Medicare Advantage HMO & HMO C-SNP Plans

DRUG FORMULARY

FORMULARIO DE MEDICAMENTOS

January 1 - December 31, 2026

Del 1 de enero al 31 de diciembre de 2026

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER INTHIS PLAN.
Approved Formulary File Submission ID 26380, Version Number 12
This document contains a list of covered drugs for Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO). The Drug Formulary was updated on 05/21/ 2026. For more recent information or other questions, please contact GlobalHealth Customer Care. Based on a Model of Care review, GlobalHealth has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2026.

1-866-494-3927 (TTY: 711), 24 hours a day, 7 days a week
www.GlobalHealth.com

POR FAVOR LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN.
Identificación del formulario aprobado 26380, número de versión 12
Este documento contiene una lista de medicamentos cubiertos para Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) y Generations Classic Plus (HMO). El Formulario de Medicamentos se actualizó el 21/05/2026. Para obtener información más reciente u otras preguntas, comuníquese con Atención al cliente de GlobalHealth. Basado en una revisión del modelo de cuidado, GlobalHealth ha sido aprobado por el Comité Nacional de Garantía de Calidad (NCQA) para operar un plan de necesidades especiales (SNP) hasta 2026.

1-866-494-3927 (TTY: 711) las 24 horas del día, los 7 días de la semana
www.GlobalHealth.com

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Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO) 2026 Formulary

(List of Covered Drugs or "Drug List")

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

HPMS Approved Formulary File Submission ID 00026380, Version Number 12.

This formulary was updated on 05/21/2026. For more recent information or other questions, please contact us, GlobalHealth Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit www.globalhealth.com.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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 GlobalHealth, Inc. When it refers to "plan" or "our plan," it means Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO).

This document includes a Drug List (formulary) for our plan which is current as of May 21, 2026. *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, 2026, and from time to time during the year.

What is the Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO) 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 our plan 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

our 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: www.globalhealth.com.

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 on the same or lower cost-sharing tier and 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 a different cost-sharing tier or 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 Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)’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, or move a drug to a higher cost-sharing tier, 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 Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)'s Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2026 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2026 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 formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of May 21, 2026. To get updated information about the drugs covered by Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO) please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 3. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular". If you know what your drug is used for, look for the category name in the list that begins on 3. 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 191. 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, Section 3.1, "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, we 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, our plan provides 30 tablets per prescription for Rosuvastatin. 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, 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.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 3. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We 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 Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)'s formulary?" on page V 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 Care and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options:

- You can ask Customer Care for a list of similar drug 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 us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)'s Formulary?

You can ask our plan 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 a coverage restriction including prior authorization, step therapy, or a quantity limit 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 lower cost-sharing level unless the drug is on the specialty tier. 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, 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 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.

If you are a current member in our plan, we will also cover a temporary transition supply if you have a change in your medications because of a level-of-care change. This may include unplanned changes in treatment settings, such as being discharged from an acute care (hospital) setting or being admitted to, or discharged from, a long-term care facility. For each drug that is not in our formulary, or if your ability to get

your drugs is limited, we will cover a temporary 30-day supply (up to a 31-day supply if you are a resident of a long-term care facility) when you go to a network pharmacy.

For more information

For more detailed information about your Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO) 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 day a week. TTY users should call 1-877-486-2048. Or visit http://www.medicare.gov.

Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO) Formulary

The formulary below 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 191.

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

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

Drug Tier

Tier 1 = Preferred Generic

Tier 2 = Generic

Tier 3 = Preferred Brand

Tier 4 = Non-Preferred Drug

Tier 5 = Specialty Tier

You can find information on what the symbols and abbreviations on this table mean here:

- **PA – Prior Authorization**. Our plan requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **QL – Drug has Quantity Limit**. For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 30 tablets per 30 days per prescription for rosuvastatin.
- **ST – 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, 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.
- **NM – Not available at our Mail-order pharmacies**.
- **LA – Limited Access**. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Care at 1-866-494- 3927, 24 hours a day, seven days a week. TTY users should call 711.www.globalhealth.com.
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- **B/D** – This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- **ED** - Excluded Drug. This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)
Formulario 2026
(Lista de Medicamentos Cubiertos o "Lista de Medicamentos")

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

Identificación de Presentación del Archivo de la Lista de Medicamentos Aprobada por el HPMS 00026380, versión 12.

Este Formulario se actualizó el 21/05/2026. Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio de Atención al Cliente al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite https://www.globalhealth.com.

Mensaje Importante Sobre Lo Que Usted Paga por Insulina -Usted no pagará más de $35 por un suplido de un mes de cada producto de insulina cubierto por nuestro plan, no importa el nivel de costo compartido.

Nota para los miembros existentes: Esta lista de medicamentos cambió desde el año pasado. Revise este documento para asegurarse de que aún contenga los medicamentos que toma.

Cuando en esta lista de medicamentos (Formulario) se hace referencia a "nosotros", "nos" o"nuestro", se hace referencia a GlobalHealth, Inc. Cuando se hace referencia a "plan" o "nuestro plan", se hace referencia a Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO).

Este documento incluye una lista de medicamentos (formulario) para nuestro plan que está actualizada a partir de 24 de mayo de 2026. Para obtener una lista de medicamentos actualizada (formulario), comuníquese con nosotros. Nuestra información de contacto, junto con la fecha en que actualizamos por última vez la Lista de medicamentos (formulario), aparece en las páginas de portada y contraportada.

Por lo general, debe usar las farmacias de la red para usar su beneficio de medicamentos recetados. Los beneficios, el Formulario, la red de farmacias o los copagos y coseguros pueden cambiar el 1 de enero de 2026 y demanera periódica durante el año.

¿Qué es el Formulario de Medicamentos de Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)?

En este documento, usamos los términos Lista de medicamentos y formulario para referirnos a lo mismo. Un formulario es una lista de medicamentos cubiertos seleccionados por nuestro plan en consulta con un equipo de proveedores de atención médica, que representa las terapias recetadas consideradas como una parte necesaria de un programa de tratamiento de calidad. Nuestro plan, por lo general, cubrirá los medicamentos que figuran en nuestro Formulario, siempre y cuando el medicamento sea médicamente necesario, la receta sea surtida en una farmacia de la red del plan y se cumplan otras normas del plan. Para obtener más información sobre cómo surtir sus recetas, consulte su *Evidencia de Cobertura*.

¿Puede cambiar la Lista (lista de medicamentos)?

La mayoría de los cambios en la cobertura de medicamentos se producen el 1 de enero, pero podemos agregar o eliminar medicamentos en el Formulario durante el año, moverlos a diferentes niveles de costo compartido o agregar nuevas restricciones. Debemos cumplir con las normas de Medicare para realizar estos cambios. Las actualizaciones del formulario se publican mensualmente en nuestro sitio web aquí: www.globalhealth.com.

Cambios que pueden afectarle este año: En los siguientes casos, usted se verá afectado por los cambios en la cobertura durante el año:

- **Sustituciones inmediatas de determinadas versiones nuevas de medicamentos de marca y productos biológicos originales.** Es posible que eliminemos inmediatamente un medicamento de nuestro formulario si lo estamos reemplazando con una nueva versión determinada de ese medicamento que aparecerá en el mismo nivel de costo compartido o en el más bajo y con las mismas o menos restricciones. Cuando agregamos una nueva versión de un medicamento a nuestro formulario, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestro formulario, pero moverlo inmediatamente a un nivel de costo compartido diferente o agregar nuevas restricciones.

  Podemos hacer estos cambios inmediatos solo si estamos agregando una nueva versión genérica de un medicamento de marca, o agregando ciertas nuevas versiones biosimilares de un producto biológico original, que ya estaba en el formulario (por ejemplo, agregando un biosimilar intercambiable que puede ser sustituido por un producto biológico original por una farmacia sin una nueva receta).

  Si actualmente está tomando el medicamento de marca o el producto biológico original, es posible que no le informemos con anticipación antes de realizar un cambio inmediato, pero más adelante le proporcionaremos información sobre los cambios específicos que hemos realizado.

  Si hacemos un cambio de este tipo, usted o su médico pueden pedirnos que hagamos una excepción y que continuemos cubriéndole el medicamento que se está cambiando. Para obtener más información, consulte la sección a continuación titulada "¿Cómo solicito una excepción al formulario de Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO).?

  Algunos de estos tipos de medicamentos pueden ser nuevos para usted. Para obtener más información, consulte la sección titulada ¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?”

- **Medicamentos retirados del mercado.** Si el fabricante retira un medicamento de la venta o la Administración de Alimentos y Medicamentos (FDA, por sus siglas en inglés) determina que se retira por razones de seguridad o eficacia, podemos eliminar inmediatamente el medicamento de nuestro formulario y luego notificar a los miembros que toman el medicamento.
  - **Otros cambios.** Es posible que realicemos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos eliminar un medicamento de marca del formulario al agregar un equivalente genérico o eliminar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original, o moverlo a un nivel diferente de costos compartidos, o ambos. Es posible que realicemos cambios en función de las nuevas directrices clínicas. Si eliminamos medicamentos de nuestro formulario, agregamos autorización previa, límites de cantidad y/o restricciones de terapia escalonada en un medicamento, o cambiamos un medicamento a un nivel de costo compartido más alto, debemos notificar a los miembros afectados del cambio al menos 30 días antes de que el cambio entre en vigencia. Alternativamente, cuando un miembro solicita una reposición del medicamento, puede recibir un suministro de 30 días del medicamento y un aviso del cambio.

    Si hacemos estos otros cambios, usted o su médico pueden pedirnos que hagamos una excepción para usted y que continuemos cubriendo el medicamento que ha estado tomando. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)?”

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si usted está tomando un medicamento de nuestro Formulario 2026 que estaba cubierto al comienzo del año,no interrumpiremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2026, salvo lo descrito anteriormente. Esto significa que estos medicamentos seguirán disponibles con el mismo costo compartido y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. Este año no se le notificarán directamente sobre los cambios que no lo afecten. Sin embargo, el 1 de enero del año siguiente, dichos cambios pueden afectarlo, y es importante revisar formulario del nuevo año de beneficios para ver si hay cambios en los medicamentos.

El Formulario adjunto entra en vigor a partir del 21 de mayo de 2026. Para obtener información actualizada sobre los medicamentos cubiertos por Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO), comuníquese con nosotros. Nuestra información de contacto aparece en la portada y en la contraportada. En caso de que se produzcan cambios a mediados de año en el Formulario que no sean de mantenimiento, el Formulario se actualizarán mensualmente y se publicaránen nuestro sitio web.

¿Cómo utilizo el Formulario?

Existen dos maneras de encontrar su medicamento en la lista de medicamentos:

<u>Afección Médica</u>

El Formulario comienza en la página 3. Los medicamentos de esta lista de medicamentos están agrupados en categorías según el tipo de afección médica para la que se utilizan. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca se enumeran en la categoría “Cardiovascular”. Si sabe para qué se utiliza su

medicamento, busque el nombre de la categoría en la lista que comienza en la página 3.Luego busque su medicamento en el nombre de la categoría.

Listado Alfabético

Si no está seguro en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 191. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca registrada como los medicamentos genéricos figuran en el Índice. Busque en el Índice para encontrar su medicamento. Junto con su medicamento, verá el número de página donde puede encontrar información sobre la cobertura. Vaya a la página que aparece en el Índice y busque el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre tanto medicamentos de marca registrada como medicamentos genéricos. Un medicamento genérico es uno aprobado por la Administración de Alimentos y Medicamentos (Food andDrug Administration, FDA) que contiene el mismo ingrediente activo que el medicamento de marca registrada. Por lo general, los medicamentos genéricos funcionan igual de bien y suelen costar menos que los medicamentos de marca. Hay sustitutos de medicamentos genéricos disponibles para muchos medicamentos de marca. Los medicamentos genéricos generalmente pueden ser sustituidos por el medicamento de marca en la farmacia sin necesidad de una nueva receta, según las leyes estatales.

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?

En el formulario, cuando nos referimos a medicamentos, esto podría significar un medicamento o un producto biológico. Los productos biológicos son medicamentos más complejos que los medicamentos típicos. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas que se denominan biosimilares. Por lo general, los biosimilares funcionan tan bien como el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, dependiendo de las leyes estatales, pueden ser sustituidos por el producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden ser sustituidos por medicamentos de marca.

- Para hablar sobre los tipos de medicamentos, consulte la Evidencia de Cobertura, Capítulo 5, Sección 3.1, "La 'Lista de Medicamentos' indica qué medicamentos de la Parte D están cubiertos.”

¿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 necesita que usted o su prescriptor obtengan una autorización previa para obtener ciertos medicamentos. Esto significa que necesitará obtener una aprobación de nuestro plan antes de obtener los medicamentos con receta médica. Si no obtiene la aprobación, es posible que no cubramos el medicamento.
- **Límites de Cantidades:** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubrirá nuestro plan. Por ejemplo, nuestro plan proporciona 30 tabletas por receta para rosuvastatina. Esto puede ser adicional a un suministro estándar para un mes o tres meses.

- **Terapia Escalonada:** En algunos casos, nuestro plan requiere que primero pruebe otros medicamentos para tratar su afección médica antes de cubrir otro medicamento para esa afección. Por ejemplo, si el medicamento A y el medicamento B tratan una condición médica, podemos no cubrir el medicamento B a menos que pruebe con el medicamento A primero. Si el medicamento A no funciona, le cubriremos el medicamento B.

Puede averiguar si su medicamento tiene requisitos o límites adicionales consultando el Formulario que comienza en la página 3. También puede obtener más información sobre las restricciones aplicadas a medicamentos cubiertos específicos visitando nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia escalonada. También puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en la portada y en la contraportada.

Puede solicitar a nuestro plan que haga una excepción a estas restricciones o límites o una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección "¿Cómo solicito una excepción al Formulario de Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)?" en la página XII para información sobre cómo solicitar una excepción.

¿Qué pasa si mi medicamento no está en el Formulario?

Si su medicamento no está incluido en esté Formulario (lista de medicamentos cubiertos), primero debe comunicarse con el Servicio de Atención al Cliente y preguntar si su medicamento está cubierto.

Si se entera de que nuestro plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar al Servicio de Atención al Cliente una lista de medicamentos similares que estén cubiertos por nuestro 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 nuestro plan haga una excepción para que cubra su medicamento. Consulte la siguiente sección para obtener información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al Formulario de Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)?

Puede solicitar a nuestro plan que haga una excepción a nuestras normas de cobertura. Existen varios tipos de excepciones que puede solicitarnos.

- Puede solicitarnos que cubramos un medicamento incluso si no está en nuestro Formulario. Si se aprueba, este medicamento estará cubierto a un nivel de costo compartido predeterminado, y usted no podrá solicitarnos que le proporcionemos el medicamento a un nivel de costo compartido más bajo.
- Puede pedirnos que renunciemos a una restricción de cobertura, incluida la autorización previa, la terapia escalonada o un límite de cantidad en su medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Si su medicamento

tiene un límite de cantidad, puede pedirnos que le eximamos del límite y cubramos una cantidad mayor.

- Puede pedirnos que cubramos un medicamento del formulario a un nivel de costo compartido más bajo, a menos que el medicamento esté en el nivel de especialidad. Si se aprueba, esto reduciría el monto que debe pagar por su medicamento.

Por lo general, nuestro plan solo aprobará su solicitud de excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de menor costo compartido o la aplicación de la restricción no serían tan efectivos para usted y/o le causarían efectos adversos.

Usted o su médico deben comunicarse con nosotros para solicitar una clasificación por niveles o una excepción al formulario, incluida una excepción a una restricción de cobertura. **Cuando solicite una excepción, su médico deberá explicar las razones médicas por las que necesita la excepción.** Por lo general, debemos tomar nuestra decisión dentro de las 72 horas posteriores a la recepción de la declaración de respaldo de su médico. Puede solicitar una decisión acelerada (rápida) si cree, y estamos de acuerdo, que su salud podría verse seriamente perjudicada si espera hasta 72 horas para recibir una decisión. Si estamos de acuerdo, o si su médico solicita una decisión rápida, debemos darle una decisión a más tardar 24 horas después de recibir la declaración de respaldo de su médico.

¿Qué puedo hacer si mi medicamento no está en el formulario o tiene una restricción?

Como miembro nuevo o continuo de nuestro plan, es posible que esté tomando medicamentos que no están en nuestro formulario. O bien, es posible que esté tomando un medicamento que está en nuestro formulario pero que tiene una restricción de cobertura, como una autorización previa. Debe hablar con su médico sobre la posibilidad de solicitar una decisión de cobertura para demostrar que cumple con los criterios para la aprobación, cambiar a un medicamento alternativo que cubrimos o solicitar una excepción al formulario para que cubramos el medicamento que toma. Mientras usted y su médico determinan el curso de acción correcto para usted, podemos cubrir su medicamento en ciertos casos durante los primeros 90 días que sea miembro de nuestro plan.

Para cada uno de sus medicamentos que no estén en nuestro formulario o que tenga una restricción de cobertura, cubriremos un suministro temporal de 30 días. Si su receta está escrita para menos días, permitiremos que los resurtidos proporcionen un suministro máximo de medicamentos para 30 días. Si no se aprueba la cobertura, después de su primer suministro de 30 días, no pagaremos estos medicamentos, incluso si ha sido miembro del plan menos de 90 días.

Si usted es residente de un centro de atención médica a largo plazo y necesita un medicamento que no está en nuestra lista de medicamentos, o si su capacidad para obtener sus medicamentos es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia por 31 días de ese medicamento mientras usted busca una excepción a la lista.

Si usted es un miembro actual de nuestro plan, también cubriremos un suministro de transición temporal si sus medicamentos cambian debido a un cambio en el nivel de atención. Esto puede incluir cambios no planificados en los entornos de tratamiento, como ser dado de alta de un centro de cuidados intensivos (hospital) o ser hospitalizado o dado de alta de un centro de atención médica a largo plazo. Por cada medicamento que no esté en nuestro Formulario o si su capacidad para obtener sus medicamentoses limitada, cubriremos un suministro temporal por 30 días (un suministro por hasta 31 días si usted es residente de un centro de atención médica a largo plazo) cuando vaya a una farmacia de la red.

Para obtener más información

Para obtener información más detallada sobre su cobertura de medicamentos recetados Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO) revise su Evidencia de Cobertura y otros materiales del plan.

Si tiene preguntas sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en la portada y en la contraportada.

Si tiene preguntas generales acerca de la cobertura de medicamentos recetados de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY/TDD deben llamar al 1-877-486-2048. O visite http://www.medicare.gov.

Formulario de Generations Chronic Care (HMO C-SNP), Generations Chronic Care Savings (HMO C-SNP), Generations Classic Rewards (HMO) and Generations Classic Plus (HMO)

El Formulario que comienza en la página siguiente proporciona información de cobertura sobre los medicamentos cubiertos por nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, consulte el Índice que comienza en la página 191.

La primera columna de la tabla enumera el nombre del medicamento. Los medicamentos de marca registrada están en mayúscula (p. ej., SYNTHROID) y los medicamentos genéricos están en minúscula cursiva (p. ej., *levotiroxina*).

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

Nivel de Medicamento

Nivel 1 = Genérico preferido

Nivel 2 = Genérico

Nivel 3 = Marca preferida

Nivel 4 = Medicamentos no preferidos

Nivel 5 = Nivel de especialidad

Puede encontrar información sobre lo que significan los símbolos y las abreviaturas en esta tabla:

- **PA - Autorización Previa.** El plan necesita que usted o su proveedor obtengan una autorización previa para ciertos medicamentos. Esto significa que necesitará obtener nuestra aprobación antes de obtener los medicamentos con receta médica. Si no obtiene la aprobación, es posible que no cubramos el medicamento.

- **QL - El medicamento tiene un límite de cantidad.** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Por ejemplo, nuestro plan proporciona 30 tabletas por 30 días por receta de rosuvastatina.
- **ST - Terapia Escalonada.** En algunos casos, nuestro plan requiere que primero pruebe otros medicamentos para tratar su afección médica antes de cubrir otro medicamento para esa afección. Por ejemplo, si el medicamento A y el medicamento B tratan una condición médica, podemos no cubrir el medicamento B a menos que pruebe con el medicamento A primero. Si el medicamento A no funciona, le cubriremos el medicamento B.
- **NM - No está disponible en nuestras farmacias de pedidos por correo.**
- **LA - Acceso Limitado. Esta receta puede estar disponible solo en ciertas farmacias.** Para obtener más información, consulte su Directorio de Proveedores y Farmacias o llame a nuestro Centro de Llamadas de Servicio al Cliente al 1-866-494-3927, las 24 horas del día, los siete días de la semana. Los usuarios de TTY deben llamar al 711 o visite www.globalhealth.com..
- **B/D - Este medicamento puede estar cubierto por Medicare Parte B o Parte D, según las circunstancias.** Es posible que sea necesario presentar información que describa el uso y el entorno del medicamento para tomar la decisión.
- **ED - Medicamento Excluido (Excluded Drug).** Este medicamento recetado generalmente no está cubierto por un Plan de Medicamentos Recetados de Medicare. El monto que usted paga cuando le dispensan una receta de este medicamento no cuenta entre los costos de medicamentos totales (es decir, el monto que paga no lo ayuda a reunir los requisitos para la cobertura catastrófica). Además, si recibe ayuda adicional para pagar sus recetas, no obtendrá ayuda adicional para pagar este medicamento.

Generations Chronic Care (HMO C-SNP)				
Tier	**Standard Retail in-network cost-sharing (up to a 30-days supply)**	**Preferred Retail in-network cost-sharing (up to a 30-days supply)**	**Standard Retail cost sharing (in-network) (up to a 100-days supply)**	**Preferred Retail cost sharing (in-network) (up to a 100-days supply)**
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$6	$0	$18	$0
Cost-Sharing Tier 2 (Generic Drugs)	$11	$5	$33	$0
Cost-Sharing Tier 3 (Preferred Brand Drugs)	$47	$41	$141	$82
Cost-Sharing Tier 4 (Non-Preferred Drugs)	50% coinsurance	40% coinsurance	50% coinsurance	40% coinsurance
Cost-Sharing Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	A long-term supply isn't available for drugs in Tier 5 (Specialty Drugs).	A long-term supply isn't available for drugs in Tier 5 (Specialty Drugs).

Generations Chronic Care Savings (HMO C-SNP)				
Tier	**Standard Retail in-network cost-sharing (up to a 30-days supply)**	**Preferred Retail in-network cost-sharing (up to a 30-days supply)**	**Standard Retail cost sharing (in-network) (up to a 100-days supply)**	**Preferred Retail cost sharing (in-network) (up to a 100-days supply)**
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$6	$0	$18	$0
Cost-Sharing Tier 2 (Generic Drugs)	$11	$5	$33	$0
Cost-Sharing Tier 3 (Preferred Brand Drugs)	$47	$41	$141	$82
Cost-Sharing Tier 4 (Non-Preferred Drugs)	50% coinsurance	40% coinsurance	50% coinsurance	40% coinsurance
Cost-Sharing Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	A long-term supply isn't available for drugs in Tier 5 (Specialty Drugs).	A long-term supply isn't available for drugs in Tier 5 (Specialty Drugs).

Generations Classic Rewards (HMO)				
Tier	**Standard Retail in-network cost-sharing (up to a 30-days supply)**	**Preferred Retail in-network cost-sharing (up to a 30-days supply)**	**Standard Retail cost sharing (in-network) (up to a 100-days supply)**	**Preferred Retail cost sharing (in-network) (up to a 100-days supply)**
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$6	$0	$18	$0
Cost-Sharing Tier 2 (Generic Drugs)	$14	$8	$42	$0
Cost-Sharing Tier 3 (Preferred Brand Drugs)	$47	$41	$141	$82
Cost-Sharing Tier 4 (Non-Preferred Drugs)	50% coinsurance	40% coinsurance	50% coinsurance	40% coinsurance
Cost-Sharing Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	A long-term supply isn't available for drugs in Tier 5 (Specialty Drugs).	A long-term supply isn't available for drugs in Tier 5 (Specialty Drugs).

Generations Classic Plus (HMO)				
Tier	**Standard Retail in-network cost-sharing (up to a 30-days supply)**	**Preferred Retail in-network cost-sharing (up to a 30-days supply)**	**Standard Retail cost sharing (in-network) (up to a 100-days supply)**	**Preferred Retail cost sharing (in-network) (up to a 100-days supply)**
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$6	$0	$18	$0
Cost-Sharing Tier 2 (Generic Drugs)	$16	$10	$48	$0
Cost-Sharing Tier 3 (Preferred Brand Drugs)	$47	$41	$141	$82
Cost-Sharing Tier 4 (Non-Preferred Drugs)	50% coinsurance	40% coinsurance	50% coinsurance	40% coinsurance
Cost-Sharing Tier 5 (Specialty Drugs)	33% coinsurance	33% coinsurance	A long-term supply isn’t available for drugs in Tier 5 (Specialty Drugs).	A long-term supply isn’t available for drugs in Tier 5 (Specialty Drugs).

List of Covered Drugs

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Drug Name	Reference	Drug Tier	Requirements/Limits
ANALGESICS			
Analgesics, Miscellaneous			
acetaminophen-codeine oral solution 120-12 mg/5ml		1	QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg		1	QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg		1	QL (180 per 30 days)
acetaminophen-codeine solution 300-30 mg/12.5ml oral		1	QL (4500 per 30 days)
buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	Butrans	4	QL (4 per 28 days)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg		2	PA; HRM; QL (180 per 30 days); AGE (Max 64 Years)
butalbital-apap-caffeine oral capsule 50-300-40 mg	Fioricet	2	PA; HRM; QL (180 per 30 days); AGE (Max 64 Years)
butalbital-apap-caffeine oral capsule 50-325-40 mg		2	PA; HRM; QL (180 per 30 days); AGE (Max 64 Years)
butalbital-apap-caffeine oral tablet 50-325-40 mg	BAC (Butalbital-Acetamin-Caff)	1	PA; HRM; QL (180 per 30 days); AGE (Max 64 Years)
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 400 mcg, 600 mcg, 800 mcg		5	PA; NM; QL (120 per 30 days); NEDS
fentanyl citrate buccal lozenge on a handle 200 mcg		2	PA; QL (120 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr		2	QL (10 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg		1	QL (180 per 30 days)
hydrocodone-acetaminophen oral tablet 5-325 mg		1	QL (240 per 30 days)
hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg	Dilaudid	1	QL (180 per 30 days)
methadone hcl oral tablet 10 mg		1	QL (120 per 30 days)
methadone hcl oral tablet 5 mg		1	QL (180 per 30 days)
morphine sulfate (concentrate) oral solution 100 mg/5ml		1	PA; QL (180 per 30 days)
morphine sulfate er oral tablet extended release 100 mg		1	QL (60 per 30 days)
morphine sulfate er oral tablet extended release 15 mg, 30 mg	MS Contin	1	QL (90 per 30 days)
morphine sulfate er oral tablet extended release 200 mg		2	QL (60 per 30 days)
morphine sulfate er oral tablet extended release 60 mg	MS Contin	1	QL (60 per 30 days)
MORPHINE SULFATE ORAL SOLUTION 10 MG/5ML		1	QL (700 per 30 days)
MORPHINE SULFATE ORAL TABLET 15 MG		4	QL (180 per 30 days)
MORPHINE SULFATE ORAL TABLET 30 MG		4	QL (120 per 30 days)
oxycodone hcl oral capsule 5 mg		1	QL (180 per 30 days)
oxycodone hcl oral tablet 10 mg, 5 mg		1	QL (180 per 30 days)
oxycodone hcl oral tablet 15 mg, 30 mg	Roxicodone	1	QL (120 per 30 days)
oxycodone hcl oral tablet 20 mg		1	QL (120 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg	Endocet	1	QL (180 per 30 days)
oxycodone-acetaminophen oral tablet 5-325 mg	Endocet	1	QL (360 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
oxycodone-acetaminophen oral tablet 7.5-325 mg	Endocet	1	QL (240 per 30 days)
tramadol hcl oral tablet 50 mg		1	QL (240 per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg		1	QL (300 per 30 days)
Nonsteroidal Anti-Inflammatory Agents			
celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg	CeleBREX	1	QL (60 per 30 days)
diclofenac epolamine external patch 1.3 %	Flector	4	PA; QL (60 per 30 days)
diclofenac potassium oral tablet 50 mg		1	QL (120 per 30 days)
diclofenac sodium er oral tablet extended release 24 hour 100 mg		1	
diclofenac sodium external solution 1.5 %		4	QL (300 per 30 days)
diclofenac sodium external solution 2 %		5	PA; NM; QL (224 per 28 days); NEDS
diclofenac sodium oral tablet delayed release 25 mg		1	
diclofenac sodium oral tablet delayed release 50 mg		1	QL (120 per 30 days)
diclofenac sodium oral tablet delayed release 75 mg		1	QL (60 per 30 days)
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	Arthrotec	2	
ibu oral tablet 400 mg	IBU	1	QL (240 per 30 days)
ibu oral tablet 600 mg, 800 mg	IBU	1	
ibuprofen oral tablet 400 mg	IBU	1	QL (240 per 30 days)
ibuprofen oral tablet 600 mg, 800 mg	IBU	1	
indomethacin oral capsule 25 mg, 50 mg		1	PA; HRM; AGE (Max 64 Years)
meloxicam oral tablet 15 mg, 7.5 mg		1	

You can find information on what the symbols and abbreviations on this table mean by going to page VII of the introduction. Formulary ID: 26380

Drug Name	Reference	Drug Tier	Requirements/Limits
nabumetone oral tablet 500 mg, 750 mg		1	
naproxen oral tablet 250 mg, 375 mg, 500 mg		1	
sulindac oral tablet 150 mg, 200 mg		1	
ANESTHETICS			
Local Anesthetics			
glydo external prefilled syringe 2 %	Glydo	1	QL (30 per 30 days)
lidocaine external ointment 5 %		2	PA; QL (240 per 30 days)
lidocaine external patch 5 %	Lidocan	4	PA; QL (90 per 30 days)
lidocaine hcl urethral/mucosal external gel 2 %		1	QL (30 per 30 days)
lidocaine hcl urethral/mucosal external prefilled syringe 2 %	Glydo	1	QL (30 per 30 days)
lidocaine viscous hcl mouth/throat solution 2 %		1	
lidocaine-prilocaine external cream 2.5-2.5 %		1	PA; QL (30 per 30 days)
lidocan external patch 5 %	Lidocan	4	PA; QL (90 per 30 days)
tridacaine ii external patch 5 %	Lidocan	4	PA; QL (90 per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS			
Anti-Addiction/Substance Abuse Treatment Agents			
acamprosate calcium oral tablet delayed release 333 mg		4	
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg		2	

Drug Name	Reference	Drug Tier	Requirements/Limits
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg	Suboxone	2	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg		1	
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg		1	
disulfiram oral tablet 250 mg, 500 mg		2	
KLOXXADO NASAL LIQUID 8 MG/0.1ML		3	QL (4 per 30 days)
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml		1	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml		2	
naloxone hcl nasal liquid 4 mg/0.1ml	Narcan	2	QL (4 per 30 days)
naltrexone hcl oral tablet 50 mg		1	
NICOTROL NS NASAL SOLUTION 10 MG/ML		4	QL (240 per 180 days)
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	Chantix Starting Month Pak	4	
varenicline tartrate oral tablet 0.5 mg, 1 mg, 1 mg (56 pack)	Chantix	4	QL (336 per 365 days)
ANTIANXIETY AGENTS			
Benzodiazepines			
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	Xanax	1	QL (120 per 30 days)
alprazolam oral tablet 2 mg	Xanax	1	QL (150 per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg		1	QL (120 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	KlonoPIN	1	QL (90 per 30 days)
clonazepam oral tablet 2 mg	KlonoPIN	1	QL (300 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg		1	QL (90 per 30 days)
clonazepam oral tablet dispersible 2 mg		1	QL (300 per 30 days)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg		2	QL (180 per 30 days)
diazepam injection solution 5 mg/ml		1	QL (10 per 28 days)
diazepam intensol oral concentrate 5 mg/ml		1	QL (1200 per 30 days)
diazepam oral solution 5 mg/5ml		1	QL (1200 per 30 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	Valium	1	QL (120 per 30 days)
diazepam solution 5 mg/ml injection		4	
lorazepam concentrate 2 mg/ml oral	LORazepam Intensol	1	QL (150 per 30 days)
lorazepam injection solution 2 mg/ml, 4 mg/ml	Ativan	1	QL (2 per 30 days)
lorazepam intensol oral concentrate 2 mg/ml	LORazepam Intensol	1	QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	Ativan	1	QL (90 per 30 days)
lorazepam oral tablet 2 mg	Ativan	1	QL (150 per 30 days)
temazepam oral capsule 15 mg, 30 mg	Restoril	1	QL (30 per 30 days)
temazepam oral capsule 22.5 mg	Restoril	2	QL (30 per 30 days)
temazepam oral capsule 7.5 mg	Restoril	2	QL (120 per 30 days)
ANTIBACTERIALS			
Aminoglycosides			
amikacin sulfate injection solution 500 mg/2ml		2	
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML		5	PA; NM; QL (235.2 per 28 days); NEDS
gentamicin sulfate injection solution 10 mg/ml, 40 mg/ml		1	
neomycin sulfate oral tablet 500 mg		1	
streptomycin sulfate intramuscular solution reconstituted 1 gm		5	NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
TOBI PODHALER INHALATION CAPSULE 28 MG		5	NM; QL (224 per 28 days); NEDS
tobramycin inhalation nebulization solution 300 mg/5ml	Kitabis Pak (w/ nebulizer)	5	PA BvD; NM; NEDS
tobramycin pak inhalation nebulization solution 300 mg/5ml	Kitabis Pak (w/ nebulizer)	5	PA BvD; NM; NEDS
tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml		4	
Antibacterials, Miscellaneous			
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	Cleocin	1	
clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 9 gm/60ml, 900 mg/6ml	Cleocin Phosphate	2	
colistimethate sodium (cba) injection solution reconstituted 150 mg	Coly-Mycin M	5	NM; NEDS
DAPTOMYCIN INTRAVENOUS SOLUTION RECONSTITUTED 350 MG		5	NM; NEDS
daptomycin intravenous solution reconstituted 500 mg		5	NM; NEDS
fosfomycin tromethamine oral packet 3 gm		2	
linezolid intravenous solution 600 mg/300ml	Zyvox	4	
linezolid oral tablet 600 mg		4	
methenamine hippurate oral tablet 1 gm	Hiprex	2	
metronidazole intravenous solution 500 mg/100ml		1	
metronidazole oral tablet 250 mg, 500 mg		1	
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	Macrodantin	1	QL (120 per 30 days)
nitrofurantoin monohyd macro oral capsule 100 mg	Macrobid	1	QL (60 per 30 days)
trimethoprim oral tablet 100 mg		1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 5 gm, 500 mg, 750 mg		4	
VANCOMYCIN HCL INTRAVENOUS SOLUTION RECONSTITUTED 1.25 GM		4	
vancomycin hcl oral capsule 125 mg	Vancocin	4	QL (56 per 14 days)
vancomycin hcl oral capsule 250 mg	Vancocin	4	QL (112 per 14 days)
XIFAXAN ORAL TABLET 200 MG		3	PA; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG		5	PA; NM; QL (90 per 30 days); NEDS
Cephalosporins			
cefaclor oral capsule 250 mg, 500 mg		2	
cefadroxil oral capsule 500 mg		1	
cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 500 mg		2	
cefdinir oral capsule 300 mg		1	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml		1	
cefepime hcl injection solution reconstituted 1 gm		4	
cefepime hcl intravenous solution reconstituted 2 gm		4	
cefixime oral capsule 400 mg		2	
cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm		4	
cefpodoxime proxetil oral tablet 100 mg, 200 mg		2	
ceftaroline fosamil intravenous solution reconstituted 400 mg, 600 mg	Teflaro	5	NM; NEDS
ceftazidime injection solution reconstituted 1 gm	Tazicef	4	

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Drug Name	Reference	Drug Tier	Requirements/Limits
ceftazidime injection solution reconstituted 6 gm		4	
ceftazidime intravenous solution reconstituted 2 gm	Tazicef	4	
ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg		2	
ceftriaxone sodium intravenous solution reconstituted 10 gm		2	
cefuroxime axetil oral tablet 250 mg, 500 mg		1	
cefuroxime sodium injection solution reconstituted 750 mg		1	
cefuroxime sodium intravenous solution reconstituted 1.5 gm		2	
cephalexin oral capsule 250 mg, 500 mg		1	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml		1	
tazicef injection solution reconstituted 1 gm	Tazicef	4	
tazicef intravenous solution reconstituted 2 gm	Tazicef	4	
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED 6 GM		4	
Macrolides			
azithromycin intravenous solution reconstituted 500 mg	Zithromax	2	
azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack)	Zithromax	1	
azithromycin oral tablet 600 mg		1	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml		4	
clarithromycin oral tablet 250 mg, 500 mg		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
erythromycin base oral tablet 250 mg, 500 mg		2	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	E.E.S. Granules	2	
erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml	EryPed 400	2	
fidaxomicin oral tablet 200 mg	Dificid	5	NM; QL (20 per 10 days); NEDS
Miscellaneous B-Lactam Antibiotics			
aztreonam injection solution reconstituted 1 gm, 2 gm	Azactam	4	
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG		5	PA; NM; NEDS
ertapenem sodium injection solution reconstituted 1 gm		4	
imipenem-cilastatin intravenous solution reconstituted 250 mg		4	
imipenem-cilastatin intravenous solution reconstituted 500 mg	Primaxin IV	4	
meropenem intravenous solution reconstituted 1 gm, 500 mg		2	
MEROPENEM INTRAVENOUS SOLUTION RECONSTITUTED 2 GM		4	
Penicillins			
amoxicillin oral capsule 250 mg, 500 mg		1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml		1	
amoxicillin oral tablet 500 mg, 875 mg		1	
amoxicillin oral tablet chewable 125 mg, 250 mg		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml		1	
amoxicillin-pot clavulanate oral suspension reconstituted 250-62.5 mg/5ml		2	
amoxicillin-pot clavulanate oral suspension reconstituted 600-42.9 mg/5ml	Augmentin ES-600	1	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg		1	
ampicillin oral capsule 500 mg		1	
ampicillin sodium injection solution reconstituted 1 gm, 125 mg		2	
ampicillin sodium intravenous solution reconstituted 10 gm		2	
ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm	Unasyn	4	
ampicillin-sulbactam sodium intravenous solution reconstituted 15 (10-5) gm	Unasyn	4	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML		4	
dicloxacillin sodium oral capsule 250 mg, 500 mg		1	
EXTENCILLINE INTRAMUSCULAR SUSPENSION RECONSTITUTED 1200000 UNIT, 2400000 UNIT		4	
LENTOCILIN INTRAMUSCULAR SUSPENSION RECONSTITUTED 1200000 UNIT		4	
nafcillin sodium injection solution reconstituted 1 gm, 2 gm		4	
nafcillin sodium intravenous solution reconstituted 10 gm		4	

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Drug Name	Reference	Drug Tier	Requirements/Limits
penicillin g potassium injection solution reconstituted 20000000 unit	Pfizerpen	4	
penicillin g procaine intramuscular suspension 600000 unit/ml		2	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml		1	
penicillin v potassium oral tablet 250 mg, 500 mg		1	
piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm		4	
Quinolones			
ciprofloxacin hcl oral tablet 250 mg, 500 mg	Cipro	1	
ciprofloxacin hcl oral tablet 750 mg		1	
ciprofloxacin in d5w intravenous solution 200 mg/100ml, 400 mg/200ml		1	
levofloxacin in d5w intravenous solution 250 mg/50ml, 500 mg/100ml, 750 mg/150ml		1	
levofloxacin oral solution 25 mg/ml		2	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg		1	
MOXIFLOXACIN HCL IN NACL INTRAVENOUS SOLUTION 400 MG/250ML		4	
moxifloxacin hcl oral tablet 400 mg		2	
MOXIFLOXACIN HCL SOLUTION 400 MG/250ML INTRAVENOUS		4	
Sulfonamides			
sulfadiazine oral tablet 500 mg		4	

Drug Name	Reference	Drug Tier	Requirements/Limits
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	Sulfatrim Pediatric	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg	Bactrim	1	
sulfamethoxazole-trimethoprim oral tablet 800-160 mg	Bactrim DS	1	
Tetracyclines			
demeclocycline hcl oral tablet 150 mg, 300 mg		2	
doxy 100 intravenous solution reconstituted 100 mg	Doxy 100	4	
doxycycline hyclate intravenous solution reconstituted 100 mg	Doxy 100	4	
doxycycline hyclate oral capsule 100 mg, 50 mg		1	
doxycycline hyclate oral tablet 100 mg, 20 mg		1	
doxycycline monohydrate oral capsule 100 mg	Mondoxyne NL	1	
doxycycline monohydrate oral capsule 50 mg		1	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml		2	
doxycycline monohydrate oral tablet 100 mg, 50 mg		1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg		1	
tetracycline hcl oral capsule 250 mg, 500 mg		2	
tigecycline intravenous solution reconstituted 50 mg	Tygacil	4	
ANTICANCER AGENTS			
Anticancer Agents			

Drug Name	Reference	Drug Tier	Requirements/Limits
ABIRATERONE ACETATE MICRONIZED ORAL TABLET 125 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
abiraterone acetate oral tablet 250 mg	Abirtega	5	PA NSO; NM; QL (120 per 30 days); NEDS
abiraterone acetate oral tablet 500 mg	Zytiga	5	PA NSO; NM; QL (120 per 30 days); NEDS
abirtega oral tablet 250 mg	Abirtega	2	PA NSO; QL (120 per 30 days)
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
ALECENSA ORAL CAPSULE 150 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
ALUNBRIG ORAL TABLET 180 MG, 90 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
ALUNBRIG ORAL TABLET 30 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG		5	PA NSO; NM; NEDS
anastrozole oral tablet 1 mg	Arimidex	1	
ANKTIVA INTRAVESICAL SOLUTION 400 MCG/0.4ML		5	PA NSO; NM; QL (1.6 per 28 days); NEDS
AUGTYRO ORAL CAPSULE 160 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
AUGTYRO ORAL CAPSULE 40 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
AVMAPKI FAKZYNJA CO-PACK ORAL THERAPY PACK 0.8 & 200 MG		5	PA NSO; NM; QL (66 per 28 days); NEDS
AXTLE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG		5	NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
azacitidine injection suspension reconstituted 100 mg	Vidaza	5	NM; NEDS
BALVERSA ORAL TABLET 3 MG		5	PA NSO; NM; QL (84 per 28 days); NEDS
BALVERSA ORAL TABLET 4 MG		5	PA NSO; NM; QL (56 per 28 days); NEDS
BALVERSA ORAL TABLET 5 MG		5	PA NSO; NM; QL (28 per 28 days); NEDS
BENDAMUSTINE HCL INTRAVENOUS SOLUTION 100 MG/4ML		5	PA NSO; NM; NEDS
bendamustine hcl intravenous solution reconstituted 100 mg, 25 mg	Treanda	5	PA NSO; NM; NEDS
BENDEKA INTRAVENOUS SOLUTION 100 MG/4ML		5	PA NSO; NM; NEDS
bexarotene external gel 1 %	Targretin	5	PA NSO; NM; NEDS
bexarotene oral capsule 75 mg	Targretin	5	PA NSO; NM; NEDS
bicalutamide oral tablet 50 mg	Casodex	1	
BIZENGRI (750 MG DOSE) INTRAVENOUS SOLUTION THERAPY PACK 375 MG/18.75ML		5	PA NSO; NM; QL (75 per 28 days); NEDS
bleomycin sulfate injection solution reconstituted 15 unit, 30 unit		1	
BORTEZOMIB INJECTION SOLUTION RECONSTITUTED 1 MG, 2.5 MG		4	PA NSO
bortezomib injection solution reconstituted 3.5 mg	Velcade	5	PA NSO; NM; NEDS
BORUZU INJECTION SOLUTION 3.5 MG/1.4ML		4	PA NSO
BOSULIF ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
BOSULIF ORAL CAPSULE 50 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
BOSULIF ORAL TABLET 100 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
BOSULIF ORAL TABLET 400 MG, 500 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
BRAFTOVI ORAL CAPSULE 75 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
BRUKINSA ORAL CAPSULE 80 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
BRUKINSA ORAL TABLET 160 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
CABOMETYX ORAL TABLET 20 MG, 60 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
CABOMETYX ORAL TABLET 40 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
CALQUENCE ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
CALQUENCE ORAL TABLET 100 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
CAMCEVI SUBCUTANEOUS PREFILLED SYRINGE 42 MG		4	PA NSO
CAPRELSA ORAL TABLET 100 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
CAPRELSA ORAL TABLET 300 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG		5	PA NSO; NM; NEDS
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG		5	PA NSO; NM; QL (112 per 28 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG		5	PA NSO; NM; NEDS
COPIKTRA ORAL CAPSULE 15 MG, 25 MG		5	PA NSO; NM; QL (56 per 28 days); NEDS
COTELLIC ORAL TABLET 20 MG		5	PA NSO; NM; QL (63 per 28 days); NEDS
cyclophosphamide injection solution reconstituted 1 gm, 2 gm, 500 mg		5	PA BvD; NM; NEDS
cyclophosphamide intravenous solution 2 gm/4ml	Frindovyx	5	PA BvD; NM; NEDS
CYCLOPHOSPHAMIDE INTRAVENOUS SOLUTION 500 MG/2.5ML, 500 MG/ML		5	PA BvD; NM; NEDS
cyclophosphamide intravenous solution 500 mg/5ml		5	PA BvD; NM; NEDS
CYCLOPHOSPHAMIDE ORAL CAPSULE 25 MG, 50 MG		4	PA BvD; ST
cyclophosphamide oral tablet 25 mg		3	PA BvD; ST
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG		3	PA BvD; ST
DANYELZA INTRAVENOUS SOLUTION 40 MG/10ML		5	PA NSO; NM; QL (120 per 28 days); NEDS
DANZITEN ORAL TABLET 71 MG, 95 MG		5	PA NSO; NM; QL (112 per 28 days); NEDS
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg	Phyrago	5	PA NSO; NM; QL (30 per 30 days); NEDS
dasatinib oral tablet 20 mg	Phyrago	5	PA NSO; NM; QL (90 per 30 days); NEDS
DATROWAY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG		5	PA NSO; NM; NEDS
DAURISMO ORAL TABLET 100 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
DAURISMO ORAL TABLET 25 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
decitabine intravenous solution reconstituted 50 mg		5	NM; NEDS
doxorubicin hcl liposomal intravenous suspension 2 mg/ml	Doxil	5	PA BvD; NM; NEDS
ELAHERE INTRAVENOUS SOLUTION 100 MG/20ML		5	PA NSO; NM; NEDS
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG		4	PA NSO
ELREXFIO SUBCUTANEOUS SOLUTION 44 MG/1.1ML		5	PA NSO; NM; NEDS
ELREXFIO SUBCUTANEOUS SOLUTION 76 MG/1.9ML		5	PA NSO; NM; QL (9.5 per 28 days); NEDS
EMCYT ORAL CAPSULE 140 MG		5	NM; NEDS
EMRELIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 20 MG		5	PA NSO; NM; NEDS
ENSACOVE ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
ENSACOVE ORAL CAPSULE 25 MG		5	PA NSO; NM; QL (270 per 30 days); NEDS
EPKINLY SUBCUTANEOUS SOLUTION 4 MG/0.8ML, 48 MG/0.8ML		5	PA NSO; NM; NEDS
ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML, 200 MG/100ML		5	PA NSO; NM; NEDS
ERIVEDGE ORAL CAPSULE 150 MG		5	PA NSO; NM; QL (28 per 28 days); NEDS
ERLEADA ORAL TABLET 240 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
ERLEADA ORAL TABLET 60 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
erlotinib hcl oral tablet 100 mg, 25 mg		5	PA NSO; NM; QL (60 per 30 days); NEDS
erlotinib hcl oral tablet 150 mg		5	PA NSO; NM; QL (90 per 30 days); NEDS
ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG		4	
etoposide intravenous solution 100 mg/5ml	Avopef	1	
EULEXIN ORAL CAPSULE 125 MG		5	NM; NEDS
everolimus oral tablet 10 mg	Torpenz	5	PA NSO; NM; QL (56 per 28 days); NEDS
everolimus oral tablet 2.5 mg	Torpenz	5	PA NSO; NM; QL (28 per 28 days); NEDS
everolimus oral tablet 5 mg	Torpenz	5	PA NSO; NM; QL (30 per 30 days); NEDS
everolimus oral tablet 7.5 mg	Torpenz	5	PA NSO; NM; QL (60 per 30 days); NEDS
everolimus oral tablet soluble 2 mg, 3 mg, 5 mg	Afinitor Disperz	5	PA NSO; NM; QL (112 per 28 days); NEDS
exemestane oral tablet 25 mg	Aromasin	2	
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL		5	PA BvD; NM; NEDS
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG		3	PA BvD
floxuridine injection solution reconstituted 0.5 gm		1	PA BvD
fluorouracil intravenous solution 1 gm/20ml, 5 gm/100ml, 500 mg/10ml		2	PA BvD
FLUTAMIDE ORAL CAPSULE 125 MG		4	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG		5	PA NSO; NM; QL (21 per 28 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
FRUZAQLA ORAL CAPSULE 1 MG		5	PA NSO; NM; QL (84 per 28 days); NEDS
FRUZAQLA ORAL CAPSULE 5 MG		5	PA NSO; NM; QL (21 per 28 days); NEDS
fulvestrant intramuscular solution prefilled syringe 250 mg/5ml	Faslodex	5	NM; NEDS
FYARRO INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG		5	PA NSO; NM; NEDS
GAVRETO ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
gefitinib oral tablet 250 mg	Iressa	5	PA NSO; NM; QL (60 per 30 days); NEDS
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
GOMEKLI ORAL CAPSULE 1 MG		5	PA NSO; NM; QL (224 per 28 days); NEDS
GOMEKLI ORAL CAPSULE 2 MG		5	PA NSO; NM; QL (112 per 28 days); NEDS
GOMEKLI ORAL TABLET SOLUBLE 1 MG		5	PA NSO; NM; QL (224 per 28 days); NEDS
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION 600-10000 MG-UNT/5ML		5	PA NSO; NM; QL (5 per 21 days); NEDS
HERNEXEOS ORAL TABLET 60 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
hydroxyurea oral capsule 500 mg	Hydrea	1	
HYRNUO ORAL TABLET 10 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG		5	PA NSO; NM; QL (21 per 28 days); NEDS
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG		5	PA NSO; NM; QL (21 per 28 days); NEDS
IBTROZI ORAL CAPSULE 200 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
IDHIFA ORAL TABLET 100 MG, 50 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
ifosfamide intravenous solution 1 gm/20ml, 3 gm/60ml		2	
ifosfamide intravenous solution reconstituted 1 gm	Ifex	2	
imatinib mesylate oral tablet 100 mg	Gleevec	2	PA NSO; QL (180 per 30 days)
imatinib mesylate oral tablet 400 mg	Gleevec	2	PA NSO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
IMBRUVICA ORAL CAPSULE 70 MG		5	PA NSO; NM; QL (28 per 28 days); NEDS
IMBRUVICA ORAL SUSPENSION 70 MG/ML		5	PA NSO; NM; QL (216 per 30 days); NEDS
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG		5	PA NSO; NM; QL (28 per 28 days); NEDS
IMDELLTRA INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 10 MG		5	PA NSO; NM; NEDS
IMJUDO INTRAVENOUS SOLUTION 25 MG/1.25ML, 300 MG/15ML		5	PA NSO; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
IMKELDI ORAL SOLUTION 80 MG/ML		5	PA NSO; NM; QL (280 per 28 days); NEDS
INLEXZO INTRAVESICAL IMPLANT 225 MG		5	PA BvD; NM; NEDS
INLURIYO ORAL TABLET 200 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
INLYTA ORAL TABLET 1 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
INLYTA ORAL TABLET 5 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
INQOVI ORAL TABLET 35-100 MG		5	PA NSO; NM; QL (5 per 28 days); NEDS
INREBIC ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
ITOVEBI ORAL TABLET 3 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
ITOVEBI ORAL TABLET 9 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
IWILFIN ORAL TABLET 192 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
JAYPIRCA ORAL TABLET 100 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
JAYPIRCA ORAL TABLET 50 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
JEMPERLI INTRAVENOUS SOLUTION 500 MG/10ML		5	PA NSO; NM; NEDS
JYLAMVO ORAL SOLUTION 2 MG/ML		4	PA BvD; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML		5	PA NSO; NM; NEDS
KEYTRUDA QLEX SUBCUTANEOUS SOLUTION 395-4800 MG -UNT/2.4ML, 790-9600 MG -UNT/4.8ML		5	PA NSO; NM; NEDS
KIMMTRAK INTRAVENOUS SOLUTION 100 MCG/0.5ML		5	PA NSO; NM; QL (2 per 28 days); NEDS
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG		5	PA NSO; NM; QL (21 per 28 days); NEDS
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG		5	PA NSO; NM; QL (42 per 28 days); NEDS
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG		5	PA NSO; NM; QL (63 per 28 days); NEDS
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG		5	PA NSO; NM; QL (49 per 28 days); NEDS
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG		5	PA NSO; NM; QL (70 per 28 days); NEDS
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG		5	PA NSO; NM; QL (91 per 28 days); NEDS
KOMZIFTI ORAL CAPSULE 200 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
KOSELUGO ORAL CAPSULE 10 MG		5	PA NSO; NM; QL (300 per 30 days); NEDS
KOSELUGO ORAL CAPSULE 25 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
KOSELUGO ORAL CAPSULE SPRINKLE 5 MG		5	PA NSO; NM; QL (600 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
KOSELUGO ORAL CAPSULE SPRINKLE 7.5 MG		5	PA NSO; NM; QL (390 per 30 days); NEDS
KRAZATI ORAL TABLET 200 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
lapatinib ditosylate oral tablet 250 mg	Tykerb	5	PA NSO; NM; NEDS
LAZCLUZE ORAL TABLET 240 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
LAZCLUZE ORAL TABLET 80 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg	Revlimid	5	PA NSO; NM; QL (28 per 28 days); NEDS
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG		5	PA NSO; NM; NEDS
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG		5	PA NSO; NM; NEDS
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG		5	PA NSO; NM; NEDS
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG		5	PA NSO; NM; NEDS
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG		5	PA NSO; NM; NEDS
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG		5	PA NSO; NM; NEDS
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG		5	PA NSO; NM; NEDS
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG		5	PA NSO; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
letrozole oral tablet 2.5 mg	Femara	1	
LEUKERAN ORAL TABLET 2 MG		5	NM; NEDS
LEUPROLIDE ACETATE (3 MONTH) INTRAMUSCULAR INJECTABLE 22.5 MG		4	PA NSO
leuprolide acetate injection kit 1 mg/0.2ml		4	PA NSO
lomustine oral capsule 10 mg	Gleostine	4	
lomustine oral capsule 100 mg, 40 mg	Gleostine	5	NM; NEDS
LONSURF ORAL TABLET 15-6.14 MG		5	PA NSO; NM; QL (100 per 28 days); NEDS
LONSURF ORAL TABLET 20-8.19 MG		5	PA NSO; NM; QL (80 per 28 days); NEDS
LOQTORZI INTRAVENOUS SOLUTION 240 MG/6ML		5	PA NSO; NM; NEDS
LORBRENA ORAL TABLET 100 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
LORBRENA ORAL TABLET 25 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
LUMAKRAS ORAL TABLET 120 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
LUMAKRAS ORAL TABLET 240 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
LUMAKRAS ORAL TABLET 320 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
LUNSUMIO INTRAVENOUS SOLUTION 1 MG/ML, 30 MG/30ML		5	PA NSO; NM; NEDS
LUNSUMIO VELO SUBCUTANEOUS SOLUTION 45 MG/ML, 5 MG/0.5ML		5	PA NSO; NM; NEDS
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 7.5 MG		5	PA NSO; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 22.5 MG		5	PA NSO; NM; NEDS
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG		5	PA NSO; NM; NEDS
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG		5	PA NSO; NM; NEDS
LUTRATE DEPOT INTRAMUSCULAR INJECTABLE 22.5 MG		4	PA NSO
LYNOZYFIC INTRAVENOUS SOLUTION 200 MG/10ML		5	PA NSO; NM; QL (40 per 28 days); NEDS
LYNOZYFIC INTRAVENOUS SOLUTION 5 MG/2.5ML		5	PA NSO; NM; QL (15 per 8 days); NEDS
LYNPARZA ORAL TABLET 100 MG, 150 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
LYSODREN ORAL TABLET 500 MG		5	NM; NEDS
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG		5	PA NSO; NM; QL (140 per 28 days); NEDS
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG		5	PA NSO; NM; QL (140 per 28 days); NEDS
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG		5	PA NSO; NM; QL (140 per 28 days); NEDS
MARGENZA INTRAVENOUS SOLUTION 250 MG/10ML		5	PA NSO; NM; NEDS
MATULANE ORAL CAPSULE 50 MG		5	NM; NEDS
megestrol acetate oral tablet 20 mg, 40 mg		1	PA NSO; HRM; AGE (Max 64 Years)
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML		5	PA NSO; NM; QL (1260 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
MEKINIST ORAL TABLET 0.5 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
MEKINIST ORAL TABLET 2 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
MEKTOVI ORAL TABLET 15 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
mercaptopurine oral suspension 2000 mg/100ml	Purixan	5	NM; NEDS
mercaptopurine oral tablet 50 mg		1	
methotrexate (anti-rheumatic) oral tablet 2.5 mg		1	PA BvD; ST
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml		1	
METHOTREXATE SODIUM INJECTION SOLUTION 50 MG/2ML		1	
methotrexate sodium injection solution reconstituted 1 gm		1	
methotrexate sodium oral tablet 2.5 mg		1	PA BvD; ST
mitoxantrone hcl intravenous concentrate 20 mg/10ml		1	
MODEYSO ORAL CAPSULE 125 MG		5	PA NSO; NM; QL (20 per 28 days); NEDS
NERLYNX ORAL TABLET 40 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
nilotinib hcl oral capsule 150 mg, 200 mg	Tasigna	5	PA NSO; NM; QL (112 per 28 days); NEDS
nilotinib hcl oral capsule 50 mg	Tasigna	5	PA NSO; NM; QL (120 per 30 days); NEDS
nilutamide oral tablet 150 mg		5	NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG		5	PA NSO; NM; QL (3 per 28 days); NEDS
NUBEQA ORAL TABLET 300 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
ODOMZO ORAL CAPSULE 200 MG		5	PA NSO; NM; NEDS
OGIVRI INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 420 MG		5	PA NSO; NM; NEDS
OGSIVEO ORAL TABLET 100 MG, 150 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
OGSIVEO ORAL TABLET 50 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
OJEMDA ORAL SUSPENSION RECONSTITUTED 25 MG/ML		5	PA NSO; NM; QL (96 per 28 days); NEDS
OJEMDA ORAL TABLET 100 MG, 100 MG (16 PACK), 100 MG (24 PACK)		5	PA NSO; NM; QL (24 per 28 days); NEDS
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
ONUREG ORAL TABLET 200 MG, 300 MG		5	PA NSO; NM; QL (14 per 28 days); NEDS
OPDIVO INTRAVENOUS SOLUTION 100 MG/10ML, 120 MG/12ML, 240 MG/24ML, 40 MG/4ML		5	PA NSO; NM; NEDS
OPDIVO QVANTIG SUBCUTANEOUS SOLUTION 300-5000 MG -UT/2.5ML, 600-10000 MG-UT/5ML		5	PA NSO; NM; NEDS
OPDUALAG INTRAVENOUS SOLUTION 240-80 MG/20ML		5	PA NSO; NM; NEDS
ORSERDU ORAL TABLET 345 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
ORSERDU ORAL TABLET 86 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
PACLITAXEL PROTEIN-BOUND PART INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG		5	PA BvD; NM; NEDS
pazopanib hcl oral tablet 200 mg	Votrient	5	PA NSO; NM; QL (120 per 30 days); NEDS
pazopanib hcl oral tablet 400 mg		5	PA NSO; NM; QL (60 per 30 days); NEDS
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
PEMETREXED DISODIUM INTRAVENOUS SOLUTION 1 GM/40ML, 100 MG/4ML, 500 MG/20ML		5	NM; NEDS
pemetrexed disodium intravenous solution reconstituted 100 mg, 1000 mg, 500 mg, 750 mg		5	NM; NEDS
PEMRYDI RTU INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML		5	NM; NEDS
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG		5	PA NSO; NM; QL (28 per 28 days); NEDS
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG		5	PA NSO; NM; QL (56 per 28 days); NEDS
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG		5	PA NSO; NM; QL (56 per 28 days); NEDS
pomalidomide oral capsule 1 mg, 2 mg, 3 mg, 4 mg	Pomalyst	5	PA NSO; NM; QL (21 per 28 days); NEDS
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG		5	PA NSO; NM; QL (21 per 28 days); NEDS
QINLOCK ORAL TABLET 50 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
RETEVMO ORAL CAPSULE 40 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
RETEVMO ORAL CAPSULE 80 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
RETEVMO ORAL TABLET 40 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
REVUFORJ ORAL TABLET 110 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
REVUFORJ ORAL TABLET 160 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
REVUFORJ ORAL TABLET 25 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
REZLIDHIA ORAL CAPSULE 150 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
RITUXAN HYCELA SUBCUTANEOUS SOLUTION 1400-23400 MG -UT/11.7ML, 1600-26800 MG -UT/13.4ML		5	PA NSO; NM; NEDS
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG		5	PA NSO; NM; QL (8 per 28 days); NEDS
ROZLYTREK ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
ROZLYTREK ORAL CAPSULE 200 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
ROZLYTREK ORAL PACKET 50 MG		5	PA NSO; NM; QL (360 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
RYBREVANT FASPRO SUBCUTANEOUS SOLUTION 1600-20000 MG-UT/10ML, 2240-28000 MG-UT/14ML, 2400-30000 MG-UT/15ML, 3520-44000 MG-UT/22ML		5	PA NSO; NM; NEDS
RYBREVANT INTRAVENOUS SOLUTION 350 MG/7ML		5	PA NSO; NM; NEDS
RYDAPT ORAL CAPSULE 25 MG		5	PA NSO; NM; QL (224 per 28 days); NEDS
RYTELO INTRAVENOUS SOLUTION RECONSTITUTED 188 MG, 47 MG		5	PA NSO; NM; NEDS
SCEMBLIX ORAL TABLET 100 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
SCEMBLIX ORAL TABLET 20 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
SCEMBLIX ORAL TABLET 40 MG		5	PA NSO; NM; QL (300 per 30 days); NEDS
SOLTAMOX ORAL SOLUTION 10 MG/5ML		5	NM; NEDS
sorafenib tosylate oral tablet 200 mg	NexAVAR	5	PA NSO; NM; QL (120 per 30 days); NEDS
STIVARGA ORAL TABLET 40 MG		5	PA NSO; NM; QL (84 per 28 days); NEDS
sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg	Sutent	5	PA NSO; NM; QL (28 per 28 days); NEDS
SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG		5	PA NSO; NM; NEDS
TABLOID ORAL TABLET 40 MG		5	NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
TABRECTA ORAL TABLET 150 MG, 200 MG		5	PA NSO; NM; QL (112 per 28 days); NEDS
TAFINLAR ORAL CAPSULE 50 MG, 75 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
TAFINLAR ORAL TABLET SOLUBLE 10 MG		5	PA NSO; NM; QL (900 per 30 days); NEDS
TAGRISSO ORAL TABLET 40 MG, 80 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
TALVEY SUBCUTANEOUS SOLUTION 3 MG/1.5ML, 40 MG/ML		5	PA NSO; NM; NEDS
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
tamoxifen citrate oral tablet 10 mg, 20 mg		1	
TASIGNA ORAL CAPSULE 150 MG, 200 MG		5	PA NSO; NM; QL (112 per 28 days); NEDS
TASIGNA ORAL CAPSULE 50 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
TAZVERIK ORAL TABLET 200 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
TECVAYLI SUBCUTANEOUS SOLUTION 153 MG/1.7ML, 30 MG/3ML		5	PA NSO; NM; NEDS
TEPMETKO ORAL TABLET 225 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
TEVIMBRA INTRAVENOUS SOLUTION 100 MG/10ML		5	PA NSO; NM; NEDS
TIBSOVO ORAL TABLET 250 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS

You can find information on what the symbols and abbreviations on this table mean by going to page VII of the introduction. Formulary ID: 26380

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Drug Name	Reference	Drug Tier	Requirements/Limits
TICE BCG INTRAVESICAL SUSPENSION RECONSTITUTED 50 MG		4	
TIVDAK INTRAVENOUS SOLUTION RECONSTITUTED 40 MG		5	PA NSO; NM; QL (5 per 21 days); NEDS
toposar intravenous solution 100 mg/5ml	Avopef	1	
toremifene citrate oral tablet 60 mg	Fareston	5	NM; NEDS
torpenz oral tablet 10 mg	Torpenz	5	PA NSO; NM; QL (60 per 30 days); NEDS
torpenz oral tablet 2.5 mg, 5 mg, 7.5 mg	Torpenz	5	PA NSO; NM; QL (30 per 30 days); NEDS
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG		4	PA NSO
tretinoin oral capsule 10 mg		5	NM; NEDS
TRUQAP ORAL TABLET 200 MG		5	PA NSO; NM; QL (64 per 28 days); NEDS
TRUQAP ORAL TABLET THERAPY PACK 160 MG		5	PA NSO; NM; QL (64 per 28 days); NEDS
TRUXIMA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML		5	PA NSO; NM; NEDS
TUKYSA ORAL TABLET 150 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
TUKYSA ORAL TABLET 50 MG		5	PA NSO; NM; QL (300 per 30 days); NEDS
TURALIO ORAL CAPSULE 125 MG, 200 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG		5	PA NSO; NM; NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
VENCLEXTA ORAL TABLET 10 MG		3	PA NSO; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
VENCLEXTA ORAL TABLET 50 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG		5	PA NSO; NM; NEDS
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG		5	PA NSO; NM; QL (56 per 28 days); NEDS
vinorelbine tartrate intravenous solution 10 mg/ml, 50 mg/5ml		4	
VITRAKVI ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
VITRAKVI ORAL CAPSULE 25 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
VITRAKVI ORAL SOLUTION 20 MG/ML		5	PA NSO; NM; QL (300 per 30 days); NEDS
VIVIMUSTA INTRAVENOUS SOLUTION 100 MG/4ML		5	PA NSO; NM; NEDS
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
VONJO ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
VORANIGO ORAL TABLET 10 MG, 40 MG		5	PA NSO; NM; NEDS
VYLOY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 300 MG		5	PA NSO; NM; NEDS
WELIREG ORAL TABLET 40 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
XALKORI ORAL CAPSULE 200 MG, 250 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
XALKORI ORAL CAPSULE SPRINKLE 150 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
XALKORI ORAL CAPSULE SPRINKLE 20 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
XALKORI ORAL CAPSULE SPRINKLE 50 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
XATMEP ORAL SOLUTION 2.5 MG/ML		4	PA BvD; ST
XOSPATA ORAL TABLET 40 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG		5	PA NSO; NM; QL (8 per 28 days); NEDS
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG		5	PA NSO; NM; QL (16 per 28 days); NEDS
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG		5	PA NSO; NM; QL (4 per 28 days); NEDS
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG		5	PA NSO; NM; QL (8 per 28 days); NEDS
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG		5	PA NSO; NM; QL (4 per 28 days); NEDS
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG		5	PA NSO; NM; QL (24 per 28 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG, 80 MG		5	PA NSO; NM; QL (8 per 28 days); NEDS
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG		5	PA NSO; NM; QL (32 per 28 days); NEDS
XTANDI ORAL CAPSULE 40 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
XTANDI ORAL TABLET 40 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
XTANDI ORAL TABLET 80 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
YERVOY INTRAVENOUS SOLUTION 200 MG/40ML, 50 MG/10ML		5	PA NSO; NM; NEDS
YONSA ORAL TABLET 125 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
ZEJULA ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (90 per 30 days); NEDS
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
ZELBORAF ORAL TABLET 240 MG		5	PA NSO; NM; QL (240 per 30 days); NEDS
ZIIHERA INTRAVENOUS SOLUTION RECONSTITUTED 300 MG		5	PA NSO; NM; NEDS
ZIRABEV INTRAVENOUS SOLUTION 100 MG/4ML, 400 MG/16ML		5	PA NSO; NM; NEDS
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG, 3.6 MG		4	PA NSO
ZOLINZA ORAL CAPSULE 100 MG		5	NM; NEDS
ZYDELIG ORAL TABLET 100 MG, 150 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
ZYKADIA ORAL TABLET 150 MG		5	PA NSO; NM; QL (84 per 28 days); NEDS
ZYNLONTA INTRAVENOUS SOLUTION RECONSTITUTED 10 MG		5	PA NSO; NM; NEDS
ZYNYZ INTRAVENOUS SOLUTION 500 MG/20ML		5	PA NSO; NM; QL (20 per 28 days); NEDS
ANTICONVULSANTS			
Anticonvulsants			
brivaracetam intravenous solution 50 mg/5ml	Briviact	5	NM; QL (80 per 30 days); NEDS
brivaracetam oral solution 10 mg/ml	Briviact	4	QL (600 per 30 days)
brivaracetam oral tablet 10 mg, 100 mg, 25 mg, 50 mg, 75 mg	Briviact	5	NM; QL (60 per 30 days); NEDS
BRIVIACT INTRAVENOUS SOLUTION 50 MG/5ML		5	NM; QL (80 per 30 days); NEDS
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	Carbatrol	2	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg	TEGretol-XR	2	
carbamazepine oral suspension 100 mg/5ml	TEGretol	2	
carbamazepine oral tablet 200 mg	TEGretol	1	
carbamazepine oral tablet chewable 100 mg		1	
carbamazepine oral tablet chewable 200 mg		2	
clobazam oral suspension 2.5 mg/ml	Onfi	4	QL (480 per 30 days)
clobazam oral tablet 10 mg, 20 mg	Onfi	4	QL (60 per 30 days)
DIACOMIT ORAL CAPSULE 250 MG		5	PA NSO; NM; QL (360 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
DIACOMIT ORAL CAPSULE 500 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
DIACOMIT ORAL PACKET 250 MG		5	PA NSO; NM; QL (360 per 30 days); NEDS
DIACOMIT ORAL PACKET 500 MG		5	PA NSO; NM; QL (180 per 30 days); NEDS
diazepam rectal gel 10 mg, 2.5 mg, 20 mg		4	
DILANTIN ORAL CAPSULE 30 MG		4	
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	Depakote ER	2	
divalproex sodium oral capsule delayed release sprinkle 125 mg	Depakote Sprinkles	2	
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	Depakote	1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML		5	PA NSO; NM; NEDS
epitol oral tablet 200 mg	TEGretol	1	
eslicarbazepine acetate oral tablet 200 mg, 400 mg	Aptiom	5	ST; NM; QL (30 per 30 days); NEDS
eslicarbazepine acetate oral tablet 600 mg, 800 mg	Aptiom	5	ST; NM; QL (60 per 30 days); NEDS
ethosuximide oral capsule 250 mg	Zarontin	1	
ethosuximide oral solution 250 mg/5ml	Zarontin	1	
felbamate oral suspension 600 mg/5ml		4	
felbamate oral tablet 400 mg, 600 mg	Felbatol	4	
FINTEPLA ORAL SOLUTION 2.2 MG/ML		5	PA NSO; NM; NEDS
fosphenytoin sodium injection solution 100 mg pe/2ml, 500 mg pe/10ml	Cerebyx	2	
gabapentin oral capsule 100 mg, 300 mg	Neurontin	1	QL (360 per 30 days)

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Drug Name	Reference	Drug Tier	Requirements/Limits
gabapentin oral capsule 400 mg	Neurontin	1	QL (270 per 30 days)
gabapentin oral solution 250 mg/5ml	Neurontin	2	QL (2160 per 30 days)
gabapentin oral tablet 600 mg	Neurontin	1	QL (180 per 30 days)
gabapentin oral tablet 800 mg	Neurontin	1	QL (120 per 30 days)
lacosamide intravenous solution 200 mg/20ml	Vimpat	1	QL (200 per 5 days)
lacosamide oral solution 10 mg/ml	Vimpat	4	QL (1200 per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	Vimpat	4	QL (60 per 30 days)
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	Subvenite	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	LaMICtal	2	
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	Keppra XR	2	
levetiracetam intravenous solution 500 mg/5ml	Keppra	2	
levetiracetam oral solution 100 mg/ml	Keppra	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	Keppra	1	
levetiracetam oral tablet disintegrating soluble 250 mg, 500 mg	Spritam	4	ST
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG		4	QL (10 per 30 days)
methsuximide oral capsule 300 mg	Celontin	4	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML		4	QL (10 per 30 days)
oxcarbazepine oral suspension 300 mg/5ml	Trileptal	4	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	Trileptal	1	
perampanel oral suspension 0.5 mg/ml	Fycompa	5	ST; NM; QL (720 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
perampanel oral tablet 10 mg, 12 mg, 8 mg	Fycompa	5	ST; NM; QL (30 per 30 days); NEDS
perampanel oral tablet 2 mg	Fycompa	4	ST; QL (30 per 30 days)
perampanel oral tablet 4 mg, 6 mg	Fycompa	5	ST; NM; QL (60 per 30 days); NEDS
phenobarbital oral elixir 20 mg/5ml		2	PA NSO; HRM; AGE (Max 64 Years)
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg		1	PA NSO; HRM; AGE (Max 64 Years)
phenytek oral capsule 200 mg, 300 mg	Phenytek	1	
phenytoin oral suspension 125 mg/5ml	Dilantin-125	1	
phenytoin oral tablet chewable 50 mg	Dilantin Infatabs	1	
phenytoin sodium extended oral capsule 100 mg	Dilantin	1	
phenytoin sodium extended oral capsule 200 mg, 300 mg	Phenytek	1	
phenytoin sodium injection solution 50 mg/ml		1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	Lyrica	1	QL (90 per 30 days)
pregabalin oral capsule 225 mg, 300 mg	Lyrica	1	QL (60 per 30 days)
pregabalin oral solution 20 mg/ml	Lyrica	4	QL (900 per 30 days)
primidone oral tablet 125 mg		2	
primidone oral tablet 250 mg, 50 mg	Mysoline	1	
rufinamide oral suspension 40 mg/ml	Banzel	5	ST; NM; NEDS
rufinamide oral tablet 200 mg	Banzel	4	ST
rufinamide oral tablet 400 mg	Banzel	5	ST; NM; NEDS
SEZABY INTRAVENOUS SOLUTION RECONSTITUTED 100 MG		5	PA BvD; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG		4	ST
SUBVENITE ORAL SUSPENSION 10 MG/ML		4	PA NSO
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	Subvenite	1	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG		5	PA NSO; NM; QL (60 per 30 days); NEDS
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg		4	
topiramate oral capsule sprinkle 15 mg, 25 mg	Topamax Sprinkle	2	
topiramate oral capsule sprinkle 50 mg		4	
topiramate oral solution 25 mg/ml	Eprontia	4	ST
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Topamax	1	
valproate sodium intravenous solution 100 mg/ml		2	
valproic acid oral capsule 250 mg		1	
valproic acid oral solution 250 mg/5ml		1	
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML		5	NM; QL (10 per 30 days); NEDS
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML		5	NM; QL (10 per 30 days); NEDS
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML		5	NM; QL (10 per 30 days); NEDS
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML		5	NM; QL (10 per 30 days); NEDS
vigabatrin oral packet 500 mg	Vigadrone	5	PA NSO; NM; QL (180 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
vigabatrin oral tablet 500 mg	Vigadrone	5	PA NSO; NM; QL (180 per 30 days); NEDS
vigadrone oral packet 500 mg	Vigadrone	5	PA NSO; NM; QL (180 per 30 days); NEDS
vigadrone oral tablet 500 mg	Vigadrone	5	PA NSO; NM; QL (180 per 30 days); NEDS
vigpoder oral packet 500 mg	Vigadrone	5	PA NSO; NM; QL (180 per 30 days); NEDS
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG		5	NM; QL (56 per 28 days); NEDS
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG		5	NM; QL (56 per 28 days); NEDS
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG		5	NM; QL (30 per 30 days); NEDS
XCOPRI ORAL TABLET 150 MG, 200 MG		5	NM; QL (60 per 30 days); NEDS
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG		4	
XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG		5	NM; NEDS
ZONISADE ORAL SUSPENSION 100 MG/5ML		4	
zonisamide oral capsule 100 mg, 25 mg	Zonegran	1	
zonisamide oral capsule 50 mg		1	
ZTALMY ORAL SUSPENSION 50 MG/ML		5	PA NSO; NM; QL (1080 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
ANTIDEMENTIA AGENTS			
Antidementia Agents			
donepezil hcl oral tablet 10 mg, 5 mg	Aricept	1	QL (30 per 30 days)
donepezil hcl oral tablet 23 mg	Aricept	2	QL (30 per 30 days)
donepezil hcl oral tablet dispersible 10 mg		1	
donepezil hcl oral tablet dispersible 5 mg		1	QL (30 per 30 days)
ergoloid mesylates oral tablet 1 mg		2	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg		2	QL (30 per 30 days)
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg		2	QL (60 per 30 days)
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg		2	ST; QL (30 per 30 days)
memantine hcl oral tablet 10 mg, 5 mg		1	QL (60 per 30 days)
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg		2	
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	Exelon	4	QL (30 per 30 days)
ANTIDEPRESSANTS			
Antidepressants			
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg		1	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg		1	
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG		5	ST; NM; NEDS
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	Wellbutrin SR	1	
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	Wellbutrin XL	1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
bupropion hcl oral tablet 100 mg, 75 mg		1	
citalopram hydrobromide oral solution 10 mg/5ml		2	
citalopram hydrobromide oral tablet 10 mg	CeleXA	1	QL (120 per 30 days)
citalopram hydrobromide oral tablet 20 mg, 40 mg	CeleXA	1	QL (30 per 30 days)
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	Anafranil	2	
desipramine hcl oral tablet 10 mg, 25 mg	Norpramin	2	
desipramine hcl oral tablet 100 mg, 150 mg, 50 mg, 75 mg		2	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	Pristiq	2	QL (30 per 30 days)
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg		1	
doxepin hcl oral concentrate 10 mg/ml		1	
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 60 MG		4	ST; QL (60 per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 40 MG		4	ST; QL (30 per 30 days)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg		1	QL (60 per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR		5	ST; NM; QL (30 per 30 days); NEDS
escitalopram oxalate oral solution 5 mg/5ml		4	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	Lexapro	1	

Drug Name	Reference	Drug Tier	Requirements/Limits
EXXUA ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG, 36.3 MG, 54.5 MG, 72.6 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
EXXUA TITRATION PACK ORAL TABLET EXTENDED RELEASE 24 HOUR 18.2 MG		5	PA NSO; NM; NEDS
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG		4	ST; QL (30 per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG		4	ST
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg		1	
fluoxetine hcl oral solution 20 mg/5ml		2	
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg		1	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg		1	
MARPLAN ORAL TABLET 10 MG		4	
mirtazapine oral tablet 15 mg, 30 mg	Remeron	1	
mirtazapine oral tablet 45 mg, 7.5 mg		1	
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	Remeron SolTab	1	
nefazodone hcl oral tablet 100 mg, 250 mg, 50 mg		2	
NEFAZODONE HCL ORAL TABLET 150 MG, 200 MG		2	
nefazodone hcl tablet 150 mg oral		2	
nefazodone hcl tablet 200 mg oral		2	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	Pamelor	1	
nortriptyline hcl oral solution 10 mg/5ml		2	

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Drug Name	Reference	Drug Tier	Requirements/Limits
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	Paxil CR	2	PA NSO; HRM; AGE (Max 64 Years)
paroxetine hcl oral suspension 10 mg/5ml		2	PA NSO; HRM; AGE (Max 64 Years)
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	Paxil	1	PA NSO; HRM; AGE (Max 64 Years)
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg		2	
phenelzine sulfate oral tablet 15 mg	Nardil	1	
protriptyline hcl oral tablet 10 mg, 5 mg		2	
RALDESY ORAL SOLUTION 10 MG/ML		5	PA NSO; NM; QL (1200 per 30 days); NEDS
sertraline hcl 100 mg tablet f/c	Zoloft	1	
sertraline hcl 25 mg tablet f/c	Zoloft	1	
sertraline hcl 50 mg tablet f/c	Zoloft	1	
sertraline hcl oral concentrate 20 mg/ml	Zoloft	2	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	Zoloft	1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE		5	PA NSO; NM; NEDS
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE		5	PA NSO; NM; NEDS
tranylcypromine sulfate oral tablet 10 mg	Parnate	2	
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg		1	
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg		2	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG		3	QL (30 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
venlafaxine hcl er oral capsule extended release 24 hour 150 mg	Effexor XR	1	QL (30 per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg	Effexor XR	1	QL (90 per 30 days)
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg		1	
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	Viibryd	2	QL (30 per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG		5	PA NSO; NM; QL (28 per 14 days); NEDS
ZURZUVAE ORAL CAPSULE 30 MG		5	PA NSO; NM; QL (14 per 14 days); NEDS
ANTIDIABETIC AGENTS			
Antidiabetic Agents, Miscellaneous			
acarbose oral tablet 100 mg, 25 mg, 50 mg		1	
dapagliflozin base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-1000 mg, 5-500 mg	Xigduo XR	1	
dapagliflozin oral tablet 10 mg, 5 mg	Farxiga	1	QL (30 per 30 days)
FARXIGA ORAL TABLET 10 MG, 5 MG		3	QL (30 per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG		3	QL (30 per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG		3	QL (60 per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG		3	QL (30 per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG		3	QL (60 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG		3	QL (30 per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG		3	QL (30 per 30 days)
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG		3	QL (60 per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG		3	QL (60 per 30 days)
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG		3	QL (30 per 30 days)
metformin hcl er oral tablet extended release 24 hour 500 mg		1	QL (120 per 30 days)
metformin hcl er oral tablet extended release 24 hour 750 mg		1	QL (60 per 30 days)
metformin hcl oral solution 500 mg/5ml	Riomet	2	QL (765 per 30 days)
metformin hcl oral tablet 1000 mg		1	QL (75 per 30 days)
metformin hcl oral tablet 500 mg		1	QL (150 per 30 days)
metformin hcl oral tablet 750 mg, 850 mg		1	QL (90 per 30 days)
metformin hcl tablet 1000 mg oral		1	QL (75 per 30 days)
metformin hcl tablet 500 mg oral		1	QL (150 per 30 days)
mifepristone oral tablet 300 mg	Korlym	5	PA; NM; QL (112 per 28 days); NEDS
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML		3	PA; QL (2 per 28 days)
nateglinide oral tablet 120 mg, 60 mg		1	QL (90 per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML, 2 MG/3ML		3	PA; QL (3 per 28 days)

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OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML		3	PA; QL (3 per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML		3	PA; QL (3 per 28 days)
OZEMPIC ORAL TABLET 1.5 MG, 4 MG, 9 MG		3	PA; QL (30 per 30 days)
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	Actos	1	QL (30 per 30 days)
pioglitazone hcl-metformin hcl oral tablet 15-500 mg		1	QL (90 per 30 days)
pioglitazone hcl-metformin hcl oral tablet 15-850 mg	Actoplus Met	1	QL (90 per 30 days)
repaglinide oral tablet 0.5 mg, 1 mg		1	QL (120 per 30 days)
repaglinide oral tablet 2 mg		1	QL (240 per 30 days)
RYBELSUS (FORMULATION R2) ORAL TABLET 1.5 MG, 4 MG, 9 MG		3	PA; QL (30 per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG		3	PA; QL (30 per 30 days)
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG		3	QL (60 per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG		3	QL (30 per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG		3	QL (60 per 30 days)
TRADJENTA ORAL TABLET 5 MG		3	QL (30 per 30 days)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG		3	QL (30 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG		3	QL (60 per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML		3	PA; QL (2 per 28 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG		3	QL (30 per 30 days)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG, 5-500 MG		3	QL (60 per 30 days)
Insulins			
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
FIASP INJECTION SOLUTION 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
FIASP PUMPCART SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML		3	max $35 copay per month supply
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML		3	max $35 copay per month supply; QL (24 per 28 days)
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	NovoLOG Mix 70/30 FlexPen	3	max $35 copay per month supply; QL (30 per 28 days)

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Drug Name	Reference	Drug Tier	Requirements/Limits
INSULIN ASPART FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
INSULIN ASPART INJECTION SOLUTION 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
INSULIN ASPART PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	NovoLOG Mix 70/30	3	max $35 copay per month supply; QL (40 per 28 days)
insulin glargine-yfgn subcutaneous solution 100 unit/ml	Semglee (yfgn)	3	max $35 copay per month supply; QL (40 per 28 days)
insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml	Semglee (yfgn)	3	max $35 copay per month supply; QL (30 per 28 days)
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLIN 70/30 RELION SUSPENSION (70-30) 100 UNIT/ML SUBCUTANEOUS		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
NOVOLIN N RELION SUSPENSION 100 UNIT/ML SUBCUTANEOUS		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLIN R RELION SOLUTION 100 UNIT/ML INJECTION		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLOG INJECTION SOLUTION 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML		3	max $35 copay per month supply; QL (40 per 28 days)
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML		3	max $35 copay per month supply; QL (30 per 28 days)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML		3	max $35 copay per month supply; QL (30 per 30 days)
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML		3	max $35 copay per month supply; QL (18 per 28 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML		3	max $35 copay per month supply; QL (13.5 per 28 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML		3	max $35 copay per month supply; QL (15 per 28 days)
Sulfonylureas			
glimepiride oral tablet 1 mg, 2 mg		1	QL (30 per 30 days)
glimepiride oral tablet 4 mg		1	QL (60 per 30 days)
glipizide er oral tablet extended release 24 hour 10 mg		1	QL (60 per 30 days)
glipizide er oral tablet extended release 24 hour 2.5 mg		1	QL (30 per 30 days)
glipizide er oral tablet extended release 24 hour 5 mg	Glucotrol XL	1	QL (30 per 30 days)
glipizide oral tablet 10 mg		1	QL (120 per 30 days)
glipizide oral tablet 2.5 mg		1	QL (90 per 30 days)
glipizide oral tablet 5 mg		1	QL (240 per 30 days)
glipizide-metformin hcl oral tablet 2.5-250 mg		1	QL (240 per 30 days)
glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg		1	QL (120 per 30 days)
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg		1	PA; HRM; AGE (Max 64 Years)
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg		1	PA; HRM; AGE (Max 64 Years)
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg		1	PA; HRM; AGE (Max 64 Years)
ANTIFUNGALS			
Antifungals			
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML		4	PA BvD

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Drug Name	Reference	Drug Tier	Requirements/Limits
amphotericin b intravenous solution reconstituted 50 mg		1	PA BvD
amphotericin b liposome intravenous suspension reconstituted 50 mg	AmBisome	5	PA BvD; NM; NEDS
ciclopirox external solution 8 %	Ciclodan	1	QL (19.8 per 30 days)
ciclopirox olamine external cream 0.77 %		1	QL (180 per 30 days)
clotrimazole external cream 1 %	Lotrimin AF	1	
clotrimazole external solution 1 %	Lasolex	1	
clotrimazole mouth/throat troche 10 mg		1	
clotrimazole-betamethasone external cream 1-0.05 %		1	QL (90 per 30 days)
CRESEMBA INTRAVENOUS SOLUTION RECONSTITUTED 372 MG		5	NM; NEDS
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG		5	PA; NM; NEDS
econazole nitrate external cream 1 %		1	QL (170 per 30 days)
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%		2	
fluconazole oral suspension reconstituted 10 mg/ml		2	
fluconazole oral suspension reconstituted 40 mg/ml	Diflucan	2	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg		1	
flucytosine oral capsule 250 mg, 500 mg	Ancobon	5	NM; NEDS
griseofulvin microsize oral suspension 125 mg/5ml		4	
itraconazole oral capsule 100 mg	Sporanox	4	
ketoconazole external cream 2 %		1	QL (180 per 30 days)
ketoconazole external shampoo 2 %		1	QL (360 per 30 days)
ketoconazole oral tablet 200 mg		1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
micafungin sodium intravenous solution reconstituted 100 mg, 50 mg		2	
MICONAZOLE 3 VAGINAL SUPPOSITORY 200 MG		1	
nyamyc external powder 100000 unit/gm	Nyamyc	1	QL (60 per 30 days)
nystatin external cream 100000 unit/gm		1	QL (60 per 30 days)
nystatin external ointment 100000 unit/gm		1	QL (60 per 30 days)
nystatin external powder 100000 unit/gm	Nyamyc	1	QL (60 per 30 days)
nystatin mouth/throat suspension 100000 unit/ml		1	
nystatin oral tablet 500000 unit		1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%		1	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%		1	
nystop external powder 100000 unit/gm	Nyamyc	1	QL (60 per 30 days)
posaconazole oral tablet delayed release 100 mg		5	PA; NM; NEDS
terbinafine hcl oral tablet 250 mg		1	
voriconazole intravenous solution reconstituted 200 mg	Vfend IV	5	PA BvD; NM; NEDS
voriconazole oral suspension reconstituted 40 mg/ml	Vfend	5	PA; NM; NEDS
voriconazole oral tablet 200 mg, 50 mg		2	
ANTIGOUT AGENTS			
Antigout Agents, Other			
allopurinol oral tablet 100 mg, 300 mg		1	
colchicine oral capsule 0.6 mg	Mitigare	4	QL (60 per 30 days)
colchicine oral tablet 0.6 mg		2	QL (120 per 30 days)
colchicine-probenecid oral tablet 0.5-500 mg		1	
febuxostat oral tablet 40 mg, 80 mg	Uloric	2	QL (30 per 30 days)

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Drug Name	Reference	Drug Tier	Requirements/Limits
probenecid oral tablet 500 mg		2	
ANTIHISTAMINES			
Antihistamines			
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg		1	
levocetirizine dihydrochloride oral tablet 5 mg	Xyzal Allergy 24HR	1	
ANTI-INFECTIVES (SKIN AND MUCOUS MEMBRANE)			
Anti-Infectives (Skin And Mucous Membrane)			
clindamycin phosphate vaginal cream 2 %	Cleocin	2	
metronidazole vaginal gel 0.75 %	Vandazole	2	
terconazole vaginal cream 0.4 %, 0.8 %		1	
ANTIMIGRAINE AGENTS			
Antimigraine Agents			
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML		3	PA; QL (1 per 30 days)
dihydroergotamine mesylate nasal solution 4 mg/ml		5	ST; NM; QL (8 per 28 days); NEDS
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML		3	PA; QL (3 per 30 days)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML		3	PA; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML		3	PA; QL (2 per 30 days)
NURTEC ORAL TABLET DISPERSIBLE 75 MG		3	PA; QL (18 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG		3	PA; QL (30 per 30 days)
rizatriptan benzoate oral tablet 10 mg	Maxalt	1	QL (18 per 30 days)
rizatriptan benzoate oral tablet 5 mg		1	QL (18 per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg	Maxalt-MLT	1	QL (18 per 30 days)
rizatriptan benzoate oral tablet dispersible 5 mg		1	QL (18 per 30 days)
sumatriptan nasal solution 20 mg/act, 5 mg/act		4	QL (12 per 30 days)
sumatriptan succinate oral tablet 100 mg	Imitrex	1	QL (9 per 30 days)
sumatriptan succinate oral tablet 25 mg, 50 mg	Imitrex	1	QL (18 per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml		2	QL (5 per 28 days)
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	Imitrex STATdose System	2	QL (4 per 28 days)
UBRELVY ORAL TABLET 100 MG, 50 MG		3	PA; QL (16 per 30 days)
ANTIMYCOBACTERIALS			
Antimycobacterials			
dapsone oral tablet 100 mg, 25 mg		1	
ethambutol hcl oral tablet 100 mg, 400 mg		1	
isoniazid oral tablet 100 mg, 300 mg		1	
PRIFTIN ORAL TABLET 150 MG		4	
pyrazinamide oral tablet 500 mg		4	
rifabutin oral capsule 150 mg		2	
rifampin intravenous solution reconstituted 600 mg	Rifadin	4	
rifampin oral capsule 150 mg, 300 mg		2	
SIRTURO ORAL TABLET 100 MG, 20 MG		5	PA; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
TRECATOR ORAL TABLET 250 MG		4	
ANTINAUSEA AGENTS			
Antinausea Agents			
aprepitant oral capsule 125 mg		4	PA BvD; QL (2 per 28 days)
aprepitant oral capsule 40 mg		4	PA BvD; QL (1 per 28 days)
aprepitant oral capsule 80 mg	Emend BiPack	4	PA BvD; QL (4 per 28 days)
aprepitant oral capsule therapy pack 80 & 125 mg	Emend TriPack	4	PA BvD
compro rectal suppository 25 mg	Compro	4	
dronabinol oral capsule 10 mg, 5 mg		2	PA; QL (60 per 30 days)
dronabinol oral capsule 2.5 mg	Marinol	2	PA; QL (60 per 30 days)
meclizine hcl oral tablet 12.5 mg		1	
meclizine hcl oral tablet 25 mg	Dramamine	1	
ondansetron hcl oral tablet 24 mg		2	PA BvD
ondansetron hcl oral tablet 4 mg, 8 mg		1	PA BvD
ondansetron oral tablet dispersible 4 mg, 8 mg		1	PA BvD
prochlorperazine edisylate injection solution 10 mg/2ml		1	
prochlorperazine maleate oral tablet 10 mg, 5 mg		1	
prochlorperazine rectal suppository 25 mg	Compro	4	
promethazine hcl injection solution 25 mg/ml	Phenergan	1	PA; HRM; AGE (Max 64 Years)
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg		1	PA; HRM; AGE (Max 64 Years)

Drug Name	Reference	Drug Tier	Requirements/Limits
promethazine hcl rectal suppository 25 mg	Promethegan	2	PA; HRM; AGE (Max 64 Years)
promethegan rectal suppository 12.5 mg		2	PA; HRM; AGE (Max 64 Years)
promethegan rectal suppository 25 mg	Promethegan	2	PA; HRM; AGE (Max 64 Years)
scopolamine transdermal patch 72 hour 1 mg/3days	Transderm Scop	2	PA; HRM; QL (10 per 30 days); AGE (Max 64 Years)
ANTIPARASITE AGENTS			
Antiparasite Agents			
albendazole oral tablet 200 mg		4	
atovaquone oral suspension 750 mg/5ml	Mepron	4	
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	Malarone	2	
chloroquine phosphate oral tablet 250 mg, 500 mg		2	
COARTEM ORAL TABLET 20-120 MG		4	
hydroxychloroquine sulfate oral tablet 100 mg		1	QL (180 per 30 days)
hydroxychloroquine sulfate oral tablet 200 mg	Plaquenil	1	QL (90 per 30 days)
hydroxychloroquine sulfate oral tablet 300 mg	Sovuna	1	QL (60 per 30 days)
hydroxychloroquine sulfate oral tablet 400 mg		1	QL (60 per 30 days)
IMPAVIDO ORAL CAPSULE 50 MG		5	PA; NM; QL (84 per 28 days); NEDS
ivermectin oral tablet 3 mg	Stromectol	1	
ivermectin oral tablet 6 mg		1	
mefloquine hcl oral tablet 250 mg		1	
nitazoxanide oral tablet 500 mg		5	NM; QL (60 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
pentamidine isethionate injection solution reconstituted 300 mg	Pentam	4	
praziquantel oral tablet 600 mg	Biltricide	4	
PRIMAQUINE PHOSPHATE ORAL TABLET 26.3 (15 BASE) MG		4	
pyrimethamine oral tablet 25 mg	Daraprim	5	PA; NM; NEDS
quinine sulfate oral capsule 324 mg		2	PA
tinidazole oral tablet 250 mg, 500 mg		2	
ANTIPARKINSONIAN AGENTS			
Antiparkinsonian Agents			
amantadine hcl oral capsule 100 mg		1	
amantadine hcl oral solution 50 mg/5ml		1	
amantadine hcl oral tablet 100 mg		2	
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg		1	
bromocriptine mesylate oral tablet 2.5 mg	Parlodel	2	
cabergoline oral tablet 0.5 mg		1	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg		1	
carbidopa-levodopa oral tablet 10-100 mg	Sinemet	1	
carbidopa-levodopa oral tablet 25-100 mg	Dhivy	1	
carbidopa-levodopa oral tablet 25-250 mg		1	
entacapone oral tablet 200 mg		4	
ONAPGO SUBCUTANEOUS SOLUTION CARTRIDGE 98 MG/20ML		5	PA; NM; QL (600 per 30 days); NEDS
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg		1	
rasagiline mesylate oral tablet 0.5 mg, 1 mg	Azilect	2	
ropinirole hcl er oral tablet extended release 24 hour 2 mg, 4 mg		2	

Drug Name	Reference	Drug Tier	Requirements/Limits
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg		1	
selegiline hcl oral capsule 5 mg		1	
selegiline hcl oral tablet 5 mg		2	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg		1	
VYALEV SUBCUTANEOUS SOLUTION 12-240 MG/ML		5	PA; NM; QL (560 per 28 days); NEDS
ANTIPSYCHOTIC AGENTS			
Antipsychotic Agents			
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML		5	NM; QL (2.4 per 42 days); NEDS
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 960 MG/3.2ML		5	NM; QL (3.2 per 42 days); NEDS
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG		5	NM; QL (2 per 28 days); NEDS
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG		5	NM; QL (2 per 28 days); NEDS
aripiprazole oral solution 1 mg/ml		4	
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	Abilify	2	
aripiprazole oral tablet dispersible 10 mg		2	ST; QL (90 per 30 days)
aripiprazole oral tablet dispersible 15 mg		2	ST; QL (60 per 30 days)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML		5	NM; QL (4.8 per 365 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML		5	NM; QL (3.9 per 14 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML		5	NM; QL (1.6 per 14 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML		5	NM; QL (2.4 per 14 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML		5	NM; QL (3.2 per 14 days); NEDS
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	Saphris	2	QL (60 per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG		5	ST; NM; QL (30 per 30 days); NEDS
chlorpromazine hcl injection solution 25 mg/ml, 50 mg/2ml		2	
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml		4	
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg		2	
clozapine oral tablet 100 mg, 25 mg	Clozaril	1	
clozapine oral tablet 200 mg, 50 mg		1	
clozapine oral tablet dispersible 100 mg, 12.5 mg, 25 mg		2	ST; QL (90 per 30 days)
clozapine oral tablet dispersible 150 mg		2	ST; QL (180 per 30 days)
clozapine oral tablet dispersible 200 mg		2	ST; QL (120 per 30 days)
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG		5	ST; NM; QL (60 per 30 days); NEDS
COBENFY STARTER PACK ORAL CAPSULE THERAPY PACK 50-20 & 100-20 MG		5	ST; NM; NEDS
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML		5	NM; QL (0.75 per 21 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML		5	NM; QL (1 per 21 days); NEDS
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML		5	NM; QL (1.5 per 21 days); NEDS
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 351 MG/2.25ML		5	NM; QL (2.25 per 21 days); NEDS
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML		5	NM; QL (0.25 per 21 days); NEDS
ERZOFRI INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML		5	NM; QL (0.5 per 21 days); NEDS
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG		5	ST; NM; QL (60 per 30 days); NEDS
FANAPT TITRATION PACK A ORAL TABLET 1 & 2 & 4 & 6 MG		4	ST
FANAPT TITRATION PACK B ORAL TABLET 1 & 2 & 6 & 8 MG		4	ST
FANAPT TITRATION PACK C ORAL TABLET 1 & 2 & 6 MG		4	ST
fluphenazine decanoate injection solution 25 mg/ml		2	
fluphenazine hcl injection solution 2.5 mg/ml		4	
fluphenazine hcl oral concentrate 5 mg/ml		4	
fluphenazine hcl oral elixir 2.5 mg/5ml		4	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg		2	
haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml, 50 mg/ml(1ml)		2	

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haloperidol lactate injection solution 5 mg/ml		2	
haloperidol lactate oral concentrate 2 mg/ml		1	
haloperidol lactate solution 5 mg/ml injection		1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg		1	
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML		5	NM; QL (3.5 per 166 days); NEDS
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML		5	NM; QL (5 per 166 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML		5	NM; QL (0.75 per 21 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML		5	NM; QL (1 per 21 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML		5	NM; QL (1.5 per 21 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML		3	QL (0.25 per 21 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML		5	NM; QL (0.5 per 21 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML		5	NM; QL (0.88 per 70 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML		5	NM; QL (1.32 per 70 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML		5	NM; QL (1.75 per 70 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML		5	NM; QL (2.63 per 70 days); NEDS
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg		2	
lurasidone hcl oral tablet 120 mg	Latuda	2	QL (30 per 30 days)
lurasidone hcl oral tablet 20 mg, 40 mg, 60 mg	Latuda	4	QL (30 per 30 days)
lurasidone hcl oral tablet 80 mg	Latuda	4	QL (60 per 30 days)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG		5	NM; QL (30 per 30 days); NEDS
molindone hcl oral tablet 10 mg		2	QL (240 per 30 days)
molindone hcl oral tablet 25 mg		2	QL (270 per 30 days)
molindone hcl oral tablet 5 mg		5	NM; QL (120 per 30 days); NEDS
NUPLAZID ORAL CAPSULE 34 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
NUPLAZID ORAL TABLET 10 MG		5	PA NSO; NM; QL (30 per 30 days); NEDS
olanzapine intramuscular solution reconstituted 10 mg	ZyPREXA	4	QL (30 per 30 days)
olanzapine oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	ZyPREXA	1	
olanzapine oral tablet 15 mg, 7.5 mg		1	
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	ZyPREXA Zydis	4	
OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG		5	ST; NM; NEDS
paliperidone er oral tablet extended release 24 hour 1.5 mg		2	QL (30 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
paliperidone er oral tablet extended release 24 hour 3 mg, 9 mg	Invega	2	QL (30 per 30 days)
paliperidone er oral tablet extended release 24 hour 6 mg	Invega	2	QL (60 per 30 days)
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg		2	
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG		5	NM; QL (1 per 30 days); NEDS
pimozide oral tablet 1 mg, 2 mg		2	
prochlorperazine edisylate solution 10 mg/2ml injection		1	
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	SEROquel XR	2	
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	SEROquel	1	
quetiapine fumarate oral tablet 150 mg		1	QL (30 per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG		5	NM; QL (30 per 30 days); NEDS
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg	RisperDAL Consta	2	QL (2 per 28 days)
risperidone microspheres er intramuscular suspension reconstituted er 37.5 mg, 50 mg	RisperDAL Consta	5	NM; QL (2 per 28 days); NEDS
risperidone oral solution 1 mg/ml	RisperDAL	2	
risperidone oral tablet 0.25 mg		1	
risperidone oral tablet 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	RisperDAL	1	
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg		2	
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG		5	NM; QL (2 per 28 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR		5	ST; NM; QL (30 per 30 days); NEDS
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg		1	
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg		2	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg		1	
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML		5	NM; QL (0.28 per 28 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML		5	NM; QL (0.35 per 28 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 150 MG/0.42ML		5	NM; QL (0.42 per 56 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 200 MG/0.56ML		5	NM; QL (0.56 per 56 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 250 MG/0.7ML		5	NM; QL (0.7 per 56 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 50 MG/0.14ML		5	NM; QL (0.14 per 28 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 75 MG/0.21ML		5	NM; QL (0.21 per 28 days); NEDS
VERSACLOZ ORAL SUSPENSION 50 MG/ML		5	ST; NM; QL (540 per 30 days); NEDS
VRAYLAR ORAL CAPSULE 0.5 MG, 0.75 MG, 1.5 MG, 3 MG, 4.5 MG, 6 MG		5	ST; NM; QL (30 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG		4	ST
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	Geodon	2	
ziprasidone mesylate intramuscular solution reconstituted 20 mg	Geodon	4	QL (6 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG		4	QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 300 MG		5	NM; QL (2 per 28 days); NEDS
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG		5	NM; QL (1 per 28 days); NEDS
ANTIVIRALS (SYSTEMIC)			
Antiretrovirals			
abacavir sulfate oral solution 20 mg/ml	Ziagen	2	
abacavir sulfate oral tablet 300 mg		2	
abacavir sulfate-lamivudine oral tablet 600-300 mg		2	
APTIVUS ORAL CAPSULE 250 MG		5	NM; NEDS
atazanavir sulfate oral capsule 150 mg		2	
atazanavir sulfate oral capsule 200 mg, 300 mg	Reyataz	2	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG		5	NM; QL (30 per 30 days); NEDS
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML, 600 & 900 MG/3ML		5	NM; NEDS
CIMDUO ORAL TABLET 300-300 MG		5	NM; NEDS
darunavir oral tablet 600 mg	Prezista	4	

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Drug Name	Reference	Drug Tier	Requirements/Limits
darunavir oral tablet 800 mg	Prezista	5	NM; NEDS
DELSTRIGO ORAL TABLET 100-300-300 MG		5	NM; NEDS
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG		5	NM; NEDS
DOVATO ORAL TABLET 50-300 MG		5	NM; NEDS
EDURANT ORAL TABLET 25 MG		5	NM; NEDS
EDURANT PED ORAL TABLET SOLUBLE 2.5 MG		5	NM; NEDS
efavirenz oral capsule 200 mg		4	
efavirenz oral capsule 50 mg		2	
efavirenz oral tablet 600 mg		4	
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg		1	
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg		5	NM; NEDS
efavirenz-lamivudine-tenofovir oral tablet 600-300-300 mg	Symfi	5	NM; NEDS
emtricitabine oral capsule 200 mg	Emtriva	4	
emtricitabine-tenofovir df oral tablet 100-150 mg, 167-250 mg	Truvada	4	
emtricitabine-tenofovir df oral tablet 133-200 mg	Truvada	5	NM; NEDS
emtricitabine-tenofovir df oral tablet 200-300 mg	Truvada	2	
emtricitab-rilpivir-tenofov df oral tablet 200-25-300 mg	Complera	5	NM; NEDS
EMTRIVA ORAL SOLUTION 10 MG/ML		4	
EPIVIR HBV ORAL SOLUTION 5 MG/ML		4	
etravirine oral tablet 100 mg, 200 mg	Intelence	5	NM; NEDS
EVOTAZ ORAL TABLET 300-150 MG		5	NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
fosamprenavir calcium oral tablet 700 mg		5	NM; NEDS
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG		5	NM; NEDS
GENVOYA ORAL TABLET 150-150-200-10 MG		5	NM; NEDS
INTELENCE ORAL TABLET 25 MG		4	
ISENTRESS HD ORAL TABLET 600 MG		5	NM; NEDS
ISENTRESS ORAL PACKET 100 MG		5	NM; NEDS
ISENTRESS ORAL TABLET 400 MG		5	NM; NEDS
ISENTRESS ORAL TABLET CHEWABLE 100 MG		5	NM; NEDS
ISENTRESS ORAL TABLET CHEWABLE 25 MG		3	
JULUCA ORAL TABLET 50-25 MG		5	NM; NEDS
KALETRA ORAL SOLUTION 400-100 MG/5ML		4	QL (480 per 30 days)
lamivudine oral solution 10 mg/ml	Epivir	2	
lamivudine oral tablet 100 mg		2	
lamivudine oral tablet 150 mg, 300 mg	Epivir	2	
lamivudine-zidovudine oral tablet 150-300 mg		4	
LEXIVA ORAL SUSPENSION 50 MG/ML		4	
lopinavir-ritonavir oral solution 400-100 mg/5ml	Kaletra	2	QL (480 per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	Kaletra	4	QL (300 per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	Kaletra	4	QL (120 per 30 days)
maraviroc oral tablet 150 mg, 300 mg	Selzentry	5	NM; NEDS
nevirapine er oral tablet extended release 24 hour 100 mg		4	QL (90 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
nevirapine er oral tablet extended release 24 hour 400 mg		4	QL (30 per 30 days)
nevirapine oral suspension 50 mg/5ml		4	QL (1200 per 30 days)
nevirapine oral tablet 200 mg		1	QL (60 per 30 days)
NORVIR ORAL PACKET 100 MG		4	
NORVIR ORAL SOLUTION 80 MG/ML		4	
ODEFSEY ORAL TABLET 200-25-25 MG		5	NM; NEDS
PIFELTRO ORAL TABLET 100 MG		5	NM; NEDS
PREZCOBIX ORAL TABLET 675-150 MG, 800-150 MG		5	NM; NEDS
PREZISTA ORAL SUSPENSION 100 MG/ML		5	NM; NEDS
PREZISTA ORAL TABLET 150 MG		5	NM; NEDS
PREZISTA ORAL TABLET 75 MG		4	
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML		4	
REYATAZ ORAL PACKET 50 MG		5	NM; NEDS
rilpivirine hcl oral tablet 25 mg	Edurant	5	NM; NEDS
ritonavir oral tablet 100 mg	Norvir	2	
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG		5	NM; NEDS
SELZENTRY ORAL SOLUTION 20 MG/ML		5	NM; NEDS
SELZENTRY ORAL TABLET 25 MG		3	
SELZENTRY ORAL TABLET 75 MG		5	NM; NEDS
stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg		2	
STRIBILD ORAL TABLET 150-150-200-300 MG		5	NM; NEDS
SUNLENCA ORAL TABLET 300 MG		5	NM; NEDS

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SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG		5	NM; NEDS
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML		5	PA BvD; NM; NEDS
SYMTUZA ORAL TABLET 800-150-200-10 MG		5	NM; NEDS
tenofovir disoproxil fumarate oral tablet 300 mg	Viread	2	
TIVICAY ORAL TABLET 10 MG		4	
TIVICAY ORAL TABLET 25 MG, 50 MG		5	NM; NEDS
TIVICAY PD ORAL TABLET SOLUBLE 5 MG		5	NM; NEDS
TRIUMEQ ORAL TABLET 600-50-300 MG		5	NM; QL (30 per 30 days); NEDS
TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG		4	
TRIZIVIR ORAL TABLET 300-150-300 MG		5	NM; NEDS
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML		5	NM; NEDS
VEMLIDY ORAL TABLET 25 MG		5	NM; QL (30 per 30 days); NEDS
VIRACEPT ORAL TABLET 250 MG, 625 MG		5	NM; NEDS
VIREAD ORAL POWDER 40 MG/GM		5	NM; NEDS
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG		5	NM; NEDS
zidovudine oral capsule 100 mg	Retrovir	2	
zidovudine oral syrup 50 mg/5ml	Retrovir	2	
zidovudine oral tablet 300 mg		1	
Antivirals, Miscellaneous			

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Drug Name	Reference	Drug Tier	Requirements/Limits
LIVTENCITY ORAL TABLET 200 MG		5	PA; NM; NEDS
oseltamivir phosphate oral capsule 30 mg		1	QL (84 per 180 days)
oseltamivir phosphate oral capsule 45 mg	Tamiflu	1	QL (48 per 180 days)
oseltamivir phosphate oral capsule 75 mg	Tamiflu	1	QL (42 per 180 days)
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	Tamiflu	2	QL (540 per 180 days)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG		1	QL (20 per 5 days)
PAXLOVID (300/100 & 150/100) ORAL TABLET THERAPY PACK 6 X 150 MG & 5 X 100MG		1	QL (11 per 28 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG		1	QL (30 per 5 days)
PREVYMIS ORAL TABLET 240 MG, 480 MG		5	PA; NM; QL (28 per 28 days); NEDS
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT		4	QL (60 per 180 days)
Hcv Antivirals			
EPCLUSA ORAL PACKET 150-37.5 MG		5	PA; NM; QL (28 per 28 days); NEDS
EPCLUSA ORAL PACKET 200-50 MG		5	PA; NM; QL (56 per 28 days); NEDS
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG		5	PA; NM; QL (28 per 28 days); NEDS
HARVONI ORAL PACKET 33.75-150 MG		5	PA; NM; QL (28 per 28 days); NEDS
HARVONI ORAL PACKET 45-200 MG		5	PA; NM; QL (56 per 28 days); NEDS
HARVONI ORAL TABLET 45-200 MG, 90-400 MG		5	PA; NM; QL (28 per 28 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
VOSEVI ORAL TABLET 400-100-100 MG		5	PA; NM; QL (28 per 28 days); NEDS
Interferons			
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML		5	PA; NM; NEDS
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML		5	PA; NM; NEDS
Nucleosides And Nucleotides			
acyclovir oral capsule 200 mg		1	
acyclovir oral tablet 400 mg, 800 mg		1	
acyclovir sodium intravenous solution 50 mg/ml		4	PA BvD
adefovir dipivoxil oral tablet 10 mg		4	
entecavir oral tablet 0.5 mg, 1 mg	Baraclude	4	
ribavirin oral tablet 200 mg		2	
valacyclovir hcl oral tablet 1 gm, 500 mg	Valtrex	1	
valganciclovir hcl oral tablet 450 mg		2	
BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS			
Anticoagulants			
dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg	Pradaxa	3	QL (60 per 30 days)
ELIQUIS (1.5 MG PACK) ORAL TABLET SOLUBLE 3 X 0.5 MG		3	QL (960 per 30 days)
ELIQUIS (2 MG PACK) ORAL TABLET SOLUBLE 4 X 0.5 MG		3	QL (960 per 30 days)
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG		3	

Drug Name	Reference	Drug Tier	Requirements/Limits
ELIQUIS ORAL CAPSULE SPRINKLE 0.15 MG		3	QL (120 per 30 days)
ELIQUIS ORAL TABLET 2.5 MG		3	QL (60 per 30 days)
ELIQUIS ORAL TABLET 5 MG		3	QL (74 per 30 days)
ELIQUIS ORAL TABLET SOLUBLE 0.5 MG		3	QL (960 per 30 days)
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml	Lovenox	4	QL (60 per 30 days)
enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml	Lovenox	4	QL (48 per 30 days)
enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml	Lovenox	4	QL (18 per 30 days)
enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml	Lovenox	4	QL (24 per 30 days)
enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml	Lovenox	4	QL (36 per 30 days)
fondaparinux sodium subcutaneous solution 10 mg/0.8ml	Arixtra	5	NM; QL (24 per 30 days); NEDS
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	Arixtra	2	QL (15 per 30 days)
fondaparinux sodium subcutaneous solution 5 mg/0.4ml	Arixtra	5	NM; QL (12 per 30 days); NEDS
fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml	Arixtra	5	NM; QL (18 per 30 days); NEDS
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml		1	
jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	Jantoven	1	
rivaroxaban oral suspension reconstituted 1 mg/ml	Xarelto	2	QL (600 per 30 days)
rivaroxaban oral tablet 2.5 mg	Xarelto	2	QL (60 per 30 days)

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Drug Name	Reference	Drug Tier	Requirements/Limits
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	Jantoven	1	
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML		3	QL (600 per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG		3	QL (30 per 30 days)
XARELTO ORAL TABLET 15 MG		3	QL (60 per 30 days)
XARELTO ORAL TABLET 2.5 MG		3	ST; QL (60 per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG		3	
Blood Formation Modifiers			
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG		5	PA; NM; QL (60 per 30 days); NEDS
eltrombopag olamine oral packet 12.5 mg	Promacta	5	PA; NM; QL (90 per 30 days); NEDS
eltrombopag olamine oral packet 25 mg	Promacta	5	PA; NM; QL (180 per 30 days); NEDS
eltrombopag olamine oral tablet 12.5 mg	Promacta	5	PA; NM; QL (90 per 30 days); NEDS
eltrombopag olamine oral tablet 25 mg	Promacta	5	PA; NM; QL (30 per 30 days); NEDS
eltrombopag olamine oral tablet 50 mg, 75 mg	Promacta	5	PA; NM; QL (60 per 30 days); NEDS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT		5	PA; NM; QL (30 per 30 days); NEDS
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 3000 UNIT		5	PA; NM; QL (20 per 30 days); NEDS
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML		5	PA; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML		5	PA; NM; NEDS
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML		5	PA; NM; NEDS
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML		3	PA; QL (12 per 28 days)
RETACRIT INJECTION SOLUTION 40000 UNIT/ML		3	PA; QL (4 per 28 days)
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML		5	PA; NM; NEDS
Hematologic Agents, Miscellaneous			
anagrelide hcl oral capsule 0.5 mg	Agrylin	4	
anagrelide hcl oral capsule 1 mg		4	
tranexamic acid oral tablet 650 mg		2	
Platelet-Aggregation Inhibitors			
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg		4	
cilostazol oral tablet 100 mg, 50 mg		1	
clopidogrel bisulfate oral tablet 75 mg	Plavix	1	
dipyridamole oral tablet 25 mg, 50 mg, 75 mg		2	PA; HRM; AGE (Max 64 Years)
pentoxifylline er oral tablet extended release 400 mg		1	
prasugrel hcl oral tablet 10 mg, 5 mg	Effient	1	QL (30 per 30 days)
ticagrelor oral tablet 60 mg, 90 mg	Brilinta	2	
CALORIC AGENTS			

Drug Name	Reference	Drug Tier	Requirements/Limits
Caloric Agents			
dextrose intravenous solution 5 %		1	
CARDIOVASCULAR AGENTS			
Alpha-Adrenergic Agents			
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg		1	
clonidine transdermal patch weekly 0.1 mg/24hr	Catapres-TTS-1	2	
clonidine transdermal patch weekly 0.2 mg/24hr	Catapres-TTS-2	2	
clonidine transdermal patch weekly 0.3 mg/24hr	Catapres-TTS-3	2	
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	Cardura	1	
droxidopa oral capsule 100 mg	Northera	2	PA; QL (180 per 30 days)
droxidopa oral capsule 200 mg, 300 mg	Northera	5	PA; NM; QL (180 per 30 days); NEDS
guanfacine hcl oral tablet 1 mg, 2 mg		1	
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg		2	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg		1	
Angiotensin Ii Receptor Antagonists			
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	Atacand	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	Atacand HCT	1	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG		3	QL (240 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG		3	QL (60 per 30 days)
irbesartan oral tablet 150 mg, 300 mg	Avapro	1	
irbesartan oral tablet 75 mg		1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	Avalide	1	
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	Cozaar	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	Hyzaar	1	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	Benicar	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	Benicar HCT	1	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	Tribenzor	1	
sacubitril-valsartan oral tablet 24-26 mg, 49-51 mg, 97-103 mg	Entresto	2	QL (60 per 30 days)
telmisartan oral tablet 20 mg		1	
telmisartan oral tablet 40 mg, 80 mg	Micardis	1	
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	Micardis HCT	1	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	Diovan	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	Diovan HCT	1	
Angiotensin-Converting Enzyme Inhibitors			
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg	Lotensin	1	
benazepril hcl oral tablet 5 mg		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Lotensin HCT	1	
benazepril-hydrochlorothiazide oral tablet 5-6.25 mg		1	
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg		1	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Vasotec	1	
enalapril-hydrochlorothiazide oral tablet 10-25 mg	Vaseretic	1	
enalapril-hydrochlorothiazide oral tablet 5-12.5 mg		1	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg		1	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg		1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	Zestril	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Zestoretic	1	
moexipril hcl oral tablet 15 mg, 7.5 mg		1	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg		1	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg		1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg		1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg		1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg		1	
Antiarrhythmic Agents			
amiodarone hcl oral tablet 100 mg, 200 mg	Pacerone	1	

Drug Name	Reference	Drug Tier	Requirements/Limits
amiodarone hcl oral tablet 400 mg		1	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	Tikosyn	4	
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg		1	
MULTAQ ORAL TABLET 400 MG		3	
pacerone oral tablet 100 mg, 200 mg	Pacerone	2	
pacerone oral tablet 400 mg		2	
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg		4	
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg		1	
quinidine sulfate oral tablet 200 mg, 300 mg		4	
Beta-Adrenergic Blocking Agents			
acebutolol hcl oral capsule 200 mg, 400 mg		1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	Tenormin	1	
atenolol-chlorthalidone oral tablet 100-25 mg	Tenoretic 100	1	
atenolol-chlorthalidone oral tablet 50-25 mg	Tenoretic 50	1	
bisoprolol fumarate oral tablet 10 mg, 2.5 mg, 5 mg		1	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg		1	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	Coreg	1	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg		1	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	Toprol XL	1	

Drug Name	Reference	Drug Tier	Requirements/Limits
metoprolol tartrate oral tablet 100 mg, 50 mg	Lopressor	1	
metoprolol tartrate oral tablet 25 mg, 37.5 mg, 75 mg		1	
metoprolol-hydrochlorothiazide oral tablet 50-25 mg		2	
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Bystolic	1	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	Inderal LA	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg		1	
sorine oral tablet 120 mg, 160 mg, 80 mg	Betapace	1	
sorine oral tablet 240 mg		1	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	Betapace AF	1	
sotalol hcl oral tablet 120 mg, 160 mg, 80 mg	Betapace	1	
sotalol hcl oral tablet 240 mg		1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg		2	
Calcium-Channel Blocking Agents			
cartia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	Cartia XT	1	
diltiazem 90 mg tablet		1	
diltiazem hcl er beads oral capsule extended release 24 hour 360 mg, 420 mg	Tiadylt ER	1	
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	Cartia XT	1	

Drug Name	Reference	Drug Tier	Requirements/Limits
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg	Cardizem	1	
diltiazem hcl oral tablet 90 mg		1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg		1	
taztia xt oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg		1	
taztia xt oral capsule extended release 24 hour 360 mg	Tiadylt ER	1	
tiadylt er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg		1	
tiadylt er oral capsule extended release 24 hour 360 mg, 420 mg	Tiadylt ER	1	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg		1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg		1	
Cardiovascular Agents, Miscellaneous			
ATTRUBY ORAL TABLET THERAPY PACK 356 MG		5	PA; NM; QL (112 per 28 days); NEDS
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG		5	PA; NM; QL (30 per 30 days); NEDS
CORLANOR ORAL SOLUTION 5 MG/5ML		4	QL (600 per 30 days)
digoxin oral tablet 125 mcg, 250 mcg	Digox	1	
epinephrine injection solution 0.3 mg/0.3ml		3	QL (4 per 30 days)
epinephrine injection solution auto-injector 0.15 mg/0.15ml	Auvi-Q	3	QL (4 per 30 days)
epinephrine injection solution auto-injector 0.15 mg/0.3ml	EpiPen Jr 2-Pak	2	QL (4 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
epinephrine injection solution auto-injector 0.3 mg/0.3ml	Auvi-Q	2	QL (4 per 30 days)
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg		1	
icatibant acetate subcutaneous solution 30 mg/3ml		5	PA; NM; QL (18 per 30 days); NEDS
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	Firazyr	5	PA; NM; QL (18 per 30 days); NEDS
ivabradine hcl oral tablet 5 mg, 7.5 mg	Corlanor	3	QL (60 per 30 days)
metyrosine oral capsule 250 mg		5	PA; NM; NEDS
ranolazine er oral tablet extended release 12 hour 1000 mg		2	QL (60 per 30 days)
ranolazine er oral tablet extended release 12 hour 500 mg		2	QL (120 per 30 days)
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG		4	PA; QL (30 per 30 days)
VYNDAMAX ORAL CAPSULE 61 MG		5	PA; NM; QL (30 per 30 days); NEDS
Dihydropyridines			
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-10 mg	Lotrel	1	
amlodipine besy-benazepril hcl oral capsule 2.5-10 mg, 5-20 mg, 5-40 mg		1	
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	Norvasc	1	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	Exforge	1	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	Azor	1	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	Exforge HCT	4	

Drug Name	Reference	Drug Tier	Requirements/Limits
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg		1	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg		1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg	Procardia XL	1	
nifedipine er osmotic release oral tablet extended release 24 hour 90 mg		1	
Diuretics			
amiloride hcl oral tablet 5 mg		1	
amiloride-hydrochlorothiazide oral tablet 5-50 mg		1	
bumetanide oral tablet 0.5 mg	Bumex	1	
bumetanide oral tablet 1 mg, 2 mg		1	
chlorthalidone oral tablet 25 mg, 50 mg		1	
furosemide injection solution 10 mg/ml		1	
furosemide oral solution 10 mg/ml, 8 mg/ml		1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	Lasix	1	
hydrochlorothiazide oral capsule 12.5 mg		1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg		1	
indapamide oral tablet 1.25 mg, 2.5 mg		1	
JYNARQUE ORAL TABLET 15 MG, 30 MG		5	PA; NM; QL (120 per 30 days); NEDS
metolazone oral tablet 10 mg, 2.5 mg, 5 mg		1	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	Aldactone	1	
spironolactone-hctz oral tablet 25-25 mg		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
tolvaptan oral tablet therapy pack 15 mg, 30 & 15 mg, 45 & 15 mg, 60 & 30 mg, 90 & 30 mg	Jynarque	5	PA; NM; QL (56 per 28 days); NEDS
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg		1	
triamterene-hctz oral capsule 37.5-25 mg		1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg		1	
Dyslipidemics			
amlodipine-atorvastatin oral tablet 10-10 mg, 5-10 mg	Caduet	1	
amlodipine-atorvastatin oral tablet 10-20 mg, 10-40 mg, 10-80 mg, 5-20 mg, 5-40 mg, 5-80 mg	Caduet	1	QL (30 per 30 days)
amlodipine-atorvastatin oral tablet 2.5-10 mg, 2.5-20 mg, 2.5-40 mg		1	
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Lipitor	1	
cholestyramine light oral packet 4 gm	Prevalite	2	
cholestyramine oral packet 4 gm	Questran	2	
colesevelam hcl oral packet 3.75 gm	Welchol	2	
colesevelam hcl oral tablet 625 mg	Welchol	4	
colestipol hcl oral tablet 1 gm	Colestid	2	
ezetimibe oral tablet 10 mg	Zetia	1	QL (30 per 30 days)
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	Vytorin	1	QL (30 per 30 days)
fenofibrate capsule 134 mg oral		1	
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg		1	
fenofibrate oral tablet 145 mg	Tricor	1	
fenofibrate oral tablet 160 mg		4	
fenofibrate oral tablet 48 mg, 54 mg		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
fenofibrate tablet 160 mg oral		1	
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	Lescol XL	1	
fluvastatin sodium oral capsule 20 mg, 40 mg		1	QL (60 per 30 days)
gemfibrozil oral tablet 600 mg	Lopid	1	
icosapent ethyl oral capsule 0.5 gm	Vascepa	4	QL (240 per 30 days)
icosapent ethyl oral capsule 1 gm	Vascepa	4	QL (120 per 30 days)
lovastatin oral tablet 10 mg, 20 mg, 40 mg		1	
NEXLETOL ORAL TABLET 180 MG		3	ST; QL (30 per 30 days)
NEXLIZET ORAL TABLET 180-10 MG		3	ST; QL (30 per 30 days)
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg		1	
niacin er (antihyperlipidemic) oral tablet extended release 750 mg		2	
omega-3-acid ethyl esters oral capsule 1 gm	Lovaza	1	ST; QL (120 per 30 days)
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg		1	
prevalite oral packet 4 gm	Prevalite	2	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML		3	ST; QL (7 per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML		3	ST; QL (6 per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML		3	ST; QL (6 per 28 days)
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Crestor	1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
simvastatin oral tablet 10 mg, 20 mg, 40 mg	Zocor	1	
simvastatin oral tablet 5 mg, 80 mg		1	
Renin-Angiotensin-Aldosterone System Inhibitors			
aliskiren fumarate oral tablet 150 mg, 300 mg	Tekturna	4	
eplerenone oral tablet 25 mg, 50 mg		2	
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG		3	PA; QL (30 per 30 days)
Vasodilators			
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg		1	
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg		1	
isosorbide mononitrate oral tablet 10 mg, 20 mg		1	
minoxidil oral tablet 10 mg, 2.5 mg		1	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	Nitrostat	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	Nitro-Dur	1	
CENTRAL NERVOUS SYSTEM AGENTS			
Central Nervous System Agents			
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg	Adderall XR	2	QL (30 per 30 days)
amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg	Adderall XR	2	QL (60 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	Adderall	1	QL (60 per 30 days)
atomoxetine hcl oral capsule 10 mg		4	QL (60 per 30 days)
atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg		2	QL (30 per 30 days)
atomoxetine hcl oral capsule 18 mg, 25 mg, 40 mg		2	QL (60 per 30 days)
AUSTEDO ORAL TABLET 12 MG, 9 MG		5	PA; NM; QL (120 per 30 days); NEDS
AUSTEDO ORAL TABLET 6 MG		5	PA; NM; QL (60 per 30 days); NEDS
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG		5	PA; NM; QL (90 per 30 days); NEDS
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 18 MG, 24 MG		5	PA; NM; QL (60 per 30 days); NEDS
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 36 MG, 42 MG, 48 MG		5	PA; NM; QL (30 per 30 days); NEDS
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 6 MG		5	PA; NM; QL (210 per 30 days); NEDS
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG, 6 & 12 & 24 MG		5	PA; NM; NEDS
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML		5	PA; NM; QL (1 per 28 days); NEDS
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML		5	PA; NM; QL (1 per 28 days); NEDS
BETASERON SUBCUTANEOUS KIT 0.3 MG		5	PA; NM; QL (15 per 30 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
dalfampridine er oral tablet extended release 12 hour 10 mg	Ampyra	2	PA; QL (60 per 30 days)
dimethyl fumarate oral capsule delayed release 120 mg	Tecfidera	4	PA; QL (14 per 7 days)
dimethyl fumarate oral capsule delayed release 240 mg	Tecfidera	5	PA; NM; QL (60 per 30 days); NEDS
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	Tecfidera	4	PA
fingolimod hcl oral capsule 0.5 mg	Gilenya	5	PA; NM; QL (30 per 30 days); NEDS
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	Glatopa	5	PA; NM; QL (30 per 30 days); NEDS
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	Glatopa	5	PA; NM; QL (12 per 28 days); NEDS
glatopa subcutaneous solution prefilled syringe 20 mg/ml	Glatopa	5	PA; NM; QL (30 per 30 days); NEDS
glatopa subcutaneous solution prefilled syringe 40 mg/ml	Glatopa	5	PA; NM; QL (12 per 28 days); NEDS
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	Intuniv	1	
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG		5	PA; NM; QL (30 per 30 days); NEDS
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG		5	PA; NM; QL (30 per 30 days); NEDS
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG		5	PA; NM; NEDS
lithium carbonate er oral tablet extended release 300 mg	Lithobid	1	
lithium carbonate er oral tablet extended release 450 mg		1	
lithium carbonate oral capsule 150 mg, 300 mg		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
LITHIUM CARBONATE ORAL CAPSULE 600 MG		1	
lithium carbonate oral tablet 300 mg		1	
lithium oral solution 8 meq/5ml		2	
methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml	Methylin	4	QL (900 per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	Ritalin	1	QL (90 per 30 days)
riluzole oral tablet 50 mg		4	
tetrabenazine oral tablet 12.5 mg	Xenazine	4	PA; QL (112 per 28 days)
tetrabenazine oral tablet 25 mg	Xenazine	5	PA; NM; QL (112 per 28 days); NEDS
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG		5	PA; NM; QL (120 per 30 days); NEDS
CONTRACEPTIVES			
Contraceptives			
alyacen 1/35 oral tablet 1-35 mg-mcg	Dasetta 1/35 (28)	1	
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	Dasetta 7/7/7	1	
apri oral tablet 0.15-30 mg-mcg	Apri	1	
aurovela 24 fe oral tablet 1-20 mg-mcg(24)		1	
aurovela fe 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
aurovela fe 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
blisovi 24 fe oral tablet 1-20 mg-mcg(24)		1	
blisovi fe 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
blisovi fe 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
camila oral tablet 0.35 mg	Camila	1	
cryselle oral tablet 0.3-30 mg-mcg		1	
cyred eq oral tablet 0.15-30 mg-mcg	Apri	1	

Drug Name	Reference	Drug Tier	Requirements/Limits
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	Dasetta 1/35 (28)	1	
dasetta 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	Dasetta 7/7/7	1	
deblitane oral tablet 0.35 mg	Camila	1	
desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg	Apri	1	
elinest oral tablet 0.3-30 mg-mcg		1	
eluryng vaginal ring 0.12-0.015 mg/24hr	EluRyng	1	QL (1 per 28 days)
emzahh oral tablet 0.35 mg	Camila	1	
enilloring vaginal ring 0.12-0.015 mg/24hr	EluRyng	2	QL (1 per 28 days)
enskyce oral tablet 0.15-30 mg-mcg	Apri	1	
errin oral tablet 0.35 mg	Camila	1	
estarylla oral tablet 0.25-35 mg-mcg	Estarylla	1	
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	EluRyng	1	QL (1 per 28 days)
feirza 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
feirza 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
femynor oral tablet 0.25-35 mg-mcg	Estarylla	1	
hailey 24 fe oral tablet 1-20 mg-mcg(24)		1	
hailey fe 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
hailey fe 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
haloette vaginal ring 0.12-0.015 mg/24hr	EluRyng	1	QL (1 per 28 days)
heather oral tablet 0.35 mg	Camila	1	
incassia oral tablet 0.35 mg	Camila	1	
isibloom oral tablet 0.15-30 mg-mcg	Apri	1	
jencycla oral tablet 0.35 mg	Camila	1	
juleber oral tablet 0.15-30 mg-mcg	Apri	1	
junel fe 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
junel fe 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
junel fe 24 oral tablet 1-20 mg-mcg(24)		1	

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Drug Name	**Reference**	**Drug Tier**	**Requirements/Limits**
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG		4	
larin 24 fe oral tablet 1-20 mg-mcg(24)		1	
larin fe 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
larin fe 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)	Balcoltra	4	
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY		3	
low-ogestrel oral tablet 0.3-30 mg-mcg		1	
lyleq oral tablet 0.35 mg	Camila	1	
lyza oral tablet 0.35 mg	Camila	1	
meleya oral tablet 0.35 mg	Camila	1	
microgestin 24 fe oral tablet 1-20 mg-mcg		1	
microgestin fe 1.5/30 oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
microgestin fe 1/20 oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
mili oral tablet 0.25-35 mg-mcg	Estarylla	1	
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/DAY		4	
mono-linyah oral tablet 0.25-35 mg-mcg	Estarylla	1	
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG		3	
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	Xulane	1	QL (3 per 28 days)
norethin ace-eth estrad-fe oral tablet 1.5-30 mg-mcg	Aurovela Fe 1.5/30	1	
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
norethindrone oral tablet 0.35 mg	Camila	1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	Tilia Fe	1	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	Estarylla	1	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	Tri-Lo-Estarylla	1	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	
norlyroc oral tablet 0.35 mg	Camila	1	
nortrel 1/35 (21) oral tablet 1-35 mg-mcg	Dasetta 1/35 (28)	1	
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	Dasetta 1/35 (28)	1	
nortrel 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	Dasetta 7/7/7	1	
nylia 1/35 oral tablet 1-35 mg-mcg	Dasetta 1/35 (28)	1	
nylia 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	Dasetta 7/7/7	1	
nymyo oral tablet 0.25-35 mg-mcg	Estarylla	1	
orquidea oral tablet 0.35 mg	Camila	1	
reclipsen oral tablet 0.15-30 mg-mcg	Apri	1	
sharobel oral tablet 0.35 mg	Camila	1	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG		4	
sprintec 28 oral tablet 0.25-35 mg-mcg	Estarylla	1	
tarina 24 fe oral tablet 1-20 mg-mcg(24)		1	
tarina fe 1/20 eq oral tablet 1-20 mg-mcg	Aurovela FE 1/20	1	
tilia fe oral tablet 1-20/1-30/1-35 mg-mcg	Tilia Fe	1	
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	
tri-legest fe oral tablet 1-20/1-30/1-35 mg-mcg	Tilia Fe	1	
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	Tri-Lo-Estarylla	1	
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	Tri-Lo-Estarylla	1	
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	Tri-Lo-Estarylla	1	
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	Tri-Lo-Estarylla	1	
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	
tri-sprintec oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	Tri-Lo-Estarylla	1	
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg	Tri-Estarylla	1	
turqoz oral tablet 0.3-30 mg-mcg		1	
vylibra oral tablet 0.25-35 mg-mcg	Estarylla	1	
xarah fe oral tablet 1-20/1-30/1-35 mg-mcg	Tilia Fe	1	
xulane transdermal patch weekly 150-35 mcg/24hr	Xulane	2	QL (3 per 28 days)
zafemy transdermal patch weekly 150-35 mcg/24hr	Xulane	2	QL (3 per 28 days)
DENTAL AND ORAL AGENTS			
Dental And Oral Agents			
cevimeline hcl oral capsule 30 mg	Evoxac	2	
chlorhexidine gluconate mouth/throat solution 0.12 %	Periogard	1	
periogard mouth/throat solution 0.12 %	Periogard	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	Salagen	2	

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Drug Name	Reference	Drug Tier	Requirements/Limits
sodium fluoride dental gel 1.1 %	PreviDent	1	
triamcinolone acetonide mouth/throat paste 0.1 %	Kourzeq	1	
DERMATOLOGICAL AGENTS			
Dermatological Agents, Other			
acitretin oral capsule 10 mg, 17.5 mg, 25 mg		2	
acyclovir external ointment 5 %	Zovirax	2	QL (30 per 30 days)
ammonium lactate external cream 12 %		1	
ammonium lactate external lotion 12 %	AL12	1	
calcipotriene external cream 0.005 %		4	QL (120 per 30 days)
calcipotriene external ointment 0.005 %	Calcitrene	4	QL (120 per 30 days)
calcipotriene external solution 0.005 %		2	QL (120 per 30 days)
fluorouracil external cream 5 %		2	
fluorouracil external solution 2 %, 5 %		2	
imiquimod external cream 5 %		1	QL (24 per 30 days)
KLISYRI (250 MG) EXTERNAL OINTMENT 1 %		5	ST; NM; QL (5 per 5 days); NEDS
methoxsalen rapid oral capsule 10 mg		5	NM; NEDS
PANRETIN EXTERNAL GEL 0.1 %		5	NM; QL (60 per 28 days); NEDS
podofilox external solution 0.5 %		2	
SANTYL EXTERNAL OINTMENT 250 UNIT/GM		4	QL (180 per 30 days)
VALCHLOR EXTERNAL GEL 0.016 %		5	PA NSO; NM; NEDS
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg		4	
Dermatological Antibacterials			
clindamycin phos-benzoyl perox external gel 1-5 %		2	

Drug Name	Reference	Drug Tier	Requirements/Limits
clindamycin phosphate external solution 1 %		1	QL (180 per 30 days)
clindamycin phosphate external swab 1 %	Clindacin ETZ	1	
erythromycin external solution 2 %		1	
gentamicin sulfate external cream 0.1 %		1	QL (90 per 30 days)
gentamicin sulfate external ointment 0.1 %		1	QL (120 per 30 days)
metronidazole external cream 0.75 %	MetroCream	2	
metronidazole external gel 0.75 %		2	
metronidazole external gel 1 %	Metrogel	2	
mupirocin external ointment 2 %		1	QL (220 per 30 days)
rosadan external cream 0.75 %	MetroCream	2	
selenium sulfide external lotion 2.5 %		1	
silver sulfadiazine external cream 1 %	SSD	1	
ssd external cream 1 %	SSD	4	
Dermatological Anti-Inflammatory Agents			
ala-cort external cream 1 %	Aveeno Anti-Itch Max St	1	
betamethasone dipropionate aug external cream 0.05 %		1	
betamethasone dipropionate aug external ointment 0.05 %	Diprolene	2	
betamethasone dipropionate external cream 0.05 %		2	
betamethasone dipropionate external lotion 0.05 %		1	
betamethasone dipropionate external ointment 0.05 %		2	
betamethasone valerate external cream 0.1 %		1	
BETAMETHASONE VALERATE EXTERNAL LOTION 0.1 %		1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
betamethasone valerate external ointment 0.1 %		1	
clobetasol propionate emulsion external foam 0.05 %	Tovet	2	
clobetasol propionate external cream 0.05 %		2	
clobetasol propionate external lotion 0.05 %	Clobex	2	
clobetasol propionate external ointment 0.05 %		2	
clobetasol propionate external shampoo 0.05 %	Clobex	2	
clobetasol propionate external solution 0.05 %		2	
EUCRISA EXTERNAL OINTMENT 2 %		3	
fluocinolone acetonide external cream 0.01 %		2	
fluocinonide external cream 0.05 %		2	
fluocinonide external ointment 0.05 %		2	
fluocinonide external solution 0.05 %		2	
halobetasol propionate external cream 0.05 %		2	
halobetasol propionate external ointment 0.05 %		2	
hydrocortisone (perianal) external cream 2.5 %	Procto-Med HC	1	
hydrocortisone cream 2.5 % external		1	
hydrocortisone external cream 1 %	Aveeno Anti-Itch Max St	1	
hydrocortisone external lotion 2.5 %		1	
hydrocortisone external ointment 1 %	Aquaphor Itch Relief Children	1	
hydrocortisone external ointment 2.5 %		1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
hydrocortisone valerate external cream 0.2 %		2	
mometasone furoate external cream 0.1 %		1	
mometasone furoate external ointment 0.1 %		1	
mometasone furoate external solution 0.1 %		1	
pimecrolimus external cream 1 %		2	QL (100 per 30 days)
procto-med hc external cream 2.5 %	Procto-Med HC	1	
proctosol hc external cream 2.5 %	Procto-Med HC	1	
proctozone-hc external cream 2.5 %	Procto-Med HC	1	
tacrolimus external ointment 0.03 %, 0.1 %		4	QL (100 per 30 days)
triamcinolone acetonide external cream 0.025 %, 0.1 %		1	
triamcinolone acetonide external cream 0.5 %	Triderm	1	
triamcinolone acetonide external lotion 0.025 %, 0.1 %		1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %		1	
Dermatological Retinoids			
adapalene external cream 0.1 %	Differin	2	
ALTRENO EXTERNAL LOTION 0.05 %		4	PA
tazarotene external cream 0.1 %	Tazorac	2	
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	Retin-A	2	PA
Scabicides And Pediculicides			
malathion external lotion 0.5 %	Ovide	2	
permethrin external cream 5 %		1	QL (60 per 30 days)
DEVICES			

Drug Name	Reference	Drug Tier	Requirements/Limits
Devices			
ABOUTTIME PEN NEEDLE 30G X 8 MM		1	PA; ST
ABOUTTIME PEN NEEDLE 31G X 5 MM		1	PA; ST
ABOUTTIME PEN NEEDLE 31G X 8 MM		1	PA; ST
ABOUTTIME PEN NEEDLE 32G X 4 MM		1	PA; ST
ADVOCATE INSULIN PEN NEEDLE 32G X 4 MM		1	PA; ST
ADVOCATE INSULIN PEN NEEDLES 29G X 12.7MM		1	PA; ST
ADVOCATE INSULIN PEN NEEDLES 31G X 5 MM		1	PA; ST
ADVOCATE INSULIN PEN NEEDLES 31G X 8 MM		1	PA; ST
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM		1	PA; ST
ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
ADVOCATE INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
ADVOCATE INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
ALCOHOL PREP PAD		1	PA; ST
ALCOHOL PREP PAD 70 %		1	PA; ST
ALCOHOL PREP PADS PAD 70 %		1	PA; ST
ALCOHOL SWABS PAD		1	PA; ST
ALCOHOL SWABS PAD 70 %		1	PA; ST
AQ INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
AQINJECT PEN NEEDLE 31G X 5 MM		1	PA; ST
AQINJECT PEN NEEDLE 32G X 4 MM		1	PA; ST
ASSURE ID DUO PRO PEN NEEDLES 31G X 5 MM		1	PA; ST
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML		1	PA; ST
ASSURE ID INSULIN SAFETY SYR 31G X 15/64" 0.5 ML		1	PA; ST
ASSURE ID INSULIN SAFETY SYR 31G X 15/64" 1 ML		1	PA; ST
ASSURE ID PRO PEN NEEDLES 30G X 5 MM		1	PA; ST
AUM ALCOHOL PREP PADS PAD 70 %		1	PA; ST
AUM INSULIN SAFETY PEN NEEDLE 31G X 4 MM		1	PA; ST
AUM INSULIN SAFETY PEN NEEDLE 31G X 5 MM		1	PA; ST
AUM MINI INSULIN PEN NEEDLE 32G X 4 MM		1	PA; ST
AUM MINI INSULIN PEN NEEDLE 32G X 5 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
AUM MINI INSULIN PEN NEEDLE 32G X 6 MM		1	PA; ST
AUM MINI INSULIN PEN NEEDLE 32G X 8 MM		1	PA; ST
AUM MINI INSULIN PEN NEEDLE 33G X 4 MM		1	PA; ST
AUM MINI INSULIN PEN NEEDLE 33G X 5 MM		1	PA; ST
AUM MINI INSULIN PEN NEEDLE 33G X 6 MM		1	PA; ST
AUM PEN NEEDLE 32G X 4 MM		1	PA; ST
AUM PEN NEEDLE 32G X 5 MM		1	PA; ST
AUM PEN NEEDLE 32G X 6 MM		1	PA; ST
AUM PEN NEEDLE 33G X 4 MM		1	PA; ST
AUM PEN NEEDLE 33G X 5 MM		1	PA; ST
AUM PEN NEEDLE 33G X 6 MM		1	PA; ST
AUM READYGARD DUO PEN NEEDLE 32G X 4 MM		1	PA; ST
AUM SAFETY PEN NEEDLE 31G X 4 MM		1	PA; ST
AURORA PEN NEEDLES 29G X 12MM		1	PA; ST
AURORA PEN NEEDLES 31G X 6 MM		1	PA; ST
AURORA PEN NEEDLES 31G X 8 MM		1	PA; ST
BD AUTOSHIELD DUO 30G X 5 MM		1	PA; ST
BD ECLIPSE SYRINGE 30G X 1/2" 1 ML		1	PA; ST
BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.3 ML		1	PA; ST
BD INSULIN SYR ULTRAFINE II 31G X 5/16" 0.5 ML		1	PA; ST
BD INSULIN SYR ULTRAFINE II 31G X 5/16" 1 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
BD INSULIN SYRINGE 27.5G X 5/8" 2 ML		1	PA; ST
BD INSULIN SYRINGE 27G X 1/2" 1 ML		1	PA; ST
BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (OTC)		1	PA; ST
BD INSULIN SYRINGE 29G X 1/2" 0.5 ML (RX)		1	PA; ST
BD INSULIN SYRINGE 29G X 1/2" 1 ML (OTC)		1	PA; ST
BD INSULIN SYRINGE 29G X 1/2" 1 ML (RX)		1	PA; ST
BD INSULIN SYRINGE HALF-UNIT 31G X 5/16" 0.3 ML		1	PA; ST
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML		1	PA; ST
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (OTC)		1	PA; ST
BD INSULIN SYRINGE MICROFINE 28G X 1/2" 1 ML (RX)		1	PA; ST
BD INSULIN SYRINGE U-100 1 ML		1	PA; ST
BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.3 ML		1	PA; ST
BD INSULIN SYRINGE ULTRAFINE 29G X 1/2" 0.5 ML		1	PA; ST
BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.3 ML		1	PA; ST
BD INSULIN SYRINGE ULTRAFINE 30G X 1/2" 0.5 ML		1	PA; ST
BD PEN NEEDLE MICRO ULTRAFINE 32G X 6 MM		1	PA; ST
BD PEN NEEDLE MINI U/F 31G X 5 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
BD PEN NEEDLE MINI ULTRAFINE 31G X 5 MM		1	PA; ST
BD PEN NEEDLE NANO 2ND GEN 32G X 4 MM		1	PA; ST
BD PEN NEEDLE NANO ULTRAFINE 32G X 4 MM		1	PA; ST
BD PEN NEEDLE ORIG ULTRAFINE 29G X 12.7MM		1	PA; ST
BD PEN NEEDLE SHORT ULTRAFINE 31G X 8 MM		1	PA; ST
BD SAFETYGLIDE INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
BD SAFETYGLIDE INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.3 ML		1	PA; ST
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 0.5 ML		1	PA; ST
BD SAFETYGLIDE INSULIN SYRINGE 31G X 15/64" 1 ML		1	PA; ST
BD SAFETYGLIDE INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
BD SAFETYGLIDE SYRINGE/NEEDLE 27G X 5/8" 1 ML		1	PA; ST
BD SWAB SINGLE USE REGULAR PAD		1	PA; ST
BD SWABS SINGLE USE BUTTERFLY PAD		1	PA; ST
BD VEO INSULIN SYR U/F 1/2UNIT 31G X 15/64" 0.3 ML		1	PA; ST
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.3 ML		1	PA; ST
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
BD VEO INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML		1	PA; ST
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.3 ML		1	PA; ST
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 0.5 ML		1	PA; ST
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML		1	PA; ST
CAREFINE PEN NEEDLES 29G X 12MM		1	PA; ST
CAREFINE PEN NEEDLES 30G X 8 MM		1	PA; ST
CAREFINE PEN NEEDLES 31G X 6 MM		1	PA; ST
CAREFINE PEN NEEDLES 31G X 8 MM		1	PA; ST
CAREFINE PEN NEEDLES 32G X 4 MM		1	PA; ST
CAREFINE PEN NEEDLES 32G X 5 MM		1	PA; ST
CAREFINE PEN NEEDLES 32G X 6 MM		1	PA; ST
CAREONE INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
CAREONE INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
CAREONE INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
CAREONE INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
CAREONE INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
CAREONE INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
CARETOUCH ALCOHOL PREP PAD 70 %		1	PA; ST
CARETOUCH INSULIN SYRINGE 28G X 5/16" 1 ML		1	PA; ST
CARETOUCH INSULIN SYRINGE 29G X 5/16" 1 ML		1	PA; ST
CARETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
CARETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
CARETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
CARETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
CARETOUCH PEN NEEDLES 29G X 12MM		1	PA; ST
CARETOUCH PEN NEEDLES 31G X 5 MM		1	PA; ST
CARETOUCH PEN NEEDLES 31G X 6 MM		1	PA; ST
CARETOUCH PEN NEEDLES 31G X 8 MM		1	PA; ST
CARETOUCH PEN NEEDLES 32G X 4 MM		1	PA; ST
CARETOUCH PEN NEEDLES 32G X 5 MM		1	PA; ST
CARETOUCH PEN NEEDLES 33G X 4 MM		1	PA; ST
CLEVER CHOICE COMFORT EZ 29G X 12MM		1	PA; ST
CLEVER CHOICE COMFORT EZ 33G X 4 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
CLICKFINE PEN NEEDLES 31G X 8 MM		1	PA; ST
CLICKFINE PEN NEEDLES 32G X 4 MM		1	PA; ST
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
COMFORT ASSIST INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 27G X 1/2" 1 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.3 ML		1	PA; ST

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COMFORT EZ INSULIN SYRINGE 31G X 15/64" 0.5 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 31G X 15/64" 1 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
COMFORT EZ INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
COMFORT EZ PEN NEEDLES 31G X 5 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 31G X 6 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 31G X 8 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 32G X 4 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 32G X 5 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 32G X 6 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 32G X 8 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 33G X 4 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 33G X 5 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 33G X 6 MM		1	PA; ST
COMFORT EZ PEN NEEDLES 33G X 8 MM		1	PA; ST
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
COMFORT EZ PRO PEN NEEDLES 31G X 4 MM		1	PA; ST
COMFORT EZ PRO PEN NEEDLES 31G X 5 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 31G X 4 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 31G X 5 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 31G X 6 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 31G X 8 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 32G X 4 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 32G X 6 MM		1	PA; ST
COMFORT TOUCH INSULIN PEN NEED 32G X 8 MM		1	PA; ST
CURITY ALCOHOL PREPS PAD 70 %		1	PA; ST
CURITY ALL PURPOSE SPONGES PAD 2"X2"		1	PA; ST
CURITY GAUZE PAD 2"X2"		1	PA; ST
CURITY GAUZE SPONGE PAD 2"X2"		1	PA; ST
CURITY SPONGES PAD 2"X2"		1	PA; ST
CVS ALCOHOL PREP PADS PAD 70 %		1	PA; ST
CVS GAUZE PAD 2"X2"		1	PA; ST
CVS GAUZE STERILE PAD 2"X2"		1	PA; ST
cvs isopropyl alcohol wipes external 70 %		1	PA; ST
CVS PREP PAD 70 %		1	PA; ST
DERMACEA GAUZE SPONGE PAD 2"X2"		1	PA; ST

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DERMACEA IV DRAIN SPONGES PAD 2"X2"		1	PA; ST
DERMACEA NON-WOVEN SPONGES PAD 2"X2"		1	PA; ST
DERMACEA TYPE VII GAUZE PAD 2"X2"		1	PA; ST
DIATHRIVE PEN NEEDLE 31G X 5 MM		1	PA; ST
DIATHRIVE PEN NEEDLE 31G X 6 MM		1	PA; ST
DIATHRIVE PEN NEEDLE 31G X 8 MM		1	PA; ST
DIATHRIVE PEN NEEDLE 32G X 4 MM		1	PA; ST
DROPLET INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
DROPLET INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
DROPLET INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 15/64" 0.3 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 15/64" 0.5 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 15/64" 1 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST

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DROPLET INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
DROPLET INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
DROPLET INSULIN SYRINGE 31G X 15/64" 0.3 ML		1	PA; ST
DROPLET INSULIN SYRINGE 31G X 15/64" 0.5 ML		1	PA; ST
DROPLET INSULIN SYRINGE 31G X 15/64" 1 ML		1	PA; ST
DROPLET INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
DROPLET INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
DROPLET INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
DROPLET MICRON 34G X 3.5 MM		1	PA; ST
DROPLET PEN NEEDLES 29G X 10MM		1	PA; ST
DROPLET PEN NEEDLES 29G X 12MM		1	PA; ST
DROPLET PEN NEEDLES 30G X 8 MM		1	PA; ST
DROPLET PEN NEEDLES 31G X 5 MM		1	PA; ST
DROPLET PEN NEEDLES 31G X 6 MM		1	PA; ST
DROPLET PEN NEEDLES 31G X 8 MM		1	PA; ST
DROPLET PEN NEEDLES 32G X 4 MM		1	PA; ST
DROPLET PEN NEEDLES 32G X 5 MM		1	PA; ST
DROPLET PEN NEEDLES 32G X 6 MM		1	PA; ST
DROPLET PEN NEEDLES 32G X 8 MM		1	PA; ST
DROPSAFE ALCOHOL PREP PAD 70 %		1	PA; ST
DROPSAFE AUTOPROTECT DUO 31G X 4 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
DROPSAFE AUTOPROTECT DUO 31G X 8 MM		1	PA; ST
DROPSAFE SAFETY PEN NEEDLES 31G X 5 MM		1	PA; ST
DROPSAFE SAFETY PEN NEEDLES 31G X 6 MM		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 29G X 1/2" 1 ML		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.3 ML		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 0.5 ML		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 15/64" 1 ML		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.3 ML		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 0.5 ML		1	PA; ST
DROPSAFE SAFETY SYRINGE/NEEDLE 31G X 5/16" 1 ML		1	PA; ST
DRUG MART ULTRA COMFORT SYR 29G X 1/2" 0.3 ML		1	PA; ST
DRUG MART ULTRA COMFORT SYR 29G X 1/2" 1 ML		1	PA; ST
DRUG MART ULTRA COMFORT SYR 30G X 5/16" 0.5 ML		1	PA; ST
DRUG MART ULTRA COMFORT SYR 30G X 5/16" 1 ML		1	PA; ST
DRUG MART UNIFINE PENTIPS 31G X 5 MM		1	PA; ST
EASY COMFORT ALCOHOL PADS PAD		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
EASY COMFORT INSULIN SYRINGE 29G X 5/16" 0.5 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 29G X 5/16" 1 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 31G X 1/2" 0.3 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 32G X 5/16" 0.5 ML		1	PA; ST
EASY COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML		1	PA; ST
EASY COMFORT PEN NEEDLES 29G X 4MM		1	PA; ST
EASY COMFORT PEN NEEDLES 29G X 5MM		1	PA; ST
EASY COMFORT PEN NEEDLES 31G X 5 MM		1	PA; ST
EASY COMFORT PEN NEEDLES 31G X 6 MM		1	PA; ST
EASY COMFORT PEN NEEDLES 31G X 8 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
EASY COMFORT PEN NEEDLES 32G X 4 MM		1	PA; ST
EASY COMFORT PEN NEEDLES 33G X 4 MM		1	PA; ST
EASY COMFORT PEN NEEDLES 33G X 5 MM		1	PA; ST
EASY COMFORT PEN NEEDLES 33G X 6 MM		1	PA; ST
EASY GLIDE PEN NEEDLES 33G X 4 MM		1	PA; ST
EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 %		1	PA; ST
EASY TOUCH FLIPLOCK INSULIN SY 29G X 1/2" 1 ML		1	PA; ST
EASY TOUCH FLIPLOCK INSULIN SY 30G X 1/2" 1 ML		1	PA; ST
EASY TOUCH FLIPLOCK INSULIN SY 30G X 5/16" 1 ML		1	PA; ST
EASY TOUCH FLIPLOCK INSULIN SY 31G X 5/16" 1 ML		1	PA; ST
EASY TOUCH FLIPLOCK SAFETY SYR 27G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN BARRELS U-100 1 ML		1	PA; ST
EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SAFETY SYR 29G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN SAFETY SYR 30G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN SAFETY SYR 30G X 5/16" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 0.5 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
EASY TOUCH INSULIN SYRINGE 27G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
EASY TOUCH INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
EASY TOUCH PEN NEEDLES 29G X 12MM		1	PA; ST
EASY TOUCH PEN NEEDLES 30G X 5 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
EASY TOUCH PEN NEEDLES 30G X 6 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 30G X 8 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 31G X 5 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 31G X 6 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 31G X 8 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 32G X 4 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 32G X 5 MM		1	PA; ST
EASY TOUCH PEN NEEDLES 32G X 6 MM		1	PA; ST
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM		1	PA; ST
EASY TOUCH SAFETY PEN NEEDLES 29G X 8MM		1	PA; ST
EASY TOUCH SAFETY PEN NEEDLES 30G X 8 MM		1	PA; ST
EASY TOUCH SHEATHLOCK SYRINGE 29G X 1/2" 1 ML		1	PA; ST
EASY TOUCH SHEATHLOCK SYRINGE 30G X 1/2" 1 ML		1	PA; ST
EASY TOUCH SHEATHLOCK SYRINGE 30G X 5/16" 1 ML		1	PA; ST
EASY TOUCH SHEATHLOCK SYRINGE 31G X 5/16" 1 ML		1	PA; ST
EMBECTA AUTOSHIELD DUO 30G X 5 MM		1	PA; ST
EMBECTA INS SYR U/F 1/2 UNIT 31G X 15/64" 0.3 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
EMBECTA INS SYR U/F 1/2 UNIT 31G X 5/16" 0.3 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.3 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 0.5 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 30G X 1/2" 1 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 0.5 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 31G X 15/64" 1 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 0.5 ML		1	PA; ST
EMBECTA INSULIN SYR ULTRAFINE 31G X 5/16" 1 ML		1	PA; ST
EMBECTA INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
EMBECTA INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)		1	PA; ST
EMBECTA INSULIN SYRINGE U-100 27G X 5/8" 1 ML		1	PA; ST
EMBECTA INSULIN SYRINGE U-500 31G X 6MM 0.5 ML		1	PA; ST
EMBECTA PEN NEEDLE NANO 2 GEN 32G X 4 MM		1	PA; ST
EMBECTA PEN NEEDLE NANO 32G X 4 MM		1	PA; ST
EMBECTA PEN NEEDLE ULTRAFINE 29G X 12.7MM		1	PA; ST
EMBECTA PEN NEEDLE ULTRAFINE 31G X 5 MM		1	PA; ST
EMBECTA PEN NEEDLE ULTRAFINE 31G X 8 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
EMBECTA PEN NEEDLE ULTRAFINE 32G X 6 MM		1	PA; ST
EMBRACE PEN NEEDLES 29G X 12MM		1	PA; ST
EMBRACE PEN NEEDLES 30G X 5 MM		1	PA; ST
EMBRACE PEN NEEDLES 30G X 8 MM		1	PA; ST
EMBRACE PEN NEEDLES 31G X 5 MM		1	PA; ST
EMBRACE PEN NEEDLES 31G X 6 MM		1	PA; ST
EMBRACE PEN NEEDLES 31G X 8 MM		1	PA; ST
EMBRACE PEN NEEDLES 32G X 4 MM		1	PA; ST
EQL ALCOHOL SWABS PAD 70 %		1	PA; ST
EQL GAUZE PAD 2"X2"		1	PA; ST
EQL INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
EXEL COMFORT POINT INSULIN SYR 29G X 1/2" 0.3 ML		1	PA; ST
EXEL COMFORT POINT INSULIN SYR 30G X 5/16" 0.3 ML		1	PA; ST
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM		1	PA; ST
FIFTY50 PEN NEEDLES 31G X 5 MM		1	PA; ST
FIFTY50 PEN NEEDLES 31G X 8 MM		1	PA; ST
FIFTY50 PEN NEEDLES 32G X 4 MM		1	PA; ST
FIFTY50 PEN NEEDLES 32G X 6 MM		1	PA; ST
GAUZE PADS PAD 2"X2"		1	PA; ST
GAUZE TYPE VII MEDI-PAK PAD 2"X2"		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
GLOBAL ALCOHOL PREP EASE PAD 70 %		1	PA; ST
GLOBAL EASE INJECT PEN NEEDLES 29G X 12MM		1	PA; ST
GLOBAL EASE INJECT PEN NEEDLES 31G X 5 MM		1	PA; ST
GLOBAL EASE INJECT PEN NEEDLES 31G X 8 MM		1	PA; ST
GLOBAL EASE INJECT PEN NEEDLES 32G X 4 MM		1	PA; ST
GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.3 ML		1	PA; ST
GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 0.5 ML		1	PA; ST
GLOBAL EASY GLIDE INSULIN SYR 31G X 15/64" 1 ML		1	PA; ST
GLOBAL INJECT EASE INSULIN SYR 30G X 1/2" 1 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
GLUCOPRO INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
GLUCOPRO INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
GNP ALCOHOL SWABS PAD		1	PA; ST
GNP CLICKFINE PEN NEEDLES 31G X 6 MM		1	PA; ST
GNP CLICKFINE PEN NEEDLES 31G X 8 MM		1	PA; ST
GNP INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
GNP INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
GNP INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
GNP INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 0.5 ML		1	PA; ST
GNP INSULIN SYRINGES 29GX1/2" 29G X 1/2" 1 ML		1	PA; ST
GNP INSULIN SYRINGES 30G X 5/16" 1 ML		1	PA; ST
GNP INSULIN SYRINGES 30GX5/16" 30G X 5/16" 0.3 ML		1	PA; ST
GNP INSULIN SYRINGES 31GX5/16" 31G X 5/16" 0.3 ML		1	PA; ST
GNP PEN NEEDLES 31G X 5 MM		1	PA; ST
GNP PEN NEEDLES 32G X 4 MM		1	PA; ST
GNP PEN NEEDLES 32G X 6 MM		1	PA; ST
GNP STERILE GAUZE PAD 2"X2"		1	PA; ST
GNP ULTRA COM INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
GNP ULTRA COM INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
GOODSENSE ALCOHOL SWABS PAD 70 %		1	PA; ST
GOODSENSE CLICKFINE PEN NEEDLE 31G X 5 MM		1	PA; ST
GOODSENSE PEN NEEDLE PENFINE 31G X 8 MM		1	PA; ST
HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.3 ML		1	PA; ST
HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 0.5 ML		1	PA; ST
HEALTHWISE INSULIN SYR/NEEDLE 30G X 5/16" 1 ML		1	PA; ST
HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.3 ML		1	PA; ST
HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 0.5 ML		1	PA; ST
HEALTHWISE INSULIN SYR/NEEDLE 31G X 5/16" 1 ML		1	PA; ST
HEALTHWISE MICRON PEN NEEDLES 32G X 4 MM		1	PA; ST
HEALTHWISE SHORT PEN NEEDLES 31G X 5 MM		1	PA; ST
HEALTHWISE SHORT PEN NEEDLES 31G X 8 MM		1	PA; ST
HEALTHY ACCENTS UNIFINE PENTIP 29G X 12MM		1	PA; ST
HEALTHY ACCENTS UNIFINE PENTIP 31G X 5 MM		1	PA; ST
HEALTHY ACCENTS UNIFINE PENTIP 31G X 6 MM		1	PA; ST
HEALTHY ACCENTS UNIFINE PENTIP 31G X 8 MM		1	PA; ST
HEALTHY ACCENTS UNIFINE PENTIP 32G X 4 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
H-E-B INCONTROL ALCOHOL PAD		1	PA; ST
H-E-B INCONTROL PEN NEEDLES 29G X 12MM		1	PA; ST
H-E-B INCONTROL PEN NEEDLES 31G X 5 MM		1	PA; ST
H-E-B INCONTROL PEN NEEDLES 31G X 6 MM		1	PA; ST
H-E-B INCONTROL PEN NEEDLES 31G X 8 MM		1	PA; ST
H-E-B INCONTROL PEN NEEDLES 32G X 4 MM		1	PA; ST
HM STERILE ALCOHOL PREP PAD		1	PA; ST
HM STERILE PADS PAD 2"X2"		1	PA; ST
HM ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
HM ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
HM ULTICARE SHORT PEN NEEDLES 31G X 8 MM		1	PA; ST
INCONTROL ULTICARE PEN NEEDLES 31G X 6 MM		1	PA; ST
INCONTROL ULTICARE PEN NEEDLES 31G X 8 MM		1	PA; ST
INCONTROL ULTICARE PEN NEEDLES 32G X 4 MM		1	PA; ST
INPEN 100-BLUE-LILLY-HUMALOG DEVICE		3	
INPEN 100-BLUE-NOVOLOG-FIASP DEVICE		3	
INPEN 100-GREY-LILLY-HUMALOG DEVICE		3	
INPEN 100-GREY-NOVOLOG-FIASP DEVICE		3	

Drug Name	Reference	Drug Tier	Requirements/Limits
INPEN 100-PINK-LILLY-HUMALOG DEVICE		3	
INPEN 100-PINK-NOVOLOG-FIASP DEVICE		3	
INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
INSULIN SYRINGE/NEEDLE 27G X 1/2" 0.5 ML		1	PA; ST
INSULIN SYRINGE/NEEDLE 28G X 1/2" 0.5 ML		1	PA; ST
INSULIN SYRINGE/NEEDLE 28G X 1/2" 1 ML		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 0.5 ML (RX)		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 27G X 1/2" 1 ML (RX)		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 0.5 ML (RX)		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 28G X 1/2" 1 ML (RX)		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 30G X 5/16" 1 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.3 ML		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 0.5 ML		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 31G X 1/4" 1 ML		1	PA; ST
INSULIN SYRINGE-NEEDLE U-100 31G X 5/16" 0.5 ML (OTC)		1	PA; ST
INSUPEN PEN NEEDLES 29G X 12MM		1	PA; ST
INSUPEN PEN NEEDLES 31G X 5 MM		1	PA; ST
INSUPEN PEN NEEDLES 31G X 8 MM		1	PA; ST
INSUPEN PEN NEEDLES 32G X 4 MM		1	PA; ST
INSUPEN PEN NEEDLES 33G X 4 MM		1	PA; ST
INSUPEN SENSITIVE 32G X 6 MM		1	PA; ST
INSUPEN SENSITIVE 32G X 8 MM		1	PA; ST
INSUPEN ULTRAFIN 30G X 8 MM		1	PA; ST
INSUPEN ULTRAFIN 31G X 6 MM		1	PA; ST
INSUPEN ULTRAFIN 31G X 8 MM		1	PA; ST
INSUPEN32G EXTR3ME 32G X 6 MM		1	PA; ST
J & J GAUZE PAD 2"X2"		1	PA; ST
KENDALL HYDROPHILIC FOAM DRESS PAD 2"X2"		1	PA; ST
KENDALL HYDROPHILIC FOAM PLUS PAD 2"X2"		1	PA; ST
KINRAY INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
KMART VALU INSULIN SYRINGE 29G U-100 1 ML		1	PA; ST
KMART VALU INSULIN SYRINGE 30G U-100 0.3 ML		1	PA; ST
KMART VALU INSULIN SYRINGE 30G U-100 1 ML		1	PA; ST

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KROGER INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
KROGER PEN NEEDLES 29G X 12MM		1	PA; ST
KROGER PEN NEEDLES 31G X 6 MM		1	PA; ST
LEADER INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
LEADER INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
LEADER UNIFINE PENTIPS 31G X 5 MM		1	PA; ST
LEADER UNIFINE PENTIPS 32G X 4 MM		1	PA; ST
LEADER UNIFINE PENTIPS PLUS 31G X 5 MM		1	PA; ST
LEADER UNIFINE PENTIPS PLUS 31G X 8 MM		1	PA; ST
LITETOUCH INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
LITETOUCH INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
LITETOUCH INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
LITETOUCH PEN NEEDLES 29G X 12.7MM		1	PA; ST
LITETOUCH PEN NEEDLES 31G X 5 MM		1	PA; ST
LITETOUCH PEN NEEDLES 31G X 6 MM		1	PA; ST
LITETOUCH PEN NEEDLES 31G X 8 MM		1	PA; ST
LITETOUCH PEN NEEDLES 32G X 4 MM		1	PA; ST
MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.3 ML		1	PA; ST
MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 0.5 ML		1	PA; ST
MAGELLAN INSULIN SAFETY SYR 29G X 1/2" 1 ML		1	PA; ST
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.3 ML		1	PA; ST
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 0.5 ML		1	PA; ST
MAGELLAN INSULIN SAFETY SYR 30G X 5/16" 1 ML		1	PA; ST
MAXICOMFORT II PEN NEEDLE 31G X 6 MM		1	PA; ST
MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
MAXI-COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 8MM		1	PA; ST
MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 0.5 ML		1	PA; ST
MAXICOMFORT SYR 27G X 1/2" 27G X 1/2" 1 ML		1	PA; ST
MEDIC INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
MEDIC INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
MEDICINE SHOPPE PEN NEEDLES 29G X 12MM		1	PA; ST
MEDICINE SHOPPE PEN NEEDLES 31G X 8 MM		1	PA; ST
MEDPURA ALCOHOL PADS 70 % EXTERNAL		1	PA; ST
MEIJER ALCOHOL SWABS PAD 70 %		1	PA; ST
MEIJER PEN NEEDLES 29G X 12MM		1	PA; ST
MEIJER PEN NEEDLES 31G X 6 MM		1	PA; ST
MEIJER PEN NEEDLES 31G X 8 MM		1	PA; ST
MICRODOT PEN NEEDLE 31G X 6 MM		1	PA; ST
MICRODOT PEN NEEDLE 32G X 4 MM		1	PA; ST
MICRODOT PEN NEEDLE 33G X 4 MM		1	PA; ST
MIRASORB SPONGES 2"X2"		1	PA; ST
MM PEN NEEDLES 31G X 6 MM		1	PA; ST
MM PEN NEEDLES 32G X 4 MM		1	PA; ST
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML		1	PA; ST
MONOJECT INSULIN SYRINGE 27G X 1/2" 1 ML (OTC)		1	PA; ST

You can find information on what the symbols and abbreviations on this table mean by going to page VII of the introduction. Formulary ID: 26380

Drug Name	Reference	Drug Tier	Requirements/Limits
MONOJECT INSULIN SYRINGE 28G X 1/2" 0.5 ML (RX)		1	PA; ST
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (OTC)		1	PA; ST
MONOJECT INSULIN SYRINGE 28G X 1/2" 1 ML (RX)		1	PA; ST
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
MONOJECT INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
MONOJECT INSULIN SYRINGE 29G X 1/2" 1 ML (RX)		1	PA; ST
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
MONOJECT INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)		1	PA; ST
MONOJECT INSULIN SYRINGE 30G X 5/16" 1 ML (RX)		1	PA; ST
MONOJECT INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
MONOJECT INSULIN SYRINGE U-100 1 ML		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (OTC)		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 0.5 ML (RX)		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 28G X 1/2" 1 ML (OTC)		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 29G X 1/2" 1 ML		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (OTC)		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.3 ML (RX)		1	PA; ST
MONOJECT ULTRA COMFORT SYRINGE 30G X 5/16" 0.5 ML (RX)		1	PA; ST
MS INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
MS INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
NOVOFINE AUTOCOVER 30G X 8 MM		1	PA; ST
NOVOFINE PEN NEEDLE 32G X 6 MM		1	PA; ST
NOVOFINE PLUS PEN NEEDLE 32G X 4 MM		1	PA; ST
NOVOTWIST PEN NEEDLE 32G X 5 MM		1	PA; ST
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT		3	QL (1 per 365 days)
OMNIPOD 5 DEXG7G6 PODS GEN 5		3	QL (10 per 30 days)
OMNIPOD 5 G7 INTRO (GEN 5) KIT		3	QL (1 per 365 days)
OMNIPOD 5 G7 PODS (GEN 5)		3	QL (10 per 30 days)
OMNIPOD 5 LIBRE2 G6 INTRO GEN5 KIT		3	QL (1 per 365 days)
OMNIPOD 5 LIBRE2 PLUS G6 PODS		3	QL (10 per 30 days)
OMNIPOD CLASSIC PDM (GEN 3) KIT		3	QL (1 per 365 days)
OMNIPOD CLASSIC PODS (GEN 3)		3	QL (10 per 30 days)
OMNIPOD DASH INTRO (GEN 4) KIT		3	QL (1 per 365 days)
OMNIPOD DASH PDM (GEN 4) KIT		3	QL (1 per 365 days)
OMNIPOD DASH PODS (GEN 4)		3	QL (10 per 30 days)
PC UNIFINE PENTIPS 31G X 5 MM		1	PA; ST
PC UNIFINE PENTIPS 31G X 6 MM		1	PA; ST
PC UNIFINE PENTIPS 31G X 8 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
PEN NEEDLE/5-BEVEL TIP 31G X 8 MM		1	PA; ST
PEN NEEDLES 30G X 5 MM (OTC)		1	PA; ST
PEN NEEDLES 30G X 8 MM		1	PA; ST
PEN NEEDLES 32G X 5 MM		1	PA; ST
PENTIPS 29G X 12MM (RX)		1	PA; ST
PENTIPS 31G X 5 MM (RX)		1	PA; ST
PENTIPS 31G X 8 MM (RX)		1	PA; ST
PENTIPS 32G X 4 MM (RX)		1	PA; ST
PENTIPS GENERIC PEN NEEDLES 29G X 12MM		1	PA; ST
PENTIPS GENERIC PEN NEEDLES 31G X 6 MM		1	PA; ST
PENTIPS GENERIC PEN NEEDLES 32G X 6 MM		1	PA; ST
PHARMACIST CHOICE ALCOHOL PAD		1	PA; ST
PIP PEN NEEDLES 31G X 5MM 31G X 5 MM		1	PA; ST
PIP PEN NEEDLES 32G X 4MM 32G X 4 MM		1	PA; ST
PRECISION SURE-DOSE SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
PREFERRED PLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
PREFERRED PLUS INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
PREFERRED PLUS INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
PREFERRED PLUS UNIFINE PENTIPS 29G X 12MM		1	PA; ST

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Effective Date: 06/01/2026
Last Updated: 05/21/2026

Drug Name	Reference	Drug Tier	Requirements/Limits
PREVENT DROPSAFE PEN NEEDLES 31G X 6 MM		1	PA; ST
PREVENT DROPSAFE PEN NEEDLES 31G X 8 MM		1	PA; ST
PREVENT SAFETY PEN NEEDLES 31G X 6 MM		1	PA; ST
PREVENT SAFETY PEN NEEDLES 31G X 8 MM		1	PA; ST
PRO COMFORT ALCOHOL PAD 70 %		1	PA; ST
PRO COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
PRO COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
PRO COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
PRO COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
PRO COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
PRO COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
PRO COMFORT PEN NEEDLES 32G X 4 MM		1	PA; ST
PRO COMFORT PEN NEEDLES 32G X 5 MM		1	PA; ST
PRO COMFORT PEN NEEDLES 32G X 6 MM		1	PA; ST
PRO COMFORT PEN NEEDLES 32G X 8 MM		1	PA; ST
PRODIGY INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
PRODIGY INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
PRODIGY INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
PURE COMFORT ALCOHOL PREP PAD		1	PA; ST
PURE COMFORT PEN NEEDLE 32G X 4 MM		1	PA; ST
PURE COMFORT PEN NEEDLE 32G X 5 MM		1	PA; ST
PURE COMFORT PEN NEEDLE 32G X 6 MM		1	PA; ST
PURE COMFORT PEN NEEDLE 32G X 8 MM		1	PA; ST
PURE COMFORT SAFETY PEN NEEDLE 31G X 5 MM		1	PA; ST
PURE COMFORT SAFETY PEN NEEDLE 31G X 6 MM		1	PA; ST
PURE COMFORT SAFETY PEN NEEDLE 32G X 4 MM		1	PA; ST
PX SHORTLENGTH PEN NEEDLES 31G X 8 MM		1	PA; ST
QC ALCOHOL EXTERNAL 70 %		1	PA; ST
QC ALCOHOL SWABS PAD 70 %		1	PA; ST
QC BORDER ISLAND GAUZE PAD 2"X2"		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 29G X 12.7MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 31G X 4 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 31G X 5 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 31G X 6 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 31G X 8 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
QUICK TOUCH INSULIN PEN NEEDLE 32G X 4 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 32G X 5 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 32G X 6 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 32G X 8 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 33G X 4 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 33G X 5 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 33G X 6 MM		1	PA; ST
QUICK TOUCH INSULIN PEN NEEDLE 33G X 8 MM		1	PA; ST
RA ALCOHOL SWABS PAD 70 %		1	PA; ST
RA INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
RA INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
RA INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
RA INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
ra isopropyl alcohol wipes external 70 %		1	PA; ST
RA PEN NEEDLES 31G X 5 MM		1	PA; ST
RA PEN NEEDLES 31G X 8 MM		1	PA; ST
RA STERILE PAD 2"X2"		1	PA; ST
RAYA SURE PEN NEEDLE 29G X 12MM		1	PA; ST
RAYA SURE PEN NEEDLE 31G X 4 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
RAYA SURE PEN NEEDLE 31G X 5 MM		1	PA; ST
RAYA SURE PEN NEEDLE 31G X 6 MM		1	PA; ST
RAYA SURE PEN NEEDLE 31G X 8 MM		1	PA; ST
REALITY INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
REALITY INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
REALITY INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
REALITY INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
REALITY SWABS PAD		1	PA; ST
RELION ALCOHOL SWABS PAD		1	PA; ST
RELION ALCOHOL SWABS PAD 70 %		1	PA; ST
RELI-ON INSULIN SYRINGE 29G 0.3 ML		1	PA; ST
RELION INSULIN SYRINGE 31G X 15/64" 0.3 ML		1	PA; ST
RELION INSULIN SYRINGE 31G X 15/64" 0.5 ML		1	PA; ST
RELION INSULIN SYRINGE 31G X 15/64" 1 ML		1	PA; ST
RELION MINI PEN NEEDLES 31G X 6 MM		1	PA; ST
RELION PEN NEEDLES 29G X 12MM		1	PA; ST
RELION PEN NEEDLES 31G X 6 MM		1	PA; ST
RELION PEN NEEDLES 31G X 8 MM		1	PA; ST
RESTORE CONTACT LAYER PAD 2"X2"		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
SAFETY INSULIN SYRINGES 29G X 1/2" 0.5 ML		1	PA; ST
SAFETY INSULIN SYRINGES 29G X 1/2" 1 ML		1	PA; ST
SAFETY INSULIN SYRINGES 30G X 1/2" 1 ML		1	PA; ST
SAFETY INSULIN SYRINGES 30G X 5/16" 0.5 ML		1	PA; ST
SAFETY PEN NEEDLES 30G X 5 MM		1	PA; ST
SAFETY PEN NEEDLES 30G X 8 MM		1	PA; ST
SB ALCOHOL PREP PAD 70 %		1	PA; ST
SB INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
SB INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
SB INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
SB INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
SB INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
SECURESAFE INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
SECURESAFE INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM		1	PA; ST
SM ALCOHOL PREP PAD		1	PA; ST
SM ALCOHOL PREP PAD 6-70 % EXTERNAL		1	PA; ST
SM ALCOHOL PREP PAD 70 %		1	PA; ST
SM GAUZE PAD 2"X2"		1	PA; ST
STERILE GAUZE PAD 2"X2"		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
SURE COMFORT ALCOHOL PREP PAD 70 %		1	PA; ST
SURE COMFORT INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.3 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 31G X 1/4" 0.5 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 31G X 1/4" 1 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
SURE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
SURE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
SURE COMFORT PEN NEEDLES 29G X 12.7MM		1	PA; ST
SURE COMFORT PEN NEEDLES 30G X 8 MM		1	PA; ST
SURE COMFORT PEN NEEDLES 31G X 5 MM		1	PA; ST
SURE COMFORT PEN NEEDLES 31G X 6 MM		1	PA; ST
SURE COMFORT PEN NEEDLES 31G X 8 MM		1	PA; ST
SURE COMFORT PEN NEEDLES 32G X 4 MM (OTC)		1	PA; ST
SURE COMFORT PEN NEEDLES 32G X 4 MM (RX)		1	PA; ST
SURE COMFORT PEN NEEDLES 32G X 6 MM		1	PA; ST
SURGICAL GAUZE SPONGE PAD 2"X2"		1	PA; ST
TECHLITE INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
THERAGAUZE PAD 2"X2"		1	PA; ST
TODAYS HEALTH PEN NEEDLES 29G X 12MM		1	PA; ST
TODAYS HEALTH SHORT PEN NEEDLE 31G X 8 MM		1	PA; ST
TOPCARE CLICKFINE PEN NEEDLES 31G X 6 MM		1	PA; ST
TOPCARE CLICKFINE PEN NEEDLES 31G X 8 MM		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.3 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 0.5 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 29G X 1/2" 1 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.3 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 0.5 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 30G X 5/16" 1 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.3 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 0.5 ML		1	PA; ST
TOPCARE ULTRA COMFORT INS SYR 31G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT ALCOHOL PREP PADS PAD 70 %		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT INSULIN SYRINGE 32G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT PEN NEEDLES 31G X 5 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
TRUE COMFORT PEN NEEDLES 31G X 6 MM		1	PA; ST
TRUE COMFORT PEN NEEDLES 32G X 4 MM		1	PA; ST
TRUE COMFORT PRO ALCOHOL PREP PAD 70 %		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 0.5 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 30G X 1/2" 1 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 0.5 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 30G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 0.5 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 31G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 0.5 ML		1	PA; ST
TRUE COMFORT PRO INSULIN SYR 32G X 5/16" 1 ML		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 31G X 5 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 31G X 6 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 31G X 8 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 32G X 4 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 32G X 5 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 32G X 6 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
TRUE COMFORT PRO PEN NEEDLES 33G X 4 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 33G X 5 MM		1	PA; ST
TRUE COMFORT PRO PEN NEEDLES 33G X 6 MM		1	PA; ST
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM		1	PA; ST
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 5 MM		1	PA; ST
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 6 MM		1	PA; ST
TRUEPLUS 5-BEVEL PEN NEEDLES 31G X 8 MM		1	PA; ST
TRUEPLUS 5-BEVEL PEN NEEDLES 32G X 4 MM		1	PA; ST
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
TRUEPLUS INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
TRUEPLUS PEN NEEDLES 29G X 12MM		1	PA; ST
TRUEPLUS PEN NEEDLES 31G X 5 MM		1	PA; ST
TRUEPLUS PEN NEEDLES 31G X 6 MM		1	PA; ST
TRUEPLUS PEN NEEDLES 31G X 8 MM		1	PA; ST
TRUEPLUS PEN NEEDLES 32G X 4 MM		1	PA; ST
ULTICARE INSULIN SAFETY SYR 29G X 1/2" 0.5 ML		1	PA; ST
ULTICARE INSULIN SAFETY SYR 29G X 1/2" 1 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 28G X 1/2" 0.5 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST

You can find information on what the symbols and abbreviations on this table mean by going to page VII of the introduction. Formulary ID: 26380

Drug Name	Reference	Drug Tier	Requirements/Limits
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (OTC)		1	PA; ST
ULTICARE INSULIN SYRINGE 30G X 5/16" 0.5 ML (RX)		1	PA; ST
ULTICARE INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.5 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 1/4" 1 ML		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (OTC)		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.3 ML (RX)		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (OTC)		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 5/16" 0.5 ML (RX)		1	PA; ST
ULTICARE INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
ULTICARE MICRO PEN NEEDLES 32G X 4 MM		1	PA; ST
ULTICARE MINI PEN NEEDLES 30G X 5 MM		1	PA; ST
ULTICARE MINI PEN NEEDLES 31G X 6 MM		1	PA; ST
ULTICARE MINI PEN NEEDLES 32G X 6 MM		1	PA; ST
ULTICARE PEN NEEDLES 29G X 12.7MM (OTC)		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
ULTICARE PEN NEEDLES 29G X 12.7MM (RX)		1	PA; ST
ULTICARE PEN NEEDLES 31G X 5 MM		1	PA; ST
ULTICARE SHORT PEN NEEDLES 30G X 8 MM		1	PA; ST
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (OTC)		1	PA; ST
ULTICARE SHORT PEN NEEDLES 31G X 8 MM (RX)		1	PA; ST
ULTIGUARD SAFEPACK PEN NEEDLE 29G X 12.7MM		1	PA; ST
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 5 MM		1	PA; ST
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 6 MM		1	PA; ST
ULTIGUARD SAFEPACK PEN NEEDLE 31G X 8 MM		1	PA; ST
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 4 MM		1	PA; ST
ULTIGUARD SAFEPACK PEN NEEDLE 32G X 6 MM		1	PA; ST
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.3 ML		1	PA; ST
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 0.5 ML		1	PA; ST
ULTIGUARD SAFEPACK SYR/NEEDLE 30G X 1/2" 1 ML		1	PA; ST
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.3 ML		1	PA; ST
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 0.5 ML		1	PA; ST
ULTIGUARD SAFEPACK SYR/NEEDLE 31G X 5/16" 1 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
ULTILET ALCOHOL SWABS PAD		1	PA; ST
ULTILET PEN NEEDLE 29G X 12.7MM		1	PA; ST
ULTILET PEN NEEDLE 31G X 5 MM		1	PA; ST
ULTILET PEN NEEDLE 31G X 8 MM		1	PA; ST
ULTILET PEN NEEDLE 32G X 4 MM		1	PA; ST
ULTRA COMFORT INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN PEN NEEDLES 29G X 12MM		1	PA; ST
ULTRA FLO INSULIN PEN NEEDLES 31G X 8 MM		1	PA; ST
ULTRA FLO INSULIN PEN NEEDLES 32G X 4 MM		1	PA; ST
ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM		1	PA; ST
ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 1/2" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYR 1/2 UNIT 30G X 5/16" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYR 1/2 UNIT 31G X 5/16" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
ULTRA FLO INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
ULTRA THIN PEN NEEDLES 32G X 4 MM		1	PA; ST
ULTRACARE INSULIN SYRINGE 30G X 1/2" 0.5 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.3 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
ULTRACARE INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
ULTRACARE PEN NEEDLES 31G X 5 MM		1	PA; ST
ULTRACARE PEN NEEDLES 31G X 6 MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
ULTRACARE PEN NEEDLES 31G X 8 MM		1	PA; ST
ULTRACARE PEN NEEDLES 32G X 4 MM		1	PA; ST
ULTRACARE PEN NEEDLES 32G X 5 MM		1	PA; ST
ULTRACARE PEN NEEDLES 32G X 6 MM		1	PA; ST
ULTRACARE PEN NEEDLES 33G X 4 MM		1	PA; ST
ULTRA-COMFORT INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.3 ML		1	PA; ST
ULTRA-THIN II INS SYR SHORT 30G X 5/16" 0.5 ML		1	PA; ST
ULTRA-THIN II INS SYR SHORT 30G X 5/16" 1 ML		1	PA; ST
ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.3 ML		1	PA; ST
ULTRA-THIN II INS SYR SHORT 31G X 5/16" 0.5 ML		1	PA; ST
ULTRA-THIN II INS SYR SHORT 31G X 5/16" 1 ML		1	PA; ST
ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
ULTRA-THIN II INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
ULTRA-THIN II MINI PEN NEEDLE 31G X 5 MM		1	PA; ST
ULTRA-THIN II PEN NEEDLE SHORT 31G X 8 MM		1	PA; ST
ULTRA-THIN II PEN NEEDLES 29G X 12.7MM		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
UNIFINE OTC PEN NEEDLES 31G X 5 MM		1	PA; ST
UNIFINE OTC PEN NEEDLES 32G X 4 MM		1	PA; ST
UNIFINE PEN NEEDLES 32G X 4 MM		1	PA; ST
UNIFINE PENTIPS 29G X 12MM		1	PA; ST
UNIFINE PENTIPS 31G X 6 MM		1	PA; ST
UNIFINE PENTIPS 31G X 8 MM		1	PA; ST
UNIFINE PENTIPS 32G X 4 MM		1	PA; ST
UNIFINE PENTIPS PLUS 29G X 12MM		1	PA; ST
UNIFINE PENTIPS PLUS 31G X 6 MM		1	PA; ST
UNIFINE PENTIPS PLUS 32G X 4 MM		1	PA; ST
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM		1	PA; ST
UNIFINE PROTECT PEN NEEDLE 30G X 8 MM		1	PA; ST
UNIFINE PROTECT PEN NEEDLE 32G X 4 MM		1	PA; ST
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM		1	PA; ST
UNIFINE SAFECONTROL PEN NEEDLE 30G X 8 MM		1	PA; ST
UNIFINE SAFECONTROL PEN NEEDLE 31G X 5 MM		1	PA; ST
UNIFINE SAFECONTROL PEN NEEDLE 31G X 6 MM		1	PA; ST
UNIFINE SAFECONTROL PEN NEEDLE 31G X 8 MM		1	PA; ST
UNIFINE SAFECONTROL PEN NEEDLE 32G X 4 MM		1	PA; ST
UNIFINE ULTRA PEN NEEDLE 31G X 5 MM		1	PA; ST

Drug Name	Reference	Drug Tier	Requirements/Limits
UNIFINE ULTRA PEN NEEDLE 31G X 6 MM		1	PA; ST
UNIFINE ULTRA PEN NEEDLE 31G X 8 MM		1	PA; ST
UNIFINE ULTRA PEN NEEDLE 32G X 4 MM		1	PA; ST
VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
VALUE HEALTH INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
VANISHPOINT INSULIN SYRINGE 29G X 5/16" 1 ML		1	PA; ST
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 0.5 ML		1	PA; ST
VANISHPOINT INSULIN SYRINGE 30G X 3/16" 1 ML		1	PA; ST
VANISHPOINT INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
VANISHPOINT INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
VERIFINE INSULIN PEN NEEDLE 29G X 12MM		1	PA; ST
VERIFINE INSULIN PEN NEEDLE 31G X 5 MM		1	PA; ST
VERIFINE INSULIN PEN NEEDLE 32G X 6 MM		1	PA; ST
VERIFINE INSULIN SYRINGE 28G X 1/2" 1 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 29G X 1/2" 0.5 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 29G X 1/2" 1 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 30G X 1/2" 1 ML		1	PA; ST

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Drug Name	Reference	Drug Tier	Requirements/Limits
VERIFINE INSULIN SYRINGE 30G X 5/16" 0.5 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 30G X 5/16" 1 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 31G X 5/16" 0.3 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 31G X 5/16" 0.5 ML		1	PA; ST
VERIFINE INSULIN SYRINGE 31G X 5/16" 1 ML		1	PA; ST
VERIFINE PLUS PEN NEEDLE 31G X 5 MM		1	PA; ST
VERIFINE PLUS PEN NEEDLE 31G X 8 MM		1	PA; ST
VERIFINE PLUS PEN NEEDLE 32G X 4 MM		1	PA; ST
V-GO 20 KIT 20 UNIT/24HR		3	QL (30 per 30 days)
V-GO 30 KIT 30 UNIT/24HR		3	QL (30 per 30 days)
V-GO 40 KIT 40 UNIT/24HR		3	QL (30 per 30 days)
VP INSULIN SYRINGE 29G X 1/2" 0.3 ML		1	PA; ST
WEBCOL ALCOHOL PREP LARGE PAD 70 %		1	PA; ST
WEGMANS UNIFINE PENTIPS PLUS 31G X 8 MM		1	PA; ST
ZEVRX STERILE ALCOHOL PREP PAD PAD 70 %		1	PA; ST
ENZYME COFACTORS/CHAPERONES			
Enzyme Cofactors/Chaperones			
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG		5	PA; NM; QL (90 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
ENZYME REPLACEMENT/MODIFIERS			
Enzyme Replacement/Modifiers			
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT		3	
javygtor oral tablet 100 mg	Javygtor	5	PA; NM; NEDS
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML		5	PA BvD; NM; NEDS
REVCOVI INTRAMUSCULAR SOLUTION 2.4 MG/1.5ML		5	PA; NM; NEDS
sapropterin dihydrochloride oral tablet 100 mg	Javygtor	5	PA; NM; NEDS
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT		3	
EYE, EAR, NOSE, THROAT AGENTS			
Eye, Ear, Nose, Throat Agents, Miscellaneous			
atropine sulfate ophthalmic solution 1 %		1	
azelastine hcl nasal solution 0.1 %		1	QL (60 per 30 days)
azelastine hcl nasal solution 0.15 %	Astepro	1	QL (30 per 25 days)
azelastine hcl ophthalmic solution 0.05 %		1	
azelastine hcl solution 137 mcg/spray nasal		1	QL (60 per 30 days)
cromolyn sodium ophthalmic solution 4 %		1	
epinastine hcl ophthalmic solution 0.05 %		2	

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Drug Name	Reference	Drug Tier	Requirements/Limits
ipratropium bromide nasal solution 0.03 %		1	QL (30 per 28 days)
ipratropium bromide nasal solution 0.06 %		1	QL (15 per 10 days)
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML		3	QL (12 per 28 days)
olopatadine hcl ophthalmic solution 0.1 %	Pataday	1	
olopatadine hcl ophthalmic solution 0.2 %	Advanced Eye Relief	1	
Eye, Ear, Nose, Throat Anti-Infectives Agents			
acetic acid otic solution 2 %		1	
ak-poly-bac ophthalmic ointment 500-10000 unit/gm		1	
bacitracin ophthalmic ointment 500 unit/gm		2	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm		1	
ciprofloxacin hcl ophthalmic solution 0.3 %		1	
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %		4	QL (7.5 per 7 days)
erythromycin ophthalmic ointment 5 mg/gm		1	QL (3.5 per 4 days)
GENTAK OPHTHALMIC OINTMENT 0.3 %		1	
gentamicin sulfate ophthalmic solution 0.3 %		1	
hydrocortisone-acetic acid otic solution 1-2 %		2	
moxifloxacin hcl ophthalmic solution 0.5 %	Vigamox	1	
NATACYN OPHTHALMIC SUSPENSION 5 %		4	

Drug Name	Reference	Drug Tier	Requirements/Limits
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000		1	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	Maxitrol	1	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	Maxitrol	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025		1	
neomycin-polymyxin-hc otic solution 1 %		2	
neomycin-polymyxin-hc otic suspension 3.5-10000-1		2	
neo-polycin ophthalmic ointment 3.5-400-10000		1	
ofloxacin ophthalmic solution 0.3 %	Ocuflox	1	
ofloxacin otic solution 0.3 %		1	
polycin ophthalmic ointment 500-10000 unit/gm		1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%		1	
sulfacetamide sodium ophthalmic ointment 10 %		2	
sulfacetamide sodium ophthalmic solution 10 %		1	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %		1	
tobramycin ophthalmic solution 0.3 %		1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %		2	
trifluridine ophthalmic solution 1 %		2	
XDEMVY OPHTHALMIC SOLUTION 0.25 %		5	PA; NM; QL (10 per 42 days); NEDS
ZIRGAN OPHTHALMIC GEL 0.15 %		4	

Drug Name	Reference	Drug Tier	Requirements/Limits
Eye, Ear, Nose, Throat Anti-Inflammatory Agents			
cyclosporine (pf) ophthalmic emulsion 0.05 %	Restasis	4	QL (60 per 30 days)
dexamethasone sodium phosphate ophthalmic solution 0.1 %		1	
diclofenac sodium ophthalmic solution 0.1 %		1	
difluprednate ophthalmic emulsion 0.05 %	Durezol	2	
EYSUVIS OPHTHALMIC SUSPENSION 0.25 %		3	QL (8.3 per 14 days)
fluocinolone acetonide otic oil 0.01 %	DermOtic	2	
fluorometholone ophthalmic suspension 0.1 %	FML Liquifilm	2	
flurbiprofen sodium ophthalmic solution 0.03 %		1	
fluticasone propionate nasal suspension 50 mcg/act	Flonase Allergy Rel Childrens	1	QL (16 per 30 days)
ketorolac tromethamine ophthalmic solution 0.5 %	Acular	1	QL (10 per 25 days)
loteprednol etabonate ophthalmic gel 0.5 %	Lotemax	2	QL (10 per 14 days)
loteprednol etabonate ophthalmic suspension 0.5 %	Lotemax	2	QL (15 per 19 days)
mometasone furoate nasal suspension 50 mcg/act	Nasonex 24HR	2	QL (34 per 30 days)
prednisolone acetate ophthalmic suspension 1 %	Pred Forte	4	
XIIDRA OPHTHALMIC SOLUTION 5 %		3	QL (60 per 30 days)
GASTROINTESTINAL AGENTS			

Drug Name	Reference	Drug Tier	Requirements/Limits
Antiulcer Agents And Acid Suppressants			
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg		2	
cimetidine hcl oral solution 300 mg/5ml		1	
esomeprazole magnesium oral capsule delayed release 20 mg	GoodSense Esomeprazole	1	QL (30 per 30 days)
esomeprazole magnesium oral capsule delayed release 40 mg	NexIUM	1	QL (60 per 30 days)
esomeprazole magnesium oral packet 10 mg, 20 mg	NexIUM	2	ST; QL (30 per 30 days)
esomeprazole magnesium oral packet 40 mg	NexIUM	2	ST; QL (60 per 30 days)
famotidine oral tablet 20 mg	MM Acid-Pep Maximum Strength	1	
famotidine oral tablet 40 mg	Pepcid	1	
lansoprazole oral capsule delayed release 15 mg	Prevacid 24HR	1	QL (30 per 30 days)
lansoprazole oral capsule delayed release 30 mg	Prevacid	1	QL (60 per 30 days)
misoprostol oral tablet 100 mcg, 200 mcg	Cytotec	1	
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg		1	
pantoprazole sodium oral tablet delayed release 20 mg	Protonix	1	QL (30 per 30 days)
pantoprazole sodium oral tablet delayed release 40 mg	Protonix	1	QL (60 per 30 days)
rabeprazole sodium oral tablet delayed release 20 mg	Aciphex	1	QL (30 per 30 days)
sucralfate oral tablet 1 gm	Carafate	1	
VOQUEZNA ORAL TABLET 10 MG, 20 MG		4	PA
Gastrointestinal Agents, Other			

Drug Name	Reference	Drug Tier	Requirements/Limits
carglumic acid oral tablet soluble 200 mg	Carbaglu	5	PA; NM; NEDS
constulose oral solution 10 gm/15ml		1	
cromolyn sodium oral concentrate 100 mg/5ml	Gastrocrom	4	
dicyclomine hcl oral capsule 10 mg		1	
dicyclomine hcl oral tablet 20 mg		1	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	Lomotil	1	PA; HRM; AGE (Max 64 Years)
enulose oral solution 10 gm/15ml		1	
generlac oral solution 10 gm/15ml		1	
glycopyrrolate oral tablet 1 mg, 2 mg		1	
kionex combination suspension 15 gm/60ml	Kionex	2	
lactulose oral solution 10 gm/15ml		1	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG		3	QL (30 per 30 days)
LOKELMA ORAL PACKET 10 GM, 5 GM		3	
loperamide hcl oral capsule 2 mg	Imodium A-D	1	
lubiprostone oral capsule 24 mcg	Amitiza	1	QL (60 per 30 days)
lubiprostone oral capsule 8 mcg	Amitiza	1	QL (120 per 30 days)
metoclopramide hcl oral solution 5 mg/5ml		1	
metoclopramide hcl oral tablet 10 mg, 5 mg	Reglan	1	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG		3	QL (30 per 30 days)
sodium polystyrene sulfonate combination suspension 15 gm/60ml	Kionex	2	
sodium polystyrene sulfonate oral powder		2	
sps (sodium polystyrene sulf) combination suspension 15 gm/60ml	Kionex	2	

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Drug Name	Reference	Drug Tier	Requirements/Limits
TRULANCE ORAL TABLET 3 MG		3	QL (30 per 30 days)
URSODIOL ORAL CAPSULE 200 MG, 400 MG		5	NM; NEDS
ursodiol oral capsule 300 mg		2	
ursodiol oral tablet 250 mg		2	
ursodiol oral tablet 500 mg	Urso Forte	2	
VELTASSA ORAL PACKET 1 GM, 16.8 GM, 25.2 GM, 8.4 GM		3	
XERMELO ORAL TABLET 250 MG		5	PA; NM; QL (84 per 28 days); NEDS
Laxatives			
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM		1	
gavilyte-g oral solution reconstituted 236 gm	GaviLyte-G	1	
gavilyte-n with flavor pack oral solution reconstituted 420 gm	GaviLyte-N with Flavor Pack	1	
na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml, 17.5-3.13-1.6 gm/177ml 2 pack (480ml)	Suprep Bowel Prep Kit	2	
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	GaviLyte-N with Flavor Pack	1	
peg-3350/electrolytes oral solution reconstituted 236 gm	GaviLyte-G	1	
Phosphate Binders			
calcium acetate (phos binder) oral capsule 667 mg		1	
calcium acetate (phos binder) oral tablet 667 mg	Calphron	1	
calcium acetate tablet 667 mg oral	Calphron	1	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	Renvela	4	
sevelamer carbonate oral tablet 800 mg	Renvela	2	

Drug Name	Reference	Drug Tier	Requirements/Limits
sevelamer hcl oral tablet 400 mg, 800 mg		4	
GENITOURINARY AGENTS			
Antispasmodics, Urinary			
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg		1	
flavoxate hcl oral tablet 100 mg		2	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG		2	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg		1	
oxybutynin chloride oral tablet 5 mg		1	
solifenacin succinate oral tablet 10 mg, 5 mg	VESIcare	1	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg		2	
tolterodine tartrate oral tablet 1 mg, 2 mg		2	
trospium chloride oral tablet 20 mg		1	
Genitourinary Agents, Miscellaneous			
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	Uroxatral	1	QL (30 per 30 days)
dutasteride oral capsule 0.5 mg	Avodart	1	
finasteride oral tablet 5 mg	Proscar	1	
tamsulosin hcl oral capsule 0.4 mg		1	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg		1	
HEAVY METAL ANTAGONISTS			
Heavy Metal Antagonists			

Drug Name	Reference	Drug Tier	Requirements/Limits
deferasirox granules oral packet 180 mg, 360 mg, 90 mg	Jadenu Sprinkle	5	PA; NM; NEDS
deferasirox oral tablet 180 mg, 360 mg, 90 mg	Jadenu	2	PA
penicillamine oral tablet 250 mg	Depen Titratabs	5	PA; NM; NEDS
trientine hcl oral capsule 250 mg	Syprine	5	PA; NM; QL (240 per 30 days); NEDS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/ MODIFYING			
Androgens			
danazol oral capsule 100 mg, 200 mg, 50 mg		4	
oxandrolone oral tablet 10 mg, 2.5 mg		4	PA
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	Depo-Testosterone	1	PA
testosterone enanthate intramuscular solution 200 mg/ml		1	PA; QL (5 per 28 days)
testosterone gel 1.62 % transdermal	AndroGel Pump	2	PA; QL (150 per 30 days)
testosterone transdermal gel 12.5 mg/act (1%)	Vogelxo Pump	2	PA; QL (300 per 30 days)
testosterone transdermal gel 20.25 mg/act (1.62%)	AndroGel Pump	2	PA; QL (150 per 30 days)
testosterone transdermal gel 25 mg/2.5gm (1%)		2	PA; QL (300 per 30 days)
testosterone transdermal gel 50 mg/5gm (1%)	Testim	2	PA; QL (300 per 30 days)
Estrogens And Antiestrogens			
abigale lo oral tablet 0.5-0.1 mg	Abigale Lo	1	
abigale oral tablet 1-0.5 mg	Abigale	2	PA; HRM; AGE (Max 64 Years)

Drug Name	Reference	Drug Tier	Requirements/Limits
estradiol oral tablet 0.5 mg, 1 mg, 2 mg		1	
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	Alora	2	QL (8 per 28 days)
estradiol transdermal patch twice weekly 0.0375 mg/24hr, 0.05 mg/24hr	Dotti	2	QL (8 per 28 days)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	Climara	2	QL (4 per 28 days)
estradiol vaginal cream 0.01 %	Estrace	1	
estradiol vaginal tablet 10 mcg	Yuvafem	2	QL (18 per 28 days)
estradiol-norethindrone acet oral tablet 0.5-0.1 mg	Abigale Lo	2	PA; HRM; AGE (Max 64 Years)
estradiol-norethindrone acet oral tablet 1-0.5 mg	Abigale	2	PA; HRM; AGE (Max 64 Years)
mimvey oral tablet 1-0.5 mg	Abigale	2	PA; HRM; AGE (Max 64 Years)
PREMARIN VAGINAL CREAM 0.625 MG/GM		3	
PREMPHASE ORAL TABLET 0.625-5 MG		3	PA; HRM; AGE (Max 64 Years)
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG		3	PA; HRM; AGE (Max 64 Years)
raloxifene hcl oral tablet 60 mg	Evista	1	
yuvafem vaginal tablet 10 mcg	Yuvafem	2	QL (18 per 28 days)
Glucocorticoids/Mineralocorticoids			
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg		1	
dexamethasone sodium phosphate injection solution 10 mg/ml, 120 mg/30ml, 4 mg/ml		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
fludrocortisone acetate oral tablet 0.1 mg		1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	Cortef	1	
methylprednisolone acetate injection suspension 40 mg/ml	Depo-Medrol	1	
methylprednisolone oral tablet 16 mg, 4 mg, 8 mg	Medrol	1	
methylprednisolone oral tablet 32 mg		1	
methylprednisolone oral tablet therapy pack 4 mg	Medrol	1	
prednisolone oral solution 15 mg/5ml		1	PA BvD
prednisolone sodium phosphate oral solution 25 mg/5ml, 5 mg/5ml		2	PA BvD
prednisolone sodium phosphate solution 15 mg/5ml oral		1	PA BvD
prednisone oral solution 5 mg/5ml		2	PA BvD
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg		1	PA BvD
triamcinolone acetonide injection suspension 40 mg/ml	Kenalog-40	1	
Pituitary			
desmopressin ace spray refrig nasal solution 0.01 %		4	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	DDAVP	1	
desmopressin acetate spray solution 0.01 % nasal		4	
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML		5	PA; NM; NEDS
LANREOTIDE ACETATE SUBCUTANEOUS SOLUTION 120 MG/0.5ML		5	PA NSO; NM; QL (0.5 per 28 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG		5	PA NSO; NM; NEDS
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG		5	PA NSO; NM; NEDS
LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 30 MG		5	PA; NM; NEDS
LUPRON DEPOT-PED (6-MONTH) INTRAMUSCULAR KIT 45 MG		5	PA; NM; NEDS
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML		5	PA; NM; NEDS
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml	SandoSTATIN	2	
octreotide acetate injection solution 1000 mcg/ml		5	NM; NEDS
octreotide acetate injection solution 200 mcg/ml		2	
ORGOVYX ORAL TABLET 120 MG		5	PA NSO; NM; NEDS
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG		5	PA; NM; NEDS
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML		5	PA; NM; QL (60 per 30 days); NEDS
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 60 MG/0.2ML		5	PA NSO; NM; QL (0.2 per 28 days); NEDS
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 90 MG/0.3ML		5	PA NSO; NM; QL (0.3 per 28 days); NEDS
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG		5	PA; NM; NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
Progestins			
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML		3	QL (0.65 per 84 days)
gallifrey oral tablet 5 mg	Gallifrey	1	
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	Depo-Provera	1	
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	Depo-Provera	1	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	Provera	1	
megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml		4	PA; HRM; AGE (Max 64 Years)
norethindrone acetate oral tablet 5 mg	Gallifrey	1	
progesterone oral capsule 100 mg, 200 mg	Prometrium	1	
Thyroid And Antithyroid Agents			
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	Levo-T	1	
liomny oral tablet 25 mcg, 5 mcg, 50 mcg	Liomny	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	Liomny	1	
methimazole oral tablet 10 mg, 5 mg		1	
propylthiouracil oral tablet 50 mg		1	
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG		5	PA; NM; NEDS
IMMUNOLOGICAL AGENTS			
Immunological Agents			
adalimumab-aaty (1 pen) auto-injector kit 40 mg/0.4ml subcutaneous	Yuflyma (1 Pen)	5	PA; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
adalimumab-aaty (1 pen) subcutaneous auto-injector kit 80 mg/0.8ml	Yuflyma (1 Pen)	5	PA; NM; NEDS
adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml	Yuflyma (1 Pen)	5	PA; NM; NEDS
adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml	Yuflyma (2 Syringe)	5	PA; NM; NEDS
adalimumab-aaty cd/uc/hs start subcutaneous auto-injector kit 80 mg/0.8ml	Yuflyma (1 Pen)	5	PA; NM; NEDS
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG		5	PA; NM; NEDS
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG		4	PA BvD
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG		5	PA BvD; NM; NEDS
azathioprine oral tablet 50 mg	Imuran	1	PA BvD
azathioprine sodium injection solution reconstituted 100 mg		1	PA BvD
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML		5	PA; NM; QL (8 per 28 days); NEDS
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML		5	PA; NM; QL (8 per 28 days); NEDS
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML		5	PA NSO; NM; QL (2 per 28 days); NEDS
CIMZIA (1 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML		5	PA; NM; NEDS
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML		5	PA; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG		5	PA; NM; NEDS
CIMZIA-STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML		5	PA; NM; NEDS
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML		5	PA; NM; NEDS
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML		5	PA; NM; NEDS
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML		5	PA; NM; NEDS
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML		5	PA; NM; NEDS
cyclosporine intravenous solution 50 mg/ml	SandIMMUNE	2	PA BvD
cyclosporine modified oral capsule 100 mg, 25 mg	Gengraf	2	PA BvD
cyclosporine modified oral capsule 50 mg		2	PA BvD
cyclosporine modified oral solution 100 mg/ml	Neoral	4	PA BvD
cyclosporine oral capsule 100 mg, 25 mg	SandIMMUNE	4	PA BvD
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; NEDS
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; NEDS
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; NEDS
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML		5	PA; NM; NEDS
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML, 200 MG/1.14ML, 300 MG/2ML		5	PA; NM; NEDS
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML		5	PA; NM; NEDS
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML		5	PA; NM; NEDS
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML		5	PA; NM; NEDS
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML		5	PA; NM; NEDS
everolimus oral tablet 0.25 mg	Zortress	4	PA BvD
everolimus oral tablet 0.5 mg, 0.75 mg, 1 mg	Zortress	5	PA BvD; NM; NEDS
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML		5	PA BvD; NM; NEDS
gengraf oral capsule 100 mg, 25 mg	Gengraf	2	PA BvD
gengraf oral solution 100 mg/ml	Neoral	4	PA BvD
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; NEDS
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML		5	PA; NM; Only NDCs starting with 00074; NEDS
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML		5	PA; NM; Only NDCs starting with 00074; NEDS
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML		5	PA; NM; NEDS
leflunomide oral tablet 10 mg, 20 mg	Arava	1	
mycophenolate mofetil hcl intravenous solution reconstituted 500 mg	CellCept Intravenous	2	PA BvD
mycophenolate mofetil oral capsule 250 mg	CellCept	2	PA BvD

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Drug Name	Reference	Drug Tier	Requirements/Limits
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	CellCept	5	PA BvD; NM; NEDS
mycophenolate mofetil oral tablet 500 mg	CellCept	2	PA BvD
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	Myfortic	2	PA BvD
NIKTIMVO INTRAVENOUS SOLUTION 22 MG/0.44ML, 9 MG/0.18ML		5	PA NSO; NM; NEDS
NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG		5	PA BvD; NM; NEDS
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML		5	PA; NM; NEDS
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG		5	PA; NM; NEDS
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML		5	PA; NM; NEDS
OTEZLA ORAL TABLET 20 MG, 30 MG		5	PA; NM; NEDS
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG, 4 X 10 & 51 X20 MG		5	PA; NM; NEDS
OTEZLA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 75 MG		5	PA; NM; NEDS
OTEZLA/OTEZLA XR INITIATION PK ORAL TABLET THERAPY PACK 10&20&30&(ER)75 MG		5	PA; NM; NEDS
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML		4	PA BvD
PROGRAF ORAL PACKET 0.2 MG, 1 MG		4	PA BvD

Drug Name	Reference	Drug Tier	Requirements/Limits
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML		4	ST
REZUROCK ORAL TABLET 200 MG		5	PA NSO; NM; NEDS
RINVOQ LQ ORAL SOLUTION 1 MG/ML		5	PA; NM; QL (360 per 30 days); NEDS
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG		5	PA; NM; NEDS
SELARSDI INTRAVENOUS SOLUTION 130 MG/26ML		5	PA; NM; NEDS
SELARSDI SUBCUTANEOUS SOLUTION 45 MG/0.5ML		3	PA
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML		3	PA
SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML		5	PA; NM; NEDS
sirolimus oral solution 1 mg/ml		4	PA BvD
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg		4	PA BvD
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML		5	PA; NM; NEDS
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML		5	PA; NM; NEDS
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML		5	PA; NM; NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML		5	PA; NM; NEDS
tacrolimus intravenous solution 5 mg/ml	Prograf	4	PA BvD
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	Prograf	4	PA BvD
TAVNEOS ORAL CAPSULE 10 MG		5	PA; NM; QL (180 per 30 days); NEDS
TREMFYA INTRAVENOUS SOLUTION 200 MG/20ML		5	PA; NM; NEDS
TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML		5	PA; NM; NEDS
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML		5	PA; NM; NEDS
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML		5	PA; NM; NEDS
TREMFYA-CD/UC INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML		5	PA; NM; NEDS
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML		5	PA; NM; NEDS
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML		5	PA; NM; NEDS
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML		5	PA; NM; NEDS
ustekinumab-aauz subcutaneous solution prefilled syringe 45 mg/0.5ml, 90 mg/ml	Otulfi	3	PA
XELJANZ ORAL SOLUTION 1 MG/ML		5	PA; NM; NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
XELJANZ ORAL TABLET 10 MG, 5 MG		5	PA; NM; NEDS
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG		5	PA; NM; NEDS
YESINTEK INTRAVENOUS SOLUTION 130 MG/26ML		5	PA; NM; NEDS
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5ML		3	PA
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML		3	PA
YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML		5	PA; NM; NEDS
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML		5	PA; NM; NEDS
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML		5	PA; NM; NEDS
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML		5	PA; NM; NEDS
Vaccines			
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML		3	$0 copay
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED		3	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 LF-MCG/0.5		3	$0 copay

Drug Name	Reference	Drug Tier	Requirements/Limits
ADACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2-15.5 LF-MCG/0.5		3	$0 copay
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML		3	$0 copay
BCG VACCINE INJECTION SOLUTION RECONSTITUTED 50 MG		3	$0 copay
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML		3	$0 copay
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5		3	$0 copay
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5		3	$0 copay
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5		3	
DENGVAXIA SUBCUTANEOUS SUSPENSION RECONSTITUTED		3	QL (3 per 365 days)
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML		3	PA BvD; $0 copay
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML		3	PA BvD; $0 copay
GARDASIL 9 INTRAMUSCULAR SUSPENSION 0.5 ML		3	$0 copay
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML		3	$0 copay
HAVRIX INTRAMUSCULAR SUSPENSION 720 EL U/0.5ML		3	
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1440 EL U/ML		3	$0 copay

Drug Name	Reference	Drug Tier	Requirements/Limits
HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720 EL U/0.5ML		3	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML		3	PA BvD; $0 copay
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG		3	
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML		3	PA BvD; $0 copay
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10		3	
IPOL INJECTION SUSPENSION		3	$0 copay
IXIARO INTRAMUSCULAR SUSPENSION		3	$0 copay
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML		3	$0 copay
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML		3	
MENACTRA INTRAMUSCULAR SOLUTION		3	$0 copay
MENQUADFI INTRAMUSCULAR SOLUTION 0.5 ML		3	$0 copay
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED		3	$0 copay
M-M-R II INJECTION SOLUTION RECONSTITUTED		3	$0 copay
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML		3	$0 copay
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE		3	

Drug Name	Reference	Drug Tier	Requirements/Limits
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML		3	
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED		3	$0 copay
PENMENVY INTRAMUSCULAR SUSPENSION RECONSTITUTED		3	$0 copay
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED		3	
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED		3	$0 copay
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED		3	
QUADRACEL INTRAMUSCULAR SUSPENSION		3	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML		3	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED		3	PA BvD; $0 copay
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML		3	PA BvD; $0 copay
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML		3	PA BvD; $0 copay
ROTARIX ORAL SUSPENSION		3	
ROTARIX ORAL SUSPENSION RECONSTITUTED		3	
ROTATEQ ORAL SOLUTION		3	
SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML		3	$0 copay; QL (2 per 365 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML		3	$0 copay; QL (2 per 365 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML		3	$0 copay
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)		3	$0 copay
TENIVAC SUSPENSION 5-2 LF/0.5ML INTRAMUSCULAR		3	$0 copay
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML		3	
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 2.4 MCG/0.5ML		3	$0 copay
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML		3	$0 copay
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML		3	$0 copay
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML		3	$0 copay
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML		3	$0 copay
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML		3	
VAQTA INTRAMUSCULAR SUSPENSION 50 UNIT/ML		3	$0 copay
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 25 UNIT/0.5ML		3	

Drug Name	Reference	Drug Tier	Requirements/Limits
VAQTA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 UNIT/ML		3	$0 copay
VARIVAX INJECTION SUSPENSION RECONSTITUTED 1350 PFU/0.5ML		3	$0 copay
VAXCHORA ORAL SUSPENSION RECONSTITUTED		3	$0 copay
VIMKUNYA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 40 MCG/0.8ML		3	$0 copay
VIVOTIF ORAL CAPSULE DELAYED RELEASE		3	$0 copay
YF-VAX SUBCUTANEOUS INJECTABLE , (2.5 ML IN 1 VIAL, MULTI-DOSE)		3	$0 copay
YF-VAX SUSPENSION RECONSTITUTED SUBCUTANEOUS		3	$0 copay
INFLAMMATORY BOWEL DISEASE AGENTS			
Inflammatory Bowel Disease Agents			
alosetron hcl oral tablet 0.5 mg	Lotronex	4	
alosetron hcl oral tablet 1 mg	Lotronex	5	NM; NEDS
balsalazide disodium oral capsule 750 mg		2	
budesonide oral capsule delayed release particles 3 mg		2	
budesonide rectal foam 2 mg	Uceris	4	
hydrocortisone rectal enema 100 mg/60ml	Cortenema	4	
mesalamine er oral capsule extended release 500 mg	Pentasa	4	
mesalamine oral tablet delayed release 1.2 gm	Lialda	2	QL (120 per 30 days)
sulfasalazine oral tablet 500 mg	Azulfidine	1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
sulfasalazine oral tablet delayed release 500 mg	Azulfidine EN-tabs	4	
METABOLIC BONE DISEASE AGENTS			
Metabolic Bone Disease Agents			
alendronate sodium oral solution 70 mg/75ml		2	QL (300 per 28 days)
alendronate sodium oral tablet 10 mg		1	QL (30 per 30 days)
alendronate sodium oral tablet 35 mg		1	QL (4 per 28 days)
alendronate sodium oral tablet 70 mg	Fosamax	1	QL (4 per 28 days)
calcitonin (salmon) nasal solution 200 unit/act		1	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	Rocaltrol	1	
cinacalcet hcl oral tablet 30 mg, 60 mg	Sensipar	4	QL (60 per 30 days)
cinacalcet hcl oral tablet 90 mg	Sensipar	2	QL (120 per 30 days)
ibandronate sodium oral tablet 150 mg		1	QL (1 per 28 days)
OSENVELT SUBCUTANEOUS SOLUTION 120 MG/1.7ML		5	PA; NM; NEDS
RAYALDEE ORAL CAPSULE EXTENDED RELEASE 30 MCG		5	NM; QL (60 per 30 days); NEDS
STOBOCLO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML		3	QL (1 per 180 days)
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml	Bonsity	5	PA; NM; QL (2.24 per 28 days); NEDS
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML		5	PA; NM; QL (1.56 per 30 days); NEDS
MISCELLANEOUS THERAPEUTIC AGENTS			
Miscellaneous Therapeutic Agents			

Drug Name	Reference	Drug Tier	Requirements/Limits
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML		5	PA; NM; NEDS
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE		3	
BAQSIMI TWO PACK POWDER 3 MG/DOSE NASAL		3	
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg		1	
diazoxide oral suspension 50 mg/ml	Proglycem	5	NM; NEDS
glucagon emergency injection solution reconstituted 1 mg		3	
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML		3	
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML		3	
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.5 MG/0.1ML, 1 MG/0.2ML		3	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg		1	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg		1	
leucovorin calcium oral tablet 5 mg	Lederle Leucovorin	1	
l-glutamine oral packet 5 gm	Endari	5	PA; NM; QL (180 per 30 days); NEDS
mesna oral tablet 400 mg	Mesnex	5	NM; NEDS
nitroglycerin rectal ointment 0.4 %	Rectiv	4	QL (30 per 30 days)
pyridostigmine bromide oral tablet 60 mg	Mestinon	1	
THALOMID ORAL CAPSULE 100 MG		5	PA NSO; NM; QL (120 per 30 days); NEDS
THALOMID ORAL CAPSULE 150 MG, 200 MG		5	PA NSO; NM; QL (56 per 28 days); NEDS

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Drug Name	Reference	Drug Tier	Requirements/Limits
THALOMID ORAL CAPSULE 50 MG		5	PA NSO; NM; QL (224 per 28 days); NEDS
VEOZAH ORAL TABLET 45 MG		4	PA; QL (30 per 30 days)
VOWST ORAL CAPSULE		5	PA; NM; QL (12 per 30 days); NEDS
OPHTHALMIC AGENTS			
Antiglaucoma Agents			
acetazolamide er oral capsule extended release 12 hour 500 mg		2	
acetazolamide oral tablet 125 mg, 250 mg		1	
acetazolamide sodium injection solution reconstituted 500 mg		1	
brimonidine tartrate ophthalmic solution 0.1 %	Alphagan P	2	
brimonidine tartrate ophthalmic solution 0.15 %	Alphagan P	1	
brimonidine tartrate ophthalmic solution 0.2 %		1	
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	Combigan	2	
brinzolamide ophthalmic suspension 1 %	Azopt	4	
carteolol hcl ophthalmic solution 1 %		1	
dorzolamide hcl ophthalmic solution 2 %		1	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	Cosopt	1	
latanoprost ophthalmic solution 0.005 %	Xalatan	1	QL (2.5 per 25 days)
levobunolol hcl ophthalmic solution 0.5 %		1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %		3	QL (2.5 per 25 days)
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %		3	QL (2.5 per 25 days)
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 %		3	QL (2.5 per 25 days)
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %		3	
timolol hemihydrate ophthalmic solution 0.5 %	Betimol	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %		1	
travoprost (bak free) ophthalmic solution 0.004 %	Travatan Z	2	QL (2.5 per 25 days)
REPLACEMENT PREPARATIONS			
Replacement Preparations			
dextrose-nacl intravenous solution 5-0.9 %		1	
dextrose-sodium chloride intravenous solution 5-0.45 %, 5-0.9 %		1	
klor-con m10 oral tablet extended release 10 meq	Klor-Con M10	1	
klor-con m15 oral tablet extended release 15 meq	Klor-Con M15	1	
klor-con m20 oral tablet extended release 20 meq	Klor-Con M20	1	
MAGNESIUM SULFATE INJECTION SOLUTION 50 %		4	
magnesium sulfate injection solution 50 % (10ml syringe)		1	
potassium chloride crys er oral tablet extended release 10 meq	Klor-Con M10	1	
potassium chloride crys er oral tablet extended release 15 meq	Klor-Con M15	1	

Drug Name	Reference	Drug Tier	Requirements/Limits
potassium chloride crys er oral tablet extended release 20 meq	Klor-Con M20	1	
potassium chloride er oral capsule extended release 10 meq, 8 meq		1	
potassium chloride er oral tablet extended release 10 meq	Klor-Con 10	1	
potassium chloride er oral tablet extended release 15 meq		4	
potassium chloride er oral tablet extended release 20 meq		1	
potassium chloride er oral tablet extended release 8 meq	Klor-Con	1	
potassium chloride intravenous solution 2 meq/ml		1	
potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)		2	
potassium citrate er oral tablet extended release 10 meq (1080 mg)	Urocit-K 10	2	
potassium citrate er oral tablet extended release 15 meq (1620 mg)	Urocit-K 15	2	
potassium citrate er oral tablet extended release 5 meq (540 mg)		2	
sodium chloride intravenous solution 0.45 %, 0.9 %		1	
RESPIRATORY TRACT AGENTS			
Anti-Inflammatories, Inhaled Corticosteroids			
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT		3	QL (12 per 30 days)
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT		3	QL (32.1 per 30 days)

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Drug Name	Reference	Drug Tier	Requirements/Limits
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT		3	QL (30 per 30 days)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH		3	QL (60 per 30 days)
breyna inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	Breyna	2	QL (30.9 per 30 days)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml	Pulmicort	4	PA BvD; QL (120 per 30 days)
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	Breyna	2	QL (30.6 per 30 days)
fluticasone propionate hfa inhalation aerosol 110 mcg/act		2	QL (12 per 30 days)
fluticasone propionate hfa inhalation aerosol 220 mcg/act		2	QL (24 per 30 days)
fluticasone propionate hfa inhalation aerosol 44 mcg/act		2	QL (21.2 per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	Wixela Inhub	1	QL (60 per 30 days)
wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act	Wixela Inhub	1	QL (60 per 30 days)
Antileukotrienes			
montelukast sodium oral tablet 10 mg	Singulair	1	
montelukast sodium oral tablet chewable 4 mg, 5 mg	Singulair	1	
zafirlukast oral tablet 10 mg, 20 mg		2	
Bronchodilators			

Drug Name	Reference	Drug Tier	Requirements/Limits
AIRSUPRA AEROSOL 90-80 MCG/ACT INHALATION		3	QL (32.1 per 30 days)
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	Ventolin HFA	1	QL (17 per 30 days)
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act (nda020503)	Ventolin HFA	1	QL (13.4 per 30 days)
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act (nda020983)	Ventolin HFA	1	QL (36 per 30 days)
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml		1	PA BvD
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT		3	QL (60 per 30 days)
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT		4	QL (25.8 per 28 days)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT		3	QL (10.7 per 30 days)
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT		3	QL (8 per 30 days)
ipratropium bromide hfa inhalation aerosol solution 17 mcg/act	Atrovent HFA	4	QL (25.8 per 28 days)
ipratropium bromide inhalation solution 0.02 %		1	PA BvD
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml		1	PA BvD; QL (540 per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT		3	QL (60 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT		3	QL (4 per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT		3	QL (4 per 30 days)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT		3	QL (4 per 28 days)
theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg		2	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg		1	
theophylline oral solution 80 mg/15ml		4	
tiotropium bromide inhalation capsule 18 mcg	Spiriva HandiHaler	4	QL (30 per 30 days)
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT		3	QL (60 per 30 days)
Respiratory Tract Agents, Other			
BRONCHITOL TOLERANCE TEST INHALATION CAPSULE 40 MG		5	NM; QL (560 per 28 days); NEDS
cromolyn sodium inhalation nebulization solution 20 mg/2ml		2	PA BvD
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML		5	PA; NM; QL (1 per 28 days); NEDS
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 30 MG/ML		5	PA; NM; QL (1 per 28 days); NEDS
JASCAYD ORAL TABLET 18 MG, 9 MG		5	PA; NM; QL (60 per 30 days); NEDS

Drug Name	Reference	Drug Tier	Requirements/Limits
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG		5	PA; NM; QL (56 per 28 days); NEDS
KALYDECO ORAL TABLET 150 MG		5	PA; NM; QL (56 per 28 days); NEDS
nintedanib esylate oral capsule 100 mg, 150 mg	Ofev	5	PA; NM; QL (60 per 30 days); NEDS
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML		5	PA; NM; QL (3 per 28 days); NEDS
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML		5	PA; NM; QL (3 per 28 days); NEDS
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML		5	PA; NM; QL (0.4 per 28 days); NEDS
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG		5	PA; NM; QL (3 per 28 days); NEDS
OFEV ORAL CAPSULE 100 MG, 150 MG		5	PA; NM; QL (60 per 30 days); NEDS
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG		5	PA; NM; QL (112 per 28 days); NEDS
pirfenidone oral capsule 267 mg		5	PA; NM; QL (270 per 30 days); NEDS
pirfenidone oral tablet 267 mg	Esbriet	5	PA; NM; QL (270 per 30 days); NEDS
pirfenidone oral tablet 534 mg		5	PA; NM; QL (90 per 30 days); NEDS
pirfenidone oral tablet 801 mg	Esbriet	5	PA; NM; QL (90 per 30 days); NEDS
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML		5	PA BvD; NM; NEDS
roflumilast oral tablet 250 mcg	Daliresp	4	QL (28 per 28 days)
roflumilast oral tablet 500 mcg	Daliresp	4	QL (30 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG		5	PA; NM; QL (84 per 28 days); NEDS
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG		5	PA; NM; QL (56 per 28 days); NEDS
WINREVAIR SUBCUTANEOUS KIT 2 X 45 MG, 2 X 60 MG, 45 MG, 60 MG		5	PA; NM; QL (1 per 21 days); NEDS
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML		5	PA; NM; NEDS
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML		5	PA; NM; NEDS
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG		5	PA; NM; NEDS
SKELETAL MUSCLE RELAXANTS			
Skeletal Muscle Relaxants			
baclofen oral tablet 10 mg, 20 mg, 5 mg		1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg		1	
methocarbamol oral tablet 500 mg, 750 mg		1	
tizanidine hcl oral tablet 2 mg		1	
tizanidine hcl oral tablet 4 mg	Zanaflex	1	
SLEEP DISORDER AGENTS			
Sleep Disorder Agents			
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	Nuvigil	2	PA; QL (30 per 30 days)
doxepin hcl oral tablet 3 mg, 6 mg	Silenor	2	QL (30 per 30 days)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	Lunesta	1	QL (30 per 30 days)

Drug Name	Reference	Drug Tier	Requirements/Limits
modafinil oral tablet 100 mg	Provigil	2	PA; QL (30 per 30 days)
modafinil oral tablet 200 mg	Provigil	2	PA; QL (60 per 30 days)
sodium oxybate oral solution 500 mg/ml	Xyrem	5	PA; NM; QL (540 per 30 days); NEDS
zaleplon oral capsule 10 mg, 5 mg		1	QL (30 per 30 days)
zolpidem tartrate oral tablet 10 mg, 5 mg	Ambien	1	QL (30 per 30 days)
VASODILATING AGENTS			
Vasodilating Agents			
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG		5	PA; NM; QL (90 per 30 days); NEDS
alyq oral tablet 20 mg		1	PA; QL (60 per 30 days)
bosentan oral tablet 125 mg, 62.5 mg	Tracleer	5	PA; NM; QL (60 per 30 days); NEDS
sildenafil citrate oral tablet 20 mg	Revatio	2	PA; QL (360 per 30 days)
tadalafil oral tablet 2.5 mg		2	PA; QL (30 per 30 days)
tadalafil oral tablet 5 mg	Cialis	2	PA; QL (30 per 30 days)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 400 MCG, 600 MCG, 800 MCG		5	PA; NM; QL (60 per 30 days); NEDS
UPTRAVI ORAL TABLET 200 MCG		5	PA; NM; QL (240 per 30 days); NEDS
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG		5	PA; NM; NEDS
VITAMINS AND MINERALS			
Vitamins And Minerals			
C-NATE DHA CAPSULE 28-1-200 MG ORAL		1	

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Drug Name	Reference	Drug Tier	Requirements/Limits
COMPLETENATE TABLET CHEWABLE 29-1 MG ORAL		1	
FOLIVANE-OB CAPSULE 85-1 MG ORAL		1	
KOSHER PRENATAL PLUS IRON TABLET 30-1 MG ORAL		1	
M-NATAL PLUS TABLET 27-1 MG ORAL		1	
NIVA-PLUS TABLET 27-1 MG ORAL		1	
OBSTETRIX DHA 29-1 & 350 MG ORAL		1	
PNV 27-CA/FE/FA TABLET 60-1 MG ORAL		1	
PNV-DHA+DOCUSATE CAPSULE 27-1.25-300 MG ORAL		1	
PNV-OMEGA CAPSULE 28-0.6-0.4-340 MG ORAL		1	
PRENA 1 TRUE 30-1.4 & 300 MG ORAL		1	
PRENAISSANCE CAPSULE 29-1.25-325 MG ORAL		1	
PRENAISSANCE PLUS CAPSULE 28-1-250 MG ORAL		1	
PRENATABS FA TABLET 29-1 MG ORAL		1	
PRENATAL ORAL TABLET 27-1 MG		1	
PRENATAL VITAMIN PLUS LOW IRON TABLET 27-1 MG ORAL		1	
PRENATAL-U CAPSULE 106.5-1 MG ORAL		1	
PREPLUS TABLET 27-1 MG ORAL		1	
SELECT-OB TABLET CHEWABLE 29-0.6-0.4 MG ORAL		1	

Drug Name	Reference	Drug Tier	Requirements/Limits
SELECT-OB TABLET CHEWABLE 29-1 MG ORAL		1	
SE-NATAL 19 TABLET CHEWABLE 29-1 MG ORAL		1	
TARON-C DHA CAPSULE 35-1 MG ORAL		1	
VIRT-C DHA CAPSULE 53.5-38-1 MG ORAL		1	
VIRT-NATE DHA CAPSULE 28-1-200 MG ORAL		1	
VIRT-PN DHA CAPSULE 27-0.6-0.4-300 MG ORAL		1	
VITAFOL GUMMIES TABLET CHEWABLE 3.33-0.333-34.8 MG ORAL		1	
VITAFOL-OB+DHA 65-1 & 250 MG ORAL		1	
VP-PNV-DHA CAPSULE 28-1-215.8 MG ORAL		1	
ZATEAN-PN DHA CAPSULE 27-0.6-0.4-300 MG ORAL		1	

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Notice of availability of language assistance services

and auxiliary aids and services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-280-5555 (TTY 711).

Español: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-844-280-5555 (TTY 711).

Chinese: 如果您會說中文，我們可以為您提供免費語言幫助服務。也免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-280-5555 (TTY 711)。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang naaangkop na mga pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 1-844-280-5555 (TTY 711).

French: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-280-5555 (TTY 711).

Vietnamese: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-844-280-5555 (TTY 711).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Auch entsprechende Hilfsmittel und Services zur Bereitstellung von Informationen in barrierefreien Formaten stehen kostenlos zur Verfügung. Rufen Sie 1-844-280-5555 (TTY 711) an.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 지원 및 서비스도 무료로 제공됩니다. 1-844-280-5555 (TTY 711) 로 전화하세요.

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Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по номеру 1-844-280-5555 (TTY 711).

Arabic: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. تتوفر المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل بالرقم 1-844-280-5555 (TTY 711).

Italian: Se parli italiano, sono a tua disposizione servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-844-280-5555 (TTY 711).

Portuguese: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-844-280-5555 (TTY 711).

French Creole: Si w pale kreyòl franse, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Rele 1-844-280-5555 (TTY 711).

Polish: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce pomocnicze i usługi umożliwiające dostarczanie informacji w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-844-280-5555 (TTY 711).

Hindi: यदि आप हिंदी बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं आपके लिए उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक एड्स और सेवाएं भी नि: शुल्क उपलब्ध हैं। कॉल 1-844-280-5555 (TTY 711).

Japanese: 日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助援助やサービスも無料で利用できます。 1-844-280-5555 (TTY 711) に電話します。

GlobalHealth is an HMO plan offered by GlobalHealth, Inc.

This formulary was updated on 05/21/2026. For more recent information or other questions, please contact Customer Care at 1-866-494-3927 (TTY users should call 711), 24 hours a day, seven days a week, or visit www.globalhealth.com.

GlobalHealth es un plan HMO ofrecido por GlobalHealth, Inc.

Esta lista se actualizó el 21/05/2026. Para obtener información más reciente o si tiene otras preguntas, comuníquese con el Servicio de Atención al Cliente al 1-866-494-3927 (los usuarios de TTY deben llamar al 711), las 24 horas del día, los siete días de la semana, o visite www.globalhealth.com.

Customer Care: 1-844-280-5555 (Toll free) (TTY:711)
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