	
JULUCA	5		<b>CIMDUO</b>	5	
STRIBILD	5		<b>DELSTRIGO</b>	5	
SYMTUZA	5		<b>DESCOVY</b>	5	
TIVICAY ORAL TABLET 50 MG	5		<i>efavirenz-emtricitabin-tenofovir</i>	5	
TIVICAY PD	5		<i>efavirenz-lamivu-tenofovir disop</i>	5	
<b>ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)</b>			<i>emtricitabine</i>	4	
COMPLERA	5		<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg</i>	5	
DELSTRIGO	5		<i>emtricitabine-tenofovir (tdf) oral tablet 133-200 mg, 167-250 mg, 200-300 mg</i>	4	
EDURANT	5		<b>EMTRIVA ORAL SOLUTION</b>	3	
<i>efavirenz oral tablet</i>	4		<b>JULUCA</b>	5	
<i>efavirenz-emtricitabin-tenofov</i>	5		<i>lamivudine</i>	3	
<i>efavirenz-lamivu-tenofovir disop</i>	5		<i>lamivudine-zidovudine</i>	3	
<i>etravirine</i>	5		<b>ODEFSEY</b>	5	
INTELENCE ORAL TABLET 25 MG	4		<i>tenofovir disoproxil fumarate</i>	4	
<i>nevirapine oral suspension</i>	4		<b>TRIUMEQ</b>	5	
<i>nevirapine oral tablet</i>	3		<b>TRIUMEQ PD</b>	5	
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	4		<b>VIREAD ORAL POWDER</b>	5	
PIFELTRO	5		<b>VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG</b>	4	
			<i>zidovudine oral capsule</i>	4	
			<i>zidovudine oral syrup</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>zidovudine oral tablet</i>	2	
<b>ANTI-HIV AGENTS, OTHER</b>		
FUZEON SUBCUTANEOUS RECON SOLN	5	
<i>maraviroc</i>	5	
RUKOBIA	5	
SELZENTRY ORAL SOLUTION	3	
SUNLENCA ORAL TABLET 300 MG	5	
TRIUMEQ	5	
TRIUMEQ PD	5	
<b>ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)</b>		
APTIVUS	5	
<i>atazanavir</i>	4	
<i>darunavir</i>	5	
EVOTAZ	5	
<i>fosamprenavir</i>	4	
<i>lopinavir-ritonavir oral solution</i>	4	
<i>lopinavir-ritonavir oral tablet</i>	3	
NORVIR ORAL POWDER IN PACKET	4	
PREZCOBIX	5	
PREZISTA ORAL SUSPENSION	5	
PREZISTA ORAL TABLET 150 MG, 75 MG	4	
REYATAZ ORAL POWDER IN PACKET	5	
<i>ritonavir</i>	3	
SYMTUZA	5	
VIRACEPT ORAL TABLET	5	

Drug Name	Drug Tier	Requirements/ Limits
<b>ANTI-INFLUENZA AGENTS</b>		
<i>amantadine hcl oral capsule</i>	3	
<i>amantadine hcl oral solution</i>	3	
<i>oseltamivir</i>	3	
RELENZA DISKHALER	4	
<i>rimantadine</i>	4	
<b>ANTIVIRAL, CORONAVIRUS AGENTS</b>		
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	2	QL (20 EA per 180 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	2	QL (30 EA per 180 days)
<b>ANXIOLYTICS</b>		
<b>ANXIOLYTICS, OTHER</b>		
<i>buspirone</i>	2	
<i>doxepin oral capsule</i>	4	
<i>doxepin oral concentrate</i>	4	
<i>doxepin oral tablet</i>	3	QL (30 EA per 30 days)
<i>hydroxyzine hcl oral tablet</i>	2	PA
<b>BENZODIAZEPINE S</b>		
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)
<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	4	QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>clonazepam oral tablet,disintegrating 2 mg</i>	4	QL (300 EA per 30 days)	<b>SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)</b>		
<i>clorazepate dipotassium oral tablet 15 mg</i>	4	PAns; QL (180 EA per 30 days)	<i>duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	ST; QL (60 EA per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	4	PAns; QL (90 EA per 30 days)	<i>escitalopram oxalate oral solution</i>	4	ST
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	4	PAns; QL (360 EA per 30 days)	<i>escitalopram oxalate oral tablet</i>	2	ST; QL (30 EA per 30 days)
DIAZEPAM INTENSOL	2	PAns; QL (240 ML per 30 days)	<i>paroxetine hcl oral suspension</i>	4	ST
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	PAns; QL (1200 ML per 30 days)	<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	ST; QL (30 EA per 30 days)
<i>diazepam oral tablet</i>	2	PAns; QL (120 EA per 30 days)	<i>paroxetine hcl oral tablet 30 mg</i>	2	ST; QL (60 EA per 30 days)
<i>diazepam rectal</i>	4		<i>sertraline oral concentrate</i>	4	ST
LORAZEPAM INTENSOL	2	PA; QL (150 ML per 30 days)	<i>sertraline oral tablet 100 mg, 50 mg</i>	1	ST; QL (60 EA per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	2	PA; QL (90 EA per 30 days)	<i>sertraline oral tablet 25 mg</i>	1	ST; QL (30 EA per 30 days)
<i>lorazepam oral tablet 2 mg</i>	2	PA; QL (150 EA per 30 days)	<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	2	ST; QL (30 EA per 30 days)
NAYZILAM	5	PAns; QL (10 EA per 30 days)	<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	2	ST; QL (90 EA per 30 days)
VALTOCO	5	PAns; QL (10 EA per 30 days)	<i>venlafaxine oral tablet</i>	2	ST; QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>BIPOLAR AGENTS</b>					
<b>BIPOLAR AGENTS, OTHER</b>					
<i>asenapine maleate</i>	4	ST; QL (60 EA per 30 days)	<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	ST; QL (60 EA per 30 days)
<i>lamotrigine oral tablet 25 mg</i>	1		<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	ST; QL (120 EA per 30 days)
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	5	ST; QL (30 EA per 30 days)	<i>risperidone oral tablet,disintegrating 4 mg</i>	4	ST; QL (60 EA per 30 days)
<i>lurasidone oral tablet 80 mg</i>	5	ST; QL (60 EA per 30 days)	<i>risperidone oral tablet,disintegrating 4 mg</i>	4	ST; QL (120 EA per 30 days)
<i>olanzapine intramuscular</i>	4		<b>SECUADO</b>	5	QL (30 EA per 30 days)
<i>olanzapine oral tablet</i>	2	ST; QL (30 EA per 30 days)	<i>ziprasidone hcl</i>	4	ST; QL (60 EA per 30 days)
<i>olanzapine oral tablet,disintegrating</i>	4	ST; QL (30 EA per 30 days)	<i>ziprasidone mesylate</i>	4	
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	ST; QL (90 EA per 30 days)	<b>ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG</b>	4	QL (2 EA per 28 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	2	ST; QL (60 EA per 30 days)	<b>MOOD STABILIZERS</b>		
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	4	ST; QL (30 EA per 30 days)	<i>carbamazepine oral capsule, er multiphase 12 hr</i>	4	
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	4	ST; QL (60 EA per 30 days)	<i>carbamazepine oral suspension 100 mg/5 ml</i>	4	
<i>risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml</i>	3	QL (2 EA per 28 days)	<i>carbamazepine oral tablet</i>	3	
<i>risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml</i>	5	QL (2 EA per 28 days)	<i>carbamazepine oral tablet extended release 12 hr 100 mg</i>	4	
<i>risperidone oral solution</i>	2	ST	<i>carbamazepine oral tablet,chewable</i>	3	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
lamotrigine oral tablet,disintegrating	4		glipizide oral tablet 10 mg	1	QL (120 EA per 30 days)
lithium carbonate	2		glipizide oral tablet 5 mg	1	QL (240 EA per 30 days)
lithium citrate	2		glipizide oral tablet extended release 24hr 10 mg	1	QL (60 EA per 30 days)
SUBVENITE	1		glipizide oral tablet extended release 24hr 2.5 mg	1	QL (240 EA per 30 days)
valproic acid	2		glipizide oral tablet extended release 24hr 5 mg	1	QL (120 EA per 30 days)
valproic acid (as sodium salt) oral solution 250 mg/5 ml	2		glipizide-metformin oral tablet 2.5-250 mg	1	QL (240 EA per 30 days)
<b>BLOOD GLUCOSE REGULATORS</b>					
<b>ANTIDIABETIC AGENTS</b>					
acarbose oral tablet 100 mg	2	QL (90 EA per 30 days)	glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	QL (120 EA per 30 days)
acarbose oral tablet 25 mg	2	QL (360 EA per 30 days)	GVOKE	3	
acarbose oral tablet 50 mg	2	QL (180 EA per 30 days)	JANUMET	3	QL (60 EA per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	3	PA; QL (2.4 ML per 30 days)	JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	QL (30 EA per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	3	PA; QL (1.2 ML per 30 days)	JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	QL (60 EA per 30 days)
colesevelam	4		JANUVIA	3	QL (30 EA per 30 days)
FARXIGA ORAL TABLET 10 MG	3	QL (30 EA per 30 days)	JARDIANCE	3	QL (30 EA per 30 days)
FARXIGA ORAL TABLET 5 MG	3	QL (60 EA per 30 days)	metformin oral tablet 1,000 mg	1	QL (75 EA per 30 days)
glimepiride oral tablet 1 mg	1	QL (240 EA per 30 days)	metformin oral tablet 500 mg	1	QL (150 EA per 30 days)
glimepiride oral tablet 2 mg	1	QL (120 EA per 30 days)	metformin oral tablet 850 mg	1	QL (90 EA per 30 days)
glimepiride oral tablet 4 mg	1	QL (60 EA per 30 days)	metformin oral tablet extended release 24 hr 500 mg	1	QL (120 EA per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	QL (60 EA per 30 days)	SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (60 EA per 30 days)
MOUNJARO	3	PA; QL (2 ML per 28 days)	TRULICITY	3	PA; QL (2 ML per 28 days)
<i>nateglinide oral tablet 120 mg</i>	2	QL (90 EA per 30 days)	XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	QL (30 EA per 30 days)
<i>nateglinide oral tablet 60 mg</i>	2	QL (180 EA per 30 days)	XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	3	QL (60 EA per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	PA; QL (3 ML per 28 days)	<b>BLOOD GLUCOSE REGULATORS</b>		
pioglitazone	1	QL (30 EA per 30 days)	ALCOHOL PADS	3	PA
<i>repaglinide oral tablet 0.5 mg</i>	2	QL (960 EA per 30 days)	GVOKE	3	
<i>repaglinide oral tablet 1 mg</i>	2	QL (480 EA per 30 days)	<i>mifepristone oral tablet 300 mg</i>	5	PA
<i>repaglinide oral tablet 2 mg</i>	2	QL (240 EA per 30 days)	<b>GLYCEMIC AGENTS</b>		
saxagliptin	3	QL (30 EA per 30 days)	<i>diazoxide</i>	5	
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	3	QL (60 EA per 30 days)	GVOKE	3	
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	3	QL (30 EA per 30 days)	GVOKE HYOPEN 2-PACK	3	
SOLIQUA 100/33	3	QL (90 ML per 30 days)	GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	3	
SYNJARDY	3	QL (60 EA per 30 days)	<i>mifepristone oral tablet 300 mg</i>	5	PA
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (30 EA per 30 days)	<b>INSULINS</b>		
<b>GAUZE PAD TOPICAL BANDAGE 2 X 2 "</b>			GAUZE PAD TOPICAL BANDAGE 2 X 2 "	3	PA
<b>HUMALOG JUNIOR KWIKPEN U-100</b>			HUMALOG JUNIOR KWIKPEN U-100	3	
<b>HUMALOG KWIKPEN INSULIN</b>			HUMALOG KWIKPEN INSULIN	3	

Drug Name	Drug Tier	Requirements/ Limits
HUMALOG MIX 50-50 KWIKPEN	3	
HUMALOG MIX 75-25 KWIKPEN	3	
HUMALOG MIX 75-25(U-100)INSULN	3	
HUMALOG U-100 INSULIN	3	
HUMULIN 70/30 U-100 INSULIN	3	
HUMULIN 70/30 U-100 KWIKPEN	3	
HUMULIN N NPH INSULIN KWIKPEN	3	
HUMULIN N NPH U-100 INSULIN	3	
HUMULIN R REGULAR U-100 INSULIN	3	
HUMULIN R U-500 (CONC) INSULIN	3	
HUMULIN R U-500 (CONC) KWIKPEN	3	
<i>insulin lispro subcutaneous solution</i>	3	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	3	PA
LANTUS SOLOSTAR U-100 INSULIN	3	
LANTUS U-100 INSULIN	3	
LYUMJEV KWIKPEN U-100 INSULIN	3	
LYUMJEV KWIKPEN U-200 INSULIN	3	
LYUMJEV U-100 INSULIN	3	
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	3	PA
SOLIQUA 100/33	3	QL (90 ML per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
TOUJEO MAX U-300 SOLOSTAR	3	
TOUJEO SOLOSTAR U-300 INSULIN	3	
<b>BLOOD PRODUCTS AND MODIFIERS</b>		
<b>ANTICOAGULANTS</b>		
<i>dabigatran etexilate</i>	4	QL (60 EA per 30 days)
ELIQUIS	3	QL (60 EA per 30 days)
ELIQUIS DVT-PE TREAT 30D START	3	QL (74 EA per 180 days)
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	4	QL (28 ML per 28 days)
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	4	QL (22.4 ML per 28 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml</i>	4	QL (16.8 ML per 28 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	4	QL (11.2 ML per 28 days)
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	4	
<i>heparin (porcine) injection solution</i>	3	
JANTOVEN	1	
warfarin	1	
XARELTO DVT-PE TREAT 30D START	3	QL (51 EA per 180 days)

Drug Name	Drug Tier	Requirements/ Limits
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	3	QL (775 ML per 28 days)
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
<b>BLOOD PRODUCTS AND MODIFIERS</b>		
PROMACTA	5	PA; LA
<b>BLOOD PRODUCTS AND MODIFIERS, OTHER</b>		
<i>anagrelide</i>	3	
NIVESTYM	5	PA
NYVEPRIA	5	PA
PROCIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA
PROCIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	5	PA
PROMACTA	5	PA; LA
RETACRIT 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	3	PA
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	5	PA

Drug Name	Drug Tier	Requirements/ Limits
<b>HEMOSTASIS AGENTS</b>		
<i>tranexamic acid oral</i>	3	
<b>PLATELET MODIFYING AGENTS</b>		
<i>aspirin-dipyridamole</i>	4	
BRILINTA	3	
CABLIVI INJECTION KIT	5	PA; LA
<i>cilostazol</i>	2	
<i>clopidogrel oral tablet 75 mg</i>	1	QL (30 EA per 30 days)
<i>dipyridamole oral</i>	4	
DOPTELET (10 TAB PACK)	5	PA; LA
DOPTELET (15 TAB PACK)	5	PA; LA
DOPTELET (30 TAB PACK)	5	PA; LA
<i>prasugrel</i>	3	
<b>CARDIOVASCULAR AGENTS</b>		
<b>ALPHA-ADRENERGIC AGONISTS</b>		
<i>clonidine</i>	4	QL (4 EA per 28 days)
<i>clonidine hcl oral tablet</i>	1	
<i>droxidopa</i>	5	PA
<i>midodrine</i>	3	
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	2	QL (30 EA per 30 days)
<i>doxazosin oral tablet 8 mg</i>	2	QL (60 EA per 30 days)
<i>prazosin</i>	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	QL (30 EA per 30 days)	diltiazem hcl oral capsule,extended release 12 hr	2	
terazosin oral capsule 10 mg	1	QL (60 EA per 30 days)	diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	2	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>					
candesartan	1		diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	2	
irbesartan	1		diltiazem hcl oral tablet	2	
losartan	1		diltiazem hcl oral tablet extended release 24 hr	2	
olmesartan	1		DILT-XR	2	
telmisartan	1		dofetilide	4	
valsartan oral tablet	1		flecainide	3	
<b>ANGIOTENSIN- CONVERTING ENZYME (ACE) INHIBITORS</b>			MATZIM LA	2	
benazepril	1		mexiletine	3	
captopril	1		PACERONE ORAL TABLET 100 MG, 400 MG	4	
enalapril maleate oral tablet	1		PACERONE ORAL TABLET 200 MG	2	
fosinopril	1		propafenone oral capsule,extended release 12 hr	4	
lisinopril	1		propafenone oral tablet	3	
moexipril	1		propranolol oral capsule,extended release 24 hr 120 mg	2	
perindopril erbumine	1		quinidine sulfate oral tablet	2	
quinapril	1		SOTALOL AF	2	
ramipril	1		sotalol oral	2	
trandolapril	1		TIADYLT ER	2	
<b>ANTIARRHYTHMI CS</b>			verapamil oral capsule, 24 hr er pellet ct	2	
acebutolol	2		verapamil oral capsule,ext rel. pellets 24 hr	2	
amiodarone oral tablet 100 mg, 400 mg	4		verapamil oral tablet	1	
amiodarone oral tablet 200 mg	2				
CARTIA XT	2				
digoxin oral solution	3				
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	2				

Drug Name	Drug Tier	Requirements/ Limits
<i>verapamil oral tablet extended release</i>	2	
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol</i>	2	
<i>atenolol</i>	1	
<i>betaxolol oral</i>	3	
<i>bisoprolol fumarate</i>	2	
<i>carvedilol</i>	1	
<i>labetalol oral</i>	2	
<i>metoprolol succinate</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	
<i>nadolol</i>	4	
<i>nebivolol</i>	2	
<i>pindolol</i>	3	
<i>propranolol oral capsule,extended release 24 hr</i>	2	
<i>propranolol oral solution</i>	2	
<i>propranolol oral tablet</i>	1	
<i>timolol maleate oral</i>	4	
<b>CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDIN ES</b>		
<i>amlodipine</i>	1	
<i>felodipine</i>	2	
<i>nicardipine oral</i>	4	
<i>nifedipine oral tablet extended release</i>	2	
<i>nifedipine oral tablet extended release 24hr</i>	2	
<i>nimodipine oral capsule</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES</b>		
<i>CARTIA XT</i>	2	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	2	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	2	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
<i>diltiazem hcl oral tablet</i>	2	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	2	
<i>DILT-XR</i>	2	
<i>MATZIM LA</i>	2	
<i>TIADYLT ER</i>	2	
<i>verapamil oral capsule, 24 hr er pellet ct</i>	2	
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	2	
<i>verapamil oral tablet</i>	1	
<i>verapamil oral tablet extended release</i>	2	
<b>CARDIOVASCULAR AGENTS, OTHER</b>		
<i>acetazolamide oral tablet</i>	3	
<i>aliskiren</i>	4	
<i>amiloride-hydrochlorothiazide</i>	2	
<i>amlodipine-benazepril</i>	1	
<i>amlodipine-olmesartan</i>	1	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>amlodipine-valsartan</i>	1	
<i>amlodipine-valsartan-hcthiazid</i>	2	
<i>atenolol-chlorthalidone</i>	1	
<i>benazepril-hydrochlorothiazide</i>	1	
<i>bisoprolol-hydrochlorothiazide</i>	1	
<i>candesartan-hydrochlorothiazid</i>	2	
<b>CORLANOR ORAL TABLET</b>	3	QL (60 EA per 30 days)
<i>digoxin oral solution</i>	3	
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	2	
<i>enalapril-hydrochlorothiazide</i>	1	
<b>ENTRESTO</b>	3	QL (60 EA per 30 days)
<i>fosinopril-hydrochlorothiazide</i>	1	
<i>irbesartan-hydrochlorothiazide</i>	1	
<i>lisinopril-hydrochlorothiazide</i>	1	
<i>losartan-hydrochlorothiazide</i>	1	
<i>metoprolol ta-hydrochlorothiaz</i>	2	
<i>metyrosine</i>	5	PA
<i>olmesartan-amlodipin-hcthiazid</i>	2	
<i>olmesartan-hydrochlorothiazide</i>	1	
<i>pentoxifylline</i>	2	
<i>ranolazine</i>	4	
<i>spironolacton-hydrochlorothiaz</i>	2	
<i>telmisartan-amlodipine</i>	2	
<i>telmisartan-hydrochlorothiazid</i>	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>triamterene-hydrochlorothiazid</i>	1	
<i>valsartan-hydrochlorothiazide</i>	1	
<b>VERQUVO</b>	3	QL (30 EA per 30 days)
<b>DIURETICS, LOOP</b>		
<i>bumetanide injection</i>	4	
<i>bumetanide oral</i>	2	
<i>furosemide injection solution</i>	4	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	2	
<i>furosemide oral tablet</i>	1	
<i>torsemide oral</i>	2	
<b>DIURETICS, POTASSIUM-SPARING</b>		
<i>amiloride</i>	2	
<i>eplerenone</i>	3	
<b>KERENDIA</b>	3	PA; QL (30 EA per 30 days)
<i>spironolactone oral tablet</i>	1	
<b>DIURETICS, THIAZIDE</b>		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	2	
<i>hydrochlorothiazide</i>	1	
<i>indapamide</i>	1	
<i>metolazone</i>	3	
<b>DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES</b>		
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	2	
<i>fenofibrate nanocrystallized</i>	2	

Drug Name	Drug Tier	Requirements/ Limits
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	2	
<i>fenofibric acid (choline)</i>	4	
<i>gemfibrozil</i>	1	
<b>DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS</b>		
<i>atorvastatin</i>	1	QL (30 EA per 30 days)
<i>fluvastatin oral capsule 20 mg</i>	2	QL (30 EA per 30 days)
<i>fluvastatin oral capsule 40 mg</i>	2	QL (60 EA per 30 days)
<i>lovastatin oral tablet 10 mg</i>	1	QL (30 EA per 30 days)
<i>lovastatin oral tablet 20 mg, 40 mg</i>	1	QL (60 EA per 30 days)
<i>pitavastatin calcium</i>	1	QL (30 EA per 30 days)
<i>pravastatin</i>	1	QL (30 EA per 30 days)
<i>rosuvastatin</i>	1	QL (30 EA per 30 days)
<i>simvastatin</i>	1	QL (30 EA per 30 days)
<b>DYSLIPIDEMICS, OTHER</b>		
<i>cholestyramine (with sugar) oral powder in packet</i>	3	
<i>CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET</i>	3	
<i>colesevelam</i>	4	
<i>colestipol oral packet</i>	4	
<i>colestipol oral tablet</i>	4	
<i>ezetimibe</i>	2	
<i>ezetimibe-simvastatin</i>	2	QL (30 EA per 30 days)
<i>icosapent ethyl</i>	3	

Drug Name	Drug Tier	Requirements/ Limits
<i>niacin oral tablet 500 mg</i>	2	
<i>niacin oral tablet extended release 24 hr</i>	4	
<i>omega-3 acid ethyl esters</i>	2	
<b>PREVALITE ORAL POWDER IN PACKET</b>	3	
<b>REPATHA PUSHTRONEX</b>	3	PA; QL (7 ML per 28 days)
<b>REPATHA SURECLICK</b>	3	PA; QL (6 ML per 28 days)
<b>REPATHA SYRINGE</b>	3	PA; QL (6 ML per 28 days)
<b>MINERALOCORTI COID RECEPTOR ANTAGONISTS</b>		
<i>eplerenone</i>	3	
<b>KERENDIA</b>	3	PA; QL (30 EA per 30 days)
<i>spironolactone oral tablet</i>	1	
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS (SGLT2I)</b>		
<b>FARXIGA ORAL TABLET 10 MG</b>	3	QL (30 EA per 30 days)
<b>FARXIGA ORAL TABLET 5 MG</b>	3	QL (60 EA per 30 days)
<b>VASODILATORS, DIRECT-ACTING ARTERIAL</b>		
<i>hydralazine oral</i>	2	
<i>minoxidil oral</i>	2	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>VASODILATORS, DIRECT-ACTING ARTERIAL/ VENOUS</b>			<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	4	QL (30 EA per 30 days)
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	2		<i>clonidine hcl oral tablet extended release 12 hr</i>	4	
<i>isosorbide mononitrate</i>	1		<i>methylphenidate hcl oral capsule,er biphasic 50-50</i>	4	
<b>NITRO-BID</b>	3		<i>methylphenidate hcl oral solution</i>	4	
<i>nitroglycerin sublingual</i>	2		<i>methylphenidate hcl oral tablet</i>	3	
<i>nitroglycerin transdermal patch 24 hour</i>	2		<i>methylphenidate hcl oral tablet extended release</i>	4	
<i>nitroglycerin translingual</i>	4		<i>methylphenidate hcl oral tablet, chewable</i>	4	
VERQUVO	3	QL (30 EA per 30 days)	<b>CENTRAL NERVOUS SYSTEM, OTHER</b>		
<b>CENTRAL NERVOUS SYSTEM AGENTS</b>			<i>carbamazepine oral tablet extended release 12 hr 100 mg</i>	4	
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES</b>			<i>gabapentin oral capsule 300 mg</i>	2	QL (360 EA per 30 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	4		<i>gabapentin oral capsule 400 mg</i>	2	QL (270 EA per 30 days)
<i>dextroamphetamine-amphetamine oral tablet</i>	3		<i>gabapentin oral solution 250 mg/5 ml</i>	3	QL (2160 ML per 30 days)
<b>ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON- AMPHETAMINES</b>			<i>gabapentin oral tablet 800 mg</i>	2	QL (120 EA per 30 days)
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	4	QL (60 EA per 30 days)	<b>NUEDEXTA</b>	5	PA
			<b>NURTEC ODT</b>	3	PA; QL (16 EA per 30 days)
			<b>RADICAVA ORS STARTER KIT SUSP</b>	5	PA
			<i>riluzole</i>	3	PA
			<i>tetrabenazine oral tablet 12.5 mg</i>	5	PA; QL (240 EA per 30 days)
			<i>tetrabenazine oral tablet 25 mg</i>	5	PA; QL (120 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<b>FIBROMYALGIA AGENTS</b>					
duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg	2	ST; QL (60 EA per 30 days)	glatiramer subcutaneous syringe 40 mg/ml	5	PA; QL (12 ML per 28 days)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	3	QL (90 EA per 30 days)	GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	5	PA; QL (30 ML per 30 days)
pregabalin oral capsule 225 mg, 300 mg	3	QL (60 EA per 30 days)	GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	5	PA; QL (12 ML per 28 days)
pregabalin oral solution	3	QL (900 ML per 30 days)	KESIMPTA PEN	5	PA; QL (1.6 ML per 28 days)
<b>MULTIPLE SCLEROSIS AGENTS</b>					
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	5	PA; QL (1 EA per 28 days)	teriflunomide	5	PA; QL (30 EA per 30 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	5	PA; QL (1 EA per 28 days)	<b>DENTAL AND ORAL AGENTS</b>		
BETASERON SUBCUTANEOUS KIT	5	PA; QL (14 EA per 28 days)	chlorhexidine gluconate mucous membrane	2	
dalfampridine	3	PA; QL (60 EA per 30 days)	doxycycline hyclate oral tablet 20 mg	2	
dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg	5	PA; QL (14 EA per 30 days)	KOURZEQ	2	
dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)	5	PA; QL (120 EA per 180 days)	PERIOGARD	2	
dimethyl fumarate oral capsule, delayed release(dr/ec) 240 mg	5	PA; QL (60 EA per 30 days)	pilocarpine hcl oral	4	
fingolimod	5	PA; QL (30 EA per 30 days)	triamcinolone acetonide dental	2	
glatiramer subcutaneous syringe 20 mg/ml	5	PA; QL (30 ML per 30 days)	<b>DERMATOLOGICAL AGENTS</b>		
<b>ACNE AND ROSACEA AGENTS</b>			ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	4	
acitretin			AMNESTEEM	4	
CLARAVIS			isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	4	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>tazarotene topical cream 0.1 %</i>	4	PA	<i>clobetasol topical ointment</i>	4	QL (120 GM per 28 days)
<i>tazarotene topical gel</i>	4	PA	<i>clobetasol topical shampoo</i>	4	QL (236 ML per 28 days)
<i>tretinoin topical cream</i>	4	PA	<i>clobetasol-emollient topical cream</i>	4	QL (120 GM per 28 days)
<i>tretinoin topical gel</i>	3	PA	<i>desonide topical cream</i>	4	
ZENATANE	4		<i>desonide topical ointment</i>	4	
<b>DERMATITIS AND PRURITUS AGENTS</b>			<b>DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML</b>	5	PA; QL (4.56 ML per 28 days)
<b>ALA-CORT TOPICAL CREAM 1 %</b>	2		<b>DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML</b>	5	PA; QL (8 ML per 28 days)
<i>alclometasone</i>	3		<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML</b>	5	PA; QL (4.56 ML per 28 days)
<i>ammonium lactate</i>	2		<b>DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML</b>	5	PA; QL (8 ML per 28 days)
<i>betamethasone dipropionate</i>	3		<i>fluocinolone and shower cap</i>	4	
<i>betamethasone valerate topical cream</i>	3		<i>fluocinolone topical cream</i>	4	
<i>betamethasone valerate topical lotion</i>	3		<i>fluocinolone topical ointment</i>	4	
<i>betamethasone valerate topical ointment</i>	3		<i>fluocinolone topical solution</i>	4	
<i>betamethasone, augmented topical cream</i>	2		<i>fluocinonide topical cream 0.05 %</i>	4	QL (120 GM per 30 days)
<i>betamethasone, augmented topical gel</i>	3		<i>fluocinonide topical gel</i>	4	QL (120 GM per 30 days)
<i>betamethasone, augmented topical lotion</i>	4		<i>fluocinonide topical ointment</i>	4	QL (120 GM per 30 days)
<i>betamethasone, augmented topical ointment</i>	2		<i>fluocinonide topical solution</i>	4	QL (120 ML per 30 days)
<i>clobetasol scalp</i>	4	QL (100 ML per 28 days)	<i>fluocinonide-emollient</i>	4	QL (120 GM per 30 days)
<i>clobetasol topical cream</i>	4	QL (120 GM per 28 days)			
<i>clobetasol topical foam</i>	4	QL (100 GM per 28 days)			
<i>clobetasol topical gel</i>	4	QL (120 GM per 28 days)			
<i>clobetasol topical lotion</i>	4	QL (118 ML per 28 days)			

Drug Name	Drug Tier	Requirements/ Limits
halobetasol propionate topical cream	4	
halobetasol propionate topical ointment	4	
hydrocortisone topical cream 1 %	2	
hydrocortisone topical cream with perineal applicator 2.5 %	2	
hydrocortisone topical lotion 2.5 %	2	
hydrocortisone topical ointment 1 %, 2.5 %	2	
mometasone topical	2	
pimecrolimus	4	PA; QL (100 GM per 30 days)
PROCTO-MED HC	2	
PROCTOSOL HC TOPICAL	2	
PROCTOZONE-HC	2	
selenium sulfide topical lotion	2	
tacrolimus topical	4	PA; QL (100 GM per 30 days)
triamcinolone acetonide topical cream	2	
triamcinolone acetonide topical lotion	2	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	2	
TRIDERM TOPICAL CREAM	2	
<b>DERMATOLOGIC AL AGENTS</b>		
ACCUTANE ORAL CAPSULE 20 MG, 40 MG	4	

Drug Name	Drug Tier	Requirements/ Limits
<b>DERMATOLOGIC AL AGENTS, OTHER</b>		
ALCOHOL PADS	3	PA
calcipotriene scalp	3	QL (120 ML per 30 days)
calcipotriene topical cream	4	QL (120 GM per 30 days)
calcipotriene topical ointment	4	QL (120 GM per 30 days)
clotrimazole-betamethasone topical cream	3	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	4	QL (60 ML per 28 days)
fluorouracil topical cream 5 %	3	
fluorouracil topical solution	3	
imiquimod topical cream in packet 5 %	3	
methoxsalen	5	
nystatin-triamcinolone	3	QL (60 GM per 28 days)
OTEZLA ORAL TABLET 30 MG	5	PA; QL (60 EA per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; QL (55 EA per 180 days)
PANRETIN	5	PAns
podofilox topical solution	3	
REGRANEX	5	QL (15 GM per 30 days)
SANTYL	3	QL (180 GM per 30 days)
silver sulfadiazine	2	
SSD	2	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>PEDICULICIDES/S CABICIDES</b>					
<i>malathion</i>	4		<i>d2.5 %-0.45 % sodium chloride</i>	4	
<i>permethrin</i>	3	QL (60 GM per 30 days)	<i>d5 % and 0.9 % sodium chloride</i>	4	
<b>TOPICAL ANTI- INFECTIVES</b>					
<i>acyclovir topical ointment</i>	4	PA; QL (30 GM per 30 days)	<i>dextrose 10 % and 0.2 % nacl</i>	4	
<i>ciclopirox topical cream</i>	2	QL (90 GM per 28 days)	<i>dextrose 10 % in water (d10w)</i>	4	
<i>ciclopirox topical gel</i>	3	QL (100 GM per 28 days)	<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	4	
<i>ciclopirox topical shampoo</i>	3	QL (120 ML per 28 days)	<i>dextrose 5%-0.2 % sod chloride</i>	4	
<i>ciclopirox topical solution</i>	2	QL (6.6 ML per 28 days)	<i>electrolyte-148</i>	3	
<i>ciclopirox topical suspension</i>	3	QL (60 ML per 28 days)	<b>INTRALIPID INTRAVENOUS EMULSION 20 %</b>	4	BvD
<i>clindamycin phosphate topical gel, once daily</i>	3	QL (120 ML per 30 days)	<b>ISOLYTE S PH 7.4</b>	4	
<i>clindamycin phosphate topical lotion</i>	3	QL (120 ML per 30 days)	<b>ISOLYTE-P IN 5 % DEXTROSE</b>	4	
<i>clindamycin phosphate topical solution</i>	3	QL (120 ML per 30 days)	<b>KLOR-CON</b>	4	
<b>ERY PADS</b>	3		<b>KLOR-CON 10</b>	2	
<i>erythromycin with ethanol topical solution</i>	2		<b>KLOR-CON 8</b>	2	
<i>mupirocin</i>	2	QL (44 GM per 30 days)	<b>KLOR-CON M10</b>	2	
<b>ELECTROLYTE S/MINERALS/M ETALS/VITAMI NS</b>			<b>KLOR-CON M15</b>	2	
<b>ELECTROLYTE/ MINERAL REPLACEMENT</b>			<b>KLOR-CON M20</b>	2	
<i>carglumic acid</i>	5	PA	<i>levocarnitine oral tablet</i>	4	
<i>d10 %-0.45 % sodium chloride</i>	4		<i>magnesium sulfate injection</i>	4	
			<i>potassium chlorid-d5-0.45%nacl</i>	4	
			<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	4	
			<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	4	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	4		<i>sodium chloride 5 % hypertonic</i>	4	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	4		<i>sodium chloride irrigation</i>	4	
<i>potassium chloride intravenous solution 2 meq/ml</i>	4		TRAVASOL 10 %	4	BvD
<i>potassium chloride oral capsule, extended release</i>	2		<b>ELECTROLYTE/MINERAL/METAL MODIFIERS</b>		
<i>potassium chloride oral liquid</i>	4		CHEMET	3	PA
<i>potassium chloride oral packet</i>	4		<i>deferasirox oral tablet 180 mg, 360 mg</i>	5	PA
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	2		<i>deferasirox oral tablet 90 mg</i>	4	PA
<i>potassium chloride oral tablet,er particles/crystals</i>	2		<i>deferiprone</i>	5	PA
<i>potassium chloride-0.45 % nacl</i>	4		KLOR-CON	4	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	4		<i>penicillamine oral tablet</i>	5	PA
<i>potassium chloride-d5-0.9%nacl</i>	4		<i>potassium chloride oral tablet,er particles/crystals 15 meq</i>	2	
<i>potassium citrate oral tablet extended release</i>	2		<i>tolvaptan</i>	5	PA
PREMASOL 10 %	4	BvD	<i>trientine oral capsule 250 mg</i>	5	PA
<i>sodium chloride 0.45 % intravenous</i>	4		<b>ELECTROLYTES/MINERALS/METALS/VITAMINS</b>		
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	4		CLINIMIX 5%/D15W SULFITE FREE	4	BvD
<i>sodium chloride 3 % hypertonic</i>	4		CLINIMIX 4.25%/D10W SULF FREE	4	BvD
			CLINIMIX 4.25%/D5W SULFIT FREE	4	BvD
			CLINIMIX 5%-D20W(SULFITE-FREE)	4	BvD
			<i>d10 %-0.45 % sodium chloride</i>	4	
			<i>d2.5 %-0.45 % sodium chloride</i>	4	
			<i>d5 % and 0.9 % sodium chloride</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>d5 % - 0.45 % sodium chloride</i>	4	
<i>dextrose 10 % and 0.2 % nacl</i>	4	
<i>dextrose 10 % in water (d10w)</i>	4	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	4	
<i>dextrose 5%-0.2 % sod chloride</i>	4	
INTRALIPID INTRAVENOUS EMULSION 20 %	4	BvD
ISOLYTE-P IN 5 % DEXTROSE	4	
<i>levocarnitine (with sugar)</i>	4	
<i>levocarnitine oral tablet</i>	4	
PREMASOL 10 %	4	BvD
TRAVASOL 10 %	4	BvD
TROPHAMINE 10 %	4	BvD
<b>POTASSIUM BINDERS</b>		
LOKELMA	3	
<i>sodium polystyrene sulfonate oral powder</i>	3	
SPS (WITH SORBITOL) ORAL	3	
<b>VITAMINS</b>		
KLOR-CON 10	2	
<i>potassium chloride oral tablet, er particles/crystals 15 meq</i>	2	
PRENATAL VITAMIN PLUS LOW IRON	2	

Drug Name	Drug Tier	Requirements/ Limits
<b>GASTROINTESTINAL AGENTS</b>		
<b>ANTI-CONSTIPATION AGENTS</b>		
CONSTULOSE	2	
ENULOSE	2	
GAVILYTE-C	2	
GAVILYTE-G	2	
GENERLAC	2	
<i>lactulose oral solution 10 gram/15 ml</i>	2	
LINZESS	4	ST; QL (30 EA per 30 days)
<i>lubiprostone</i>	4	QL (60 EA per 30 days)
MOVANTIK	3	QL (30 EA per 30 days)
<i>peg 3350-electrolytes</i>	2	
<i>peg-electrolyte soln</i>	2	
RELISTOR SUBCUTANEOUS SOLUTION	5	PA; QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	5	PA; QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	5	PA; QL (12 ML per 30 days)
<i>sodium,potassium,magnesium sulfates oral recon soln 17.5-3.13-1.6 gram</i>	4	
TRULANCE	3	ST; QL (30 EA per 30 days)
<b>ANTI-DIARRHEAL AGENTS</b>		
<i>alosetron oral tablet 0.5 mg</i>	4	PA
<i>alosetron oral tablet 1 mg</i>	5	PA

Drug Name	Drug Tier	Requirements/ Limits
diphenoxylate-atropine oral liquid	4	
diphenoxylate-atropine oral tablet	3	
loperamide oral capsule	2	
XERMELO	5	PA; LA; QL (84 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	3	PA; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; QL (90 EA per 30 days)
<b>ANTISPASMODICS</b>		
<b>GASTROINTESTINAL AGENTS</b>		
dicyclomine oral capsule	2	
dicyclomine oral solution	4	
dicyclomine oral tablet	2	
glycopyrrolate oral tablet 1 mg, 2 mg	3	
scopolamine base	4	
<b>GASTROINTESTINAL AGENTS, OTHER</b>		
GATTEX 30-VIAL	5	PA
GAVILYTE-C	2	
GAVILYTE-G	2	
metoclopramide hcl oral solution	2	
metoclopramide hcl oral tablet	2	
OCALIVA	5	PA; LA; QL (30 EA per 30 days)
peg 3350-electrolytes	2	
peg-electrolyte soln	2	
ursodiol oral capsule 300 mg	3	
ursodiol oral tablet	3	

Drug Name	Drug Tier	Requirements/ Limits
XIFAXAN ORAL TABLET 200 MG	3	PA; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; QL (90 EA per 30 days)
<b>HISTAMINE2 (H2) RECEPTOR ANTAGONISTS</b>		
famotidine oral tablet 20 mg, 40 mg	1	
<b>PROTECTANTS</b>		
misoprostol	3	
sucralfate oral suspension	4	
sucralfate oral tablet	2	
<b>PROTON PUMP INHIBITORS</b>		
esomeprazole magnesium oral capsule, delayed release(dr/ec) 20 mg	3	QL (30 EA per 30 days)
esomeprazole magnesium oral capsule, delayed release(dr/ec) 40 mg	3	QL (60 EA per 30 days)
lansoprazole oral capsule, delayed release(dr/ec) 15 mg	3	QL (30 EA per 30 days)
lansoprazole oral capsule, delayed release(dr/ec) 30 mg	3	QL (60 EA per 30 days)
omeprazole oral capsule, delayed release(dr/ec) 10 mg, 20 mg	1	QL (30 EA per 30 days)
omeprazole oral capsule, delayed release(dr/ec) 40 mg	1	QL (60 EA per 30 days)
pantoprazole oral tablet, delayed release (dr/ec) 20 mg	1	QL (30 EA per 30 days)
pantoprazole oral tablet, delayed release (dr/ec) 40 mg	1	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT , MODIFIERS, TREATMENT</b>			<i>oxybutynin chloride oral tablet 5 mg</i>	2	
			<i>oxybutynin chloride oral tablet extended release 24hr</i>	2	
			<i>tolterodine</i>	4	
			<i>trospium oral tablet</i>	2	
<b>GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT</b>			<b>BENIGN PROSTATIC HYPERTROPHY AGENTS</b>		
<i>betaine</i>	5		<i>alfuzosin</i>	2	
CREON	3		<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	2	QL (30 EA per 30 days)
<i>cromolyn inhalation</i>	4	BvD	<i>doxazosin oral tablet 8 mg</i>	2	QL (60 EA per 30 days)
<i>cromolyn oral</i>	4		<i>dutasteride</i>	2	
CYSTAGON	4	PA; LA	<i>finasteride oral tablet 5 mg</i>	2	
CYSTARAN	5	PA	<i>prazosin</i>	2	
DROXIA	3		<i>tamsulosin</i>	2	
ENDARI	5	PA	<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	QL (30 EA per 30 days)
<i>nitisinone</i>	5	PA	<i>terazosin oral capsule 10 mg</i>	1	QL (60 EA per 30 days)
PLENAMINE	4	BvD	<b>GENITOURINARY AGENTS, OTHER</b>		
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; LA	<i>bethanechol chloride</i>	3	
<i>sapropterin</i>	5	PA	ELMIRON	3	
<i>sodium phenylbutyrate</i>	5	PA	<i>penicillamine oral tablet</i>	5	PA
SUCRAID	5	PA			
VYNDAMAX	5	PA			
WELIREG	5	PAns; LA			
<b>GENITOURINA RY AGENTS</b>					
<b>ANTISPASMODICS , URINARY</b>					
MYRBETRIQ	3				
<i>oxybutynin chloride oral syrup</i>	2				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (ADRENAL)</b>			TRIDERM TOPICAL CREAM 0.5 %	2	
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)</b>			<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (PITUITARY)</b>		
<i>budesonide oral capsule, delayed, extend.r elease</i>	4		<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)</b>		
<i>budesonide oral tablet, delayed and ext.release</i>	5		<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	4	
<i>dexamethasone oral solution</i>	2		<i>desmopressin oral</i>	3	
<i>dexamethasone oral tablet</i>	2		INCRELEX	5	LA
<i>fludrocortisone</i>	2		OMNITROPE	5	PA
<i>hydrocortisone oral</i>	2		<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (PROSTAGLAN DINS)</b>		
<i>methylprednisolone oral tablet</i>	2	BvD	<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PROSTAGLANDIN S)</b>		
<i>methylprednisolone oral tablets, dose pack</i>	2		<i>misoprostol oral tablet 200 mcg</i>	3	
<i>prednisolone oral solution</i>	3				
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	3				
<b>PREDNISONE INTENSOL</b>	4				
<i>prednisone oral solution</i>	2				
<i>prednisone oral tablet</i>	2				
<i>prednisone oral tablets, dose pack 10 mg, 5 mg</i>	2				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (SEX HORMONES/ MODIFIERS)</b>			<i>drosipirenone-ethinyl estradiol</i>	2	
<b>ANDROGENS</b>			ELURYNG	4	
<i>danazol</i>	4		<i>estradiol oral</i>	4	PA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	3	PA	<i>estradiol transdermal patch semiweekly</i>	3	PA; QL (8 EA per 28 days)
<i>testosterone enanthate</i>	3	PAns	<i>estradiol transdermal patch weekly</i>	3	PA; QL (4 EA per 28 days)
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	3	PA; QL (300 GM per 30 days)	<i>estradiol vaginal</i>	4	
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	4	PA; QL (150 GM per 30 days)	<i>estradiol valerate</i>	4	
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	4	PA; QL (300 GM per 30 days)	<i>ethynodiol diac-eth estradiol</i>	2	
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	4	PA; QL (37.5 GM per 30 days)	<i>etongestrel-ethinyl estradiol</i>	4	
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	4	PA; QL (150 GM per 30 days)	JASMIEL (28)	2	
<i>testosterone transdermal solution in metered pump w/app</i>	4	PA; QL (180 ML per 30 days)	KELNOR 1/35 (28)	2	
<b>ESTROGENS</b>			KELNOR 1/50 (28)	2	
DOTTI	3	PA; QL (8 EA per 28 days)	LORYNA (28)	2	
			LYLLANA	3	PA; QL (8 EA per 28 days)
			NIKKI (28)	2	
			SYEDA	2	
			VESTURA (28)	2	
			YUVAFEM	4	
			ZOVIA 1-35 (28)	2	
			<b>HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)</b>		
			ALTAVERA (28)	2	
			ALYACEN 1/35 (28)	2	
			APRI	2	
			ARANELLE (28)	2	
			AUBRA EQ	2	
			AVIANE	2	
			CRYSELLE (28)	2	
			CYRED EQ	2	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>desog-e.estradiol/e.estradiol</i>	2		<i>levonorg-eth estrad triphasic</i>	2	
<i>drospirenone-ethinyl estradiol</i>	2		LEVORA-28	2	
ELURYNG	4		LORYNA (28)	2	
ENPRESSE	2		LOW-OGESTREL (28)	2	
ENSKYCE	2		LUTERA (28)	2	
ESTARYLLA	2		MARLISSA (28)	2	
<i>estradiol-norethindrone acet</i>	3	PA	MICROGESTIN 1.5/30 (21)	2	
<i>ethynodiol diac-eth estradiol</i>	2		MICROGESTIN 1/20 (21)	2	
<i>etonogestrel-ethinyl estradiol</i>	4		MICROGESTIN FE 1.5/30 (28)	2	
FALMINA (28)	2		MICROGESTIN FE 1/20 (28)	2	
FYAVOLV	4	PA	MILI	2	
ISIBLOOM	2		MIMVEY	3	PA
JASMIEL (28)	2		NIKKI (28)	2	
JINTELI	4	PA	<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	PA
JULEBER	2		<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	4	
KARIVA (28)	2		<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2	
KELNOR 1/35 (28)	2		<i>norgestimate-ethinyl estradiol</i>	2	
KELNOR 1/50 (28)	2		NORTREL 0.5/35 (28)	2	
KURVELO (28)	2		NORTREL 1/35 (21)	2	
<i>l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)</i>	2		NORTREL 1/35 (28)	2	
LARIN 1.5/30 (21)	2		NORTREL 7/7/7 (28)	2	
LARIN 1/20 (21)	2		PIMTREA (28)	2	
LARIN FE 1.5/30 (28)	2		PORTIA 28	2	
LARIN FE 1/20 (28)	2		RECLIPSEN (28)	2	
LESSINA	2		SETLAKIN	2	
LEVONEST (28)	2		SPRINTEC (28)	2	
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg</i>	2		SRONYX	2	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	2				

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
SYEDA	2		FYAVOLV	4	PA
TARINA FE 1-20 EQ (28)	2		HEATHER	2	
TILIA FE	4		INCASSIA	2	
TRI-ESTARYLLA	2		ISIBLOOM	2	
TRI-LEGEST FE	4		JINTELI	4	PA
TRI-LO-ESTARYLLA	2		JULEBER	2	
TRI-LO-SPRINTEC	2		KARIVA (28)	2	
TRI-SPRINTEC (28)	2		KURVELO (28)	2	
TRIVORA (28)	2		<i>l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)</i>	2	
TURQOZ (28)	2		LARIN 1.5/30 (21)	2	
VELIVET TRIPHASIC REGIMEN (28)	2		LARIN 1/20 (21)	2	
VESTURA (28)	2		LARIN FE 1.5/30 (28)	2	
VIENVA	2		LARIN FE 1/20 (28)	2	
XULANE	4		LESSINA	2	
ZAFEMY	4		LEVONEST (28)	2	
ZOVIA 1-35 (28)	2		<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg</i>	2	
<b>PROGESTINS</b>			<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	2	
ALTAVERA (28)	2		LEVORA-28	2	
ALYACEN 1/35 (28)	2		LOW-OGESTREL (28)	2	
APRI	2		LUTERA (28)	2	
ARANELLE (28)	2		LYLEQ	2	
AUBRA EQ	2		LYZA	2	
AVIANE	2		MARLISSA (28)	2	
CAMILA	2		<i>medroxyprogesterone</i>	2	
CRYSELLA (28)	2		<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	4	PA
CYRED EQ	2		<i>megestrol oral tablet</i>	3	PAns
DEBLITANE	2		MICROGESTIN 1.5/30 (21)	2	
DEPO-SUBQ PROVERA 104	4		MICROGESTIN 1/20 (21)	2	
<i>desog-e.estradiol/e.estradiol</i>	2				
ENPRESSE	2				
ENSKYCE	2				
ERRIN	2				
ESTARYLLA	2				
FALMINA (28)	2				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
MICROGESTIN FE 1.5/30 (28)	2		TRIVORA (28)	2	
MICROGESTIN FE 1/20 (28)	2		TURQOZ (28)	2	
MILI	2		VELIVET TRIPHASIC REGIMEN (28)	2	
NORA-BE	2		VIENVA	2	
<i>norethindrone (contraceptive)</i>	2		XULANE	4	
<i>norethindrone acetate</i>	2		ZAFEMY	4	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	PA	<b>SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS</b>		
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	4		<i>raloxifene</i>	3	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	2		<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT / MODIFYING (THYROID)</b>		
<i>norgestimate-ethinyl estradiol</i>	2		<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/ MODIFYING (THYROID)</b>		
NORTREL 0.5/35 (28)	2		EUTHYROX	1	
NORTREL 1/35 (21)	2		<i>levothyroxine oral tablet</i>	1	
NORTREL 1/35 (28)	2		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	1	
NORTREL 7/7/7 (28)	2		<i>liothyronine oral</i>	2	
PIMTREA (28)	2		UNITHROID	1	
PORTIA 28	2				
<i>progesterone micronized</i>	3				
RECLIPSEN (28)	2				
SETLAKIN	2				
SHAROBEL	2				
SPRINTEC (28)	2				
SRONYX	2				
TARINA FE 1-20 EQ (28)	2				
TRI-ESTARYLLA	2				
TRI-LO-ESTARYLLA	2				
TRI-LO-SPRINTEC	2				
TRI-SPRINTEC (28)	2				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits		
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)</b>							
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)</b>							
<i>bromocriptine</i>	4		<i>methimazole oral tablet 10 mg, 5 mg</i>	2			
<i>cabergoline</i>	3		<i>propylthiouracil</i>	3			
ELIGARD	3	PAns	<b>IMMUNOLOGIC AL AGENTS</b>				
ELIGARD (3 MONTH)	3	PAns	<b>ANGIOEDEMA AGENTS</b>				
ELIGARD (4 MONTH)	3	PAns	CINRYZE	5	PA		
ELIGARD (6 MONTH)	3	PAns	<i>icatibant</i>	5	PA		
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	PAns	SAJAZIR	5	PA		
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	PAns	<b>IMMUNOGLOBUL INS</b>				
<i>leuprolide subcutaneous kit</i>	5	PAns	PRIVIGEN	5	PA		
LUPRON DEPOT	5	PAns	<b>IMMUNOLOGICA L AGENTS, OTHER</b>				
LYSODREN	5		ARCALYST	5	PA		
MYFEMBREE	5	PA	BENLYSTA SUBCUTANEOUS	5	PA		
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	5	PA	COSENTYX (2 SYRINGES)	5	PA; QL (10 ML per 28 days)		
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA	COSENTYX PEN (2 PENS)	5	PA; QL (10 ML per 28 days)		
SIGNIFOR	5	PA	COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; QL (2.5 ML per 28 days)		
SOMAVERT	5	PA	COSENTYX UNOREADY PEN	5	PA; QL (10 ML per 28 days)		
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	4	PAns	DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)		

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)	SKYRIZI SUBCUTANEOUS PEN INJECTOR	5	PA; QL (2 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)	SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; QL (2 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)	SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	5	PA; QL (1.2 ML per 56 days)
<i>leflunomide</i>	3	QL (30 EA per 30 days)	SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	5	PA; QL (2.4 ML per 56 days)
ORENCIA CLICKJECT	5	PA; QL (4 ML per 28 days)	STELARA SUBCUTANEOUS SOLUTION	5	PA; QL (0.5 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	5	PA; QL (4 ML per 28 days)	STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; QL (0.5 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	5	PA; QL (1.6 ML per 28 days)	STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; QL (1 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	5	PA; QL (2.8 ML per 28 days)	TREMFYA	5	PA; QL (2 ML per 28 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	2	QL (20 EA per 180 days)	XELJANZ ORAL SOLUTION	5	PA; QL (300 ML per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	2	QL (30 EA per 180 days)	XELJANZ ORAL TABLET	5	PA; QL (60 EA per 30 days)
RIDAURA	5		XELJANZ XR	5	PA; QL (30 EA per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	5	PA; QL (30 EA per 30 days)	XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	5	PA; LA; QL (8 ML per 28 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	5	PA; QL (84 EA per 180 days)	XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	5	PA; LA; QL (1 ML per 28 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
XOLAIR SUBCUTANEOUS RECON SOLN	5	PA; LA; QL (8 EA per 28 days)	CYLTEZO(CF) PEN PSORIASIS-UV	5	PA; QL (4 EA per 180 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	5	PA; LA; QL (8 ML per 28 days)	CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	5	PA; QL (2 EA per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; LA; QL (1 ML per 28 days)	CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML, 40 MG/0.8 ML	5	PA; QL (4 EA per 28 days)
<b>IMMUNOSTIMULANTS</b>					
ACTIMMUNE	5	PA	DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
BESREMI	5	PAns; LA	DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION	5	QL (4 ML per 28 days)	DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	5	QL (2 ML per 28 days)	ENBREL MINI	5	PA; QL (8 ML per 28 days)
<b>IMMUNOSUPPRESSANTS</b>					
ACTEMRA ACTPEN	5	PA; QL (3.6 ML per 28 days)	ENBREL SUBCUTANEOUS SOLUTION	5	PA; QL (8 ML per 28 days)
ACTEMRA SUBCUTANEOUS	5	PA; QL (3.6 ML per 28 days)	ENBREL SUBCUTANEOUS SYRINGE	5	PA; QL (8 ML per 28 days)
<i>azathioprine oral tablet 50 mg</i>	2	BvD	ENBREL SURECLICK	5	PA; QL (8 ML per 28 days)
BENLYSTA SUBCUTANEOUS	5	PA	ENVARSUS XR	4	BvD
<i>cyclosporine modified</i>	4	BvD	<i>everolimus (antineoplastic) oral tablet</i>	5	PAns; QL (30 EA per 30 days)
<i>cyclosporine ophthalmic (eye)</i>	3	QL (60 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	5	PAns; QL (330 EA per 30 days)
<i>cyclosporine oral capsule</i>	4	BvD			
CYLTEZO(CF) PEN	5	PA; QL (4 EA per 28 days)			
CYLTEZO(CF) PEN CROHN'S-UC-HS	5	PA; QL (6 EA per 180 days)			

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	5	PA ns; QL (240 EA per 30 days)	<i>leflunomide</i>	3	QL (30 EA per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	5	PA ns; QL (180 EA per 30 days)	<i>mercaptopurine</i>	3	
<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	4	BvD	<i>methotrexate sodium</i>	2	BvD
<i>everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	5	BvD	<i>methotrexate sodium (pf) injection solution</i>	2	BvD
GENGRAF	4	BvD	<i>mycophenolate mofetil oral capsule</i>	3	BvD
HUMIRA PEN	5	PA; QL (4 EA per 28 days)	<i>mycophenolate mofetil oral suspension for reconstitution</i>	5	BvD
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (4 EA per 28 days)	<i>mycophenolate mofetil oral tablet</i>	3	BvD
HUMIRA(CF) PEN CROHNS-UC-HS	5	PA; QL (3 EA per 180 days)	<i>mycophenolate sodium</i>	4	BvD
HUMIRA(CF) PEN PEDIATRIC UC	5	PA; QL (4 EA per 180 days)	OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; QL (55 EA per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	5	PA; QL (3 EA per 180 days)	PROGRAF ORAL GRANULES IN PACKET	4	BvD
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	5	PA; QL (4 EA per 28 days)	REZUROCK	5	PA; LA; QL (30 EA per 30 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; QL (2 EA per 28 days)	<i>sirolimus oral solution</i>	5	BvD
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5	PA; QL (2 EA per 28 days)	<i>sirolimus oral tablet</i>	4	BvD
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (4 EA per 28 days)	<i>tacrolimus oral capsule</i>	4	BvD
			XATMEP	4	BvD
			<i>YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML</i>	5	PA; QL (2 EA per 28 days)
			<i>YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML</i>	5	PA; QL (2 EA per 28 days)
			<b>VACCINES</b>		
			ABRYSVO (PF)	1	
			ACTHIB (PF)	3	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>	<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
ADACEL(TDAP ADOLESN/ADULT)(P F)	1		PENBRAYA (PF)	1	
AREXVY (PF)	1		PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG- 62DU -10 MCG/0.5ML	3	
<i>bcg vaccine, live (pf)</i>	1		PREHEVBRIOS (PF)	1	BvD
BEXSERO	1		PRIORIX (PF)	1	
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	1		PROQUAD (PF)	3	
DAPTACEL (DTAP PEDIATRIC) (PF)	3		QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF- 48 MCG- 5 LF UNIT/0.5ML	3	
ENGERIX-B (PF)	1	BvD	QUADRACEL (PF) INTRAMUSCULAR SYRINGE	3	
ENGERIX-B PEDIATRIC (PF)	1	BvD	RABAVERT (PF)	1	
GARDASIL 9 (PF)	1		RECOMBIVAX HB (PF)	1	BvD
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1		ROTARIX ORAL SUSPENSION	3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	3		ROTATEQ VACCINE	3	
HEPLISAV-B (PF)	1	BvD	SHINGRIX (PF)	1	QL (2 EA per 720 days)
HIBERIX (PF)	3		TDVAX	1	
IMOVAX RABIES VACCINE (PF)	1		TENIVAC (PF)	1	
INFANRIX (DTAP) (PF)	3		TICOVAC	3	
IPOP	1		TRUMENBA	1	
IXCHIQ (PF)	1		TWINRIX (PF)	1	
IXIARO (PF)	1		TYPHIM VI	1	
JYNNEOS (PF)	1	BvD	VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	3	
KINRIX (PF)	3		VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	1	
MENQUADFI (PF)	1		VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	3	
MENVEO A-C-Y-W- 135-DIP (PF) INTRAMUSCULAR KIT	1				
M-M-R II (PF)	1				
PEDIARIX (PF)	3				
PEDVAX HIB (PF)	3				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1		<i>methylprednisolone oral tablet</i>	2	BvD
VARIVAX (PF)	1		<i>methylprednisolone oral tablets, dose pack</i>	2	
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML	1		<i>prednisolone oral solution</i>	3	
<b>INFLAMMATOR Y BOWEL DISEASE AGENTS</b>			<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	3	
<b>AMINOSALICYLA TES</b>			PREDNISONE INTENSOL	4	
<i>balsalazide</i>	4		<i>prednisone oral solution</i>	2	
<i>mesalamine oral capsule (with del rel tablets)</i>	4		<i>prednisone oral tablet</i>	2	
<i>mesalamine oral capsule, extended release 24hr</i>	4		<i>prednisone oral tablets, dose pack 10 mg, 5 mg</i>	2	
<i>mesalamine oral tablet, delayed release (dr/ec)</i>	4		PROCTO-MED HC	2	
<i>mesalamine rectal</i>	4		PROCTOSOL HC TOPICAL	2	
<i>sulfasalazine</i>	2		PROCTOZONE-HC	2	
<b>GLUCOCORTICOI DS</b>			<b>METABOLIC BONE DISEASE AGENTS</b>		
<i>budesonide oral capsule, delayed, extend.r elease</i>	4		<b>METABOLIC BONE DISEASE AGENTS</b>		
<i>budesonide oral tablet, delayed and ext.release</i>	5		<i>alendronate oral tablet 10 mg</i>	1	QL (30 EA per 30 days)
<i>dexamethasone oral solution</i>	2		<i>alendronate oral tablet 35 mg, 70 mg</i>	1	QL (4 EA per 28 days)
<i>dexamethasone oral tablet</i>	2		<i>calcitonin (salmon) nasal</i>	3	
<i>hydrocortisone oral</i>	2		<i>calcitriol oral capsule</i>	2	
<i>hydrocortisone rectal</i>	4		<i>calcitriol oral solution</i>	4	
			<i>cinacalcet oral tablet 30 mg, 60 mg</i>	4	PA
			<i>cinacalcet oral tablet 90 mg</i>	5	PA
			<i>doxercalciferol oral</i>	4	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>ibandronate oral</i>	3	QL (1 EA per 30 days)	BD INSULIN SYRINGE (HALF UNIT)	3	PA
<i>paricalcitol oral</i>	4		BD INSULIN SYRINGE U-500	3	PA
PROLIA	4	PA; QL (1 ML per 180 days)	BD INSULIN SYRINGE ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2"	3	PA
<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i>	5	PA; QL (2.48 ML per 28 days)	BD NANO 2ND GEN PEN NEEDLE	3	PA
XGEVA	5	BvD	BD ULTRA-FINE MICRO PEN NEEDLE	3	PA
<b>NON-FRF</b>			BD ULTRA-FINE MINI PEN NEEDLE	3	PA
<b>NON-FRF</b>			BD ULTRA-FINE NANO PEN NEEDLE	3	PA
ABRAXANE	5	BvD	BD ULTRA-FINE SHORT PEN NEEDLE	3	PA
ACTEMRA INTRAVENOUS	5	PA; QL (160 ML per 28 days)	BD VEO INSULIN SYR (HALF UNIT)	3	PA
ADCETRIS	5	BvD	BD VEO INSULIN SYRINGE UF SYRINGE 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64"	3	PA
ADSTILADRIN	5	PA	<i>bendamustine intravenous recon soln</i>	5	BvD
ALDURAZYME	5	PA	<i>bleomycin</i>	2	BvD
ALIQOPA	5	BvD; LA	<i>bortezomib injection recon soln 3.5 mg</i>	5	BvD
<i>amikacin injection solution 1,000 mg/4 ml</i>	4	PA	<i>BRIUMVI</i>	5	PA; QL (24 ML per 180 days)
<i>amoxicillin-pot clavulanate oral tablet, chewable 200-28.5 mg</i>	2		<i>busulfan</i>	5	BvD
<i>ampicillin sodium injection recon soln 2 gram, 250 mg, 500 mg</i>	4	PA	<i>CABENUVA</i>	5	
<i>ampicillin sodium intravenous</i>	4	PA	<i>carboplatin intravenous solution</i>	2	BvD
<i>ampicillin-sulbactam intravenous</i>	4	PA	<i>carmustine intravenous recon soln 100 mg</i>	5	BvD
ANKTIVA	5	PA			
<i>arsenic trioxide</i>	5	BvD			
ASPARLAS	5	PA			
<i>azacitidine</i>	5	BvD			
<i>azathioprine sodium</i>	2	BvD			
BD AUTOSHIELD DUO PEN NEEDLE	3	PA			

Drug Name	Drug Tier	Requirements/ Limits
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml, 2 gram/50 ml</i>	4	
<i>cefazolin injection recon soln 100 gram, 300 gram</i>	4	
<i>cefazolin intravenous recon soln 1 gram</i>	4	
<i>cefepime in dextrose, iso-osm</i>	4	
<i>cefoxitin in dextrose, iso-osm</i>	4	PA
<i>ceftriaxone in dextrose, iso-os</i>	4	
<i>ceftriaxone intravenous</i>	4	
<i>cefuroxime sodium intravenous recon soln 7.5 gram</i>	4	PA
CEPROTIN (BLUE BAR)	3	PA
CEPROTIN (GREEN BAR)	3	PA
CEQUR SIMPLICITY	3	
CEQUR SIMPLICITY INSERTER	3	
<i>chloramphenicol sod succinate</i>	4	
<i>cidofovir</i>	5	BvD
CIMERLI	5	PA
<i>ciprofloxacin hcl otic (ear)</i>	4	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 400 mg/200 ml</i>	4	PA
<i>ciprofloxacin oral suspension, microcapsule recon 500 mg/5 ml</i>	4	
<i>cisplatin intravenous solution</i>	2	BvD
<i>cladribine</i>	5	BvD
<i>clofarabine</i>	5	BvD

Drug Name	Drug Tier	Requirements/ Limits
CLOMID	2	PA
COLUMVI	5	PA
CRYSVITA	5	PA; LA
<i>cyclophosphamide intravenous recon soln</i>	2	BvD
<i>cytarabine</i>	2	BvD
<i>cytarabine (pf)</i>	2	BvD
<i>dacarbazine</i>	2	BvD
<i>dactinomycin</i>	2	BvD
<i>daunorubicin</i>	2	BvD
<i>decitabine</i>	5	BvD
DEXCOM G6 TRANSMITTER	3	
DEXCOM G7 RECEIVER	3	
DEXCOM G7 SENSOR	3	
<i>dexrazoxane hcl</i>	5	BvD
<i>diazepam injection</i>	2	PA
<i>diazepam oral concentrate</i>	2	PA; QL (240 ML per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml, 5 ml)</i>	2	PA; QL (1200 ML per 30 days)
<i>diclofenac sodium topical gel 1 %</i>	3	QL (1000 GM per 28 days)
<i>docetaxel</i>	5	BvD
<i>doxorubicin</i>	2	BvD
<i>doxorubicin, peg-liposomal</i>	5	BvD
<i>doxycycline hyclate intravenous</i>	4	PA
<i>efavirenz oral capsule</i>	4	
ELAPRASE	5	PA
ELITEK	5	
ELREXFIO	5	PA
ENTYVIO	5	PA; QL (2 EA per 28 days)
<i>epirubicin intravenous solution 200 mg/100 ml</i>	2	BvD

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
EPKINLY	5	PA	<i>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)</i>	2	BvD
<i>eribulin</i>	5	BvD	<i>gentamicin sulfate (ped) (pf)</i>	4	PA
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	4		<i>ibandronate intravenous</i>	3	PA
<i>etoposide intravenous</i>	2	BvD	<i>idarubicin</i>	2	BvD
EYLEA	5	PA	<i>ifosfamide</i>	2	BvD
FABRAZYME	5	PA	ILARIS (PF)	5	PA; LA; QL (2 ML per 28 days)
<i>flouxuridine</i>	2	BvD	IMDELLTRA	5	PA
<i>fluconazole in nacl (isosm) intravenous piggyback 100 mg/50 ml</i>	4	PA	IMJUDO	5	PA
<i>fludarabine</i>	2	BvD	INFLECTRA	5	PA; QL (20 EA per 28 days)
<i>fluorouracil intravenous</i>	2	BvD	<i>irinotecan intravenous solution 100 mg/5 ml</i>	2	BvD
FREESTYLE FREEDOM LITE	3		<i>irinotecan intravenous solution 300 mg/15 ml, 40 mg/2 ml, 500 mg/25 ml</i>	5	BvD
FREESTYLE INSULINX STRIP	3		<i>isoniazid injection</i>	4	
FREESTYLE LIBRE 14 DAY READER	3		JEMPERLI	5	PA
FREESTYLE LIBRE 14 DAY SENSOR	3		KADCYLA	5	PA
FREESTYLE LIBRE 2 READER	3		KANUMA	5	PA
FREESTYLE LIBRE 2 SENSOR	3		KEYTRUDA	5	PA
FREESTYLE LIBRE 3 READER	3		KHAPZORY INTRAVENOUS RECON SOLN 175 MG	5	BvD
FREESTYLE LIBRE 3 SENSOR	3		<i>lanreotide subcutaneous syringe 120 mg/0.5 ml</i>	5	PA
FREESTYLE LITE METER	3		LEUKERAN	5	
FREESTYLE LITE STRIPS	3		<i>levofloxacin in d5w intravenous piggyback 250 mg/50 ml</i>	4	PA
<i>fulvestrant</i>	5	BvD	<i>levofloxacin intravenous</i>	4	PA
FYARRO	5	PA	<i>levoleucovorin calcium</i>	5	BvD
<i>ganciclovir sodium</i>	2	BvD	LIBTAYO	5	PA; LA
<i>gemcitabine intravenous recon soln</i>	2	BvD	<i>lincomycin</i>	4	PA

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>linezolid-0.9% sodium chloride</i>	4	PA	<i>octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml)</i>	4	PA
LOQTORZI	5	PA	<i>octreotide acetate injection syringe 500 mcg/ml (1 ml)</i>	5	PA
<i>lorazepam injection solution</i>	2	PA	OMNIPOD 5 G6 INTRO KIT (GEN 5)	3	QL (1 EA per 365 days)
<i>lorazepam injection syringe 2 mg/ml</i>	2	PA	OMNIPOD 5 G6 PODS (GEN 5)	3	
<i>lorazepam oral concentrate</i>	2	PA; QL (150 ML per 30 days)	OMNIPOD DASH INTRO KIT (GEN 4)	3	QL (1 EA per 365 days)
LUMIZYME	5	PA	OMNIPOD DASH PODS (GEN 4)	3	
LUNSUMIO	5	PA	OMNIPOD GO PODS	3	
<i>megestrol oral suspension 400 mg/10 ml (10 ml)</i>	3	PA	OMNIPOD GO PODS 10 UNITS/DAY	3	
<i>melphalan hcl</i>	5	BvD	OMNIPOD GO PODS 15 UNITS/DAY	3	
MEPSEVII	5	PA	OMNIPOD GO PODS 20 UNITS/DAY	3	
<i>mesna</i>	2	BvD	OMNIPOD GO PODS 25 UNITS/DAY	3	
<i>methenamine mandelate</i>	2		OMNIPOD GO PODS 30 UNITS/DAY	3	
<i>methotrexate sodium (pf) injection recon soln</i>	2	BvD	OMNIPOD GO PODS 40 UNITS/DAY	3	
<i>methylergonovine oral</i>	4	PA	ONETOUCH ULTRA2 METER	3	
METRO I.V.	4	PA	ONETOUCH VERIO FLEX METER	3	
<i>mitomycin intravenous recon soln 20 mg, 5 mg</i>	2	BvD	ONETOUCH VERIO TEST STRIPS	3	
<i>mitomycin intravenous recon soln 40 mg</i>	5	BvD	OPDIVO	5	PA
<i>mitoxantrone</i>	2	BvD	OPDUALAG	5	PA
MONDOXYNE NL ORAL CAPSULE 100 MG	2		ORENCIA (WITH MALTOSE)	5	PA; QL (12 EA per 28 days)
MONJUVI	5	PA; LA	<i>oxaliplatin</i>	2	BvD
<i>mycophenolate mofetil (hcl)</i>	4	BvD	<i>paclitaxel</i>	2	BvD
<i>nafcillin in dextrose iso-osm intravenous piggyback 2 gram/100 ml</i>	4	PA	PADCEV	5	PA
NAGLAZYME	5	PA; LA	PARAPLATIN	2	BvD
NATACYN	4				
<i>nelarabine</i>	5	BvD			

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>pemetrexed disodium intravenous recon soln 1,000 mg, 500 mg, 750 mg</i>	5	BvD	<b>STELARA INTRAVENOUS</b>	5	PA; QL (104 ML per 180 days)
<i>pemetrexed disodium intravenous recon soln 100 mg</i>	4	BvD	<i>sulfamethoxazole-trimethoprim intravenous</i>	4	PA
<i>penicillin g potassium injection recon soln 5 million unit</i>	4	PA	<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	4	QL (8 ML per 28 days)
<b>PFIZERPEN-G</b>	4	PA	<b>SUNLENCA SUBCUTANEOUS</b>	5	
<i>piperacillin-tazobactam intravenous recon soln 13.5 gram</i>	4		<b>SYNAGIS</b>	5	LA
<b>POLIVY</b>	5	PA	<b>TABLOID</b>	4	
<b>POTELIGEO</b>	5	PA	<b>TALVEY</b>	5	PA
<b>PRECISION XTRA MONITOR</b>	3		<b>TAZICEF INTRAVENOUS</b>	4	PA
<b>PREVYMIS INTRAVENOUS</b>	5	PA	<b>TECVAYLI</b>	5	PA
<b>RETROVIR INTRAVENOUS</b>	3		<i>temsirolimus</i>	5	BvD
<i>romidepsin intravenous recon soln</i>	5	BvD	<i>thiotepa</i>	5	BvD
<b>RUXIENCE</b>	5	PA	<b>TIVDAK</b>	5	PA
<b>RYBREVANT</b>	5	PA	<i>tobramycin sulfate injection recon soln</i>	4	PA; QL (9 EA per 14 days)
<b>SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTEN DED REL RECON</b>	5	PA	<i>topotecan</i>	5	BvD
<b>SARCLISA</b>	5	PA; LA	<i>treprostinil sodium</i>	5	PA; LA
<i>sildenafil (pulm.hypertension) intravenous</i>	5	PA	<b>TRODELVY</b>	5	PA; LA
<b>SOMATULINE DEPOT</b>	5	PA	<b>TROGARZO</b>	5	LA
<b>SPRAVATO NASAL SPRAY, NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)</b>	5	PA	<i>valrubicin</i>	5	BvD
			<i>vancomycin in 0.9 % sodium chl intravenous piggyback 1 gram/200 ml</i>	3	PA; QL (400 ML per 10 days)
			<i>vancomycin in 0.9 % sodium chl intravenous piggyback 500 mg/100 ml</i>	3	PA; QL (1000 ML per 10 days)
			<i>vancomycin in 0.9 % sodium chl intravenous piggyback 750 mg/150 ml</i>	3	PA; QL (4050 ML per 10 days)
			<i>vancomycin intravenous recon soln 5 gram</i>	4	PA; QL (4 EA per 10 days)
			<b>VIMIZIM</b>	5	PA; LA

Drug Name	Drug Tier	Requirements/ Limits
<i>vinblastine</i>	2	BvD
<i>vincristine</i>	2	BvD
<i>vinorelbine</i>	2	BvD
XIAFLEX	5	PA
ZEPZELCA	5	PA
ZOLADEX	4	PA
ZYNLONTA	5	PA; LA
ZYNYZ	5	PA
<b>OPHTHALMIC AGENTS</b>		
<b>OPHTHALMIC AGENTS, OTHER</b>		
<i>atropine ophthalmic (eye) drops 1 %</i>	3	
<i>cyclosporine ophthalmic (eye)</i>	3	QL (60 EA per 30 days)
CYSTARAN	5	PA
<i>dorzolamide-timolol</i>	2	
<i>neomycin-bacitracin- poly-hc</i>	3	
<i>neomycin-bacitracin- polymyxin</i>	3	
<i>neomycin-polymyxin b- dexameth</i>	2	
<i>neomycin-polymyxin- gramicidin</i>	3	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	4	
NEO-POLYCIN	3	
NEO-POLYCIN HC	3	
OXERVATE	5	PA
<i>polymyxin b sulf- trimethoprim</i>	2	
<i>sulfacetamide- prednisolone</i>	2	
<i>tobramycin- dexamethasone</i>	3	QL (10 ML per 14 days)
XDEMVY	5	PA; QL (10 ML per 42 days)

Drug Name	Drug Tier	Requirements/ Limits
<b>OPHTHALMIC ANTI-ALLERGY AGENTS</b>		
<i>azelastine ophthalmic (eye)</i>	3	
<i>cromolyn ophthalmic (eye)</i>	2	
<i>epinastine</i>	3	
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
<i>bacitracin ophthalmic (eye)</i>	3	
<i>bacitracin-polymyxin b</i>	2	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	2	
<i>erythromycin ophthalmic (eye)</i>	2	QL (3.5 GM per 14 days)
<i>gentamicin ophthalmic (eye) drops</i>	2	QL (70 ML per 30 days)
<i>moxifloxacin ophthalmic (eye) drops</i>	3	
<i>neomycin-bacitracin- polymyxin</i>	3	
<i>neomycin-polymyxin- gramicidin</i>	3	
NEO-POLYCIN	3	
<i>ofloxacin ophthalmic (eye)</i>	2	
POLYCIN	2	
<i>polymyxin b sulf- trimethoprim</i>	2	
<i>sulfacetamide sodium ophthalmic (eye)</i>	2	
<i>tobramycin ophthalmic (eye)</i>	2	QL (10 ML per 14 days)
<i>trifluridine</i>	3	
XDEMVY	5	PA; QL (10 ML per 42 days)
ZIRGAN	4	

Drug Name	Drug Tier	Requirements/ Limits
<b>OPHTHALMIC ANTI-INFLAMMATORYS</b>		
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	2	
<i>diclofenac sodium ophthalmic (eye)</i>	2	
<i>fluorometholone</i>	3	
<i>flurbiprofen sodium</i>	2	
<i>ketorolac ophthalmic (eye)</i>	2	
<i>loteprednol etabonate</i>	3	
<i>prednisolone acetate</i>	2	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	2	
XIIDRA	3	QL (60 EA per 30 days)
<b>OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>betaxolol ophthalmic (eye)</i>	3	
<i>carteolol</i>	2	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	2	
<i>timolol maleate ophthalmic (eye) drops</i>	1	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	4	
<b>OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER</b>		
<i>acetazolamide</i>	3	
<i>apraclonidine</i>	3	

Drug Name	Drug Tier	Requirements/ Limits
<i>brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %</i>	3	
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	2	
<i>dorzolamide</i>	2	
<i>dorzolamide-timolol</i>	2	
<i>methazolamide</i>	4	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	3	
<b>OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS</b>		
<i>latanoprost</i>	1	
<i>travoprost</i>	3	
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS</b>		
<i>acetic acid otic (ear)</i>	2	
<i>ciprofloxacin-dexamethasone</i>	3	QL (7.5 ML per 7 days)
<i>FLAC OTIC OIL</i>	4	
<i>fluocinolone acetonide oil</i>	4	
<i>hydrocortisone-acetic acid</i>	4	
<i>neomycin-polymyxin-hc otic (ear)</i>	3	
<i>ofloxacin otic (ear)</i>	3	
<b>RESPIRATORY TRACT/PULMONARY AGENTS</b>		
<b>ANTIHISTAMINES</b>		
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	3	QL (60 ML per 30 days)
<i>cetirizine oral solution 1 mg/ml</i>	2	

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
hydroxyzine hcl oral tablet	2	PA	fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	4	ST; QL (12 GM per 30 days)
levocetirizine oral solution	4		fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	4	ST; QL (24 GM per 30 days)
levocetirizine oral tablet	2	QL (30 EA per 30 days)	fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	4	ST; QL (10.6 GM per 30 days)
promethazine oral	4	PA	fluticasone propionate nasal	2	QL (16 GM per 30 days)
<b>ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS</b>			QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	3	ST; QL (10.6 GM per 30 days)
ASMANEX HFA	3	ST; QL (13 GM per 30 days)	QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	3	ST; QL (21.2 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	3	ST; QL (1 EA per 30 days)	<b>ANTILEUKOTRIENES</b>		
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	3	ST; QL (2 EA per 30 days)	montelukast oral granules in packet	4	
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml	4	BvD; QL (120 ML per 30 days)	montelukast oral tablet	2	
budesonide inhalation suspension for nebulization 1 mg/2 ml	4	BvD; QL (60 ML per 30 days)	montelukast oral tablet, chewable	2	
flunisolide	3	QL (50 ML per 30 days)	zafirlukast	4	
<b>BRONCHODILATORS, ANTICHOLINERGICS</b>			<b>ATROVENT HFA</b>		
			ATROVENT HFA	4	QL (25.8 GM per 30 days)
			COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
			ipratropium bromide inhalation	2	BvD
			ipratropium bromide nasal	2	QL (30 ML per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>ipratropium-albuterol</i>	2	BvD
SPIRIVA RESPIMAT	3	QL (4 GM per 30 days)
<i>tiotropium bromide</i>	3	QL (90 EA per 90 days)
<b>BRONCHODILATO RS, SYMPATHOMIME TIC</b>		
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	2	QL (17 GM per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	2	BvD
<i>albuterol sulfate oral syrup</i>	2	
<i>albuterol sulfate oral tablet</i>	4	
<i>arformoterol</i>	4	BvD; QL (120 ML per 30 days)
DULERA	3	QL (13 GM per 30 days)
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	3	QL (2 EA per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	4	ST; QL (12 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	4	ST; QL (24 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	4	ST; QL (10.6 GM per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
<i>formoterol fumarate</i>	4	BvD; QL (120 ML per 30 days)
STRIVERDI RESPIMAT	3	QL (4 GM per 30 days)
<i>terbutaline oral</i>	4	
<b>CYSTIC FIBROSIS AGENTS</b>		
CAYSTON	5	PA; LA; QL (84 ML per 56 days)
KALYDECO	5	PA; QL (56 EA per 28 days)
ORKAMBI ORAL GRANULES IN PACKET	5	PA; QL (56 EA per 28 days)
ORKAMBI ORAL TABLET	5	PA; QL (112 EA per 28 days)
PULMOZYME	5	BvD
SYMDEKO	5	PA; QL (56 EA per 28 days)
<i>tobramycin in 0.225 % nacl</i>	5	PA; QL (280 ML per 28 days)
<i>tobramycin inhalation</i>	5	PA; QL (224 ML per 28 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	5	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	5	PA; QL (84 EA per 28 days)
<b>MAST CELL STABILIZERS</b>		
<i>cromolyn inhalation</i>	4	BvD
<i>cromolyn oral</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<b>PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE</b>		
roflumilast	4	PA; QL (30 EA per 30 days)
theophylline oral solution	4	
theophylline oral tablet extended release 12 hr 300 mg, 450 mg	2	
theophylline oral tablet extended release 24 hr	2	
<b>PULMONARY ANTIHYPERTENSIVES</b>		
ADEMPAS	5	PA; LA
ALYQ	5	PA; QL (60 EA per 30 days)
ambrisentan	5	PA; LA
bosentan	5	PA; LA
OPSUMIT	5	PA; LA
OPSYNVI	5	PA; QL (30 EA per 30 days)
sildenafil (pulm.hypertension) oral tablet	3	PA; QL (90 EA per 30 days)
tadalafil (pulm. hypertension)	5	PA; QL (60 EA per 30 days)
UPTRAVI ORAL	5	PA; LA
<b>PULMONARY FIBROSIS AGENTS</b>		
OFEV	5	PA; QL (60 EA per 30 days)
pirfenidone oral capsule	5	PA; QL (270 EA per 30 days)
pirfenidone oral tablet 267 mg	5	PA; QL (270 EA per 30 days)
pirfenidone oral tablet 801 mg	5	PA; QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
<b>RESPIRATORY TRACT AGENTS, OTHER</b>		
acetylcysteine	3	BvD
BREYNA	3	QL (10.3 GM per 30 days)
BREZTRI AEROSPHERE	3	QL (10.7 GM per 30 days)
budesonide-formoterol	3	QL (10.2 GM per 30 days)
COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
DULERA	3	QL (13 GM per 30 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
fluticasone propion-salmeterol inhalation blister with device	3	QL (60 EA per 30 days)
ipratropium-albuterol	2	BvD
STIOLTO RESPIMAT	3	QL (4 GM per 30 days)
TRELEGY ELLIPTA	3	QL (60 EA per 30 days)
WIXELA INHUB	3	QL (60 EA per 30 days)
<b>RESPIRATORY TRACT/ PULMONARY AGENTS</b>		
BREZTRI AEROSPHERE	3	QL (10.7 GM per 30 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/ Limits</b>
COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
<i>ipratropium-albuterol</i>	2	BvD
<b>SKELETAL MUSCLE RELAXANTS</b>		
<b>SKELETAL MUSCLE RELAXANTS</b>		
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	4	PA
<b>SLEEP DISORDER AGENTS</b>		
<b>SLEEP PROMOTING AGENTS</b>		
<i>doxepin oral tablet</i>	3	QL (30 EA per 30 days)
<i>ramelteon</i>	3	QL (30 EA per 30 days)
<i>zaleplon oral capsule 10 mg</i>	4	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	4	QL (30 EA per 30 days)
<i>zolpidem oral tablet</i>	2	QL (30 EA per 30 days)
<b>WAKEFULNESS PROMOTING AGENTS</b>		
<i>armodafinil</i>	4	PA; QL (30 EA per 30 days)
<i>modafinil oral tablet 100 mg</i>	3	PA; QL (30 EA per 30 days)
<i>modafinil oral tablet 200 mg</i>	3	PA; QL (60 EA per 30 days)
<i>sodium oxybate</i>	5	PA; LA; QL (540 ML per 30 days)



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## Contact us

**Prospective Members:**

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