



Blue adVantage (HMO) - 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

CONTACT CUSTOMER SERVICE

1-866-508-7145 TTY 711

This formulary was updated on 11/19/2024. 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.

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.

Blue Cross and Blue Shield of Louisiana is an independent licensee
of the Blue Cross Blue Shield Association.

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 11/19/2024. 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 11/19/2024. 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 96. 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 96.

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
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
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 oral</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
ANTIVIRALS		
<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
APTIVUS	1	MO
<i>atazanavir</i>	1	MO
BARACLUDGE 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
DESCOVY	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 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
DOVATO	1	MO
EDURANT	1	MO
<i>efavirenz oral tablet</i>	1	MO
<i>efavirenz-emtricitabin-tenofov</i>	1	MO
<i>efavirenz-lamivu-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
<i>ganciclovir sodium intravenous recon soln</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
<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 30 days)
<i>lamivudine</i>	1	MO
<i>lamivudine-zidovudine</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 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<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 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	1	QL (30 per 30 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
PREZISTA ORAL TABLET 150 MG, 75 MG	1	MO

Drug Name	Drug Tier	Requirements /Limits
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
TROGARZO	1	MO; LA
<i>valacyclovir oral tablet 1 gram</i>	1	MO; QL (120 per 30 days)

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 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<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
CEPHALOSPORINS		
<i>cefaclor oral capsule</i>	1	MO
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml</i>	1	MO
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml, 375 mg/5 ml</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<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
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>cefoxitin intravenous recon soln 10 gram</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.

This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<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
<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

Drug Name	Drug Tier	Requirements /Limits
ERYTHROMYCINS / OTHER MACROLIDES		
<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
MISCELLANEOUS ANTIINFECTIVES		
<i>albendazole</i>	1	MO
<i>amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml</i>	1	PA; 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 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
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
EMVERM	1	MO
<i>ertapenem</i>	1	PA; MO; QL (14 per 14 days)
<i>ethambutol</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<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
<i>mefloquine</i>	1	
<i>meropenem intravenous recon soln 1 gram</i>	1	PA; QL (30 per 10 days)

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Drug Name	Drug Tier	Requirements /Limits
<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
TOBI PODHALER	1	MO; QL (224 per 56 days)

Drug Name	Drug Tier	Requirements /Limits
<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)
<i>vancomycin intravenous recon soln 5 gram</i>	1	PA; QL (4 per 10 days)

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Drug Name	Drug Tier	Requirements /Limits
<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)
PENICILLINS		
<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
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<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
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	1	MO

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Drug Name	Drug Tier	Requirements /Limits
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
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

Drug Name	Drug Tier	Requirements /Limits
<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
QUINOLONES		
<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, microcap sule recon 500 mg/5 ml</i>	1	
<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

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Drug Name	Drug Tier	Requirements /Limits
<i>levofloxacin oral tablet</i>	1	MO
<i>moxifloxacin oral</i>	1	MO
<i>moxifloxacin-sod.chloride(iso)</i>	1	PA; MO
SULFA'S / RELATED AGENTS		
<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
TETRACYCLINES		
<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
<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

Drug Name	Drug Tier	Requirements /Limits
<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
URINARY TRACT AGENTS		
<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		
ADJUNCTIVE AGENTS		
<i>dexrazoxane hcl</i>	1	B/D PA; MO
ELITEK	1	MO
KEPIVANCE INTRAVENOUS RECON SOLN 5.16 MG	1	

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Drug Name	Drug Tier	Requirements /Limits
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

ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS

<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)
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)

Drug Name	Drug Tier	Requirements /Limits
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 ORAL CAPSULE 40 MG	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
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

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Drug Name	Drug Tier	Requirements /Limits
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)
CALQUENCE	1	PA; LA; QL (60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	1	PA; LA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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)
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

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Drug Name	Drug Tier	Requirements /Limits
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
DARZALEX	1	B/D PA; MO; LA
<i>dasatinib oral tablet 100 mg, 140 mg, 50 mg, 80 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>dasatinib oral tablet 20 mg, 70 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>daunorubicin</i>	1	B/D PA

Drug Name	Drug Tier	Requirements /Limits
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
ELIGARD	1	PA; MO
ELIGARD (3 MONTH)	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
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
<i>everolimus (antineoplastic) oral tablet</i>	1	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<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
<i>fludarabine intravenous solution</i>	1	B/D PA

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Drug Name	Drug Tier	Requirements /Limits
<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
<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

Drug Name	Drug Tier	Requirements /Limits
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)
<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)

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Drug Name	Drug Tier	Requirements /Limits
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
<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)

Drug Name	Drug Tier	Requirements /Limits
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)
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)

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
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)
LAZCLUZE ORAL TABLET 240 MG	1	PA; LA; QL (30 per 30 days)
LAZCLUZE ORAL TABLET 80 MG	1	PA; LA; QL (60 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 X2), 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 ORAL TABLET 120 MG, 320 MG	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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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 (1260 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
<i>octreotide, microspheres</i>	1	PA
ODOMZO	1	PA; MO; LA; QL (30 per 30 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	1	PA; QL (56 per 28 days)
OGSIVEO ORAL TABLET 50 MG	1	PA; QL (180 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

Drug Name	Drug Tier	Requirements /Limits
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)
<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

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Drug Name	Drug Tier	Requirements /Limits
<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
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)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	1	PA; MO; LA; QL (60 per 30 days)
RETEVMO ORAL TABLET 40 MG	1	PA; MO; LA; QL (90 per 30 days)
REVLIMID	1	PA; MO; LA; QL (28 per 28 days)
REZLIDHIA	1	PA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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)
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
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)

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Drug Name	Drug Tier	Requirements /Limits
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
<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)

Drug Name	Drug Tier	Requirements /Limits
TAGRISSEO	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)
TASIGNA ORAL CAPSULE 50 MG	1	PA; MO; QL (120 per 30 days)
TAZVERIK	1	PA; LA
TECENTRIQ	1	B/D PA; MO; LA
TECENTRIQ HYBREZA	1	B/D PA; LA
TECVAYLI	1	PA
TEMODAR INTRAVENOUS	1	B/D PA; MO
<i>temsirolimus</i>	1	B/D PA; MO
TEPMETKO	1	PA; LA
TEVIMBRA	1	PA
THALOMID ORAL CAPSULE 100 MG	1	PA; MO; QL (112 per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	1	PA; QL (56 per 28 days)
THALOMID ORAL CAPSULE 50 MG	1	PA; MO; QL (28 per 28 days)
<i>thiotepa injection recon soln 100 mg</i>	1	B/D PA

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Drug Name	Drug Tier	Requirements /Limits
<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
<i>torpenz</i>	1	PA; QL (30 per 30 days)
TRAZIMERA	1	B/D PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	PA; MO
<i>tretinoin (antineoplastic)</i>	1	MO
TRODELVY	1	PA; LA
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)

Drug Name	Drug Tier	Requirements /Limits
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)
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)
VORANIGO ORAL TABLET 10 MG	1	PA; QL (60 per 30 days)
VORANIGO ORAL TABLET 40 MG	1	PA; QL (30 per 30 days)
VOTRIENT	1	PA; MO; QL (120 per 30 days)
VYXEOS	1	B/D PA
WELIREG	1	PA; LA

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Drug Name	Drug Tier	Requirements /Limits
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)
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)

Drug Name	Drug Tier	Requirements /Limits
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

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

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Drug Name	Drug Tier	Requirements /Limits
<i>carbamazepine oral suspension 100 mg/5 ml</i>	1	MO
<i>carbamazepine oral suspension 100 mg/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 100 mg</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)
<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

Drug Name	Drug Tier	Requirements /Limits
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)
<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)

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Drug Name	Drug Tier	Requirements /Limits
<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)
<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

Drug Name	Drug Tier	Requirements /Limits
<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
<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

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Drug Name	Drug Tier	Requirements /Limits
<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
<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

Drug Name	Drug Tier	Requirements /Limits
<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
<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

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<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)
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)

Drug Name	Drug Tier	Requirements /Limits
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
<i>carbidopa-levodopa oral tablet, disintegrating</i>	1	
<i>carbidopa-levodopa-entacapone</i>	1	MO
<i>entacapone</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
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
<i>naratriptan</i>	1	MO; QL (18 per 28 days)
NURTEC ODT	1	PA; QL (16 per 30 days)

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

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Drug Name	Drug Tier	Requirements /Limits
<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
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	1	MO
<i>galantamine oral solution</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<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
NAMZARIC ORAL CAP, SPRINKLE, ER 24HR DOSE PACK	1	PA
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
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)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
<i>baclofen oral tablet</i>	1	MO
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	1	PA; MO
<i>dantrolene intravenous</i>	1	
<i>dantrolene oral</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
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
NARCOTIC ANALGESICS		
<i>acetaminophen-codeine oral solution 120 mg-12 mg /5 ml (5 ml), 300 mg-30 mg /12.5 ml</i>	1	QL (4500 per 30 days)
<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	

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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, 600 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 10-325 mg/15 ml</i>	1	QL (5550 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)

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<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 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)

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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)

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)

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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, 600 mg, 800 mg</i>	1	MO
<i>meloxicam oral tablet</i>	1	MO; QL (30 per 30 days)
<i>nabumetone</i>	1	MO
<i>nalbuphine</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<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)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	1	MO; QL (60 per 30 days)

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
PSYCHOTHERAPEUTIC DRUGS		
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)

Drug Name	Drug Tier	Requirements /Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	1	MO; QL (1.6 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	1	MO; QL (2.4 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	1	MO; QL (3.2 per 28 days)
<i>armodafinil</i>	1	PA; MO; QL (30 per 30 days)
<i>asenapine maleate</i>	1	MO; QL (60 per 30 days)
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	1	MO; QL (60 per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	1	MO; QL (30 per 30 days)
AUVELITY	1	ST; QL (60 per 30 days)
BELSOMRA	1	PA; QL (30 per 30 days)
<i>bupropion hcl oral tablet</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	1	MO; QL (90 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	1	MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	1	MO; QL (60 per 30 days)
<i>bupropion</i>	1	MO
CAPLYTA	1	MO; QL (30 per 30 days)
<i>chlorpromazine injection</i>	1	MO
<i>chlorpromazine oral</i>	1	MO
<i>citalopram oral solution</i>	1	MO
<i>citalopram oral tablet</i>	1	MO; QL (30 per 30 days)
<i>clomipramine</i>	1	MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	1	MO
<i>clorazepate dipotassium oral tablet 15 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>clozapine oral tablet</i>	1	
<i>clozapine oral tablet, disintegrating</i>	1	
COBENFY	1	QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
COBENFY STARTER PACK	1	QL (56 per 180 days)
<i>desipramine</i>	1	MO
<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)

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Drug Name	Drug Tier	Requirements /Limits
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	MO; QL (90 per 30 days)
<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 (pmdd) oral tablet 10 mg</i>	1	QL (240 per 30 days)
<i>fluoxetine (pmdd) 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)

Drug Name	Drug Tier	Requirements /Limits
<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<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

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>haloperidol lactate intramuscular</i>	1	
<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)

Drug Name	Drug Tier	Requirements /Limits
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	1	MO; QL (0.5 per 28 days)
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</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)

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Drug Name	Drug Tier	Requirements /Limits
<i>lurasidone oral tablet 80 mg</i>	1	MO; QL (60 per 30 days)
MARPLAN	1	MO
<i>methylphenidate hcl oral capsule,er biphasic 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)

Drug Name	Drug Tier	Requirements /Limits
<i>olanzapine intramuscular</i>	1	MO
<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)

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)
<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)

Drug Name	Drug Tier	Requirements /Limits
<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)
<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

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Drug Name	Drug Tier	Requirements /Limits
TRINTELLIX	1	QL (30 per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 100 MG/0.28 ML	1	MO; QL (0.28 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 125 MG/0.35 ML	1	MO; QL (0.35 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 150 MG/0.42 ML	1	MO; QL (0.42 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 200 MG/0.56 ML	1	MO; QL (0.56 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 250 MG/0.7 ML	1	MO; QL (0.7 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 50 MG/0.14 ML	1	MO; QL (0.14 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
UZEDY SUBCUTANEOUS SUSPENSION,EXT ENDED REL SYRING 75 MG/0.21 ML	1	MO; QL (0.21 per 28 days)
<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)

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Drug Name	Drug Tier	Requirements /Limits
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	1	MO; QL (2 per 28 days)

ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	1	MO; QL (1 per 28 days)
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CARDIOVASCULAR, HYPERTENSION / LIPIDS

ANTIARRHYTHMIC AGENTS

<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	

Drug Name	Drug Tier	Requirements /Limits
<i>mexiletine</i>	1	MO
MULTAQ	1	MO
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	1	MO

<i>procainamide injection</i>	1	
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<i>propafenone oral capsule, extended release 12 hr</i>	1	MO
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<i>propafenone oral tablet</i>	1	MO
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<i>quinidine sulfate oral tablet</i>	1	MO
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<i>sorine oral tablet 120 mg</i>	1	
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<i>sorine oral tablet 160 mg</i>	1	MO
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<i>sotalol af</i>	1	
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<i>sotalol oral</i>	1	MO
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ANTIHYPERTENSIVE THERAPY

<i>acebutolol</i>	1	MO
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<i>aliskiren</i>	1	MO
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<i>amiloride</i>	1	MO
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<i>amiloride- hydrochlorothiazide</i>	1	MO
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<i>amlodipine</i>	1	MO
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<i>amlodipine- benazepril</i>	1	MO
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<i>amlodipine- olmesartan</i>	1	MO
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<i>amlodipine- valsartan</i>	1	MO
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<i>amlodipine- valsartan-hctiazid</i>	1	MO
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Drug Name	Drug Tier	Requirements /Limits
<i>atenolol</i>	1	MO
<i>atenolol-chlorthalidone</i>	1	MO
<i>benazepril</i>	1	MO
<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

Drug Name	Drug Tier	Requirements /Limits
<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)
<i>EDARBI</i>	1	MO
<i>EDARBYCLOR</i>	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

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Drug Name	Drug Tier	Requirements /Limits
<i>isosorbide-hydralazine</i>	1	MO; QL (180 per 30 days)
<i>isradipine</i>	1	
KERENDIA	1	PA; QL (30 per 30 days)
<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

Drug Name	Drug Tier	Requirements /Limits
<i>nicardipine intravenous solution</i>	1	
<i>nicardipine oral</i>	1	MO
<i>nifedipine oral tablet extended release</i>	1	MO
<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

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Drug Name	Drug Tier	Requirements /Limits
<i>spironolactone oral tablet</i>	1	MO
<i>spironolacton-hydrochlorothiaz</i>	1	MO
<i>telmisartan</i>	1	MO
<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

Drug Name	Drug Tier	Requirements /Limits
<i>verapamil oral tablet</i>	1	MO
<i>verapamil oral tablet extended release</i>	1	MO
COAGULATION THERAPY		
<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

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Drug Name	Drug Tier	Requirements /Limits
<i>enoxaparin subcutaneous solution</i>	1	MO; QL (30 per 30 days)
<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

Drug Name	Drug Tier	Requirements /Limits
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml</i>	1	MO
<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

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Drug Name	Drug Tier	Requirements /Limits
HEPARIN, PORCINE (PF) INJECTION SYRINGE 5,000 UNIT/ML	1	
HEPARIN, PORCINE (PF) SUBCUTANEOUS	1	MO
<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

Drug Name	Drug Tier	Requirements /Limits
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-40 mg, 10-80 mg</i>	1	MO; QL (30 per 30 days)
<i>ezetimibe-simvastatin oral tablet 10-20 mg</i>	1	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
<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

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

**MISCELLANEOUS
CARDIOVASCULAR AGENTS**

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

Drug Name	Drug Tier	Requirements /Limits
<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
<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	QL (60 per 30 days)
ENTRESTO SPRINKLE	1	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

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Drug Name	Drug Tier	Requirements /Limits
<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
NITRATES		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1	MO
<i>isosorbide mononitrate oral tablet</i>	1	
<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

Drug Name	Drug Tier	Requirements /Limits
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
<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
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)

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Drug Name	Drug Tier	Requirements /Limits
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; MO; QL (0.25 per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
TALTZ SUBCUTANEOUS SYRINGE 80 MG/ML	1	PA; MO; QL (1 per 28 days)
MISCELLANEOUS DERMATOLOGICALS		
ADBRY	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)

Drug Name	Drug Tier	Requirements /Limits
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)
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

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Drug Name	Drug Tier	Requirements /Limits
<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	
<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	MO; QL (15 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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)
VALCHLOR	1	PA; MO
THERAPY FOR ACNE		
<i>accutane</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

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Drug Name	Drug Tier	Requirements /Limits
<i>tazarotene topical cream</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
<i>zenatane</i>	1	

TOPICAL ANTIBACTERIALS

<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

TOPICAL ANTIFUNGALS

<i>ciclofanol topical solution</i>	1	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)

Drug Name	Drug Tier	Requirements /Limits
<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)
<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

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Drug Name	Drug Tier	Requirements /Limits
<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
<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

Drug Name	Drug Tier	Requirements /Limits
<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)
<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

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Drug Name	Drug Tier	Requirements /Limits
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	MO
<i>triderm topical cream</i>	1	
TOPICAL SCABICIDES / PEDICULICIDES		
<i>crotan</i>	1	
<i>malathion</i>	1	MO
<i>permethrin</i>	1	MO; QL (60 per 30 days)
DIAGNOSTICS / MISCELLANEOUS AGENTS		
ANTIDOTES		
<i>acetylcysteine intravenous</i>	1	
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

Drug Name	Drug Tier	Requirements /Limits
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
<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

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Drug Name	Drug Tier	Requirements /Limits
<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	
<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
REVCOVI	1	PA; LA
REZDIFFRA	1	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<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
<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

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Drug Name	Drug Tier	Requirements /Limits
XIAFLEX	1	PA
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml	1	PA; MO

SMOKING DETERRENTS

bupropion hcl (smoking deter)	1	MO
NICOTROL	1	
NICOTROL NS	1	MO
varenicline oral tablet 0.5 mg, 1 mg	1	MO
varenicline oral tablet 1 mg (56 pack)	1	
varenicline oral tablets,dose pack	1	MO

EAR, NOSE / THROAT MEDICATIONS

MISCELLANEOUS AGENTS

azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	1	MO; QL (60 per 30 days)
azelastine nasal spray,non-aerosol 205.5 mcg (0.15 %)	1	QL (60 per 30 days)
chlorhexidine gluconate mucous membrane	1	MO
denta 5000 plus	1	MO
dentagel	1	MO
fluoride (sodium) dental cream	1	
fluoride (sodium) dental gel	1	

Drug Name	Drug Tier	Requirements /Limits
fluoride (sodium) dental paste	1	MO
fraiche 5000	1	
ipratropium bromide nasal	1	MO; QL (30 per 30 days)
kourzeq	1	
oralone	1	
periogard	1	
PREVIDENT 5000 BOOSTER PLUS	1	MO
PREVIDENT 5000 DRY MOUTH	1	MO
sf	1	MO
sf 5000 plus	1	MO
sodium fluoride 5000 dry mouth	1	MO
sodium fluoride 5000 plus	1	
sodium fluoride-pot nitrate	1	MO
triamcinolone acetone dental	1	MO

MISCELLANEOUS OTIC PREPARATIONS

acetic acid otic (ear)	1	MO
ciprofloxacin hcl otic (ear)	1	MO
flac otic oil	1	
fluocinolone acetone oil	1	MO
hydrocortisone-acetic acid	1	MO
ofloxacin otic (ear)	1	MO

OTIC STEROID / ANTIBIOTIC

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Drug Name	Drug Tier	Requirements /Limits
<i>ciprofloxacin-dexamethasone</i>	1	MO; QL (7.5 per 7 days)
<i>neomycin-polymyxin-hc otic (ear)</i>	1	MO

ENDOCRINE/DIABETES

ADRENAL HORMONES

<i>cortisone</i>	1	
<i>dexamethasone intensol</i>	1	MO
<i>dexamethasone oral elixir</i>	1	MO
<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

Drug Name	Drug Tier	Requirements /Limits
<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
<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

ANTITHYROID AGENTS

<i>methimazole oral tablet 10 mg, 5 mg</i>	1	MO
<i>propylthiouracil</i>	1	MO

DIABETES THERAPY

<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)

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Drug Name	Drug Tier	Requirements /Limits
<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)
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)

Drug Name	Drug Tier	Requirements /Limits
<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)
<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

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Drug Name	Drug Tier	Requirements /Limits
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
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)

Drug Name	Drug Tier	Requirements /Limits
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)
<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	MO
NOVOLIN N FLEXPEN	1	MO
NOVOLIN N NPH U-100 INSULIN	1	MO
NOVOLIN R FLEXPEN	1	MO

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Drug Name	Drug Tier	Requirements /Limits
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	MO
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)

Drug Name	Drug Tier	Requirements /Limits
<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)
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)

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Drug Name	Drug Tier	Requirements /Limits
TOUJEO MAX U-300 SOLOSTAR	1	MO
TOUJEO SOLOSTAR U-300 INSULIN	1	MO
TRADJENTA	1	MO; QL (30 per 30 days)
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
MISCELLANEOUS HORMONES		
ALDURAZYME	1	PA; MO
<i>cabergoline</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>calcitonin (salmon) injection</i>	1	MO
<i>calcitonin (salmon) nasal</i>	1	MO
<i>calcitriol intravenous solution 1 mcg/ml</i>	1	
<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

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Drug Name	Drug Tier	Requirements /Limits
<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	
<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)

Drug Name	Drug Tier	Requirements /Limits
<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)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	1	PA; MO; 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
VIMIZIM	1	PA; MO; LA
<i>zoledronic acid intravenous solution</i>	1	B/D PA; MO
THYROID HORMONES		
<i>euthyrox</i>	1	MO
<i>levo-t</i>	1	
<i>levothyroxine intravenous recon soln</i>	1	
<i>levothyroxine oral tablet</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>levoxyl oral tablet</i> 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO
<i>liothyronine</i>	1	MO
SYNTHROID	1	MO
<i>unithroid</i>	1	MO

GASTROENTEROLOGY

ANTIDIARRHEALS / ANTISPASMODICS

<i>atropine injection</i> solution 0.4 mg/ml	1	
<i>atropine injection</i> syringe 0.1 mg/ml	1	
<i>atropine intravenous</i> solution 0.4 mg/ml	1	
<i>atropine intravenous</i> syringe 0.25 mg/5 ml (0.05 mg/ml)	1	
<i>dicyclomine</i> intramuscular	1	MO
<i>dicyclomine oral</i> capsule	1	MO
<i>dicyclomine oral</i> solution	1	MO
<i>dicyclomine oral</i> tablet	1	MO
<i>diphenoxylate- atropine oral liquid</i>	1	MO
<i>diphenoxylate- atropine oral tablet</i>	1	MO
<i>glycopyrrolate (pf)</i> in water intravenous syringe 0.4 mg/2 ml (0.2 mg/ml)	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>glycopyrrolate</i> injection	1	MO
<i>glycopyrrolate oral</i> tablet 1 mg, 2 mg	1	MO
<i>glycopyrrolate oral</i> tablet 1.5 mg	1	
<i>loperamide oral</i> capsule	1	MO
<i>opium tincture</i>	1	MO

MISCELLANEOUS GASTROINTESTINAL AGENTS

<i>alosetron oral tablet</i> 0.5 mg	1	PA; MO
<i>alosetron oral tablet</i> 1 mg	1	PA; MO
<i>aprepitant</i>	1	B/D PA; MO
<i>balsalazide</i>	1	MO
<i>betaine</i>	1	MO
<i>budesonide oral</i> capsule, delayed, exte nd.release	1	MO
<i>budesonide oral</i> tablet, delayed and ext.release	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 POWDER FOR RECONST	1	PA; MO; QL (2 per 28 days)
CIMZIA STARTER KIT	1	PA; MO; QL (3 per 180 days)

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Drug Name	Drug Tier	Requirements /Limits
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	1	PA; MO; QL (2 per 28 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
<i>dimenhydrinate injection solution</i>	1	MO
<i>dronabinol oral capsule 10 mg</i>	1	B/D PA; MO
<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	1	B/D PA
<i>droperidol injection solution</i>	1	MO
EMEND ORAL SUSPENSION FOR RECONSTITUTIO N	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	

Drug Name	Drug Tier	Requirements /Limits
<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
<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

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Drug Name	Drug Tier	Requirements /Limits
<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)
<i>nitroglycerin rectal</i>	1	MO
OICALIVA	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

Drug Name	Drug Tier	Requirements /Limits
<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
<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

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Drug Name	Drug Tier	Requirements /Limits
<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
<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

Drug Name	Drug Tier	Requirements /Limits
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
ZYMFENTRA	1	PA; MO; QL (2 per 28 days)
ULCER THERAPY		
<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

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Drug Name	Drug Tier	Requirements /Limits
<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)
<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

Drug Name	Drug Tier	Requirements /Limits
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)
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)

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
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
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

Drug Name	Drug Tier	Requirements /Limits
ZARXIO	1	PA; MO
ZIEXTENZO	1	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
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
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) INTRAMUSCULA R SYRINGE 1,440 ELISA UNIT/ML	1	V
HAVRIX (PF) INTRAMUSCULA R 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

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
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	
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	

Drug Name	Drug Tier	Requirements /Limits
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
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	

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Drug Name	Drug Tier	Requirements /Limits
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1	V
VARIVAX (PF)	1	V
VARIZIG	1	
VAXCHORA VACCINE	1	V
YF-VAX (PF)	1	V

MISCELLANEOUS SUPPLIES

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

Drug Name	Drug Tier	Requirements /Limits
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
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	1	MO; QL (1 per 720 days)
OMNIPOD 5 G6-G7 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	

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Drug Name	Drug Tier	Requirements /Limits
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

MUSCULOSKELETAL / RHEUMATOLOGY

GOUT THERAPY

<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

OSTEOPOROSIS THERAPY

<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

Drug Name	Drug Tier	Requirements /Limits
<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)
<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)

OTHER RHEUMATOLOGICALS

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)

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
ADALIMUMAB- ADBIM (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)
ADALIMUMAB- ADBIM (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- ADBIM (ONLY NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; QL (4 per 28 days)
ADALIMUMAB- ADBIM (ONLY NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
ADALIMUMAB- ADBIM(CF) PEN CROHNS (ONLY NDCS STARTING WITH 00597)	1	PA; QL (6 per 180 days)
ADALIMUMAB- ADBIM(CF) PEN PS-UV (ONLY NDCS STARTING WITH 00597)	1	PA; QL (4 per 180 days)
BENLYSTA	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
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)
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)

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Drug Name	Drug Tier	Requirements /Limits
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)
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)

Drug Name	Drug Tier	Requirements /Limits
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)
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)

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Drug Name	Drug Tier	Requirements /Limits
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)
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)

Drug Name	Drug Tier	Requirements /Limits
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)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	1	PA; MO; QL (2.8 per 28 days)
OTEZLA	1	PA; MO; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 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)

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Drug Name	Drug Tier	Requirements /Limits
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)
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; MO; QL (3.6 per 28 days)
TYENNE INTRAVENOUS	1	PA; MO; QL (160 per 28 days)
TYENNE SUBCUTANEOUS	1	PA; MO; 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

Drug Name	Drug Tier	Requirements /Limits
<i>dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	1	PA; MO; QL (8 per 28 days)
<i>dotti transdermal patch semiweekly 0.05 mg/24 hr</i>	1	PA; 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)
<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>gallifrey</i>	1	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

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Drug Name	Drug Tier	Requirements /Limits
<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
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	
MISCELLANEOUS OB/GYN		
<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

Drug Name	Drug Tier	Requirements /Limits
<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
ORAL CONTRACEPTIVES / RELATED AGENTS		
<i>altavera (28)</i>	1	MO
<i>alyacen 1/35 (28)</i>	1	MO
<i>alyacen 7/7/7 (28)</i>	1	MO
<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	

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Drug Name	Drug Tier	Requirements /Limits
<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	
<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	

Drug Name	Drug Tier	Requirements /Limits
<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
<i>levonorgestrel-ethinyl estradiol oral tablet 0.15-0.03 mg, 90-20 mcg (28)</i>	1	
<i>levonorgestrel-ethinyl estradiol oral tablets,dose pack,3 month</i>	1	
<i>levonorg-eth estradiol 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

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This drug list was last updated on 11/19/2024.

Drug Name	Drug Tier	Requirements /Limits
<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-lynyah</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	
<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

Drug Name	Drug Tier	Requirements /Limits
<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-lynyah</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
<i>velivet triphasic regimen (28)</i>	1	MO
<i>vestura (28)</i>	1	MO
<i>vienva</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	
<i>bacitracin-polymyxin b</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
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	
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		

Drug Name	Drug Tier	Requirements /Limits
<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
<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	

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Drug Name	Drug Tier	Requirements /Limits
<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)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
<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
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide</i>	1	MO
<i>acetazolamide sodium</i>	1	MO
<i>methazolamide</i>	1	MO
OTHER GLAUCOMA DRUGS		
<i>brimonidine-timolol</i>	1	MO
<i>dorzolamide</i>	1	
<i>dorzolamide-timolol</i>	1	MO
<i>latanoprost</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
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
STEROID-ANTIBIOTIC COMBINATIONS		
<i>neomycin-bacitracin-poly-hc</i>	1	MO
<i>neomycin-polymyxin b-dexameth</i>	1	MO
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	1	MO
<i>neo-polycin hc</i>	1	
TOBRADEX OPTHALMIC (EYE) OINTMENT	1	MO; QL (3.5 per 14 days)
<i>tobramycin-dexamethasone</i>	1	MO; QL (10 per 14 days)
STERIODS		
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

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Drug Name	Drug Tier	Requirements /Limits
<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

<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 (4 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<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)
<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

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Drug Name	Drug Tier	Requirements /Limits
<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)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION , 200 MCG/ACTUATION	1	MO; QL (13 per 30 days)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 50 MCG/ACTUATION	1	QL (13 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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>breynd</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
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
<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
MISCELLANEOUS UROLOGICALS		
<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
VITAMINS, HEMATINICS / ELECTROLYTES		
BLOOD DERIVATIVES		
<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	
ELECTROLYTES		
<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
MISCELLANEOUS NUTRITION PRODUCTS		

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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	

Drug Name	Drug Tier	Requirements /Limits
<i>intralipid intravenous emulsion 20 %</i>	1	B/D PA
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
VITAMINS / HEMATINICS		
<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

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 11/19/2024.

Index

A		
<i>abacavir</i>	9	<i>adrenalin</i>
<i>abacavir-lamivudine</i>	9	ADSTILADRIN.....
ABELCET.....	9	ADVAIR HFA.....
ABILIFY ASIMTUFII.....	42	AIMOVIG AUTOINJECTOR
ABILIFY MAINTENA.....	42	.....
<i>abiraterone</i>	19	AKEEGA.....
ABRAXANE.....	19	<i>ala-cort</i>
ABRYSVO (PF).....	75	<i>albendazole</i>
<i>acamprosate</i>	61	<i>albumin, human 25 %</i>
<i>acarbose</i>	64	<i>alburx (human) 25 %</i>
<i>accutane</i>	58	<i>alburx (human) 5 %</i>
<i>acebutolol</i>	49	<i>albutein 25 %</i>
<i>acetaminophen-codeine</i>	38	<i>albutein 5 %</i>
<i>acetazolamide</i>	87	<i>albuterol sulfate</i>
<i>acetazolamide sodium</i>	87	<i>alclometasone</i>
<i>acetic acid</i>	61, 63	<i>alcohol pads</i>
<i>acetylcysteine</i>	61, 88	ALDURAZYME.....
<i>acitretin</i>	56	ALECENSA.....
ACTEMRA.....	78	<i>alendronate</i>
ACTEMRA ACTPEN.....	78	<i>alfuzosin</i>
ACTHIB (PF).....	75	ALIQOPA.....
ACTIMMUNE.....	74	<i>aliskiren</i>
<i>acyclovir</i>	9, 59	<i>allopurinol</i>
<i>acyclovir sodium</i>	9	<i>allopurinol sodium</i>
ADACEL(TDAP		<i>aloprim</i>
ADOLESN/ADULT)(PF) 75		<i>alose tron</i>
ADALIMUMAB-ADAZ.....	78	ALREX.....
ADALIMUMAB-ADBM		<i>altavera (28)</i>
(ONLY NDCS STARTING		ALUNBRIG.....
WITH 00597).....	79	ALVESCO.....
ADALIMUMAB-ADBM(CF)		<i>alyacen 1/35 (28)</i>
PEN CROHNS (ONLY		<i>alyacen 7/7/7 (28)</i>
NDCS STARTING WITH		<i>alyq</i>
00597).....	79	<i>amantadine hcl</i>
ADALIMUMAB-ADBM(CF)		<i>ambrisentan</i>
PEN PS-UV (ONLY NDCS		<i>amethyst (28)</i>
STARTING WITH 00597)		<i>amikacin</i>
.....	79	<i>amiloride</i>
ADBRY.....	57	<i>amiloride-hydrochlorothiazide</i>
ADCETRIS.....	19	.....
<i>adefovir</i>	9	<i>aminocaproic acid</i>
ADEMPAS.....	88	<i>amiodarone</i>
<i>adenosine</i>	49	<i>amitriptyline</i>
		<i>amlodipine</i>
		<i>amlodipine-atorvastatin</i>
		<i>amlodipine-benazepril</i>
		<i>amlodipine-olmesartan</i>
		<i>amlodipine-valsartan</i>
		<i>amlodipine-valsartan-hcthiazyd</i>
	
		<i>ammonium lactate</i>
		<i>amnestem</i>
		<i>amoxapine</i>
		<i>amoxicillin</i>
		<i>amoxicillin-pot clavulanate</i> ..
		<i>amphotericin b</i>
		<i>ampicillin</i>
		<i>ampicillin sodium</i>
		<i>ampicillin-sulbactam</i>
		<i>anagrelide</i>
		<i>anastrozole</i>
		ANKTIVA.....
		APOKYN.....
		<i>apomorphine</i>
		<i>apraclonidine</i>
		<i>aprepitant</i>
		<i>apri</i>
		APTIOM.....
		APTIVUS.....
		<i>aranelle (28)</i>
		ARCALYST.....
		AREXVY (PF).....
		<i>arformoterol</i>
		ARIKAYCE.....
		<i>aripiprazole</i>
		ARISTADA.....
		ARISTADA INITIO.....
		<i>armodafinil</i>
		<i>arsenic trioxide</i>
		<i>asenapine maleate</i>
		ASMANEX HFA.....
		ASMANEX TWISTHALER.....
		ASPARLAS.....
		<i>aspirin-dipyridamole</i>
		<i>atazanavir</i>
		<i>atenolol</i>
		<i>atenolol-chlorthalidone</i>
		<i>atomoxetine</i>

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 11/19/2024.

<i>atorvastatin</i>	54	<i>betaine</i>	70	<i>bupropion hcl (smoking deter)</i>	
<i>atovaquone</i>	14	<i>betamethasone dipropionate</i>	60	.....	63
<i>atovaquone-proguanil</i>	14	<i>betamethasone valerate</i>	60	<i>buspirone</i>	43
<i>atropine</i>	70, 86	<i>betamethasone, augmented</i> ..	60	<i>busulfan</i>	20
ATROVENT HFA	89	BETASERON.....	74	<i>butorphanol</i>	41
<i>abra eq</i>	83	<i>betaxolol</i>	50, 86	BYDUREON BCISE	65
AUGMENTIN	16	<i>bethanechol chloride</i>	93	BYETTA	65
AUGTYRO.....	19	BEVESPI AEROSPHERE... ..	89	C	
AUVELITY.....	42	<i>bexarotene</i>	19	CABENUVA.....	9
<i>aviane</i>	83	BEXSERO.....	75	<i>cabergoline</i>	68
AVONEX.....	74	<i>bicalutamide</i>	19	CABLIVI.....	52
AYVAKIT.....	19	BICILLIN C-R.....	17	CABOMETYX	20
<i>azacitidine</i>	19	BICILLIN L-A.....	17	<i>caffeine citrate</i>	61
AZASITE	85	BIKTARVY.....	9	<i>calcipotriene</i>	56
<i>azathioprine</i>	19	<i>bisoprolol fumarate</i>	50	<i>calcitonin (salmon)</i>	68
<i>azathioprine sodium</i>	19	<i>bisoprolol-hydrochlorothiazide</i>		<i>calcitriol</i>	56, 68
<i>azelaic acid</i>	58	.....	50	<i>calcium acetate(phosphat bind)</i>	
<i>azelastine</i>	63, 86	<i>bleomycin</i>	19	.....	93
<i>azithromycin</i>	13	BLINCYTO.....	20	<i>calcium chloride</i>	93
<i>aztreonam</i>	14	BOOSTRIX TDAP	75	<i>calcium gluconate</i>	93
<i>azurette (28)</i>	83	<i>bortezomib</i>	20	CALQUENCE.....	20
B		BORTEZOMIB	20	CALQUENCE	
<i>bacitracin</i>	14, 85	<i>bosentan</i>	89	(ACALABRUTINIB MAL)	
<i>bacitracin-polymyxin b</i>	85	BOSULIF	20	.....	20
<i>baclofen</i>	38	BRAFTOVI.....	20	<i>camila</i>	82
<i>balsalazide</i>	70	BREO ELLIPTA.....	89	<i>camrese</i>	83
BALVERSA	19	<i>breyna</i>	89	<i>candesartan</i>	50
BAQSIMI	65	BREZTRI AEROSPHERE ..	89	<i>candesartan-</i>	
BARACLUDE.....	9	BRILINTA	52	<i>hydrochlorothiazid</i>	50
BAVENCIO.....	19	<i>brimonidine</i>	88	CAPLYTA.....	43
BCG VACCINE, LIVE (PF)75		<i>brimonidine-timolol</i>	87	CAPRELSA.....	20
BD INSULIN SYRINGE....	77	BRIUMVI.....	37	<i>captopril</i>	50
BD PEN NEEDLE	77	BRIVIACT	31	<i>captopril-hydrochlorothiazide</i>	
BELBUCA	38	<i>bromfenac</i>	87	.....	50
BELEODAQ.....	19	<i>bromocriptine</i>	35	<i>carbamazepine</i>	31, 32
BELSOMRA	42	BROMSITE.....	87	<i>carbidopa</i>	35
<i>benazepril</i>	50	BRUKINSA.....	20	<i>carbidopa-levodopa</i>	35
<i>benazepril-hydrochlorothiazide</i>		<i>bss</i>	86	<i>carbidopa-levodopa-</i>	
.....	50	<i>budesonide</i>	70, 90	<i>entacapone</i>	35
<i>bendamustine</i>	19	<i>budesonide-formoterol</i>	90	<i>carboplatin</i>	20
BENDEKA	19	<i>bumetanide</i>	50	<i>carglumic acid</i>	61
BENLYSTA	79	<i>buprenorphine hcl</i>	38, 39	<i>carmustine</i>	20
<i>benztropine</i>	35	<i>buprenorphine transdermal</i>		<i>carteolol</i>	86
<i>bepotastine besilate</i>	86	<i>patch</i>	39	<i>cartia xt</i>	50
BESIVANCE.....	86	<i>buprenorphine-naloxone</i>	40	<i>carvedilol</i>	50
BESPONSA.....	19	<i>bupropion hcl</i>	42, 43	<i>caspofungin</i>	9
BESREMI.....	74			CAYSTON	14

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 11/19/2024.

<i>cefactor</i>	12	CIMERLI	86	<i>clonazepam</i>	32
<i>cefadroxil</i>	12	<i>cimetidine</i>	73	<i>clonidine (pf)</i>	41, 50
<i>cefazolin</i>	12	<i>cimetidine hcl</i>	73	<i>clonidine hcl</i>	43, 50
<i>cefazolin in dextrose (iso-os)</i>	12	CIMZIA.....	71	<i>clonidine transdermal patch</i>	50
<i>cefdinir</i>	12	CIMZIA POWDER FOR		<i>clopidogrel</i>	52
<i>cefepime</i>	12	RECONST	70	<i>clorazepate dipotassium</i>	43
<i>cefepime in dextrose, iso-osm</i>	12	CIMZIA STARTER KIT	70	<i>clotrimazole</i>	9, 59
<i>cefixime</i>	12	<i>cinacalcet</i>	68	<i>clotrimazole-betamethasone</i>	59
<i>cefoxitin</i>	12	CINRYZE.....	90	<i>clozapine</i>	43
<i>cefoxitin in dextrose, iso-osm</i>	12	CINVANTI.....	71	COARTEM.....	14
.....	12	<i>ciprofloxacin</i>	17	COBENFY	43
<i>cefpodoxime</i>	13	<i>ciprofloxacin hcl</i>	17, 63, 86	COBENFY STARTER PACK	
<i>cefprozil</i>	13	<i>ciprofloxacin in 5 % dextrose</i>		.....	43
<i>ceftazidime</i>	13	.....	17	<i>colchicine</i>	78
<i>ceftriaxone</i>	13	<i>ciprofloxacin-dexamethasone</i>		<i>colesevelam</i>	54
<i>ceftriaxone in dextrose, iso-os</i>	13	.....	64	<i>colestipol</i>	54
.....	13	<i>cisplatin</i>	20	<i>colistin (colistimethate na)</i> ...	14
<i>cefuroxime axetil</i>	13	<i>citalopram</i>	43	COLUMVI	20
<i>cefuroxime sodium</i>	13	<i>cladribine</i>	20	COMBIVENT RESPIMAT	90
<i>celecoxib</i>	41	<i>claravis</i>	58	COMETRIQ	20
<i>cephalexin</i>	13	<i>clarithromycin</i>	13	COMPLERA	9
CEPROTIN (BLUE BAR)...	52	<i>clindamycin hcl</i>	14	<i>compro</i>	71
CEPROTIN (GREEN BAR)	52	<i>clindamycin in 5 % dextrose</i>	14	<i>constulose</i>	71
CEQR SIMPLICITY	77	<i>clindamycin phosphate</i> .	14, 58,	COPIKTRA.....	20
CEQR SIMPLICITY		83		CORLANOR.....	55
INSERTER	77	CLINIMIX 5%/D15W		CORTIFOAM.....	71
<i>cetirizine</i>	88	SULFITE FREE	95	<i>cortisone</i>	64
<i>cevimeline</i>	61	CLINIMIX 4.25%/D10W		COTELLIC.....	20
CHEMET	61	SULF FREE	95	CREON	71
CHENODAL.....	70	CLINIMIX 4.25%/D5W		CRESEMBA.....	9
<i>chloramphenicol sod succinate</i>		SULFIT FREE	61	<i>cromolyn</i>	71, 86, 90
.....	14	CLINIMIX 5%-		<i>crotan</i>	61
<i>chlorhexidine gluconate</i>	63	D20W(SULFITE-FREE) .	95	<i>cryselle (28)</i>	83
<i>chlorprocaine (pf)</i>	57	CLINIMIX 6%-D5W		CRYSVITA	68
<i>chloroquine phosphate</i>	14	(SULFITE-FREE)	95	<i>cyclobenzaprine</i>	38
<i>chlorothiazide sodium</i>	50	CLINIMIX 8%-		<i>cyclophosphamide</i>	20
<i>chlorpromazine</i>	43	D10W(SULFITE-FREE) .	95	CYCLOPHOSPHAMIDE ...	21
<i>chlorthalidone</i>	50	CLINIMIX 8%-		<i>cyclosporine</i>	21, 86
CHOLBAM.....	70	D14W(SULFITE-FREE) .	95	<i>cyclosporine modified</i>	21
<i>cholestyramine (with sugar)</i> ..	54	<i>clobazam</i>	32	CYLTEZO(CF).....	79
<i>cholestyramine light</i>	54	<i>clobetasol</i>	60	CYLTEZO(CF) PEN.....	79
CIBINQO	57	<i>clobetasol-emollient</i>	60	CYLTEZO(CF) PEN	
<i>ciclodan</i>	59	<i>clodan</i>	60	CROHN'S-UC-HS.....	79
<i>ciclopirox</i>	59	<i>clofarabine</i>	20	CYLTEZO(CF) PEN	
<i>cidofovir</i>	9	<i>clomid</i>	68	PSORIASIS-UV	79
<i>cilostazol</i>	52	<i>clomiphene citrate</i>	68	CYRAMZA	21
CIMDUO.....	9	<i>clomipramine</i>	43	<i>cyred eq</i>	83

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 11/19/2024.

CYSTAGON	93	<i>desipramine</i>	43	<i>dilt-xr</i>	50
CYSTARAN.....	86	<i>desmopressin</i>	68	<i>dimenhydrinate</i>	71
<i>cytarabine</i>	21	<i>desog-e.estradiol/e.estradiol</i> 83		<i>dimethyl fumarate</i>	37
<i>cytarabine (pf)</i>	21	<i>desogestrel-ethinyl estradiol</i> 83		<i>diphenhydramine hcl</i>	88
D		<i>desonide</i>	60	<i>diphenoxylate-atropine</i>	70
<i>d10 %-0.45 % sodium chloride</i>		<i>desvenlafaxine succinate</i>	43	<i>dipyridamole</i>	52
.....	61	<i>dexamethasone</i>	64	<i>disulfiram</i>	62
<i>d2.5 %-0.45 % sodium</i>		<i>dexamethasone intensol</i>	64	<i>divalproex</i>	32
<i>chloride</i>	61	<i>dexamethasone sodium phos</i>		<i>dobutamine</i>	55
<i>d5 % and 0.9 % sodium</i>		<i>(pf)</i>	64	<i>dobutamine in d5w</i>	55
<i>chloride</i>	61	<i>dexamethasone sodium</i>		<i>docetaxel</i>	21
<i>d5 %-0.45 % sodium chloride</i>		<i>phosphate</i>	64, 87	<i>dofetilide</i>	49
.....	61	<i>dextrazoxane hcl</i>	18	<i>donepezil</i>	37
<i>dabigatran etexilate</i>	52	<i>dextroamphetamine-</i>		<i>dopamine</i>	55
<i>dacarbazine</i>	21	<i>amphetamine</i>	43	<i>dopamine in 5 % dextrose</i> ... 55	
<i>dactinomycin</i>	21	<i>dextrose 10 % and 0.2 % nacl</i>		DOPTELET (10 TAB PACK)	
<i>dalfampridine</i>	37	.....	61	.....	52
<i>danazol</i>	68	<i>dextrose 10 % in water (d10w)</i>		DOPTELET (15 TAB PACK)	
<i>dantrolene</i>	38	.....	61	.....	52
DANYELZA	21	<i>dextrose 25 % in water (d25w)</i>		DOPTELET (30 TAB PACK)	
<i>dapsone</i>	14	.....	61	.....	52
DAPTACEL (DTAP		<i>dextrose 5 % in water (d5w)</i> 61		<i>dorzolamide</i>	87
PEDIATRIC) (PF).....	75	<i>dextrose 5 %-lactated ringers</i>		<i>dorzolamide-timolol</i>	87
<i>daptomycin</i>	14	.....	61	<i>dotti</i>	82
DAPTOMYCIN.....	14	<i>dextrose 5%-0.2 % sod</i>		DOVATO.....	10
<i>darunavir</i>	9	<i>chloride</i>	62	<i>doxazosin</i>	50
DARZALEX.....	21	<i>dextrose 5%-0.3 %</i>		<i>doxepin</i>	43
<i>dasatinib</i>	21	<i>sod.chloride</i>	62	<i>doxercalciferol</i>	68
<i>dasetta 1/35 (28)</i>	83	<i>dextrose 50 % in water (d50w)</i>		<i>doxorubicin</i>	21
<i>dasetta 7/7/7 (28)</i>	83	.....	62	<i>doxorubicin, peg-liposomal</i> .21	
<i>daunorubicin</i>	21	<i>dextrose 70 % in water (d70w)</i>		<i>doxy-100</i>	18
DAURISMO.....	21	.....	62	<i>doxycycline hyclate</i>	18
<i>daysee</i>	83	DIACOMIT	32	<i>doxycycline monohydrate</i>	18
<i>deblitane</i>	82	<i>diazepam</i>	32, 43	DRIZALMA SPRINKLE ...	43,
<i>decitabine</i>	21	<i>diazepam intensol</i>	43	44	
<i>deferasirox</i>	61	<i>diazoxide</i>	65	<i>dronabinol</i>	71
<i>deferiprone</i>	61	<i>diclofenac potassium</i>	41	<i>droperidol</i>	71
<i>deferoxamine</i>	61	<i>diclofenac sodium</i> ...	41, 57, 87	DROPSAFE ALCOHOL	
DELSTRIGO	9	<i>diclofenac-misoprostol</i>	41	PREP PADS.....	65
<i>demeclocycline</i>	18	<i>dicloxacillin</i>	17	<i>drospirenone-e.estradiol-lm.fa</i>	
DENG VAXIA (PF).....	75	<i>dicyclomine</i>	70	.....	84
<i>denta 5000 plus</i>	63	DIFICID	13	<i>drospirenone-ethinyl estradiol</i>	
<i>denta gel</i>	63	<i>diflunisal</i>	41	.....	84
DEPO-SUBQ PROVERA 104		<i>digoxin</i>	55	DROXIA	21
.....	82	<i>dihydroergotamine</i>	36	<i>droxidopa</i>	62
<i>dermacinrx lidocan</i>	57	DILANTIN 30 MG	32	DUAVEE	82
DESCOVY	9	<i>diltiazem hcl</i>	50	DULERA.....	90

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 11/19/2024.

<i>duloxetine</i>	44	<i>enalapril maleate</i>	50	<i>esmolol</i>	50
DUPIXENT PEN	57	<i>enalaprilat</i>	50	<i>esomeprazole magnesium</i> ...	73
DUPIXENT SYRINGE.....	57	<i>enalapril-hydrochlorothiazide</i>		<i>esomeprazole sodium</i>	73
<i>dutasteride</i>	93	.....	50	<i>estarylla</i>	84
<i>dutasteride-tamsulosin</i>	93	ENBREL	79	<i>estradiol</i>	82
E		ENBREL MINI.....	79	<i>estradiol valerate</i>	82
<i>e.e.s. 400</i>	13	ENBREL SURECLICK.....	79	<i>estradiol-norethindrone acet</i>	82
<i>ec-naproxen</i>	41	ENDARI.....	62	<i>eszopiclone</i>	44
<i>econazole</i>	59	<i>endocet</i>	39	<i>ethacrynate sodium</i>	50
EDARBI.....	50	ENGERIX-B (PF)	75	<i>ethambutol</i>	14
EDARBYCLOR	50	ENGERIX-B PEDIATRIC		<i>ethosuximide</i>	32
EDURANT.....	10	(PF)	75	<i>ethynodiol diac-eth estradiol</i>	84
<i>efavirenz</i>	10	<i>enoxaparin</i>	53	<i>etodolac</i>	41
<i>efavirenz-emtricitabin-tenofov</i>		<i>enpresse</i>	84	<i>etonogestrel-ethinyl estradiol</i>	
.....	10	<i>enskyce</i>	84	.....	83
<i>efavirenz-lamivu-tenofov disop</i>		<i>entacapone</i>	35	ETOPOPHOS	22
.....	10	<i>entecavir</i>	10	<i>etoposide</i>	22
<i>effe-r-k</i>	93	ENTRESTO.....	55	<i>etravirine</i>	10
ELAPRASE	68	ENTRESTO SPRINKLE	55	<i>euthyrox</i>	69
<i>electrolyte-148</i>	95	ENTYVIO	71	<i>everolimus (antineoplastic)</i> ..	22
<i>electrolyte-48 in d5w</i>	95	<i>enulose</i>	71	<i>everolimus</i>	
<i>electrolyte-a</i>	95	ENVARUSUS XR.....	22	(<i>immunosuppressive</i>).....	22
<i>eletriptan</i>	36	EPCLUSA	10	EVOTAZ.....	10
ELIGARD	21	EPIDIOLEX	32	<i>exemestane</i>	22
ELIGARD (3 MONTH).....	21	<i>epinastine</i>	86	EYLEA.....	86
ELIGARD (4 MONTH).....	22	<i>epinephrine</i>	88	<i>ezetimibe</i>	54
ELIGARD (6 MONTH).....	22	<i>epirubicin</i>	22	<i>ezetimibe-simvastatin</i>	54
<i>elinest</i>	84	<i>epitol</i>	32	F	
ELIQUIS	52	EPKINLY	22	FABRAZYME.....	68
ELIQUIS DVT-PE TREAT		<i>eplerenone</i>	50	<i>falmina (28)</i>	84
30D START.....	52	EPRONTIA	32	<i>famciclovir</i>	10
ELITEK.....	18	ERBITUX.....	22	<i>famotidine</i>	74
ELIXOPHYLLIN.....	90	<i>ergotamine-caffeine</i>	36	<i>famotidine (pf)</i>	74
ELMIRON.....	93	<i>eribulin</i>	22	<i>famotidine (pf)-nacl (iso-os)</i>	74
ELREXFIO.....	22	ERIVEDGE	22	FANAPT	44
<i>eluryng</i>	83	ERLEADA	22	FARXIGA	65
ELZONRIS.....	22	<i>erlotinib</i>	22	FASENRA.....	90
EMEND.....	71	<i>errin</i>	82	FASENRA PEN.....	90
EMGALITY PEN	36	<i>ertapenem</i>	14	<i>febuxostat</i>	78
EMGALITY SYRINGE.....	36	ERWINASE.....	22	<i>felbamate</i>	32
EMPLICITI	22	<i>ery pads</i>	58	<i>felodipine</i>	50
EMSAM	44	<i>ery-tab</i>	13	<i>fenofibrate</i>	54
<i>emtricitabine</i>	10	<i>erythrocin (as stearate)</i>	13	<i>fenofibrate micronized</i>	54
<i>emtricitabine-tenofov (tdf)</i>	10	<i>erythromycin</i>	13, 86	<i>fenofibrate nanocrystallized</i>	54
EMTRIVA.....	10	<i>erythromycin ethylsuccinate</i>	13	<i>fenofibric acid</i>	54
EMVERM	14	<i>erythromycin with ethanol</i> ...	58	<i>fenofibric acid (choline)</i>	54
<i>emzahn</i>	82	<i>escitalopram oxalate</i>	44	<i>fentanyl</i>	39

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 11/19/2024.

<i>fentanyl citrate</i>	39	<i>fosinopril</i>	50	<i>glyburide</i>	65
<i>fentanyl citrate (pf)</i>	39	<i>fosinopril-hydrochlorothiazide</i>	50	<i>glyburide micronized</i>	65
<i>fesoterodine</i>	92	<i>fosphenytoin</i>	32	<i>glyburide-metformin</i>	65
FETZIMA.....	44	FOTIVDA.....	23	<i>glycine urologic</i>	93
<i>finasteride</i>	93	<i>fraiche 5000</i>	63	<i>glycine urologic solution</i>	93
<i>fingolimod</i>	37	FRUZAQLA.....	23	<i>glycopyrrolate</i>	70
FINTEPLA.....	32	<i>fulvestrant</i>	23	<i>glycopyrrolate (pf) in water</i>	70
FIRDAPSE.....	37	<i>furosemide</i>	50	<i>glydo</i>	57
FIRMAGON KIT W DILUENT SYRINGE.....	22	FUZEON.....	10	GLYXAMBI.....	65
<i>flac otic oil</i>	63	FYARRO.....	23	GRALISE.....	33
<i>flavoxate</i>	92	<i>fyavolv</i>	82	<i>granisetron (pf)</i>	71
<i>flecainide</i>	49	FYCOMPA.....	32	<i>granisetron hcl</i>	71
<i>floxuridine</i>	22	G		<i>griseofulvin microsize</i>	9
<i>fluconazole</i>	9	<i>gabapentin</i>	32, 33	<i>griseofulvin ultramicrosize</i>	9
<i>fluconazole in nacl (iso-osm)</i>	9	<i>galantamine</i>	37	GVOKE.....	65
<i>flucytosine</i>	9	<i>gallifrey</i>	82	GVOKE HYPOPEN 1-PACK	65
<i>fludarabine</i>	22	GAMASTAN.....	75	GVOKE HYPOPEN 2-PACK	65
<i>fludrocortisone</i>	64	<i>ganciclovir sodium</i>	10	GVOKE PFS 1-PACK SYRINGE.....	65
<i>flumazenil</i>	44	GARDASIL 9 (PF).....	75	GVOKE PFS 2-PACK SYRINGE.....	66
<i>flunisolide</i>	90	<i>gatifloxacin</i>	86	H	
<i>fluocinolone</i>	60	GATTEX 30-VIAL.....	71	HALAVEN.....	23
<i>fluocinolone acetonide oil</i>	63	GATTEX ONE-VIAL.....	71	<i>halobetasol propionate</i>	60
<i>fluocinolone and shower cap</i>	60	GAUZE PAD.....	77	<i>haloperidol</i>	44
<i>fluocinonide</i>	60	<i>gavilyte-c</i>	71	<i>haloperidol decanoate</i>	44
<i>fluocinonide-emollient</i>	60	<i>gavilyte-g</i>	71	<i>haloperidol lactate</i>	44, 45
<i>fluoride (sodium)</i>	63, 95	<i>gavilyte-n</i>	71	HARVONI.....	10
<i>fluorometholone</i>	87	GAVRETO.....	23	HAVRIX (PF).....	75
<i>fluorouracil</i>	23, 57	GAZYVA.....	23	<i>heather</i>	82
<i>fluoxetine</i>	44	<i>gefitinib</i>	23	<i>heparin (porcine)</i>	53
<i>fluoxetine (pmd)</i>	44	<i>gemcitabine</i>	23	<i>heparin (porcine) in 5 % dex</i>	53
<i>fluphenazine decanoate</i>	44	GEMCITABINE.....	23	<i>heparin (porcine) in nacl (pf)</i>	53
<i>fluphenazine hcl</i>	44	<i>gemfibrozil</i>	54	<i>heparin (porcine) in 0.45% nacl</i>	53
<i>flurbiprofen</i>	41	<i>generlac</i>	71	HEPARIN(PORCINE) IN 0.45% NACL.....	53
<i>flurbiprofen sodium</i>	87	<i>gengraf</i>	23	<i>heparin, porcine (pf)</i>	53
<i>fluticasone propionate</i>	90	<i>gentamicin</i>	14, 59, 86	HEPARIN, PORCINE (PF).....	54
<i>fluticasone propion-salmeterol</i>	90	<i>gentamicin in nacl (iso-osm)</i>	14	HEPLISAV-B (PF).....	75
<i>fluvastatin</i>	54	<i>gentamicin sulfate (ped) (pf)</i>	14	HIBERIX (PF).....	75
<i>fluvoxamine</i>	44	GENVOYA.....	10	HIZENTRA.....	75
FOLOTYN.....	23	GILOTRIF.....	23		
<i>fomepizole</i>	75	<i>glatiramer</i>	37		
<i>fondaparinux</i>	53	<i>glatopa</i>	37		
<i>formoterol fumarate</i>	90	GLEOSTINE.....	23		
FOSAMAX PLUS D.....	78	<i>glimepiride</i>	65		
<i>fosamprenavir</i>	10	<i>glipizide</i>	65		
<i>fosaprepitant</i>	71	<i>glipizide-metformin</i>	65		
		<i>glutamine (sickle cell)</i>	62		

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 11/19/2024.

HUMIRA (ONLY NDCS STARTING WITH 00074)	79	HYRIMOZ PEN PSORIASIS STARTER (PREFERRED NDCS STARTING WITH 61314).....	80	INCRELEX	62
HUMIRA PEN (ONLY NDCS STARTING WITH 00074)	80	HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314)	80, 81	<i>indapamide</i>	50
HUMIRA(CF) (ONLY NDCS STARTING WITH 00074)	80	HYRIMOZ(CF) PEDI CROHN STARTER (PREFERRED NDCS STARTING WITH 61314)	81	INFANRIX (DTAP) (PF)	76
HUMIRA(CF) PEN (ONLY NDCS STARTING WITH 00074).....	80	HYRIMOZ(CF) PEN (PREFERRED NDCS STARTING WITH 61314)	81	INGREZZA	37
HUMIRA(CF) PEN CROHNS-UC-HS (ONLY NDCS STARTING WITH 00074).....	80	I		INGREZZA INITIATION PK(TARDIV).....	37
HUMIRA(CF) PEN PEDIATRIC UC (ONLY NDCS STARTING WITH 00074).....	80	<i>ibandronate</i>	78	INGREZZA SPRINKLE	37
HUMIRA(CF) PEN PSOR-UV-ADOL HS (ONLY NDCS STARTING WITH 00074).....	80	IBRANCE	23	INLYTA	24
HUMULIN R U-500 (CONC) INSULIN	66	<i>ibu</i>	41	INPEFA	66
HUMULIN R U-500 (CONC) KWIKPEN.....	66	<i>ibuprofen</i>	41	INQOVI.....	24
<i>hydralazine</i>	50	<i>ibutilide fumarate</i>	49	INREBIC.....	24
<i>hydrochlorothiazide</i>	50	<i>icatibant</i>	90	INSULIN SYRINGE-NEEDLE U-100	77
<i>hydrocodone-acetaminophen</i>	39	ICLUSIG	23	INTELENCE	10
<i>hydrocodone-ibuprofen</i>	39	<i>icosapent ethyl</i>	54	<i>intralipid</i>	95
<i>hydrocortisone</i>	60, 64, 71	<i>idarubicin</i>	23	<i>introvale</i>	84
<i>hydrocortisone-acetic acid</i>	63	IDHIFA	23	INVEGA HAFYERA.....	45
<i>hydromorphone</i>	39	<i>ifosfamide</i>	23	INVEGA SUSTENNA.....	45
<i>hydromorphone (pf)</i>	39	ILARIS (PF)	74	INVEGA TRINZA.....	45
<i>hydroxychloroquine</i>	14	<i>imatinib</i>	23	INVELTYS.....	87
<i>hydroxyurea</i>	23	IMBRUVICA	23, 24	IPOL.....	76
<i>hydroxyzine hcl</i>	88	IMDELLTRA	24	<i>ipratropium bromide</i>	63, 90
HYPERHEP B	76	IMFINZI.....	24	<i>ipratropium-albuterol</i>	90
HYPERHEP B NEONATAL	76	<i>imipenem-cilastatin</i>	14	<i>irbesartan</i>	50
HYRIMOZ PEN CROHN'S-UC STARTER (PREFERRED NDCS STARTING WITH 61314)	80	<i>imipramine hcl</i>	45	<i>irbesartan-hydrochlorothiazide</i>	50
		<i>imipramine pamoate</i>	45	<i>irinotecan</i>	24
		<i>imiquimod</i>	57	ISENTRESS	10
		IMJUDO.....	24	ISENTRESS HD	10
		IMOVAX RABIES VACCINE (PF)	76	<i>isibloom</i>	84
		IMVEXXY MAINTENANCE PACK	82	ISOLYTE S PH 7.4.....	95
		IMVEXXY STARTER PACK	82	ISOLYTE-P IN 5 % DEXTROSE.....	95
		INBRIJA	36	ISOLYTE-S	95
		<i>incassia</i>	82	<i>isoniazid</i>	14
				<i>isosorbide dinitrate</i>	56
				<i>isosorbide mononitrate</i>	56
				<i>isosorbide-hydralazine</i>	51
				<i>isotretinoin</i>	58
				<i>isradipine</i>	51
				ISTODAX	24
				<i>itraconazole</i>	9
				<i>ivabradine</i>	55
				<i>ivermectin</i>	14, 58
				IWILFIN.....	24
				IXCHIQ (PF)	76
				IXEMPRA	24

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 11/19/2024.

IXIARO (PF).....	76	<i>klor-con m15</i>	93	<i>levetiracetam in nacl (iso-os)</i>	
J		<i>klor-con m20</i>	93	.....	33
JAKAFI.....	24	<i>klor-con oral packet 20</i>	93	<i>levobunolol</i>	86
<i>jantoven</i>	54	<i>klor-con/ef</i>	93	<i>levocarnitine</i>	62
JANUMET.....	66	KORLYM.....	68	<i>levocarnitine (with sugar)</i>	62
JANUMET XR.....	66	KOSELUGO.....	25	<i>levocetirizine</i>	88
JANUVIA.....	66	<i>kourzeg</i>	63	<i>levofloxacin</i>	17, 18, 86
JARDIANCE.....	66	K-PHOS NO 2.....	93	<i>levofloxacin in d5w</i>	17
<i>jasmiel (28)</i>	84	K-PHOS ORIGINAL.....	93	<i>levoleucovorin calcium</i>	19
JAYPIRCA.....	24	KRAZATI.....	25	<i>levonest (28)</i>	84
JEMPERLI.....	24	<i>kurvelo (28)</i>	84	<i>levonorgestrel-ethinyl estrad</i>	84
<i>jencycla</i>	82	KYPROLIS.....	25	<i>levonorg-eth estrad triphasic</i>	84
JENTADUETO.....	66	L		<i>levora-28</i>	84
JENTADUETO XR.....	66	<i>l norgest/e.estradiol-e.estrad</i>	84	<i>levo-t</i>	69
JEVTANA.....	24	<i>labetalol</i>	51	<i>levothyroxine</i>	69
<i>jinteli</i>	82	<i>lacosamide</i>	33	<i>levoxyl</i>	70
<i>jolessa</i>	84	<i>lactated ringers</i>	61, 93	LIBERVANT.....	33
<i>juleber</i>	84	<i>lactulose</i>	71	LIBTAYO.....	25
JULUCA.....	10	LAGEVRIO (EUA).....	10	<i>lidocaine</i>	58
JUXTAPID.....	54	<i>lamivudine</i>	10	<i>lidocaine (pf)</i>	49, 57
JYLAMVO.....	24	<i>lamivudine-zidovudine</i>	10	<i>lidocaine hcl</i>	57, 58
JYNNEOS (PF).....	76	<i>lamotrigine</i>	33	<i>lidocaine in 5 % dextrose (pf)</i>	
K		<i>lanreotide</i>	25	.....	49
KADCYLA.....	24	<i>lansoprazole</i>	74	<i>lidocaine viscous</i>	58
<i>kalliga</i>	84	LANTUS SOLOSTAR U-100		<i>lidocaine-epinephrine</i>	58
KALYDECO.....	90	INSULIN.....	66	<i>lidocaine-epinephrine (pf)</i> ...	58
KANUMA.....	68	LANTUS U-100 INSULIN..	66	<i>lidocaine-prilocaine</i>	58
<i>kariva (28)</i>	84	<i>lapatinib</i>	25	<i>lidocan iii</i>	58
<i>kelnor 1/35 (28)</i>	84	<i>larin 1.5/30 (21)</i>	84	<i>lidocan iv</i>	58
<i>kelnor 1/50 (28)</i>	84	<i>larin 1/20 (21)</i>	84	<i>lidocan v</i>	58
KEPIVANCE.....	18	<i>larin 24 fe</i>	84	<i>lincomycin</i>	14
KERENDIA.....	51	<i>larin fe 1.5/30 (28)</i>	84	<i>linezolid</i>	14
KESIMPTA PEN.....	37	<i>larin fe 1/20 (28)</i>	84	<i>linezolid in dextrose 5%</i>	14
<i>ketoconazole</i>	9, 59	<i>latanoprost</i>	87	<i>linezolid-0.9% sodium chloride</i>	
<i>ketorolac</i>	87	LAZCLUZE.....	25	.....	14
KEYTRUDA.....	24	<i>leflunomide</i>	81	LINZESS.....	71
KHAPZORY.....	19	<i>lenalidomide</i>	25	LIORESAL.....	38
KIMMTRAK.....	24	LENVIMA.....	25	<i>liothyronine</i>	70
KINRIX (PF).....	76	<i>lessina</i>	84	<i>lisinopril</i>	51
<i>kionex (with sorbitol)</i>	62	<i>letrozole</i>	25	<i>lisinopril-hydrochlorothiazide</i>	
KISQALI.....	24, 25	<i>leucovorin calcium</i>	19	.....	51
KISQALI FEMARA CO-		LEUKERAN.....	25	<i>lithium carbonate</i>	45
PACK.....	24	LEUKINE.....	74	<i>lithium citrate</i>	45
<i>klayesta</i>	59	<i>leuprolide</i>	25	LOKELMA.....	62
<i>klor-con 10</i>	93	<i>levabuterol hcl</i>	90	LONSURF.....	25
<i>klor-con 8</i>	93	<i>levetiracetam</i>	33	<i>loperamide</i>	70
<i>klor-con m10</i>	93			<i>lopinavir-ritonavir</i>	11

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 11/19/2024.

LOQTORZI.....	25	MEKTOVI.....	26	<i>micafungin</i>	9
<i>lorazepam</i>	45	<i>meloxicam</i>	41	<i>microgestin 1.5/30 (21)</i>	84
<i>lorazepam intensol</i>	45	<i>melphalan hcl</i>	26	<i>microgestin 1/20 (21)</i>	85
LORBRENA.....	25	<i>memantine</i>	37	<i>microgestin fe 1.5/30 (28)</i>	85
<i>loryna (28)</i>	84	MENACTRA (PF).....	76	<i>microgestin fe 1/20 (28)</i>	85
<i>losartan</i>	51	MENEST.....	83	<i>midodrine</i>	62
<i>losartan-hydrochlorothiazide</i>	51	MENQUADFI (PF).....	76	MIEBO (PF).....	86
<i>loteprednol etabonate</i>	87	MENVEO A-C-Y-W-135-DIP (PF).....	76	<i>mifepristone</i>	69, 83
<i>lovastatin</i>	54	MEPSEVII.....	68	<i>mili</i>	85
<i>low-ogestrel (28)</i>	84	<i>mercaptapurine</i>	26	<i>milrinone</i>	55
<i>loxapine succinate</i>	45	<i>meropenem</i>	14, 15	<i>milrinone in 5 % dextrose</i>	55
<i>lo-zumandimine (28)</i>	84	<i>mesalamine</i>	71, 72	<i>mimvey</i>	83
<i>lubiprostone</i>	71	<i>mesalamine with cleansing</i> <i>wipe</i>	72	<i>minocycline</i>	18
LUMAKRAS.....	25	<i>mesna</i>	19	<i>minoxidil</i>	51
LUMIGAN.....	87	MESNEX.....	19	<i>miostat</i>	87
LUMIZYME.....	68	<i>metformin</i>	66	<i>mirabegron</i>	92
LUNSUMIO.....	25	<i>methadone</i>	39, 40	<i>mirtazapine</i>	46
LUPRON DEPOT.....	25	<i>methadone intensol</i>	39	<i>misoprostol</i>	74
<i>lurasidone</i>	45, 46	<i>methadose</i>	40	<i>mitomycin</i>	26
<i>lutera (28)</i>	84	<i>methazolamide</i>	87	<i>mitoxantrone</i>	26
<i>lyleq</i>	82	<i>methenamine hippurate</i>	18	M-M-R II (PF).....	76
<i>lyllana</i>	83	<i>methenamine mandelate</i>	18	<i>modafinil</i>	46
LYNPARZA.....	25	<i>methimazole</i>	64	<i>moexipril</i>	51
LYSODREN.....	25	<i>methotrexate sodium</i>	26	<i>molindone</i>	46
LYTGOBI.....	25	<i>methotrexate sodium (pf)</i>	26	<i>mometasone</i>	60, 90
<i>lyza</i>	83	<i>methoxsalen</i>	58	<i>mondoxyne nl</i>	18
M		<i>methsuximide</i>	33	MONJUVI.....	26
<i>magnesium chloride</i>	93	<i>methyletergonovine</i>	85	<i>mono-lynyah</i>	85
<i>magnesium sulfate</i>	93	<i>methylphenidate hcl</i>	46	<i>montelukast</i>	90
MAGNESIUM SULFATE IN D5W.....	93	<i>methylprednisolone</i>	64	<i>morphine</i>	40
<i>magnesium sulfate in water</i>	93	<i>methylprednisolone acetate</i>	64	<i>morphine (pf)</i>	40
<i>malathion</i>	61	<i>methylprednisolone sodium</i> <i>succ</i>	64	<i>morphine concentrate</i>	40
<i>mannitol 20 %</i>	51	<i>metoclopramide hcl</i>	72	MOUNJARO.....	66
<i>mannitol 25 %</i>	51	<i>metolazone</i>	51	MOVANTIK.....	72
<i>maraviroc</i>	11	<i>metoprolol succinate</i>	51	<i>moxifloxacin</i>	18, 86
MARGENZA.....	25	<i>metoprolol ta-hydrochlorothiaz</i>	51	<i>moxifloxacin-sod.chloride(iso)</i>	18
<i>marlissa (28)</i>	84	<i>metoprolol tartrate</i>	51	MOZOBIL.....	74
MARPLAN.....	46	<i>metro i.v.</i>	15	MRESVIA (PF).....	76
MATULANE.....	25	<i>metronidazole</i>	15, 58, 83	MULTAQ.....	49
<i>matzim la</i>	51	<i>metronidazole in nacl (iso-os)</i>	15	<i>mupirocin</i>	59
<i>meclizine</i>	71	<i>metyrosine</i>	51	MYALEPT.....	69
<i>medroxyprogesterone</i>	83	<i>mexiletine</i>	49	<i>mycophenolate mofetil</i>	26
<i>mefloquine</i>	14			<i>mycophenolate mofetil (hcl)</i>	26
<i>megestrol</i>	26			<i>mycophenolate sodium</i>	26
MEKINIST.....	26			MYFEMBREE.....	83
				MYHIBBIN.....	26

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 11/19/2024.

MYLOTARG.....	26	<i>nimodipine</i>	51	NOVOLOG MIX 70-	
MYRBETRIQ.....	92	NINLARO.....	26	30FLEXPEN U-100	67
N		<i>nisoldipine</i>	51	NOVOLOG PENFILL U-100	
<i>nabumetone</i>	41	<i>nitazoxanide</i>	15	INSULIN	67
<i>nadolol</i>	51	<i>nitisinone</i>	62	NOVOLOG U-100 INSULIN	
<i>nafcillin</i>	17	<i>nitro-bid</i>	56	ASPART	67
<i>nafcillin in dextrose iso-osm</i>	17	<i>nitrofurantoin macrocrystal</i>	18	NUBEQA	26
<i>naftifine</i>	59	<i>nitrofurantoin monohyd/m-</i>		NUCALA	90
NAGLAZYME	69	<i>cryst</i>	18	NUEDEXTA	38
<i>nalbuphine</i>	41	<i>nitroglycerin</i>	56, 72	NULOJIX.....	26
<i>naloxone</i>	41	<i>nitroglycerin in 5 % dextrose</i>		NUPLAZID	46
<i>naltrexone</i>	41	.....	56	NURTEC ODT	36
NAMZARIC.....	37	NIVESTYM.....	74	<i>nyamyc</i>	59
<i>naproxen</i>	41	<i>nizatidine</i>	74	<i>nystatin</i>	9, 59
<i>naproxen sodium</i>	41	<i>nora-be</i>	83	<i>nystatin-triamcinolone</i>	59
<i>naratriptan</i>	36	<i>norelgestromin-ethin.estradiol</i>		<i>nystop</i>	59
NATACYN.....	86	.....	83	NYVEPRIA.....	74
<i>nateglinide</i>	66	<i>norepinephrine bitartrate</i>	56	O	
NAYZILAM.....	33	<i>norethindrone (contraceptive)</i>		OCALIVA.....	72
<i>nebivolol</i>	51	.....	83	<i>octreotide acetate</i>	26, 27
<i>nefazodone</i>	46	<i>norethindrone acetate</i>	83	<i>octreotide,microspheres</i>	27
<i>nelarabine</i>	26	<i>norethindrone ac-eth estradiol</i>		ODEFSEY	11
<i>neomycin</i>	15	.....	83, 85	ODOMZO	27
<i>neomycin-bacitracin-poly-hc</i>	87	<i>norethindrone-e.estradiol-iron</i>		OFEV	90
<i>neomycin-bacitracin-</i>		.....	85	<i>ofloxacin</i>	63, 86
<i>polymyxin</i>	86	<i>norgestimate-ethinyl estradiol</i>		OGSIVEO	27
<i>neomycin-polymyxin b gu</i>	61	.....	85	OJEMDA.....	27
<i>neomycin-polymyxin b-</i>		<i>nortrel 0.5/35 (28)</i>	85	OJJAARA.....	27
<i>dexameth</i>	87	<i>nortrel 1/35 (21)</i>	85	<i>olanzapine</i>	46
<i>neomycin-polymyxin-</i>		<i>nortrel 1/35 (28)</i>	85	<i>olanzapine-fluoxetine</i>	46
<i>gramicidin</i>	86	<i>nortrel 7/7/7 (28)</i>	85	<i>olmesartan</i>	51
<i>neomycin-polymyxin-hc</i> .64, 87		<i>nortriptyline</i>	46	<i>olmesartan-amlodipin-</i>	
<i>neo-polycin</i>	86	NORVIR	11	<i>hcthiazyd</i>	51
<i>neo-polycin hc</i>	87	NOVOLIN 70/30 U-100		<i>olmesartan-</i>	
NERLYNX.....	26	INSULIN	66	<i>hydrochlorothiazide</i>	51
NEUPRO.....	36	NOVOLIN 70-30 FLEXPEN		<i>olopatadine</i>	86
<i>nevirapine</i>	11	U-100.....	66	<i>omega-3 acid ethyl esters</i>	55
NEXLETOL	54	NOVOLIN N FLEXPEN.....	66	<i>omeprazole</i>	74
NEXLIZET	54	NOVOLIN N NPH U-100		OMNIPOD 5 G6-G7 INTRO	
NEXPLANON.....	83	INSULIN	66	KT(GEN5).....	77
<i>niacin</i>	54	NOVOLIN R FLEXPEN	66	OMNIPOD 5 G6-G7 PODS	
<i>nicardipine</i>	51	NOVOLIN R REGULAR		(GEN 5).....	77
NICOTROL.....	63	U100 INSULIN.....	67	OMNIPOD CLASSIC PODS	
NICOTROL NS	63	NOVOLOG FLEXPEN U-100		(GEN 3).....	77
<i>nifedipine</i>	51	INSULIN	67	OMNIPOD DASH INTRO	
<i>nikki (28)</i>	85	NOVOLOG MIX 70-30 U-100		KIT (GEN 4).....	77
<i>nilutamide</i>	26	INSULN	67		

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 11/19/2024.

OMNIPOD DASH PODS (GEN 4).....	77	<i>oxycodone</i>	40	<i>permethrin</i>	61
OMNIPOD GO PODS	77	<i>oxycodone-acetaminophen</i> ...	40	<i>perphenazine</i>	46
OMNIPOD GO PODS 10 UNITS/DAY	77	OXYCONTIN.....	40	PERSERIS	46
OMNIPOD GO PODS 15 UNITS/DAY	77	OZEMPIC	67	<i>pfizerpen-g</i>	17
OMNIPOD GO PODS 20 UNITS/DAY	77	OZURDEX.....	87	<i>phenelzine</i>	46
OMNIPOD GO PODS 25 UNITS/DAY	77	P		<i>phenobarbital</i>	33, 34
OMNIPOD GO PODS 30 UNITS/DAY	77	<i>pacerone</i>	49	<i>phenobarbital sodium</i>	34
OMNIPOD GO PODS 40 UNITS/DAY	77	<i>paclitaxel</i>	27	<i>phentolamine</i>	51
OMNITROPE.....	74	PADCEV	27	<i>phenytoin</i>	34
ONCASPAR.....	27	<i>paliperidone</i>	46	<i>phenytoin sodium</i>	34
<i>ondansetron</i>	72	<i>palonosetron</i>	72	<i>phenytoin sodium extended</i> ..	34
<i>ondansetron hcl</i>	72	<i>pamidronate</i>	69	<i>philit</i>	85
<i>ondansetron hcl (pf)</i>	72	PANRETIN	58	PHOSPHOLINE IODIDE ..	86
ONIVYDE.....	27	<i>pantoprazole</i>	74	PIFELTRO	11
ONUREG	27	<i>paraplatin</i>	27	<i>pilocarpine hcl</i>	62, 87
OPDIVO.....	27	<i>paricalcitol</i>	69	<i>pimecrolimus</i>	58
OPDUALAG	27	<i>paromomycin</i>	15	<i>pimozide</i>	46
<i>opium tincture</i>	70	<i>paroxetine hcl</i>	46	<i>pimtree (28)</i>	85
OPSUMIT	90	PAXLOVID.....	11	<i>pindolol</i>	51
OPSYNVI.....	91	<i>pazopanib</i>	27	<i>pioglitazone</i>	67
<i>oralone</i>	63	PEDIARIX (PF).....	76	<i>piperacillin-tazobactam</i>	17
ORENCIA	81	PEDVAX HIB (PF).....	76	PIQRAY	28
ORENCIA (WITH MALTOSE)	81	<i>peg 3350-electrolytes</i>	72	<i>pirfenidone</i>	91
ORENCIA CLICKJECT	81	<i>peg3350-sod sul-nacl-kcl-asb-c</i>	72	<i>piroxicam</i>	41
ORGOVYX.....	27	PEGASYS	74	<i>pitavastatin calcium</i>	55
ORKAMBI	91	<i>peg-electrolyte</i>	72	PLASMA-LYTE A	95
ORSERDU	27	PEMAZYRE.....	27	PLEGRIDY	74, 75
<i>oseltamivir</i>	11	<i>pemetrexed disodium</i>	27, 28	PLENAMINE	95
<i>osmitrol 20 %</i>	51	PEN NEEDLES (NON- PREFERRED BRANDS) 78		<i>plerixafor</i>	75
OTEZLA	81	PENBRAYA (PF)	76	<i>podofilox</i>	58
OTEZLA STARTER.....	81	<i>penciclovir</i>	59	POLIVY	28
<i>oxacillin</i>	17	<i>penicillamine</i>	81	<i>polocaine</i>	58
<i>oxacillin in dextrose(iso-osm)</i>	17	PENICILLIN G POT IN DEXTROSE.....	17	<i>polocaine-mpf</i>	58
<i>oxaliplatin</i>	27	<i>penicillin g potassium</i>	17	<i>polycin</i>	86
<i>oxaprozin</i>	41	<i>penicillin g sodium</i>	17	<i>polymyxin b sulf-trimethoprim</i>	86
<i>oxcarbazepine</i>	33	<i>penicillin v potassium</i>	17	POMALYST.....	28
OXERVATE.....	86	PENTACEL (PF)	76	<i>portia 28</i>	85
<i>oxybutynin chloride</i>	92	<i>pentamidine</i>	15	PORTRAZZA.....	28
		PENTASA	72	<i>posaconazole</i>	9
		<i>pentobarbital sodium</i>	46	<i>potassium acetate</i>	93
		<i>pentoxifylline</i>	54	<i>potassium chlorid-d5-</i> <i>0.45%nacl</i>	93
		<i>perindopril erbumine</i>	51	<i>potassium chloride</i>	94
		<i>periogard</i>	63	<i>potassium chloride in</i> <i>0.9%nacl</i>	94
		PERJETA	28		

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 11/19/2024.

<i>potassium chloride in 5 % dex</i>.....94	PRIVIGEN .....76	RADICAVA ORS.....38
<i>potassium chloride in 1r-d5</i> ..94	<i>probenecid</i>.....78	RADICAVA ORS STARTER KIT SUSP .....38
<i>potassium chloride in water</i> .94	<i>probenecid-colchicine</i> .....78	<i>raloxifene</i>.....78
<i>potassium chloride-0.45 %</i> <i>nacl</i>.....94	<i>procainamide</i>.....49	<i>ramelteon</i>.....47
<i>potassium chloride-d5-</i> <i>0.2%nacl</i>.....94	<i>prochlorperazine</i>.....72	<i>ramipril</i> .....51
<i>potassium chloride-d5-</i> <i>0.9%nacl</i>.....94	<i>prochlorperazine edisylate</i> ..72	<i>ranolazine</i>.....56
<i>potassium citrate</i>.....93	<i>prochlorperazine maleate oral</i>.....72	<i>rasagiline</i>.....36
<i>potassium phosphate m-/d-</i> <i>basic</i>.....94	PROCRIT .....75	<i>reclipsen (28)</i>.....85
POTELIGEO .....28	<i>procto-med hc</i>.....72	RECOMBIVAX HB (PF)....76
PRALATREXATE.....28	<i>proctosol hc</i>.....72	RECTIV .....72
<i>pramipexole</i> .....36	<i>proctozone-hc</i> .....72	REGRANEX .....58
<i>prasugrel</i> .....54	<i>progesterone</i> .....83	RELENZA DISKHALER...11
<i>pravastatin</i>.....55	<i>progesterone micronized</i> ....83	RELISTOR .....72
<i>praziquantel</i>.....15	PROGRAF.....28	REMICADE .....72
<i>prazosin</i>.....51	PROLASTIN-C .....62	RENACIDIN .....93
<i>prednicarbate</i>.....60	PROLENSA .....87	<i>repaglinide</i>.....67
<i>prednisolone</i> .....64	PROLIA .....78	REPATHA.....55
<i>prednisolone acetate</i>.....88	PROMACTA .....54	REPATHA PUSHTRONEX 55
<i>prednisolone sodium</i> <i>phosphate</i>.....64, 88	<i>promethazine</i> .....88	REPATHA SURECLICK...55
<i>prednisone</i> .....64	<i>propafenone</i>.....49	RETACRIT.....75
<i>prednisone intensol</i> .....64	<i>propranolol</i>.....51	RETEVMO.....28
<i>pregabalin</i> .....34	<i>propylthiouracil</i> .....64	RETROVIR.....11
PREHEVBRIO (PF).....76	PROQUAD (PF) .....76	REVCОВI.....62
PREMARIN .....83	<i>protamine</i> .....54	REVLIMID.....28
<i>premasol 10 %</i>95	<i>protriptyline</i>.....46	<i>revonto</i> .....38
PREMPHASE .....83	PULMICORT FLEXHALER.....91	REXULTI.....47
PREMPRO .....83	PULMOZYME .....91	REYATAZ .....11
<i>prenatal vitamin oral tablet</i> .95	PURIXAN .....28	REZDIFFRA .....62
<i>prevalite</i>.....55	<i>pyrazinamide</i> .....15	REZLIDHIA .....28
PREVIDENT 5000 BOOSTER PLUS .....63	<i>pyridostigmine bromide</i>.....38	REZUROCK.....28
PREVIDENT 5000 DRY MOUTH .....63	<i>pyrimethamine</i> .....15	RHOPRESSA .....87
PREVYMIS .....11	Q	<i>ribavirin</i>.....11
PREZCOBIX .....11	QINLOCK.....28	RIDAURA.....81
PREZISTA .....11	QTERN .....67	<i>rifabutin</i>.....15
PRIFTIN.....15	QUADRACEL (PF) .....76	<i>rifampin</i>.....15
PRIMAQUINE .....15	<i>quetiapine</i>.....46, 47	<i>riluzole</i> .....62
<i>primidone</i> .....34	<i>quinapril</i>.....51	<i>rimantadine</i>.....11
PRIMIDONE.....34	<i>quinapril-hydrochlorothiazide</i>.....51	<i>ringer's</i>.....61, 94
PRIORIX (PF) .....76	<i>quinidine sulfate</i>.....49	RINVOQ .....81, 82
	<i>quinine sulfate</i>.....15	RINVOQ LQ .....81
	QULIPTA.....36	<i>risedronate</i>.....62, 78
	QVAR REDIHALER.....91	RISPERDAL CONSTA.....47
	R	<i>risperidone</i>.....47
	RABAVERT (PF) .....76	<i>risperidone microspheres</i> ...47
		<i>ritonavir</i>.....11
		<i>rivastigmine</i>.....38

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 11/19/2024.

<i>rivastigmine tartrate</i>	38	<i>sildenafil (pulmonary arterial hypertension)</i>	91	<i>sprintec (28)</i>	85
<i>rizatriptan</i>	36	<i>silodosin</i>	93	SPRITAM.....	34
ROCKLATAN.....	87	<i>silver sulfadiazine</i>	58	SPRYCEL	29
<i>roflumilast</i>	91	SIMBRINZA	87	<i>sps (with sorbitol)</i>	62
<i>romidepsin</i>	28	SIMLANDI(CF)		<i>sronyx</i>	85
<i>ropinirole</i>	36	AUTOINJECTOR.....	82	<i>ssd</i>	58
<i>rosuvastatin</i>	55	SIMULECT	29	STEGLATRO	67
ROTARIX	76	<i>simvastatin</i>	55	STELARA	56
ROTATEQ VACCINE.....	76	<i>sirolimus</i>	29	STIOLTO RESPIMAT	91
<i>roweepra</i>	34	SIRTURO.....	15	STIVARGA.....	29
ROZLYTREK.....	28	SKYRIZI	56, 73	STRENSIQ	69
RUBRACA.....	28	<i>sodium acetate</i>	94	STREPTOMYCIN	15
<i>rufinamide</i>	34	<i>sodium benzoate-sodium phenylacet</i>	62	STRIBILD	11
RUKOBIA.....	11	<i>sodium bicarbonate</i>	94	STRIVERDI RESPIMAT ...	91
RUXIENCE.....	28	<i>sodium chloride</i>	62, 94	<i>subvenite</i>	34
RYBELSUS.....	67	<i>sodium chloride 0.45 %</i>	94	<i>subvenite starter (blue) kit</i> ...	34
RYBREVANT.....	28	<i>sodium chloride 0.9 %</i>	62	<i>subvenite starter (green) kit</i> .	34
RYDAPT.....	28	<i>sodium chloride 3 % hypertonic</i>	94	<i>subvenite starter (orange) kit</i> 34	
RYLAZE	28	<i>sodium chloride 5 % hypertonic</i>	94	SUCRAID	73
RYTELO	28	<i>sodium fluoride 5000 dry mouth</i>	63	<i>sucrafate</i>	74
S		<i>sodium fluoride 5000 plus</i> ...	63	<i>sulfacetamide sodium</i>	87
<i>sajazir</i>	91	<i>sodium fluoride-pot nitrate</i> ..	63	<i>sulfacetamide sodium (acne)</i> 59	
<i>salsalate</i>	41	<i>sodium nitroprusside</i>	56	<i>sulfacetamide-prednisolone</i> .	87
SANCUSO	72	SODIUM OXYBATE	47	<i>sulfadiazine</i>	18
SANDOSTATIN LAR		<i>sodium phenylbutyrate</i>	62	<i>sulfamethoxazole-trimethoprim</i>	
DEPOT	28	<i>sodium phosphate</i>	94	.....	18
SANTYL	58	<i>sodium polystyrene sulfonate</i> 62		<i>sulfasalazine</i>	73
<i>sapropterin</i>	69	<i>sodium, potassium, magnesium sulfates</i>	73	<i>sulindac</i>	41
SARCLISA.....	28	<i>solifenacin</i>	92	<i>sumatriptan</i>	36
SAVELLA.....	82	SOLQUA 100/33	67	<i>sumatriptan succinate</i>	36
<i>saxagliptin</i>	67	SOLTAMOX	29	<i>sunitinib malate</i>	29
<i>saxagliptin-metformin</i>	67	SOMATULINE DEPOT	29	SUNLENCA.....	11
SCSEMBLIX	28, 29	SOMAVERT	69	<i>syeda</i>	85
<i>scopolamine base</i>	73	<i>sorafenib</i>	29	SYMDEKO	91
SECUADO	47	<i>sorine</i>	49	SYMLINPEN 120.....	67
SEGLUROMET.....	67	<i>sotalol</i>	49	SYMLINPEN 60.....	67
<i>selegiline hcl</i>	36	<i>sotalol af</i>	49	SYMPAZAN	34
<i>selenium sulfide</i>	56	SPIRIVA RESPIMAT	91	SYMTUZA.....	11
SELZENTRY	11	<i>spironolactone</i>	52	SYNAGIS.....	11
<i>sertraline</i>	47	<i>spironolactone-hydrochlorothiaz</i>	52	SYNJARDY	67
<i>setlakin</i>	85			SYNJARDY XR.....	67
<i>sevelamer carbonate</i>	62			SYNTHROID	70
<i>sf 63</i>				T	
<i>sf 5000 plus</i>	63			TABLOID	29
<i>sharobel</i>	83			TABRECTA	29
SHINGRIX (PF)	76			<i>tacrolimus</i>	29, 58
SIGNIFOR.....	29				

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 11/19/2024.

<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	TETANUS,DIPHTHERIA TOX PED(PF).....	<i>tranexamic acid</i>
91	76	83
TAFINLAR.....	<i>tetrabenazine</i>	<i>tranylcypramine</i>
29	38	47
<i>tafluprost (pf)</i>	<i>tetracycline</i>	<i>travasol 10 %</i>
87	18	95
TAGRISSO.....	TEVIMBRA.....	<i>travoprost</i>
29	29	87
TALTZ AUTOINJECTOR..	THALOMID.....	TRAZIMERA.....
56	29	30
TALTZ AUTOINJECTOR (2 PACK).....	THEO-24.....	<i>trazodone</i>
57	91	47
TALTZ AUTOINJECTOR (3 PACK).....	<i>theophylline</i>	TRECTOR.....
57	91, 92	15
TALTZ SYRINGE.....	<i>thioridazine</i>	TRELEGY ELLIPTA.....
57	47	92
TALVEY.....	<i>thiotepa</i>	TRELSTAR.....
29	29, 30	30
TALZENNA.....	<i>thiothixene</i>	<i>treprostinil sodium</i>
29	47	52
<i>tamoxifen</i>	<i>tiadylt er</i>	<i>tretinoin (antineoplastic)</i>
29	52	30
<i>tamsulosin</i>	<i>tiagabine</i>	<i>tretinoin topical</i>
93	34	59
<i>tarina 24 fe</i>	TIBSOVO.....	<i>triamcinolone acetonide</i> 60, 61, 63, 64
85	30	<i>triamterene-hydrochlorothiazid</i>
<i>tarina fe 1-20 eq (28)</i>	TICE BCG.....	52
85	76	<i>tridacaine ii</i>
TASIGNA.....	TICOVAC.....	58
29	76	<i>triderm</i>
<i>tazarotene</i>	<i>tigecycline</i>	61
59	15	<i>trientine</i>
<i>tazicef</i>	<i>tilia fe</i>	62
13	85	<i>tri-estarylla</i>
TAZVERIK.....	<i>timolol maleate</i>	85
29	52, 86	<i>trifluoperazine</i>
TDVAX.....	<i>tinidazole</i>	47
76	15	<i>trifluridine</i>
TECENTRIQ.....	<i>tiotropium bromide</i>	86
29	92	TRIJARDY XR.....
TECENTRIQ HYBREZA ...	TIVDAK.....	68
29	30	TRIKAFTA.....
TECVAYLI.....	TIVICAY.....	92
29	11	<i>tri-legest fe</i>
TEFLARO.....	TIVICAY PD.....	85
13	11	<i>tri-linyah</i>
<i>telmisartan</i>	<i>tizanidine</i>	85
52	38	<i>tri-lo-estarylla</i>
<i>telmisartan-hydrochlorothiazid</i>	TOBI PODHALER.....	85
52	15	<i>tri-lo-marzia</i>
TEMODAR.....	TOBRADEX.....	85
29	87	<i>tri-lo-sprintec</i>
<i>temsirolimus</i>	<i>tobramycin</i>	85
29	15, 86	<i>trimethoprim</i>
TENIVAC (PF).....	<i>tobramycin in 0.225 % nacl</i>	18
76	15	<i>trimipramine</i>
<i>tenofovir disoproxil fumarate</i>	<i>tobramycin sulfate</i>	47
11	15	TRINTELLIX.....
TEPMETKO.....	<i>tobramycin-dexamethasone</i>	48
29	87	<i>tri-sprintec (28)</i>
<i>terazosin</i>	<i>tolterodine</i>	85
52	92	TRIUMEQ.....
<i>terbinafine hcl</i>	<i>tolvaptan</i>	11
9	69	TRIUMEQ PD.....
<i>terbutaline</i>	<i>topiramate</i>	11
91	34	<i>trivora (28)</i>
<i>terconazole</i>	<i>topotecan</i>	85
83	30	TRODELVY.....
<i>teriflunomide</i>	<i>toremifene</i>	30
38	30	TROGARZO.....
TERIPARATIDE.....	<i>torpenz</i>	11
78	30	TROPHAMINE 10 %.....
<i>testosterone</i>	<i>torse mide</i>	95
69	52	<i>trospium</i>
<i>testosterone cypionate</i>	TOUJEO MAX U-300 SOLOSTAR.....	93
69	68	TRULANCE.....
<i>testosterone enanthate</i>	TOUJEO SOLOSTAR U-300 INSULIN.....	73
69	68	TRULICITY.....
	TRADJENTA.....	68
	<i>tramadol</i>	76
	<i>tramadol-acetaminophen</i>	30
	<i>trandolapril</i>	TUKYSA.....
	52	30
	<i>trandolapril-verapamil</i>	TURALIO.....
	52	30
		<i>turqoz (28)</i>
		85

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 11/19/2024.

TWINRIX (PF).....	76	<i>velivet triphasic regimen (28)</i>	85	<i>water for irrigation, sterile</i> ..	62
TYENNE.....	82	.....	85	WELIREG.....	30
TYENNE AUTOINJECTOR	82	VELPHORO.....	62	<i>wera (28)</i>	85
.....	82	VELTASSA.....	62	<i>wescap-pn dha</i>	95
TYPHIM VI.....	76	VEMLIDY.....	12	<i>wixela inhub</i>	92
TYVASO.....	92	VENCLEXTA.....	30	X	
TYVASO INSTITUTIONAL		VENCLEXTA STARTING		XALKORI.....	31
START KIT.....	92	PACK.....	30	XARELTO.....	54
TYVASO REFILL KIT.....	92	<i>venlafaxine</i>	48	XARELTO DVT-PE TREAT	
TYVASO STARTER KIT...	92	<i>verapamil</i>	52	30D START.....	54
U		VERQUOVO.....	56	XATMEP.....	31
UBRELVY.....	36	VERSACLOZ.....	48	XCOPRI.....	35
<i>unithroid</i>	70	VERZENIO.....	30	XCOPRI MAINTENANCE	
UNITUXIN.....	30	<i>vestura (28)</i>	85	PACK.....	35
UPTRAVI.....	52	V-GO 20.....	78	XCOPRI TITRATION PACK	
<i>ursodiol</i>	73	V-GO 30.....	78	.....	35
UZEDY.....	48	V-GO 40.....	78	XDEMVY.....	87
V		VIBATIV.....	16	XELJANZ.....	82
<i>valacyclovir</i>	11, 12	VIBERZI.....	73	XELJANZ XR.....	82
VALCHLOR.....	58	<i>vienna</i>	85	XERMELO.....	31
<i>valganciclovir</i>	12	<i>vigabatrin</i>	35	XGEVA.....	19
<i>valproate sodium</i>	34	<i>vigadrone</i>	35	XIAFLEX.....	63
<i>valproic acid</i>	34	<i>vigpoder</i>	35	XIFAXAN.....	16
<i>valproic acid (as sodium salt)</i>		<i>vilazodone</i>	48	XIGDUO XR.....	68
.....	35	VIMIZIM.....	69	XIIDRA.....	87
<i>valrubicin</i>	30	<i>vinblastine</i>	30	XOFLUZA.....	12
<i>valsartan</i>	52	<i>vincristine</i>	30	XOLAIR.....	92
<i>valsartan-hydrochlorothiazide</i>		<i>vinorelbine</i>	30	XOSPATA.....	31
.....	52	VIOKACE.....	73	XPOVIO.....	31
VALTOCO.....	35	<i>viorele (28)</i>	85	XTANDI.....	31
<i>vancomycin</i>	15, 16	VIRACEPT.....	12	<i>xulane</i>	83
VANCOMYCIN.....	15	VIREAD.....	12	Y	
VANCOMYCIN IN 0.9 %		VISTOGARD.....	19	YERVOY.....	31
SODIUM CHL.....	15	VITRAKVI.....	30	YF-VAX (PF).....	77
<i>vandazole</i>	83	VIVITROL.....	41	YONDELIS.....	31
VANFLYTA.....	30	VIZIMPRO.....	30	<i>yuvafem</i>	83
VAQTA (PF).....	76, 77	VONJO.....	30	Z	
<i>varenicline</i>	63	VORANIGO.....	30	<i>zafemy</i>	83
VARIVAX (PF).....	77	<i>voriconazole</i>	9	<i>zafirlukast</i>	92
VARIZIG.....	77	VOSEVI.....	12	<i>zaleplon</i>	48
VARUBI.....	73	VOTRIENT.....	30	ZALTRAP.....	31
VAXCHORA VACCINE...	77	VRAYLAR.....	48	ZANOSAR.....	31
VECAMYL.....	56	VUMERITY.....	38	ZARXIO.....	75
VECTIBIX.....	30	VYNDAMAX.....	56	ZEGALOGUE	
VEKLURY.....	12	VYXEOS.....	30	AUTOINJECTOR.....	68
<i>veletri</i>	52	W		ZEGALOGUE SYRINGE...	68
		<i>warfarin</i>	54	ZEJULA.....	31

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 11/19/2024.

ZELBORAF	31	<i>ziprasidone mesylate</i>	48	<i>zovia 1-35 (28)</i>	85
<i>zenatane</i>	59	ZIRABEV.....	31	ZTALMY	35
ZENPEP	73	ZIRGAN.....	86	ZUBSOLV.....	41
ZEPOSIA	38	ZOLADEX.....	31	<i>zumandimine (28)</i>	85
ZEPOSIA STARTER KIT (28- DAY).....	38	<i>zoledronic acid</i>	69	ZURZUVAE.....	48
ZEPOSIA STARTER PACK (7-DAY).....	38	<i>zoledronic acid-mannitol-water</i>	63	ZYDELIG.....	31
ZEPZELCA	31	ZOLINZA.....	31	ZYKADIA.....	31
<i>zidovudine</i>	12	<i>zolmitriptan</i>	37	ZYMFENTRA	73
ZIEXTENZO	75	<i>zolpidem</i>	48	ZYNLONTA	31
<i>ziprasidone hcl</i>	48	ZONISADE	35	ZYNYZ	31
		<i>zonisamide</i>	35	ZYPREXA RELPREVV48, 49	

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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If you need these services, call Customer Service at 1-866-508-7145 (TTY 711). Our phone lines are open 8 a.m. to 8 p.m., 7 days a week from October – March and 8 a.m. to 8 p.m., Monday – Friday from April – September.

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**By mail: Section 1557 Coordinator • P. O. Box 98012 • Baton Rouge, LA 70898-9012
225-295-2300**

1-800-711-5519 (TTY 711)

Fax: 225-298-7240 (Attention: Government Programs)

Email: Section1557Coordinator@bcbsla.com

If you need help filing a grievance, our Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Multi-Language Insert

Multi-language Interpreter Services

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Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-508-7145 (711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费~~的~~翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-508-7145 (711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

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Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-866-508-7145 (711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-866-508-7145 (711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-866-508-7145 (711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-508-7145 (711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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This formulary was updated on 11/19/2024. 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.

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