



Louisiana

Blue adVantage (HMO) - Dual Plus (HMO-POS D-SNP)

# 2024 Formulary

## LIST OF COVERED DRUGS

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

### **CONTACT CUSTOMER SERVICE**

*1-866-508-7145 TTY 711*

This formulary was updated on 09/24/2024. For more recent information or other questions, please call Blue Advantage Customer Service department toll-free at 1 (866) 508- 7145. TTY users should call 711. Customer Service will operate seven (7) days a week from 8 a.m. to 8 p.m. CST, from October – March. After March, Customer Service will operate five (5) days a week, Monday - Friday from 8 a.m. to 8 p.m. CST. You may also visit us on the web at [www.bcbsla.com/blueadvantage](http://www.bcbsla.com/blueadvantage).

**Important Message About What You Pay for Vaccines –** Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if your plan has a deductible).

**Important Message About What You Pay for Insulin –** 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, even if you haven't paid your deductible (if your plan has a deductible).

Call Customer Service for more information if you have questions regarding vaccines or insulin.

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# **Blue Advantage Dual Plus (HMO-POS D-SNP) 2024 Formulary (List of Covered Drugs)**

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

**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 Blue Cross and Blue Shield of Louisiana. When it refers to “plan” or “our plan,” it means Blue Advantage Dual Plus (HMO-POS D-SNP).

This document includes a list of the drugs (formulary) for our plan which is current as of 09/24/2024. 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, 2024, and from time to time during the year.

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## What is the Blue Advantage Formulary?

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

## Can the Formulary (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 entitled “How do I request an exception to the Blue Advantage 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 new generic drug 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, 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 Blue Advantage Formulary?”

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 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 09/24/2024. To get updated information about the drugs covered by Blue Advantage, please contact us. Our contact information appears on the front and back cover pages. All mid-year changes in drug coverage are updated monthly with a “Formulary Change Notice” posted on our website and available upon request from Customer Service. If we make mid-year non-maintenance formulary changes, we will mail written notification to affected members in the form of Formulary Errata Sheets.

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

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

### **Medical Condition**

The formulary begins on page 9. 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 page number 9. 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 95. 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?**

Blue Advantage 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:** Blue Advantage requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Blue Advantage before you fill your prescriptions. If you don't get approval, Blue Advantage may not cover the drug.
- **Quantity Limits:** For certain drugs, Blue Advantage limits the amount of the drug that Blue Advantage will cover. For example, Blue Advantage provides 18 tablets per 28-day prescription for *sumatriptan succinate oral tablets*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Blue Advantage 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, Blue Advantage may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Blue Advantage 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 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. 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 Blue Advantage 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 Blue Advantage'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 Service and ask if your drug is covered.

If you learn that Blue Advantage does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Blue Advantage. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Blue Advantage.
- You can ask Blue Advantage 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 Blue Advantage Formulary?**

You can ask Blue Advantage to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a 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, Blue Advantage 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, Blue Advantage 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, tiering or utilization restriction exception. **When you request a formulary, tiering 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. For example, this could include members who:

- Enter long-term care (LTC) facilities from hospitals. They are sometimes accompanied by a discharge list of medications from the hospital formulary, with very short-term planning taken into account (often under 8 hours).
- Are discharged from a hospital to a home.
- End their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert to their Part D plan formulary.
- End a long-term care facility stay and return to the community.

If a member has more than one change in level of care in a month, the pharmacy will have to call Blue Advantage to request an extension of the transition policy.

### **For more information**

For more detailed information about your Blue Advantage prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Blue Advantage, 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>.

### **Blue Advantage's Formulary**

The formulary below provides coverage information about the drugs covered by Blue Advantage. If you have trouble finding your drug in the list, turn to the Index that begins on page 95.

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

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

### **Your Medicare Prescription Drug Costs**

You can find out which drug tier your drug is in by looking in the formulary included in this booklet. The amount you pay depends on which drug tier your drug is in under your plan. To know what you can expect to pay for drugs in each tier in the Initial Coverage Stage before you enter the coverage gap, please refer to your *Summary of Benefits* or *Evidence of Coverage*.

Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the

total yearly drug cost (including what our plan has paid and what you have paid) reaches a certain amount based on your plan. Not everyone will enter the coverage gap. Please review your *Evidence of Coverage* or call us at the number on the back of your ID card for more about your drug costs during and after the coverage gap.



Below is a list of abbreviations that may appear on the following pages in the Requirements/Limits column that tells you if there are any special requirements for coverage of your drug.

### **List of Abbreviations**

**B/D PA:** This prescription drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

**LA:** Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.

**MO:** Mail-Order Drug. This prescription drug is available through our mail-order service, as well as through our retail network pharmacies. Consider using mail order for your long-term (maintenance) medications (such as high blood pressure medications). Retail network pharmacies may be more appropriate for short-term prescriptions (such as antibiotics).

**PA:** Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

**QL:** Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.

**ST:** Step Therapy. In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

**V:** This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

Drug Name	Drug Tier	Requirements /Limits
<b>ANTI - INFECTIVES</b>		
<b>ANTIFUNGAL AGENTS</b>		
ABELCET	1	B/D PA
<i>amphotericin b</i>	1	B/D PA; MO
<i>caspofungin</i>	1	
<i>clotrimazole mucous membrane</i>	1	MO
CRESEMBA ORAL	1	PA
<i>fluconazole</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 100 mg/50 ml, 400 mg/200 ml</i>	1	PA
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	1	PA; MO
<i>flucytosine</i>	1	MO
<i>griseofulvin microsize</i>	1	MO
<i>griseofulvin ultramicrosize</i>	1	MO
<i>itraconazole oral capsule</i>	1	MO; QL (120 per 30 days)
<i>itraconazole oral solution</i>	1	MO
<i>ketoconazole oral</i>	1	MO
<i>miconazole</i>	1	MO
<i>nystatin oral</i>	1	MO
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	1	PA; MO; QL (96 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>terbinafine hcl oral</i>	1	MO
<i>voriconazole intravenous</i>	1	PA; MO
<i>voriconazole oral suspension for reconstitution</i>	1	PA; MO
<i>voriconazole oral tablet</i>	1	PA; MO
<b>ANTIVIRALS</b>		
<i>abacavir</i>	1	MO
<i>abacavir-lamivudine</i>	1	MO
<i>acyclovir oral capsule</i>	1	MO
<i>acyclovir oral suspension 200 mg/5 ml</i>	1	MO
<i>acyclovir oral tablet</i>	1	MO
<i>acyclovir sodium intravenous solution</i>	1	B/D PA; MO
<i>adefovir</i>	1	MO
<i>amantadine hcl</i>	1	MO
APRETUDE	1	MO
APTIVUS	1	MO
<i>atazanavir</i>	1	MO
BARACLUDE ORAL SOLUTION	1	MO
BIKTARVY	1	MO
CABENUVA	1	MO
<i>cidofovir</i>	1	B/D PA; MO
CIMDUO	1	MO
COMPLERA	1	MO
<i>darunavir</i>	1	MO
DELSTRIGO	1	MO

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

This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
DESCOVY	1	MO
DOVATO	1	MO
EDURANT	1	MO
<i>efavirenz</i>	1	MO
<i>efavirenz-emtricitabin-tenofov</i>	1	MO
<i>efavirenz-lamivudine-tenofov disop</i>	1	MO
<i>emtricitabine</i>	1	MO
<i>emtricitabine-tenofov (tdf)</i>	1	MO
EMTRIVA ORAL SOLUTION	1	MO
<i>entecavir</i>	1	MO
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	1	PA; MO; QL (28 per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	1	PA; MO; QL (56 per 28 days)
EPCLUSA ORAL TABLET 200-50 MG	1	PA; MO; QL (56 per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	1	PA; MO; QL (28 per 28 days)
<i>etravirine</i>	1	MO
EVOTAZ	1	MO
<i>famciclovir</i>	1	MO
<i>fosamprenavir</i>	1	MO
FUZEON SUBCUTANEOUS RECON SOLN	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>ganciclovir sodium intravenous recon soln</i>	1	B/D PA; MO
<i>ganciclovir sodium intravenous solution</i>	1	B/D PA
GENVOYA	1	MO
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	1	PA; MO; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	1	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 45-200 MG	1	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 90-400 MG	1	PA; MO; QL (28 per 28 days)
INTELENCE ORAL TABLET 25 MG	1	MO
ISENTRESS HD	1	MO
ISENTRESS ORAL POWDER IN PACKET	1	MO
ISENTRESS ORAL TABLET	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	1	MO
JULUCA	1	MO
LAGEVRIO (EUA)	1	QL (40 per 180 days)
<i>lamivudine</i>	1	MO

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

This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>lamivudine-zidovudine</i>	1	MO
<i>lopinavir-ritonavir oral solution</i>	1	MO
<i>lopinavir-ritonavir oral tablet</i>	1	MO
<i>maraviroc</i>	1	MO
<i>nevirapine oral suspension</i>	1	
<i>nevirapine oral tablet</i>	1	MO
<i>nevirapine oral tablet extended release 24 hr</i>	1	MO
NORVIR ORAL POWDER IN PACKET	1	MO
ODEFSEY	1	MO
<i>oseltamivir</i>	1	MO
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	1	QL (20 per 180 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	1	QL (30 per 180 days)
PIFELTRO	1	MO
PREVYMIS INTRAVENOUS	1	PA
PREVYMIS ORAL	1	PA; MO; QL (30 per 30 days)
PREZCOBIX	1	MO
PREZISTA ORAL SUSPENSION	1	MO

Drug Name	Drug Tier	Requirements /Limits
PREZISTA ORAL TABLET 150 MG, 75 MG	1	MO
RELENZA DISKHALER	1	MO
RETROVIR INTRAVENOUS	1	MO
REYATAZ ORAL POWDER IN PACKET	1	MO
<i>ribavirin oral capsule</i>	1	MO
<i>ribavirin oral tablet 200 mg</i>	1	MO
<i>rimantadine</i>	1	MO
<i>ritonavir</i>	1	MO
RUKOBIA	1	MO
SELZENTRY ORAL SOLUTION	1	MO
SELZENTRY ORAL TABLET 25 MG, 75 MG	1	MO
STRIBILD	1	MO
SUNLENCA	1	
SYMTUZA	1	MO
SYNAGIS	1	MO; LA
<i>tenofovir disoproxil fumarate</i>	1	MO
TIVICAY ORAL TABLET 10 MG	1	
TIVICAY ORAL TABLET 25 MG, 50 MG	1	MO
TIVICAY PD	1	MO
TRIUMEQ	1	MO
TRIUMEQ PD	1	MO

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

This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
TRIZIVIR	1	
TROGARZO	1	MO; LA
<i>valacyclovir oral tablet 1 gram</i>	1	MO; QL (120 per 30 days)
<i>valacyclovir oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
<i>valganciclovir oral recon soln</i>	1	MO
<i>valganciclovir oral tablet</i>	1	MO
VEKLURY	1	
VEMLIDY	1	MO
VIRACEPT ORAL TABLET	1	MO
VIREAD ORAL POWDER	1	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	MO
VOSEVI	1	PA; MO; QL (28 per 28 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	1	MO
<i>zidovudine oral capsule</i>	1	MO
<i>zidovudine oral syrup</i>	1	MO
<i>zidovudine oral tablet</i>	1	MO
<b>CEPHALOSPORINS</b>		
<i>cefaclor oral capsule</i>	1	MO
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml, 375 mg/5 ml</i>	1	
<i>cefaclor oral tablet extended release 12 hr</i>	1	MO
<i>cefadroxil oral capsule</i>	1	MO
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	1	MO
<i>cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml, 2 gram/50 ml</i>	1	MO
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	1	MO
<i>cefazolin injection recon soln 10 gram, 100 gram, 300 gram</i>	1	
<i>cefazolin intravenous recon soln 1 gram</i>	1	
<i>cefdinir oral capsule</i>	1	MO
<i>cefdinir oral suspension for reconstitution</i>	1	MO
<i>cefepime in dextrose, iso-osm</i>	1	
<i>cefepime injection</i>	1	MO
<i>cefixime</i>	1	MO
<i>cefoxitin in dextrose, iso-osm</i>	1	PA

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

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Drug Name	Drug Tier	Requirements /Limits
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>cefoxitin intravenous recon soln 10 gram</i>	1	PA
<i>cefpodoxime</i>	1	MO
<i>cefprozil</i>	1	MO
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>ceftazidime injection recon soln 6 gram</i>	1	PA
<i>ceftriaxone in dextrose, iso-os</i>	1	MO
<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	1	MO
<i>ceftriaxone injection recon soln 10 gram</i>	1	
<i>ceftriaxone intravenous</i>	1	MO
<i>cefuroxime axetil oral tablet</i>	1	MO
<i>cefuroxime sodium injection recon soln 750 mg</i>	1	PA; MO
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	1	PA; MO
<i>cefuroxime sodium intravenous recon soln 7.5 gram</i>	1	PA
<i>cephalexin oral capsule 250 mg, 500 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>cephalexin oral suspension for reconstitution</i>	1	MO
<i>tazicef injection</i>	1	PA; MO
<i>tazicef intravenous</i>	1	PA
TEFLARO	1	PA; MO
<b>ERYTHROMYCINS / OTHER MACROLIDES</b>		
<i>azithromycin intravenous</i>	1	PA; MO
<i>azithromycin oral packet</i>	1	MO
<i>azithromycin oral suspension for reconstitution</i>	1	MO
<i>azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	MO
<i>clarithromycin</i>	1	MO
DIFICID ORAL TABLET	1	MO; QL (20 per 10 days)
<i>e.e.s. 400 oral tablet</i>	1	MO
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	1	MO
<i>erythrocin (as stearate) oral tablet 250 mg</i>	1	
<i>erythromycin ethylsuccinate oral tablet</i>	1	MO
<i>erythromycin oral</i>	1	MO

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

This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
<b>MISCELLANEOUS ANTIINFECTIVES</b>		
<i>albendazole</i>	1	MO
<i>amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml</i>	1	PA; MO
ARIKAYCE	1	PA; LA
<i>atovaquone</i>	1	MO
<i>atovaquone-proguanil</i>	1	MO
<i>aztreonam</i>	1	PA; MO
<i>bacitracin intramuscular</i>	1	
CAYSTON	1	PA; MO; LA; QL (84 per 56 days)
<i>chloramphenicol sod succinate</i>	1	
<i>chloroquine phosphate</i>	1	MO
<i>clindamycin hcl</i>	1	MO
<i>clindamycin in 5 % dextrose</i>	1	PA; MO
<i>clindamycin phosphate injection</i>	1	PA; MO
COARTEM	1	MO
<i>colistin (colistimethate na)</i>	1	PA; MO; QL (30 per 10 days)
<i>dapsone oral</i>	1	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	1	MO
<i>daptomycin intravenous recon soln 500 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
EMVERM	1	MO
<i>ertapenem</i>	1	PA; MO; QL (14 per 14 days)
<i>ethambutol</i>	1	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml</i>	1	PA; MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml</i>	1	PA
<i>gentamicin injection solution 40 mg/ml</i>	1	PA; MO
<i>gentamicin sulfate (ped) (pf)</i>	1	PA; MO
<i>hydroxychloroquine oral tablet 200 mg</i>	1	MO
<i>imipenem-cilastatin</i>	1	PA; MO
<i>isoniazid injection</i>	1	
<i>isoniazid oral</i>	1	MO
<i>ivermectin oral</i>	1	PA; MO; QL (20 per 30 days)
<i>lincomycin</i>	1	PA
<i>linezolid in dextrose 5%</i>	1	PA; MO
<i>linezolid oral suspension for reconstitution</i>	1	MO
<i>linezolid oral tablet</i>	1	MO
<i>linezolid-0.9% sodium chloride</i>	1	PA

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Drug Name	Drug Tier	Requirements /Limits
<i>mefloquine</i>	1	
<i>meropenem intravenous recon soln 1 gram</i>	1	PA; QL (30 per 10 days)
<i>meropenem intravenous recon soln 500 mg</i>	1	PA; QL (10 per 10 days)
<i>metro i.v.</i>	1	PA; MO
<i>metronidazole in nacl (iso-os)</i>	1	PA; MO
<i>metronidazole oral tablet</i>	1	MO
<i>neomycin</i>	1	MO
<i>nitazoxanide</i>	1	MO
<i>paromomycin</i>	1	
<i>pentamidine inhalation</i>	1	B/D PA; MO; QL (1 per 28 days)
<i>pentamidine injection</i>	1	MO
<i>praziquantel</i>	1	MO
PRIFTIN	1	MO
PRIMAQUINE	1	MO
<i>pyrazinamide</i>	1	MO
<i>pyrimethamine</i>	1	PA; MO
<i>quinine sulfate</i>	1	MO
<i>rifabutin</i>	1	MO
<i>rifampin intravenous</i>	1	MO
<i>rifampin oral</i>	1	MO
SIRTURO	1	PA; LA
STREPTOMYCIN	1	PA; MO; QL (60 per 30 days)
<i>tigecycline</i>	1	PA; MO
<i>tinidazole</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
TOBI PODHALER	1	MO; QL (224 per 56 days)
<i>tobramycin in 0.225 % nacl</i>	1	PA; MO; QL (280 per 28 days)
<i>tobramycin inhalation</i>	1	PA; MO; QL (224 per 28 days)
<i>tobramycin sulfate injection recon soln</i>	1	PA; QL (9 per 14 days)
<i>tobramycin sulfate injection solution</i>	1	PA; MO
TRECTOR	1	MO
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 1 GRAM/200 ML	1	PA; QL (4000 per 10 days)
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 500 MG/100 ML	1	PA; QL (1000 per 10 days)
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 750 MG/150 ML	1	PA; QL (4050 per 10 days)
VANCOMYCIN INJECTION	1	PA; QL (1 per 10 days)
<i>vancomycin intravenous recon soln 1,000 mg</i>	1	PA; MO; QL (20 per 10 days)
<i>vancomycin intravenous recon soln 10 gram</i>	1	PA; QL (2 per 10 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>vancomycin intravenous recon soln 5 gram</i>	1	PA; QL (4 per 10 days)
<i>vancomycin intravenous recon soln 500 mg</i>	1	PA; MO; QL (10 per 10 days)
<i>vancomycin intravenous recon soln 750 mg</i>	1	PA; MO; QL (27 per 10 days)
<i>vancomycin oral capsule 125 mg</i>	1	PA; MO; QL (40 per 10 days)
<i>vancomycin oral capsule 250 mg</i>	1	PA; MO; QL (80 per 10 days)
VIBATIV INTRAVENOUS RECON SOLN 750 MG	1	PA
XIFAXAN ORAL TABLET 200 MG	1	QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	1	MO; QL (90 per 30 days)
<b>PENICILLINS</b>		
<i>amoxicillin oral capsule</i>	1	MO
<i>amoxicillin oral suspension for reconstitution 125 mg/5 ml, 400 mg/5 ml</i>	1	MO
<i>amoxicillin oral suspension for reconstitution 200 mg/5 ml, 250 mg/5 ml</i>	1	MO
<i>amoxicillin oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	MO
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet, chewable 200-28.5 mg</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	1	
<i>ampicillin oral capsule 500 mg</i>	1	MO
<i>ampicillin sodium injection</i>	1	PA; MO
<i>ampicillin sodium intravenous</i>	1	PA
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	1	PA; MO
<i>ampicillin-sulbactam injection recon soln 15 gram</i>	1	PA
<i>ampicillin-sulbactam intravenous</i>	1	PA

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Drug Name	Drug Tier	Requirements /Limits
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	1	MO
BICILLIN C-R	1	PA; MO
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML	1	PA; MO
BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML	1	PA
<i>dicloxacillin</i>	1	MO
<i>nafcillin in dextrose iso-osm intravenous piggyback 2 gram/100 ml</i>	1	PA
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>nafcillin injection recon soln 10 gram</i>	1	PA
<i>oxacillin in dextrose(iso-osm)</i>	1	PA
<i>oxacillin injection recon soln 1 gram, 10 gram</i>	1	PA
<i>oxacillin injection recon soln 2 gram</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	1	PA
<i>penicillin g potassium</i>	1	PA; MO
<i>penicillin g sodium</i>	1	PA; MO
<i>penicillin v potassium</i>	1	MO
<i>pfizerpen-g</i>	1	PA
<i>piperacillin-tazobactam intravenous recon soln 13.5 gram, 40.5 gram</i>	1	
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram</i>	1	MO
<b>QUINOLONES</b>		
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg</i>	1	MO
<i>ciprofloxacin hcl oral tablet 750 mg</i>	1	MO
<i>ciprofloxacin in 5 % dextrose</i>	1	PA; MO
<i>ciprofloxacin oral suspension, microcapsule recon 500 mg/5 ml</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>levofloxacin in d5w intravenous piggyback 250 mg/50 ml</i>	1	PA
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	1	PA; MO
<i>levofloxacin intravenous</i>	1	PA
<i>levofloxacin oral solution</i>	1	MO
<i>levofloxacin oral tablet</i>	1	MO
<i>moxifloxacin oral</i>	1	MO
<i>moxifloxacin-sod.chloride(iso)</i>	1	PA; MO
<b>SULFA'S / RELATED AGENTS</b>		
<i>sulfadiazine</i>	1	MO
<i>sulfamethoxazole-trimethoprim intravenous</i>	1	PA; MO
<i>sulfamethoxazole-trimethoprim oral suspension</i>	1	MO
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1	MO
<b>TETRACYCLINES</b>		
<i>demeclocycline</i>	1	MO
<i>doxy-100</i>	1	PA; MO
<i>doxycycline hyclate intravenous</i>	1	PA
<i>doxycycline hyclate oral capsule</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>doxycycline hyclate oral tablet 100 mg, 20 mg, 50 mg</i>	1	MO
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	MO
<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	MO
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1	MO
<i>minocycline oral capsule</i>	1	MO
<i>minocycline oral tablet</i>	1	MO
<i>mondoxyne nl oral capsule 100 mg</i>	1	
<i>tetracycline oral capsule</i>	1	MO
<b>URINARY TRACT AGENTS</b>		
<i>methenamine hippurate</i>	1	MO
<i>methenamine mandelate</i>	1	MO
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	1	MO
<i>nitrofurantoin monohyd/m-cryst</i>	1	MO
<i>trimethoprim</i>	1	MO

**ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS**

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Drug Name	Drug Tier	Requirements /Limits
<b>ADJUNCTIVE AGENTS</b>		
<i>dexrazoxane hcl</i>	1	B/D PA; MO
ELITEK	1	MO
KEPIVANCE INTRAVENOUS RECON SOLN 5.16 MG	1	
KHAPZORY INTRAVENOUS RECON SOLN 175 MG	1	B/D PA
<i>leucovorin calcium oral</i>	1	MO
<i>levoleucovorin calcium intravenous recon soln</i>	1	B/D PA; MO
<i>levoleucovorin calcium intravenous solution</i>	1	B/D PA
<i>mesna</i>	1	B/D PA; MO
MESNEX ORAL	1	MO
VISTOGARD	1	PA
XGEVA	1	B/D PA; MO
<b>ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS</b>		
<i>abiraterone oral tablet 250 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>abiraterone oral tablet 500 mg</i>	1	PA; MO; QL (60 per 30 days)
ABRAXANE	1	B/D PA; MO
ADCETRIS	1	B/D PA; MO
ADSTILADRIN	1	PA
AKEEGA	1	PA; LA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ALECENSA	1	PA; MO; QL (240 per 30 days)
ALIQOPA	1	B/D PA; LA
ALUNBRIG ORAL TABLET 180 MG, 90 MG	1	PA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	1	PA; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	1	PA; QL (30 per 180 days)
<i>anastrozole</i>	1	MO
ANKTIVA	1	PA; MO
<i>arsenic trioxide intravenous solution 1 mg/ml</i>	1	B/D PA
<i>arsenic trioxide intravenous solution 2 mg/ml</i>	1	B/D PA; MO
ASPARLAS	1	PA
AUGTYRO	1	PA; MO; QL (240 per 30 days)
AYVAKIT	1	PA; LA; QL (30 per 30 days)
<i>azacitidine</i>	1	B/D PA; MO
<i>azathioprine oral tablet 50 mg</i>	1	B/D PA; MO
<i>azathioprine sodium</i>	1	B/D PA; MO
BALVERSA	1	PA; LA
BAVENCIO	1	B/D PA; LA
BELEODAQ	1	B/D PA
<i>bendamustine intravenous recon soln</i>	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
BENDEKA	1	B/D PA; MO
BESPONSA	1	B/D PA; MO; LA
<i>bexarotene</i>	1	PA; MO
<i>bicalutamide</i>	1	MO
<i>bleomycin</i>	1	B/D PA; MO
BLINCYTO INTRAVENOUS KIT	1	B/D PA
BORTEZOMIB INJECTION RECON SOLN 1 MG, 2.5 MG	1	B/D PA
<i>bortezomib injection recon soln 3.5 mg</i>	1	B/D PA; MO
BOSULIF ORAL CAPSULE 100 MG	1	PA; MO; QL (90 per 30 days)
BOSULIF ORAL CAPSULE 50 MG	1	PA; MO; QL (30 per 30 days)
BOSULIF ORAL TABLET 100 MG	1	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	1	PA; MO; QL (30 per 30 days)
BRAFTOVI	1	PA; MO; LA; QL (180 per 30 days)
BRUKINSA	1	PA; LA; QL (120 per 30 days)
<i>busulfan</i>	1	B/D PA
CABOMETYX	1	PA; MO; LA; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
CALQUENCE	1	PA; LA; QL (60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	1	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	1	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	1	PA; LA; QL (30 per 30 days)
<i>carboplatin intravenous solution</i>	1	B/D PA; MO
<i>carmustine intravenous recon soln 100 mg</i>	1	B/D PA; MO
<i>cisplatin intravenous solution</i>	1	B/D PA; MO
<i>cladribine</i>	1	B/D PA; MO
<i>clofarabine</i>	1	B/D PA
COLUMVI	1	PA; MO
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	1	PA; MO; QL (56 per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	1	PA; MO; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	1	PA; MO; QL (84 per 28 days)
COPIKTRA	1	PA; LA; QL (60 per 30 days)
COSMEGEN	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
COTELLIC	1	PA; MO; LA; QL (63 per 28 days)
<i>cyclophosphamide intravenous recon soln</i>	1	B/D PA; MO
<i>cyclophosphamide oral capsule</i>	1	B/D PA; MO
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG	1	B/D PA
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	1	B/D PA; MO
<i>cyclosporine intravenous</i>	1	B/D PA
<i>cyclosporine modified oral capsule</i>	1	B/D PA; MO
<i>cyclosporine modified oral solution</i>	1	B/D PA
<i>cyclosporine oral capsule</i>	1	B/D PA; MO
CYRAMZA	1	B/D PA; MO
<i>cytarabine</i>	1	B/D PA; MO
<i>cytarabine (pf) injection solution 100 mg/5 ml (20 mg/ml), 2 gram/20 ml (100 mg/ml)</i>	1	B/D PA; MO
<i>cytarabine (pf) injection solution 20 mg/ml</i>	1	B/D PA
<i>dacarbazine</i>	1	B/D PA; MO
<i>dactinomycin</i>	1	B/D PA; MO
DANYELZA	1	PA

Drug Name	Drug Tier	Requirements /Limits
DARZALEX	1	B/D PA; MO; LA
<i>daunorubicin</i>	1	B/D PA
DAURISMO ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	1	PA; MO; QL (60 per 30 days)
<i>decitabine</i>	1	B/D PA; MO
<i>docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 80 mg/8 ml (10 mg/ml)</i>	1	B/D PA
<i>docetaxel intravenous solution 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml)</i>	1	B/D PA; MO
<i>doxorubicin intravenous recon soln 10 mg</i>	1	B/D PA
<i>doxorubicin intravenous recon soln 50 mg</i>	1	B/D PA; MO
<i>doxorubicin intravenous solution 10 mg/5 ml, 20 mg/10 ml, 50 mg/25 ml</i>	1	B/D PA; MO
<i>doxorubicin intravenous solution 2 mg/ml</i>	1	B/D PA
<i>doxorubicin, peg-liposomal</i>	1	B/D PA; MO
DROXIA	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ELIGARD	1	PA; MO
ELIGARD (3 MONTH)	1	PA; MO
ELIGARD (4 MONTH)	1	PA; MO
ELIGARD (6 MONTH)	1	PA; MO
ELREXFIO	1	PA
ELZONRIS	1	PA; LA
EMPLICITI	1	B/D PA; MO
ENVARUSUS XR	1	B/D PA; MO
<i>epirubicin intravenous solution 200 mg/100 ml</i>	1	B/D PA
EPKINLY	1	PA
ERBITUX	1	B/D PA; MO
<i>eribulin</i>	1	B/D PA
ERIVEDGE	1	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 240 MG	1	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 60 MG	1	PA; MO; QL (120 per 30 days)
<i>erlotinib oral tablet 100 mg, 150 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>erlotinib oral tablet 25 mg</i>	1	PA; MO; QL (60 per 30 days)
ERWINASE	1	B/D PA
ETOPOPHOS	1	B/D PA; MO
<i>etoposide intravenous</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>everolimus (antineoplastic) oral tablet</i>	1	PA; MO; QL (30 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	1	PA; MO; QL (330 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	1	B/D PA; MO
<i>everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	1	B/D PA; MO
<i>exemestane</i>	1	MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	1	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	1	PA; MO
<i>floxuridine</i>	1	B/D PA
<i>fludarabine intravenous recon soln</i>	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
<i>fludarabine intravenous solution</i>	1	B/D PA
<i>fluorouracil intravenous solution 1 gram/20 ml, 500 mg/10 ml</i>	1	B/D PA; MO
<i>fluorouracil intravenous solution 2.5 gram/50 ml, 5 gram/100 ml</i>	1	B/D PA
FOLOTYN	1	B/D PA; MO
FOTIVDA	1	PA; LA; QL (21 per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	1	PA; QL (84 per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	1	PA; QL (21 per 28 days)
<i>fulvestrant</i>	1	B/D PA; MO
FYARRO	1	PA
GAVRETO	1	PA; LA; QL (120 per 30 days)
GAZYVA	1	B/D PA; MO
<i>gefitinib</i>	1	PA; MO; QL (30 per 30 days)
<i>gemcitabine intravenous recon soln 1 gram, 200 mg</i>	1	B/D PA; MO
<i>gemcitabine intravenous recon soln 2 gram</i>	1	B/D PA

Drug Name	Drug Tier	Requirements /Limits
<i>gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)</i>	1	B/D PA; MO
GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML	1	B/D PA
<i>gengraf</i>	1	B/D PA; MO
GILOTRIF	1	PA; MO; QL (30 per 30 days)
GLEOSTINE	1	MO
HALAVEN	1	B/D PA; MO
<i>hydroxyurea</i>	1	MO
IBRANCE	1	PA; MO; QL (21 per 28 days)
ICLUSIG	1	PA; QL (30 per 30 days)
<i>idarubicin</i>	1	B/D PA; MO
IDHIFA	1	PA; MO; LA; QL (30 per 30 days)
<i>ifosfamide intravenous recon soln</i>	1	B/D PA; MO
<i>ifosfamide intravenous solution 1 gram/20 ml</i>	1	B/D PA; MO
<i>ifosfamide intravenous solution 3 gram/60 ml</i>	1	B/D PA
<i>imatinib oral tablet 100 mg</i>	1	PA; MO; QL (180 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>imatinib oral tablet 400 mg</i>	1	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	1	PA; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	1	PA; QL (30 per 30 days)
IMBRUVICA ORAL SUSPENSION	1	PA; QL (324 per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	1	PA; QL (30 per 30 days)
IMDELLTRA	1	PA
IMFINZI	1	B/D PA; MO; LA
IMJUDO	1	PA; MO
INLYTA ORAL TABLET 1 MG	1	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	1	PA; MO; QL (120 per 30 days)
INQOVI	1	PA; MO; QL (5 per 28 days)
INREBIC	1	PA; MO; LA; QL (120 per 30 days)
<i>irinotecan intravenous solution 100 mg/5 ml</i>	1	B/D PA; MO
<i>irinotecan intravenous solution 300 mg/15 ml, 500 mg/25 ml</i>	1	B/D PA

Drug Name	Drug Tier	Requirements /Limits
<i>irinotecan intravenous solution 40 mg/2 ml</i>	1	B/D PA; MO
ISTODAX	1	B/D PA; MO
IWILFIN	1	PA; LA; QL (240 per 30 days)
IXEMPRA	1	B/D PA; MO
JAKAFI	1	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 100 MG	1	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	1	PA; MO; QL (30 per 30 days)
JEMPERLI	1	PA; MO
JEVTANA	1	B/D PA; MO
JYLAMVO	1	B/D PA; MO
KADCYLA	1	PA; MO
KEYTRUDA	1	PA
KIMMTRAK	1	PA
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	1	PA; MO; QL (49 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	1	PA; MO; QL (70 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	1	PA; MO; QL (91 per 28 days)

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	1	PA; MO; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	1	PA; MO; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	1	PA; MO; QL (63 per 28 days)
KOSELUGO	1	PA
KRAZATI	1	PA; QL (180 per 30 days)
KYPROLIS	1	B/D PA
<i>lanreotide subcutaneous syringe 120 mg/0.5 ml</i>	1	PA; MO
<i>lapatinib</i>	1	PA; MO; QL (180 per 30 days)
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	1	PA; MO; QL (28 per 28 days)
<i>lenalidomide oral capsule 2.5 mg, 20 mg</i>	1	PA; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	1	PA; MO; QL (30 per 30 days)
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X 2), 24 MG/DAY (10 MG X 2-4 MG X 1)	1	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
LENVIMA ORAL CAPSULE 14 MG/DAY (10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	1	PA; MO; QL (60 per 30 days)
<i>letrozole</i>	1	MO
LEUKERAN	1	MO
<i>leuprolide subcutaneous kit</i>	1	PA; MO
LIBTAYO	1	PA; LA
LONSURF	1	PA; MO
LOQTORZI	1	PA
LORBRENA ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	1	PA; MO; QL (90 per 30 days)
LUMAKRAS	1	PA; MO
LUNSUMIO	1	PA; MO
LUPRON DEPOT	1	PA; MO
LYNPARZA	1	PA; MO; QL (120 per 30 days)
LYSODREN	1	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)	1	PA; LA
MARGENZA	1	PA
MATULANE	1	

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>megestrol oral suspension 400 mg/10 ml (10 ml)</i>	1	PA
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	1	PA; MO
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	1	PA; MO
<i>megestrol oral tablet</i>	1	PA; MO
MEKINIST ORAL RECON SOLN	1	PA; MO; QL (1200 per 30 days)
MEKINIST ORAL TABLET 0.5 MG	1	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	1	PA; MO; QL (30 per 30 days)
MEKTOVI	1	PA; MO; LA; QL (180 per 30 days)
<i>melphalan hcl</i>	1	B/D PA
<i>mercaptopurine</i>	1	MO
<i>methotrexate sodium</i>	1	B/D PA; MO
<i>methotrexate sodium (pf) injection recon soln</i>	1	B/D PA
<i>methotrexate sodium (pf) injection solution</i>	1	B/D PA; MO
<i>mitomycin intravenous recon soln 20 mg, 5 mg</i>	1	B/D PA; MO
<i>mitomycin intravenous recon soln 40 mg</i>	1	B/D PA; MO
<i>mitoxantrone</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
MONJUVI	1	PA; LA
<i>mycophenolate mofetil (hcl)</i>	1	B/D PA; MO
<i>mycophenolate mofetil oral capsule</i>	1	B/D PA; MO
<i>mycophenolate mofetil oral suspension for reconstitution</i>	1	B/D PA; MO
<i>mycophenolate mofetil oral tablet</i>	1	B/D PA; MO
<i>mycophenolate sodium</i>	1	B/D PA; MO
MYHIBBIN	1	B/D PA
MYLOTARG	1	B/D PA; MO; LA
<i>nelarabine</i>	1	B/D PA; MO
NERLYNX	1	PA; MO; LA
<i>nilutamide</i>	1	PA; MO
NINLARO	1	PA; MO; QL (3 per 28 days)
NUBEQA	1	PA; MO; LA; QL (120 per 30 days)
NULOJIX	1	B/D PA; MO
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	1	PA; MO
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	1	PA; MO
<i>octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml)</i>	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
<i>octreotide acetate injection syringe 500 mcg/ml (1 ml)</i>	1	PA; MO
ODOMZO	1	PA; MO; LA; QL (30 per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	1	PA; QL (96 per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	1	PA; QL (16 per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	1	PA; QL (20 per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	1	PA; QL (24 per 28 days)
OJJAARA	1	PA; QL (30 per 30 days)
ONCASPAR	1	B/D PA
ONIVYDE	1	B/D PA
ONUREG	1	PA; MO; QL (14 per 28 days)
OPDIVO	1	PA; MO
OPDUALAG	1	PA; MO
ORGOVYX	1	PA; LA; QL (30 per 28 days)
ORSERDU ORAL TABLET 345 MG	1	PA; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	1	PA; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>oxaliplatin intravenous recon soln 100 mg</i>	1	B/D PA
<i>oxaliplatin intravenous recon soln 50 mg</i>	1	B/D PA; MO
<i>oxaliplatin intravenous solution 100 mg/20 ml, 50 mg/10 ml (5 mg/ml)</i>	1	B/D PA; MO
<i>oxaliplatin intravenous solution 200 mg/40 ml</i>	1	B/D PA
<i>paclitaxel</i>	1	B/D PA; MO
PADCEV	1	PA; MO
<i>paraplatin</i>	1	B/D PA
<i>pazopanib</i>	1	PA; MO; QL (120 per 30 days)
PEMAZYRE	1	PA; LA; QL (28 per 28 days)
<i>pemetrexed disodium intravenous recon soln 1,000 mg, 500 mg</i>	1	B/D PA; MO
<i>pemetrexed disodium intravenous recon soln 100 mg</i>	1	B/D PA; MO
<i>pemetrexed disodium intravenous recon soln 750 mg</i>	1	B/D PA
PERJETA	1	B/D PA; MO
PIQRAY	1	PA; MO
POLIVY	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
POMALYST	1	PA; MO; LA
PORTRAZZA	1	B/D PA; MO
POTELIGEO	1	PA
PRALATREXATE	1	B/D PA; MO
PROGRAF INTRAVENOUS	1	B/D PA; MO
PROGRAF ORAL GRANULES IN PACKET	1	B/D PA; MO
PURIXAN	1	
QINLOCK	1	PA; LA; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	1	PA; MO; LA; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	1	PA; MO; LA; QL (120 per 30 days)
REVLIMID	1	PA; MO; LA; QL (28 per 28 days)
REZLIDHIA	1	PA; QL (60 per 30 days)
REZUROCK	1	PA; LA; QL (30 per 30 days)
<i>romidepsin intravenous recon soln</i>	1	B/D PA
ROZLYTREK ORAL CAPSULE 100 MG	1	PA; MO; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	1	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ROZLYTREK ORAL PELLETS IN PACKET	1	PA; MO; QL (336 per 28 days)
RUBRACA	1	PA; MO; LA; QL (120 per 30 days)
RUXIENCE	1	PA; MO
RYBREVANT	1	PA; MO
RYDAPT	1	PA; MO; QL (224 per 28 days)
RYLAZE	1	PA
RYTELO	1	PA
SANDIMMUNE ORAL SOLUTION	1	B/D PA
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON	1	PA; MO
SARCLISA	1	PA; LA
SCEMBLIX ORAL TABLET 100 MG	1	PA; QL (120 per 30 days)
SCEMBLIX ORAL TABLET 20 MG	1	PA; QL (600 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	1	PA; QL (300 per 30 days)
SIGNIFOR	1	PA
SIMULECT	1	B/D PA; MO
<i>sirolimus oral solution</i>	1	B/D PA; MO
<i>sirolimus oral tablet</i>	1	B/D PA; MO
SOLTAMOX	1	MO
SOMATULINE DEPOT	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
<i>sorafenib</i>	1	PA; MO; QL (120 per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	1	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	1	PA; MO; QL (60 per 30 days)
STIVARGA	1	PA; MO; QL (84 per 28 days)
<i>sunitinib malate</i>	1	PA; MO; QL (30 per 30 days)
TABLOID	1	MO
TABRECTA	1	PA; MO
<i>tacrolimus oral capsule</i>	1	B/D PA; MO
TAFINLAR ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	1	PA; MO; QL (840 per 28 days)
TAGRISO	1	PA; MO; LA; QL (30 per 30 days)
TALVEY	1	PA
TALZENNA	1	PA; MO; QL (30 per 30 days)
<i>tamoxifen</i>	1	MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	1	PA; MO; QL (112 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
TASIGNA ORAL CAPSULE 50 MG	1	PA; MO; QL (120 per 30 days)
TAZVERIK	1	PA; LA
TECENTRIQ	1	B/D PA; MO; LA
TECVAYLI	1	PA
TEMODAR INTRAVENOUS	1	B/D PA; MO
<i>temsirolimus</i>	1	B/D PA; MO
TEPMETKO	1	PA; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	1	PA; MO; QL (28 per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	1	PA; QL (56 per 28 days)
<i>thiotepa injection recon soln 100 mg</i>	1	B/D PA
<i>thiotepa injection recon soln 15 mg</i>	1	B/D PA; MO
TIBSOVO	1	PA
TIVDAK	1	PA; MO
<i>topotecan</i>	1	B/D PA; MO
<i>toremifene</i>	1	MO
TRAZIMERA	1	B/D PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	PA; MO
<i>tretinoin (antineoplastic)</i>	1	MO
TRODELVY	1	PA; LA

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Drug Name	Drug Tier	Requirements /Limits
TRUQAP	1	PA; QL (64 per 28 days)
TUKYSA ORAL TABLET 150 MG	1	PA; LA; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	1	PA; LA; QL (300 per 30 days)
TURALIO ORAL CAPSULE 125 MG	1	PA; LA; QL (120 per 30 days)
UNITUXIN	1	B/D PA
<i>valrubicin</i>	1	B/D PA; MO
VANFLYTA	1	PA; QL (56 per 28 days)
VECTIBIX	1	B/D PA; MO
VENCLEXTA ORAL TABLET 10 MG	1	PA; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	1	PA; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	1	PA; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK	1	PA; LA; QL (42 per 180 days)
VERZENIO	1	PA; MO; LA; QL (60 per 30 days)
<i>vinblastine</i>	1	B/D PA; MO
<i>vincristine</i>	1	B/D PA; MO
<i>vinorelbine</i>	1	B/D PA; MO
VITRAKVI ORAL CAPSULE 100 MG	1	PA; MO; LA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
VITRAKVI ORAL CAPSULE 25 MG	1	PA; MO; LA; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	1	PA; MO; LA; QL (300 per 30 days)
VIZIMPRO	1	PA; MO; QL (30 per 30 days)
VONJO	1	PA; QL (120 per 30 days)
VOTRIENT	1	PA; MO; QL (120 per 30 days)
VYXEOS	1	B/D PA
WELIREG	1	PA; LA
XALKORI ORAL CAPSULE	1	PA; MO; QL (60 per 30 days)
XALKORI ORAL PELLETT 150 MG	1	PA; MO; QL (180 per 30 days)
XALKORI ORAL PELLETT 20 MG, 50 MG	1	PA; MO; QL (120 per 30 days)
XATMEP	1	B/D PA; MO
XERMELO	1	PA; LA; QL (84 per 28 days)
XOSPATA	1	PA; LA; QL (90 per 30 days)
XPOVIO	1	PA; LA
XTANDI ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
XTANDI ORAL TABLET 40 MG	1	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	1	PA; MO; QL (60 per 30 days)
YERVOY	1	B/D PA; MO
YONDELIS	1	B/D PA
ZALTRAP	1	B/D PA; MO
ZANOSAR	1	B/D PA; MO
ZEJULA ORAL TABLET 100 MG	1	PA; MO; LA; QL (90 per 30 days)
ZEJULA ORAL TABLET 200 MG, 300 MG	1	PA; MO; LA; QL (30 per 30 days)
ZELBORAF	1	PA; MO; QL (240 per 30 days)
ZEPZELCA	1	PA
ZIRABEV	1	B/D PA; MO
ZOLADEX	1	PA; MO
ZOLINZA	1	PA; MO; QL (120 per 30 days)
ZYDELIG	1	PA; MO; QL (60 per 30 days)
ZYKADIA	1	PA; MO; QL (90 per 30 days)
ZYNLONTA	1	PA; LA
ZYNYZ	1	PA

**AUTONOMIC / CNS DRUGS,  
NEUROLOGY / PSYCH  
ANTICONVULSANTS**

Drug Name	Drug Tier	Requirements /Limits
APTIOM ORAL TABLET 200 MG	1	MO; QL (180 per 30 days)
APTIOM ORAL TABLET 400 MG	1	MO; QL (90 per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	1	MO; QL (60 per 30 days)
BRIVIACT INTRAVENOUS	1	MO; QL (600 per 30 days)
BRIVIACT ORAL SOLUTION	1	MO; QL (600 per 30 days)
BRIVIACT ORAL TABLET	1	MO; QL (60 per 30 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	1	MO
<i>carbamazepine oral suspension 100mg/5 ml</i>	1	MO
<i>carbamazepine oral suspension 100mg/5 ml (5 ml), 200 mg/10 ml</i>	1	
<i>carbamazepine oral tablet</i>	1	MO
<i>carbamazepine oral tablet extended release 12 hr</i>	1	MO
<i>carbamazepine oral tablet, chewable</i>	1	MO
<i>clobazam oral suspension</i>	1	PA; MO; QL (480 per 30 days)
<i>clobazam oral tablet</i>	1	PA; MO; QL (60 per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>clonazepam oral tablet 2 mg</i>	1	MO; QL (300 per 30 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	1	MO; QL (300 per 30 days)
DIACOMIT	1	PA; LA
<i>diazepam rectal</i>	1	MO
DILANTIN 30 MG	1	MO
<i>divalproex</i>	1	MO
EPIDIOLEX	1	PA; MO; LA
<i>epitol</i>	1	MO
EPRONTIA	1	PA; MO
<i>ethosuximide</i>	1	MO
<i>felbamate oral suspension</i>	1	MO
<i>felbamate oral tablet</i>	1	MO
FINTEPLA	1	PA; LA; QL (360 per 30 days)
<i>fosphenytoin</i>	1	MO
FYCOMPA ORAL SUSPENSION	1	MO; QL (720 per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	1	MO; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG	1	MO; QL (60 per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG	1	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>gabapentin oral capsule 100 mg, 400 mg</i>	1	MO; QL (270 per 30 days)
<i>gabapentin oral capsule 300 mg</i>	1	MO; QL (360 per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	1	MO; QL (2160 per 30 days)
<i>gabapentin oral solution 250 mg/5 ml (5 ml), 300 mg/6 ml (6 ml)</i>	1	QL (2160 per 30 days)
<i>gabapentin oral tablet 600 mg</i>	1	MO; QL (180 per 30 days)
<i>gabapentin oral tablet 800 mg</i>	1	MO; QL (120 per 30 days)
<i>gabapentin oral tablet extended release 24 hr 300 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>gabapentin oral tablet extended release 24 hr 600 mg</i>	1	PA; MO; QL (90 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	1	PA; MO; QL (30 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG, 750 MG, 900 MG	1	PA; MO; QL (60 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	1	PA; MO; QL (90 per 30 days)
<i>lacosamide intravenous</i>	1	MO; QL (1200 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>lacosamide oral solution</i>	1	MO; QL (1200 per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg</i>	1	MO; QL (60 per 30 days)
<i>lacosamide oral tablet 50 mg</i>	1	MO; QL (120 per 30 days)
<i>lamotrigine oral tablet</i>	1	MO
<i>lamotrigine oral tablet disintegrating, dose pk</i>	1	MO
<i>lamotrigine oral tablet, chewable dispersible</i>	1	MO
<i>lamotrigine oral tablet, disintegrating</i>	1	MO
<i>lamotrigine oral tablets, dose pack</i>	1	MO
<i>levetiracetam in nacl (iso-os) intravenous piggyback 1,000 mg/100 ml, 500 mg/100 ml</i>	1	MO
<i>levetiracetam in nacl (iso-os) intravenous piggyback 1,500 mg/100 ml</i>	1	
<i>levetiracetam intravenous</i>	1	MO
<i>levetiracetam oral solution 100 mg/ml</i>	1	MO
<i>levetiracetam oral solution 500 mg/5 ml (5 ml)</i>	1	
<i>levetiracetam oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>levetiracetam oral tablet extended release 24 hr</i>	1	MO
LIBERVANT	1	PA; QL (10 per 30 days)
<i>methsuximide</i>	1	MO
NAYZILAM	1	PA; MO; QL (10 per 30 days)
<i>oxcarbazepine oral suspension</i>	1	MO
<i>oxcarbazepine oral tablet</i>	1	MO
<i>phenobarbital oral elixir</i>	1	PA; MO
<i>phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg</i>	1	PA
<i>phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg</i>	1	PA; MO
<i>phenobarbital sodium injection solution 130 mg/ml</i>	1	MO
<i>phenobarbital sodium injection solution 65 mg/ml</i>	1	
<i>phenytoin oral suspension 100 mg/4 ml</i>	1	
<i>phenytoin oral suspension 125 mg/5 ml</i>	1	MO
<i>phenytoin oral tablet, chewable</i>	1	MO
<i>phenytoin sodium extended oral capsule 100 mg</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>phenytoin sodium extended oral capsule 200 mg, 300 mg</i>	1	
<i>phenytoin sodium intravenous solution</i>	1	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	1	MO; QL (90 per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1	MO; QL (60 per 30 days)
<i>pregabalin oral solution</i>	1	MO; QL (900 per 30 days)
PRIMIDONE ORAL TABLET 125 MG	1	MO
<i>primidone oral tablet 250 mg, 50 mg</i>	1	MO
<i>roweepra oral tablet 500 mg</i>	1	MO
<i>rufinamide oral suspension</i>	1	PA; MO
<i>rufinamide oral tablet 200 mg</i>	1	PA; MO
<i>rufinamide oral tablet 400 mg</i>	1	PA; MO
SPRITAM	1	MO
<i>subvenite oral tablet 100 mg, 200 mg, 25 mg</i>	1	MO
<i>subvenite oral tablet 150 mg</i>	1	
<i>subvenite starter (blue) kit</i>	1	MO
<i>subvenite starter (green) kit</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>subvenite starter (orange) kit</i>	1	MO
SYMPAZAN ORAL FILM 10 MG, 20 MG	1	PA; MO; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	1	PA; MO; QL (60 per 30 days)
<i>tiagabine</i>	1	MO
<i>topiramate oral capsule, sprinkle</i>	1	PA; MO
<i>topiramate oral tablet</i>	1	PA; MO
<i>valproate sodium</i>	1	MO
<i>valproic acid</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)</i>	1	
VALTOCO	1	PA; MO; QL (10 per 30 days)
<i>vigabatrin</i>	1	PA; MO; LA
<i>vigadrone</i>	1	PA; LA
<i>vigpoder</i>	1	PA; LA
XCOPRI MAINTENANCE PACK	1	MO; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG	1	MO; QL (120 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	1	MO; QL (60 per 30 days)

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
XCOPRI ORAL TABLET 25 MG	1	MO; QL (30 per 30 days)
XCOPRI ORAL TABLET 50 MG	1	MO; QL (240 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	1	MO; QL (28 per 180 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	1	MO; QL (28 per 180 days)
ZONISADE	1	PA; MO
<i>zonisamide</i>	1	PA; MO
ZTALMY	1	PA; LA; QL (1100 per 30 days)

#### ANTIPARKINSONISM AGENTS

APOKYN	1	PA; MO; LA; QL (90 per 30 days)
<i>apomorphine</i>	1	PA; QL (90 per 30 days)
<i>benztropine injection</i>	1	MO
<i>benztropine oral</i>	1	PA; MO
<i>bromocriptine</i>	1	MO
<i>carbidopa</i>	1	MO
<i>carbidopa-levodopa oral tablet</i>	1	MO
<i>carbidopa-levodopa oral tablet extended release</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>carbidopa-levodopa oral tablet,disintegrating</i>	1	
<i>carbidopa-levodopa-entacapone</i>	1	MO
<i>entacapone</i>	1	MO
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	1	PA; QL (300 per 30 days)
NEUPRO	1	MO
<i>pramipexole oral tablet</i>	1	MO
<i>rasagiline</i>	1	MO
<i>ropinirole oral tablet</i>	1	MO
<i>ropinirole oral tablet extended release 24 hr</i>	1	MO
<i>selegiline hcl</i>	1	MO

#### MIGRAINE / CLUSTER HEADACHE THERAPY

AIMOVIG AUTOINJECTOR	1	PA; MO; QL (1 per 30 days)
<i>dihydroergotamine injection</i>	1	
<i>dihydroergotamine nasal</i>	1	QL (8 per 28 days)
<i>eletriptan</i>	1	MO; QL (18 per 28 days)
EMGALITY PEN	1	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	1	PA; MO; QL (2 per 30 days)
<i>ergotamine-caffeine</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>naratriptan</i>	1	MO; QL (18 per 28 days)
NURTEC ODT	1	PA; QL (16 per 30 days)
QULIPTA	1	PA; MO; QL (30 per 30 days)
<i>rizatriptan oral tablet</i>	1	MO; QL (36 per 28 days)
<i>rizatriptan oral tablet, disintegrating</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 20 mg/actuation</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 5 mg/actuation</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan succinate oral</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	1	QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	1	QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	1	MO; QL (8 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<i>sumatriptan succinate subcutaneous solution</i>	1	MO; QL (8 per 28 days)
UBRELVY	1	PA; QL (20 per 30 days)
<i>zolmitriptan oral</i>	1	MO; QL (18 per 28 days)

### MISCELLANEOUS NEUROLOGICAL THERAPY

BRIUMVI	1	PA; MO; QL (24 per 180 days)
<i>dalfampridine</i>	1	PA; MO; QL (60 per 30 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg</i>	1	PA; MO; QL (14 per 30 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	1	PA; MO; QL (120 per 180 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 240 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>donepezil oral tablet 10 mg, 5 mg</i>	1	MO
<i>donepezil oral tablet 23 mg</i>	1	MO
<i>donepezil oral tablet, disintegrating</i>	1	MO
<i>fingolimod</i>	1	PA; MO; QL (30 per 30 days)
FIRDAPSE	1	PA; LA

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Drug Name	Drug Tier	Requirements /Limits
<i>galantamine oral capsule,ext rel. pellets 24 hr</i>	1	MO
<i>galantamine oral solution</i>	1	MO
<i>galantamine oral tablet</i>	1	MO
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	1	PA; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	1	PA; QL (12 per 28 days)
<i>glatopa subcutaneous syringe 20 mg/ml</i>	1	PA; MO; QL (30 per 30 days)
<i>glatopa subcutaneous syringe 40 mg/ml</i>	1	PA; MO; QL (12 per 28 days)
INGREZZA	1	PA; LA; QL (30 per 30 days)
INGREZZA INITIATION PK(TARDIV)	1	PA; LA; QL (28 per 180 days)
INGREZZA SPRINKLE	1	PA; LA; QL (30 per 30 days)
KESIMPTA PEN	1	PA; MO; QL (1.6 per 28 days)
<i>memantine oral capsule,sprinkle,er 24hr</i>	1	PA; MO
<i>memantine oral solution</i>	1	PA; MO
<i>memantine oral tablet</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK	1	PA
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR	1	PA; MO
NUEDEXTA	1	PA; MO
RADICAVA ORS	1	PA; MO
RADICAVA ORS STARTER KIT SUSP	1	PA; MO
<i>rivastigmine</i>	1	MO
<i>rivastigmine tartrate</i>	1	MO
<i>teriflunomide</i>	1	PA; MO; QL (30 per 30 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	1	PA; MO; QL (120 per 30 days)
VUMERITY	1	PA; MO; QL (120 per 30 days)
ZEPOSIA	1	PA; MO; QL (30 per 30 days)
ZEPOSIA STARTER KIT (28-DAY)	1	PA; MO; QL (28 per 180 days)
ZEPOSIA STARTER PACK (7-DAY)	1	PA; MO; QL (7 per 180 days)
<b>MUSCLE RELAXANTS / ANTISPASMODIC THERAPY</b>		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	1	PA; MO
<i>dantrolene intravenous</i>	1	
<i>dantrolene oral</i>	1	MO
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	1	B/D PA; MO
LIORESAL INTRATHECAL SOLUTION 50 MCG/ML	1	B/D PA
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	MO
<i>pyridostigmine bromide oral tablet extended release</i>	1	
<i>revonto</i>	1	
<i>tizanidine oral tablet</i>	1	MO
<b>NARCOTIC ANALGESICS</b>		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	1	MO; QL (4500 per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	1	MO; QL (360 per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	1	MO; QL (180 per 30 days)
BELBUCA	1	PA; MO; QL (60 per 30 days)
<i>buprenorphine hcl injection syringe</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>buprenorphine hcl sublingual</i>	1	MO
<i>buprenorphine transdermal patch</i>	1	PA; MO; QL (4 per 28 days)
<i>endocet oral tablet 10-325 mg, 2.5-325 mg, 7.5-325 mg</i>	1	QL (360 per 30 days)
<i>endocet oral tablet 5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>fentanyl citrate (pf) injection solution</i>	1	
<i>fentanyl citrate (pf) intravenous syringe 100 mcg/2 ml (50 mcg/ml)</i>	1	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	1	PA; MO; QL (120 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	1	PA; MO; QL (120 per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	1	PA; MO; QL (10 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	MO; QL (390 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>hydrocodone-ibuprofen</i>	1	MO; QL (50 per 30 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml, 2 mg/ml</i>	1	
<i>hydromorphone injection solution 1 mg/ml</i>	1	
<i>hydromorphone injection solution 2 mg/ml</i>	1	MO
<i>hydromorphone injection syringe 1 mg/ml, 4 mg/ml</i>	1	MO
<i>hydromorphone injection syringe 2 mg/ml</i>	1	
<i>hydromorphone oral liquid</i>	1	MO; QL (2400 per 30 days)
<i>hydromorphone oral tablet</i>	1	MO; QL (180 per 30 days)
<i>hydromorphone oral tablet extended release 24 hr</i>	1	PA; MO; QL (60 per 30 days)
<i>methadone injection solution</i>	1	
<i>methadone intensol</i>	1	PA; MO; QL (90 per 30 days)
<i>methadone oral concentrate</i>	1	PA; QL (90 per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	1	PA; MO; QL (600 per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	1	PA; MO; QL (1200 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>methadone oral tablet 10 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>methadone oral tablet 5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>methadose oral concentrate</i>	1	PA; MO; QL (90 per 30 days)
<i>morphine (pf) injection solution 0.5 mg/ml</i>	1	
<i>morphine (pf) injection solution 1 mg/ml</i>	1	MO
<i>morphine concentrate oral solution</i>	1	MO; QL (900 per 30 days)
<i>morphine injection syringe 4 mg/ml</i>	1	MO
<i>morphine intravenous solution 10 mg/ml, 4 mg/ml</i>	1	MO
<i>morphine intravenous syringe 10 mg/ml, 2 mg/ml, 4 mg/ml</i>	1	
<i>morphine oral solution</i>	1	MO; QL (900 per 30 days)
<i>morphine oral tablet</i>	1	MO; QL (180 per 30 days)
<i>morphine oral tablet extended release</i>	1	PA; MO; QL (120 per 30 days)
<i>oxycodone oral capsule</i>	1	MO; QL (360 per 30 days)
<i>oxycodone oral concentrate</i>	1	MO; QL (180 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>oxycodone oral solution</i>	1	MO; QL (1200 per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	MO; QL (180 per 30 days)
<i>oxycodone oral tablet 5 mg</i>	1	MO; QL (360 per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
OXYCONTIN, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	1	PA; MO; QL (90 per 30 days)
OXYCONTIN, ORAL ONLY, EXT.REL.12 HR 80 MG	1	PA; MO; QL (60 per 30 days)

**NON-NARCOTIC ANALGESICS**

<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	1	MO; QL (60 per 30 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg</i>	1	MO; QL (90 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	1	MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>butorphanol injection</i>	1	MO
<i>butorphanol nasal</i>	1	MO; QL (10 per 28 days)
<i>celecoxib</i>	1	MO
<i>clonidine (pf) epidural solution 5,000 mcg/10 ml</i>	1	
<i>diclofenac potassium oral tablet 50 mg</i>	1	MO
<i>diclofenac sodium oral</i>	1	MO
<i>diclofenac sodium topical gel 1 %</i>	1	MO; QL (1000 per 28 days)
<i>diclofenac-misoprostol</i>	1	MO
<i>diflunisal</i>	1	MO
<i>ec-naproxen</i>	1	
<i>etodolac oral capsule</i>	1	MO
<i>etodolac oral tablet</i>	1	MO
<i>etodolac oral tablet extended release 24 hr</i>	1	MO
<i>flurbiprofen oral tablet 100 mg</i>	1	MO
<i>ibu</i>	1	MO
<i>ibuprofen oral suspension</i>	1	MO
<i>ibuprofen oral tablet 400 mg, 800 mg</i>	1	MO
<i>ibuprofen oral tablet 600 mg</i>	1	
<i>meloxicam oral tablet</i>	1	MO; QL (30 per 30 days)
<i>nabumetone</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>nalbuphine</i>	1	
<i>naloxone injection solution</i>	1	MO
<i>naloxone injection syringe 0.4 mg/ml (prefilled syringe)</i>	1	
<i>naloxone injection syringe 0.4 mg/ml, 1 mg/ml</i>	1	MO
<i>naloxone nasal</i>	1	MO
<i>naltrexone</i>	1	MO
<i>naproxen oral tablet</i>	1	MO
<i>naproxen oral tablet, delayed release (dr/ec)</i>	1	MO
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	MO
<i>oxaprozin oral tablet</i>	1	MO
<i>piroxicam</i>	1	MO
<i>salsalate</i>	1	MO
<i>sulindac</i>	1	MO
<i>tramadol oral tablet 50 mg</i>	1	MO; QL (240 per 30 days)
<i>tramadol-acetaminophen</i>	1	MO; QL (240 per 30 days)
VIVITROL	1	MO
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	1	MO; QL (60 per 30 days)
<b>PSYCHOTHERAPEUTIC DRUGS</b>		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 720 MG/2.4 ML	1	MO; QL (2.4 per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 960 MG/3.2 ML	1	MO; QL (3.2 per 56 days)
ABILIFY MAINTENA	1	MO; QL (1 per 28 days)
<i>amitriptyline</i>	1	MO
<i>amoxapine</i>	1	MO
<i>aripiprazole oral solution</i>	1	MO
<i>aripiprazole oral tablet</i>	1	MO; QL (30 per 30 days)
<i>aripiprazole oral tablet, disintegrating</i>	1	MO; QL (60 per 30 days)
ARISTADA INITIO	1	MO; QL (4.8 per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 1,064 MG/3.9 ML	1	MO; QL (3.9 per 56 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>desvenlafaxine succinate</i>	1	MO; QL (30 per 30 days)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	1	MO
<i>dextroamphetamine-amphetamine oral tablet</i>	1	MO
<i>diazepam injection</i>	1	PA
<i>diazepam intensol</i>	1	PA; MO; QL (240 per 30 days)
<i>diazepam oral concentrate</i>	1	PA; QL (240 per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	1	PA; MO; QL (1200 per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml, 5 ml)</i>	1	PA; QL (1200 per 30 days)
<i>diazepam oral tablet</i>	1	PA; MO; QL (120 per 30 days)
<i>doxepin oral capsule</i>	1	MO
<i>doxepin oral concentrate</i>	1	MO
<i>doxepin oral tablet</i>	1	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	1	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	1	MO; QL (60 per 30 days)
EMSAM	1	MO
<i>escitalopram oxalate oral solution</i>	1	MO
<i>escitalopram oxalate oral tablet</i>	1	MO; QL (30 per 30 days)
<i>eszopiclone</i>	1	MO; QL (30 per 30 days)
FANAPT ORAL TABLET	1	MO; QL (60 per 30 days)
FANAPT ORAL TABLETS, DOSE PACK	1	MO; QL (8 per 180 days)
FETZIMA ORAL CAPSULE, EXT REL 24HR DOSE PACK 20 MG (2)-40 MG (26)	1	QL (28 per 180 days)
FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24 HR	1	QL (30 per 30 days)
<i>flumazenil</i>	1	
<i>fluoxetine (pmd) oral tablet 10 mg</i>	1	QL (240 per 30 days)
<i>fluoxetine (pmd) oral tablet 20 mg</i>	1	QL (120 per 30 days)
<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (30 per 30 days)
<i>fluoxetine oral capsule 20 mg</i>	1	MO; QL (90 per 30 days)
<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	1	MO; QL (4 per 28 days)
<i>fluoxetine oral solution</i>	1	MO
<i>fluoxetine oral tablet 10 mg</i>	1	MO; QL (240 per 30 days)
<i>fluoxetine oral tablet 20 mg</i>	1	MO; QL (120 per 30 days)
<i>fluphenazine decanoate</i>	1	MO
<i>fluphenazine hcl</i>	1	MO
<i>fluvoxamine oral capsule, extended release 24hr</i>	1	MO; QL (60 per 30 days)
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (60 per 30 days)
<i>haloperidol</i>	1	MO
<i>haloperidol decanoate intramuscular solution 100 mg/ml (1 ml), 50 mg/ml(1ml)</i>	1	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	1	MO
<i>haloperidol lactate injection</i>	1	MO
<i>haloperidol lactate intramuscular</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>haloperidol lactate oral</i>	1	MO
<i>imipramine hcl</i>	1	MO
<i>imipramine pamoate</i>	1	MO
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	1	MO; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	1	MO; QL (5 per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	1	MO; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	1	MO; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	1	MO; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	1	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	1	MO; QL (0.5 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	1	MO; QL (0.88 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	1	MO; QL (1.32 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	1	MO; QL (1.75 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	1	MO; QL (2.63 per 90 days)
<i>lithium carbonate</i>	1	MO
<i>lithium citrate</i>	1	
<i>lorazepam injection solution</i>	1	PA; MO
<i>lorazepam injection syringe 2 mg/ml</i>	1	PA; MO
<i>lorazepam intensol</i>	1	PA; QL (150 per 30 days)
<i>lorazepam oral concentrate</i>	1	PA; MO; QL (150 per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>lorazepam oral tablet 2 mg</i>	1	PA; MO; QL (150 per 30 days)
<i>loxapine succinate</i>	1	MO
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	1	MO; QL (30 per 30 days)
<i>lurasidone oral tablet 80 mg</i>	1	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
MARPLAN	1	MO
<i>methylphenidate hcl oral capsule,erbiphasic 50-50</i>	1	MO
<i>methylphenidate hcl oral solution</i>	1	MO
<i>methylphenidate hcl oral tablet</i>	1	MO
<i>methylphenidate hcl oral tablet extended release</i>	1	MO
<i>methylphenidate hcl oral tablet,chewable</i>	1	MO
<i>mirtazapine oral tablet</i>	1	MO
<i>mirtazapine oral tablet,disintegrating</i>	1	MO
<i>modafinil oral tablet 100 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>modafinil oral tablet 200 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>molindone oral tablet 10 mg, 25 mg</i>	1	
<i>molindone oral tablet 5 mg</i>	1	MO
<i>nefazodone</i>	1	MO
<i>nortriptyline oral capsule</i>	1	MO
<i>nortriptyline oral solution</i>	1	MO
NUPLAZID	1	PA; MO; QL (30 per 30 days)
<i>olanzapine intramuscular</i>	1	MO

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>olanzapine oral tablet</i>	1	MO; QL (30 per 30 days)
<i>olanzapine oral tablet, disintegrating</i>	1	MO; QL (30 per 30 days)
<i>olanzapine-fluoxetine</i>	1	MO
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	1	MO; QL (30 per 30 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	1	MO; QL (60 per 30 days)
<i>paroxetine hcl oral suspension</i>	1	MO
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	1	MO; QL (30 per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	1	MO; QL (60 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr</i>	1	MO; QL (60 per 30 days)
<i>pentobarbital sodium injection solution</i>	1	
<i>perphenazine</i>	1	MO
PERSERIS	1	MO; QL (1 per 30 days)
<i>phenelzine</i>	1	MO
<i>pimozide</i>	1	MO
<i>protriptyline</i>	1	MO
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	MO; QL (90 per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	1	MO; QL (30 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
<i>ramelteon</i>	1	MO; QL (30 per 30 days)
REXULTI ORAL TABLET	1	MO; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	1	MO; QL (2 per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	1	MO; QL (2 per 28 days)
<i>risperidone microspheres intramuscular suspension, extended rel recon 12.5 mg/2 ml, 25 mg/2 ml</i>	1	MO; QL (2 per 28 days)
<i>risperidone microspheres intramuscular suspension, extended rel recon 37.5 mg/2 ml, 50 mg/2 ml</i>	1	MO; QL (2 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>risperidone oral solution</i>	1	MO
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>risperidone oral tablet 4 mg</i>	1	MO; QL (120 per 30 days)
<i>risperidone oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>risperidone oral tablet, disintegrating 4 mg</i>	1	MO; QL (120 per 30 days)
SECUADO	1	MO; QL (30 per 30 days)
<i>sertraline oral concentrate</i>	1	MO
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
SODIUM OXYBATE	1	PA; LA; QL (540 per 30 days)
<i>thioridazine</i>	1	MO
<i>thiothixene</i>	1	MO
<i>tranylcypromine</i>	1	MO
<i>trazodone</i>	1	MO
<i>trifluoperazine</i>	1	MO
<i>trimipramine</i>	1	MO
TRINTELLIX	1	QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 100 MG/0.28 ML	1	MO; QL (0.28 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 125 MG/0.35 ML	1	MO; QL (0.35 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 150 MG/0.42 ML	1	MO; QL (0.42 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 200 MG/0.56 ML	1	MO; QL (0.56 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 250 MG/0.7 ML	1	MO; QL (0.7 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 50 MG/0.14 ML	1	MO; QL (0.14 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 75 MG/0.21 ML	1	MO; QL (0.21 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	1	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet</i>	1	MO; QL (90 per 30 days)
VERSACLOZ	1	
<i>vilazodone</i>	1	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	1	MO; QL (30 per 30 days)
<i>zaleplon oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
<i>zaleplon oral capsule 5 mg</i>	1	MO; QL (30 per 30 days)
<i>ziprasidone hcl</i>	1	MO; QL (60 per 30 days)
<i>ziprasidone mesylate</i>	1	MO
<i>zolpidem oral tablet</i>	1	MO; QL (30 per 30 days)
ZURZUVAE	1	PA; MO
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	1	MO; QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	1	MO; QL (2 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	1	MO; QL (1 per 28 days)
<b>CARDIOVASCULAR, HYPERTENSION / LIPIDS</b>		
<b>ANTIARRHYTHMIC AGENTS</b>		
<i>adenosine</i>	1	
<i>amiodarone intravenous solution</i>	1	B/D PA; MO
<i>amiodarone intravenous syringe</i>	1	B/D PA
<i>amiodarone oral tablet 100 mg, 200 mg</i>	1	MO
<i>amiodarone oral tablet 400 mg</i>	1	
<i>dofetilide</i>	1	MO
<i>flecainide</i>	1	MO
<i>ibutilide fumarate</i>	1	
<i>lidocaine (pf) intravenous</i>	1	
<i>lidocaine in 5 % dextrose (pf) intravenous parenteral solution 4 mg/ml (0.4 %), 8 mg/ml (0.8 %)</i>	1	
<i>mexiletine</i>	1	MO
MULTAQ	1	MO
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>procainamide injection</i>	1	
<i>propafenone oral capsule, extended release 12 hr</i>	1	MO
<i>propafenone oral tablet</i>	1	MO
<i>quinidine sulfate oral tablet</i>	1	MO
<i>sorine oral tablet 120 mg</i>	1	
<i>sorine oral tablet 160 mg</i>	1	MO
<i>sotalol af</i>	1	
<i>sotalol oral</i>	1	MO
<b>ANTIHYPERTENSIVE THERAPY</b>		
<i>acebutolol</i>	1	MO
<i>aliskiren</i>	1	MO
<i>amiloride</i>	1	MO
<i>amiloride-hydrochlorothiazide</i>	1	MO
<i>amlodipine</i>	1	MO
<i>amlodipine-benazepril</i>	1	MO
<i>amlodipine-olmesartan</i>	1	MO
<i>amlodipine-valsartan</i>	1	MO
<i>amlodipine-valsartan-hcthiazyd</i>	1	MO
<i>atenolol</i>	1	MO
<i>atenolol-chlorthalidone</i>	1	MO
<i>benazepril</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>benazepril-hydrochlorothiazide</i>	1	MO
<i>betaxolol oral</i>	1	MO
<i>bisoprolol fumarate</i>	1	MO
<i>bisoprolol-hydrochlorothiazide</i>	1	MO
<i>bumetanide injection</i>	1	MO
<i>bumetanide oral</i>	1	MO
<i>candesartan</i>	1	MO
<i>candesartan-hydrochlorothiazid</i>	1	MO
<i>captopril</i>	1	MO
<i>captopril-hydrochlorothiazide</i>	1	
<i>cartia xt</i>	1	MO
<i>carvedilol</i>	1	MO
<i>chlorothiazide sodium</i>	1	MO
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	MO
<i>clonidine transdermal patch</i>	1	MO; QL (4 per 28 days)
<i>clonidine (pf) epidural solution 1,000 mcg/10 ml (100 mcg/ml)</i>	1	
<i>clonidine hcl oral tablet</i>	1	MO
<i>diltiazem hcl intravenous</i>	1	
<i>diltiazem hcl oral</i>	1	MO
<i>dilt-xr</i>	1	MO
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	1	MO; QL (30 per 30 days)
<i>doxazosin oral tablet 8 mg</i>	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
EDARBI	1	MO
EDARBYCLOR	1	MO
<i>enalapril maleate oral tablet</i>	1	MO
<i>enalaprilat intravenous solution</i>	1	
<i>enalapril-hydrochlorothiazide</i>	1	MO
<i>eplerenone</i>	1	MO
<i>esmolol intravenous solution</i>	1	
<i>ethacrynate sodium</i>	1	
<i>felodipine</i>	1	MO
<i>fosinopril</i>	1	MO
<i>fosinopril-hydrochlorothiazide</i>	1	MO
<i>furosemide injection solution</i>	1	MO
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	MO
<i>furosemide oral tablet</i>	1	MO
<i>hydralazine</i>	1	MO
<i>hydrochlorothiazide</i>	1	MO
<i>indapamide</i>	1	MO
<i>irbesartan</i>	1	MO
<i>irbesartan-hydrochlorothiazide</i>	1	MO
<i>isosorbide-hydralazine</i>	1	MO; QL (180 per 30 days)
<i>isradipine</i>	1	
KERENDIA	1	PA; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>labetalol intravenous solution</i>	1	
<i>labetalol intravenous syringe 20 mg/4 ml (5 mg/ml)</i>	1	
<i>labetalol oral</i>	1	MO
<i>lisinopril</i>	1	MO
<i>lisinopril-hydrochlorothiazide</i>	1	MO
<i>losartan</i>	1	MO
<i>losartan-hydrochlorothiazide</i>	1	MO
<i>mannitol 20 %</i>	1	
<i>mannitol 25 % intravenous solution</i>	1	MO
<i>matzim la</i>	1	MO
<i>metolazone</i>	1	MO
<i>metoprolol succinate</i>	1	MO
<i>metoprolol ta-hydrochlorothiaz</i>	1	MO
<i>metoprolol tartrate intravenous</i>	1	
<i>metoprolol tartrate oral</i>	1	MO
<i>metyrosine</i>	1	PA; MO
<i>minoxidil oral</i>	1	MO
<i>moexipril</i>	1	
<i>nadolol</i>	1	MO
<i>nebivolol</i>	1	MO
<i>nicardipine intravenous solution</i>	1	
<i>nicardipine oral</i>	1	MO
<i>nifedipine oral tablet extended release</i>	1	MO

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>nifedipine oral tablet extended release 24hr</i>	1	MO
<i>nimodipine oral capsule</i>	1	MO
<i>nisoldipine</i>	1	MO
<i>olmesartan</i>	1	MO
<i>olmesartan-amlodipin-hcthiazyd</i>	1	MO
<i>olmesartan-hydrochlorothiazide</i>	1	MO
<i>osmitrol 20 %</i>	1	
<i>perindopril erbumine</i>	1	MO
<i>phentolamine</i>	1	
<i>pindolol</i>	1	MO
<i>prazosin</i>	1	MO
<i>propranolol intravenous</i>	1	
<i>propranolol oral capsule, extended release 24 hr</i>	1	MO
<i>propranolol oral solution</i>	1	MO
<i>propranolol oral tablet</i>	1	MO
<i>quinapril</i>	1	MO
<i>quinapril-hydrochlorothiazide</i>	1	MO
<i>ramipril</i>	1	MO
<i>spironolactone oral tablet</i>	1	MO
<i>spironolacton-hydrochlorothiaz</i>	1	MO
<i>telmisartan</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>telmisartan-amlodipine</i>	1	MO
<i>telmisartan-hydrochlorothiazid</i>	1	MO
<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	MO; QL (30 per 30 days)
<i>terazosin oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
<i>tiadylt er</i>	1	MO
<i>timolol maleate oral</i>	1	MO
<i>torse mide oral</i>	1	MO
<i>trandolapril</i>	1	MO
<i>trandolapril-verapamil</i>	1	MO
<i>treprostinil sodium</i>	1	PA; MO; LA
<i>triamterene-hydrochlorothiazid</i>	1	MO
UPTRAVI ORAL	1	PA; MO; LA
<i>valsartan oral tablet</i>	1	MO
<i>valsartan-hydrochlorothiazide</i>	1	MO
<i>veletri</i>	1	B/D PA; MO
<i>verapamil intravenous</i>	1	
<i>verapamil oral capsule, 24 hr er pellet ct</i>	1	MO
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	1	MO
<i>verapamil oral tablet</i>	1	MO
<i>verapamil oral tablet extended release</i>	1	MO

## COAGULATION THERAPY

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Drug Name	Drug Tier	Requirements /Limits
<i>aminocaproic acid intravenous</i>	1	MO
<i>aminocaproic acid oral</i>	1	MO
<i>aspirin-dipyridamole</i>	1	MO
BRILINTA	1	MO
CABLIVI INJECTION KIT	1	PA; LA
CEPROTIN (BLUE BAR)	1	PA; MO
CEPROTIN (GREEN BAR)	1	PA; MO
<i>cilostazol</i>	1	MO
<i>clopidogrel oral tablet 300 mg</i>	1	MO
<i>clopidogrel oral tablet 75 mg</i>	1	MO; QL (30 per 30 days)
<i>dabigatran etexilate</i>	1	MO
<i>dipyridamole intravenous</i>	1	
<i>dipyridamole oral</i>	1	MO
DOPTELET (10 TAB PACK)	1	PA; MO; LA
DOPTELET (15 TAB PACK)	1	PA; MO; LA
DOPTELET (30 TAB PACK)	1	PA; MO; LA
ELIQUIS	1	MO
ELIQUIS DVT-PE TREAT 30D START	1	MO
<i>enoxaparin subcutaneous solution</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	1	MO; QL (28 per 28 days)
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	1	MO; QL (22.4 per 28 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml</i>	1	MO; QL (16.8 per 28 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	1	MO; QL (11.2 per 28 days)
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	1	MO
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	1	MO
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml)</i>	1	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	1	MO
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution 2,000 unit/1,000 ml</i>	1	
<i>heparin (porcine) injection cartridge</i>	1	MO
<i>heparin (porcine) injection solution</i>	1	MO
<i>heparin (porcine) injection syringe 5,000 unit/ml</i>	1	MO
HEPARIN(PORCINE) IN 0.45% NACL INTRAVENOUS PARENTERAL SOLUTION 12,500 UNIT/250 ML	1	
<i>heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml</i>	1	MO
<i>heparin, porcine (pf) injection solution 1,000 unit/ml</i>	1	
<i>heparin, porcine (pf) injection solution 5,000 unit/0.5 ml</i>	1	MO
<i>heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml</i>	1	MO
HEPARIN, PORCINE (PF) INJECTION SYRINGE 5,000 UNIT/ML	1	
HEPARIN, PORCINE (PF) SUBCUTANEOUS	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>jantoven</i>	1	MO
<i>pentoxifylline</i>	1	MO
<i>prasugrel</i>	1	MO
PROMACTA	1	PA; MO; LA
<i>protamine</i>	1	
<i>warfarin</i>	1	MO
XARELTO	1	MO
XARELTO DVT-PE TREAT 30D START	1	MO

### LIPID/CHOLESTEROL LOWERING AGENTS

<i>amlodipine-atorvastatin</i>	1	MO; QL (30 per 30 days)
<i>atorvastatin</i>	1	MO; QL (30 per 30 days)
<i>cholestyramine (with sugar)</i>	1	MO
<i>cholestyramine light</i>	1	
<i>colesevelam</i>	1	MO
<i>colestipol oral granules</i>	1	MO
<i>colestipol oral packet</i>	1	
<i>colestipol oral tablet</i>	1	MO
<i>ezetimibe</i>	1	MO
<i>ezetimibe-simvastatin</i>	1	MO; QL (30 per 30 days)
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	1	MO
<i>fenofibrate nanocrystallized</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	1	MO
<i>fenofibric acid</i>	1	
<i>fenofibric acid (choline)</i>	1	MO
<i>fluvastatin oral capsule 20 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvastatin oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>gemfibrozil</i>	1	MO
<i>icosapent ethyl</i>	1	MO
JUXTAPID	1	PA; MO; LA
<i>lovastatin oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>lovastatin oral tablet 20 mg, 40 mg</i>	1	MO; QL (60 per 30 days)
NEXLETOL	1	PA; MO
NEXLIZET	1	PA; MO
<i>niacin oral tablet 500 mg</i>	1	MO
<i>niacin oral tablet extended release 24 hr</i>	1	MO
<i>omega-3 acid ethyl esters</i>	1	MO
<i>pitavastatin calcium</i>	1	MO; QL (30 per 30 days)
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite</i>	1	MO
REPATHA	1	PA; QL (6 per 28 days)
REPATHA PUSHTRONEX	1	PA; QL (7 per 28 days)
REPATHA SURECLICK	1	PA; QL (6 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
<i>simvastatin</i>	1	MO; QL (30 per 30 days)
<b>MISCELLANEOUS CARDIOVASCULAR AGENTS</b>		
CORLANOR ORAL SOLUTION	1	QL (450 per 30 days)
CORLANOR ORAL TABLET	1	MO; QL (60 per 30 days)
<i>digoxin oral solution</i>	1	MO
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	1	MO
<i>digoxin oral tablet 62.5 mcg (0.0625 mg)</i>	1	MO
<i>dobutamine</i>	1	B/D PA
<i>dobutamine in d5w intravenous parenteral solution 1,000 mg/250 ml (4,000 mcg/ml), 250 mg/250 ml (1 mg/ml), 500 mg/250 ml (2,000 mcg/ml)</i>	1	B/D PA
<i>dopamine in 5 % dextrose intravenous solution 200 mg/250 ml (800 mcg/ml), 400 mg/250 ml (1,600 mcg/ml), 400 mg/500 ml (800 mcg/ml), 800 mg/500 ml (1,600 mcg/ml)</i>	1	B/D PA
<i>dopamine in 5 % dextrose intravenous solution 800 mg/250 ml (3,200 mcg/ml)</i>	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
<i>dopamine intravenous solution 200 mg/5 ml (40 mg/ml)</i>	1	B/D PA
<i>dopamine intravenous solution 400 mg/10 ml (40 mg/ml)</i>	1	B/D PA; MO
ENTRESTO	1	MO; QL (60 per 30 days)
ENTRESTO SPRINKLE	1	MO; QL (240 per 30 days)
<i>ivabradine</i>	1	MO; QL (60 per 30 days)
<i>milrinone</i>	1	B/D PA
<i>milrinone in 5 % dextrose</i>	1	B/D PA
<i>norepinephrine bitartrate</i>	1	
<i>ranolazine</i>	1	MO
<i>sodium nitroprusside</i>	1	B/D PA
VECAMYL	1	
VERQUVO	1	MO; QL (30 per 30 days)
VYNDAMAX	1	PA; MO
<b>NITRATES</b>		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1	MO
<i>isosorbide mononitrate oral tablet 10 mg</i>	1	
<i>isosorbide mononitrate oral tablet 20 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>isosorbide mononitrate oral tablet extended release 24 hr</i>	1	MO
<i>nitro-bid</i>	1	MO
<i>nitroglycerin in 5 % dextrose intravenous solution 100 mg/250 ml (400 mcg/ml), 25 mg/250 ml (100 mcg/ml), 50 mg/250 ml (200 mcg/ml)</i>	1	B/D PA
<i>nitroglycerin intravenous</i>	1	B/D PA
<i>nitroglycerin sublingual</i>	1	MO
<i>nitroglycerin transdermal patch 24 hour</i>	1	MO
<i>nitroglycerin translingual</i>	1	MO
<b>DERMATOLOGICALS/TOPICAL THERAPY</b>		
<b>ANTIPSORIATIC / ANTISEBORRHEIC</b>		
<i>acitretin</i>	1	MO
<i>calcipotriene scalp</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene topical cream</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene topical ointment</i>	1	MO; QL (120 per 30 days)
<i>calcitriol topical</i>	1	
<i>selenium sulfide topical lotion</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
SKYRIZI SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (2 per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	1	PA; MO; QL (2 per 28 days)
STELARA INTRAVENOUS	1	PA; MO; QL (104 per 180 days)
STELARA SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
TALTZ AUTOINJECTOR	1	PA; MO; QL (1 per 28 days)
TALTZ AUTOINJECTOR (2 PACK)	1	PA; MO; QL (4 per 28 days)
TALTZ AUTOINJECTOR (3 PACK)	1	PA; MO; QL (3 per 180 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML	1	PA; QL (0.25 per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML	1	PA; QL (0.5 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
TALTZ SUBCUTANEOUS SYRINGE 80 MG/ML	1	PA; MO; QL (1 per 28 days)
<b>MISCELLANEOUS DERMATOLOGICALS</b>		
ADBRY SUBCUTANEOUS AUTO-INJECTOR	1	PA; QL (6 per 28 days)
ADBRY SUBCUTANEOUS SYRINGE	1	PA; MO; QL (6 per 28 days)
<i>ammonium lactate</i>	1	MO
<i>chloroprocaine (pf)</i>	1	
CIBINQO	1	PA; MO; QL (30 per 30 days)
<i>dermacinrx lidocan</i>	1	PA; QL (90 per 30 days)
<i>diclofenac sodium topical gel 3 %</i>	1	PA; MO; QL (100 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	1	PA; QL (1.34 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
<i>fluorouracil topical cream 5 %</i>	1	MO
<i>fluorouracil topical solution</i>	1	MO
<i>glydo</i>	1	MO; QL (60 per 30 days)
<i>imiquimod topical cream in packet 5 %</i>	1	MO
<i>lidocaine (pf) injection solution</i>	1	
<i>lidocaine hcl injection solution</i>	1	
<i>lidocaine hcl laryngotracheal</i>	1	
<i>lidocaine hcl mucous membrane jelly in applicator</i>	1	MO; QL (60 per 30 days)
<i>lidocaine hcl mucous membrane solution 2 %</i>	1	MO
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	1	MO
<i>lidocaine topical adhesive patch,medicated 5 %</i>	1	PA; MO; QL (90 per 30 days)
<i>lidocaine topical ointment</i>	1	MO; QL (36 per 30 days)
<i>lidocaine viscous</i>	1	
<i>lidocaine-epinephrine</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>lidocaine-epinephrine (pf) injection solution 1.5 %-1:200,000, 2 %-1:200,000</i>	1	
<i>lidocaine-prilocaine topical cream</i>	1	MO; QL (30 per 30 days)
<i>lidocan iii</i>	1	PA; QL (90 per 30 days)
<i>lidocan iv</i>	1	PA; QL (90 per 30 days)
<i>lidocan v</i>	1	PA; QL (90 per 30 days)
<i>methoxsalen</i>	1	MO
PANRETIN	1	PA; MO
<i>pimecrolimus</i>	1	PA; MO; QL (100 per 30 days)
<i>podofilox topical solution</i>	1	MO
<i>polocaine injection solution 1 % (10 mg/ml)</i>	1	
<i>polocaine-mpf</i>	1	
REGRANEX	1	QL (15 per 30 days)
SANTYL	1	MO; QL (180 per 30 days)
<i>silver sulfadiazine</i>	1	MO
<i>ssd</i>	1	MO
<i>tacrolimus topical</i>	1	PA; MO; QL (100 per 30 days)
<i>tridacaine ii</i>	1	PA; QL (90 per 30 days)
<i>tridacaine iii</i>	1	PA; QL (90 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
VALCHLOR	1	PA; MO
<b>THERAPY FOR ACNE</b>		
<i>acutane</i>	1	
<i>amnesteem</i>	1	
<i>azelaic acid</i>	1	MO
<i>claravis</i>	1	
<i>clindamycin phosphate topical gel</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical gel, once daily</i>	1	MO; QL (150 per 30 days)
<i>clindamycin phosphate topical lotion</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical solution</i>	1	MO; QL (120 per 30 days)
<i>ery pads</i>	1	MO
<i>erythromycin with ethanol topical solution</i>	1	MO
<i>isotretinoin</i>	1	
<i>ivermectin topical cream</i>	1	MO; QL (90 per 30 days)
<i>metronidazole topical</i>	1	MO
<i>tazarotene topical cream 0.1 %</i>	1	PA; MO
<i>tazarotene topical gel</i>	1	PA; MO
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	1	PA; MO
<i>tretinoin topical gel 0.01 %, 0.025 %, 0.05 %</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>zenatane</i>	1	
<b>TOPICAL ANTIBACTERIALS</b>		
<i>gentamicin topical</i>	1	MO; QL (60 per 30 days)
<i>mupirocin</i>	1	MO; QL (44 per 30 days)
<i>sulfacetamide sodium (acne)</i>	1	MO
<b>TOPICAL ANTIFUNGALS</b>		
<i>ciclodan topical solution</i>	1	MO; QL (6.6 per 28 days)
<i>ciclopirox topical cream</i>	1	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	1	MO; QL (100 per 28 days)
<i>ciclopirox topical shampoo</i>	1	MO; QL (120 per 28 days)
<i>ciclopirox topical solution</i>	1	MO; QL (6.6 per 28 days)
<i>ciclopirox topical suspension</i>	1	MO; QL (60 per 28 days)
<i>clotrimazole topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole topical solution</i>	1	MO; QL (30 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	1	MO; QL (60 per 28 days)
<i>econazole</i>	1	MO; QL (85 per 28 days)
<i>ketoconazole topical cream</i>	1	MO; QL (60 per 28 days)
<i>ketoconazole topical shampoo</i>	1	MO; QL (120 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>klayesta</i>	1	MO; QL (180 per 30 days)
<i>naftifine topical cream</i>	1	MO; QL (60 per 28 days)
<i>naftifine topical gel 2 %</i>	1	MO; QL (60 per 28 days)
<i>nyamyc</i>	1	MO; QL (180 per 30 days)
<i>nystatin topical cream</i>	1	MO; QL (30 per 28 days)
<i>nystatin topical ointment</i>	1	MO; QL (30 per 28 days)
<i>nystatin topical powder</i>	1	MO; QL (180 per 30 days)
<i>nystatin-triamcinolone</i>	1	MO; QL (60 per 28 days)
<i>nystop</i>	1	MO; QL (180 per 30 days)

#### TOPICAL ANTIVIRALS

<i>acyclovir topical ointment</i>	1	PA; MO; QL (30 per 30 days)
<i>penciclovir</i>	1	MO; QL (5 per 30 days)

#### TOPICAL CORTICOSTEROIDS

<i>ala-cort topical cream 1 %</i>	1	MO
<i>ala-cort topical cream 2.5 %</i>	1	
<i>alclometasone</i>	1	MO
<i>betamethasone dipropionate</i>	1	MO
<i>betamethasone valerate topical cream</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>betamethasone valerate topical lotion</i>	1	MO
<i>betamethasone valerate topical ointment</i>	1	MO
<i>betamethasone, augmented</i>	1	MO
<i>clobetasol scalp</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical cream</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical foam</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical gel</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical lotion</i>	1	MO; QL (118 per 28 days)
<i>clobetasol topical ointment</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical shampoo</i>	1	MO; QL (236 per 28 days)
<i>clobetasol-emollient topical cream</i>	1	MO; QL (120 per 28 days)
<i>clodan</i>	1	MO; QL (236 per 28 days)
<i>desonide</i>	1	MO
<i>fluocinolone</i>	1	MO
<i>fluocinolone and shower cap</i>	1	MO
<i>fluocinonide topical cream 0.05 %</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical gel</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical ointment</i>	1	MO; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>fluocinonide topical solution</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide-emollient</i>	1	MO; QL (120 per 30 days)
<i>halobetasol propionate topical cream</i>	1	MO
<i>halobetasol propionate topical ointment</i>	1	MO
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	1	MO
<i>hydrocortisone topical lotion 2.5 %</i>	1	MO
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	1	MO
<i>mometasone topical</i>	1	MO
<i>prednicarbate topical ointment</i>	1	
<i>triamcinolone acetonide topical cream</i>	1	MO
<i>triamcinolone acetonide topical lotion</i>	1	MO
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	MO
<i>triderm topical cream</i>	1	
<b>TOPICAL SCABICIDES / PEDICULICIDES</b>		
<i>crotan</i>	1	
<i>malathion</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>permethrin</i>	1	MO; QL (60 per 30 days)

## DIAGNOSTICS / MISCELLANEOUS AGENTS

### ANTIDOTES

<i>acetylcysteine intravenous</i>	1	
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### IRRIGATING SOLUTIONS

<i>lactated ringers irrigation</i>	1	
<i>neomycin-polymyxin b gu</i>	1	
<i>ringer's irrigation</i>	1	MO

### MISCELLANEOUS AGENTS

<i>acamprosate</i>	1	MO
<i>acetic acid irrigation</i>	1	MO
<i>anagrelide</i>	1	MO
<i>caffeine citrate intravenous</i>	1	
<i>caffeine citrate oral</i>	1	MO
<i>carglumic acid</i>	1	PA; MO
<i>cevimeline</i>	1	MO
CHEMET	1	PA
CLINIMIX 4.25%/D5W SULFIT FREE	1	B/D PA
<i>d10 %-0.45 % sodium chloride</i>	1	
<i>d2.5 %-0.45 % sodium chloride</i>	1	
<i>d5 % and 0.9 % sodium chloride</i>	1	MO
<i>d5 %-0.45 % sodium chloride</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>deferasirox oral granules in packet</i>	1	PA; MO
<i>deferasirox oral tablet 180 mg, 360 mg</i>	1	PA; MO
<i>deferasirox oral tablet 90 mg</i>	1	PA; MO
<i>deferasirox oral tablet, dispersible 125 mg</i>	1	PA; MO
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</i>	1	PA; MO
<i>deferiprone</i>	1	PA; MO
<i>deferoxamine</i>	1	B/D PA; MO
<i>dextrose 10 % and 0.2 % nacl</i>	1	
<i>dextrose 10 % in water (d10w)</i>	1	
<i>dextrose 25 % in water (d25w)</i>	1	
<i>dextrose 5 % in water (d5w)</i>	1	MO
<i>dextrose 5 %-lactated ringers</i>	1	MO
<i>dextrose 5%-0.2 % sod chloride</i>	1	
<i>dextrose 5%-0.3 % sod.chloride</i>	1	
<i>dextrose 50 % in water (d50w)</i>	1	
<i>dextrose 70 % in water (d70w)</i>	1	
<i>disulfiram oral tablet 250 mg</i>	1	MO
<i>disulfiram oral tablet 500 mg</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>droxidopa</i>	1	PA; MO
ENDARI	1	PA; MO
<i>glutamine (sickle cell)</i>	1	PA; MO
INCRELEX	1	MO; LA
<i>kionex (with sorbitol)</i>	1	
<i>levocarnitine (with sugar)</i>	1	MO
<i>levocarnitine oral solution 100 mg/ml</i>	1	MO
<i>levocarnitine oral tablet</i>	1	MO
LOKELMA	1	MO
<i>midodrine</i>	1	MO
<i>nitisinone</i>	1	PA; MO
<i>pilocarpine hcl oral</i>	1	MO
PROLASTIN-C INTRAVENOUS SOLUTION	1	PA; MO; LA
REVCIVI	1	PA; LA
REZDIFFRA	1	PA; MO; QL (30 per 30 days)
<i>riluzole</i>	1	PA; MO
<i>risedronate oral tablet 30 mg</i>	1	MO; QL (30 per 30 days)
<i>sevelamer carbonate oral tablet</i>	1	MO; QL (270 per 30 days)
<i>sodium benzoate-sod phenylacet</i>	1	
<i>sodium chloride 0.9 % intravenous</i>	1	MO
<i>sodium chloride irrigation</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>sodium phenylbutyrate oral powder</i>	1	PA; MO
<i>sodium phenylbutyrate oral tablet</i>	1	PA
<i>sodium polystyrene sulfonate oral powder</i>	1	MO
<i>sps (with sorbitol) oral</i>	1	MO
<i>sps (with sorbitol) rectal</i>	1	
<i>trientine oral capsule 250 mg</i>	1	PA; MO
VELPHORO	1	MO; QL (180 per 30 days)
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 8.4 GRAM	1	MO
VELTASSA ORAL POWDER IN PACKET 25.2 GRAM	1	
<i>water for irrigation, sterile</i>	1	MO
XIAFLEX	1	PA
<i>zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml</i>	1	PA; MO
<b>SMOKING DETERRENTS</b>		
<i>bupropion hcl (smoking deter)</i>	1	MO
NICOTROL	1	
NICOTROL NS	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>varenicline oral tablet 0.5 mg, 1 mg</i>	1	MO
<i>varenicline oral tablet 1 mg (56 pack)</i>	1	
<i>varenicline oral tablets,dose pack</i>	1	MO
<b>EAR, NOSE / THROAT MEDICATIONS</b>		
<b>MISCELLANEOUS AGENTS</b>		
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	1	MO; QL (60 per 30 days)
<i>azelastine nasal spray,non-aerosol 205.5 mcg (0.15 %)</i>	1	QL (60 per 30 days)
<i>chlorhexidine gluconate mucous membrane</i>	1	MO
<i>denta 5000 plus</i>	1	MO
<i>dentagel</i>	1	MO
<i>fluoride (sodium) dental cream</i>	1	
<i>fluoride (sodium) dental gel</i>	1	
<i>fluoride (sodium) dental paste</i>	1	MO
<i>ipratropium bromide nasal</i>	1	MO; QL (30 per 30 days)
<i>kourzeq</i>	1	
<i>oralone</i>	1	
<i>periogard</i>	1	MO
PREVIDENT 5000 BOOSTER PLUS	1	MO
PREVIDENT 5000 DRY MOUTH	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>sf</i>	1	MO
<i>sf 5000 plus</i>	1	MO
<i>sodium fluoride 5000 dry mouth</i>	1	MO
<i>sodium fluoride 5000 plus</i>	1	
<i>sodium fluoride-pot nitrate</i>	1	MO
<i>triamcinolone acetonide dental</i>	1	MO
<b>MISCELLANEOUS OTIC PREPARATIONS</b>		
<i>acetic acid otic (ear)</i>	1	MO
<i>ciprofloxacin hcl otic (ear)</i>	1	MO
<i>flac otic oil</i>	1	
<i>fluocinolone acetonide oil</i>	1	MO
<i>hydrocortisone-acetic acid</i>	1	MO
<i>ofloxacin otic (ear)</i>	1	MO
<b>OTIC STEROID / ANTIBIOTIC</b>		
<i>ciprofloxacin-dexamethasone</i>	1	MO; QL (7.5 per 7 days)
<i>neomycin-polymyxin-hc otic (ear)</i>	1	MO
<b>ENDOCRINE/DIABETES</b>		
<b>ADRENAL HORMONES</b>		
<i>cortisone</i>	1	
<i>dexamethasone intensol</i>	1	MO
<i>dexamethasone oral elixir</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>dexamethasone oral solution</i>	1	MO
<i>dexamethasone oral tablet</i>	1	MO
<i>dexamethasone sodium phos (pf) injection solution 10 mg/ml</i>	1	MO
<i>dexamethasone sodium phosphate injection</i>	1	MO
<i>fludrocortisone</i>	1	MO
<i>hydrocortisone oral</i>	1	MO
<i>methylprednisolone acetate</i>	1	MO
<i>methylprednisolone oral tablet</i>	1	B/D PA; MO
<i>methylprednisolone oral tablets,dose pack</i>	1	MO
<i>methylprednisolone sodium succ injection recon soln 125 mg, 40 mg</i>	1	MO
<i>methylprednisolone sodium succ intravenous</i>	1	MO
<i>prednisolone oral solution</i>	1	MO
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (5 ml)</i>	1	
<i>prednisone intensol</i>	1	MO
<i>prednisone oral solution</i>	1	MO
<i>prednisone oral tablet</i>	1	MO
<i>prednisone oral tablets,dose pack</i>	1	MO
<i>triamcinolone acetonide injection suspension 40 mg/ml</i>	1	MO
<b>ANTITHYROID AGENTS</b>		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	MO
<i>propylthiouracil</i>	1	MO
<b>DIABETES THERAPY</b>		
<i>acarbose oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>acarbose oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>acarbose oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
<i>alcohol pads</i>	1	MO
BAQSIMI	1	MO
BYDUREON BCISE	1	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	1	PA; MO; QL (2.4 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	1	PA; MO; QL (1.2 per 30 days)
<i>diazoxide</i>	1	MO
DROPSAFE ALCOHOL PREP PADS	1	
FARXIGA ORAL TABLET 10 MG	1	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	1	MO; QL (60 per 30 days)
<i>glimepiride oral tablet 1 mg</i>	1	MO; QL (240 per 30 days)
<i>glimepiride oral tablet 2 mg</i>	1	MO; QL (120 per 30 days)
<i>glimepiride oral tablet 4 mg</i>	1	MO; QL (60 per 30 days)
<i>glipizide oral tablet 10 mg</i>	1	MO; QL (120 per 30 days)
<i>glipizide oral tablet 5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	MO; QL (60 per 30 days)
<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 5 mg</i>	1	MO; QL (120 per 30 days)
<i>glipizide-metformin oral tablet 2.5-250 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1	MO; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>glyburide</i>	1	MO
<i>glyburide micronized</i>	1	MO
<i>glyburide-metformin oral tablet 1.25-250 mg</i>	1	
<i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1	MO
GLYXAMBI	1	MO; QL (30 per 30 days)
GVOKE	1	MO
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML	1	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 1 MG/0.2 ML	1	MO
GVOKE HYPOPEN 2-PACK	1	MO
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	MO
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	MO
HUMULIN R U-500 (CONC) INSULIN	1	MO
HUMULIN R U-500 (CONC) KWIKPEN	1	MO

Drug Name	Drug Tier	Requirements /Limits
INPEFA ORAL TABLET 200 MG	1	PA; MO; QL (60 per 30 days)
INPEFA ORAL TABLET 400 MG	1	PA; MO; QL (30 per 30 days)
JANUMET	1	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	1	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	1	MO; QL (60 per 30 days)
JANUVIA	1	MO; QL (30 per 30 days)
JARDIANCE	1	MO; QL (30 per 30 days)
JENTADUETO	1	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	1	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	1	MO; QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN	1	MO
LANTUS U-100 INSULIN	1	MO
<i>metformin oral tablet 1,000 mg</i>	1	MO; QL (75 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>metformin oral tablet 500 mg</i>	1	MO; QL (150 per 30 days)
<i>metformin oral tablet 850 mg</i>	1	MO; QL (90 per 30 days)
<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	MO; QL (120 per 30 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	MO; QL (60 per 30 days)
MOUNJARO	1	PA; MO; QL (2 per 28 days)
<i>nateglinide oral tablet 120 mg</i>	1	MO; QL (90 per 30 days)
<i>nateglinide oral tablet 60 mg</i>	1	MO; QL (180 per 30 days)
NOVOLIN 70/30 U-100 INSULIN	1	MO
NOVOLIN 70-30 FLEXPEN U-100	1	
NOVOLIN N FLEXPEN	1	MO
NOVOLIN N NPH U-100 INSULIN	1	MO
NOVOLIN R FLEXPEN	1	
NOVOLIN R REGULAR U100 INSULIN	1	MO
NOVOLOG FLEXPEN U-100 INSULIN	1	MO
NOVOLOG MIX 70-30 U-100 INSULIN	1	MO
NOVOLOG MIX 70-30FLEXPEN U-100	1	

Drug Name	Drug Tier	Requirements /Limits
NOVOLOG PENFILL U-100 INSULIN	1	MO
NOVOLOG U-100 INSULIN ASPART	1	MO
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	1	PA; MO; QL (3 per 28 days)
<i>pioglitazone</i>	1	MO; QL (30 per 30 days)
QTERN	1	MO; QL (30 per 30 days)
<i>repaglinide oral tablet 0.5 mg</i>	1	MO; QL (960 per 30 days)
<i>repaglinide oral tablet 1 mg</i>	1	MO; QL (480 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	1	MO; QL (240 per 30 days)
RYBELSUS	1	PA; MO; QL (30 per 30 days)
<i>saxagliptin</i>	1	MO; QL (30 per 30 days)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	1	MO; QL (60 per 30 days)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5- 1,000 MG, 7.5-500 MG	1	MO; QL (60 per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	1	MO; QL (120 per 30 days)
SOLIQUA 100/33	1	MO; QL (90 per 30 days)
STEGLATRO	1	MO; QL (30 per 30 days)
SYMLINPEN 120	1	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	1	PA; MO; QL (6 per 30 days)
SYNJARDY	1	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	1	MO; QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	1	MO; QL (60 per 30 days)
TOUJEO MAX U- 300 SOLOSTAR	1	MO
TOUJEO SOLOSTAR U-300 INSULIN	1	MO
TRADJENTA	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	1	MO; QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5- 1,000 MG, 5-2.5- 1,000 MG	1	MO; QL (60 per 30 days)
TRULICITY	1	PA; MO; QL (2 per 28 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	1	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5- 500 MG	1	MO; QL (60 per 30 days)
ZEGALOGUE AUTOINJECTOR	1	MO
ZEGALOGUE SYRINGE	1	MO
<b>MISCELLANEOUS HORMONES</b>		
ALDURAZYME	1	PA; MO
<i>cabergoline</i>	1	MO
<i>calcitonin (salmon) injection</i>	1	MO
<i>calcitonin (salmon) nasal</i>	1	MO
<i>calcitriol intravenous solution 1 mcg/ml</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>calcitriol oral capsule</i>	1	MO
<i>calcitriol oral solution</i>	1	
<i>cinacalcet</i>	1	PA; MO
<i>clomid</i>	1	PA; MO
<i>clomiphene citrate</i>	1	PA
CRYSVITA	1	PA; MO; LA
<i>danazol</i>	1	MO
<i>desmopressin injection</i>	1	MO
<i>desmopressin nasal spray with pump</i>	1	MO
<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	1	
<i>desmopressin oral</i>	1	MO
<i>doxercalciferol intravenous</i>	1	MO
<i>doxercalciferol oral</i>	1	MO
ELAPRASE	1	PA; MO
FABRAZYME	1	PA; MO
KANUMA	1	PA; MO
KORLYM	1	PA
LUMIZYME	1	PA; MO
MEPSEVII	1	PA; MO
<i>mifepristone oral tablet 300 mg</i>	1	PA; MO
MYALEPT	1	PA; MO; LA
NAGLAZYME	1	PA; MO; LA
<i>pamidronate intravenous solution</i>	1	MO
<i>paricalcitol intravenous</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>paricalcitol oral</i>	1	MO
<i>sapropterin</i>	1	PA; MO
SOMAVERT	1	PA; MO
STRENSIQ	1	PA; LA
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	1	PA; MO
<i>testosterone cypionate intramuscular oil 200 mg/ml (1 ml)</i>	1	PA
<i>testosterone enanthate</i>	1	PA; MO
<i>testosterone transdermal gel</i>	1	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	1	PA; QL (120 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	1	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	1	PA; MO; QL (300 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	1	PA; QL (37.5 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal solution in metered pump w/app</i>	1	PA; MO; QL (180 per 30 days)
<i>tolvaptan</i>	1	PA; MO
<b>VIMIZIM</b>	1	PA; MO; LA
<i>zoledronic acid intravenous solution</i>	1	B/D PA; MO
<i>zoledronic acid-mannitol-water intravenous piggyback 4 mg/100 ml</i>	1	B/D PA; MO
<b>THYROID HORMONES</b>		
<i>euthyrox</i>	1	MO
<i>levo-t</i>	1	
<i>levothyroxine intravenous recon soln</i>	1	
<i>levothyroxine oral tablet</i>	1	MO
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO
<i>liothyronine</i>	1	MO
<b>SYNTHROID</b>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>unithroid</i>	1	MO
<b>GASTROENTEROLOGY</b>		
<b>ANTIDIARRHEALS / ANTISPASMODICS</b>		
<i>atropine injection solution 0.4 mg/ml</i>	1	
<i>atropine injection syringe 0.1 mg/ml</i>	1	
<i>atropine intravenous solution 0.4 mg/ml</i>	1	
<i>atropine intravenous syringe 0.25 mg/5 ml (0.05 mg/ml)</i>	1	
<i>dicyclomine intramuscular</i>	1	MO
<i>dicyclomine oral capsule</i>	1	MO
<i>dicyclomine oral solution</i>	1	MO
<i>dicyclomine oral tablet</i>	1	MO
<i>diphenoxylate-atropine oral liquid</i>	1	MO
<i>diphenoxylate-atropine oral tablet</i>	1	MO
<i>glycopyrrolate (pf) in water intravenous syringe 0.4 mg/2 ml (0.2 mg/ml)</i>	1	MO
<i>glycopyrrolate injection</i>	1	MO
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	MO
<i>glycopyrrolate oral tablet 1.5 mg</i>	1	
<i>loperamide oral capsule</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>opium tincture</i>	1	MO
<b>MISCELLANEOUS GASTROINTESTINAL AGENTS</b>		
<i>alosetron oral tablet 0.5 mg</i>	1	PA; MO
<i>alosetron oral tablet 1 mg</i>	1	PA; MO
<i>aprepitant</i>	1	B/D PA; MO
<i>balsalazide</i>	1	MO
<i>betaine</i>	1	MO
<i>budesonide oral capsule, delayed, extended release</i>	1	MO
<i>budesonide oral tablet, delayed and extended release</i>	1	MO
CHENODAL	1	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	1	PA
CHOLBAM ORAL CAPSULE 50 MG	1	PA; QL (120 per 30 days)
CIMZIA	1	PA; MO; QL (2 per 28 days)
CIMZIA POWDER FOR RECONST	1	PA; MO; QL (2 per 28 days)
CIMZIA STARTER KIT	1	PA; MO; QL (3 per 180 days)
CINVANTI	1	MO
<i>compro</i>	1	MO
<i>constulose</i>	1	MO
CORTIFOAM	1	MO
CREON	1	MO
<i>cromolyn oral</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>dimenhydrinate injection solution</i>	1	MO
<i>dronabinol</i>	1	B/D PA
<i>droperidol injection solution</i>	1	MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	1	B/D PA
ENTYVIO	1	PA; MO; QL (2 per 28 days)
<i>enulose</i>	1	MO
<i>fosaprepitant</i>	1	MO
GATTEX 30-VIAL	1	PA; MO
GATTEX ONE-VIAL	1	PA; MO
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>gavilyte-n</i>	1	
<i>generlac</i>	1	
<i>granisetron (pf) intravenous solution 1 mg/ml (1 ml)</i>	1	MO
<i>granisetron hcl intravenous solution 1 mg/ml</i>	1	MO
<i>granisetron hcl intravenous solution 1 mg/ml (1 ml)</i>	1	
<i>granisetron hcl oral</i>	1	B/D PA; MO
<i>hydrocortisone rectal</i>	1	MO
<i>hydrocortisone topical cream with perineal applicator</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>lactulose oral solution 10 gram/15 ml</i>	1	MO
<i>lactulose oral solution 10 gram/15 ml (15 ml), 20 gram/30 ml</i>	1	
LINZESS	1	MO; QL (30 per 30 days)
<i>lubiprostone</i>	1	MO; QL (60 per 30 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	MO
<i>mesalamine oral capsule (with del rel tablets)</i>	1	MO
<i>mesalamine oral capsule, extended release</i>	1	
<i>mesalamine oral capsule, extended release 24hr</i>	1	MO
<i>mesalamine oral tablet, delayed release (dr/ec)</i>	1	MO
<i>mesalamine rectal</i>	1	MO
<i>mesalamine with cleansing wipe</i>	1	MO
<i>metoclopramide hcl injection solution</i>	1	MO
<i>metoclopramide hcl injection syringe</i>	1	
<i>metoclopramide hcl oral solution</i>	1	MO
<i>metoclopramide hcl oral tablet</i>	1	MO
MOVANTIK	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>nitroglycerin rectal</i>	1	MO
OCALIVA	1	PA; MO; LA; QL (30 per 30 days)
<i>ondansetron hcl (pf) injection solution</i>	1	MO
<i>ondansetron hcl (pf) injection syringe</i>	1	
<i>ondansetron hcl intravenous</i>	1	MO
<i>ondansetron hcl oral solution</i>	1	B/D PA; MO
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	B/D PA; MO
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	1	B/D PA; MO
<i>palonosetron intravenous solution 0.25 mg/5 ml</i>	1	MO
<i>palonosetron intravenous syringe</i>	1	
<i>peg 3350-electrolytes</i>	1	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	1	MO
<i>peg-electrolyte</i>	1	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	1	MO
<i>prochlorperazine</i>	1	MO
<i>prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)</i>	1	MO
<i>prochlorperazine maleate oral</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>procto-med hc</i>	1	MO
<i>proctosol hc topical</i>	1	MO
<i>proctozone-hc</i>	1	MO
RECTIV	1	MO
RELISTOR SUBCUTANEOUS SOLUTION	1	MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	1	MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	1	MO; QL (12 per 30 days)
REMICADE	1	PA; MO; QL (20 per 28 days)
SANCUSO	1	MO
<i>scopolamine base</i>	1	MO
SKYRIZI INTRAVENOUS	1	PA; MO; QL (30 per 180 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	1	PA; MO; QL (1.2 per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	1	PA; MO; QL (2.4 per 56 days)
<i>sodium,potassium,m ag sulfates oral recon soln 17.5-3.13-1.6 gram</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>sodium,potassium,m ag sulfates oral recon soln 17.5-3.13-1.6 gram 2 pack (480ml)</i>	1	
SUCRAID	1	PA
<i>sulfasalazine</i>	1	MO
TRULANCE	1	QL (30 per 30 days)
<i>ursodiol oral capsule 300 mg</i>	1	MO
<i>ursodiol oral tablet</i>	1	MO
VARUBI	1	B/D PA
VIBERZI	1	MO; QL (60 per 30 days)
VIOKACE	1	MO
ZENPEP ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	1	MO
ZENPEP ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 60,000-189,600- 252,600 UNIT	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ZYMFENTRA	1	PA; MO; QL (2 per 28 days)
<b>ULCER THERAPY</b>		
<i>cimetidine</i>	1	MO
<i>cimetidine hcl oral</i>	1	
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec) 40 mg</i>	1	MO; QL (60 per 30 days)
<i>esomeprazole sodium intravenous recon soln 40 mg</i>	1	MO
<i>famotidine (pf)</i>	1	MO
<i>famotidine (pf)-nacl (iso-os)</i>	1	MO
<i>famotidine intravenous</i>	1	MO
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	MO
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg</i>	1	MO; QL (30 per 30 days)
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	1	MO; QL (60 per 30 days)
<i>misoprostol</i>	1	MO
<i>nizatidine oral capsule</i>	1	MO
<i>omeprazole oral capsule, delayed release(dr/ec) 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>omeprazole oral capsule, delayed release(dr/ec) 40 mg</i>	1	MO; QL (60 per 30 days)
<i>pantoprazole intravenous</i>	1	MO
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>pantoprazole oral tablet, delayed release (dr/ec) 40 mg</i>	1	MO; QL (60 per 30 days)
<i>sucralfate oral suspension</i>	1	MO
<i>sucralfate oral tablet</i>	1	MO

## IMMUNOLOGY, VACCINES / BIOTECHNOLOGY

### BIOTECHNOLOGY DRUGS

ACTIMMUNE	1	B/D PA; MO
ARCALYST	1	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	1	PA; MO; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	1	PA; MO; QL (1 per 28 days)
BESREMI	1	PA; LA
BETASERON SUBCUTANEOUS KIT	1	PA; MO; QL (14 per 28 days)
ILARIS (PF)	1	PA; MO; LA; QL (2 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
LEUKINE INJECTION RECON SOLN	1	PA; MO
MOZOBIL	1	B/D PA; MO
NIVESTYM	1	PA; MO
NYVEPRIA	1	PA; MO
OMNITROPE	1	PA; MO
PEGASYS SUBCUTANEOUS SOLUTION	1	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	1	MO; QL (2 per 28 days)
PLEGRIDY INTRAMUSCULAR	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	1	PA; MO; QL (1 per 180 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	1	PA; MO; QL (1 per 180 days)
<i>plerixafor</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	1	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	1	PA; MO
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	1	PA; MO
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	1	PA; MO
ZARXIO	1	PA; MO
ZIEXTENZO	1	PA; MO
<b>VACCINES / MISCELLANEOUS IMMUNOLOGICALS</b>		
ABRYSVO (PF)	1	V
ACTHIB (PF)	1	
ADACEL(TDAP ADOLESN/ADULT )(PF)	1	V
AREXVY (PF)	1	V
BCG VACCINE, LIVE (PF)	1	V
BEXSERO	1	V

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
BOOSTRIX TDAP	1	V
DAPTACEL (DTAP PEDIATRIC) (PF)	1	
DENGVAXIA (PF)	1	
ENGERIX-B (PF)	1	B/D PA; V
ENGERIX-B PEDIATRIC (PF)	1	B/D PA; V
<i>fomepizole</i>	1	
GAMASTAN	1	MO
GARDASIL 9 (PF)	1	V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1	V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	1	
HEPLISAV-B (PF)	1	B/D PA; V
HIBERIX (PF)	1	
HIZENTRA	1	B/D PA; MO
HYPERHEP B INTRAMUSCULAR SOLUTION	1	
HYPERHEP B NEONATAL	1	
IMOVAX RABIES VACCINE (PF)	1	V
INFANRIX (DTAP) (PF)	1	
IPOL	1	V
IXCHIQ (PF)	1	V
IXIARO (PF)	1	V
JYNNEOS (PF)	1	B/D PA; V
KINRIX (PF)	1	

Drug Name	Drug Tier	Requirements /Limits
MENACTRA (PF) INTRAMUSCULAR SOLUTION	1	V
MENQUADFI (PF)	1	V
MENVEO A-C-Y-W-135-DIP (PF)	1	V
M-M-R II (PF)	1	V
MRESVIA (PF)	1	V
PEDIARIX (PF)	1	
PEDVAX HIB (PF)	1	
PENBRAYA (PF)	1	V
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	1	
PREHEVBRIO (PF)	1	B/D PA; V
PRIORIX (PF)	1	V
PRIVIGEN	1	PA; MO
PROQUAD (PF)	1	
QUADRACEL (PF)	1	
RABAVERT (PF)	1	V
RECOMBIVAX HB (PF)	1	B/D PA; V
ROTARIX	1	
ROTATEQ VACCINE	1	
SHINGRIX (PF)	1	V; QL (2 per 720 days)
TDVAX	1	V
TENIVAC (PF)	1	V
TETANUS, DIPHTHERIA TOX PED(PF)	1	
TICE BCG	1	B/D PA

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Drug Name	Drug Tier	Requirements /Limits
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	1	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	1	V
TRUMENBA	1	V
TWINRIX (PF)	1	V
TYPHIM VI	1	V
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	1	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	1	V
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	1	
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1	V
VARIVAX (PF)	1	V
VARIZIG	1	
YF-VAX (PF)	1	V

**MISCELLANEOUS SUPPLIES**

**MISCELLANEOUS SUPPLIES**

Drug Name	Drug Tier	Requirements /Limits
BD INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64"	1	MO
BD PEN NEEDLE	1	MO
BD PEN NEEDLE	1	
CEQR SIMPLICITY	1	MO
CEQR SIMPLICITY INSERTER	1	MO
GAUZE PADS 2 X 2	1	MO
INSULIN SYRINGE- NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	1	MO
INSULIN SYRINGES (NON- PREFERRED BRANDS) SYRINGE 1 ML 29 GAUGE X 1/2"	1	MO
OMNIPOD 5 G6 INTRO KIT (GEN 5)	1	MO; QL (1 per 720 days)

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Drug Name	Drug Tier	Requirements /Limits
OMNIPOD 5 G6 PODS (GEN 5)	1	MO
OMNIPOD CLASSIC PODS (GEN 3)	1	
OMNIPOD DASH INTRO KIT (GEN 4)	1	QL (1 per 720 days)
OMNIPOD DASH PODS (GEN 4)	1	MO
OMNIPOD GO PODS	1	
OMNIPOD GO PODS 10 UNITS/DAY	1	
OMNIPOD GO PODS 15 UNITS/DAY	1	
OMNIPOD GO PODS 20 UNITS/DAY	1	
OMNIPOD GO PODS 25 UNITS/DAY	1	
OMNIPOD GO PODS 30 UNITS/DAY	1	
OMNIPOD GO PODS 40 UNITS/DAY	1	
PEN NEEDLES (NON-PREFERRED BRANDS) NEEDLE 29 GAUGE X 1/2"	1	MO
V-GO 20	1	MO
V-GO 30	1	MO
V-GO 40	1	MO

Drug Name	Drug Tier	Requirements /Limits
<b>MUSCULOSKELETAL / RHEUMATOLOGY</b>		
<b>GOUT THERAPY</b>		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	MO
<i>allopurinol sodium</i>	1	
<i>aloprim</i>	1	
<i>colchicine oral tablet</i>	1	MO
<i>febuxostat</i>	1	MO
<i>probenecid</i>	1	MO
<i>probenecid-colchicine</i>	1	MO
<b>OSTEOPOROSIS THERAPY</b>		
<i>alendronate oral solution</i>	1	MO; QL (300 per 28 days)
<i>alendronate oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	MO; QL (4 per 28 days)
FOSAMAX PLUS D	1	ST; MO; QL (4 per 28 days)
<i>ibandronate intravenous solution</i>	1	PA
<i>ibandronate intravenous syringe</i>	1	PA; MO
<i>ibandronate oral</i>	1	MO; QL (1 per 30 days)
PROLIA	1	PA; MO; QL (1 per 180 days)
<i>raloxifene</i>	1	MO
<i>risedronate oral tablet 150 mg</i>	1	MO; QL (1 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	1	MO; QL (4 per 28 days)
<i>risedronate oral tablet 5 mg</i>	1	MO; QL (30 per 30 days)
<i>risedronate oral tablet, delayed release (dr/ec)</i>	1	MO; QL (4 per 28 days)
TERIPARATIDE SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (620MCG/2.48ML)	1	PA; QL (2.48 per 28 days)
<b>OTHER RHEUMATOLOGICALS</b>		
ACTEMRA ACTPEN	1	PA; MO; QL (3.6 per 28 days)
ACTEMRA INTRAVENOUS	1	PA; MO; QL (160 per 28 days)
ACTEMRA SUBCUTANEOUS	1	PA; MO; QL (3.6 per 28 days)
ADALIMUMAB-ADAZ	1	PA; MO; QL (1.6 per 28 days)
ADALIMUMAB-ADBM (ONLY NDCS STARTING WITH 00597) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
ADALIMUMAB-ADBM (ONLY NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	1	PA; MO; QL (2 per 28 days)
ADALIMUMAB-ADBM (ONLY NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; QL (4 per 28 days)
ADALIMUMAB-ADBM (ONLY NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS (ONLY NDCS STARTING WITH 00597)	1	PA; QL (6 per 180 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV (ONLY NDCS STARTING WITH 00597)	1	PA; QL (4 per 180 days)
BENLYSTA	1	PA; MO
CYLTEZO(CF) PEN	1	PA; MO; QL (4 per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS	1	PA; QL (6 per 180 days)
CYLTEZO(CF) PEN PSORIASIS-UV	1	PA; QL (4 per 180 days)

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Drug Name	Drug Tier	Requirements /Limits
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	1	PA; MO; QL (2 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; QL (4 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
ENBREL MINI	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	1	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	1	PA; MO; QL (8 per 28 days)
HUMIRA (ONLY NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA PEN (ONLY NDCS STARTING WITH 00074)	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) (ONLY NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	1	PA; MO; QL (2 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
HUMIRA(CF) (ONLY NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEN (ONLY NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEN (ONLY NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	1	PA; MO; QL (2 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS (ONLY NDCS STARTING WITH 00074)	1	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC (ONLY NDCS STARTING WITH 00074)	1	PA; QL (4 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS (ONLY NDCS STARTING WITH 00074)	1	PA; MO; QL (3 per 180 days)
HYRIMOZ PEN CROHN'S-UC STARTER (PREFERRED NDCS STARTING WITH 61314)	1	PA; MO; QL (2.4 per 180 days)

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Drug Name	Drug Tier	Requirements /Limits
HYRIMOZ PEN PSORIASIS STARTER (PREFERRED NDCS STARTING WITH 61314)	1	PA; MO; QL (1.6 per 180 days)
HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	1	PA; MO; QL (0.2 per 28 days)
HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	1	PA; MO; QL (0.4 per 28 days)
HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	1	PA; QL (1.6 per 28 days)
HYRIMOZ(CF) PEDI CROHN STARTER (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 80 MG/0.8 ML	1	PA; MO; QL (2.4 per 180 days)

Drug Name	Drug Tier	Requirements /Limits
HYRIMOZ(CF) PEDI CROHN STARTER (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 80 MG/0.8 ML- 40 MG/0.4 ML	1	PA; MO; QL (1.2 per 180 days)
HYRIMOZ(CF) PEN (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML	1	PA; QL (1.6 per 28 days)
HYRIMOZ(CF) PEN (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML	1	PA; MO; QL (1.6 per 28 days)
<i>leflunomide</i>	1	MO; QL (30 per 30 days)
ORENCIA (WITH MALTOSE)	1	PA; MO; QL (12 per 28 days)
ORENCIA CLICKJECT	1	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	1	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	1	PA; MO; QL (1.6 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	1	PA; MO; QL (2.8 per 28 days)
OTEZLA ORAL TABLET 20 MG	1	PA; QL (60 per 30 days)
OTEZLA ORAL TABLET 30 MG	1	PA; MO; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (51)	1	PA; QL (55 per 180 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	1	PA; MO; QL (55 per 180 days)
<i>penicillamine oral tablet</i>	1	PA; MO
RIDAURA	1	MO
RINVOQ LQ	1	PA; MO; QL (360 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	1	PA; MO; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	1	PA; MO; QL (84 per 180 days)
SAVELLA ORAL TABLET	1	QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
SAVELLA ORAL TABLETS,DOSE PACK	1	QL (55 per 180 days)
SIMLANDI(CF) AUTOINJECTOR	1	PA; MO; QL (6 per 28 days)
TYENNE AUTOINJECTOR	1	PA; QL (3.6 per 28 days)
TYENNE INTRAVENOUS	1	PA; QL (160 per 28 days)
TYENNE SUBCUTANEOUS	1	PA; QL (3.6 per 28 days)
XELJANZ ORAL SOLUTION	1	PA; MO; QL (480 per 24 days)
XELJANZ ORAL TABLET	1	PA; MO; QL (60 per 30 days)
XELJANZ XR	1	PA; MO; QL (30 per 30 days)

## OBSTETRICS / GYNECOLOGY

### ESTROGENS / PROGESTINS

<i>camila</i>	1	MO
<i>deblitane</i>	1	MO
DEPO-SUBQ PROVERA 104	1	MO
<i>dotti</i>	1	PA; MO; QL (8 per 28 days)
DUAVEE	1	MO
<i>emzahh</i>	1	
<i>errin</i>	1	MO
<i>estradiol oral</i>	1	PA; MO
<i>estradiol transdermal patch semiweekly</i>	1	PA; MO; QL (8 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>estradiol transdermal patch weekly</i>	1	PA; MO; QL (4 per 28 days)
<i>estradiol vaginal</i>	1	MO
<i>estradiol valerate</i>	1	MO
<i>estradiol-norethindrone acet</i>	1	PA; MO
<i>fyavolv</i>	1	PA; MO
<i>heather</i>	1	MO
IMVEXXY MAINTENANCE PACK	1	MO
IMVEXXY STARTER PACK	1	MO
<i>incassia</i>	1	MO
<i>jencycla</i>	1	MO
<i>jinteli</i>	1	PA; MO
<i>lyleq</i>	1	MO
<i>lyllana</i>	1	PA; MO; QL (8 per 28 days)
<i>lyza</i>	1	
<i>medroxyprogesterone</i>	1	MO
MENEST	1	PA; MO
<i>mimvey</i>	1	PA; MO
<i>nora-be</i>	1	MO
<i>norethindrone (contraceptive)</i>	1	
<i>norethindrone acetate</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	PA; MO
PREMARIN ORAL	1	MO

Drug Name	Drug Tier	Requirements /Limits
PREMARIN VAGINAL	1	MO
PREMPHASE	1	MO
PREMPRO	1	MO
<i>progesterone</i>	1	MO
<i>progesterone micronized</i>	1	MO
<i>sharobel</i>	1	MO
<i>yuvafem</i>	1	
<b>MISCELLANEOUS OB/GYN</b>		
<i>clindamycin phosphate vaginal</i>	1	MO
<i>eluryng</i>	1	MO
<i>etonogestrel-ethinyl estradiol</i>	1	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	1	MO
<i>mifepristone oral tablet 200 mg</i>	1	LA
MYFEMBREE	1	PA; MO
NEXPLANON	1	
<i>norelgestromin-ethin.estradiol</i>	1	
<i>terconazole</i>	1	MO
<i>tranexamic acid oral</i>	1	MO
<i>vandazole</i>	1	MO
<i>xulane</i>	1	
<i>zafemy</i>	1	MO
<b>ORAL CONTRACEPTIVES / RELATED AGENTS</b>		
<i>altavera (28)</i>	1	MO
<i>alyacen 1/35 (28)</i>	1	MO
<i>alyacen 7/7/7 (28)</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>amethyst (28)</i>	1	MO
<i>apri</i>	1	MO
<i>aranelle (28)</i>	1	MO
<i>aubra eq</i>	1	MO
<i>aviane</i>	1	MO
<i>azurette (28)</i>	1	MO
<i>camrese</i>	1	MO
<i>cryselle (28)</i>	1	MO
<i>cyred eq</i>	1	MO
<i>dasetta 1/35 (28)</i>	1	MO
<i>dasetta 7/7/7 (28)</i>	1	MO
<i>daysee</i>	1	MO
<i>desog- e.estradiol/e.estradiol</i>	1	
<i>desogestrel-ethinyl estradiol</i>	1	
<i>drospirenone- e.estradiol-lm.fa oral tablet 3-0.03- 0.451 mg (21) (7)</i>	1	MO
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg</i>	1	MO
<i>drospirenone-ethinyl estradiol oral tablet 3-0.03 mg</i>	1	
<i>elinest</i>	1	MO
<i>enpresse</i>	1	MO
<i>enskyce</i>	1	MO
<i>estarylla</i>	1	MO
<i>ethynodiol diac-eth estradiol</i>	1	
<i>falmina (28)</i>	1	MO
<i>introvale</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>isibloom</i>	1	MO
<i>jasmiel (28)</i>	1	MO
<i>jolessa</i>	1	MO
<i>juleber</i>	1	MO
<i>kalliga</i>	1	
<i>kariva (28)</i>	1	
<i>kelnor 1/35 (28)</i>	1	MO
<i>kelnor 1/50 (28)</i>	1	MO
<i>kurvelo (28)</i>	1	MO
<i>l norgest/e.estradiol- e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	1	
<i>l norgest/e.estradiol- e.estradiol oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	1	MO
<i>larin 1.5/30 (21)</i>	1	MO
<i>larin 1/20 (21)</i>	1	MO
<i>larin 24 fe</i>	1	MO
<i>larin fe 1.5/30 (28)</i>	1	MO
<i>larin fe 1/20 (28)</i>	1	MO
<i>lessina</i>	1	MO
<i>levonest (28)</i>	1	MO
<i>levonorgestrel- ethinyl estradiol oral tablet 0.1-20 mg- mcg</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg, 90-20 mcg (28)</i>	1	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	1	
<i>levonorg-eth estrad triphasic</i>	1	
<i>levora-28</i>	1	MO
<i>loryna (28)</i>	1	MO
<i>low-ogestrel (28)</i>	1	MO
<i>lo-zumandimine (28)</i>	1	MO
<i>lutura (28)</i>	1	MO
<i>marlissa (28)</i>	1	MO
<i>microgestin 1.5/30 (21)</i>	1	MO
<i>microgestin 1/20 (21)</i>	1	MO
<i>microgestin fe 1.5/30 (28)</i>	1	MO
<i>microgestin fe 1/20 (28)</i>	1	MO
<i>mili</i>	1	MO
<i>mono-linyah</i>	1	MO
<i>nikki (28)</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	MO
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.25-35 mg-mcg</i>	1	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)</i>	1	MO
<i>nortrel 0.5/35 (28)</i>	1	MO
<i>nortrel 1/35 (21)</i>	1	MO
<i>nortrel 1/35 (28)</i>	1	MO
<i>nortrel 7/7/7 (28)</i>	1	MO
<i>philith</i>	1	MO
<i>pimtrea (28)</i>	1	MO
<i>portia 28</i>	1	MO
<i>reclipsen (28)</i>	1	MO
<i>setlakin</i>	1	MO
<i>sprintec (28)</i>	1	MO
<i>sronyx</i>	1	MO
<i>syeda</i>	1	MO
<i>tarina 24 fe</i>	1	MO
<i>tarina fe 1-20 eq (28)</i>	1	MO
<i>tilia fe</i>	1	MO
<i>tri-estarylla</i>	1	MO
<i>tri-legest fe</i>	1	MO
<i>tri-linyah</i>	1	MO
<i>tri-lo-estarylla</i>	1	MO
<i>tri-lo-marzia</i>	1	MO
<i>tri-lo-sprintec</i>	1	
<i>tri-sprintec (28)</i>	1	MO
<i>trivora (28)</i>	1	MO
<i>turqoz (28)</i>	1	MO

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This drug list was last updated on 09/24/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>velivet triphasic regimen (28)</i>	1	MO
<i>vestura (28)</i>	1	MO
<i>vienna</i>	1	MO
<i>viorele (28)</i>	1	MO
<i>wera (28)</i>	1	MO
<i>zovia 1-35 (28)</i>	1	MO
<i>zumandimine (28)</i>	1	MO

### OXYTOCICS

<i>methylergonovine oral</i>	1	PA
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## OPHTHALMOLOGY

### ANTIBIOTICS

AZASITE	1	MO
<i>bacitracin ophthalmic (eye)</i>	1	MO
<i>bacitracin-polymyxin b</i>	1	MO
BESIVANCE	1	MO
<i>ciprofloxacin hcl ophthalmic (eye)</i>	1	MO
<i>erythromycin ophthalmic (eye)</i>	1	MO; QL (3.5 per 14 days)
<i>gatifloxacin</i>	1	MO
<i>gentamicin ophthalmic (eye) drops</i>	1	MO; QL (70 per 30 days)
<i>levofloxacin ophthalmic (eye)</i>	1	
<i>moxifloxacin ophthalmic (eye) drops</i>	1	MO
<i>moxifloxacin ophthalmic (eye) drops, viscous</i>	1	

Drug Name	Drug Tier	Requirements /Limits
NATACYN	1	
<i>neomycin-bacitracin-polymyxin</i>	1	MO
<i>neomycin-polymyxin-gramicidin</i>	1	MO
<i>neo-polycin</i>	1	
<i>ofloxacin ophthalmic (eye)</i>	1	MO
<i>polycin</i>	1	
<i>polymyxin b sulf-trimethoprim</i>	1	MO
<i>tobramycin ophthalmic (eye)</i>	1	MO; QL (10 per 14 days)

**ANTIVIRALS**

<i>trifluridine</i>	1	MO
ZIRGAN	1	MO

**BETA-BLOCKERS**

<i>betaxolol ophthalmic (eye)</i>	1	MO
<i>carteolol</i>	1	MO
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	1	MO
<i>timolol maleate ophthalmic (eye) drops</i>	1	MO
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	1	MO

**MISCELLANEOUS OPHTHALMOLOGICS**

<i>atropine ophthalmic (eye) drops 1 %</i>	1	MO
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Drug Name	Drug Tier	Requirements /Limits
<i>azelastine ophthalmic (eye)</i>	1	MO
<i>bepotastine besilate</i>	1	MO
<i>bss</i>	1	
CIMERLI	1	PA; MO
<i>cromolyn ophthalmic (eye)</i>	1	MO
<i>cyclosporine ophthalmic (eye)</i>	1	MO; QL (60 per 30 days)
CYSTARAN	1	PA
<i>epinastine</i>	1	MO
EYLEA	1	PA; MO
MIEBO (PF)	1	MO
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	1	MO
OXERVATE	1	PA; MO
PHOSPHOLINE IODIDE	1	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	MO
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	1	MO
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	1	
<i>sulfacetamide-prednisolone</i>	1	MO
XDEMVI	1	PA; QL (10 per 42 days)
XIIDRA	1	MO; QL (60 per 30 days)
<b>NON-STEROIDAL ANTI-INFLAMMATORY AGENTS</b>		

Drug Name	Drug Tier	Requirements /Limits
<i>bromfenac</i>	1	MO
BROMSITE	1	MO
<i>diclofenac sodium ophthalmic (eye)</i>	1	MO
<i>flurbiprofen sodium</i>	1	MO
<i>ketorolac ophthalmic (eye)</i>	1	MO
PROLENSA	1	MO
<b>ORAL DRUGS FOR GLAUCOMA</b>		
<i>acetazolamide</i>	1	MO
<i>acetazolamide sodium</i>	1	MO
<i>methazolamide</i>	1	MO
<b>OTHER GLAUCOMA DRUGS</b>		
<i>brimonidine-timolol</i>	1	MO
<i>dorzolamide</i>	1	
<i>dorzolamide-timolol</i>	1	MO
<i>latanoprost</i>	1	MO
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	1	MO
<i>miostat</i>	1	
RHOPRESSA	1	
ROCKLATAN	1	
SIMBRINZA	1	MO
<i>tafluprost (pf)</i>	1	MO
<i>travoprost</i>	1	MO
<b>STEROID-ANTIBIOTIC COMBINATIONS</b>		
<i>neomycin-bacitracin-poly-hc</i>	1	MO
<i>neomycin-polymyxin b-dexameth</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	1	MO
<i>neo-polycin hc</i>	1	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	1	MO; QL (3.5 per 14 days)
<i>tobramycin-dexamethasone</i>	1	MO; QL (10 per 14 days)

### STEROIDS

ALREX	1	MO
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	1	MO
<i>fluorometholone</i>	1	MO
INVELTYS	1	MO
<i>loteprednol etabonate</i>	1	MO
OZURDEX	1	MO
<i>prednisolone acetate</i>	1	MO
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	1	MO

### SYMPATHOMIMETICS

<i>apraclonidine</i>	1	MO
<i>brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %</i>	1	MO
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	1	MO

## RESPIRATORY AND ALLERGY

### ANTI-HISTAMINE / ANTI-ALLERGENIC AGENTS

Drug Name	Drug Tier	Requirements /Limits
<i>adrenalin injection solution 1 mg/ml</i>	1	
<i>adrenalin injection solution 1 mg/ml (1 ml)</i>	1	MO
<i>cetirizine oral solution 1 mg/ml</i>	1	MO
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	1	MO
<i>diphenhydramine hcl injection syringe</i>	1	MO
<i>diphenhydramine hcl oral elixir</i>	1	PA
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)</i>	1	MO; QL (2 per 30 days)
<i>epinephrine injection solution 1 mg/ml</i>	1	
<i>hydroxyzine hcl oral tablet</i>	1	PA; MO
<i>levocetirizine oral solution</i>	1	MO
<i>levocetirizine oral tablet</i>	1	MO; QL (30 per 30 days)
<i>promethazine injection solution</i>	1	MO
<i>promethazine oral</i>	1	PA; MO

### PULMONARY AGENTS

<i>acetylcysteine</i>	1	B/D PA; MO
ADEMPAS	1	PA; MO; LA
ADVAIR HFA	1	MO; QL (12 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	1	MO; QL (17 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation package size 6.7 gm</i>	1	QL (13.4 per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml</i>	1	B/D PA; MO
<i>albuterol sulfate inhalation solution for nebulization 5 mg/ml</i>	1	B/D PA
<i>albuterol sulfate oral syrup</i>	1	MO
<i>albuterol sulfate oral tablet</i>	1	MO
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	1	MO; QL (12.2 per 30 days)
ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	1	MO; QL (6.1 per 30 days)
<i>alyq</i>	1	PA; QL (60 per 30 days)
<i>ambrisentan</i>	1	PA; MO; LA
<i>arformoterol</i>	1	B/D PA; MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ASMANEX HFA	1	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	1	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	1	MO; QL (2 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (14)	1	QL (2 per 28 days)
ATROVENT HFA	1	MO; QL (25.8 per 30 days)
BEVESPI AEROSPHERE	1	MO; QL (10.7 per 30 days)
<i>bosentan</i>	1	PA; MO; LA
BREO ELLIPTA	1	MO; QL (60 per 30 days)
<i>breyana</i>	1	MO; QL (10.3 per 30 days)
BREZTRI AEROSPHERE	1	MO; QL (10.7 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	1	B/D PA; MO; QL (120 per 30 days)
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	1	B/D PA; MO; QL (60 per 30 days)
<i>budesonide-formoterol</i>	1	QL (10.2 per 30 days)
CINRYZE	1	PA; MO
COMBIVENT RESPIMAT	1	QL (8 per 30 days)
<i>cromolyn inhalation</i>	1	B/D PA; MO
DULERA	1	MO; QL (13 per 30 days)
ELIXOPHYLLIN	1	
FASENRA PEN	1	PA; MO; QL (1 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	1	PA; MO; QL (1 per 28 days)
<i>flunisolide</i>	1	MO; QL (50 per 30 days)
<i>fluticasone propionate nasal</i>	1	MO; QL (16 per 30 days)
<i>fluticasone propionate-salmeterol inhalation blister with device</i>	1	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>formoterol fumarate</i>	1	B/D PA; MO; QL (120 per 30 days)
<i>icatibant</i>	1	PA; MO
<i>ipratropium bromide inhalation</i>	1	B/D PA; MO
<i>ipratropium-albuterol</i>	1	B/D PA; MO
KALYDECO	1	PA; MO; QL (56 per 28 days)
<i>levalbuterol hcl</i>	1	B/D PA; MO
<i>mometasone nasal</i>	1	MO; QL (34 per 30 days)
<i>montelukast oral granules in packet</i>	1	MO
<i>montelukast oral tablet</i>	1	MO
<i>montelukast oral tablet, chewable</i>	1	MO
NUCALA SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	1	PA; MO; LA; QL (0.4 per 28 days)
OFEV	1	PA; MO; QL (60 per 30 days)
OPSUMIT	1	PA; MO; LA

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Drug Name	Drug Tier	Requirements /Limits
OPSYNVI	1	PA; MO; QL (30 per 30 days)
ORKAMBI ORAL GRANULES IN PACKET	1	PA; MO; QL (56 per 28 days)
ORKAMBI ORAL TABLET	1	PA; MO; QL (112 per 28 days)
<i>pirfenidone oral capsule</i>	1	PA; MO; QL (270 per 30 days)
<i>pirfenidone oral tablet 267 mg</i>	1	PA; MO; QL (270 per 30 days)
<i>pirfenidone oral tablet 801 mg</i>	1	PA; MO; QL (90 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	1	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	1	MO; QL (1 per 30 days)
PULMOZYME	1	B/D PA; MO
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	1	QL (10.6 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	1	QL (21.2 per 30 days)
<i>roflumilast</i>	1	PA; MO; QL (30 per 30 days)
<i>sajazir</i>	1	PA; MO
<i>sildenafil (pulmonary arterial hypertension) intravenous solution 10 mg/12.5 ml</i>	1	PA
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; MO; QL (90 per 30 days)
SPIRIVA RESPIMAT	1	MO; QL (4 per 30 days)
STIOLTO RESPIMAT	1	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	1	MO; QL (4 per 30 days)
SYMDEKO	1	PA; MO; QL (56 per 28 days)
<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; QL (60 per 30 days)
<i>terbutaline oral</i>	1	MO
<i>terbutaline subcutaneous</i>	1	MO
THEO-24	1	MO
<i>theophylline oral elixir</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>theophylline oral solution</i>	1	
<i>theophylline oral tablet extended release 12 hr</i>	1	MO
<i>theophylline oral tablet extended release 24 hr</i>	1	MO
<i>tiotropium bromide</i>	1	QL (90 per 90 days)
TRELEGY ELLIPTA	1	MO; QL (60 per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	1	PA; MO; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	1	PA; MO; QL (84 per 28 days)
TYVASO	1	B/D PA; MO
TYVASO INSTITUTIONAL START KIT	1	B/D PA
TYVASO REFILL KIT	1	B/D PA; MO
TYVASO STARTER KIT	1	B/D PA; MO
<i>wixela inhub</i>	1	QL (60 per 30 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	1	PA; MO; LA; QL (1 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
XOLAIR SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	1	PA; MO; LA; QL (1 per 28 days)
<i>zafirlukast</i>	1	MO

## UROLOGICALS

### ANTICHOLINERGICS / ANTISPASMODICS

<i>fesoterodine</i>	1	MO
<i>flavoxate</i>	1	MO
<i>mirabegron</i>	1	MO
MYRBETRIQ ORAL SUSPENSION, EXTENDED REL RECON	1	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	1	MO
<i>oxybutynin chloride oral syrup</i>	1	MO
<i>oxybutynin chloride oral tablet 5 mg</i>	1	MO
<i>oxybutynin chloride oral tablet extended release 24hr</i>	1	MO
<i>solifenacin</i>	1	MO
<i>tolterodine</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>trosipium oral tablet</i>	1	MO
<b>BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY</b>		
<i>alfuzosin</i>	1	MO
<i>dutasteride</i>	1	MO
<i>dutasteride-tamsulosin</i>	1	MO
<i>finasteride oral tablet 5 mg</i>	1	MO
<i>silodosin</i>	1	MO
<i>tamsulosin</i>	1	MO
<b>MISCELLANEOUS UROLOGICALS</b>		
<i>bethanechol chloride</i>	1	MO
CYSTAGON	1	PA; LA
ELMIRON	1	MO
<i>glycine urologic</i>	1	
<i>glycine urologic solution</i>	1	
K-PHOS NO 2	1	MO
K-PHOS ORIGINAL	1	MO
<i>potassium citrate oral tablet extended release</i>	1	MO
RENACIDIN	1	MO
<b>VITAMINS, HEMATINICS / ELECTROLYTES</b>		
<b>BLOOD DERIVATIVES</b>		
<i>albumin, human 25 %</i>	1	
<i>alburx (human) 25 %</i>	1	
<i>alburx (human) 5 %</i>	1	
<i>albutein 25 %</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>albutein 5 %</i>	1	
<b>ELECTROLYTES</b>		
<i>calcium acetate(phosphat bind)</i>	1	MO; QL (360 per 30 days)
<i>calcium chloride</i>	1	
<i>calcium gluconate intravenous</i>	1	
<i>effer-k oral tablet, effervescent 25 meq</i>	1	MO
<i>klor-con 10</i>	1	MO
<i>klor-con 8</i>	1	MO
<i>klor-con m10</i>	1	MO
<i>klor-con m15</i>	1	MO
<i>klor-con m20</i>	1	MO
<i>klor-con oral packet 20</i>	1	MO
<i>klor-con/ef</i>	1	MO
<i>lactated ringers intravenous</i>	1	MO
<i>magnesium chloride injection</i>	1	
MAGNESIUM SULFATE IN D5W INTRAVENOUS PIGGYBACK 1 GRAM/100 ML	1	
<i>magnesium sulfat in water</i>	1	
<i>magnesium sulfat injection solution</i>	1	MO
<i>magnesium sulfat injection syringe</i>	1	
<i>potassium acetate</i>	1	
<i>potassium chlorid-d5-0.45%nacl</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	1	
<i>potassium chloride in 5 % dex intravenous parenteral solution 10 meq/l, 20 meq/l</i>	1	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 10 meq/50 ml, 20 meq/100 ml, 20 meq/50 ml, 40 meq/100 ml</i>	1	
<i>potassium chloride intravenous</i>	1	
<i>potassium chloride oral capsule, extended release</i>	1	MO
<i>potassium chloride oral liquid</i>	1	MO
<i>potassium chloride oral packet</i>	1	
<i>potassium chloride oral tablet extended release 10 meq, 8 meq</i>	1	MO
<i>potassium chloride oral tablet extended release 20 meq</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride oral tablet,er particles/crystals 10 meq</i>	1	MO
<i>potassium chloride oral tablet,er particles/crystals 15 meq, 20 meq</i>	1	
<i>potassium chloride-0.45 % nacl</i>	1	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride-d5-0.9%nacl</i>	1	
<i>potassium phosphate m-/d-basic intravenous solution 3 mmol/ml</i>	1	
<i>ringer's intravenous</i>	1	
<i>sodium acetate</i>	1	
<i>sodium bicarbonate intravenous</i>	1	
<i>sodium chloride 0.45 % intravenous</i>	1	MO
<i>sodium chloride 3 % hypertonic</i>	1	
<i>sodium chloride 5 % hypertonic</i>	1	MO
<i>sodium chloride intravenous</i>	1	
<i>sodium phosphate</i>	1	MO
<b>MISCELLANEOUS NUTRITION PRODUCTS</b>		

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Drug Name	Drug Tier	Requirements /Limits
CLINIMIX 5%/D15W SULFITE FREE	1	B/D PA
CLINIMIX 4.25%/D10W SULF FREE	1	B/D PA
CLINIMIX 5%-D20W(SULFITE-FREE)	1	B/D PA
CLINIMIX 6%-D5W (SULFITE-FREE)	1	B/D PA
CLINIMIX 8%-D10W(SULFITE-FREE)	1	B/D PA
CLINIMIX 8%-D14W(SULFITE-FREE)	1	B/D PA
<i>electrolyte-148</i>	1	
<i>electrolyte-48 in d5w</i>	1	
<i>electrolyte-a</i>	1	
<i>intralipid intravenous emulsion 20 %</i>	1	B/D PA

Drug Name	Drug Tier	Requirements /Limits
ISOLYTE S PH 7.4	1	
ISOLYTE-P IN 5 % DEXTROSE	1	
ISOLYTE-S	1	
PLASMA-LYTE A	1	
PLENAMINE	1	B/D PA
<i>premasol 10 %</i>	1	B/D PA
<i>travasol 10 %</i>	1	B/D PA
TROPHAMINE 10 %	1	B/D PA
<b>VITAMINS / HEMATINICS</b>		
<i>fluoride (sodium) oral tablet</i>	1	MO
<i>fluoride (sodium) oral tablet,chewable 1 mg (2.2 mg sod. fluoride)</i>	1	MO
<i>prenatal vitamin oral tablet</i>	1	MO
<i>wescap-pn dha</i>	1	MO

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**1-800-711-5519 (TTY 711)**

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**Email: [Section1557Coordinator@bcbsla.com](mailto:Section1557Coordinator@bcbsla.com)**

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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)

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