



GlobalHealth

Medicare Advantage Plans

DRUG FORMULARY

FORMULARIO DE MEDICAMENTOS

January 1–December 31, 2023

Entre el 1 de enero y el 31 de diciembre del 2023

This document contains a list of covered drugs for Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP). The Drug Formulary was updated on 11/29/2022. For more recent information or other questions, please contact GlobalHealth Customer Care.

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

GlobalHealth is a HMO/SNP HMO with a Medicare contract and a state Medicaid contract for D-SNP. Enrollment in GlobalHealth depends on contract renewal.

Este documento contiene una lista de medicamentos cubiertos para Generations Dual Support (HMO D-SNP) y Generations Dual Support Premier (HMO D-SNP). El Formulario de medicamentos se actualizó el 11/29/2022. Para obtener información más reciente u otras preguntas, comuníquese con Atención al cliente de GlobalHealth.

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

GlobalHealth es un HMO/SNP HMO que tiene un contrato con Medicare y un contrato estatal de Medicaid para los planes D-SNP. La inscripción en GlobalHealth depende de la renovación del contrato.

**Generations Dual Support (HMO D-SNP) and
Generations Dual Premier (HMO D-SNP)
2023 Formulary
(List of Covered Drugs)**

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

HPMS Approved Formulary File Submission ID 00023371, Version Number 8

This formulary was updated on 11/29/2022. For more recent information or other questions, please contact 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 Vaccines** – Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.
- **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. For D-SNP, our plan covers insulin at no cost to you.

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 Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP).

This document includes a list of the drugs (formulary) for our plan which is current as of 11/29/2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2023, and from time to time during the year.

What is the Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) Formulary?

A formulary is a list of covered drugs selected by Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) 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. Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

For a complete listing of all prescription drugs covered by Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP), please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that 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 the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP)’s Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or 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, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. 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 Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP)’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 11/29/2022. To get updated information about the drugs covered by Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) 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 18. 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 89. 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 89. 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 cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your physician 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 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 18. 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 Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP)'s formulary?" on page 5 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 Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP)'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 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.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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 additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. 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 Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

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

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

Generations Dual Support (HMO D-SNP) and Generations Dual Premier (HMO D-SNP) Formulary

The formulary that begins on the next page 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 89.

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.

You can find information on what the symbols and abbreviations 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.
- **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.
- **GC** – Gap Coverage. Your plan offers additional coverage in the Coverage Gap phase for these medications. Refer to your Explanation of Coverage for cost sharing information.

Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)

Formulario 2023

(Lista de Medicamentos Cubiertos)

**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
00023371, versión 8

Esta lista se actualizó el 11/29/2022. 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.

- **Mensaje importante sobre lo que paga por las vacunas** - nuestro plan cubre la mayoría de las vacunas de la Parte D sin costo alguno para usted. Llame a Servicios para miembros para obtener más información.
- **Mensaje importante sobre lo que paga por la insulina** - no pagará más de \$35 por un suministro de un mes de cada producto de insulina cubierto por nuestro plan, sin importar en qué nivel de costo compartido se encuentre. Para D-SNP, nuestro plan cubre la insulina sin costo alguno para usted.

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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 (lista) se hace referencia a "nosotros" o "nuestro", se hace referencia a GlobalHealth, Inc. Cuando se hace referencia a "plan" o "nuestro plan", se hace referencia a Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP).

Este documento incluye una lista de los medicamentos (lista) de nuestro plan que entra en vigor a partir del 11/29/2022. Para obtener una lista actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

Por lo general, debe usar las farmacias de la red para usar su beneficio de medicamentos recetados. Los beneficios, la lista, la red de farmacias o los copagos y coseguros pueden cambiar el 1 de enero de 2023 y de manera periódica durante el año.

¿Qué es la Lista de Medicamentos de Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)?

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 nuestra lista, siempre y cuando el medicamento sea medicamento 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.

Para obtener una lista completa de todos los medicamentos recetados cubiertos por nuestro plan, visite nuestro sitio web o llámenos. Nuestra información de contacto, junto con la fecha de la última actualización de la lista, aparece en la portada y en la contraportada.

¿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 de la Lista de Medicamentos 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.

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

- **Nuevos medicamentos genéricos.** Podemos eliminar inmediatamente un medicamento de marca registrada de nuestra Lista de Medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de costo compartido o uno más bajo, y con las mismas o con menos restricciones. Además, al agregar el nuevo

medicamento genérico, podemos decidir mantener el medicamento de marca registrada en nuestra Lista de Medicamentos, pero inmediatamente moverlo a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente usted está tomando ese medicamento de marca registrada, podríamos no avisarle con anticipación que realizaremos ese cambio, pero luego le proporcionaremos información sobre el cambio o los cambios específicos que hicimos.

- Si realizamos ese cambio, usted o el recetador pueden solicitarnos hacer una excepción y continuar con la cobertura de su medicamento de marca registrada. El aviso que le enviaremos también incluirá información sobre cómo solicitar una excepción, y puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción a la Lista de Medicamentos de Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)?”
- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento incluido en nuestra lista de medicamentos no es seguro, o si el fabricante del medicamento lo retira del mercado, lo retiraremos de nuestra lista de inmediato y se lo notificaremos 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 agregar un medicamento genérico que es nuevo en el mercado para reemplazar un medicamento de marca registrada que se encuentra actualmente en la lista de medicamentos, o podemos agregar nuevas restricciones al medicamento de marca registrada, moverlo a un nivel de costo compartido diferente, o ambas cosas. También podemos realizar cambios basados en nuevas pautas clínicas. Si retiramos medicamentos de nuestra lista de medicamentos, agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada para un medicamento, o cambiamos un medicamento a un nivel de costo compartido más alto, debemos notificar a los miembros afectados sobre el cambio al menos 30 días antes de que el cambio entre en vigor, o cuando el miembro solicita un nuevo surtido del medicamento, momento en el cual recibirá un suministro por 30 días del medicamento.
 - Si realizamos estos cambios, usted o el recetador pueden solicitarnos hacer una excepción y continuar con la cobertura de su medicamento de marca registrada. El aviso que le enviaremos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción a la Lista de medicamentos de Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)?”

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si usted está tomando un medicamento de nuestra Lista de Medicamentos 2023 que estaba cubierto al comienzo del año, no interrumpiremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2023, 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 la Lista de Medicamentos del nuevo año de beneficios para ver si hay cambios en los medicamentos.

La lista adjunta entra en vigor a partir del 11/29/2022. Para obtener información actualizada sobre los medicamentos cubiertos por nuestro plan, 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 la lista de medicamentos que no sean de mantenimiento, las listas se actualizarán mensualmente y se publicarán en nuestro sitio web.

¿Cómo utilizo la Lista de Medicamentos?

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

Afección Médica

La lista comienza en la página 18. 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 89. 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 89. 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 and Drug Administration, FDA) que contiene el mismo ingrediente activo que el medicamento de marca registrada. Por lo general, los medicamentos genéricos cuestan menos que los medicamentos de marca registrada.

¿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 médico 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 comprimidos 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 la lista que comienza en la página 18. 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 de la lista, aparece en la portada y en la contraportada.

Puede solicitar que se haga una excepción a estas restricciones o límites en nuestros planes, o que le hagan una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección “¿Cómo solicito una excepción a la Lista de medicamentos de Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)?” en la página 13 para obtener información sobre cómo solicitar una excepción.

¿Qué pasa si mi medicamento no está en la Lista de Medicamentos?

Si su medicamento no está incluido en esta lista (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 a la Lista de Medicamentos de Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)?

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

- Puede solicitarnos que cubramos un medicamento incluso si no está en nuestra lista de medicamentos. 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 solicitarnos que cubramos un medicamento de la lista de medicamentos en un nivel de costo compartido más bajo, a menos que el medicamento se encuentre en el nivel especializado. Si se aprueba, esto disminuiría el monto que debe pagar por su medicamento.
- Puede solicitarnos que no apliquemos restricciones ni límites de cobertura a su medicamento. Por ejemplo, para ciertos medicamentos, el plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitarnos que no apliquemos el límite y que cubramos una cantidad mayor.

Por lo general, nuestro plan aprobará su solicitud de una excepción únicamente si los medicamentos alternativos incluidos en la lista de medicamentos del plan, el medicamento de menor costo compartido o las restricciones de utilización adicionales no son tan eficaces para tratar su afección o harán que padezca efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión inicial sobre la cobertura de una excepción a la lista, el nivel o la restricción de utilización. **Cuando solicita una excepción a la lista, el nivel o la restricción de utilización, debe presentar una declaración de su recetador o médico que respalde su solicitud.** Por lo general, debemos tomar una decisión dentro de las 72 horas después de recibir la declaración de apoyo de su recetador. Puede solicitar una excepción acelerada (rápida) si usted o su médico creen que su salud podría verse gravemente afectada si espera hasta 72 horas por una decisión. Si se concede su solicitud acelerada, debemos darle una decisión a más tardar 24 horas después de recibir una declaración de apoyo de su médico u otro recetador.

¿Qué debo hacer antes de hablar con mi médico sobre cambiar mis medicamentos o solicitar una excepción?

Como miembro nuevo o existente de nuestro plan, es posible que esté tomando medicamentos que no están en nuestra lista de medicamentos. También puede suceder que esté tomando un

medicamento que está en nuestra lista de medicamentos, pero su capacidad para conseguirlo es limitada. Por ejemplo, es posible que necesite nuestra autorización previa antes de que pueda obtener su receta. Debe hablar con su médico para decidir si debe cambiar a un medicamento apropiado que cubramos, o solicitar una excepción a la lista de medicamentos para que cubramos el medicamento que toma. Mientras habla con su médico para determinar qué medida es adecuada para usted, podemos cubrir su medicamento en ciertos casos durante los primeros 90 días en los que usted es miembro de nuestro plan.

Para cada uno de sus medicamentos que no está en nuestra lista de medicamentos, o si su capacidad para obtener sus medicamentos es limitada, cubriremos un suministro temporal por 30 días. Si su receta médica está escrita por menos días, entregaremos renovaciones para proporcionar hasta un suministro máximo por 30 días de medicamentos. Después de su primer suministro por 30 días, no pagaremos estos medicamentos, incluso si ha sido miembro del plan durante 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 nuestra lista de medicamentos o si su capacidad para obtener sus medicamentos es 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 Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP), 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 de la lista, 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>.

Lista de Medicamentos de Generations Dual Support (HMO D-SNP) y Generations Dual Premier (HMO D-SNP)

La lista de medicamentos 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 89.

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.

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 comprimidos 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 Farmacias o llame al Servicio de Atención 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.
- **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.
- **GC** - Etapa sin Cobertura (Gap Coverage). Brindamos cobertura adicional de este medicamento recetado en la etapa sin cobertura. Consulte su Evidencia de Cobertura para obtener más información sobre esta cobertura.

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Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
<i>allopurinol</i> TABS 100mg, 300mg	1	
<i>colchicine</i> TABS .6mg	1	QL (120 tabs / 30 days)
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	
MITIGARE CAPS .6mg	1	QL (60 caps / 30 days)
<i>probenecid</i> TABS 500mg	1	
NSAIDS		
<i>celecoxib</i> CAPS 50mg, 100mg, 200mg	1	QL (60 caps / 30 days)
<i>celecoxib</i> CAPS 400mg	1	QL (30 caps / 30 days)
<i>diclofenac potassium</i> TABS 50mg	1	QL (120 tabs / 30 days)
<i>diclofenac sodium</i> TB24 100mg; TBEC 25mg, 50mg, 75mg	1	
<i>diflunisal</i> TABS 500mg	1	
<i>ec-naproxen</i> TBEC 375mg	1	QL (120 tabs / 30 days)
<i>ec-naproxen</i> TBEC 500mg	1	QL (90 tabs / 30 days)
<i>etodolac</i> CAPS 200mg, 300mg; TABS 400mg, 500mg; TB24 400mg, 500mg, 600mg	1	
<i>flurbiprofen</i> TABS 100mg	1	
<i>ibu</i> TABS 600mg, 800mg	1	
<i>ibuprofen</i> SUSP 100mg/5ml; TABS 400mg, 600mg, 800mg	1	
<i>meloxicam</i> TABS 7.5mg, 15mg	1	
<i>nabumetone</i> TABS 500mg, 750mg	1	
<i>naproxen</i> TABS 250mg, 375mg, 500mg	1	
<i>naproxen</i> TBEC 375mg	1	QL (120 tabs / 30 days)
<i>naproxen</i> TBEC 500mg	1	QL (90 tabs / 30 days)
<i>naproxen sodium</i> TABS 275mg, 550mg	1	
<i>piroxicam</i> CAPS 10mg, 20mg	1	
<i>sulindac</i> TABS 150mg, 200mg	1	
OPIOID ANALGESICS, LONG-ACTING		
<i>fentanyl</i> PT72 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr	1	QL (10 patches / 30 days), PA
<i>hydrocodone bitartrate</i> T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	1	QL (30 tabs / 30 days), PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg	1	QL (30 tabs / 30 days), PA
<i>methadone hcl</i> SOLN 5mg/5ml, 10mg/5ml	1	QL (450 mL / 30 days), PA
<i>methadone hcl</i> TABS 5mg, 10mg	1	QL (90 tabs / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
<i>methadone hydrochloride i</i> CONC 10mg/ml	1	QL (90 mL / 30 days), PA
<i>morphine sulfate</i> TBCR 15mg, 30mg, 60mg, 100mg, 200mg	1	QL (90 tabs / 30 days), PA
OPIOID ANALGESICS, SHORT-ACTING		
<i>acetaminophen w/ codeine soln</i> 120-12 mg/5ml	1	QL (2700 mL / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-15 mg	1	QL (400 tabs / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-30 mg	1	QL (360 tabs / 30 days)
<i>acetaminophen w/ codeine tab</i> 300-60 mg	1	QL (180 tabs / 30 days)
<i>butorphanol tartrate</i> SOLN 1mg/ml, 2mg/ml	1	
<i>endocet tab</i> 2.5-325mg	1	QL (360 tabs / 30 days)
<i>endocet tab</i> 5-325mg	1	QL (360 tabs / 30 days)
<i>endocet tab</i> 7.5-325mg	1	QL (240 tabs / 30 days)
<i>endocet tab</i> 10-325mg	1	QL (180 tabs / 30 days)
<i>fentanyl citrate</i> LPOP 200mcg, 400mcg, 600mcg, 800mcg, 1200mcg, 1600mcg	1	QL (120 lozenges / 30 days), PA
<i>hydrocodone-acetaminophen soln</i> 7.5-325 mg/15ml	1	QL (2700 mL / 30 days)
<i>hydrocodone-acetaminophen tab</i> 5-325 mg	1	QL (240 tabs / 30 days)
<i>hydrocodone-acetaminophen tab</i> 7.5-325 mg	1	QL (180 tabs / 30 days)
<i>hydrocodone-acetaminophen tab</i> 10-325 mg	1	QL (180 tabs / 30 days)
<i>hydrocodone-ibuprofen tab</i> 7.5-200 mg	1	QL (150 tabs / 30 days)
<i>hydromorphone hcl</i> LIQD 1mg/ml	1	QL (600 mL / 30 days)
<i>hydromorphone hcl</i> TABS 2mg, 4mg, 8mg	1	QL (180 tabs / 30 days)
MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	1	B/D
<i>morphine sulfate</i> SOLN 4mg/ml, 8mg/ml, 10mg/ml	1	B/D
<i>morphine sulfate</i> SOLN 10mg/5ml, 20mg/5ml	1	QL (900 mL / 30 days)
<i>morphine sulfate</i> SOLN 20mg/ml	1	QL (180 mL / 30 days)
<i>morphine sulfate</i> TABS 15mg, 30mg	1	QL (180 tabs / 30 days)
<i>nalbuphine hcl</i> SOLN 10mg/ml, 20mg/ml	1	
<i>oxycodone hcl</i> CAPS 5mg	1	QL (180 caps / 30 days)
<i>oxycodone hcl</i> CONC 100mg/5ml	1	QL (180 mL / 30 days)
<i>oxycodone hcl</i> SOLN 5mg/5ml	1	QL (900 mL / 30 days)
<i>oxycodone hcl</i> TABS 5mg, 10mg, 15mg, 20mg, 30mg	1	QL (180 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab</i> 2.5-325 mg	1	QL (360 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab</i> 5-325 mg	1	QL (360 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	1	QL (240 tabs / 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	1	QL (180 tabs / 30 days)
<i>tramadol hcl TABS 50mg</i>	1	QL (240 tabs / 30 days)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	1	QL (240 tabs / 30 days)

ANESTHETICS

LOCAL ANESTHETICS

<i>lidocaine hcl (local anesth.) SOLN .5%, 1%, 1.5%, 2%</i>	1	B/D
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ANTI-INFECTIVES

ANTI-INFECTIVES - MISCELLANEOUS

<i>albendazole TABS 200mg</i>	1	
<i>amikacin sulfate SOLN 1gm/4ml, 500mg/2ml</i>	1	
<i>atovaquone SUSP 750mg/5ml</i>	1	
<i>aztreonam SOLR 1gm, 2gm</i>	1	
<i>CAYSTON SOLR 75mg</i>	1	NM, LA, PA
<i>clindamycin hcl CAPS 75mg, 150mg, 300mg</i>	1	
<i>clindamycin palmitate hydrochloride SOLR 75mg/5ml</i>	1	
<i>clindamycin phosphate SOLN 300mg/2ml, 600mg/4ml, 900mg/6ml, 9000mg/60ml</i>	1	
<i>clindamycin phosphate in d5w iv soln 300 mg/50ml</i>	1	
<i>clindamycin phosphate in d5w iv soln 600 mg/50ml</i>	1	
<i>clindamycin phosphate in d5w iv soln 900 mg/50ml</i>	1	
<i>CLINDMYC/NAC INJ 300/50ML</i>	1	
<i>CLINDMYC/NAC INJ 600/50ML</i>	1	
<i>CLINDMYC/NAC INJ 900/50ML</i>	1	
<i>colistimethate sodium SOLR 150mg</i>	1	
<i>dapsone TABS 25mg, 100mg</i>	1	
<i>DAPTOMYCIN SOLR 350mg</i>	1	
<i>daptomycin SOLR 350mg, 500mg</i>	1	
<i>EMVERM CHEW 100mg</i>	1	QL (12 tabs / year)
<i>ertapenem sodium SOLR 1gm</i>	1	
<i>gentamicin in saline inj 0.8 mg/ml</i>	1	
<i>gentamicin in saline inj 1 mg/ml</i>	1	
<i>gentamicin in saline inj 1.2 mg/ml</i>	1	
<i>gentamicin in saline inj 1.6 mg/ml</i>	1	
<i>gentamicin in saline inj 2 mg/ml</i>	1	
<i>gentamicin sulfate SOLN 10mg/ml, 40mg/ml</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>imipenem-cilastatin intravenous for soln 250 mg</i>	1	
<i>imipenem-cilastatin intravenous for soln 500 mg</i>	1	
<i>ivermectin TABS 3mg</i>	1	QL (12 tabs / 90 days), PA
<i>linezolid SOLN 600mg/300ml</i>	1	
<i>linezolid SUSR 100mg/5ml</i>	1	QL (1800 mL / 30 days)
<i>linezolid TABS 600mg</i>	1	QL (60 tabs / 30 days)
<i>linezolid in sodium chloride iv soln 600 mg/300ml-0.9%</i>	1	
<i>meropenem SOLR 1gm, 500mg</i>	1	
<i>methenamine hippurate TABS 1gm</i>	1	
<i>metronidazole SOLN 500mg/100ml; TABS 250mg, 500mg</i>	1	
<i>neomycin sulfate TABS 500mg</i>	1	
<i>nitazoxanide TABS 500mg</i>	1	QL (6 tabs / 30 days)
<i>nitrofurantoin macrocrystal CAPS 50mg, 100mg</i>	1	
<i>nitrofurantoin monohyd macro CAPS 100mg</i>	1	
<i>paromomycin sulfate CAPS 250mg</i>	1	
<i>pentamidine isethionate inh SOLR 300mg</i>	1	B/D
<i>pentamidine isethionate inj SOLR 300mg</i>	1	
<i>praziquantel TABS 600mg</i>	1	
<i>SIVEXTRO SOLR 200mg; TABS 200mg</i>	1	
<i>streptomycin sulfate SOLR 1gm</i>	1	
<i>sulfadiazine TABS 500mg</i>	1	
<i>sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
<i>SYNERCID INJ 500MG</i>	1	
<i>tobramycin NEBU 300mg/5ml</i>	1	NM, PA
<i>tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml</i>	1	
<i>TRIMETHOPRIM TABS 100mg</i>	1	
<i>vancomycin hcl CAPS 125mg</i>	1	QL (80 caps / 180 days)
<i>vancomycin hcl CAPS 250mg</i>	1	QL (160 caps / 180 days)
<i>vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg</i>	1	

Drug Name	Drug Tier	Requirements/Limits
VANCOMYCIN INJ 1 GM	1	
VANCOMYCIN INJ 500MG	1	
VANCOMYCIN INJ 750MG	1	

ANTIFUNGALS

ABELCET SUSP 5mg/ml	1	B/D
<i>amphotericin b</i> SOLR 50mg	1	B/D
<i>amphotericin b liposome</i> SUSR 50mg	1	B/D
<i>casprofungin acetate</i> SOLR 50mg, 70mg	1	
<i>fluconazole</i> SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 150mg, 200mg	1	
<i>fluconazole in nacl 0.9% inj 200 mg/100ml</i>	1	
<i>fluconazole in nacl 0.9% inj 400 mg/200ml</i>	1	
<i>flucytosine</i> CAPS 250mg, 500mg	1	PA
<i>griseofulvin microsize</i> SUSP 125mg/5ml; TABS 500mg	1	
<i>griseofulvin ultramicrosize</i> TABS 125mg, 250mg	1	
<i>itraconazole</i> CAPS 100mg	1	PA
<i>ketoconazole</i> TABS 200mg	1	PA
<i>miconazole sodium</i> SOLR 50mg, 100mg	1	
NOXAFIL SUSP 40mg/ml	1	QL (630 mL / 30 days), PA
<i>nystatin</i> TABS 500000unit	1	
<i>posaconazole</i> TBEC 100mg	1	QL (93 tabs / 30 days), PA
<i>terbinafine hcl</i> TABS 250mg	1	QL (90 tabs / year)
<i>voriconazole</i> SOLR 200mg; SUSR 40mg/ml	1	PA
<i>voriconazole</i> TABS 50mg	1	QL (480 tabs / 30 days), PA
<i>voriconazole</i> TABS 200mg	1	QL (120 tabs / 30 days), PA

ANTIMALARIALS

<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
<i>chloroquine phosphate</i> TABS 250mg, 500mg	1	
COARTEM TAB 20-120MG	1	
<i>mefloquine hcl</i> TABS 250mg	1	
<i>primaquine phosphate</i> TABS 26.3mg	1	
PRIMAQUINE PHOSPHATE TABS 26.3mg	1	
<i>quinine sulfate</i> CAPS 324mg	1	PA

ANTIRETROVIRAL AGENTS

<i>abacavir sulfate</i> SOLN 20mg/ml; TABS 300mg	1	
APTIVUS CAPS 250mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>atazanavir sulfate</i> CAPS 150mg, 200mg, 300mg	1	
EDURANT TABS 25mg	1	
<i>efavirenz</i> CAPS 50mg, 200mg; TABS 600mg	1	
<i>emtricitabine</i> CAPS 200mg	1	
EMTRIVA SOLN 10mg/ml	1	
<i>etravirine</i> TABS 100mg, 200mg	1	
<i>fosamprenavir calcium</i> TABS 700mg	1	
FUZEON SOLR 90mg	1	
INTELENCE TABS 25mg	1	
ISENTRESS CHEW 25mg, 100mg; PACK 100mg; TABS 400mg	1	
ISENTRESS HD TABS 600mg	1	
<i>lamivudine</i> SOLN 10mg/ml; TABS 150mg, 300mg	1	
LEXIVA SUSP 50mg/ml	1	
<i>maraviroc</i> TABS 150mg, 300mg	1	
<i>nevirapine</i> SUSP 50mg/5ml; TABS 200mg; TB24 100mg, 400mg	1	
NORVIR PACK 100mg; SOLN 80mg/ml	1	
PIFELTRO TABS 100mg	1	
PREZISTA SUSP 100mg/ml	1	QL (400 mL / 30 days)
PREZISTA TABS 75mg	1	QL (480 tabs / 30 days)
PREZISTA TABS 150mg	1	QL (240 tabs / 30 days)
PREZISTA TABS 600mg	1	QL (60 tabs / 30 days)
PREZISTA TABS 800mg	1	QL (30 tabs / 30 days)
REYATAZ PACK 50mg	1	
<i>ritonavir</i> TABS 100mg	1	
RUKOBIA TB12 600mg	1	
SELZENTRY SOLN 20mg/ml; TABS 25mg, 75mg	1	
<i>stavudine</i> CAPS 15mg, 20mg, 30mg, 40mg	1	
<i>tenofovir disoproxil fumarate</i> TABS 300mg	1	
TIVICAY TABS 10mg, 25mg, 50mg	1	
TIVICAY PD TBSO 5mg	1	
TROGARZO SOLN 200mg/1.33ml	1	LA
TYBOST TABS 150mg	1	
VIRACEPT TABS 250mg, 625mg	1	
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	1	
<i>zidovudine</i> CAPS 100mg; SYRP 50mg/5ml; TABS 300mg	1	

Drug Name	Drug Tier	Requirements/Limits
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	
BIKTARVY TAB 30-120-15 MG	1	
BIKTARVY TAB 50-200-25 MG	1	
CIMDUO TAB 300-300	1	
COMPLERA TAB	1	
DELSTRIGO TAB	1	
DESCOVY TAB 120-15MG	1	QL (30 tabs / 30 days)
DESCOVY TAB 200/25MG	1	QL (30 tabs / 30 days)
DOVATO TAB 50-300MG	1	
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	1	
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	QL (30 tabs / 30 days)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	QL (30 tabs / 30 days)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	QL (30 tabs / 30 days)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	1	QL (30 tabs / 30 days)
EVOTAZ TAB 300-150	1	
GENVOYA TAB	1	
JULUCA TAB 50-25MG	1	
<i>lamivudine-zidovudine tab 150-300 mg</i>	1	
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	1	
<i>lopinavir-ritonavir tab 100-25 mg</i>	1	
<i>lopinavir-ritonavir tab 200-50 mg</i>	1	
ODEFSEY TAB	1	
PREZCOBIX TAB 800-150	1	
STRIBILD TAB	1	
SYMTUZA TAB	1	
TRIUMEQ PD TAB	1	
TRIUMEQ TAB	1	
TRIZIVIR TAB	1	
ANTITUBERCULAR AGENTS		
<i>cycloserine CAPS 250mg</i>	1	
<i>ethambutol hcl TABS 100mg, 400mg</i>	1	
<i>isoniazid SYRP 50mg/5ml; TABS 100mg, 300mg</i>	1	
PASER PACK 4gm	1	

Drug Name	Drug Tier	Requirements/Limits
PRIFTIN TABS 150mg	1	
<i>pyrazinamide</i> TABS 500mg	1	
<i>rifabutin</i> CAPS 150mg	1	
<i>rifampin</i> CAPS 150mg, 300mg; SOLR 600mg	1	
SIRTURO TABS 20mg, 100mg	1	NM, LA, PA
TRECTOR TABS 250mg	1	
ANTIVIRALS		
<i>acyclovir</i> CAPS 200mg; SUSP 200mg/5ml; TABS 400mg, 800mg	1	
<i>acyclovir sodium</i> SOLN 50mg/ml	1	B/D
<i>adefovir dipivoxil</i> TABS 10mg	1	
BARACLUDE SOLN .05mg/ml	1	
<i>entecavir</i> TABS .5mg, 1mg	1	
EPCLUSA PAK 150-37.5	1	NM, PA
EPCLUSA PAK 200-50MG	1	NM, PA
EPCLUSA TAB 200-50MG	1	NM, PA
EPCLUSA TAB 400-100	1	NM, PA
EPIVIR HBV SOLN 5mg/ml	1	
<i>famciclovir</i> TABS 125mg, 250mg, 500mg	1	
<i>ganciclovir sodium</i> SOLR 500mg	1	B/D
HARVONI PAK 33.75-150MG	1	NM, PA
HARVONI PAK 45-200MG	1	NM, PA
HARVONI TAB 45-200MG	1	NM, PA
HARVONI TAB 90-400MG	1	NM, PA
<i>lamivudine (hbv)</i> TABS 100mg	1	
MAVYRET PAK 50-20MG	1	NM, PA
MAVYRET TAB 100-40MG	1	NM, PA
<i>oseltamivir phosphate</i> CAPS 30mg	1	QL (168 caps / year)
<i>oseltamivir phosphate</i> CAPS 45mg, 75mg	1	QL (84 caps / year)
<i>oseltamivir phosphate</i> SUSR 6mg/ml	1	QL (1080 mL / year)
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	1	NM, PA
PREVYMIS TABS 240mg, 480mg	1	QL (28 tabs / 28 days), PA
RELENZA DISKHALER AEPB 5mg/blister	1	QL (6 inhalers / year)
<i>ribavirin (hepatitis c)</i> CAPS 200mg; TABS 200mg	1	NM
<i>rimantadine hydrochloride</i> TABS 100mg	1	
<i>valacyclovir hcl</i> TABS 1gm, 500mg	1	
<i>valganciclovir hcl</i> SOLR 50mg/ml; TABS 450mg	1	
VEMLIDY TABS 25mg	1	PA
VOSEVI TAB	1	NM, PA
XOFLUZA TBPK 40mg, 80mg	1	QL (1 tab / 180 days)

Drug Name	Drug Tier	Requirements/Limits
CEPHALOSPORINS		
<i>cefactor</i> CAPS 250mg, 500mg; SUSR 125mg/5ml, 250mg/5ml, 375mg/5ml	1	
CEFACTOR ER TB12 500mg	1	
<i>cefadroxil</i> CAPS 500mg; SUSR 250mg/5ml, 500mg/5ml	1	
CEFAZOLIN INJ 1GM/50ML	1	
<i>cefazolin sodium</i> SOLR 1gm, 2gm, 10gm, 500mg	1	
CEFAZOLIN SOLN 2GM/100ML-4%	1	
<i>cefdinir</i> CAPS 300mg; SUSR 125mg/5ml, 250mg/5ml	1	
<i>cefepime hcl</i> SOLR 1gm, 2gm	1	
<i>cefixime</i> CAPS 400mg; SUSR 100mg/5ml, 200mg/5ml	1	
<i>cefoxitin sodium</i> SOLR 1gm, 2gm, 10gm	1	
<i>cefpodoxime proxetil</i> SUSR 50mg/5ml, 100mg/5ml; TABS 100mg, 200mg	1	
<i>cefprozil</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
<i>ceftazidime</i> SOLR 1gm, 2gm, 6gm	1	
CEFTAZIDIME/ SOL D5W 1GM	1	
CEFTAZIDIME/ SOL D5W 2GM	1	
<i>ceftriaxone sodium</i> SOLR 1gm, 2gm, 10gm, 250mg, 500mg	1	
<i>cefuroxime axetil</i> TABS 250mg, 500mg	1	
<i>cefuroxime sodium</i> SOLR 1.5gm, 750mg	1	
<i>cephalexin</i> CAPS 250mg, 500mg; SUSR 125mg/5ml, 250mg/5ml	1	
<i>tazicef</i> SOLR 1gm, 2gm, 6gm	1	
TEFLARO SOLR 400mg, 600mg	1	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i> PACK 1gm; SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml; TABS 250mg, 500mg, 600mg	1	
<i>clarithromycin</i> SUSR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg; TB24 500mg	1	
DIFICID SUSR 40mg/ml; TABS 200mg	1	
<i>e.e.s. 400</i> TABS 400mg	1	
<i>ery-tab</i> TBEC 250mg, 333mg, 500mg	1	
ERYTHROCIN LACTOBIONATE SOLR 500mg	1	
<i>erythrocin stearate</i> TABS 250mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>erythromycin base</i> CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	1	
<i>erythromycin ethylsuccinate</i> TABS 400mg	1	
<i>erythromycin lactobionate</i> SOLR 500mg	1	
FLUOROQUINOLONES		
CIPRO SUSR 500mg/5ml	1	
<i>ciprofloxacin 200 mg/100ml in d5w</i>	1	
<i>ciprofloxacin 400 mg/200ml in d5w</i>	1	
<i>ciprofloxacin hcl</i> TABS 100mg, 250mg, 500mg, 750mg	1	
<i>levofloxacin</i> SOLN 25mg/ml; TABS 250mg, 500mg, 750mg	1	
<i>levofloxacin in d5w iv soln 250 mg/50ml</i>	1	
<i>levofloxacin in d5w iv soln 500 mg/100ml</i>	1	
<i>levofloxacin in d5w iv soln 750 mg/150ml</i>	1	
<i>moxifloxacin hcl</i> TABS 400mg	1	
PENICILLINS		
<i>amoxicillin</i> CAPS 250mg, 500mg; CHEW 125mg, 250mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg, 875mg	1	
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
<i>ampicillin</i> CAPS 500mg	1	
<i>ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm</i>	1	
<i>ampicillin & sulbactam sodium for inj 3 (2-1) gm</i>	1	
<i>ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>ampicillin & sulbactam sodium for iv soln 3 (2-1) gm</i>	1	
<i>ampicillin & sulbactam sodium for iv soln 15 (10-5) gm</i>	1	
<i>ampicillin sodium</i> SOLR 1gm, 2gm, 10gm, 125mg, 250mg, 500mg	1	
BICILLIN L-A SUSP 2400000unit/4ml; SUSY 600000unit/ml, 1200000unit/2ml	1	
<i>dicloxacillin sodium</i> CAPS 250mg, 500mg	1	
<i>nafcillin sodium</i> SOLR 1gm, 2gm, 10gm	1	
<i>oxacillin sodium</i> SOLR 1gm, 2gm, 10gm	1	
PEN GK/DEXTR INJ 40000/ML	1	
PEN GK/DEXTR INJ 60000/ML	1	
<i>penicillin g potassium</i> SOLR 5000000unit, 20000000unit	1	
PENICILLIN G PROCAINE SUSP 600000unit/ml	1	
<i>penicillin g sodium</i> SOLR 5000000unit	1	
<i>penicillin v potassium</i> SOLR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	1	
<i>pfizerpen</i> SOLR 5000000unit, 20000000unit	1	
<i>piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)</i>	1	
<i>piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)</i>	1	
<i>piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)</i>	1	
<i>piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)</i>	1	
<i>piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)</i>	1	
TETRACYCLINES		
<i>doxy 100</i> SOLR 100mg	1	
<i>doxycycline (monohydrate)</i> CAPS 50mg, 100mg; TABS 50mg, 75mg, 100mg	1	
<i>doxycycline hyclate</i> CAPS 50mg, 100mg; SOLR 100mg; TABS 20mg, 100mg	1	
<i>minocycline hcl</i> CAPS 50mg, 75mg, 100mg	1	
NUZYRA SOLR 100mg; TABS 150mg	1	NM, LA
<i>tetracycline hcl</i> CAPS 250mg, 500mg	1	PA
<i>tigecycline</i> SOLR 50mg	1	
TIGECYCLINE SOLR 50mg	1	

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
BENDEKA SOLN 100mg/4ml	1	B/D, NM, LA
<i>carboplatin</i> SOLN 50mg/5ml, 150mg/15ml, 450mg/45ml, 600mg/60ml	1	B/D
<i>cisplatin</i> SOLN 50mg/50ml, 100mg/100ml, 200mg/200ml	1	B/D
<i>cyclophosphamide</i> CAPS 25mg, 50mg; SOLR 1gm, 2gm, 500mg	1	B/D
CYCLOPHOSPHAMIDE SOLN 1gm/5ml, 500mg/2.5ml; TABS 25mg, 50mg	1	B/D
CYCLOPHOSPHAMIDE MONOHYDR SOLN 2gm/10ml	1	B/D
LEUKERAN TABS 2mg	1	
<i>oxaliplatin</i> SOLN 50mg/10ml, 100mg/20ml, 200mg/40ml; SOLR 50mg, 100mg	1	B/D
<i>paraplatin</i> SOLN 1000mg/100ml	1	B/D
ANTIBIOTICS		
<i>doxorubicin hcl</i> SOLN 2mg/ml	1	B/D
<i>doxorubicin hcl liposomal</i> INJ 2mg/ml	1	B/D
ELLENCE SOLN 50mg/25ml, 200mg/100ml	1	B/D
ANTIMETABOLITES		
<i>azacitidine</i> SUSR 100mg	1	B/D, NM
<i>cytarabine</i> SOLN 20mg/ml	1	B/D
<i>fluorouracil</i> SOLN 1gm/20ml, 2.5gm/50ml, 5gm/100ml, 500mg/10ml	1	B/D
<i>gemcitabine hcl</i> SOLN 1gm/26.3ml, 2gm/52.6ml, 200mg/5.26ml; SOLR 1gm, 2gm, 200mg	1	B/D
INQOVI TAB 35-100MG	1	NM, LA, PA
LONSURF TAB 15-6.14	1	NM, LA, PA
LONSURF TAB 20-8.19	1	NM, LA, PA
<i>mercaptopurine</i> TABS 50mg	1	
<i>methotrexate sodium</i> SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	1	B/D
ONUREG TABS 200mg, 300mg	1	NM, LA, PA
<i>pemetrexed disodium</i> SOLR 100mg, 500mg, 750mg, 1000mg	1	B/D
PURIXAN SUSP 2000mg/100ml	1	NM
TABLOID TABS 40mg	1	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i> TABS 250mg, 500mg	1	NM, PA
<i>anastrozole</i> TABS 1mg	1	
<i>bicalutamide</i> TABS 50mg	1	

Drug Name	Drug Tier	Requirements/Limits
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	1	NM, PA
EMCYT CAPS 140mg	1	
ERLEADA TABS 60mg	1	NM, LA, PA
EULEXIN CAPS 125mg	1	
<i>exemestane</i> TABS 25mg	1	
<i>fulvestrant</i> SOSY 250mg/5ml	1	B/D
<i>letrozole</i> TABS 2.5mg	1	
<i>leuprolide acetate</i> KIT 1mg/0.2ml	1	NM, PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	1	NM, PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	1	NM, PA
LYSODREN TABS 500mg	1	NM
<i>megestrol acetate</i> TABS 20mg, 40mg	1	
<i>nilutamide</i> TABS 150mg	1	
NUBEQA TABS 300mg	1	NM, LA, PA
ORGOVYX TABS 120mg	1	NM, LA, PA
SOLTAMOX SOLN 10mg/5ml	1	
<i>tamoxifen citrate</i> TABS 10mg, 20mg	1	
<i>toremifene citrate</i> TABS 60mg	1	
XTANDI CAPS 40mg; TABS 40mg, 80mg	1	NM, LA, PA
IMMUNOMODULATORS		
<i>lenalidomide</i> CAPS 2.5mg, 5mg, 10mg, 15mg	1	QL (28 caps / 28 days), NM, LA, PA
<i>lenalidomide</i> CAPS 20mg, 25mg	1	QL (21 caps / 28 days), NM, LA, PA
POMALYST CAPS 1mg, 2mg, 3mg, 4mg	1	QL (21 caps / 28 days), NM, LA, PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg	1	QL (28 caps / 28 days), NM, LA, PA
REVLIMID CAPS 20mg, 25mg	1	QL (21 caps / 28 days), NM, LA, PA
THALOMID CAPS 50mg, 100mg	1	QL (28 caps / 28 days), NM, LA, PA
THALOMID CAPS 150mg, 200mg	1	QL (56 caps / 28 days), NM, LA, PA
MISCELLANEOUS		
BESREMI SOSY 500mcg/ml	1	NM, LA, PA
<i>bexarotene</i> CAPS 75mg	1	NM, PA
<i>hydroxyurea</i> CAPS 500mg	1	
<i>irinotecan hcl</i> SOLN 40mg/2ml, 100mg/5ml, 300mg/15ml, 500mg/25ml	1	B/D
KISQALI 200 PAK FEMARA	1	QL (49 tabs / 28 days), NM, PA
KISQALI 400 PAK FEMARA	1	QL (70 tabs / 28 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
KISQALI 600 PAK FEMARA	1	QL (91 tabs / 28 days), NM, PA
MATULANE CAPS 50mg	1	NM, LA
SYNRIBO SOLR 3.5mg	1	NM, PA
<i>tretinoin (chemotherapy)</i> CAPS 10mg	1	
WELIREG TABS 40mg	1	NM, LA, PA

MITOTIC INHIBITORS

<i>docetaxel</i> CONC 20mg/ml, 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
DOCETAXEL CONC 80mg/4ml, 160mg/8ml; SOLN 20mg/2ml, 80mg/8ml, 160mg/16ml	1	B/D
<i>etoposide</i> SOLN 100mg/5ml, 500mg/25ml	1	B/D
<i>paclitaxel</i> CONC 6mg/ml, 30mg/5ml, 150mg/25ml, 300mg/50ml	1	B/D
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	1	B/D, NM
<i>toposar</i> SOLN 1gm/50ml, 100mg/5ml	1	B/D
<i>vincristine sulfate</i> SOLN 1mg/ml	1	B/D
<i>vinorelbine tartrate</i> SOLN 10mg/ml, 50mg/5ml	1	B/D

MOLECULAR TARGET AGENTS

ALECENSA CAPS 150mg	1	NM, LA, PA
ALUNBRIG TABS 30mg, 90mg, 180mg	1	NM, LA, PA
ALUNBRIG PAK	1	NM, LA, PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg	1	QL (30 tabs / 30 days), NM, LA, PA
BALVERSA TABS 3mg, 4mg, 5mg	1	NM, LA, PA
BORTEZOMIB SOLR 1mg, 2.5mg, 3.5mg	1	NM, PA
<i>bortezomib</i> SOLR 3.5mg	1	NM, PA
BOSULIF TABS 100mg, 400mg, 500mg	1	NM, PA
BRAFTOVI CAPS 75mg	1	NM, LA, PA
BRUKINSA CAPS 80mg	1	NM, LA, PA
CABOMETYX TABS 20mg, 40mg, 60mg	1	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE CAPS 100mg	1	QL (60 caps / 30 days), NM, LA, PA
CALQUENCE TABS 100mg	1	QL (60 tabs / 30 days), NM, LA, PA
CAPRELSA TABS 100mg, 300mg	1	NM, LA, PA
COMETRIQ (60MG DOSE) KIT 20mg	1	NM, LA, PA
COMETRIQ KIT 100MG	1	NM, LA, PA
COMETRIQ KIT 140MG	1	NM, LA, PA
COPIKTRA CAPS 15mg, 25mg	1	NM, LA, PA
COTELLIC TABS 20mg	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
DAURISMO TABS 25mg, 100mg	1	NM, LA, PA
ERIVEDGE CAPS 150mg	1	NM, LA, PA
<i>erlotinib hcl</i> TABS 25mg	1	QL (90 tabs / 30 days), NM, PA
<i>erlotinib hcl</i> TABS 100mg, 150mg	1	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TABS 2.5mg, 5mg, 7.5mg, 10mg	1	QL (30 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 2mg	1	QL (150 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 3mg	1	QL (90 tabs / 30 days), NM, PA
<i>everolimus</i> TBSO 5mg	1	QL (60 tabs / 30 days), NM, PA
EXKIVITY CAPS 40mg	1	NM, LA, PA
FOTIVDA CAPS .89mg, 1.34mg	1	QL (21 caps / 28 days), NM, LA, PA
GAVRETO CAPS 100mg	1	NM, LA, PA
GILOTRIF TABS 20mg, 30mg, 40mg	1	NM, LA, PA
HERCEP HYLEC SOL 60-10000	1	NM, LA, PA
HERCEPTIN SOLR 150mg	1	NM, LA, PA
HERZUMA SOLR 150mg, 420mg	1	NM, LA, PA
IBRANCE CAPS 75mg, 100mg, 125mg	1	QL (21 caps / 28 days), NM, LA, PA
IBRANCE TABS 75mg, 100mg, 125mg	1	QL (21 tabs / 28 days), NM, LA, PA
ICLUSIG TABS 10mg, 15mg, 30mg, 45mg	1	QL (30 tabs / 30 days), NM, LA, PA
IDHIFA TABS 50mg, 100mg	1	QL (30 tabs / 30 days), NM, LA, PA
<i>imatinib mesylate</i> TABS 100mg	1	QL (90 tabs / 30 days), NM, PA
<i>imatinib mesylate</i> TABS 400mg	1	QL (60 tabs / 30 days), NM, PA
IMBRUVICA CAPS 70mg	1	QL (30 caps / 30 days), NM, LA, PA
IMBRUVICA CAPS 140mg	1	QL (120 caps / 30 days), NM, LA, PA
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg	1	QL (30 tabs / 30 days), NM, LA, PA
INLYTA TABS 1mg	1	QL (180 tabs / 30 days), NM, LA, PA
INLYTA TABS 5mg	1	QL (120 tabs / 30 days), NM, LA, PA
INREBIC CAPS 100mg	1	NM, LA, PA
IRESSA TABS 250mg	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg	1	QL (60 tabs / 30 days), NM, LA, PA
KADCYLA SOLR 100mg, 160mg	1	B/D, NM, LA
KANJINTI SOLR 150mg, 420mg	1	NM, LA, PA
KEYTRUDA SOLN 100mg/4ml	1	NM, LA, PA
KISQALI 200 DOSE TBPK 200mg	1	QL (21 tabs / 28 days), NM, PA
KISQALI 400 DOSE TBPK 200mg	1	QL (42 tabs / 28 days), NM, PA
KISQALI 600 DOSE TBPK 200mg	1	QL (63 tabs / 28 days), NM, PA
<i>lapatinib ditosylate</i> TABS 250mg	1	NM, PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg	1	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg	1	QL (60 caps / 30 days), NM, LA, PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg	1	QL (30 caps / 30 days), NM, LA, PA
LENVIMA 12MG DAILY DOSE CPPK 4mg	1	QL (90 caps / 30 days), NM, LA, PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg	1	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 14 MG	1	QL (60 caps / 30 days), NM, LA, PA
LENVIMA CAP 18 MG	1	QL (90 caps / 30 days), NM, LA, PA
LENVIMA CAP 24 MG	1	QL (90 caps / 30 days), NM, LA, PA
LORBRENA TABS 25mg, 100mg	1	NM, LA, PA
LUMAKRAS TABS 120mg	1	NM, LA, PA
LYNPARZA TABS 100mg, 150mg	1	QL (120 tabs / 30 days), NM, LA, PA
MEKINIST TABS .5mg, 2mg	1	NM, LA, PA
MEKTOVI TABS 15mg	1	NM, LA, PA
MONJUVI SOLR 200mg	1	NM, LA, PA
MVASI SOLN 100mg/4ml, 400mg/16ml	1	NM, LA, PA
NERLYNX TABS 40mg	1	NM, LA, PA
NEXAVAR TABS 200mg	1	QL (120 tabs / 30 days), NM, LA, PA
NINLARO CAPS 2.3mg, 3mg, 4mg	1	QL (3 caps / 28 days), NM, PA
ODOMZO CAPS 200mg	1	NM, LA, PA
OGIVRI SOLR 150mg	1	NM, LA, PA
OGIVRI INJ 420MG	1	NM, LA, PA
ONTRUZANT SOLR 150mg, 420mg	1	NM, LA, PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	1	NM, LA, PA
PHESGO SOL	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
PIQRAY 200MG DAILY DOSE TBPK 200mg	1	NM, PA
PIQRAY 250MG TAB DOSE	1	NM, PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	1	NM, PA
QINLOCK TABS 50mg	1	NM, LA, PA
RETEVMO CAPS 40mg, 80mg	1	NM, LA, PA
ROZLYTREK CAPS 100mg, 200mg	1	NM, LA, PA
RUBRACA TABS 200mg, 250mg, 300mg	1	QL (120 tabs / 30 days), NM, LA, PA
RYDAPT CAPS 25mg	1	NM, PA
SCSEMBLIX TABS 20mg	1	QL (60 tabs / 30 days), NM, PA
SCSEMBLIX TABS 40mg	1	QL (300 tabs / 30 days), NM, PA
<i>sorafenib tosylate</i> TABS 200mg	1	QL (120 tabs / 30 days), NM, PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg, 140mg	1	NM, PA
STIVARGA TABS 40mg	1	NM, LA, PA
<i>sunitinib malate</i> CAPS 12.5mg, 25mg, 37.5mg, 50mg	1	QL (30 caps / 30 days), NM, PA
TABRECTA TABS 150mg, 200mg	1	NM, PA
TAFINLAR CAPS 50mg, 75mg	1	NM, LA, PA
TAGRISSE TABS 40mg, 80mg	1	QL (30 tabs / 30 days), NM, LA, PA
TALZENNA CAPS .5mg, .75mg, 1mg	1	QL (30 caps / 30 days), NM, LA, PA
TALZENNA CAPS .25mg	1	QL (90 caps / 30 days), NM, LA, PA
TASIGNA CAPS 50mg, 150mg, 200mg	1	NM, PA
TAZVERIK TABS 200mg	1	NM, LA, PA
TECENTRIQ SOLN 840mg/14ml, 1200mg/20ml	1	NM, LA, PA
TEPMETKO TABS 225mg	1	NM, LA, PA
TIBSOVO TABS 250mg	1	NM, LA, PA
TRAZIMERA SOLR 150mg, 420mg	1	NM, PA
TRUSELTIQ 50 MG DAILY DOSE CPPK 25mg	1	NM, LA, PA
TRUSELTIQ 75 MG DAILY DOSE CPPK 25mg	1	NM, LA, PA
TRUSELTIQ 100 MG DAILY DOSE CPPK 100mg	1	NM, LA, PA
TRUSELTIQ 125 MG DAILY DOSE	1	NM, LA, PA
TRUXIMA SOLN 100mg/10ml, 500mg/50ml	1	NM, PA
TUKYSA TABS 50mg, 150mg	1	NM, LA, PA
TURALIO CAPS 200mg	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA TABS 10mg, 50mg	1	QL (112 tabs / 28 days), NM, LA, PA
VENCLEXTA TABS 100mg	1	QL (180 tabs / 30 days), NM, LA, PA
VENCLEXTA TAB START PK	1	QL (42 tabs / 28 days), NM, LA, PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg	1	QL (56 tabs / 28 days), NM, LA, PA
VITRAKVI CAPS 25mg, 100mg; SOLN 20mg/ml	1	NM, LA, PA
VIZIMPRO TABS 15mg, 30mg, 45mg	1	NM, LA, PA
VONJO CAPS 100mg	1	QL (120 caps / 30 days), NM, LA, PA
VOTRIENT TABS 200mg	1	NM, LA, PA
XALKORI CAPS 200mg, 250mg	1	NM, LA, PA
XOSPATA TABS 40mg	1	NM, LA, PA
XPOVIO 40 MG ONCE WEEKLY TBPK 40mg	1	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 40 MG TWICE WEEKLY TBPK 40mg	1	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG ONCE WEEKLY TBPK 60mg	1	QL (4 tabs / 28 days), NM, LA, PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg	1	QL (24 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG ONCE WEEKLY TBPK 40mg	1	QL (8 tabs / 28 days), NM, LA, PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg	1	QL (32 tabs / 28 days), NM, LA, PA
XPOVIO 100 MG ONCE WEEKLY TBPK 50mg	1	QL (8 tabs / 28 days), NM, LA, PA
ZEJULA CAPS 100mg	1	QL (90 caps / 30 days), NM, LA, PA
ZELBORAF TABS 240mg	1	NM, LA, PA
ZIRABEV SOLN 100mg/4ml, 400mg/16ml	1	NM, LA, PA
ZOLINZA CAPS 100mg	1	NM, PA
ZYDELIG TABS 100mg, 150mg	1	NM, LA, PA
ZYKADIA TABS 150mg	1	NM, LA, PA
PROTECTIVE AGENTS		
<i>leucovorin calcium</i> SOLN 500mg/50ml; SOLR 50mg, 100mg, 200mg, 350mg, 500mg	1	B/D
<i>leucovorin calcium</i> TABS 5mg, 10mg, 15mg, 25mg	1	
MESNEX TABS 400mg	1	

Drug Name	Drug Tier	Requirements/Limits
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	QL (30 caps / 30 days)
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	QL (30 caps / 30 days)
<i>benazepril & hydrochlorothiazide tab 5-6.25mg</i>	1	
<i>benazepril & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>benazepril & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	1	
ACE INHIBITORS		
<i>benazepril hcl TABS 5mg, 10mg, 20mg, 40mg</i>	1	
<i>captopril TABS 12.5mg, 25mg, 50mg, 100mg</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>enalapril maleate</i> TABS 2.5mg, 5mg, 10mg, 20mg	1	
<i>fosinopril sodium</i> TABS 10mg, 20mg, 40mg	1	
<i>lisinopril</i> TABS 2.5mg, 5mg, 10mg, 20mg, 30mg, 40mg	1	
<i>moexipril hcl</i> TABS 7.5mg, 15mg	1	
<i>perindopril erbumine</i> TABS 2mg, 4mg, 8mg	1	
<i>quinapril hcl</i> TABS 5mg, 10mg, 20mg, 40mg	1	
<i>ramipril</i> CAPS 1.25mg, 2.5mg, 5mg, 10mg	1	
<i>trandolapril</i> TABS 1mg, 2mg, 4mg	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i> TABS 25mg, 50mg	1	
KERENDIA TABS 10mg, 20mg	1	QL (30 tabs / 30 days)
<i>spironolactone</i> TABS 25mg, 50mg, 100mg	1	
ALPHA BLOCKERS		
<i>doxazosin mesylate</i> TABS 1mg, 2mg, 4mg, 8mg	1	
<i>prazosin hcl</i> CAPS 1mg, 2mg, 5mg	1	
<i>terazosin hcl</i> CAPS 1mg, 2mg, 5mg, 10mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	QL (30 tabs / 30 days)
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	QL (30 tabs / 30 days)
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	1	QL (60 tabs / 30 days)
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	QL (30 tabs / 30 days)
ENTRESTO TAB 24-26MG	1	

Drug Name	Drug Tier	Requirements/Limits
ENTRESTO TAB 49-51MG	1	
ENTRESTO TAB 97-103MG	1	
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	QL (60 tabs / 30 days)
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 40-5 mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 40-10 mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 80-5 mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan-amlodipine tab 80-10 mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan-hydrochlorothiazide tab 40-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	QL (60 tabs / 30 days)
<i>telmisartan-hydrochlorothiazide tab 80-25 mg</i>	1	QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	QL (30 tabs / 30 days)
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	QL (30 tabs / 30 days)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil TABS 4mg, 8mg, 16mg</i>	1	QL (60 tabs / 30 days)
<i>candesartan cilexetil TABS 32mg</i>	1	QL (30 tabs / 30 days)
<i>irbesartan TABS 75mg, 150mg, 300mg</i>	1	QL (30 tabs / 30 days)
<i>losartan potassium TABS 25mg, 50mg, 100mg</i>	1	
<i>olmesartan medoxomil TABS 5mg</i>	1	QL (60 tabs / 30 days)
<i>olmesartan medoxomil TABS 20mg, 40mg</i>	1	QL (30 tabs / 30 days)
<i>telmisartan TABS 20mg, 40mg, 80mg</i>	1	QL (30 tabs / 30 days)
<i>valsartan TABS 40mg, 80mg, 160mg</i>	1	QL (60 tabs / 30 days)
<i>valsartan TABS 320mg</i>	1	QL (30 tabs / 30 days)
ANTIARRHYTHMICS		
<i>amiodarone hcl SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 200mg, 400mg</i>	1	
<i>disopyramide phosphate CAPS 100mg, 150mg</i>	1	
<i>dofetilide CAPS 125mcg, 250mcg, 500mcg</i>	1	
<i>flecainide acetate TABS 50mg, 100mg, 150mg</i>	1	
MULTAQ TABS 400mg	1	
NORPACE CR CP12 100mg, 150mg	1	
<i>pacerone TABS 100mg, 200mg, 400mg</i>	1	
<i>propafenone hcl CP12 225mg, 325mg, 425mg; TABS 150mg, 225mg, 300mg</i>	1	
<i>quinidine sulfate TABS 200mg, 300mg</i>	1	
<i>sorine TABS 80mg, 120mg, 160mg, 240mg</i>	1	
<i>sotalol hcl TABS 80mg, 120mg, 160mg, 240mg</i>	1	
<i>sotalol hcl (afib/afl) TABS 80mg, 120mg, 160mg</i>	1	
ANTILIPEMICS, FIBRATES		
<i>fenofibrate TABS 48mg, 54mg, 145mg, 160mg</i>	1	
<i>fenofibrate micronized CAPS 67mg, 134mg, 200mg</i>	1	
<i>gemfibrozil TABS 600mg</i>	1	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
<i>atorvastatin calcium TABS 10mg, 20mg, 40mg, 80mg</i>	1	QL (30 tabs / 30 days)
<i>lovastatin TABS 10mg, 20mg, 40mg</i>	1	QL (60 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>pravastatin sodium</i> TABS 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
<i>rosuvastatin calcium</i> TABS 5mg, 10mg, 20mg, 40mg	1	QL (30 tabs / 30 days)
<i>simvastatin</i> TABS 5mg, 10mg, 20mg, 40mg, 80mg	1	QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
<i>cholestyramine</i> PACK 4gm; POWD 4gm/dose	1	
<i>cholestyramine light</i> PACK 4gm; POWD 4gm/dose	1	
<i>colesevelam hcl</i> PACK 3.75gm; TABS 625mg	1	
<i>colestipol hcl</i> GRAN 5gm; PACK 5gm; TABS 1gm	1	
<i>ezetimibe</i> TABS 10mg	1	
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	QL (30 tabs / 30 days)
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	QL (30 tabs / 30 days)
<i>niacin (antihyperlipidemic)</i> TBCR 500mg, 750mg, 1000mg	1	QL (60 tabs / 30 days)
PRALUENT SOAJ 75mg/ml, 150mg/ml	1	NM, PA
<i>prevalite</i> PACK 4gm; POWD 4gm/dose	1	
VASCEPA CAPS .5gm, 1gm	1	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol & chlorthalidone tab 50-25 mg</i>	1	
<i>atenolol & chlorthalidone tab 100-25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	1	
BETA-BLOCKERS		
<i>acebutolol hcl</i> CAPS 200mg, 400mg	1	
<i>atenolol</i> TABS 25mg, 50mg, 100mg	1	
<i>betaxolol hcl</i> TABS 10mg, 20mg	1	
<i>bisoprolol fumarate</i> TABS 5mg, 10mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>carvedilol</i> TABS 3.125mg, 6.25mg, 12.5mg, 25mg	1	
<i>labetalol hcl</i> TABS 100mg, 200mg, 300mg	1	
<i>metoprolol succinate</i> TB24 25mg, 50mg, 100mg, 200mg	1	
<i>metoprolol tartrate</i> SOLN 5mg/5ml; TABS 25mg, 50mg, 100mg	1	
<i>nadolol</i> TABS 20mg, 40mg, 80mg	1	
<i>nebivolol hcl</i> TABS 2.5mg, 5mg, 10mg	1	QL (30 tabs / 30 days)
<i>nebivolol hcl</i> TABS 20mg	1	QL (60 tabs / 30 days)
<i>pindolol</i> TABS 5mg, 10mg	1	
<i>propranolol hcl</i> CP24 60mg, 80mg, 120mg, 160mg; SOLN 20mg/5ml, 40mg/5ml; TABS 10mg, 20mg, 40mg, 60mg, 80mg	1	
<i>timolol maleate</i> TABS 5mg, 10mg, 20mg	1	
CALCIUM CHANNEL BLOCKERS		
<i>amlodipine besylate</i> TABS 2.5mg, 5mg, 10mg	1	
<i>cartia xt</i> CP24 120mg, 180mg, 240mg, 300mg	1	
<i>dilt-xr</i> CP24 120mg, 180mg, 240mg	1	
<i>diltiazem hcl</i> CP12 60mg, 90mg, 120mg; SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml; TABS 30mg, 60mg, 90mg, 120mg	1	
<i>diltiazem hcl coated beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
<i>diltiazem hcl extended release beads</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
<i>felodipine</i> TB24 2.5mg, 5mg, 10mg	1	
<i>isradipine</i> CAPS 2.5mg, 5mg	1	
<i>nicardipine hcl</i> CAPS 20mg, 30mg	1	
<i>nifedipine</i> TB24 30mg, 60mg, 90mg	1	
<i>nimodipine</i> CAPS 30mg	1	
NYMALIZE SOLN 6mg/ml	1	
<i>taztia xt</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg	1	
<i>tiadylt er</i> CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	1	
<i>verapamil hcl</i> CP24 100mg, 120mg, 180mg, 200mg, 240mg, 300mg, 360mg; SOLN 2.5mg/ml; TABS 40mg, 80mg, 120mg; TBCR 120mg, 180mg, 240mg	1	

Drug Name	Drug Tier	Requirements/Limits
DIURETICS		
<i>acetazolamide</i> CP12 500mg; TABS 125mg, 250mg	1	
<i>amiloride & hydrochlorothiazide tab</i> 5-50 mg	1	
<i>amiloride hcl</i> TABS 5mg	1	
<i>bumetanide</i> SOLN .25mg/ml; TABS .5mg, 1mg, 2mg	1	
<i>chlorthalidone</i> TABS 25mg, 50mg	1	
<i>furosemide</i> SOLN 10mg/ml, 40mg/5ml; TABS 20mg, 40mg, 80mg	1	
<i>furosemide inj</i> SOLN 10mg/ml	1	
<i>hydrochlorothiazide</i> CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	1	
<i>indapamide</i> TABS 1.25mg, 2.5mg	1	
<i>methazolamide</i> TABS 25mg, 50mg	1	
<i>metolazone</i> TABS 2.5mg, 5mg, 10mg	1	
<i>spironolactone & hydrochlorothiazide tab</i> 25-25 mg	1	
<i>toremide</i> TABS 5mg, 10mg, 20mg, 100mg	1	
<i>triamterene & hydrochlorothiazide cap</i> 37.5-25 mg	1	
<i>triamterene & hydrochlorothiazide tab</i> 37.5-25 mg	1	
<i>triamterene & hydrochlorothiazide tab</i> 75-50 mg	1	
MISCELLANEOUS		
ADRENALIN SOLN 1mg/ml	1	
<i>aliskiren fumarate</i> TABS 150mg, 300mg	1	
<i>clonidine</i> PTWK .1mg/24hr, .2mg/24hr, .3mg/24hr	1	
<i>clonidine hcl</i> TABS .1mg, .2mg, .3mg	1	
CORLANOR SOLN 5mg/5ml; TABS 5mg, 7.5mg	1	
<i>digoxin</i> SOLN .05mg/ml, .25mg/ml	1	
<i>digoxin</i> TABS 125mcg, 250mcg	1	QL (30 tabs / 30 days)
<i>droxidopa</i> CAPS 100mg	1	QL (90 caps / 30 days), NM, PA
<i>droxidopa</i> CAPS 200mg, 300mg	1	QL (180 caps / 30 days), NM, PA
<i>guanfacine hcl</i> TABS 1mg, 2mg	1	PA; PA if 70 years and older
<i>hydralazine hcl</i> SOLN 20mg/ml; TABS 10mg, 25mg, 50mg, 100mg	1	
<i>metyrosine</i> CAPS 250mg	1	PA

Drug Name	Drug Tier	Requirements/Limits
<i>midodrine hcl</i> TABS 2.5mg, 5mg, 10mg	1	
<i>minoxidil</i> TABS 2.5mg, 10mg	1	
<i>ranolazine</i> TB12 500mg, 1000mg	1	
VERQUVO TABS 2.5mg, 5mg, 10mg	1	

NITRATES

<i>isosorbide dinitrate</i> TABS 5mg, 10mg, 20mg, 30mg	1	
<i>isosorbide mononitrate</i> TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg	1	
NITRO-BID OINT 2%	1	
<i>nitroglycerin</i> PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr; SOLN .4mg/spray; SUBL .3mg, .4mg, .6mg	1	

PULMONARY ARTERIAL HYPERTENSION

ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg	1	QL (90 tabs / 30 days), NM, LA, PA
<i>ambrisentan</i> TABS 5mg, 10mg	1	QL (30 tabs / 30 days), NM, LA, PA
<i>bosentan</i> TABS 62.5mg, 125mg	1	QL (60 tabs / 30 days), NM, LA, PA
OPSUMIT TABS 10mg	1	QL (30 tabs / 30 days), NM, LA, PA
<i>sildenafil citrate (pulmonary hypertension)</i> TABS 20mg	1	QL (90 tabs / 30 days), NM, PA
<i>treprostinil</i> SOLN 20mg/20ml, 50mg/20ml, 100mg/20ml, 200mg/20ml	1	NM, LA, PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	1	NM, LA, PA

CENTRAL NERVOUS SYSTEM

ANTI-ANXIETY

<i>alprazolam</i> TABS .25mg, .5mg, 1mg, 2mg	1	QL (150 tabs / 30 days)
<i>bupirone hcl</i> TABS 5mg, 7.5mg, 10mg, 15mg, 30mg	1	
<i>fluvoxamine maleate</i> TABS 25mg, 50mg, 100mg	1	
<i>lorazepam</i> CONC 2mg/ml	1	QL (150 mL / 30 days)
<i>lorazepam</i> SOLN 2mg/ml, 4mg/ml	1	
<i>lorazepam</i> TABS .5mg, 1mg, 2mg	1	QL (150 tabs / 30 days)
<i>lorazepam intensol</i> CONC 2mg/ml	1	QL (150 mL / 30 days)

ANTICONVULSANTS

APTIOM TABS 200mg, 400mg	1	QL (30 tabs / 30 days)
APTIOM TABS 600mg, 800mg	1	QL (60 tabs / 30 days)
BRIVIACT SOLN 10mg/ml	1	QL (600 mL / 30 days), PA
BRIVIACT SOLN 50mg/5ml	1	PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg	1	QL (60 tabs / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
<i>carbamazepine</i> CHEW 100mg; CP12 100mg, 200mg, 300mg; SUSP 100mg/5ml; TABS 200mg; TB12 100mg, 200mg, 400mg	1	
CELONTIN CAPS 300mg	1	
<i>clobazam</i> SUSP 2.5mg/ml	1	QL (480 mL / 30 days), PA
<i>clobazam</i> TABS 10mg, 20mg	1	QL (60 tabs / 30 days), PA
<i>clonazepam</i> TABS 2mg; TBDP 2mg	1	QL (300 tabs / 30 days)
<i>clonazepam</i> TABS .5mg, 1mg; TBDP .125mg, .25mg, .5mg, 1mg	1	QL (90 tabs / 30 days)
<i>clorazepate dipotassium</i> TABS 3.75mg, 7.5mg, 15mg	1	QL (180 tabs / 30 days), PA; PA if 65 years and older
DIACOMIT CAPS 250mg	1	QL (360 caps / 30 days), NM, LA, PA
DIACOMIT CAPS 500mg	1	QL (180 caps / 30 days), NM, LA, PA
DIACOMIT PACK 250mg	1	QL (360 packets / 30 days), NM, LA, PA
DIACOMIT PACK 500mg	1	QL (180 packets / 30 days), NM, LA, PA
<i>diazepam</i> CONC 5mg/ml	1	QL (240 mL / 30 days), PA; PA if 65 years and older
<i>diazepam</i> SOLN 5mg/5ml	1	QL (1200 mL / 30 days), PA; PA if 65 years and older
<i>diazepam</i> TABS 2mg, 5mg, 10mg	1	QL (120 tabs / 30 days), PA; PA if 65 years and older
<i>diazepam (anticonvulsant)</i> GEL 2.5mg, 10mg, 20mg	1	
<i>diazepam inj</i> SOLN 5mg/ml	1	
DILANTIN CAPS 30mg, 100mg	1	
DILANTIN INFATABS CHEW 50mg	1	
DILANTIN-125 SUSP 125mg/5ml	1	
<i>divalproex sodium</i> CSDR 125mg; TB24 250mg, 500mg; TBEC 125mg, 250mg, 500mg	1	
EPIDIOLEX SOLN 100mg/ml	1	QL (600 mL / 30 days), NM, LA, PA
<i>epitol</i> TABS 200mg	1	
EPRONTIA SOLN 25mg/ml	1	QL (480 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
<i>ethosuximide</i> CAPS 250mg; SOLN 250mg/5ml	1	
<i>felbamate</i> SUSP 600mg/5ml; TABS 400mg, 600mg	1	
FINTEPLA SOLN 2.2mg/ml	1	QL (360 mL / 30 days), NM, LA, PA
FYCOMPA SUSP .5mg/ml	1	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	1	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg, 8mg, 10mg, 12mg	1	QL (30 tabs / 30 days), PA
<i>gabapentin</i> CAPS 100mg, 300mg, 400mg	1	QL (180 caps / 30 days)
<i>gabapentin</i> SOLN 250mg/5ml	1	QL (2160 mL / 30 days)
<i>gabapentin</i> TABS 600mg	1	QL (180 tabs / 30 days)
<i>gabapentin</i> TABS 800mg	1	QL (120 tabs / 30 days)
<i>lacosamide</i> SOLN 200mg/20ml	1	
<i>lacosamide</i> TABS 50mg	1	QL (120 tabs / 30 days)
<i>lacosamide</i> TABS 100mg, 150mg, 200mg	1	QL (60 tabs / 30 days)
<i>lacosamide oral</i> SOLN 10mg/ml	1	QL (1200 mL / 30 days)
<i>lamotrigine</i> CHEW 5mg, 25mg; TABS 25mg, 100mg, 150mg, 200mg; TB24 25mg, 50mg, 100mg, 200mg, 250mg, 300mg	1	
<i>levetiracetam</i> SOLN 100mg/ml, 500mg/5ml; TABS 250mg, 500mg, 750mg, 1000mg; TB24 500mg, 750mg	1	
<i>levetiracetam in sodium chloride iv soln</i> 500 mg/100ml	1	
<i>levetiracetam in sodium chloride iv soln</i> 1000 mg/100ml	1	
<i>levetiracetam in sodium chloride iv soln</i> 1500 mg/100ml	1	
NAYZILAM SOLN 5mg/0.1ml	1	
<i>oxcarbazepine</i> SUSP 300mg/5ml; TABS 150mg, 300mg, 600mg	1	
<i>phenobarbital</i> ELIX 20mg/5ml; TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg	1	PA; PA if 70 years and older
<i>phenobarbital sodium</i> SOLN 65mg/ml, 130mg/ml	1	PA; PA if 70 years and older
PHENYTEK CAPS 200mg, 300mg	1	
<i>phenytoin</i> CHEW 50mg; SUSP 125mg/5ml	1	
<i>phenytoin sodium</i> SOLN 50mg/ml	1	
<i>phenytoin sodium extended</i> CAPS 100mg, 200mg, 300mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>pregabalin</i> CAPS 25mg, 50mg, 75mg, 100mg, 150mg	1	QL (120 caps / 30 days), PA
<i>pregabalin</i> CAPS 200mg	1	QL (90 caps / 30 days), PA
<i>pregabalin</i> CAPS 225mg, 300mg	1	QL (60 caps / 30 days), PA
<i>pregabalin</i> SOLN 20mg/ml	1	QL (900 mL / 30 days), PA
<i>primidone</i> TABS 50mg, 250mg	1	
<i>roweepra</i> TABS 500mg	1	
<i>rufinamide</i> SUSP 40mg/ml	1	QL (2400 mL / 30 days), PA
<i>rufinamide</i> TABS 200mg	1	QL (480 tabs / 30 days), PA
<i>rufinamide</i> TABS 400mg	1	QL (240 tabs / 30 days), PA
SPRITAM TB3D 250mg	1	QL (360 tabs / 30 days)
SPRITAM TB3D 500mg	1	QL (180 tabs / 30 days)
SPRITAM TB3D 750mg	1	QL (120 tabs / 30 days)
SPRITAM TB3D 1000mg	1	QL (90 tabs / 30 days)
<i>subvenite</i> TABS 25mg, 100mg, 150mg, 200mg	1	
SYMPAZAN FILM 5mg, 10mg, 20mg	1	QL (60 films / 30 days), PA
<i>tiagabine hcl</i> TABS 2mg, 4mg, 12mg, 16mg	1	
<i>topiramate</i> CPSP 15mg, 25mg; TABS 25mg, 50mg, 100mg, 200mg	1	
<i>valproate sodium</i> SOLN 100mg/ml, 250mg/5ml	1	
<i>valproic acid</i> CAPS 250mg	1	
VALTOCO LIQD 5mg/0.1ml, 10mg/0.1ml; LQPK 7.5mg/0.1ml, 10mg/0.1ml	1	
<i>vigabatrin</i> PACK 500mg	1	QL (180 packets / 30 days), NM, LA, PA
<i>vigabatrin</i> TABS 500mg	1	QL (180 tabs / 30 days), NM, LA, PA
<i>vigadrone</i> PACK 500mg	1	QL (180 packets / 30 days), NM, LA, PA
VIMPAT SOLN 10mg/ml	1	QL (1200 mL / 30 days)
XCOPRI TABS 50mg, 100mg	1	QL (30 tabs / 30 days)
XCOPRI TABS 150mg, 200mg	1	QL (60 tabs / 30 days)
XCOPRI PAK 12.5-25	1	QL (28 tabs / 28 days)
XCOPRI PAK 50-100MG	1	QL (28 tabs / 28 days)
XCOPRI PAK 100-150	1	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (MAINTENANCE)	1	QL (56 tabs / 28 days)
XCOPRI PAK 150-200MG (TITRATION)	1	QL (28 tabs / 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>zonisamide</i> CAPS 25mg, 50mg, 100mg	1	
ZTALMY SUSP 50mg/ml	1	QL (1100 mL / 30 days), NM, LA, PA

ANTIDEMENTIA

<i>donepezil hydrochloride</i> TABS 5mg; TBDP 5mg	1	QL (30 tabs / 30 days)
<i>donepezil hydrochloride</i> TABS 10mg; TBDP 10mg	1	
<i>galantamine hydrobromide</i> CP24 8mg, 16mg, 24mg	1	QL (30 caps / 30 days)
<i>galantamine hydrobromide</i> SOLN 4mg/ml	1	
<i>galantamine hydrobromide</i> TABS 4mg, 8mg, 12mg	1	QL (60 tabs / 30 days)
<i>memantine hcl</i> CP24 7mg, 14mg, 21mg, 28mg; SOLN 2mg/ml; TABS 5mg, 10mg	1	PA; PA if < 30 yrs
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	1	PA; PA if < 30 yrs
NAMZARIC CAP 7-10MG	1	
NAMZARIC CAP 14-10MG	1	
NAMZARIC CAP 21-10MG	1	
NAMZARIC CAP 28-10MG	1	
NAMZARIC CAP PACK	1	
<i>rivastigmine</i> PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr	1	QL (30 patches / 30 days)
<i>rivastigmine tartrate</i> CAPS 1.5mg, 3mg, 4.5mg, 6mg	1	QL (60 caps / 30 days)

ANTIDEPRESSANTS

<i>amitriptyline hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	1	
<i>amoxapine</i> TABS 25mg, 50mg, 100mg, 150mg	1	
<i>bupropion hcl</i> TABS 75mg, 100mg; TB12 100mg, 150mg, 200mg; TB24 150mg, 300mg	1	
<i>citalopram hydrobromide</i> SOLN 10mg/5ml; TABS 10mg, 20mg, 40mg	1	
<i>clomipramine hcl</i> CAPS 25mg, 50mg, 75mg	1	PA
<i>desipramine hcl</i> TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	1	
<i>desvenlafaxine succinate</i> TB24 25mg, 50mg, 100mg	1	QL (30 tabs / 30 days), PA
<i>doxepin hcl</i> CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	1	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg	1	QL (60 caps / 30 days), PA
<i>duloxetine hcl</i> CPEP 20mg, 30mg, 60mg	1	QL (60 caps / 30 days)

Drug Name	Drug Tier	Requirements/Limits
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr	1	QL (30 patches / 30 days), PA
<i>escitalopram oxalate</i> SOLN 5mg/5ml; TABS 5mg, 10mg, 20mg	1	
FETZIMA CP24 20mg, 40mg	1	QL (60 caps / 30 days), PA
FETZIMA CP24 80mg, 120mg	1	QL (30 caps / 30 days), PA
FETZIMA CAP TITRATIO	1	PA
<i>fluoxetine hcl</i> CAPS 10mg, 20mg, 40mg; SOLN 20mg/5ml	1	
<i>imipramine hcl</i> TABS 10mg, 25mg, 50mg	1	
MARPLAN TABS 10mg	1	QL (180 tabs / 30 days)
<i>mirtazapine</i> TABS 7.5mg, 15mg, 30mg, 45mg; TBDP 15mg, 30mg, 45mg	1	
<i>nefazodone hcl</i> TABS 50mg, 100mg, 150mg, 200mg, 250mg	1	
<i>nortriptyline hcl</i> CAPS 10mg, 25mg, 50mg, 75mg; SOLN 10mg/5ml	1	
<i>paroxetine hcl</i> SUSP 10mg/5ml	1	QL (900 mL / 30 days), PA
<i>paroxetine hcl</i> TABS 10mg, 20mg, 30mg, 40mg	1	
<i>phenelzine sulfate</i> TABS 15mg	1	
<i>protriptyline hcl</i> TABS 5mg, 10mg	1	
<i>sertraline hcl</i> CONC 20mg/ml; TABS 25mg, 50mg, 100mg	1	
<i>tranylcypromine sulfate</i> TABS 10mg	1	
<i>trazodone hcl</i> TABS 50mg, 100mg, 150mg	1	
<i>trimipramine maleate</i> CAPS 25mg, 50mg	1	QL (120 caps / 30 days)
<i>trimipramine maleate</i> CAPS 100mg	1	QL (60 caps / 30 days)
TRINTELLIX TABS 5mg, 10mg, 20mg	1	QL (30 tabs / 30 days)
<i>venlafaxine hcl</i> CP24 37.5mg, 75mg, 150mg; TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	1	
VIIBRYD KIT STARTER	1	
<i>vilazodone hcl</i> TABS 10mg, 20mg, 40mg	1	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
<i>amantadine hcl</i> CAPS 100mg	1	QL (120 caps / 30 days)
<i>amantadine hcl</i> SOLN 50mg/5ml; TABS 100mg	1	
<i>benztropine mesylate</i> SOLN 1mg/ml	1	
<i>benztropine mesylate</i> TABS .5mg, 1mg, 2mg	1	PA; PA if 70 years and older
<i>bromocriptine mesylate</i> CAPS 5mg; TABS 2.5mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>carb/levo orally disintegrating tab 10-100mg</i>	1	
<i>carb/levo orally disintegrating tab 25-100mg</i>	1	
<i>carb/levo orally disintegrating tab 25-250mg</i>	1	
<i>carbidopa & levodopa tab 10-100 mg</i>	1	
<i>carbidopa & levodopa tab 25-100 mg</i>	1	
<i>carbidopa & levodopa tab 25-250 mg</i>	1	
<i>carbidopa & levodopa tab er 25-100 mg</i>	1	
<i>carbidopa & levodopa tab er 50-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	1	
<i>entacapone TABS 200mg</i>	1	
<i>KYNMOBI FILM 10mg, 15mg, 20mg, 25mg, 30mg</i>	1	QL (150 films / 30 days), NM, PA
<i>NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr, 8mg/24hr</i>	1	
<i>pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg</i>	1	
<i>rasagiline mesylate TABS .5mg, 1mg</i>	1	QL (30 tabs / 30 days)
<i>ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg</i>	1	
<i>selegiline hcl CAPS 5mg; TABS 5mg</i>	1	
<i>trihexyphenidyl hcl SOLN .4mg/ml; TABS 2mg, 5mg</i>	1	PA; PA if 70 years and older
ANTIPSYCHOTICS		
<i>ABILIFY MAINTENA PRSY 300mg, 400mg</i>	1	QL (1 syringe / 28 days)
<i>ABILIFY MAINTENA SRER 300mg, 400mg</i>	1	QL (1 injection / 28 days)
<i>aripiprazole SOLN 1mg/ml</i>	1	QL (900 mL / 30 days)
<i>aripiprazole TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg</i>	1	QL (30 tabs / 30 days)
<i>aripiprazole TBDP 10mg, 15mg</i>	1	QL (60 tabs / 30 days)
<i>ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml</i>	1	QL (1 syringe / 28 days)

Drug Name	Drug Tier	Requirements/Limits
ARISTADA PRSY 1064mg/3.9ml	1	QL (1 syringe / 56 days)
ARISTADA INITIO PRSY 675mg/2.4ml	1	
<i>asenapine maleate</i> SUBL 2.5mg, 5mg, 10mg	1	QL (60 tabs / 30 days)
CAPLYTA CAPS 10.5mg, 21mg, 42mg	1	QL (30 caps / 30 days), PA
<i>chlorpromazine hcl</i> SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	1	
CHLORPROMAZINE HYDROCHLOR CONC 30mg/ml, 100mg/ml	1	
<i>clozapine</i> TABS 25mg, 50mg	1	
<i>clozapine</i> TABS 100mg	1	QL (270 tabs / 30 days)
<i>clozapine</i> TABS 200mg	1	QL (120 tabs / 30 days)
<i>clozapine</i> TBDP 12.5mg, 25mg	1	PA
<i>clozapine</i> TBDP 100mg	1	QL (270 tabs / 30 days), PA
<i>clozapine</i> TBDP 150mg	1	QL (180 tabs / 30 days), PA
<i>clozapine</i> TBDP 200mg	1	QL (120 tabs / 30 days), PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg	1	QL (60 tabs / 30 days), PA
FANAPT PAK	1	PA
<i>fluphenazine decanoate</i> SOLN 25mg/ml	1	
<i>fluphenazine hcl</i> CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	1	
<i>haloperidol</i> TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	1	
<i>haloperidol decanoate</i> SOLN 50mg/ml, 100mg/ml	1	
<i>haloperidol lactate</i> CONC 2mg/ml; SOLN 5mg/ml	1	
INVEGA SUSTENNA SUSY 39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml	1	QL (1 syringe / 28 days)
LATUDA TABS 20mg, 40mg, 60mg, 120mg	1	QL (30 tabs / 30 days)
LATUDA TABS 80mg	1	QL (60 tabs / 30 days)
<i>loxapine succinate</i> CAPS 5mg, 10mg, 25mg, 50mg	1	
<i>molindone hcl</i> TABS 5mg, 10mg, 25mg	1	
NUPLAZID CAPS 34mg	1	QL (30 caps / 30 days), NM, LA, PA
NUPLAZID TABS 10mg	1	QL (30 tabs / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
<i>olanzapine</i> SOLR 10mg	1	QL (3 vials / 1 day)
<i>olanzapine</i> TABS 2.5mg, 5mg, 10mg; TBDP 10mg	1	QL (60 tabs / 30 days)
<i>olanzapine</i> TABS 7.5mg, 15mg, 20mg; TBDP 5mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
<i>paliperidone</i> TB24 1.5mg, 3mg, 9mg	1	QL (30 tabs / 30 days)
<i>paliperidone</i> TB24 6mg	1	QL (60 tabs / 30 days)
<i>perphenazine</i> TABS 2mg, 4mg, 8mg, 16mg	1	
PERSERIS PRSY 90mg, 120mg	1	QL (1 syringe / 30 days)
<i>pimozide</i> TABS 1mg, 2mg	1	
<i>quetiapine fumarate</i> TABS 25mg, 50mg, 100mg, 150mg, 200mg, 300mg, 400mg	1	
<i>quetiapine fumarate</i> TB24 50mg, 300mg, 400mg	1	QL (60 tabs / 30 days), PA
<i>quetiapine fumarate</i> TB24 150mg, 200mg	1	QL (30 tabs / 30 days), PA
REXULTI TABS 3mg, 4mg	1	QL (30 tabs / 30 days)
REXULTI TABS .25mg, .5mg, 1mg, 2mg	1	QL (60 tabs / 30 days)
<i>risperidone</i> SOLN 1mg/ml	1	QL (240 mL / 30 days)
<i>risperidone</i> TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg	1	
<i>risperidone</i> TBDP 1mg, 2mg, 3mg	1	QL (60 tabs / 30 days)
<i>risperidone</i> TBDP 4mg	1	QL (120 tabs / 30 days)
<i>risperidone</i> TBDP .25mg, .5mg	1	QL (90 tabs / 30 days)
SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr	1	QL (30 patches / 30 days)
<i>thioridazine hcl</i> TABS 10mg, 25mg, 50mg, 100mg	1	
<i>thiothixene</i> CAPS 1mg, 2mg, 5mg, 10mg	1	
<i>trifluoperazine hcl</i> TABS 1mg, 2mg, 5mg, 10mg	1	
VERSACLOZ SUSP 50mg/ml	1	QL (600 mL / 30 days), PA
VRAYLAR CAPS 1.5mg	1	QL (60 caps / 30 days)
VRAYLAR CAPS 3mg, 4.5mg, 6mg	1	QL (30 caps / 30 days)
VRAYLAR CAP 1.5-3MG	1	
<i>ziprasidone hcl</i> CAPS 20mg, 40mg, 60mg, 80mg	1	QL (60 caps / 30 days)
<i>ziprasidone mesylate</i> SOLR 20mg	1	QL (6 injections / 3 days)
ZYPREXA RELPREVV SUSR 210mg, 300mg	1	QL (2 vials / 28 days), NM, PA
ZYPREXA RELPREVV SUSR 405mg	1	QL (1 vial / 28 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	1	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	1	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	1	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	1	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	1	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	1	QL (30 caps / 30 days), PA
<i>amphetamine-dextroamphetamine tab 5 mg</i>	1	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	1	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 10 mg</i>	1	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	1	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 15 mg</i>	1	QL (60 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 20 mg</i>	1	QL (90 tabs / 30 days), PA
<i>amphetamine-dextroamphetamine tab 30 mg</i>	1	QL (60 tabs / 30 days), PA
<i>atomoxetine hcl CAPS 10mg, 18mg, 25mg</i>	1	QL (120 caps / 30 days)
<i>atomoxetine hcl CAPS 40mg</i>	1	QL (60 caps / 30 days)
<i>atomoxetine hcl CAPS 60mg, 80mg, 100mg</i>	1	QL (30 caps / 30 days)
<i>dexmethylphenidate hcl TABS 2.5mg, 5mg</i>	1	QL (120 tabs / 30 days), PA
<i>dexmethylphenidate hcl TABS 10mg</i>	1	QL (60 tabs / 30 days), PA
<i>guanfacine hcl (adhd) TB24 1mg, 2mg, 4mg</i>	1	QL (30 tabs / 30 days), PA; PA if 70 years and older
<i>guanfacine hcl (adhd) TB24 3mg</i>	1	QL (60 tabs / 30 days), PA; PA if 70 years and older
<i>metadate er TBCR 20mg</i>	1	QL (90 tabs / 30 days), PA
<i>methylphenidate hcl SOLN 5mg/5ml</i>	1	QL (1800 mL / 30 days), PA
<i>methylphenidate hcl SOLN 10mg/5ml</i>	1	QL (900 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl</i> TABS 5mg, 10mg	1	QL (180 tabs / 30 days), PA
<i>methylphenidate hcl</i> TABS 20mg; TBCR 10mg, 20mg	1	QL (90 tabs / 30 days), PA
HYPNOTICS		
BELSOMRA TABS 5mg, 10mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
<i>doxepin hcl (sleep)</i> TABS 3mg, 6mg	1	QL (30 tabs / 30 days)
<i>eszopiclone</i> TABS 1mg, 2mg, 3mg	1	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
HETLIOZ CAPS 20mg	1	QL (30 caps / 30 days), NM, LA, PA
<i>temazepam</i> CAPS 7.5mg, 30mg	1	QL (30 caps / 30 days), PA; PA if 65 years and older
<i>temazepam</i> CAPS 15mg	1	QL (60 caps / 30 days), PA; PA if 65 years and older
<i>zaleplon</i> CAPS 5mg	1	QL (30 caps / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
<i>zaleplon</i> CAPS 10mg	1	QL (60 caps / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
<i>zolpidem tartrate</i> TABS 5mg, 10mg	1	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
MIGRAINE		
AIMOVIG SOAJ 70mg/ml, 140mg/ml	1	QL (1 pen / 30 days), NM, PA
<i>dihydroergotamine mesylate</i> SOLN 1mg/ml	1	
<i>dihydroergotamine mesylate</i> SOLN 4mg/ml	1	QL (8 mL / 30 days), PA
<i>ergotamine w/ caffeine tab 1-100 mg</i>	1	QL (40 tabs / 28 days), PA
<i>naratriptan hcl</i> TABS 1mg, 2.5mg	1	QL (12 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
NURTEC TBDP 75mg	1	QL (16 tabs / 30 days), PA
<i>rizatriptan benzoate</i> TABS 5mg, 10mg; TBDP 5mg, 10mg	1	QL (18 tabs / 30 days)
<i>sumatriptan</i> SOLN 5mg/act	1	QL (24 units / 30 days)
<i>sumatriptan</i> SOLN 20mg/act	1	QL (12 units / 30 days)
<i>sumatriptan succinate</i> SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml	1	QL (18 injections / 30 days)
<i>sumatriptan succinate</i> SOAJ 6mg/0.5ml; SOCT 6mg/0.5ml; SOLN 6mg/0.5ml	1	QL (12 injections / 30 days)
<i>sumatriptan succinate</i> TABS 25mg, 50mg, 100mg	1	QL (12 tabs / 30 days)
<i>zolmitriptan</i> TABS 2.5mg, 5mg; TBDP 2.5mg, 5mg	1	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO TABS 6mg	1	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO TABS 9mg, 12mg	1	QL (120 tabs / 30 days), NM, LA, PA
INGREZZA CAPS 40mg, 60mg, 80mg	1	QL (30 caps / 30 days), NM, LA, PA
INGREZZA CAP 40-80MG	1	QL (28 caps / 28 days), NM, LA, PA
<i>lithium carbonate</i> CAPS 150mg, 300mg, 600mg; TABS 300mg; TBCR 300mg, 450mg	1	
NUEDEXTA CAP 20-10MG	1	QL (60 caps / 30 days), PA
<i>pyridostigmine bromide</i> TABS 60mg	1	
<i>riluzole</i> TABS 50mg	1	
<i>tetrabenazine</i> TABS 12.5mg	1	QL (90 tabs / 30 days), NM, PA
<i>tetrabenazine</i> TABS 25mg	1	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
BAFIERTAM CPDR 95mg	1	QL (120 caps / 30 days), NM, LA, PA
BETASERON KIT .3mg	1	QL (14 syringes / 28 days), NM, PA
<i>dalfampridine</i> TB12 10mg	1	NM, PA
GILENYA CAPS .5mg	1	QL (28 caps / 28 days), NM, PA
<i>glatiramer acetate</i> SOSY 20mg/ml	1	QL (30 syringes / 30 days), NM, PA
<i>glatiramer acetate</i> SOSY 40mg/ml	1	QL (12 syringes / 28 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
<i>glatopa</i> SOSY 20mg/ml	1	QL (30 syringes / 30 days), NM, PA
<i>glatopa</i> SOSY 40mg/ml	1	QL (12 syringes / 28 days), NM, PA
KESIMPTA SOAJ 20mg/0.4ml	1	QL (16 pens / year), NM, LA, PA

MUSCULOSKELETAL THERAPY AGENTS

<i>baclofen</i> TABS 10mg, 20mg	1	
<i>carisoprodol</i> TABS 350mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older
<i>cyclobenzaprine hcl</i> TABS 5mg, 10mg	1	PA; PA if 70 years and older
<i>dantrolene sodium</i> CAPS 25mg, 50mg, 100mg	1	
<i>methocarbamol</i> TABS 500mg, 750mg	1	PA; PA if 70 years and older
<i>tizanidine hcl</i> TABS 2mg, 4mg	1	
<i>vanadom</i> TABS 350mg	1	QL (120 tabs / 30 days), PA; PA if 70 years and older

NARCOLEPSY/CATAPLEXY

<i>armodafinil</i> TABS 50mg	1	QL (60 tabs / 30 days), PA
<i>armodafinil</i> TABS 150mg, 200mg, 250mg	1	QL (30 tabs / 30 days), PA
XYREM SOLN 500mg/ml	1	QL (540 mL / 30 days), NM, LA, PA

PSYCHOTHERAPEUTIC-MISC

<i>acamprosate calcium</i> TBEC 333mg	1	
<i>buprenorphine hcl</i> SUBL 2mg, 8mg	1	QL (90 tabs / 30 days), PA
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	1	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	1	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	1	QL (90 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1	QL (60 films / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	1	QL (90 tabs / 30 days)
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	1	QL (90 tabs / 30 days)
<i>bupropion hcl (smoking deterrent)</i> TB12 150mg	1	
<i>disulfiram</i> TABS 250mg, 500mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>naloxone hcl</i> LIQD 4mg/0.1ml; SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	1	
<i>naltrexone hcl</i> TABS 50mg	1	
NICOTROL INHALER INHA 10mg	1	
NICOTROL NS SOLN 10mg/ml	1	
<i>varenicline tartrate</i> TABS .5mg, 1mg	1	QL (56 tabs / 28 days), PA
<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	1	PA
VIVITROL SUSR 380mg	1	NM

ENDOCRINE AND METABOLIC

ANDROGENS

<i>oxandrolone</i> TABS 2.5mg	1	QL (120 tabs / 30 days), PA
<i>oxandrolone</i> TABS 10mg	1	QL (60 tabs / 30 days), PA
<i>testosterone</i> GEL 1%, 25mg/2.5gm, 50mg/5gm	1	QL (300 gm / 30 days), PA
<i>testosterone</i> GEL 1.62%	1	QL (150 gm / 30 days), PA
<i>testosterone cypionate</i> SOLN 100mg/ml, 200mg/ml	1	PA
<i>testosterone enanthate</i> SOLN 200mg/ml	1	PA

ANTIDIABETICS

<i>acarbose</i> TABS 25mg, 50mg, 100mg	1	
BYDUREON BCISE AUIJ 2mg/0.85ml	1	QL (4 pens / 28 days)
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml	1	QL (1 pen / 30 days)
FARXIGA TABS 5mg, 10mg	1	QL (30 tabs / 30 days)
<i>glimepiride</i> TABS 1mg, 2mg	1	QL (90 tabs / 30 days)
<i>glimepiride</i> TABS 4mg	1	QL (60 tabs / 30 days)
<i>glipizide</i> TABS 5mg	1	QL (240 tabs / 30 days)
<i>glipizide</i> TABS 10mg	1	QL (120 tabs / 30 days)
<i>glipizide</i> TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
<i>glipizide</i> TB24 10mg	1	QL (60 tabs / 30 days)
<i>glipizide xl</i> TB24 2.5mg, 5mg	1	QL (90 tabs / 30 days)
<i>glipizide xl</i> TB24 10mg	1	QL (60 tabs / 30 days)
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	QL (240 tabs / 30 days)
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	QL (120 tabs / 30 days)
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	QL (120 tabs / 30 days)
GLYXAMBI TAB 10-5 MG	1	QL (30 tabs / 30 days)
GLYXAMBI TAB 25-5 MG	1	QL (30 tabs / 30 days)
JANUMET TAB 50-500MG	1	QL (60 tabs / 30 days)
JANUMET TAB 50-1000	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	1	QL (60 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **NM** - Not available at mail-order **B/D** - Covered under Medicare B or D **LA** - Limited Access

Drug Name	Drug Tier	Requirements/Limits
JANUMET XR TAB 50-1000	1	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	1	QL (30 tabs / 30 days)
JANUVIA TABS 25mg, 50mg, 100mg	1	QL (30 tabs / 30 days)
JARDIANCE TABS 10mg	1	QL (60 tabs / 30 days)
JARDIANCE TABS 25mg	1	QL (30 tabs / 30 days)
JENTADUETO TAB 2.5-500	1	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-850	1	QL (60 tabs / 30 days)
JENTADUETO TAB 2.5-1000	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000MG	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000MG	1	QL (30 tabs / 30 days)
<i>metformin hcl</i> TABS 500mg	1	QL (150 tabs / 30 days)
<i>metformin hcl</i> TABS 850mg	1	QL (90 tabs / 30 days)
<i>metformin hcl</i> TABS 1000mg	1	QL (75 tabs / 30 days)
<i>metformin hcl</i> TB24 500mg	1	QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>metformin hcl</i> TB24 750mg	1	QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
<i>nateglinide</i> TABS 60mg, 120mg	1	QL (90 tabs / 30 days)
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/1.5ml	1	QL (1 pen / 28 days)
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml	1	QL (1 pen / 28 days)
OZEMPIC (2MG/DOSE) SOPN 8MG/3ML	1	QL (1 pen / 28 days)
<i>pioglitazone hcl</i> TABS 15mg, 30mg, 45mg	1	QL (30 tabs / 30 days)
<i>repaglinide</i> TABS 2mg	1	QL (240 tabs / 30 days)
<i>repaglinide</i> TABS .5mg, 1mg	1	QL (120 tabs / 30 days)
RYBELSUS TABS 3mg, 7mg, 14mg	1	QL (30 tabs / 30 days)
SYNJARDY TAB 5-500MG	1	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500	1	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	1	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000	1	QL (30 tabs / 30 days)
TRADJENTA TABS 5mg	1	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	1	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 10-5-1000MG	1	QL (30 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 12.5-2.5- 1000MG	1	QL (60 tabs / 30 days)
TRIJARDY XR TAB ER 24HR 25-5-1000MG	1	QL (30 tabs / 30 days)
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml	1	QL (4 pens / 28 days)
VICTOZA SOPN 18mg/3ml	1	QL (3 pens / 30 days)
XIGDUO XR TAB 2.5-1000	1	QL (60 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR TAB 5-500MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	1	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000	1	QL (30 tabs / 30 days)

ANTIDIABETICS, INSULINS

BASAGLAR KWIKPEN SOPN 100unit/ml	1	
BD ALCOHOL SWABS	1	
FIASP FLEX INJ TOUCH	1	
FIASP INJ 100/ML	1	
FIASP PENFIL INJ U-100	1	
GAUZE PADS 2" X 2"	1	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	1	B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	1	
INSULIN PEN NEEDLES: BD/NOVO	1	
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGES: BD	1	
LANTUS SOLN 100unit/ml	1	
LANTUS SOLOSTAR SOPN 100unit/ml	1	
LEVEMIR SOLN 100unit/ml	1	
LEVEMIR FLEXTOUCH SOPN 100unit/ml	1	
NOVOLIN INJ 70/30	1	(brand RELION not covered)
NOVOLIN INJ 70/30 FP	1	(brand RELION not covered)
NOVOLIN N SUSP 100unit/ml	1	(brand RELION not covered)
NOVOLIN N FLEXPEN SUPN 100unit/ml	1	(brand RELION not covered)
NOVOLIN R SOLN 100unit/ml	1	(brand RELION not covered)
NOVOLIN R FLEXPEN SOPN 100unit/ml	1	(brand RELION not covered)
NOVOLOG SOLN 100unit/ml	1	(brand RELION not covered)
NOVOLOG FLEXPEN SOPN 100unit/ml	1	(brand RELION not covered)
NOVOLOG MIX INJ 70/30	1	(brand RELION not covered)
NOVOLOG MIX INJ FLEXPEN	1	(brand RELION not covered)
NOVOLOG PENFILL SOCT 100unit/ml	1	(brand RELION not covered)
OMNIPOD 5 G6 KIT INTRO	1	QL (1 kit / year), PA

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD 5 G6 MIS PODS	1	QL (15 pods / 30 days), PA
OMNIPOD DASH KIT INTRO	1	QL (1 kit / year), PA
OMNIPOD DASH MIS PODS	1	QL (15 pods / 30 days), PA
OMNIPOD MIS CLASSIC	1	QL (15 pods / 30 days), PA
OMNIPOD PDM KIT CLASSIC	1	QL (1 kit / year), PA
SOLIQUA INJ 100/33	1	QL (5 pens / 25 days)
TOUJEO MAX SOLOSTAR SOPN 300unit/ml	1	
TOUJEO SOLOSTAR SOPN 300unit/ml	1	
TRESIBA SOLN 100unit/ml	1	
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	1	
V-GO 20 KIT	1	QL (1 kit / 30 days), PA
V-GO 30 KIT	1	QL (1 kit / 30 days), PA
V-GO 40 KIT	1	QL (1 kit / 30 days), PA
XULTOPHY INJ 100/3.6	1	QL (5 pens / 30 days)

CALCIUM REGULATORS

<i>alendronate sodium</i> SOLN 70mg/75ml; TABS 10mg, 35mg, 70mg	1	
<i>calcitonin (salmon) spray</i> SOLN 200unit/act	1	B/D
FORTEO SOPN 600mcg/2.4ml	1	NM, PA
<i>ibandronate sodium</i> TABS 150mg	1	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	1	NM, LA, PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	1	B/D
<i>pamidronate disodium</i> SOLN 30mg/10ml, 90mg/10ml	1	B/D
PROLIA SOSY 60mg/ml	1	QL (1 syringe / 180 days), NM
<i>risedronate sodium</i> TABS 5mg, 35mg, 150mg; TBEC 35mg	1	
TERIPARATIDE SOPN 620mcg/2.48ml	1	NM, PA
XGEVA SOLN 120mg/1.7ml	1	NM, PA
<i>zoledronic acid</i> CONC 4mg/5ml; SOLN 4mg/100ml, 5mg/100ml	1	B/D, NM

CHELATING AGENTS

CHEMET CAPS 100mg	1	
<i>deferasirox</i> PACK 90mg, 180mg, 360mg; TABS 90mg, 180mg, 360mg	1	NM, PA
LOKELMA PACK 5gm, 10gm	1	
<i>penicillamine</i> TABS 250mg	1	NM
<i>sodium polystyrene sulfonate powder</i>	1	
<i>sps</i> SUSP 15gm/60ml	1	

Drug Name	Drug Tier	Requirements/Limits
<i>trientine hcl</i> CAPS 250mg	1	NM, PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	1	
CONTRACEPTIVES		
<i>afirmelle</i>	1	
<i>altavera</i>	1	
<i>alyacen 1/35</i>	1	
<i>alyacen 7/7/7</i>	1	
<i>amethia</i>	1	
<i>apri</i>	1	
<i>aranelle</i>	1	
<i>ashlyna</i>	1	
<i>aubra eq</i>	1	
<i>aurovela 1/20</i>	1	
<i>aurovela 24 fe</i>	1	
<i>aurovela fe 1.5/30</i>	1	
<i>aurovela fe 1/20</i>	1	
<i>aviane</i>	1	
<i>ayuna</i>	1	
<i>azurette</i>	1	
<i>balziva</i>	1	
<i>blisovi 24 fe</i>	1	
<i>blisovi fe 1.5/30</i>	1	
<i>briellyn</i>	1	
<i>camila</i> TABS .35mg	1	
<i>camrese</i>	1	
<i>camrese lo</i>	1	
<i>chateal</i>	1	
<i>cryselle-28</i>	1	
<i>cyred eq</i>	1	
<i>dasetta 1/35</i>	1	
<i>dasetta 7/7/7</i>	1	
<i>daysee</i>	1	
<i>deblitane</i> TABS .35mg	1	
<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	1	
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	1	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i>	1	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	1	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	1	
<i>elinest</i>	1	
ELLA TABS 30mg	1	

Drug Name	Drug Tier	Requirements/Limits
<i>eluryng</i>	1	
<i>emoquette</i>	1	
<i>enpresse-28</i>	1	
<i>enskyce</i>	1	
<i>errin</i> TABS .35mg	1	
<i>estarylla</i>	1	
<i>ethynodiol diacetate & ethinyl estradiol tab</i> <i>1 mg-35 mcg</i>	1	
<i>ethynodiol diacetate & ethinyl estradiol tab</i> <i>1 mg-50 mcg</i>	1	
<i>etonogestrel-ethinyl estradiol va ring</i> <i>0.120-0.015 mg/24hr</i>	1	
<i>falmina</i>	1	
<i>femynor</i>	1	
<i>hailey 1.5/30</i>	1	
<i>hailey 24 fe</i>	1	
<i>heather</i> TABS .35mg	1	
<i>iclevia</i>	1	
<i>incassia</i> TABS .35mg	1	
<i>introvale</i>	1	
<i>isibloom</i>	1	
<i>jasmiel</i>	1	
<i>jolessa</i>	1	
<i>juleber</i>	1	
<i>junel 1.5/30</i>	1	
<i>junel 1/20</i>	1	
<i>junel fe 1.5/30</i>	1	
<i>junel fe 1/20</i>	1	
<i>junel fe 24</i>	1	
<i>kaitlib fe</i>	1	
<i>kariva</i>	1	
<i>kelnor 1/35</i>	1	
<i>kelnor 1/50</i>	1	
<i>kurvelo</i>	1	
<i>larin 1.5/30</i>	1	
<i>larin 1/20</i>	1	
<i>larin 24 fe</i>	1	
<i>larin fe 1.5/30</i>	1	
<i>larin fe 1/20</i>	1	
<i>larissia</i>	1	
<i>layolis fe</i>	1	
<i>leena</i>	1	
<i>lessina</i>	1	
<i>levonest</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg</i>	1	
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	1	
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	1	
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	1	
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	1	
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	1	
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	1	
<i>levora 0.15/30-28</i>	1	
<i>lillow</i>	1	
<i>loestrin 1.5/30-21</i>	1	
<i>loestrin 1/20-21</i>	1	
<i>loestrin fe 1.5/30</i>	1	
<i>loestrin fe 1/20</i>	1	
<i>loryna</i>	1	
<i>low-ogestrel</i>	1	
<i>lutera</i>	1	
<i>lyleq TABS .35mg</i>	1	
<i>lyza TABS .35mg</i>	1	
<i>marlissa</i>	1	
<i>medroxyprogesterone acetate (contraceptive) SUSP 150mg/ml; SUSY 150mg/ml</i>	1	
<i>microgestin 1.5/30</i>	1	
<i>microgestin 1/20</i>	1	
<i>microgestin 24 fe</i>	1	
<i>microgestin fe 1.5/30</i>	1	
<i>microgestin fe 1/20</i>	1	
<i>mili</i>	1	
<i>mono-linyah</i>	1	
<i>necon 0.5/35-28</i>	1	
<i>nikki</i>	1	
<i>nora-be TABS .35mg</i>	1	
<i>norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	1	
<i>norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg</i>	1	
<i>norethindrone (contraceptive) TABS .35mg</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	1	
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	1	
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	1	
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	1	
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	1	
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	1	
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	1	
<i>norlyroc TABS .35mg</i>	1	
<i>nortrel 0.5/35 (28)</i>	1	
<i>nortrel 1/35 (21)</i>	1	
<i>nortrel 1/35 (28)</i>	1	
<i>nortrel 7/7/7</i>	1	
<i>nylia 1/35</i>	1	
<i>nylia 7/7/7</i>	1	
<i>nymyo</i>	1	
<i>ocella</i>	1	
<i>philith</i>	1	
<i>pimtrea</i>	1	
<i>pirmella 1/35</i>	1	
<i>portia-28</i>	1	
<i>reclipsen</i>	1	
<i>rivelsa</i>	1	
<i>setlakin</i>	1	
<i>sharobel TABS .35mg</i>	1	
<i>simliya</i>	1	
<i>simpesse</i>	1	
<i>sprintec 28</i>	1	
<i>sronyx</i>	1	
<i>syeda</i>	1	
<i>tarina 24 fe</i>	1	
<i>tarina fe 1/20 eq</i>	1	
<i>tilia fe</i>	1	
<i>tri-estarylla</i>	1	
<i>tri-legest fe</i>	1	
<i>tri-linyah</i>	1	
<i>tri-lo-estarylla</i>	1	
<i>tri-lo-marzia</i>	1	
<i>tri-lo-mili</i>	1	
<i>tri-lo-sprintec</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>tri-mili</i>	1	
<i>tri-nymyo</i>	1	
<i>tri-sprintec</i>	1	
<i>tri-vylibra</i>	1	
<i>tri-vylibra lo</i>	1	
<i>trivora-28</i>	1	
<i>tydemy</i>	1	
<i>velivet</i>	1	
<i>vestura</i>	1	
<i>vienva</i>	1	
<i>viorele</i>	1	
<i>vyfemla</i>	1	
<i>vylibra</i>	1	
<i>wera</i>	1	
<i>wymzya fe</i>	1	
<i>xulane</i>	1	
<i>zafemy</i>	1	
<i>zovia 1/35</i>	1	
<i>zumandimine</i>	1	
ENDOMETRIOSIS		
<i>danazol CAPS 50mg, 100mg, 200mg</i>	1	
<i>SYNAREL SOLN 2mg/ml</i>	1	
ESTROGENS		
<i>amabelz</i>	1	
<i>DELESTROGEN OIL 10mg/ml</i>	1	
<i>dotti PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr</i>	1	
<i>estradiol PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr; PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr, .1mg/24hr, 37.5mcg/24hr; TABS .5mg, 1mg, 2mg</i>	1	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	1	
<i>estradiol vaginal CREA .1mg/gm; TABS 10mcg</i>	1	
<i>estradiol valerate OIL 20mg/ml, 40mg/ml</i>	1	
<i>fyavolv tab 0.5mg-2.5mcg</i>	1	
<i>fyavolv tab 1mg-5mcg</i>	1	
<i>jinteli</i>	1	
<i>lyllana PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr</i>	1	
<i>mimvey</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone acetate-ethinyl estradiol tab</i> 0.5 mg-2.5 mcg	1	
<i>norethindrone acetate-ethinyl estradiol tab</i> 1 mg-5 mcg	1	
<i>yuvaferm</i> TABS 10mcg	1	
GLUCOCORTICOIDS		
<i>dexamethasone</i> ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	1	
DEXAMETHASONE INTENSOL CONC 1mg/ml	1	
<i>dexamethasone sodium phosphate</i> SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	1	
<i>fludrocortisone acetate</i> TABS .1mg	1	
<i>hydrocortisone</i> TABS 5mg, 10mg, 20mg	1	
<i>methylprednisolone</i> TABS 4mg, 8mg, 16mg, 32mg	1	B/D
<i>methylprednisolone</i> TBPK 4mg	1	
<i>methylprednisolone acetate</i> SUSP 40mg/ml, 80mg/ml	1	B/D
<i>methylprednisolone sod succ</i> SOLR 40mg, 125mg, 1000mg	1	B/D
<i>prednisolone</i> SOLN 15mg/5ml	1	B/D
<i>prednisolone sodium phosphate</i> SOLN 5mg/5ml, 15mg/5ml, 25mg/5ml	1	B/D
<i>prednisone</i> SOLN 5mg/5ml; TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	1	B/D
<i>prednisone</i> TBPK 5mg, 10mg	1	
PREDNISONE INTENSOL CONC 5mg/ml	1	B/D
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	1	
GLUCOSE ELEVATING AGENTS		
<i>diazoxide</i> SUSP 50mg/ml	1	
GVOKE HYOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	1	
GVOKE KIT SOLN 1mg/0.2ml	1	
GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml	1	
MISCELLANEOUS		
ALDURAZYME SOLN 2.9mg/5ml	1	NM, LA, PA
<i>betaine powder for oral solution</i>	1	NM, LA
<i>cabergoline</i> TABS .5mg	1	
<i>carglumic acid</i> TBSO 200mg	1	NM, LA, PA
CERDELGA CAPS 84mg	1	NM, LA, PA
CEREZYME SOLR 400unit	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
<i>cinacalcet hcl</i> TABS 30mg, 60mg	1	B/D, QL (60 tabs / 30 days), NM
<i>cinacalcet hcl</i> TABS 90mg	1	B/D, QL (120 tabs / 30 days), NM
CYSTAGON CAPS 50mg, 150mg	1	NM, LA, PA
<i>desmopressin acetate</i> SOLN 4mcg/ml; TABS .1mg, .2mg	1	
<i>desmopressin acetate spray</i> SOLN .01%	1	
<i>desmopressin acetate spray refrigerated</i> SOLN .01%	1	
FABRAZYME SOLR 5mg, 35mg	1	NM, LA, PA
GENOTROPIN CART 5mg, 12mg	1	NM, PA
GENOTROPIN MINIQUICK PRSY .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	1	NM, PA
INCRELEX SOLN 40mg/4ml	1	NM, LA, PA
KORLYM TABS 300mg	1	NM, LA, PA
<i>levocarnitine (metabolic modifiers)</i> SOLN 1gm/10ml; TABS 330mg	1	B/D
LUMIZYME SOLR 50mg	1	NM, LA, PA
LUPRON DEPOT-PED (1-MONTH KIT 7.5mg, 11.25mg, 15mg	1	NM, PA
LUPRON DEPOT-PED (3-MONTH KIT 11.25mg, 30mg	1	NM, PA
<i>miglustat</i> CAPS 100mg	1	QL (90 caps / 30 days), NM, PA
NAGLAZYME SOLN 1mg/ml	1	NM, LA, PA
<i>nitisinone</i> CAPS 2mg, 5mg, 10mg	1	NM, PA
<i>octreotide acetate</i> SOLN 50mcg/ml, 100mcg/ml, 200mcg/ml, 500mcg/ml, 1000mcg/ml; SOSY 50mcg/ml, 100mcg/ml, 500mcg/ml	1	NM, PA
<i>raloxifene hcl</i> TABS 60mg	1	
<i>sapropterin dihydrochloride</i> PACK 100mg, 500mg; TABS 100mg	1	NM, PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	1	NM, LA, PA
<i>sodium phenylbutyrate</i> POWD 3gm/tsp; TABS 500mg	1	NM, PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	1	NM, LA, PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	1	NM, LA, PA
PHOSPHATE BINDER AGENTS		
<i>calcium acetate (phosphate binder)</i> CAPS 667mg	1	QL (360 caps / 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>calcium acetate (phosphate binder)</i> TABS 667mg	1	QL (360 tabs / 30 days)
<i>sevelamer carbonate</i> PACK 2.4gm	1	QL (180 packets / 30 days)
<i>sevelamer carbonate</i> PACK .8gm	1	QL (540 packets / 30 days)
<i>sevelamer carbonate</i> TABS 800mg	1	QL (540 tabs / 30 days)
VELPHORO CHEW 500mg	1	QL (180 tabs / 30 days)

PROGESTINS

<i>medroxyprogesterone acetate</i> TABS 2.5mg, 5mg, 10mg	1	
<i>megestrol acetate</i> SUSP 40mg/ml	1	
<i>megestrol acetate (appetite)</i> SUSP 625mg/5ml	1	PA
<i>norethindrone acetate</i> TABS 5mg	1	

THYROID AGENTS

<i>euthyrox</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
<i>levo-t</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
<i>levothyroxine sodium</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
<i>levoxyl</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
<i>liothyronine sodium</i> TABS 5mcg, 25mcg, 50mcg	1	
<i>methimazole</i> TABS 5mg, 10mg	1	
<i>propylthiouracil</i> TABS 50mg	1	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	
<i>unithroid</i> TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	1	

VITAMIN D ANALOGS

<i>calcitriol</i> CAPS .25mcg, .5mcg; SOLN 1mcg/ml	1	B/D
<i>paricalcitol</i> CAPS 1mcg, 2mcg, 4mcg	1	B/D
RAYALDEE CPCR 30mcg	1	

Drug Name	Drug Tier	Requirements/Limits
GASTROINTESTINAL		
ANTIEMETICS		
<i>aprepitant</i> CAPS 40mg, 80mg, 125mg	1	B/D
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	1	B/D
<i>compro</i> SUPP 25mg	1	
<i>dronabinol</i> CAPS 2.5mg, 5mg, 10mg	1	B/D, QL (60 caps / 30 days)
<i>granisetron hcl</i> SOLN 1mg/ml, 4mg/4ml	1	
<i>granisetron hcl</i> TABS 1mg	1	B/D
<i>meclizine hcl</i> TABS 12.5mg, 25mg	1	
<i>metoclopramide hcl</i> SOLN 5mg/5ml, 5mg/ml; TABS 5mg, 10mg	1	
<i>ondansetron</i> TBDP 4mg, 8mg	1	B/D
<i>ondansetron hcl</i> SOLN 4mg/2ml, 40mg/20ml; SOSY 4mg/2ml	1	
<i>ondansetron hcl</i> SOLN 4mg/5ml; TABS 4mg, 8mg	1	B/D
<i>prochlorperazine</i> SUPP 25mg	1	
<i>prochlorperazine edisylate</i> SOLN 10mg/2ml	1	
<i>prochlorperazine maleate</i> TABS 5mg, 10mg	1	
<i>promethazine hcl</i> SOLN 25mg/ml, 50mg/ml; SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg	1	PA; PA if 70 years and older
<i>scopolamine</i> PT72 1mg/3days	1	QL (10 patches / 30 days), PA; PA if 70 years and older
ANTISPASMODICS		
<i>dicyclomine hcl</i> CAPS 10mg; SOLN 10mg/5ml; TABS 20mg	1	
<i>glycopyrrolate</i> TABS 1mg, 2mg	1	
H2-RECEPTOR ANTAGONISTS		
<i>famotidine</i> SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	1	
<i>famotidine</i> SUSR 40mg/5ml	1	QL (300 mL / 30 days)
<i>famotidine</i> TABS 20mg	1	QL (120 tabs / 30 days)
<i>famotidine</i> TABS 40mg	1	QL (60 tabs / 30 days)
<i>famotidine in nacl 0.9% iv soln 20 mg/50ml</i>	1	
<i>nizatidine</i> CAPS 150mg, 300mg	1	
INFLAMMATORY BOWEL DISEASE		
<i>balsalazide disodium</i> CAPS 750mg	1	
<i>budesonide</i> CPEP 3mg	1	QL (90 caps / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide</i> TB24 9mg	1	QL (30 tabs / 30 days), PA
<i>hydrocortisone (intrarectal)</i> ENEM 100mg/60ml	1	
<i>mesalamine</i> CP24 .375gm	1	QL (120 caps / 30 days)
<i>mesalamine</i> CPDR 400mg	1	QL (180 caps / 30 days)
<i>mesalamine</i> ENEM 4gm; SUPP 1000mg	1	
<i>mesalamine</i> TBEC 1.2gm	1	QL (120 tabs / 30 days)
<i>mesalamine w/ cleanser</i> KIT 4gm	1	
<i>sulfasalazine</i> TABS 500mg; TBEC 500mg	1	
LAXATIVES		
<i>constulose</i> SOLN 10gm/15ml	1	
<i>enulose</i> SOLN 10gm/15ml	1	
<i>gavilyte-c</i>	1	
<i>gavilyte-g</i>	1	
<i>generlac</i> SOLN 10gm/15ml	1	
GOLYTELY SOL	1	
<i>lactulose</i> SOLN 10gm/15ml	1	
<i>lactulose (encephalopathy)</i> SOLN 10gm/15ml	1	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	1	
PLENVU SOL	1	
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	1	
SUPREP BOWEL SOL PREP KIT	1	
MISCELLANEOUS		
<i>alose tron hcl</i> TABS .5mg, 1mg	1	QL (60 tabs / 30 days), PA
<i>cromolyn sodium (mastocytosis)</i> CONC 100mg/5ml	1	
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
GATTEX KIT 5mg	1	NM, LA, PA
LINZESS CAPS 72mcg, 145mcg, 290mcg	1	QL (30 caps / 30 days)
<i>loperamide hcl</i> CAPS 2mg	1	
<i>misoprostol</i> TABS 100mcg, 200mcg	1	
MOVANTIK TABS 12.5mg, 25mg	1	QL (30 tabs / 30 days)
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	1	PA
<i>sucral fate</i> TABS 1gm	1	
<i>ursodiol</i> CAPS 300mg; TABS 250mg, 500mg	1	

Drug Name	Drug Tier	Requirements/Limits
XERMELO TABS 250mg	1	QL (90 tabs / 30 days), NM, LA, PA
XIFAXAN TABS 550mg	1	PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	1	
CREON CAP 6000UNIT	1	
CREON CAP 12000UNT	1	
CREON CAP 24000UNT	1	
CREON CAP 36000UNT	1	
ZENPEP CAP 3000UNIT	1	
ZENPEP CAP 5000UNIT	1	
ZENPEP CAP 10000UNT	1	
ZENPEP CAP 15000UNT	1	
ZENPEP CAP 20000UNT	1	
ZENPEP CAP 25000UNT	1	
ZENPEP CAP 40000UNT	1	
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium</i> CPDR 20mg, 40mg	1	QL (30 caps / 30 days), ST
<i>lansoprazole</i> CPDR 15mg, 30mg	1	QL (60 caps / 30 days)
<i>omeprazole</i> CPDR 10mg, 20mg, 40mg	1	
<i>pantoprazole sodium</i> SOLR 40mg; TBEC 20mg, 40mg	1	
<i>rabeprazole sodium</i> TBEC 20mg	1	QL (30 tabs / 30 days)
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin hcl</i> TB24 10mg	1	QL (30 tabs / 30 days)
<i>dutasteride</i> CAPS .5mg	1	QL (30 caps / 30 days)
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	1	QL (30 caps / 30 days)
<i>finasteride</i> TABS 5mg	1	
<i>tamsulosin hcl</i> CAPS .4mg	1	
MISCELLANEOUS		
<i>acetic acid</i> SOLN .25%	1	
<i>bethanechol chloride</i> TABS 5mg, 10mg, 25mg, 50mg	1	
<i>potassium citrate (alkalinizer)</i> TBCR 15meq, 540mg, 1080mg	1	
URINARY ANTISPASMODICS		
<i>fesoterodine fumarate</i> TB24 4mg, 8mg	1	QL (30 tabs / 30 days)
GEMTESA TABS 75mg	1	QL (30 tabs / 30 days)
MYRBETRIQ SRER 8mg/ml	1	QL (300 mL / 28 days)
MYRBETRIQ TB24 25mg, 50mg	1	QL (30 tabs / 30 days)
<i>oxybutynin chloride</i> SYRP 5mg/5ml; TABS 5mg	1	
<i>oxybutynin chloride</i> TB24 5mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>oxybutynin chloride</i> TB24 10mg, 15mg	1	QL (60 tabs / 30 days)
<i>solifenacin succinate</i> TABS 5mg, 10mg	1	QL (30 tabs / 30 days)
<i>tolterodine tartrate</i> CP24 2mg, 4mg	1	QL (30 caps / 30 days), ST
<i>tolterodine tartrate</i> TABS 1mg, 2mg	1	QL (60 tabs / 30 days)
<i>tropium chloride</i> TABS 20mg	1	QL (60 tabs / 30 days)

VAGINAL ANTI-INFECTIVES

<i>clindamycin phosphate vaginal</i> CREA 2%	1	
<i>metronidazole vaginal</i> GEL .75%	1	
<i>terconazole vaginal</i> CREA .4%, .8%; SUPP 80mg	1	

HEMATOLOGIC

ANTICOAGULANTS

<i>dabigatran etexilate mesylate</i> CAPS 75mg, 150mg	1	QL (60 caps / 30 days)
ELIQUIS TABS 2.5mg	1	QL (60 tabs / 30 days)
ELIQUIS TABS 5mg	1	QL (74 tabs / 30 days)
ELIQUIS STARTER PACK TBPK 5mg	1	QL (74 tabs / 30 days)
<i>enoxaparin sodium</i> SOLN 300mg/3ml; SOSY 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	1	
<i>fondaparinux sodium</i> SOLN 2.5mg/0.5ml, 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	1	
HEP SOD/D5W INJ 20000UNT	1	
HEP SOD/D5W INJ 25000UNT	1	
HEP SOD/NAACL INJ 25000UNT	1	
<i>heparin sodium (porcine)</i> SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	1	B/D
HEPARIN/NAACL INJ 25000UNT	1	
<i>jantoven</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
PRADAXA CAPS 75mg, 150mg	1	QL (60 caps / 30 days)
PRADAXA CAPS 110mg	1	QL (120 caps / 30 days)
<i>warfarin sodium</i> TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	1	
XARELTO SUSR 1mg/ml	1	QL (620 mL / 30 days)
XARELTO TABS 2.5mg	1	QL (60 tabs / 30 days)
XARELTO TABS 10mg, 15mg, 20mg	1	QL (30 tabs / 30 days)
XARELTO STAR TAB 15/20MG	1	QL (51 tabs / 30 days)

HEMATOPOIETIC GROWTH FACTORS

PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml, 20000unit/ml, 40000unit/ml	1	NM, PA
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Drug Name	Drug Tier	Requirements/Limits
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	1	NM, PA
ZIEXTENZO SOSY 6mg/0.6ml	1	NM, PA
MISCELLANEOUS		
<i>anagrelide hcl</i> CAPS .5mg, 1mg	1	
BERINERT KIT 500unit	1	QL (24 boxes / 30 days), NM, LA, PA
<i>cilostazol</i> TABS 50mg, 100mg	1	
DOPTELET TABS 20mg	1	NM, LA, PA
DROXIA CAPS 200mg, 300mg, 400mg	1	
ENDARI PACK 5gm	1	NM, LA, PA
HAEGARDA SOLR 2000unit	1	QL (30 vials / 30 days), NM, LA, PA
HAEGARDA SOLR 3000unit	1	QL (20 vials / 30 days), NM, LA, PA
<i>icatibant acetate</i> SOLN 30mg/3ml	1	QL (9 syringes / 30 days), NM, PA
<i>pentoxifylline</i> TBCR 400mg	1	
PROMACTA PACK 12.5mg	1	QL (360 packets / 30 days), NM, LA, PA
PROMACTA PACK 25mg	1	QL (180 packets / 30 days), NM, LA, PA
PROMACTA TABS 12.5mg, 25mg	1	QL (30 tabs / 30 days), NM, LA, PA
PROMACTA TABS 50mg, 75mg	1	QL (60 tabs / 30 days), NM, LA, PA
<i>sajazir</i> SOLN 30mg/3ml	1	QL (9 syringes / 30 days), NM, LA, PA
<i>tranexamic acid</i> SOLN 1000mg/10ml; TABS 650mg	1	
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	1	
BRILINTA TABS 60mg, 90mg	1	
<i>clopidogrel bisulfate</i> TABS 75mg	1	
<i>dipyridamole</i> TABS 25mg, 50mg, 75mg	1	PA; PA if 70 years and older
<i>prasugrel hcl</i> TABS 5mg, 10mg	1	
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
DUPIXENT SOPN 200mg/1.14ml, 300mg/2ml; SOSY 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml	1	NM, PA
ENBREL SOLN 25mg/0.5ml; SOLR 25mg	1	QL (16 vials / 28 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
ENBREL SOSY 25mg/0.5ml	1	QL (16 syringes / 28 days), NM, PA
ENBREL SOSY 50mg/ml	1	QL (8 syringes / 28 days), NM, PA
ENBREL MINI SOCT 50mg/ml	1	QL (8 cartridges / 28 days), NM, PA
ENBREL SURECLICK SOAJ 50mg/ml	1	QL (8 pens / 28 days), NM, PA
HUMIRA PSKT 10mg/0.1ml, 20mg/0.2ml	1	QL (2 syringes / 28 days), NM, PA
HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml	1	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIA INJ CROHNS	1	NM, PA
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml	1	NM, PA
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml	1	QL (6 pens / 28 days), NM, PA
HUMIRA PEN PNKT 80mg/0.8ml	1	QL (4 pens / 28 days), NM, PA
HUMIRA PEN KIT PS/UV	1	NM, PA
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml	1	NM, PA
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml	1	NM, PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml	1	NM, PA
INFLIXIMAB SOLR 100mg	1	NM, LA, PA
KEVZARA SOAJ 150mg/1.14ml, 200mg/1.14ml	1	QL (2 pens / 28 days), NM, PA
KEVZARA SOSY 150mg/1.14ml, 200mg/1.14ml	1	QL (2 syringes / 28 days), NM, PA
OTEZLA TABS 30mg	1	QL (60 tabs / 30 days), NM, PA
OTEZLA TAB 10/20/30	1	QL (110 tabs / year), NM, PA
REMICADE SOLR 100mg	1	NM, LA, PA
RENFLEXIS SOLR 100mg	1	NM, LA, PA
RINVOQ TB24 15mg, 30mg	1	QL (30 tabs / 30 days), NM, PA
RINVOQ TB24 45mg	1	QL (112 tabs / year), NM, PA
SKYRIZI SOCT 360mg/2.4ml	1	QL (1 cartridge / 56 days), NM, PA
SKYRIZI SOLN 600mg/10ml	1	QL (6 vials / year), NM, PA
SKYRIZI SOSY 150mg/ml	1	QL (6 syringes / 365 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI PEN SOAJ 150mg/ml	1	QL (6 pens / 365 days), NM, PA
TALTZ SOAJ 80mg/ml; SOSY 80mg/ml	1	QL (3 syringes / 28 days), NM, LA, PA
XELJANZ SOLN 1mg/ml	1	QL (480 mL / 24 days), NM, PA
XELJANZ TABS 5mg, 10mg	1	QL (60 tabs / 30 days), NM, PA
XELJANZ XR TB24 11mg, 22mg	1	QL (30 tabs / 30 days), NM, PA

DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)

<i>hydroxychloroquine sulfate</i> TABS 200mg	1	
<i>leflunomide</i> TABS 10mg, 20mg	1	QL (30 tabs / 30 days)
<i>methotrexate sodium</i> TABS 2.5mg	1	
XATMEP SOLN 2.5mg/ml	1	B/D

IMMUNOGLOBULINS

BIVIGAM SOLN 5gm/50ml, 10%	1	NM, LA, PA
FLEBOGAMMA DIF SOLN 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM, PA
GAMASTAN INJ	1	B/D, NM, LA
GAMMAGARD LIQUID SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM, PA
GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	1	NM, PA
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	1	NM, PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	1	NM, LA, PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM, PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 25gm/500ml, 30gm/300ml	1	NM, PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	1	NM, PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	1	NM, PA

IMMUNOMODULATORS

ACTIMMUNE SOLN 2000000unit/0.5ml	1	NM, LA, PA
ARCALYST SOLR 220mg	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
INTRON A SOLR 10000000unit, 18000000unit, 50000000unit	1	B/D, NM, LA
IMMUNOSUPPRESSANTS		
<i>azathioprine</i> TABS 50mg	1	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml	1	QL (8 syringes / 28 days), NM, LA, PA
BENLYSTA SOLR 120mg, 400mg	1	NM, LA, PA
<i>cyclosporine</i> CAPS 25mg, 100mg; SOLN 50mg/ml	1	B/D
<i>cyclosporine modified (for microemulsion)</i> CAPS 25mg, 50mg, 100mg; SOLN 100mg/ml	1	B/D
<i>everolimus (immunosuppressant)</i> TABS .25mg, .5mg, .75mg, 1mg	1	B/D
<i>gengraf</i> CAPS 25mg, 100mg; SOLN 100mg/ml	1	B/D
<i>mycophenolate mofetil</i> CAPS 250mg; SUSR 200mg/ml; TABS 500mg	1	B/D
<i>mycophenolate sodium</i> TBEC 180mg, 360mg	1	B/D
NULOJIX SOLR 250mg	1	B/D
PROGRAF PACK .2mg, 1mg	1	B/D
REZUROCK TABS 200mg	1	NM, LA, PA
SANDIMMUNE SOLN 100mg/ml	1	B/D
<i>sirolimus</i> SOLN 1mg/ml; TABS .5mg, 1mg, 2mg	1	B/D
<i>tacrolimus</i> CAPS .5mg, 1mg, 5mg	1	B/D
VACCINES		
ACTHIB INJ	1	
ADACEL INJ	1	
BCG VACCINE SOLR 50mg	1	
BEXSERO INJ	1	
BOOSTRIX INJ	1	
DAPTACEL INJ	1	
DENG VAXIA SUS	1	
DIP/TET PED INJ 25-5LFU	1	B/D
ENGERIX-B SUSP 20mcg/ml; SUSY 10mcg/0.5ml, 20mcg/ml	1	B/D
GARDASIL 9 INJ	1	
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	1	
HIBERIX SOLR 10mcg	1	
IMOVAX RABIES (H.D.C.V.) SUSR 2.5unit/ml	1	B/D
INFANRIX INJ	1	
IPOL INJ INACTIVE	1	
IXIARO INJ	1	

Drug Name	Drug Tier	Requirements/Limits
KINRIX INJ	1	
M-M-R II INJ	1	
MENACTRA INJ	1	
MENQUADFI INJ	1	
MENVEO INJ	1	
PEDIARIX INJ 0.5ML	1	
PEDVAX HIB SUSP 7.5mcg/0.5ml	1	
PENTACEL INJ	1	
PREHEVBRIO SUSP 10mcg/ml	1	B/D
PRIORIX INJ	1	
PROQUAD INJ	1	
QUADRACEL INJ	1	
QUADRACEL INJ 0.5ML	1	
RABAVERT INJ	1	B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml; SUSY 5mcg/0.5ml, 10mcg/ml	1	B/D
ROTARIX SUS	1	
ROTATEQ SOL	1	
SHINGRIX SUSR 50mcg/0.5ml	1	QL (2 vials per lifetime)
TDVAX INJ 2-2 LF	1	B/D
TENIVAC INJ 5-2LF	1	B/D
TICOVAC SUSY 1.2mcg/0.25ml, 2.4mcg/0.5ml	1	
TRUMENBA INJ	1	
TWINRIX INJ	1	
TYPHIM VI SOLN 25mcg/0.5ml; SOSY 25mcg/0.5ml	1	
VAQTA SUSP 25unit/0.5ml, 50unit/ml	1	
VARIVAX INJ 1350pfu/0.5ml	1	
YF-VAX INJ	1	

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES/MINERALS, INJECTABLE

D2.5W/NACL INJ 0.45%	1	
D5W/LYTES INJ #48	1	
D10W/NACL INJ 0.2%	1	
<i>dextrose 2.5% w/ sodium chloride 0.45%</i>	1	
<i>dextrose 5% in lactated ringers</i>	1	
<i>dextrose 5% w/ sodium chloride 0.2%</i>	1	
<i>dextrose 5% w/ sodium chloride 0.3%</i>	1	
<i>dextrose 5% w/ sodium chloride 0.9%</i>	1	
<i>dextrose 5% w/ sodium chloride 0.45%</i>	1	
<i>dextrose 5% w/ sodium chloride 0.225%</i>	1	
<i>dextrose 10% w/ sodium chloride 0.45%</i>	1	
ISOLYTE-P INJ /D5W	1	

Drug Name	Drug Tier	Requirements/Limits
ISOLYTE-S INJ	1	
ISOLYTE-S INJ PH 7.4	1	
<i>kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj</i>	1	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj</i>	1	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj</i>	1	
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj</i>	1	
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	1	
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	1	
KCL 20 MEQ/L (0.15%) IN NACL 0.45% INJ	1	
<i>kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj</i>	1	
<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj</i>	1	
KCL 40 MEQ/L (0.3%) IN NACL 0.9% INJ	1	
KCL/D5W/NACL INJ 0.3/0.9%	1	
<i>lactated ringer's solution</i>	1	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	1	
<i>magnesium sulfate SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%</i>	1	
<i>magnesium sulfate in dextrose 5% iv soln 1 gm/100ml</i>	1	
MG SO4/D5W INJ 10MG/ML	1	
PLASMA-LYTE INJ -148	1	
PLASMA-LYTE INJ -A	1	
<i>potassium chloride SOLN 2meq/ml, 10meq/100ml, 20meq/100ml, 40meq/100ml</i>	1	
POTASSIUM CHLORIDE SOLN 10meq/50ml, 20meq/50ml	1	
<i>potassium chloride 20 meq/l (0.15%) in dextrose 5% inj</i>	1	
<i>sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%</i>	1	
TPN ELECTROL INJ	1	B/D
<i>ELECTROLYTES/MINERALS/VITAMINS, ORAL</i>		
<i>klor-con PACK 20meq</i>	1	
<i>klor-con 8 TBCR 8meq</i>	1	
<i>klor-con 10 TBCR 10meq</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>klor-con m10</i> TBCR 10meq	1	
<i>klor-con m15</i> TBCR 15meq	1	
<i>klor-con m20</i> TBCR 20meq	1	
M-NATAL PLUS TAB	1	
<i>potassium chloride</i> CPCR 8meq, 10meq; PACK 20meq; SOLN 10%, 20%; TBCR 8meq, 10meq, 20meq	1	
<i>potassium chloride microencapsulated crystals er</i> TBCR 10meq, 15meq, 20meq	1	
PRENATAL TAB 27-1MG	1	
PRENATAL TAB PLUS	1	
PRENATAL VIT TAB LOW IRON	1	
<i>sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln</i>	1	
TRICARE TAB PRENATAL	1	

IV NUTRITION

CLINIMIX INJ 4.25/D5W	1	B/D
CLINIMIX INJ 4.25/D10	1	B/D
CLINIMIX INJ 5%/D15W	1	B/D
CLINIMIX INJ 5%/D20W	1	B/D
CLINIMIX INJ 6/5	1	B/D
CLINIMIX INJ 8/10	1	B/D
CLINIMIX INJ 8/14	1	B/D
<i>clinisol sf 15%</i>	1	B/D
CLINOLIPID EMU 20%	1	B/D
<i>dextrose</i> SOLN 5%, 10%	1	
<i>dextrose</i> SOLN 50%, 70%	1	B/D
FREAMINE III INJ 10%	1	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	1	B/D
NUTRILIPID EMUL 20gm/100ml	1	B/D
<i>plenamine</i>	1	B/D
PREMASOL SOL 10%	1	B/D
PROCALAMINE INJ 3%	1	B/D
PROSOL INJ 20%	1	B/D
TRAVASOL INJ 10%	1	B/D
TROPHAMINE INJ 10%	1	B/D

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>neomycin-polymyxin-hc ophth susp</i>	1	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
TOBRADEX OIN 0.3-0.1%	1	
TOBRADEX ST SUS 0.3-0.05	1	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
ZYLET SUS 0.5-0.3%	1	

ANTI-INFECTIVES

<i>bacitracin (ophthalmic) OINT 500unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
BESIVANCE SUSP .6%	1	
CILOXAN OINT .3%	1	
<i>ciprofloxacin hcl (ophth) SOLN .3%</i>	1	
<i>erythromycin (ophth) OINT 5mg/gm</i>	1	
<i>gatifloxacin (ophth) SOLN .5%</i>	1	
<i>gentak OINT .3%</i>	1	
<i>gentamicin sulfate (ophth) SOLN .3%</i>	1	
<i>moxifloxacin hcl (ophth) SOLN .5%</i>	1	
NATACYN SUSP 5%	1	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	1	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	1	
<i>ofloxacin (ophth) SOLN .3%</i>	1	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	
<i>sulfacetamide sodium (ophth) OINT 10%; SOLN 10%</i>	1	
<i>tobramycin (ophth) SOLN .3%</i>	1	
trifluridine SOLN 1%	1	
ZIRGAN GEL .15%	1	

ANTI-INFLAMMATORIES

ALREX SUSP .2%	1	
BROMSITE SOLN .075%	1	
<i>dexamethasone sodium phosphate (ophth) SOLN .1%</i>	1	
<i>diclofenac sodium (ophth) SOLN .1%</i>	1	
<i>difluprednate EMUL .05%</i>	1	
FLAREX SUSP .1%	1	
<i>fluorometholone (ophth) SUSP .1%</i>	1	
<i>flurbiprofen sodium SOLN .03%</i>	1	
ILEVRO SUSP .3%	1	
<i>ketorolac tromethamine (ophth) SOLN .4%, .5%</i>	1	

Drug Name	Drug Tier	Requirements/Limits
LOTEMAX OINT .5%	1	
<i>prednisolone acetate (ophth)</i> SUSP 1%	1	
PREDNISOLONE SODIUM PHOSP SOLN 1%	1	
PROLENSA SOLN .07%	1	

ANTIALLERGICS

<i>azelastine hcl (ophth)</i> SOLN .05%	1	
<i>cromolyn sodium (ophth)</i> SOLN 4%	1	
<i>olopatadine hcl</i> SOLN .1%	1	
ZERVIAE SOLN .24%	1	

ANTI GLAUCOMA

ALPHAGAN P SOLN .1%	1	
<i>betaxolol hcl (ophth)</i> SOLN .5%	1	
BETOPTIC-S SUSP .25%	1	
<i>brimonidine tartrate</i> SOLN .15%, .2%	1	
<i>brinzolamide</i> SUSP 1%	1	
<i>carteolol hcl (ophth)</i> SOLN 1%	1	
COMBIGAN SOL 0.2/0.5%	1	
<i>dorzolamide hcl</i> SOLN 2%	1	
<i>dorzolamide hcl-timolol maleate ophth soln</i> 22.3-6.8 mg/ml	1	
<i>latanoprost</i> SOLN .005%	1	
<i>levobunolol hcl</i> SOLN .5%	1	
LUMIGAN SOLN .01%	1	
<i>pilocarpine hcl</i> SOLN 1%, 2%, 4%	1	
RHOPRESSA SOLN .02%	1	
SIMBRINZA SUS 1-0.2%	1	
<i>timolol maleate (ophth)</i> SOLG .25%, .5%; SOLN .25%, .5%	1	
VYZULTA SOLN .024%	1	

MISCELLANEOUS

ATROPINE SULFATE SOLN 1%	1	
<i>atropine sulfate (ophthalmic)</i> SOLN 1%	1	
CYSTADROPS SOLN .37%	1	NM, LA, PA
CYSTARAN SOLN .44%	1	NM, LA, PA
ISOPTO ATROPINE SOLN 1%	1	
<i>proparacaine hcl</i> SOLN .5%	1	
RESTASIS EMUL .05%	1	
RESTASIS MULTIDOSE EMUL .05%	1	
XIIDRA SOLN 5%	1	

OTIC

OTIC AGENTS

<i>acetic acid (otic)</i> SOLN 2%	1	
<i>ciprofloxacin-dexamethasone otic susp</i> 0.3- 0.1%	1	

Drug Name	Drug Tier	Requirements/Limits
<i>flac</i> OIL .01%	1	
<i>fluocinolone acetonide (otic)</i> OIL .01%	1	
<i>neomycin-polymyxin-hc otic soln</i> 1%	1	
<i>neomycin-polymyxin-hc otic susp</i> 3.5 mg/ml-10000 unit/ml-1%	1	
<i>ofloxacin (otic)</i> SOLN .3%	1	

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

ANORO ELLIPT AER 62.5-25	1	QL (60 blisters / 30 days)
BEVESPI AER 9-4.8MCG	1	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE	1	QL (1 inhaler / 30 days)
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK)	1	QL (4 inhalers / 28 days)
COMBIVENT AER 20-100	1	QL (2 inhalers / 30 days)
<i>ipratropium-albuterol nebu soln</i> 0.5-2.5(3) mg/3ml	1	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG	1	QL (60 blisters / 30 days)
TRELEGY AER ELLIPTA 200-62.5-25 MCG	1	QL (60 blisters / 30 days)

ANTICHOLINERGICS

ATROVENT HFA AERS 17mcg/act	1	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA AEPB 62.5mcg/inh	1	QL (30 blisters / 30 days)
<i>ipratropium bromide</i> SOLN .02%	1	B/D
<i>ipratropium bromide (nasal)</i> SOLN .03%, .06%	1	

ANTI-HISTAMINES

<i>azelastine hcl</i> SOLN .1%, .15%	1	
<i>cetirizine hcl</i> SOLN 1mg/ml	1	
<i>cyproheptadine hcl</i> SYRP 2mg/5ml; TABS 4mg	1	PA; PA if 70 years and older
<i>diphenhydramine hcl</i> SOLN 50mg/ml	1	
<i>hydroxyzine hcl</i> SOLN 25mg/ml, 50mg/ml; SYRP 10mg/5ml; TABS 10mg, 25mg, 50mg	1	PA; PA if 70 years and older
<i>hydroxyzine pamoate</i> CAPS 25mg, 50mg	1	PA; PA if 70 years and older
<i>levocetirizine dihydrochloride</i> SOLN 2.5mg/5ml; TABS 5mg	1	

Drug Name	Drug Tier	Requirements/Limits
BETA AGONISTS		
<i>albuterol sulfate</i> AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Proair HFA)
<i>albuterol sulfate</i> AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Proventil HFA)
<i>albuterol sulfate</i> AERS 108mcg/act	1	QL (2 inhalers / 30 days); (generic of Ventolin HFA)
<i>albuterol sulfate</i> NEBU .083%, .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	1	B/D
<i>albuterol sulfate</i> SYRP 2mg/5ml; TABS 2mg, 4mg	1	
<i>levalbuterol hcl</i> NEBU .31mg/3ml, .63mg/3ml, 1.25mg/0.5ml, 1.25mg/3ml	1	B/D
<i>levalbuterol tartrate</i> AERO 45mcg/act	1	QL (2 inhalers / 30 days), ST
SEREVENT DISKUS AEPB 50mcg/dose	1	QL (60 inhalations / 30 days)
<i>terbutaline sulfate</i> TABS 2.5mg, 5mg	1	
VENTOLIN HFA AERS 108mcg/act	1	QL (2 inhalers / 30 days)
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act	1	QL (6 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
<i>montelukast sodium</i> CHEW 4mg, 5mg; PACK 4mg; TABS 10mg	1	
<i>zafirlukast</i> TABS 10mg, 20mg	1	
MISCELLANEOUS		
<i>acetylcysteine</i> SOLN 10%, 20%	1	B/D
ARALAST NP SOLR 500mg, 1000mg	1	NM, LA, PA
<i>cromolyn sodium</i> NEBU 20mg/2ml	1	B/D
DALIRESP TABS 250mcg, 500mcg	1	
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.3ml, .3mg/0.3ml	1	(generic of EpiPen)
<i>epinephrine (anaphylaxis)</i> SOAJ .15mg/0.15ml, .3mg/0.3ml	1	(generic of Adrenaclick)
ESBRIET CAPS 267mg	1	QL (270 caps / 30 days), NM, LA, PA
FASENRA SOSY 30mg/ml	1	NM, LA, PA
FASENRA PEN SOAJ 30mg/ml	1	NM, LA, PA
KALYDECO PACK 25mg, 50mg, 75mg	1	QL (56 packs / 28 days), NM, LA, PA
KALYDECO TABS 150mg	1	QL (60 tabs / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
OFEV CAPS 100mg, 150mg	1	QL (60 caps / 30 days), NM, LA, PA
ORKAMBI GRA 100-125	1	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI GRA 150-188	1	QL (56 packs / 28 days), NM, LA, PA
ORKAMBI TAB 100-125	1	QL (112 tabs / 28 days), NM, LA, PA
ORKAMBI TAB 200-125	1	QL (112 tabs / 28 days), NM, LA, PA
<i>pirfenidone</i> TABS 267mg	1	QL (270 tabs / 30 days), NM, PA
<i>pirfenidone</i> TABS 801mg	1	QL (90 tabs / 30 days), NM, PA
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	1	NM, LA, PA
PULMOZYME SOLN 2.5mg/2.5ml	1	NM, PA
SYMDEKO TAB 50-75MG	1	QL (56 tabs / 28 days), NM, LA, PA
SYMDEKO TAB 100-150	1	QL (56 tabs / 28 days), NM, LA, PA
SYMJEPI SOSY .15mg/0.3ml, .3mg/0.3ml	1	
THEO-24 CP24 100mg, 200mg, 300mg, 400mg	1	
<i>theophylline</i> SOLN 80mg/15ml; TB12 300mg, 450mg; TB24 400mg, 600mg	1	
TRIKAFTA TAB 50-25-37.5MG & 75MG	1	QL (84 tabs / 28 days), NM, LA, PA
TRIKAFTA TAB 100-50-75MG & 150MG	1	QL (84 tabs / 28 days), NM, LA, PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	1	NM, LA, PA
ZEMAIRA SOLR 1000mg	1	NM, LA, PA
NASAL STEROIDS		
<i>flunisolide (nasal)</i> SOLN .025%	1	QL (3 bottles / 30 days)
<i>fluticasone propionate (nasal)</i> SUSP 50mcg/act	1	QL (1 bottle / 30 days)
XHANCE EXHU 93mcg/act	1	QL (32 mL / 30 days), PA
STEROID INHALANTS		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act	1	QL (30 inhalations / 30 days)
<i>budesonide (inhalation)</i> SUSP .25mg/2ml, .5mg/2ml	1	B/D
FLOVENT DISKUS AEPB 50mcg/blist	1	QL (180 inhalations / 30 days)

Drug Name	Drug Tier	Requirements/Limits
FLOVENT DISKUS AEPB 100mcg/blist, 250mcg/blist	1	QL (240 inhalations / 30 days)
FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act	1	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 90mcg/act	1	QL (3 inhalers / 30 days)
PULMICORT FLEXHALER AEPB 180mcg/act	1	QL (2 inhalers / 30 days)

STEROID/BETA-AGONIST COMBINATIONS

ADVAIR DISKU AER 100/50	1	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 250/50	1	QL (60 inhalations / 30 days)
ADVAIR DISKU AER 500/50	1	QL (60 inhalations / 30 days)
ADVAIR HFA AER 45/21	1	QL (1 inhaler / 30 days)
ADVAIR HFA AER 115/21	1	QL (1 inhaler / 30 days)
ADVAIR HFA AER 230/21	1	QL (1 inhaler / 30 days)
BREO ELLIPTA INH 100-25	1	QL (60 blisters / 30 days)
BREO ELLIPTA INH 200-25	1	QL (60 blisters / 30 days)
SYMBICORT AER 80-4.5	1	QL (1 inhaler / 30 days)
SYMBICORT AER 160-4.5	1	QL (1 inhaler / 30 days)

TOPICAL

DERMATOLOGY, ACNE

<i>acutane</i> CAPS 10mg, 20mg, 30mg, 40mg	1	PA
<i>amneesteem</i> CAPS 10mg, 20mg, 40mg	1	PA
<i>avita</i> CREA .025%; GEL .025%	1	QL (45 gm / 30 days), PA
<i>benzoyl peroxide-erythromycin gel</i> 5-3%	1	QL (46.6 gm / 30 days)
<i>claravis</i> CAPS 10mg, 20mg, 30mg, 40mg	1	PA
<i>clindamycin phosphate (topical)</i> GEL 1%	1	QL (75 gm / 30 days)
<i>clindamycin phosphate (topical)</i> LOTN 1%; SOLN 1%	1	QL (60 mL / 30 days)
<i>ery</i> PADS 2%	1	QL (60 pledgets / 30 days)
<i>erythromycin (acne aid)</i> SOLN 2%	1	QL (60 mL / 30 days)
<i>isotretinoin</i> CAPS 10mg, 20mg, 30mg, 40mg	1	PA
<i>myorisan</i> CAPS 10mg, 20mg, 30mg, 40mg	1	PA
<i>sulfacetamide sodium (acne)</i> LOTN 10%	1	QL (118 mL / 30 days)
<i>tretinoin</i> CREA .025%, .05%, .1%; GEL .01%, .025%	1	QL (45 gm / 30 days), PA
<i>zenatane</i> CAPS 10mg, 20mg, 30mg, 40mg	1	PA

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, ANTIBIOTICS		
<i>gentamicin sulfate (topical)</i> CREA .1%; OINT .1%	1	QL (30 gm / 30 days)
<i>mupirocin</i> OINT 2%	1	QL (220 gm / 30 days)
<i>silver sulfadiazine</i> CREA 1%	1	
<i>ssd</i> CREA 1%	1	
SULFAMYLON CREA 85mg/gm	1	QL (453.6 gm / 30 days)
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox olamine</i> CREA .77%	1	QL (90 gm / 30 days)
<i>ciclopirox olamine</i> SUSP .77%	1	QL (60 mL / 30 days)
<i>clotrimazole (topical)</i> CREA 1%	1	QL (45 gm / 30 days)
<i>clotrimazole (topical)</i> SOLN 1%	1	QL (30 mL / 30 days)
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1	QL (45 gm / 30 days)
<i>ketoconazole (topical)</i> CREA 2%	1	QL (60 gm / 30 days)
<i>nyamyc</i> POWD 100000unit/gm	1	QL (60 gm / 30 days)
<i>nystatin (topical)</i> CREA 100000unit/gm; OINT 100000unit/gm	1	QL (30 gm / 30 days)
<i>nystatin (topical)</i> POWD 100000unit/gm	1	QL (60 gm / 30 days)
<i>nystop</i> POWD 100000unit/gm	1	QL (60 gm / 30 days)
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin</i> CAPS 10mg, 17.5mg, 25mg	1	PA
<i>calcipotriene</i> OINT .005%	1	QL (120 gm / 30 days), PA
<i>calcipotriene</i> SOLN .005%	1	QL (120 mL / 30 days), PA
<i>calcitrene</i> OINT .005%	1	QL (120 gm / 30 days), PA
<i>tazarotene</i> CREA .1%	1	QL (60 gm / 30 days), PA
TAZORAC CREA .05%	1	QL (60 gm / 30 days), PA
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole (topical)</i> SHAM 2%	1	QL (120 mL / 30 days)
<i>selenium sulfide</i> LOTN 2.5%	1	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort</i> CREA 1%, 2.5%	1	
<i>alclometasone dipropionate</i> CREA .05%; OINT .05%	1	QL (60 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> CREA .05%; OINT .05%	1	QL (120 gm / 30 days)
<i>betamethasone dipropionate (topical)</i> LOTN .05%	1	QL (120 mL / 30 days)
<i>betamethasone dipropionate augmented</i> CREA .05%; GEL .05%; OINT .05%	1	QL (120 gm / 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>betamethasone dipropionate augmented</i> LOTN .05%	1	QL (120 mL / 30 days)
<i>betamethasone valerate</i> CREA .1%; OINT .1%	1	QL (120 gm / 30 days)
<i>betamethasone valerate</i> LOTN .1%	1	QL (120 mL / 30 days)
<i>clobetasol propionate</i> CREA .05%; GEL .05%; OINT .05%	1	QL (60 gm / 30 days)
<i>clobetasol propionate</i> SOLN .05%	1	QL (50 mL / 30 days)
<i>clobetasol propionate e</i> CREA .05% ENSTILAR AER	1	QL (120 gm / 30 days), PA
<i>fluocinolone acetonide</i> CREA .01%	1	QL (60 gm / 30 days)
<i>fluocinolone acetonide</i> CREA .025%; OINT .025%	1	QL (120 gm / 30 days)
<i>fluocinolone acetonide</i> OIL .01%	1	QL (118.28 mL / 30 days)
<i>fluocinolone acetonide</i> SOLN .01%	1	QL (90 mL / 30 days)
<i>fluocinonide</i> CREA .05%	1	QL (120 gm / 30 days)
<i>fluocinonide</i> GEL .05%; OINT .05%	1	QL (60 gm / 30 days)
<i>fluocinonide</i> SOLN .05%	1	QL (60 mL / 30 days)
<i>fluocinonide emulsified base</i> CREA .05%	1	QL (120 gm / 30 days)
<i>fluticasone propionate</i> CREA .05%; OINT .005%	1	
<i>halobetasol propionate</i> CREA .05%; OINT .05%	1	QL (50 gm / 30 days)
<i>hydrocortisone (topical)</i> CREA 1%, 2.5%; LOTN 2.5%; OINT 2.5%	1	
<i>mometasone furoate</i> CREA .1%; OINT .1%; SOLN .1%	1	
<i>triamcinolone acetonide (topical)</i> CREA .1%	1	QL (454 gm / 30 days)
<i>triamcinolone acetonide (topical)</i> CREA .025%, .5%; LOTN .025%, .1%; OINT .025%, .1%, .5%	1	
DERMATOLOGY, LOCAL ANESTHETICS		
<i>glydo</i> PRSY 2%	1	QL (60 mL / 30 days), PA
<i>lidocaine</i> OINT 5%	1	QL (50 gm / 30 days), PA
<i>lidocaine</i> PTCH 5%	1	QL (3 patches / 1 day), PA
<i>lidocaine hcl</i> GEL 2%	1	QL (30 mL / 30 days), PA
<i>lidocaine hcl</i> SOLN 4%	1	QL (50 mL / 30 days), PA
<i>lidocaine-prilocaine cream</i> 2.5-2.5%	1	QL (30 gm / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>bexarotene (topical)</i> GEL 1%	1	QL (60 gm / 30 days), NM, PA
<i>diclofenac sodium (topical)</i> GEL 1%	1	QL (1000 gm / 30 days)
<i>fluorouracil (topical)</i> CREA 5%	1	QL (40 gm / 30 days)
<i>fluorouracil (topical)</i> SOLN 2%, 5%	1	QL (10 mL / 30 days)
<i>hydrocortisone (rectal)</i> CREA 2.5%	1	
<i>imiquimod</i> CREA 5%	1	QL (24 packets / 30 days)
<i>lactic acid (ammonium lactate)</i> CREA 12%; LOTN 12%	1	
<i>metronidazole (topical)</i> CREA .75%; GEL .75%	1	QL (45 gm / 30 days)
<i>metronidazole (topical)</i> LOTN .75%	1	QL (59 mL / 30 days)
PANRETIN GEL .1%	1	QL (60 gm / 30 days), PA
<i>podofilox</i> SOLN .5%	1	QL (7 mL / 28 days)
<i>procto-med hc</i> CREA 2.5%	1	
<i>procto-pak</i> CREA 1%	1	
<i>proctosol hc</i> CREA 2.5%	1	
<i>proctozone-hc</i> CREA 2.5%	1	
RECTIV OINT .4%	1	QL (30 gm / 30 days)
<i>rosadan</i> CREA .75%	1	QL (45 gm / 30 days)
<i>tacrolimus (topical)</i> OINT .03%, .1%	1	QL (100 gm / 30 days)
VALCHLOR GEL .016%	1	QL (60 gm / 30 days), NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
<i>malathion</i> LOTN .5%	1	QL (59 mL / 30 days)
<i>permethrin</i> CREA 5%	1	QL (60 gm / 30 days)
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01%	1	QL (30 gm / 30 days), PA
SANTYL OINT 250unit/gm	1	QL (180 gm / 30 days)
<i>sodium chloride (gu irrigant)</i> SOLN .9%	1	
<i>water for irrigation, sterile irrigation soln</i>	1	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl</i> CAPS 30mg	1	
<i>chlorhexidine gluconate (mouth-throat)</i> SOLN .12%	1	
<i>clotrimazole</i> TROC 10mg	1	QL (150 lozenges / 30 days)
<i>lidocaine hcl (mouth-throat)</i> SOLN 2%	1	
<i>nystatin (mouth-throat)</i> SUSP 100000unit/ml	1	
<i>periogard</i> SOLN .12%	1	

Drug Name	Drug Tier	Requirements/Limits
<i>pilocarpine hcl (oral) TABS 5mg, 7.5mg</i>	1	
<i>triamcinolone acetonide (mouth) PSTE .1%</i>	1	

Index

A	
<i>abacavir sulfate</i>	22
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	24
ABELCET.....	22
ABILIFY MAINTENA.....	49
<i>abiraterone acetate</i>	29
<i>acamprosate calcium</i>	55
<i>acarbose</i>	56
<i>accutane</i>	84
<i>acebutolol hcl</i>	40
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	19
<i>acetaminophen w/ codeine tab 300-15 mg</i>	19
<i>acetaminophen w/ codeine tab 300-30 mg</i>	19
<i>acetaminophen w/ codeine tab 300-60 mg</i>	19
<i>acetazolamide</i>	42
<i>acetic acid</i>	70
<i>acetic acid (otic)</i>	80
<i>acetylcysteine</i>	82
<i>acitretin</i>	85
ACTHIB INJ.....	75
ACTIMMUNE.....	74
<i>acyclovir</i>	25
<i>acyclovir sodium</i>	25
ADACEL INJ.....	75
<i>adefovir dipivoxil</i>	25
ADEMPAS.....	43
ADRENALIN.....	42
ADVAIR DISKU AER 100/50.....	84
ADVAIR DISKU AER 250/50.....	84
ADVAIR DISKU AER 500/50.....	84
ADVAIR HFA AER 115/21.....	84
ADVAIR HFA AER 230/21.....	84
ADVAIR HFA AER 45/21.....	84
<i>afirmelle</i>	60
AIMOVIG.....	53
<i>ala-cort</i>	85
<i>albendazole</i>	20
<i>albuterol sulfate</i>	82
<i>alclometasone dipropionate</i>	85
ALDURAZYME.....	65
ALECENSA.....	31
<i>alendronate sodium</i>	59
<i>alfuzosin hcl</i>	70
<i>aliskiren fumarate</i>	42
<i>allopurinol</i>	18
<i>alosetron hcl</i>	69
ALPHAGAN P.....	80
<i>alprazolam</i>	43
ALREX.....	79
<i>altavera</i>	60
ALUNBRIG.....	31
ALUNBRIG PAK.....	31
<i>alyacen 1/35</i>	60
<i>alyacen 7/7/7</i>	60
<i>amabelz</i>	64
<i>amantadine hcl</i>	48
<i>ambrisentan</i>	43
<i>amethia</i>	60
<i>amikacin sulfate</i>	20
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	42
<i>amiloride hcl</i>	42
<i>amiodarone hcl</i>	39
<i>amitriptyline hcl</i>	47
<i>amlodipine besylate</i>	41
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	36
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	36
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	36
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	36
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	36
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	36
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	37
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	37
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	37
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	37
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	37

<i>amlodipine besylate-valsartan tab 10-320 mg</i>	37	<i>amphetamine-dextroamphetamine tab 20 mg</i>	52
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	37	<i>amphetamine-dextroamphetamine tab 30 mg</i>	52
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	37	<i>amphetamine-dextroamphetamine tab 5 mg</i>	52
<i>amnestem</i>	84	<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	52
<i>amoxapine</i>	47	<i>amphotericin b</i>	22
<i>amoxicillin</i>	27	<i>amphotericin b liposome</i>	22
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	27	<i>ampicillin</i>	27
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	27	<i>ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm</i>	27
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	27	<i>ampicillin & sulbactam sodium for inj 3 (2-1) gm</i>	27
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	27	<i>ampicillin & sulbactam sodium for iv soln 1.5 (1-0.5) gm</i>	27
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	27	<i>ampicillin & sulbactam sodium for iv soln 15 (10-5) gm</i>	28
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	27	<i>ampicillin & sulbactam sodium for iv soln 3 (2-1) gm</i>	28
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	27	<i>ampicillin sodium</i>	28
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	27	<i>anagrelide hcl</i>	72
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	27	<i>anastrozole</i>	29
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	27	<i>ANORO ELLIPT AER 62.5-25</i>	81
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	52	<i>aprepitant</i>	68
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	52	<i>aprepitant capsule therapy pack 80 & 125 mg</i>	68
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	52	<i>apri</i>	60
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	52	<i>APTIOM</i>	43
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	52	<i>APTIVUS</i>	22
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	52	<i>ARALAST NP</i>	82
<i>amphetamine-dextroamphetamine tab 10 mg</i>	52	<i>aranelle</i>	60
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	52	<i>ARCALYST</i>	74
<i>amphetamine-dextroamphetamine tab 15 mg</i>	52	<i>aripiprazole</i>	49
		<i>ARISTADA</i>	49, 50
		<i>ARISTADA INITIO</i>	50
		<i>armodafinil</i>	55
		<i>ARNUITY ELLIPTA</i>	83
		<i>asenapine maleate</i>	50
		<i>ashlyna</i>	60
		<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	72
		<i>atazanavir sulfate</i>	23
		<i>atenolol</i>	40
		<i>atenolol & chlorthalidone tab 100-25 mg</i>	40

<i>atenolol & chlorthalidone tab 50-25 mg</i>	
.....	40
<i>atomoxetine hcl</i>	52
<i>atorvastatin calcium</i>	39
<i>atovaquone</i>	20
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	
.....	22
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	
.....	22
ATROPINE SULFATE	80
<i>atropine sulfate (ophthalmic)</i>	80
ATROVENT HFA	81
<i>aubra eq</i>	60
<i>aurovela 1/20</i>	60
<i>aurovela 24 fe</i>	60
<i>aurovela fe 1.5/30</i>	60
<i>aurovela fe 1/20</i>	60
AUSTEDO	54
<i>aviane</i>	60
<i>avita</i>	84
<i>ayuna</i>	60
AYVAKIT	31
<i>azacitidine</i>	29
<i>azathioprine</i>	75
<i>azelastine hcl</i>	81
<i>azelastine hcl (ophth)</i>	80
<i>azithromycin</i>	26
<i>aztreonam</i>	20
<i>azurette</i>	60
B	
<i>bacitracin (ophthalmic)</i>	79
<i>bacitracin-polymyxin b ophth oint</i>	79
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	
.....	78
<i>baclofen</i>	55
BAFIERTAM	54
<i>balsalazide disodium</i>	68
BALVERSA	31
<i>balziva</i>	60
BARACLUDGE.....	25
BASAGLAR KWIKPEN	58
BCG VACCINE	75
BD ALCOHOL SWABS	58
BELSOMRA	53
<i>benazepril & hydrochlorothiazide tab 10-12.5 mg</i>	
.....	36
<i>benazepril & hydrochlorothiazide tab 20-12.5 mg</i>	
.....	36
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	
.....	36
<i>benazepril & hydrochlorothiazide tab 5-6.25mg</i>	
.....	36
<i>benazepril hcl</i>	36
BENDEKA	29
BENLYSTA	75
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	
.....	84
<i>benztropine mesylate</i>	48
BERINERT	72
BESIVANCE	79
BESREMI.....	30
<i>betaine powder for oral solution</i>	65
<i>betamethasone dipropionate (topical)</i>	
.....	85
<i>betamethasone dipropionate augmented</i>	
.....	85, 86
<i>betamethasone valerate</i>	86
BETASERON	54
<i>betaxolol hcl</i>	40
<i>betaxolol hcl (ophth)</i>	80
<i>bethanechol chloride</i>	70
BETOPTIC-S	80
BEVESPI AER 9-4.8MCG	81
<i>bexarotene</i>	30
<i>bexarotene (topical)</i>	87
BEXSERO INJ.....	75
<i>bicalutamide</i>	29
BICILLIN L-A	28
BIKTARVY TAB 30-120-15 MG.....	24
BIKTARVY TAB 50-200-25 MG.....	24
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	
.....	40
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	
.....	40
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	
.....	40
<i>bisoprolol fumarate</i>	40
BIVIGAM	74
<i>blisovi 24 fe</i>	60
<i>blisovi fe 1.5/30</i>	60
BOOSTRIX INJ	75
<i>bortezomib</i>	31
BORTEZOMIB.....	31

<i>bosentan</i>	43
BOSULIF	31
BRAFTOVI	31
BREO ELLIPTA INH 100-25	84
BREO ELLIPTA INH 200-25	84
BREZTRI AERO AER SPHERE	81
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK).....	81
<i>briellyn</i>	60
BRILINTA	72
<i>brimonidine tartrate</i>	80
<i>brinzolamide</i>	80
BRIVIACT	43
<i>bromocriptine mesylate</i>	48
BROMSITE	79
BRUKINSA	31
<i>budesonide</i>	68, 69
<i>budesonide (inhalation)</i>	83
<i>bumetanide</i>	42
<i>buprenorphine hcl</i>	55
<i>buprenorphine hcl-naloxone hcl sl film</i> <i>12-3 mg (base equiv)</i>	55
<i>buprenorphine hcl-naloxone hcl sl film</i> <i>2-0.5 mg (base equiv)</i>	55
<i>buprenorphine hcl-naloxone hcl sl film</i> <i>4-1 mg (base equiv)</i>	55
<i>buprenorphine hcl-naloxone hcl sl film</i> <i>8-2 mg (base equiv)</i>	55
<i>buprenorphine hcl-naloxone hcl sl tab</i> <i>2-0.5 mg (base equiv)</i>	55
<i>buprenorphine hcl-naloxone hcl sl tab</i> <i>8-2 mg (base equiv)</i>	55
<i>bupropion hcl</i>	47
<i>bupropion hcl (smoking deterrent)</i> ...	55
<i>bupirone hcl</i>	43
<i>butorphanol tartrate</i>	19
BYDUREON BCISE	56
BYETTA	56
C	
<i>cabergoline</i>	65
CABOMETYX	31
<i>calcipotriene</i>	85
<i>calcitonin (salmon) spray</i>	59
<i>calcitrene</i>	85
<i>calcitriol</i>	67
<i>calcium acetate (phosphate binder)</i> .66,	

CALQUENCE	31
<i>camila</i>	60
<i>camrese</i>	60
<i>camrese lo</i>	60
<i>candesartan cilexetil</i>	39
<i>candesartan cilexetil-</i> <i>hydrochlorothiazide tab 16-12.5 mg</i>	37
<i>candesartan cilexetil-</i> <i>hydrochlorothiazide tab 32-12.5 mg</i>	37
<i>candesartan cilexetil-</i> <i>hydrochlorothiazide tab 32-25 mg</i> .	37
CAPLYTA	50
CAPRELSA	31
<i>captopril</i>	36
<i>carb/levo orally disintegrating tab 10-</i> <i>100mg</i>	49
<i>carb/levo orally disintegrating tab 25-</i> <i>100mg</i>	49
<i>carb/levo orally disintegrating tab 25-</i> <i>250mg</i>	49
<i>carbamazepine</i>	44
<i>carbidopa & levodopa tab 10-100 mg</i>	49
<i>carbidopa & levodopa tab 25-100 mg</i>	49
<i>carbidopa & levodopa tab 25-250 mg</i>	49
<i>carbidopa & levodopa tab er 25-100</i> <i>mg</i>	49
<i>carbidopa & levodopa tab er 50-200</i> <i>mg</i>	49
<i>carbidopa-levodopa-entacapone tabs</i> <i>12.5-50-200 mg</i>	49
<i>carbidopa-levodopa-entacapone tabs</i> <i>18.75-75-200 mg</i>	49
<i>carbidopa-levodopa-entacapone tabs</i> <i>25-100-200 mg</i>	49
<i>carbidopa-levodopa-entacapone tabs</i> <i>31.25-125-200 mg</i>	49
<i>carbidopa-levodopa-entacapone tabs</i> <i>37.5-150-200 mg</i>	49
<i>carbidopa-levodopa-entacapone tabs</i> <i>50-200-200 mg</i>	49
<i>carboplatin</i>	29
<i>carglumic acid</i>	65
<i>carisoprodol</i>	55
<i>carteolol hcl (ophth)</i>	80
<i>cartia xt</i>	41

<i>carvedilol</i>	41	<i>ciprofloxacin hcl (ophth)</i>	79
<i>caspofungin acetate</i>	22	<i>ciprofloxacin-dexamethasone otic susp</i>	
CAYSTON	20	0.3-0.1%	80
<i>cefaclor</i>	26	<i>cisplatin</i>	29
CEFACLOR ER	26	<i>citalopram hydrobromide</i>	47
<i>cefadroxil</i>	26	<i>claravis</i>	84
CEFAZOLIN INJ 1GM/50ML	26	<i>clarithromycin</i>	26
<i>cefazolin sodium</i>	26	<i>clindamycin hcl</i>	20
CEFAZOLIN SOLN 2GM/100ML-4% ...	26	<i>clindamycin palmitate hydrochloride</i> .	20
<i>cefdinir</i>	26	<i>clindamycin phosphate</i>	20
<i>cefepime hcl</i>	26	<i>clindamycin phosphate (topical)</i>	84
<i>cefixime</i>	26	<i>clindamycin phosphate in d5w iv soln</i>	
<i>cefoxitin sodium</i>	26	300 mg/50ml	20
<i>cefpodoxime proxetil</i>	26	<i>clindamycin phosphate in d5w iv soln</i>	
<i>cefprozil</i>	26	600 mg/50ml	20
<i>ceftazidime</i>	26	<i>clindamycin phosphate in d5w iv soln</i>	
CEFTAZIDIME/ SOL D5W 1GM.....	26	900 mg/50ml	20
CEFTAZIDIME/ SOL D5W 2GM.....	26	<i>clindamycin phosphate vaginal</i>	71
<i>ceftriaxone sodium</i>	26	CLINDMYC/NAC INJ 300/50ML	20
<i>cefuroxime axetil</i>	26	CLINDMYC/NAC INJ 600/50ML	20
<i>cefuroxime sodium</i>	26	CLINDMYC/NAC INJ 900/50ML	20
<i>celecoxib</i>	18	CLINIMIX INJ 4.25/D10.....	78
CELONTIN	44	CLINIMIX INJ 4.25/D5W.....	78
<i>cephalexin</i>	26	CLINIMIX INJ 5%/D15W	78
CERDELGA.....	65	CLINIMIX INJ 5%/D20W	78
CEREZYME.....	65	CLINIMIX INJ 6/5	78
<i>cetirizine hcl</i>	81	CLINIMIX INJ 8/10	78
<i>cevimeline hcl</i>	87	CLINIMIX INJ 8/14	78
<i>chateal</i>	60	<i>clinisol sf 15%</i>	78
CHEMET	59	CLINOLIPID EMU 20%	78
<i>chlorhexidine gluconate (mouth-throat)</i>		<i>clobazam</i>	44
.....	87	<i>clobetasol propionate</i>	86
<i>chloroquine phosphate</i>	22	<i>clobetasol propionate e</i>	86
<i>chlorpromazine hcl</i>	50	<i>clomipramine hcl</i>	47
CHLORPROMAZINE HYDROCHLOR	50	<i>clonazepam</i>	44
<i>chlorthalidone</i>	42	<i>clonidine</i>	42
<i>cholestyramine</i>	40	<i>clonidine hcl</i>	42
<i>cholestyramine light</i>	40	<i>clopidogrel bisulfate</i>	72
<i>ciclopirox olamine</i>	85	<i>clorazepate dipotassium</i>	44
<i>cilostazol</i>	72	<i>clotrimazole</i>	87
CILOXAN	79	<i>clotrimazole (topical)</i>	85
CIMDUO TAB 300-300	24	<i>clotrimazole w/ betamethasone cream</i>	
<i>cinacalcet hcl</i>	66	1-0.05%	85
CIPRO	27	<i>clozapine</i>	50
<i>ciprofloxacin 200 mg/100ml in d5w</i> ..	27	COARTEM TAB 20-120MG.....	22
<i>ciprofloxacin 400 mg/200ml in d5w</i> ..	27	<i>colchicine</i>	18
<i>ciprofloxacin hcl</i>	27		

<i>colchicine w/ probenecid tab 0.5-500 mg</i>	18	<i>dantrolene sodium</i>	55
<i>colesevelam hcl</i>	40	<i>dapsone</i>	20
<i>colestipol hcl</i>	40	DAPTACEL INJ	75
<i>colistimethate sodium</i>	20	<i>daptomycin</i>	20
COMBIGAN SOL 0.2/0.5%	80	DAPTOMYCIN	20
COMBIVENT AER 20-100	81	<i>dasetta 1/35</i>	60
COMETRIQ (60MG DOSE)	31	<i>dasetta 7/7/7</i>	60
COMETRIQ KIT 100MG	31	DAURISMO	32
COMETRIQ KIT 140MG	31	<i>daysee</i>	60
COMPLERA TAB	24	<i>deblitane</i>	60
<i>compro</i>	68	<i>deferasirox</i>	59
<i>constulose</i>	69	DELESTROGEN	64
COPIKTRA	31	DELSTRIGO TAB	24
CORLANOR	42	DENG VAXIA SUS	75
COTELIC	31	DESCOVY TAB 120-15MG	24
CREON CAP 12000UNT	70	DESCOVY TAB 200/25MG	24
CREON CAP 24000UNT	70	<i>desipramine hcl</i>	47
CREON CAP 3000UNIT	70	<i>desmopressin acetate</i>	66
CREON CAP 36000UNT	70	<i>desmopressin acetate spray</i>	66
CREON CAP 6000UNIT	70	<i>desmopressin acetate spray refrigerated</i>	66
<i>cromolyn sodium</i>	82	<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	60
<i>cromolyn sodium (mastocytosis)</i>	69	<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	60
<i>cromolyn sodium (ophth)</i>	80	<i>desvenlafaxine succinate</i>	47
<i>cryselle-28</i>	60	<i>dexamethasone</i>	65
<i>cyclobenzaprine hcl</i>	55	DEXAMETHASONE INTENSOL	65
<i>cyclophosphamide</i>	29	<i>dexamethasone sodium phosphate</i>	65
CYCLOPHOSPHAMIDE	29	<i>dexamethasone sodium phosphate (ophth)</i>	79
CYCLOPHOSPHAMIDE MONOHYDR	29	<i>dexmethylphenidate hcl</i>	52
<i>cycloserine</i>	24	<i>dextrose</i>	78
<i>cyclosporine</i>	75	<i>dextrose 10% w/ sodium chloride 0.45%</i>	76
<i>cyclosporine modified (for microemulsion)</i>	75	<i>dextrose 2.5% w/ sodium chloride 0.45%</i>	76
<i>cyproheptadine hcl</i>	81	<i>dextrose 5% in lactated ringers</i>	76
<i>cyred eq</i>	60	<i>dextrose 5% w/ sodium chloride 0.2%</i>	76
CYSTADROPS	80	<i>dextrose 5% w/ sodium chloride</i>	76
CYSTAGON	66	<i>dextrose 5% w/ sodium chloride 0.225%</i>	76
CYSTARAN	80	<i>dextrose 5% w/ sodium chloride 0.3%</i>	76
<i>cytarabine</i>	29	<i>dextrose 5% w/ sodium chloride 0.45%</i>	76
D			
D10W/NAACL INJ 0.2%	76		
D2.5W/NAACL INJ 0.45%	76		
D5W/LYTES INJ #48	76		
<i>dabigatran etexilate mesylate</i>	71		
<i>dalfampridine</i>	54		
DALIRESP	82		
<i>danazol</i>	64		

<i>dextrose 5% w/ sodium chloride 0.9%</i>	
.....	76
DIACOMIT	44
<i>diazepam</i>	44
<i>diazepam (anticonvulsant)</i>	44
<i>diazepam inj.</i>	44
<i>diazoxide</i>	65
<i>diclofenac potassium</i>	18
<i>diclofenac sodium</i>	18
<i>diclofenac sodium (ophth)</i>	79
<i>diclofenac sodium (topical)</i>	87
<i>dicloxacillin sodium</i>	28
<i>dicyclomine hcl</i>	68
DIFICID	26
<i>diflunisal</i>	18
<i>difluprednate</i>	79
<i>digoxin</i>	42
<i>dihydroergotamine mesylate</i>	53
DILANTIN.....	44
DILANTIN INFATABS.....	44
DILANTIN-125	44
<i>diltiazem hcl</i>	41
<i>diltiazem hcl coated beads</i>	41
<i>diltiazem hcl extended release beads</i>	41
<i>dilt-xr</i>	41
DIP/TET PED INJ 25-5LFU	75
<i>diphenhydramine hcl</i>	81
<i>diphenoxylate w/ atropine liq 2.5-0.025</i> <i>mg/5ml</i>	69
<i>diphenoxylate w/ atropine tab 2.5-</i> <i>0.025 mg</i>	69
<i>dipyridamole</i>	72
<i>disopyramide phosphate</i>	39
<i>disulfiram</i>	55
<i>divalproex sodium</i>	44
<i>docetaxel</i>	31
DOCETAXEL.....	31
<i>dofetilide</i>	39
<i>donepezil hydrochloride</i>	47
DOPTELET	72
<i>dorzolamide hcl</i>	80
<i>dorzolamide hcl-timolol maleate ophth</i> <i>soln 22.3-6.8 mg/ml</i>	80
<i>dotti</i>	64
DOVATO TAB 50-300MG.....	24
<i>doxazosin mesylate</i>	37
<i>doxepin hcl</i>	47
<i>doxepin hcl (sleep)</i>	53
<i>doxorubicin hcl</i>	29
<i>doxorubicin hcl liposomal</i>	29
<i>doxy 100</i>	28
<i>doxycycline (monohydrate)</i>	28
<i>doxycycline hyclate</i>	28
DRIZALMA SPRINKLE.....	47
<i>dronabinol</i>	68
<i>drospirenone-ethinyl estradiol tab 3-</i> <i>0.02 mg</i>	60
<i>drospirenone-ethinyl estradiol tab 3-</i> <i>0.03 mg</i>	60
<i>drospirenone-ethinyl estrad-</i> <i>levomefolate tab 3-0.03-0.451 mg</i>	60
DROXIA	72
<i>droxidopa</i>	42
<i>duloxetine hcl</i>	47
DUPIXENT	72
<i>dutasteride</i>	70
<i>dutasteride-tamsulosin hcl cap 0.5-0.4</i> <i>mg</i>	70
E	
<i>e.e.s. 400</i>	26
<i>ec-naproxen</i>	18
EDURANT	23
<i>efavirenz</i>	23
<i>efavirenz-emtricitabine-tenofovir df tab</i> <i>600-200-300 mg</i>	24
<i>efavirenz-lamivudine-tenofovir df tab</i> <i>400-300-300 mg</i>	24
<i>efavirenz-lamivudine-tenofovir df tab</i> <i>600-300-300 mg</i>	24
ELIGARD	30
<i>elinest</i>	60
ELIQUIS.....	71
ELIQUIS STARTER PACK.....	71
ELLA.....	60
ELLENCE	29
<i>eluryng</i>	61
EMCYT	30
<i>emoquette</i>	61
EMSAM	48
<i>emtricitabine</i>	23
<i>emtricitabine-tenofovir disoproxil</i> <i>fumarate tab 100-150 mg</i>	24
<i>emtricitabine-tenofovir disoproxil</i> <i>fumarate tab 133-200 mg</i>	24

<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	24	<i>ery</i>	84
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	24	<i>ery-tab</i>	26
EMTRIVA	23	ERYTHROCIN LACTOBIONATE	26
EMVERM.....	20	<i>erythrocin stearate</i>	26
<i>enalapril maleate</i>	37	<i>erythromycin (acne aid)</i>	84
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	36	<i>erythromycin (ophth)</i>	79
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	36	<i>erythromycin base</i>	27
ENBREL.....	72, 73	<i>erythromycin ethylsuccinate</i>	27
ENBREL MINI	73	<i>erythromycin lactobionate</i>	27
ENBREL SURECLICK.....	73	ESBRIET	82
ENDARI.....	72	<i>escitalopram oxalate</i>	48
<i>endocet tab 10-325mg</i>	19	<i>esomeprazole magnesium</i>	70
<i>endocet tab 2.5-325mg</i>	19	<i>estarylla</i>	61
<i>endocet tab 5-325mg</i>	19	<i>estradiol</i>	64
<i>endocet tab 7.5-325mg</i>	19	<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	64
ENGERIX-B.....	75	<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	64
<i>enoxaparin sodium</i>	71	<i>estradiol vaginal</i>	64
<i>enpresse-28</i>	61	<i>estradiol valerate</i>	64
<i>enskyce</i>	61	<i>eszopiclone</i>	53
ENSTILAR AER	86	<i>ethambutol hcl</i>	24
<i>entacapone</i>	49	<i>ethosuximide</i>	45
<i>entecavir</i>	25	<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	61
ENTRESTO TAB 24-26MG	37	<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	61
ENTRESTO TAB 49-51MG	38	<i>etodolac</i>	18
ENTRESTO TAB 97-103MG.....	38	<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	61
<i>enulose</i>	69	<i>etoposide</i>	31
EPCLUSA PAK 150-37.5.....	25	<i>etravirine</i>	23
EPCLUSA PAK 200-50MG.....	25	EULEXIN	30
EPCLUSA TAB 200-50MG.....	25	<i>euthyrox</i>	67
EPCLUSA TAB 400-100.....	25	<i>everolimus</i>	32
EPIDIOLEX	44	<i>everolimus (immunosuppressant)</i>	75
<i>epinephrine (anaphylaxis)</i>	82	EVOTAZ TAB 300-150	24
<i>epitol</i>	44	<i>exemestane</i>	30
EPIVIR HBV	25	EXKIVITY	32
<i>eplerenone</i>	37	<i>ezetimibe</i>	40
EPRONTIA	44	<i>ezetimibe-simvastatin tab 10-10 mg</i>	40
<i>ergotamine w/ caffeine tab 1-100 mg</i>	53	<i>ezetimibe-simvastatin tab 10-20 mg</i>	40
ERIVEDGE	32	<i>ezetimibe-simvastatin tab 10-40 mg</i>	40
ERLEADA.....	30	<i>ezetimibe-simvastatin tab 10-80 mg</i>	40
<i>erlotinib hcl</i>	32	F	
<i>errin</i>	61	FABRAZYME.....	66
<i>ertapenem sodium</i>	20	<i>falmina</i>	61

<i>famciclovir</i>	25	<i>fluphenazine hcl</i>	50
<i>famotidine</i>	68	<i>flurbiprofen</i>	18
<i>famotidine in nacl 0.9% iv soln 20</i> <i>mg/50ml</i>	68	<i>flurbiprofen sodium</i>	79
FANAPT.....	50	<i>fluticasone propionate</i>	86
FANAPT PAK.....	50	<i>fluticasone propionate (nasal)</i>	83
FARXIGA.....	56	<i>fluvoxamine maleate</i>	43
FASENRA.....	82	<i>fondaparinux sodium</i>	71
FASENRA PEN.....	82	FORTEO.....	59
<i>felbamate</i>	45	<i>fosamprenavir calcium</i>	23
<i>felodipine</i>	41	<i>fosinopril sodium</i>	37
<i>femynor</i>	61	<i>fosinopril sodium & hydrochlorothiazide</i> <i>tab 10-12.5 mg</i>	36
<i>fenofibrate</i>	39	<i>fosinopril sodium & hydrochlorothiazide</i> <i>tab 20-12.5 mg</i>	36
<i>fenofibrate micronized</i>	39	FOTIVDA.....	32
<i>fentanyl</i>	18	FREAMINE III INJ 10%.....	78
<i>fentanyl citrate</i>	19	<i>fulvestrant</i>	30
<i>fesoterodine fumarate</i>	70	<i>furosemide</i>	42
FETZIMA.....	48	<i>furosemide inj</i>	42
FETZIMA CAP TITRATIO.....	48	FUZEON.....	23
FIASP FLEX INJ TOUCH.....	58	<i>fyavolv tab 0.5mg-2.5mcg</i>	64
FIASP INJ 100/ML.....	58	<i>fyavolv tab 1mg-5mcg</i>	64
FIASP PENFIL INJ U-100.....	58	FYCOMPA.....	45
<i>finasteride</i>	70	G	
FINTEPLA.....	45	<i>gabapentin</i>	45
<i>flac</i>	81	<i>galantamine hydrobromide</i>	47
FLAREX.....	79	GAMASTAN INJ.....	74
FLEBOGAMMA DIF.....	74	GAMMAGARD LIQUID.....	74
<i>flecainide acetate</i>	39	GAMMAGARD S/D IGA LESS TH.....	74
FLOVENT DISKUS.....	83, 84	GAMMAKED.....	74
FLOVENT HFA.....	84	GAMMAPLEX.....	74
<i>fluconazole</i>	22	GAMUNEX-C.....	74
<i>fluconazole in nacl 0.9% inj 200</i> <i>mg/100ml</i>	22	<i>ganciclovir sodium</i>	25
<i>fluconazole in nacl 0.9% inj 400</i> <i>mg/200ml</i>	22	GARDASIL 9 INJ.....	75
<i>flucytosine</i>	22	<i>gatifloxacin (ophth)</i>	79
<i>fludrocortisone acetate</i>	65	GATTEX.....	69
<i>flunisolide (nasal)</i>	83	GAUZE PADS 2.....	58
<i>fluocinolone acetonide</i>	86	<i>gavilyte-c</i>	69
<i>fluocinolone acetonide (otic)</i>	81	<i>gavilyte-g</i>	69
<i>fluocinonide</i>	86	GAVRETO.....	32
<i>fluocinonide emulsified base</i>	86	<i>gemcitabine hcl</i>	29
<i>fluorometholone (ophth)</i>	79	<i>gemfibrozil</i>	39
<i>fluorouracil</i>	29	GEMTESA.....	70
<i>fluorouracil (topical)</i>	87	<i>generlac</i>	69
<i>fluoxetine hcl</i>	48	<i>gengraf</i>	75
<i>fluphenazine decanoate</i>	50	GENOTROPIN.....	66
		GENOTROPIN MINIQUICK.....	66

<i>gentak</i>	79	HAVRIX.....	75
<i>gentamicin in saline inj 0.8 mg/ml</i>	20	<i>heather</i>	61
<i>gentamicin in saline inj 1 mg/ml</i>	20	HEP SOD/D5W INJ 20000UNT	71
<i>gentamicin in saline inj 1.2 mg/ml</i>	20	HEP SOD/D5W INJ 25000UNT	71
<i>gentamicin in saline inj 1.6 mg/ml</i>	20	HEP SOD/NAACL INJ 25000UNT	71
<i>gentamicin in saline inj 2 mg/ml</i>	20	<i>heparin sodium (porcine)</i>	71
<i>gentamicin sulfate</i>	20	HEPARIN/NAACL INJ 25000UNT	71
<i>gentamicin sulfate (ophth)</i>	79	HERCEP HYLEC SOL 60-10000	32
<i>gentamicin sulfate (topical)</i>	85	HERCEPTIN	32
GENVOYA TAB	24	HERZUMA.....	32
GILENYA	54	HETLIOZ	53
GILOTRIF	32	HIBERIX.....	75
<i>glatiramer acetate</i>	54	HUMIRA	73
<i>glatopa</i>	55	HUMIRA PEDIA INJ CROHNS	73
<i>glimepiride</i>	56	HUMIRA PEDIATRIC CROHNS D.....	73
<i>glipizide</i>	56	HUMIRA PEN.....	73
<i>glipizide xl</i>	56	HUMIRA PEN KIT PS/UV	73
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	56	HUMIRA PEN-CD/UC/HS START	73
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	56	HUMIRA PEN-PEDIATRIC UC S	73
<i>glipizide-metformin hcl tab 5-500 mg</i>	56	HUMIRA PEN-PS/UV STARTER.....	73
<i>glycopyrrolate</i>	68	HUMULIN R U-500 (CONCENTR	58
<i>glydo</i>	86	HUMULIN R U-500 KWIKPEN.....	58
GLYXAMBI TAB 10-5 MG.....	56	<i>hydralazine hcl</i>	42
GLYXAMBI TAB 25-5 MG.....	56	<i>hydrochlorothiazide</i>	42
GOLYTELY SOL.....	69	<i>hydrocodone bitartrate</i>	18
<i>granisetron hcl</i>	68	<i>hydrocodone-acetaminophen soln 7.5-</i> <i>325 mg/15ml</i>	19
<i>griseofulvin microsize</i>	22	<i>hydrocodone-acetaminophen tab 10-</i> <i>325 mg</i>	19
<i>griseofulvin ultramicrosize</i>	22	<i>hydrocodone-acetaminophen tab 5-325</i> <i>mg</i>	19
<i>guanfacine hcl</i>	42	<i>hydrocodone-acetaminophen tab 7.5-</i> <i>325 mg</i>	19
<i>guanfacine hcl (adhd)</i>	52	<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	19
GVOKE HYOPEN 2-PACK	65	<i>hydrocortisone</i>	65
GVOKE KIT	65	<i>hydrocortisone (intrarectal)</i>	69
GVOKE PFS.....	65	<i>hydrocortisone (rectal)</i>	87
H		<i>hydrocortisone (topical)</i>	86
HAEGARDA	72	<i>hydromorphone hcl</i>	19
<i>hailey 1.5/30</i>	61	<i>hydroxychloroquine sulfate</i>	74
<i>hailey 24 fe</i>	61	<i>hydroxyurea</i>	30
<i>halobetasol propionate</i>	86	<i>hydroxyzine hcl</i>	81
<i>haloperidol</i>	50	<i>hydroxyzine pamoate</i>	81
<i>haloperidol decanoate</i>	50	HYSINGLA ER	18
<i>haloperidol lactate</i>	50	I	
HARVONI PAK 33.75-150MG	25	<i>ibandronate sodium</i>	59
HARVONI PAK 45-200MG	25		
HARVONI TAB 45-200MG	25		
HARVONI TAB 90-400MG	25		

IBRANCE	32	<i>irinotecan hcl</i>	30
<i>ibu</i>	18	ISENTRESS	23
<i>ibuprofen</i>	18	ISENTRESS HD	23
<i>icatibant acetate</i>	72	<i>isibloom</i>	61
<i>iclevia</i>	61	ISOLYTE-P INJ /D5W	76
ICLUSIG	32	ISOLYTE-S INJ	77
IDHIFA	32	ISOLYTE-S INJ PH 7.4	77
ILEVRO	79	<i>isoniazid</i>	24
<i>imatinib mesylate</i>	32	ISOPTO ATROPINE	80
IMBRUVICA	32	<i>isosorbide dinitrate</i>	43
<i>imipenem-cilastatin intravenous for</i> <i>soln 250 mg</i>	21	<i>isosorbide mononitrate</i>	43
<i>imipenem-cilastatin intravenous for</i> <i>soln 500 mg</i>	21	<i>isotretinoin</i>	84
<i>imipramine hcl</i>	48	<i>isradipine</i>	41
<i>imiquimod</i>	87	<i>itraconazole</i>	22
IMOVAX RABIES (H.D.C.V.)	75	<i>ivermectin</i>	21
<i>incassia</i>	61	IXIARO INJ	75
INCRELEX	66	J	
INCRUSE ELLIPTA	81	JAKAFI	33
<i>indapamide</i>	42	<i>jantoven</i>	71
INFANRIX INJ	75	JANUMET TAB 50-1000	56
INFLIXIMAB	73	JANUMET TAB 50-500MG	56
INGREZZA	54	JANUMET XR TAB 100-1000	57
INGREZZA CAP 40-80MG	54	JANUMET XR TAB 50-1000	57
INLYTA	32	JANUMET XR TAB 50-500MG	56
INQOVI TAB 35-100MG	29	JANUVIA	57
INREBIC	32	JARDIANCE	57
INSULIN PEN NEEDLES: BD/NOVO ...	58	<i>jasmiel</i>	61
INSULIN SAFETY NEEDLES	58	JENTADUETO TAB 2.5-1000	57
INSULIN SYRINGES: BD	58	JENTADUETO TAB 2.5-500	57
INTELENCE	23	JENTADUETO TAB 2.5-850	57
INTRALIPID	78	JENTADUETO TAB XR 2.5-1000MG ...	57
INTRON A	75	JENTADUETO TAB XR 5-1000MG	57
<i>introvale</i>	61	<i>jinteli</i>	64
INVEGA SUSTENNA	50	<i>jolessa</i>	61
IPOL INJ INACTIVE	75	<i>juleber</i>	61
<i>ipratropium bromide</i>	81	JULUCA TAB 50-25MG	24
<i>ipratropium bromide (nasal)</i>	81	<i>junel 1.5/30</i>	61
<i>ipratropium-albuterol nebu soln 0.5-</i> <i>2.5(3) mg/3ml</i>	81	<i>junel 1/20</i>	61
<i>irbesartan</i>	39	<i>junel fe 1.5/30</i>	61
<i>irbesartan-hydrochlorothiazide tab</i> <i>150-12.5 mg</i>	38	<i>junel fe 1/20</i>	61
<i>irbesartan-hydrochlorothiazide tab</i> <i>300-12.5 mg</i>	38	<i>junel fe 24</i>	61
IRESSA	32	K	
		KADCYLA	33
		<i>kaitlib fe</i>	61
		KALYDECO	82
		KANJINTI	33
		<i>kariva</i>	61

<i>kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj</i>	77
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj</i>	77
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj</i>	77
<i>kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj</i>	77
<i>kcl 20 meq/l (0.15%) in nacl 0.45% inj</i>	77
KCL 20 MEQ/L (0.15%) IN NACL 0.45% INJ	77
<i>kcl 20 meq/l (0.15%) in nacl 0.9% inj</i>	77
<i>kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj</i>	77
<i>kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj</i>	77
KCL 40 MEQ/L (0.3%) IN NACL 0.9% INJ	77
KCL/D5W/NACL INJ 0.3/0.9%	77
<i>kelnor 1/35</i>	61
<i>kelnor 1/50</i>	61
KERENDIA	37
KESIMPTA	55
<i>ketoconazole</i>	22
<i>ketoconazole (topical)</i>	85
<i>ketorolac tromethamine (ophth)</i>	79
KEVZARA	73
KEYTRUDA.....	33
KINRIX INJ	76
KISQALI 200 DOSE.....	33
KISQALI 200 PAK FEMARA.....	30
KISQALI 400 DOSE.....	33
KISQALI 400 PAK FEMARA.....	30
KISQALI 600 DOSE.....	33
KISQALI 600 PAK FEMARA.....	31
<i>klor-con</i>	77
<i>klor-con 10</i>	77
<i>klor-con 8</i>	77
<i>klor-con m10</i>	78
<i>klor-con m15</i>	78
<i>klor-con m20</i>	78
KORLYM	66
<i>kurvelo</i>	61
KYNMOBI	49

L	
<i>labetalol hcl</i>	41
<i>lacosamide</i>	45
<i>lacosamide oral</i>	45
<i>lactated ringer's solution</i>	77
<i>lactic acid (ammonium lactate)</i>	87
<i>lactulose</i>	69
<i>lactulose (encephalopathy)</i>	69
<i>lamivudine</i>	23
<i>lamivudine (hbv)</i>	25
<i>lamivudine-zidovudine tab 150-300 mg</i>	24
<i>lamotrigine</i>	45
<i>lansoprazole</i>	70
LANTUS	58
LANTUS SOLOSTAR	58
<i>lapatinib ditosylate</i>	33
<i>larin 1.5/30</i>	61
<i>larin 1/20</i>	61
<i>larin 24 fe</i>	61
<i>larin fe 1.5/30</i>	61
<i>larin fe 1/20</i>	61
<i>larissia</i>	61
<i>latanoprost</i>	80
LATUDA	50
<i>layolis fe</i>	61
<i>leena</i>	61
<i>leflunomide</i>	74
<i>lenalidomide</i>	30
LENVIMA 10 MG DAILY DOSE	33
LENVIMA 12MG DAILY DOSE	33
LENVIMA 20 MG DAILY DOSE	33
LENVIMA 4 MG DAILY DOSE	33
LENVIMA 8 MG DAILY DOSE	33
LENVIMA CAP 14 MG	33
LENVIMA CAP 18 MG	33
LENVIMA CAP 24 MG	33
<i>lessina</i>	61
<i>letrozole</i>	30
<i>leucovorin calcium</i>	35
LEUKERAN.....	29
<i>leuprolide acetate</i>	30
<i>levalbuterol hcl</i>	82
<i>levalbuterol tartrate</i>	82
LEVEMIR	58
LEVEMIR FLEXTOUCH	58
<i>levetiracetam</i>	45

<i>levetiracetam in sodium chloride iv soln</i> 1000 mg/100ml	45	<i>liothyronine sodium</i>	67
<i>levetiracetam in sodium chloride iv soln</i> 1500 mg/100ml	45	<i>lisinopril</i>	37
<i>levetiracetam in sodium chloride iv soln</i> 500 mg/100ml	45	<i>lisinopril & hydrochlorothiazide tab 10-</i> 12.5 mg	36
<i>levobunolol hcl</i>	80	<i>lisinopril & hydrochlorothiazide tab 20-</i> 12.5 mg	36
<i>levocarnitine (metabolic modifiers)</i> ...	66	<i>lisinopril & hydrochlorothiazide tab 20-</i> 25 mg	36
<i>levocetirizine dihydrochloride</i>	81	<i>lithium carbonate</i>	54
<i>levofloxacin</i>	27	<i>loestrin 1.5/30-21</i>	62
<i>levofloxacin in d5w iv soln 250</i> mg/50ml	27	<i>loestrin 1/20-21</i>	62
<i>levofloxacin in d5w iv soln 500</i> mg/100ml	27	<i>loestrin fe 1.5/30</i>	62
<i>levofloxacin in d5w iv soln 750</i> mg/150ml	27	<i>loestrin fe 1/20</i>	62
<i>levonest</i>	61	LOKELMA	59
<i>levonor-eth est tab 0.15-</i> 0.02/0.025/0.03 mg & eth est 0.01 mg	62	LONSURF TAB 15-6.14	29
<i>levonorgestrel & ethinyl estradiol (91-</i> day) tab 0.15-0.03 mg	62	LONSURF TAB 20-8.19	29
<i>levonorgestrel & ethinyl estradiol tab</i> 0.1 mg-20 mcg	62	<i>loperamide hcl</i>	69
<i>levonorgestrel & ethinyl estradiol tab</i> 0.15 mg-30 mcg	62	<i>lopinavir-ritonavir soln 400-100</i> mg/5ml (80-20 mg/ml)	24
<i>levonorgestrel-eth estra tab 0.05-</i> 30/0.075-40/0.125-30mg-mcg	62	<i>lopinavir-ritonavir tab 100-25 mg</i>	24
<i>levonorg-eth est tab 0.1-0.02mg(84) &</i> eth est tab 0.01mg(7)	62	<i>lopinavir-ritonavir tab 200-50 mg</i>	24
<i>levonorg-eth est tab 0.15-0.03mg(84)</i> & eth est tab 0.01mg(7)	62	<i>lorazepam</i>	43
<i>levora 0.15/30-28</i>	62	<i>lorazepam intensol</i>	43
<i>levo-t</i>	67	LORBRENA	33
<i>levothyroxine sodium</i>	67	<i>loryna</i>	62
<i>levoxyl</i>	67	<i>losartan potassium</i>	39
LEXIVA	23	<i>losartan potassium &</i> <i>hydrochlorothiazide tab 100-12.5 mg</i>	38
<i>lidocaine</i>	86	<i>losartan potassium &</i> <i>hydrochlorothiazide tab 100-25 mg</i> 38	
<i>lidocaine hcl</i>	86	<i>losartan potassium &</i> <i>hydrochlorothiazide tab 50-12.5 mg</i>	38
<i>lidocaine hcl (local anesth.)</i>	20	LOTEMAX	80
<i>lidocaine hcl (mouth-throat)</i>	87	<i>lovastatin</i>	39
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	86	<i>low-ogestrel</i>	62
<i>lillow</i>	62	<i>loxapine succinate</i>	50
<i>linezolid</i>	21	LUMAKRAS	33
<i>linezolid in sodium chloride iv soln 600</i> mg/300ml-0.9%	21	LUMIGAN	80
LINZESS	69	LUMIZYME	66
		LUPRON DEPOT (1-MONTH)	30
		LUPRON DEPOT (3-MONTH)	30
		LUPRON DEPOT-PED (1-MONTH)	66
		LUPRON DEPOT-PED (3-MONTH)	66
		<i>lutera</i>	62
		<i>lyleq</i>	62

<i>lyllana</i>	64	<i>methylprednisolone</i>	65
LYNPARZA	33	<i>methylprednisolone acetate</i>	65
LYSODREN	30	<i>methylprednisolone sod succ</i>	65
<i>lyza</i>	62	<i>metoclopramide hcl</i>	68
M		<i>metolazone</i>	42
<i>magnesium sulfate</i>	77	<i>metoprolol & hydrochlorothiazide tab</i> 100-25 mg	40
MAGNESIUM SULFATE.....	77	<i>metoprolol & hydrochlorothiazide tab</i> 100-50 mg	40
<i>magnesium sulfate in dextrose 5% iv</i> <i>soln 1 gm/100ml</i>	77	<i>metoprolol & hydrochlorothiazide tab</i> 50-25 mg	40
<i>malathion</i>	87	<i>metoprolol succinate</i>	41
<i>maraviroc</i>	23	<i>metoprolol tartrate</i>	41
<i>marlissa</i>	62	<i>metronidazole</i>	21
MARPLAN	48	<i>metronidazole (topical)</i>	87
MATULANE	31	<i>metronidazole vaginal</i>	71
MAVYRET PAK 50-20MG	25	<i>metyrosine</i>	42
MAVYRET TAB 100-40MG	25	MG SO4/D5W INJ 10MG/ML.....	77
<i>meclizine hcl</i>	68	<i>micafungin sodium</i>	22
<i>medroxyprogesterone acetate</i>	67	<i>microgestin 1.5/30</i>	62
<i>medroxyprogesterone acetate</i> <i>(contraceptive)</i>	62	<i>microgestin 1/20</i>	62
<i>mefloquine hcl</i>	22	<i>microgestin 24 fe</i>	62
<i>megestrol acetate</i>	30, 67	<i>microgestin fe 1.5/30</i>	62
<i>megestrol acetate (appetite)</i>	67	<i>microgestin fe 1/20</i>	62
MEKINIST.....	33	<i>midodrine hcl</i>	43
MEKTOVI.....	33	<i>miglustat</i>	66
<i>meloxicam</i>	18	<i>mili</i>	62
<i>memantine hcl</i>	47	<i>mimvey</i>	64
<i>memantine hcl tab 28 x 5 mg & 21 x</i> <i>10 mg titration pack</i>	47	<i>minocycline hcl</i>	28
MENACTRA INJ.....	76	<i>minoxidil</i>	43
MENQUADFI INJ	76	<i>mirtazapine</i>	48
MENVEO INJ	76	<i>misoprostol</i>	69
<i>mercaptapurine</i>	29	MITIGARE	18
<i>meropenem</i>	21	M-M-R II INJ.....	76
<i>mesalamine</i>	69	M-NATAL PLUS TAB	78
<i>mesalamine w/ cleanser</i>	69	<i>moexipril hcl</i>	37
MESNEX	35	<i>molindone hcl</i>	50
<i>metadate er</i>	52	<i>mometasone furoate</i>	86
<i>metformin hcl</i>	57	MONJUVI.....	33
<i>methadone hcl</i>	18	<i>mono-linyah</i>	62
<i>methadone hydrochloride i</i>	19	<i>montelukast sodium</i>	82
<i>methazolamide</i>	42	<i>morphine sulfate</i>	19
<i>methenamine hippurate</i>	21	MORPHINE SULFATE	19
<i>methimazole</i>	67	MOVANTIK	69
<i>methocarbamol</i>	55	<i>moxifloxacin hcl</i>	27
<i>methotrexate sodium</i>	29, 74	<i>moxifloxacin hcl (ophth)</i>	79
<i>methylphenidate hcl</i>	52, 53	MULTAQ.....	39

<i>mupirocin</i>	85	<i>nicardipine hcl</i>	41
MVASI	33	NICOTROL INHALER	56
<i>mycophenolate mofetil</i>	75	NICOTROL NS	56
<i>mycophenolate sodium</i>	75	<i>nifedipine</i>	41
<i>myorisan</i>	84	<i>nikki</i>	62
MYRBETRIQ	70	<i>nilutamide</i>	30
N		<i>nimodipine</i>	41
<i>nabumetone</i>	18	NINLARO	33
<i>nadolol</i>	41	<i>nitazoxanide</i>	21
<i>naftillol sodium</i>	28	<i>nitisinone</i>	66
NAGLAZYME	66	NITRO-BID	43
<i>nalbuphine hcl</i>	19	<i>nitrofurantoin macrocrystal</i>	21
<i>naloxone hcl</i>	56	<i>nitrofurantoin monohyd macro</i>	21
<i>naltrexone hcl</i>	56	<i>nitroglycerin</i>	43
NAMZARIC CAP 14-10MG	47	<i>nizatidine</i>	68
NAMZARIC CAP 21-10MG	47	<i>nora-be</i>	62
NAMZARIC CAP 28-10MG	47	<i>norethindrone & ethinyl estradiol-fe</i>	
NAMZARIC CAP 7-10MG	47	<i>chew tab 0.4 mg-35 mcg</i>	62
NAMZARIC CAP PACK	47	<i>norethindrone & ethinyl estradiol-fe</i>	
<i>naproxen</i>	18	<i>chew tab 0.8 mg-25 mcg</i>	62
<i>naproxen sodium</i>	18	<i>norethindrone (contraceptive)</i>	62
<i>naratriptan hcl</i>	53	<i>norethindrone ace & ethinyl estradiol</i>	
NATACYN	79	<i>tab 1 mg-20 mcg</i>	63
<i>nateglinide</i>	57	<i>norethindrone ace & ethinyl estradiol</i>	
NATPARA	59	<i>tab 1.5 mg-30 mcg</i>	63
NAYZILAM	45	<i>norethindrone ace & ethinyl estradiol-fe</i>	
<i>nebivolol hcl</i>	41	<i>tab 1 mg-20 mcg</i>	63
<i>necon 0.5/35-28</i>	62	<i>norethindrone ace-eth estradiol-fe</i>	
<i>nefazodone hcl</i>	48	<i>chew tab 1 mg-20 mcg (24)</i>	63
<i>neomycin sulfate</i>	21	<i>norethindrone acetate</i>	67
<i>neomycin-bacitrac zn-polymyx</i>		<i>norethindrone acetate-ethinyl estradiol</i>	
5(3.5)mg-400unt-10000unt op oin	79	<i>tab 0.5 mg-2.5 mcg</i>	65
<i>neomycin-polymy-gramicid op sol</i>		<i>norethindrone acetate-ethinyl estradiol</i>	
1.75-10000-0.025mg-unt-mg/ml	79	<i>tab 1 mg-5 mcg</i>	65
<i>neomycin-polymyxin-dexamethasone</i>		<i>norgestimate & ethinyl estradiol tab</i>	
<i>ophth oint 0.1%</i>	78	<i>0.25 mg-35 mcg</i>	63
<i>neomycin-polymyxin-dexamethasone</i>		<i>norgestimate-eth estrad tab 0.18-</i>	
<i>ophth susp 0.1%</i>	78	<i>25/0.215-25/0.25-25 mg-mcg</i>	63
<i>neomycin-polymyxin-hc ophth susp</i>	79	<i>norgestimate-eth estrad tab 0.18-</i>	
<i>neomycin-polymyxin-hc otic soln 1%</i>	81	<i>35/0.215-35/0.25-35 mg-mcg</i>	63
<i>neomycin-polymyxin-hc otic susp 3.5</i>		<i>norlyroc</i>	63
<i>mg/ml-10000 unit/ml-1%</i>	81	NORPACE CR	39
NERLYNX	33	<i>nortrel 0.5/35 (28)</i>	63
NEUPRO	49	<i>nortrel 1/35 (21)</i>	63
<i>nevirapine</i>	23	<i>nortrel 1/35 (28)</i>	63
NEXAVAR	33	<i>nortrel 7/7/7</i>	63
<i>niacin (antihyperlipidemic)</i>	40	<i>nortriptyline hcl</i>	48

NORVIR	23	<i>olmesartan medoxomil-</i>	
NOVOLIN INJ 70/30.....	58	<i>hydrochlorothiazide tab 40-12.5 mg</i>	
NOVOLIN INJ 70/30 FP	58	.....	38
NOVOLIN N	58	<i>olmesartan medoxomil-</i>	
NOVOLIN N FLEXPEN	58	<i>hydrochlorothiazide tab 40-25 mg</i>	.38
NOVOLIN R.....	58	<i>olmesartan-amlodipine-</i>	
NOVOLIN R FLEXPEN	58	<i>hydrochlorothiazide tab 20-5-12.5</i>	
NOVOLOG	58	mg	38
NOVOLOG FLEXPEN	58	<i>olmesartan-amlodipine-</i>	
NOVOLOG MIX INJ 70/30	58	<i>hydrochlorothiazide tab 40-10-12.5</i>	
NOVOLOG MIX INJ FLEXPEN	58	mg	38
NOVOLOG PENFILL	58	<i>olmesartan-amlodipine-</i>	
NOXAFIL	22	<i>hydrochlorothiazide tab 40-10-25 mg</i>	
NUBEQA.....	30	.....	38
NUDEXTA CAP 20-10MG	54	<i>olmesartan-amlodipine-</i>	
NULOJIX	75	<i>hydrochlorothiazide tab 40-5-12.5</i>	
NUPLAZID	50	mg	38
NURTEC	54	<i>olmesartan-amlodipine-</i>	
NUTRILIPID	78	<i>hydrochlorothiazide tab 40-5-25 mg</i>	
NUZYRA	28	.....	38
<i>nyamyc</i>	85	<i>olopatadine hcl</i>	80
<i>nylia 1/35</i>	63	<i>omeprazole</i>	70
<i>nylia 7/7/7</i>	63	OMNIPOD 5 G6 KIT INTRO	58
NYMALIZE	41	OMNIPOD 5 G6 MIS PODS	59
<i>nymyo</i>	63	OMNIPOD DASH KIT INTRO	59
<i>nystatin</i>	22	OMNIPOD DASH MIS PODS.....	59
<i>nystatin (mouth-throat)</i>	87	OMNIPOD MIS CLASSIC	59
<i>nystatin (topical)</i>	85	OMNIPOD PDM KIT CLASSIC.....	59
<i>nystop</i>	85	<i>ondansetron</i>	68
o		<i>ondansetron hcl</i>	68
<i>ocella</i>	63	ONTRUZANT	33
OCTAGAM	74	ONUREG	29
<i>octreotide acetate</i>	66	OPSUMIT.....	43
ODEFSEY TAB	24	ORGOVYX.....	30
ODOMZO.....	33	ORKAMBI GRA 100-125	83
OFEV	83	ORKAMBI GRA 150-188	83
<i>ofloxacin (ophth)</i>	79	ORKAMBI TAB 100-125	83
<i>ofloxacin (otic)</i>	81	ORKAMBI TAB 200-125	83
OGIVRI	33	<i>oseltamivir phosphate</i>	25
OGIVRI INJ 420MG	33	OTEZLA.....	73
<i>olanzapine</i>	51	OTEZLA TAB 10/20/30	73
<i>olmesartan medoxomil</i>	39	<i>oxacillin sodium</i>	28
<i>hydrochlorothiazide tab 20-12.5 mg</i>		<i>oxaliplatin</i>	29
.....	38	<i>oxandrolone</i>	56
		<i>oxcarbazepine</i>	45
		<i>oxybutynin chloride</i>	70, 71
		<i>oxycodone hcl</i>	19

<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	20	<i>pentoxifylline</i>	72
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	19	<i>perindopril erbumine</i>	37
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	19	<i>periogard</i>	87
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	20	<i>permethrin</i>	87
OZEMPIC (0.25 OR 0.5MG/DOSE).....	57	<i>perphenazine</i>	51
OZEMPIC (1MG/DOSE).....	57	PERSERIS.....	51
OZEMPIC (2MG/DOSE) SOPN 8MG/3ML	57	<i>pfizerpen</i>	28
P		<i>phenelzine sulfate</i>	48
<i>pacerone</i>	39	<i>phenobarbital</i>	45
<i>paclitaxel</i>	31	<i>phenobarbital sodium</i>	45
<i>paclitaxel protein-bound particles for iv susp 100 mg</i>	31	PHENYTEK	45
<i>paliperidone</i>	51	<i>phenytoin</i>	45
<i>pamidronate disodium</i>	59	<i>phenytoin sodium</i>	45
PAMIDRONATE DISODIUM	59	<i>phenytoin sodium extended</i>	45
PANRETIN	87	PHESGO SOL	33
<i>pantoprazole sodium</i>	70	<i>philith</i>	63
PANZYGA	74	PIFELTRO	23
<i>paraplatin</i>	29	<i>pilocarpine hcl</i>	80
<i>paricalcitol</i>	67	<i>pilocarpine hcl (oral)</i>	88
<i>paromomycin sulfate</i>	21	<i>pimozide</i>	51
<i>paroxetine hcl</i>	48	<i>pimtrea</i>	63
PASER	24	<i>pindolol</i>	41
PEDIARIX INJ 0.5ML	76	<i>pioglitazone hcl</i>	57
PEDVAX HIB	76	<i>piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)</i>	28
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	69	<i>piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)</i>	28
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	69	<i>piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)</i>	28
PEGASYS.....	25	<i>piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)</i>	28
PEMAZYRE	33	<i>piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)</i>	28
<i>pemetrexed disodium</i>	29	PIQRAY 200MG DAILY DOSE	34
PEN GK/DEXTR INJ 40000/ML.....	28	PIQRAY 250MG TAB DOSE	34
PEN GK/DEXTR INJ 60000/ML	28	PIQRAY 300MG DAILY DOSE	34
<i>penicillamine</i>	59	<i>pirfenidone</i>	83
<i>penicillin g potassium</i>	28	<i>pirmella 1/35</i>	63
PENICILLIN G PROCAINE.....	28	<i>piroxicam</i>	18
<i>penicillin g sodium</i>	28	PLASMA-LYTE INJ -148	77
<i>penicillin v potassium</i>	28	PLASMA-LYTE INJ -A.....	77
PENTACEL INJ.....	76	<i>plenamine</i>	78
<i>pentamidine isethionate inh</i>	21	PLENVU SOL	69
<i>pentamidine isethionate inj</i>	21	<i>podofilox</i>	87
		<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	79
		POMALYST.....	30

<i>portia-28</i>	63	<i>proctozone-hc</i>	87
<i>posaconazole</i>	22	PROGRAF	75
<i>potassium chloride</i>	77, 78	PROLASTIN-C	83
POTASSIUM CHLORIDE	77	PROLENSA.....	80
<i>potassium chloride 20 meq/l (0.15%)</i> <i>in dextrose 5% inj</i>	77	PROLIA	59
<i>potassium chloride microencapsulated</i> <i>crystals er</i>	78	PROMACTA	72
<i>potassium citrate (alkalinizer)</i>	70	<i>promethazine hcl</i>	68
PRADAXA	71	<i>propafenone hcl</i>	39
PRALUENT	40	<i>proparacaine hcl</i>	80
<i>pramipexole dihydrochloride</i>	49	<i>propranolol hcl</i>	41
<i>prasugrel hcl</i>	72	<i>propylthiouracil</i>	67
<i>pravastatin sodium</i>	40	PROQUAD INJ	76
<i>praziquantel</i>	21	PROSOL INJ 20%	78
<i>prazosin hcl</i>	37	<i>protriptyline hcl</i>	48
<i>prednisolone</i>	65	PULMICORT FLEXHALER	84
<i>prednisolone acetate (ophth)</i>	80	PULMOZYME	83
PREDNISOLONE SODIUM PHOSP	80	PURIXAN	29
<i>prednisolone sodium phosphate</i>	65	<i>pyrazinamide</i>	25
<i>prednisone</i>	65	<i>pyridostigmine bromide</i>	54
PREDNISONE INTENSOL.....	65	Q	
<i>pregabalin</i>	46	QINLOCK.....	34
PREHEVBRIO	76	QUADRACEL INJ.....	76
PREMASOL SOL 10%	78	QUADRACEL INJ 0.5ML	76
PRENATAL TAB 27-1MG.....	78	<i>quetiapine fumarate</i>	51
PRENATAL TAB PLUS.....	78	<i>quinapril hcl</i>	37
PRENATAL VIT TAB LOW IRON	78	<i>quinapril-hydrochlorothiazide tab 10-</i> <i>12.5 mg</i>	36
<i>prevalite</i>	40	<i>quinapril-hydrochlorothiazide tab 20-</i> <i>12.5 mg</i>	36
PREVYMIS	25	<i>quinapril-hydrochlorothiazide tab 20-25</i> <i>mg</i>	36
PREZCOBIX TAB 800-150	24	<i>quinidine sulfate</i>	39
PREZISTA.....	23	<i>quinine sulfate</i>	22
PRIFTIN	25	R	
<i>primaquine phosphate</i>	22	RABAVERT INJ	76
PRIMAQUINE PHOSPHATE	22	<i>rabeprazole sodium</i>	70
<i>primidone</i>	46	<i>raloxifene hcl</i>	66
PRIORIX INJ	76	<i>ramipril</i>	37
PRIVIGEN.....	74	<i>ranolazine</i>	43
<i>probenecid</i>	18	<i>rasagiline mesylate</i>	49
PROCALAMINE INJ 3%	78	RAYALDEE	67
<i>prochlorperazine</i>	68	<i>reclipsen</i>	63
<i>prochlorperazine edisylate</i>	68	RECOMBIVAX HB.....	76
<i>prochlorperazine maleate</i>	68	RECTIV	87
PROCRIT	71	REGRANEX	87
<i>procto-med hc</i>	87	RELENZA DISKHALER	25
<i>procto-pak</i>	87	RELISTOR	69
<i>proctosol hc</i>	87		

REMICADE	73	SEREVENT DISKUS	82
RENFLEXIS	73	<i>sertraline hcl</i>	48
<i>repaglinide</i>	57	<i>setlakin</i>	63
RESTASIS	80	<i>sevelamer carbonate</i>	67
RESTASIS MULTIDOSE.....	80	<i>sharobel</i>	63
RETEVMO	34	SHINGRIX	76
REVLIMID.....	30	SIGNIFOR	66
REXULTI.....	51	<i>sildenafil citrate (pulmonary</i>	
REYATAZ	23	<i>hypertension)</i>	43
REZUROCK	75	<i>silver sulfadiazine</i>	85
RHOPRESSA	80	SIMBRINZA SUS 1-0.2%.....	80
<i>ribavirin (hepatitis c)</i>	25	<i>simliya</i>	63
<i>rifabutin</i>	25	<i>simpesse</i>	63
<i>rifampin</i>	25	<i>simvastatin</i>	40
<i>riluzole</i>	54	<i>sirolimus</i>	75
<i>rimantadine hydrochloride</i>	25	SIRTURO	25
RINVOQ	73	SIVEXTRO	21
<i>risedronate sodium</i>	59	SKYRIZI	73
<i>risperidone</i>	51	SKYRIZI PEN	74
<i>ritonavir</i>	23	<i>sod sulfate-pot sulf-mg sulf oral sol</i>	
<i>rivastigmine</i>	47	<i>17.5-3.13-1.6 gm/177ml</i>	69
<i>rivastigmine tartrate</i>	47	<i>sodium chloride</i>	77
<i>rivelsa</i>	63	<i>sodium chloride (gu irrigant)</i>	87
<i>rizatriptan benzoate</i>	54	<i>sodium fluoride chew; tab; 1.1 (0.5 f)</i>	
<i>ropinirole hydrochloride</i>	49	<i>mg/ml soln</i>	78
<i>rosadan</i>	87	<i>sodium phenylbutyrate</i>	66
<i>rosuvastatin calcium</i>	40	<i>sodium polystyrene sulfonate powder</i>	
ROTARIX SUS	76	.....	59
ROTATEQ SOL.....	76	<i>solifenacin succinate</i>	71
<i>roweepra</i>	46	SOLQUA INJ 100/33	59
ROZLYTREK	34	SOLTAMOX	30
RUBRACA	34	SOLU-CORTEF	65
<i>rufinamide</i>	46	SOMATULINE DEPOT	66
RUKOBIA.....	23	SOMAVERT	66
RYBELSUS	57	<i>sorafenib tosylate</i>	34
RYDAPT.....	34	<i>sorine</i>	39
S		<i>sotalol hcl</i>	39
<i>sajazir</i>	72	<i>sotalol hcl (afib/af)</i>	39
SANDIMMUNE	75	<i>spironolactone</i>	37
SANTYL.....	87	<i>spironolactone & hydrochlorothiazide</i>	
<i>sapropterin dihydrochloride</i>	66	<i>tab 25-25 mg</i>	42
SCEMBLIX	34	<i>sprintec 28</i>	63
<i>scopolamine</i>	68	SPRITAM	46
SECUADO	51	SPRYCEL	34
<i>selegiline hcl</i>	49	<i>sps</i>	59
<i>selenium sulfide</i>	85	<i>sronyx</i>	63
SELZENTRY	23	<i>ssd</i>	85

<i>stavudine</i>	23
STIVARGA	34
<i>streptomycin sulfate</i>	21
STRIBILD TAB.....	24
<i>subvenite</i>	46
<i>sucralfate</i>	69
<i>sulfacetamide sodium (acne)</i>	84
<i>sulfacetamide sodium (ophth)</i>	79
<i>sulfacetamide sodium-prednisolone</i> <i>ophth soln 10-0.23(0.25)%</i>	79
<i>sulfadiazine</i>	21
<i>sulfamethoxazole-trimethoprim iv soln</i> <i>400-80 mg/5ml</i>	21
<i>sulfamethoxazole-trimethoprim susp</i> <i>200-40 mg/5ml</i>	21
<i>sulfamethoxazole-trimethoprim tab</i> <i>400-80 mg</i>	21
<i>sulfamethoxazole-trimethoprim tab</i> <i>800-160 mg</i>	21
SULFAMYLON	85
<i>sulfasalazine</i>	69
<i>sulindac</i>	18
<i>sumatriptan</i>	54
<i>sumatriptan succinate</i>	54
<i>sunitinib malate</i>	34
SUPREP BOWEL SOL PREP KIT	69
<i>syeda</i>	63
SYMBICORT AER 160-4.5	84
SYMBICORT AER 80-4.5	84
SYMDEKO TAB 100-150	83
SYMDEKO TAB 50-75MG	83
SYMJEPI	83
SYMPAZAN	46
SYMTUZA TAB.....	24
SYNAREL.....	64
SYNERCID INJ 500MG.....	21
SYNJARDY TAB 12.5-1000MG	57
SYNJARDY TAB 12.5-500.....	57
SYNJARDY TAB 5-1000MG	57
SYNJARDY TAB 5-500MG.....	57
SYNJARDY XR TAB 10-1000.....	57
SYNJARDY XR TAB 12.5-1000MG.....	57
SYNJARDY XR TAB 25-1000.....	57
SYNJARDY XR TAB 5-1000MG	57
SYNRIBO.....	31
SYNTHROID.....	67

T	
TABLOID	29
TABRECTA	34
<i>tacrolimus</i>	75
<i>tacrolimus (topical)</i>	87
TAFINLAR.....	34
TAGRISO.....	34
TALTZ.....	74
TALZENNA.....	34
<i>tamoxifen citrate</i>	30
<i>tamsulosin hcl</i>	70
<i>tarina 24 fe</i>	63
<i>tarina fe 1/20 eq</i>	63
TASIGNA.....	34
<i>tazarotene</i>	85
<i>tazicef</i>	26
TAZORAC	85
<i>taztia xt</i>	41
TAZVERIK	34
TDVAX INJ 2-2 LF.....	76
TECENTRIQ	34
TEFLARO	26
<i>telmisartan</i>	39
<i>telmisartan-amlodipine tab 40-10 mg</i>	38
<i>telmisartan-amlodipine tab 40-5 mg</i> .	38
<i>telmisartan-amlodipine tab 80-10 mg</i>	38
<i>telmisartan-amlodipine tab 80-5 mg</i> .	38
<i>telmisartan-hydrochlorothiazide tab 40- 12.5 mg</i>	38
<i>telmisartan-hydrochlorothiazide tab 80- 12.5 mg</i>	38
<i>telmisartan-hydrochlorothiazide tab 80- 25 mg</i>	38
<i>temazepam</i>	53
TENIVAC INJ 5-2LF.....	76
<i>tenofovir disoproxil fumarate</i>	23
TEPMETKO	34
<i>terazosin hcl</i>	37
<i>terbinafine hcl</i>	22
<i>terbutaline sulfate</i>	82
<i>terconazole vaginal</i>	71
TERIPARATIDE.....	59
<i>testosterone</i>	56
<i>testosterone cypionate</i>	56
<i>testosterone enanthate</i>	56

<i>tetrabenazine</i>	54	TRELEGY AER ELLIPTA 200-62.5-25	
<i>tetracycline hcl</i>	28	MCG	81
THALOMID.....	30	<i>treprostinil</i>	43
THEO-24	83	TRESIBA	59
<i>theophylline</i>	83	TRESIBA FLEXTOUCH.....	59
<i>thioridazine hcl</i>	51	<i>tretinoin</i>	84
<i>thiothixene</i>	51	<i>tretinoin (chemotherapy)</i>	31
<i>tiadylt er</i>	41	<i>triamcinolone acetonide (mouth)</i>	88
<i>tiagabine hcl</i>	46	<i>triamcinolone acetonide (topical)</i>	86
TIBSOVO.....	34	<i>triamterene & hydrochlorothiazide cap</i>	
TICOVAC	76	37.5-25 mg	42
<i>tigecycline</i>	28	<i>triamterene & hydrochlorothiazide tab</i>	
TIGECYCLINE.....	28	37.5-25 mg	42
<i>tilia fe</i>	63	<i>triamterene & hydrochlorothiazide tab</i>	
<i>timolol maleate</i>	41	75-50 mg	42
<i>timolol maleate (ophth)</i>	80	TRICARE TAB PRENATAL	78
TIVICAY	23	<i>trientine hcl</i>	60
TIVICAY PD	23	<i>tri-estarylla</i>	63
<i>tizanidine hcl</i>	55	<i>trifluoperazine hcl</i>	51
TOBRADEX OIN 0.3-0.1%	79	<i>trifluridine</i>	79
TOBRADEX ST SUS 0.3-0.05.....	79	<i>trihexyphenidyl hcl</i>	49
<i>tobramycin</i>	21	TRIJARDY XR TAB ER 24HR 10-5-	
<i>tobramycin (ophth)</i>	79	1000MG	57
<i>tobramycin sulfate</i>	21	TRIJARDY XR TAB ER 24HR 12.5-2.5-	
<i>tobramycin-dexamethasone ophth susp</i>		1000MG	57
0.3-0.1%.....	79	TRIJARDY XR TAB ER 24HR 25-5-	
<i>tolterodine tartrate</i>	71	1000MG	57
<i>topiramate</i>	46	TRIJARDY XR TAB ER 24HR 5-2.5-	
<i>toposar</i>	31	1000MG	57
<i>toremifene citrate</i>	30	TRIKAFTA TAB 100-50-75MG & 150MG	
<i>toremide</i>	42	.....	83
TOUJEO MAX SOLOSTAR	59	TRIKAFTA TAB 50-25-37.5MG & 75MG	
TOUJEO SOLOSTAR	59	.....	83
TPN ELECTROL INJ	77	<i>tri-legest fe</i>	63
TRADJENTA	57	<i>tri-linyah</i>	63
<i>tramadol hcl</i>	20	<i>tri-lo-estarylla</i>	63
<i>tramadol-acetaminophen tab 37.5-325</i>		<i>tri-lo-marzia</i>	63
mg	20	<i>tri-lo-mili</i>	63
<i>trandolapril</i>	37	<i>tri-lo-sprintec</i>	63
<i>tranexamic acid</i>	72	TRIMETHOPRIM.....	21
<i>tranylcypromine sulfate</i>	48	<i>tri-mili</i>	64
TRAVASOL INJ 10%.....	78	<i>trimipramine maleate</i>	48
TRAZIMERA	34	TRINTELLIX	48
<i>trazodone hcl</i>	48	<i>tri-nymyo</i>	64
TRECTOR.....	25	<i>tri-sprintec</i>	64
TRELEGY AER ELLIPTA 100-62.5-25		TRIUMEQ PD TAB	24
MCG	81	TRIUMEQ TAB	24

<i>trivora-28</i>	64	<i>varenicline tartrate</i>	56
<i>tri-vylibra</i>	64	<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	56
<i>tri-vylibra lo</i>	64	VARIVAX.....	76
TRIZIVIR TAB.....	24	VASCEPA.....	40
TROGARZO.....	23	<i>velivet</i>	64
TROPHAMINE INJ 10%.....	78	VELPHORO.....	67
<i>tropium chloride</i>	71	VELTASSA.....	60
TRULICITY.....	57	VEMLIDY.....	25
TRUMENBA INJ.....	76	VENCLEXTA.....	35
TRUSELTIQ 100 MG DAILY DOSE.....	34	VENCLEXTA TAB START PK.....	35
TRUSELTIQ 125 MG DAILY DOSE.....	34	<i>venlafaxine hcl</i>	48
TRUSELTIQ 50 MG DAILY DOSE.....	34	VENTAVIS.....	43
TRUSELTIQ 75 MG DAILY DOSE.....	34	VENTOLIN HFA.....	82
TRUXIMA.....	34	VENTOLIN HFA (INSTITUTIONAL PACK).....	82
TUKYSA.....	34	<i>verapamil hcl</i>	41
TURALIO.....	34	VERQUVO.....	43
TWINRIX INJ.....	76	VERSACLOZ.....	51
TYBOST.....	23	VERZENIO.....	35
<i>tydemy</i>	64	<i>vestura</i>	64
TYPHIM VI.....	76	V-GO 20 KIT.....	59
U		V-GO 30 KIT.....	59
<i>unithroid</i>	67	V-GO 40 KIT.....	59
<i>ursodiol</i>	69	VICTOZA.....	57
V		<i>vienva</i>	64
<i>valacyclovir hcl</i>	25	<i>vigabatrin</i>	46
VALCHLOR.....	87	<i>vigadrone</i>	46
<i>valganciclovir hcl</i>	25	VIIBRYD KIT STARTER.....	48
<i>valproate sodium</i>	46	<i>vilazodone hcl</i>	48
<i>valproic acid</i>	46	VIMPAT.....	46
<i>valsartan</i>	39	<i>vincristine sulfate</i>	31
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	38	<i>vinorelbine tartrate</i>	31
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	38	<i>viorele</i>	64
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	38	VIRACEPT.....	23
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	39	VIREAD.....	23
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	38	VITRAKVI.....	35
VALTOCO.....	46	VIVITROL.....	56
<i>vanadom</i>	55	VIZIMPRO.....	35
<i>vancomycin hcl</i>	21	VONJO.....	35
VANCOMYCIN INJ 1 GM.....	22	<i>voriconazole</i>	22
VANCOMYCIN INJ 500MG.....	22	VOSEVI TAB.....	25
VANCOMYCIN INJ 750MG.....	22	VOTRIENT.....	35
VAQTA.....	76	VRAYLAR.....	51
		VRAYLAR CAP 1.5-3MG.....	51
		<i>vyfemla</i>	64
		<i>vylibra</i>	64

VYZULTA	80	XTANDI.....	30
W		<i>xulane</i>	64
<i>warfarin sodium</i>	71	XULTOPHY INJ 100/3.6	59
<i>water for irrigation, sterile irrigation</i>		XYREM	55
<i>soln</i>	87	Y	
WELIREG.....	31	YF-VAX INJ.....	76
<i>wera</i>	64	<i>yuvafem</i>	65
<i>wymzya fe</i>	64	Z	
X		<i>zafemy</i>	64
XALKORI	35	<i>zafirlukast</i>	82
XARELTO	71	<i>zaleplon</i>	53
XARELTO STAR TAB 15/20MG	71	ZARXIO.....	72
XATMEP	74	ZEJULA	35
XCOPRI.....	46	ZELBORAF.....	35
XCOPRI PAK 100-150.....	46	ZEMAIRA.....	83
XCOPRI PAK 12.5-25	46	<i>zenatane</i>	84
XCOPRI PAK 150-200MG		ZENPEP CAP 10000UNT.....	70
(MAINTENANCE).....	46	ZENPEP CAP 15000UNT.....	70
XCOPRI PAK 150-200MG (TITRATION)		ZENPEP CAP 20000UNT.....	70
.....	46	ZENPEP CAP 25000UNT.....	70
XCOPRI PAK 50-100MG	46	ZENPEP CAP 3000UNIT	70
XELJANZ	74	ZENPEP CAP 40000UNT.....	70
XELJANZ XR	74	ZENPEP CAP 5000UNIT	70
XERMELO	70	ZERVIATE.....	80
XGEVA.....	59	<i>zidovudine</i>	23
XHANCE	83	ZIEXTENZO	72
XIFAXAN	70	<i>ziprasidone hcl</i>	51
XIGDUO XR TAB 10-1000	58	<i>ziprasidone mesylate</i>	51
XIGDUO XR TAB 10-500MG	58	ZIRABEV	35
XIGDUO XR TAB 2.5-1000	57	ZIRGAN	79
XIGDUO XR TAB 5-1000MG	58	<i>zoledronic acid</i>	59
XIGDUO XR TAB 5-500MG	58	ZOLINZA.....	35
XIIDRA	80	<i>zolmitriptan</i>	54
XOFLUZA.....	25	<i>zolpidem tartrate</i>	53
XOLAIR.....	83	<i>zonisamide</i>	47
XOSPATA	35	<i>zovia 1/35</i>	64
XPOVIO 100 MG ONCE WEEKLY.....	35	ZTALMY	47
XPOVIO 40 MG ONCE WEEKLY	35	<i>zumandimine</i>	64
XPOVIO 40 MG TWICE WEEKLY	35	ZYDELIG	35
XPOVIO 60 MG ONCE WEEKLY	35	ZYKADIA	35
XPOVIO 60 MG TWICE WEEKLY	35	ZYLET SUS 0.5-0.3%	79
XPOVIO 80 MG ONCE WEEKLY	35	ZYPREXA RELPREVV	51
XPOVIO 80 MG TWICE WEEKLY	35		

This formulary was updated on 11/29/2022. 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.

Esta lista se actualizó el 11/29/2022. 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.

Important Plan Materials

GlobalHealth provides important plan materials that explain how to use your health plan benefits.

Evidence of Coverage

The Evidence of Coverage (EOC) is essentially your Member Handbook. It contains detailed information on your benefits, cost-shares, and coverage rules for your plan. For example, if you are unsure whether a service requires prior authorization or not, you can find that information in your plan's EOC. You can find your health plan's EOC online at www.GlobalHealth.com. For the upcoming plan year, EOC information is available no later than October 15th.

Provider Directory

In most cases, you must receive care from an in-network provider. You can find a network provider in the Provider Directory at www.GlobalHealth.com.

Drug Formulary*

The Drug Formulary (List of Covered Drugs) provides you information about the prescription drugs covered under your plan, including tier placement, availability of mail order and certain drugs covered in the coverage gap phase. Additionally, if a prescription drug has prior authorization, step therapy or quantity limits, this information is provided in the Drug Formulary. You can locate the Drug Formulary for your plan online at www.GlobalHealth.com.

Pharmacy Directory*

In most cases, your prescriptions are covered only if they are filled at a network pharmacy. Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. Your cost-sharing may be less at pharmacies with preferred cost-sharing. You can find a network pharmacy in the Pharmacy Directory at www.GlobalHealth.com.



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Generations Medicare
Advantage Plans

If you would like a hard copy of any plan materials, please contact Customer Care.

Customer Care

Toll Free:

1-844-280-5555

Local:

405-280-5555

TTY: 711

8am to 8pm,
seven days a week
(Oct 1 – Mar 31)
8am to 8pm,
Monday through Friday
(Apr 1 - Sept 30)

*Only applicable to plans with prescription drug coverage.

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How GlobalHealth May Use or Disclose Your Health Information

For Treatment. We may use and/or disclose your PHI to a healthcare provider, hospital, or other healthcare facility in order to arrange for or facilitate treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, hospitals, and other healthcare providers for services delivered to you that are covered by your health plan; to determine your eligibility for benefits; to coordinate benefits; to review for medical necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.

For Health Plan Operations. We may use and/or disclose PHI about you for health plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc.

Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, providers, or care settings.

Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information:

- To a regulatory agency for activities including, but not limited to, licensure, certification, accreditation, audits, investigations, inspections, and medical device reporting;
- To law enforcement upon receipt of a court order, warrant, summons, or other similar process;
- In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute or other lawful process;
- To public health agencies or legal authorities charged with preventing or controlling disease, injury or disability;
- For health oversight activities conducted by agencies such as the Centers for Medicare and Medicaid Services ("CMS"), State Department of Health, Insurance Department, etc.;
- For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations;
- In order to comply with laws and regulations related to Workers' Compensation;
- For coordination of insurance or Medicare benefits, if applicable;
- When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat); and
- In the course of any administrative or judicial proceeding, where required by law.

Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Personal/Authorized Representative. We may use and/or disclose PHI to your authorized representative.

Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Emergencies. We may use and/or disclose your PHI if necessary in an emergency if the use or disclosure is necessary for your emergency treatment.

Military/Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities.

Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclosure your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.

Limited Data Set. If we use your PHI to make a "limited data set," we may give that information to others for purposes of research, public health action or health care operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information.

Any Other Uses. We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI require your written authorization.

NOTE: The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

Your Health Information Rights

Right to Inspect and Copy

You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by State and Federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may appeal to our Privacy Officer.

Right to Confidential Communication

You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with.

Right to Accounting of Disclosures

You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or health care or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.

Right to Request Restrictions on Uses or Disclosures

You have the right to request restrictions or limitations on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If we do agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf.

Right to Request Amendment of PHI

You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer.

Right to Be Notified of a Breach

You have the right to receive notification of any breaches of your unsecured PHI.

Right to Revoke Authorization

You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required.

Right to Receive a Copy of this Notice

You have the right to receive a paper copy of this Notice upon request.

Changes to this Notice

GlobalHealth reserves the right to change this notice and make the new provisions effective for all PHI that we maintain.

To Report a Privacy Violation

If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at:

**ATTN: Privacy OfficerGlobalHealth
210 Park Avenue
Suite 2800
Oklahoma City, OK 73102**

**Toll-free 1-877-280-5852 (leave message) or
Email privacy@globalhealth.com**

You may also file a complaint with the U.S. Department of Health and Human Services 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, D.C. 20201. You will not be penalized or retaliated against for filing a complaint.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844-280-5555. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-280-5555. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-844-280-5555。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-844-280-5555。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-280-5555. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-280-5555. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-844-280-5555 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-280-5555. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-280-5555번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-280-5555. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول . سيقوم شخص ما يتحدث العربية 1-844-280-5555 على مترجم فوري، ليس عليك سوى الاتصال بنا على . بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-280-5555 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-280-5555. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-280-5555. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-280-5555. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-280-5555. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-844-280-5555にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Non-Discrimination Notice

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

GlobalHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free) (TTY:711).

If you believe that GlobalHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **ATTN: Director, Compliance & Legal Services**, 210 Park Ave, Suite 2800, Oklahoma City, OK 73102 or Email: compliance@globalhealth.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

GlobalHealth cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. GlobalHealth no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

GlobalHealth:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
 - Intérpretes de lenguaje de señas capacitados.
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
 - Intérpretes capacitados.
 - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con GlobalHealth Customer Care en 1-844-280-5555 (toll-free) (TTY:711).

Si considera que GlobalHealth no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: ATTN: **Director, Compliance & Legal Services**, 210 Park Ave, Suite 2800, Oklahoma City, OK 73102 o Email: compliance@globalhealth.com. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Customer Care está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Puede obtener los formularios de reclamo en el sitio web <http://www.hhs.gov/ocr/office/file/index.html>