



The Health Plan SecureCare SNP
(HMO D-SNP)

2023 Comprehensive Formulary (List of Covered Drugs)

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

This formulary was updated on

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 applicable). Call Member Services for more information.

Important Message About What You Pay for Insulin - If you receive "Extra Help", you pay \$0 for a one-month supply of each insulin product covered by our plan. If you no longer receive "Extra Help", you won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, even if you haven't paid your deductible.

For more recent information or other questions, please contact The Health Plan at 1.877.847.7907 or, for TTY users, 711, or visit healthplan.org/medicare.

Hours of Operation:

- October 1 to March 31: 8:00 am to 8:00 pm, 7 days a week
- April 1 to September 30: 8:00 am to 8:00 pm, Monday through Friday

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 The Health Plan. When it refers to “plan” or “our plan,” it means The Health Plan Medicare Advantage D-SNP Plan.

This document includes a list of the drugs (formulary) for our plan which is current as of 01/27/2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

What is The Health Plan SecureCare SNP (HMO D-SNP) Formulary?

A formulary is a list of covered drugs selected by The Health Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan 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 also find information in the section below entitled “How do I request an exception to The Health Plan Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration (FDA) deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, 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 Health Plan Formulary?”

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

The enclosed formulary is current as of 01/27/2022. To get updated information about the drugs covered by The Health Plan, please contact us. Our contact information appears on the front and back cover pages. We update our printed formularies each month, and they are available upon request by calling us (contact information on the front and back covers). You may also view and print an updated formulary on our website at healthplan.org/medicare.

How do I use the formulary?

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

Medical Condition

- The formulary begins on Page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular, Hypertension/Lipids.” If you know what your drug is used for, look for the category name in the list that begins below. 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 79. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** The Health Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, The Health Plan limits the amount of the drug that we will cover. For example, our plan provides 30 tablets for a 30-day prescription for atorvastatin. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, The Health 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, our plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on Page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted on line 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 us 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 Health Plan formulary?" on the next page for more information.

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 Member Services and ask if your drug is covered.

If you learn that The Health Plan does not cover your drug, you have two options:

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

How do I request an exception to The Health Plan SecureCare SNP (HMO D-SNP) Formulary?

You can ask us 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 if this drug is

not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, we 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, or utilization restriction exception. **When you request a formulary 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.

TRANSITION POLICY:

A transition policy allows a member to obtain drugs when they are subject to certain coverage rules. Most Medicare Part D drugs are eligible for transition. Transition eligible Part D drugs include those that are not on the formulary (list of covered drugs) or are on the formulary with a restriction such as step-therapy, quantity limits or prior authorization (but otherwise considered a "Part D drug"). Some Part D drugs are excluded for transition and are not covered under the transition policy. Examples are drugs used for cosmetic purposes, drugs used for erectile dysfunction, or over the counter drugs.

Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Chapter 5 of your Evidence of Coverage, Section 5 under "What is an exception?" to learn more about how to request an exception. Please contact Pharmacy Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on

our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception. We will provide current members an opportunity to request a formulary exception 60 days in advance for the following year.

While members are talking to their prescribers about their drug choices, we may provide a temporary supply of a transition eligible drug if members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of a transition eligible drug if you need a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and we provide a temporary supply of a transition eligible drug, we will cover a 30-day supply (unless the prescription is written for fewer days, in which case the plan will allow multiple fills to provide up to a total of 30 days of medication). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your prescriber to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 90-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our plan to meet the temporary 90-day transition supply. If the resident has been enrolled in our plan for more than 90 days and needs a drug that is not on our formulary, or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access.

For more information

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

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

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1.800.MEDICARE (1.800.633.4227) 24 hours a day/7 days a week. TTY users should call 1.877.486.2048. Or, visit medicare.gov.

The Health Plan SecureCare SNP (HMO D-SNP) Formulary

The formulary that begins on Page 2 provides coverage information about the drugs covered by us. If you have trouble finding your drug in the list, turn to the Index that begins on Page 79.

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

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

- Drug tier(s). Your plan has one drug tier. All covered drugs are in this tier.

Tier 1: Covered drugs

For more information about cost share amounts, please refer to the Evidence of Coverage (EOC). The EOC explains the plan's coverage stages and lists the copayment and co-insurance amounts for each tier.

If you qualify for Extra Help

If you qualify for Extra Help for your prescription drugs, your copays and co-insurance may be lower. Members who qualify for Extra Help will receive the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Please read it to learn about your costs, or call us with questions.

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.

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	1	B/D PA; MO
<i>amphotericin b</i>	1	B/D PA; MO
<i>casprofungin intravenous recon soln 50 mg</i>	1	
<i>casprofungin intravenous recon soln 70 mg</i>	1	
<i>clotrimazole mucous membrane</i>	1	MO
CRESEMBA ORAL	1	PA
<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>fluconazole oral suspension for reconstitution</i>	1	MO
<i>fluconazole oral tablet</i>	1	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)

Drug Name	Drug Tier	Requirements /Limits
<i>itraconazole oral solution</i>	1	MO
<i>ketoconazole oral</i>	1	MO
<i>micafungin</i>	1	MO
<i>nystatin oral</i>	1	MO
<i>posaconazole</i>	1	PA; MO; QL (96 per 30 days)
<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 oral capsule</i>	1	MO
<i>amantadine hcl oral solution</i>	1	MO
APRETUDE	1	MO
APTIVUS	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 01/24/2023.

Drug Name	Drug Tier	Requirements /Limits
<i>atazanavir</i>	1	MO
BARACLUDE ORAL SOLUTION	1	MO
BIKTARVY	1	MO
CABENUVA	1	MO
<i>cidofovir</i>	1	B/D PA; MO
CIMDUO	1	MO
COMPLERA	1	MO
DELSTRIGO	1	MO
DESCOVY	1	MO
DOVATO	1	MO
EDURANT	1	MO
<i>efavirenz</i>	1	MO
<i>efavirenz-emtricitabin-tenofov</i>	1	MO
<i>efavirenz-lamivudine-tenofov disop</i>	1	MO
<i>emtricitabine</i>	1	MO
<i>emtricitabine-tenofovir (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)

Drug Name	Drug Tier	Requirements /Limits
EPCLUSA ORAL TABLET 400-100 MG	1	PA; MO; QL (28 per 28 days)
EPIVIR HBV ORAL SOLUTION	1	MO
<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</i>	1	B/D PA; MO
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
INVIRASE ORAL TABLET	1	MO
ISENTRESS HD	1	MO
ISENTRESS ORAL POWDER IN PACKET	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ISENTRESS ORAL TABLET	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	1	MO
JULUCA	1	MO
<i>lamivudine</i>	1	MO
<i>lamivudine-zidovudine</i>	1	MO
LEXIVA ORAL SUSPENSION	1	MO
<i>lopinavir-ritonavir oral solution</i>	1	MO
<i>lopinavir-ritonavir oral tablet</i>	1	MO
<i>maraviroc</i>	1	MO
<i>nevirapine oral suspension</i>	1	
<i>nevirapine oral tablet</i>	1	MO
<i>nevirapine oral tablet extended release 24 hr</i>	1	MO
NORVIR ORAL POWDER IN PACKET	1	MO
NORVIR ORAL SOLUTION	1	MO
ODEFSEY	1	MO
<i>oseltamivir</i>	1	MO
PIFELTRO	1	MO
PREVYMIS INTRAVENOUS	1	

Drug Name	Drug Tier	Requirements /Limits
PREVYMIS ORAL	1	MO; QL (30 per 30 days)
PREZCOBIX	1	MO
PREZISTA ORAL SUSPENSION	1	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	1	MO
PREZISTA ORAL TABLET 600 MG, 800 MG	1	MO
RELENZA DISKHALER	1	MO
RETROVIR INTRAVENOUS	1	MO
REYATAZ ORAL POWDER IN PACKET	1	MO
<i>ribavirin oral capsule</i>	1	
<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
<i>stavudine oral capsule</i>	1	MO
STRIBILD	1	MO
SYMTUZA	1	MO
SYNAGIS	1	MO; LA

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This drug list was last updated on 01/24/2023.

Drug Name	Drug Tier	Requirements /Limits
<i>tenofovir disoproxil fumarate</i>	1	MO
TIVICAY ORAL TABLET 10 MG	1	MO
TIVICAY ORAL TABLET 25 MG, 50 MG	1	MO
TIVICAY PD	1	MO
TRIUMEQ	1	MO
TRIUMEQ PD	1	MO
TRIZIVIR	1	MO
TROGARZO	1	MO; LA
<i>valacyclovir oral tablet 1 gram</i>	1	MO; QL (120 per 30 days)
<i>valacyclovir oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
<i>valganciclovir oral recon soln</i>	1	MO
<i>valganciclovir oral tablet</i>	1	MO
VEKLURY	1	
VEMLIDY	1	MO
VIRACEPT ORAL TABLET	1	MO
VIREAD ORAL POWDER	1	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	MO
VOSEVI	1	PA; MO; QL (28 per 28 days)
<i>zidovudine oral capsule</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<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, 250 mg/5 ml</i>	1	MO
<i>cefaclor oral suspension for reconstitution 375 mg/5 ml</i>	1	
<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 g</i>	1	
<i>cefazolin intravenous</i>	1	
<i>cefdinir oral capsule</i>	1	MO
<i>cefdinir oral suspension for reconstitution</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.

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Drug Name	Drug Tier	Requirements /Limits
<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
<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

Drug Name	Drug Tier	Requirements /Limits
<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
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 oral suspension for reconstitution</i>	1	MO
<i>clarithromycin oral tablet</i>	1	MO
<i>clarithromycin oral tablet extended release 24 hr</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
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	MO
<i>erythromycin ethylsuccinate oral tablet</i>	1	
<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
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

Drug Name	Drug Tier	Requirements /Limits
<i>clindamycin in 5 % dextrose</i>	1	PA; MO
<i>clindamycin pediatric</i>	1	MO
<i>clindamycin phosphate injection</i>	1	PA; MO
<i>clindamycin phosphate intravenous</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
<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

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Drug Name	Drug Tier	Requirements /Limits
<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	PA; MO
<i>imipenem-cilastatin</i>	1	PA; MO
<i>isoniazid injection</i>	1	
<i>isoniazid oral solution</i>	1	MO
<i>isoniazid oral tablet</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	MO
<i>meropenem intravenous recon soln 1 gram</i>	1	PA; MO; QL (30 per 10 days)
<i>meropenem intravenous recon soln 500 mg</i>	1	PA; MO; 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

Drug Name	Drug Tier	Requirements /Limits
<i>neomycin</i>	1	MO
<i>nitazoxanide</i>	1	MO
<i>paromomycin</i>	1	MO
PASER	1	MO
<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
<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

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Drug Name	Drug Tier	Requirements /Limits
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)
<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)
<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)

Drug Name	Drug Tier	Requirements /Limits
<i>vancomycin oral capsule 250 mg</i>	1	PA; MO; QL (80 per 10 days)
XIFAXAN ORAL TABLET 200 MG	1	MO; 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</i>	1	MO
<i>amoxicillin oral tablet</i>	1	MO
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	MO
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	1	MO
<i>amoxicillin-pot clavulanate oral tablet, chewable</i>	1	MO
<i>ampicillin oral capsule 500 mg</i>	1	MO
<i>ampicillin sodium injection</i>	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
<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
BICILLIN C-R	1	PA; MO
BICILLIN L-A	1	PA; MO
<i>dicloxacillin</i>	1	MO
<i>nafcillin in dextrose iso-osm</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>nafcillin intravenous recon soln 2 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
<i>penicillin g potassium</i>	1	PA; MO
<i>penicillin g procaine</i>	1	PA; MO
<i>penicillin g sodium</i>	1	PA; MO
<i>penicillin v potassium</i>	1	MO
<i>pfizerpen-g</i>	1	PA

Drug Name	Drug Tier	Requirements /Limits
<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		
CIPRO ORAL SUSPENSION, MIC ROCAPSULE RECON	1	
<i>ciprofloxacin hcl oral tablet 100 mg</i>	1	MO
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	MO
<i>ciprofloxacin in 5 % dextrose</i>	1	PA; MO
<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; MO
<i>levofloxacin oral solution</i>	1	MO
<i>levofloxacin oral tablet</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<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>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
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1	MO
<i>minocycline oral capsule</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>minocycline oral tablet</i>	1	MO
<i>mondoxyne nl oral capsule 100 mg</i>	1	MO
<i>tetracycline</i>	1	MO
URINARY TRACT AGENTS		
<i>methenamine hippurate</i>	1	MO
<i>methenamine mandelate</i>	1	MO
<i>nitrofurantoin</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	1	
KHAPZORY	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

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Drug Name	Drug Tier	Requirements /Limits
<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
ALECENSA	1	PA; MO; QL (240 per 30 days)
ALIMTA	1	B/D PA; MO
ALIQOPA	1	B/D PA; LA
ALUNBRIG ORAL TABLET 180 MG, 90 MG	1	PA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	1	PA; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	1	PA; QL (30 per 180 days)
<i>anastrozole</i>	1	MO
<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
ARZERRA	1	B/D PA; MO

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

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Drug Name	Drug Tier	Requirements /Limits
BOSULIF ORAL TABLET 400 MG, 500 MG	1	PA; MO; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	1	PA; MO; LA; QL (180 per 30 days)
BRUKINSA	1	PA; LA
<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)
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
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	1	PA; MO; QL (56 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	1	PA; MO; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	1	PA; MO; QL (84 per 28 days)
COPIKTRA	1	PA; LA; QL (60 per 30 days)
COSMEGEN	1	B/D PA; MO
COTELLIC	1	PA; MO; LA; QL (63 per 28 days)
<i>cyclophosphamide intravenous recon soln</i>	1	B/D PA; MO
<i>cyclophosphamide oral capsule</i>	1	B/D PA; MO
CYCLOPHOSPHAMIDE ORAL TABLET	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

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Drug Name	Drug Tier	Requirements /Limits
<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
DANYELZA	1	PA
DARZALEX	1	B/D PA; MO; LA
<i>daunorubicin intravenous solution</i>	1	B/D PA
DAURISMO ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	1	PA; MO; QL (60 per 30 days)
<i>decitabine</i>	1	B/D PA; MO
<i>docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 20 mg/2 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/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

Drug Name	Drug Tier	Requirements /Limits
<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
ELZONRIS	1	PA; LA
EMCYT	1	MO
EMPLICITI	1	B/D PA; MO
<i>epirubicin intravenous solution 200 mg/100 ml</i>	1	B/D PA; MO
ERBITUX	1	B/D PA; MO
ERIVEDGE	1	PA; MO; QL (30 per 30 days)
ERLEADA	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

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

Drug Name	Drug Tier	Requirements /Limits
<i>fludarabine intravenous solution</i>	1	B/D PA
<i>fluorouracil intravenous solution 1 gram/20 ml, 500 mg/10 ml</i>	1	B/D PA; MO
<i>fluorouracil intravenous solution 2.5 gram/50 ml, 5 gram/100 ml</i>	1	B/D PA
FOLOTYN	1	B/D PA; MO
FOTIVDA	1	PA; LA; QL (21 per 28 days)
<i>fulvestrant</i>	1	B/D PA; MO
GAVRETO	1	PA; MO; LA; QL (120 per 30 days)
GAZYVA	1	B/D PA; MO
<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
GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML	1	B/D PA
<i>gengraf</i>	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
GILOTRIF	1	PA; MO; QL (30 per 30 days)
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)
IMBRUVICA ORAL CAPSULE 70 MG	1	PA; QL (30 per 30 days)
IMBRUVICA ORAL SUSPENSION	1	PA; QL (324 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
IMBRUVICA ORAL TABLET	1	PA; QL (30 per 30 days)
IMFINZI	1	B/D PA; MO; LA
IMJUDO	1	PA
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)
IRESSA	1	PA; MO; QL (30 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
IXEMPRA	1	B/D PA; MO
JAKAFI	1	PA; MO; QL (60 per 30 days)
JEMPERLI	1	PA; MO
JEVTANA	1	B/D PA; MO
KADCYLA	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
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)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	1	PA; MO; QL (63 per 28 days)
KYPROLIS	1	B/D PA
<i>lapatinib</i>	1	PA; MO; QL (180 per 30 days)
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	1	PA; MO; QL (28 per 28 days)
<i>lenalidomide oral capsule 2.5 mg, 20 mg</i>	1	PA; QL (28 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
LENVIMA	1	PA; MO
<i>letrozole</i>	1	MO
LEUKERAN	1	MO
<i>leuprolide subcutaneous kit</i>	1	PA; MO
LIBTAYO	1	PA; LA
LONSURF	1	PA; MO
LORBRENA ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	1	PA; MO; QL (90 per 30 days)
LUMAKRAS	1	PA; MO
LUMOXITI	1	PA; LA
LUPRON DEPOT	1	PA; MO
LUPRON DEPOT (3 MONTH)	1	PA; MO
LUPRON DEPOT (4 MONTH)	1	PA; MO
LUPRON DEPOT (6 MONTH)	1	PA; MO
LUPRON DEPOT-PED	1	PA; MO
LUPRON DEPOT-PED (3 MONTH)	1	PA; MO
LYNPARZA	1	PA; MO; QL (120 per 30 days)
LYSODREN	1	
MARGENZA	1	PA
MATULANE	1	
<i>megestrol oral suspension 400 mg/10 ml (10 ml)</i>	1	PA

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Drug Name	Drug Tier	Requirements /Limits
<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 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>melfhalan</i>	1	B/D PA; MO
<i>melfhalan 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
MONJUVI	1	PA; LA
<i>mycophenolate mofetil (hcl)</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
<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
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
<i>octreotide acetate injection syringe 500 mcg/ml (1 ml)</i>	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
ODOMZO	1	PA; MO; LA; QL (30 per 30 days)
ONCASPAR	1	B/D PA
ONIVYDE	1	B/D PA
ONUREG	1	PA; MO; QL (14 per 28 days)
OPDIVO	1	PA; MO
OPDUALAG	1	PA; MO
ORGOVYX	1	PA; LA; QL (30 per 28 days)
<i>oxaliplatin intravenous recon soln 100 mg</i>	1	B/D PA; MO
<i>oxaliplatin intravenous recon soln 50 mg</i>	1	B/D PA
<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
PEMAZYRE	1	PA; LA; QL (14 per 21 days)
<i>pemetrexed disodium intravenous recon soln 1,000 mg, 500 mg</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>pemetrexed disodium intravenous recon soln 100 mg</i>	1	B/D PA; MO
<i>pemetrexed disodium intravenous recon soln 750 mg</i>	1	B/D PA
PERJETA	1	B/D PA; MO
PIQRAY	1	PA; MO
POLIVY	1	PA; MO
POMALYST	1	PA; MO; LA
PORTRAZZA	1	B/D PA; MO
POTELIGEO	1	PA
PROGRAF INTRAVENOUS	1	B/D PA; MO
PROGRAF ORAL GRANULES IN PACKET	1	B/D PA; MO
PURIXAN	1	
QINLOCK	1	PA; LA; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	1	PA; MO; LA; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	1	PA; MO; LA; QL (120 per 30 days)
REVLIMID	1	PA; MO; LA; QL (28 per 28 days)
<i>romidepsin intravenous recon soln</i>	1	B/D PA

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Drug Name	Drug Tier	Requirements /Limits
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)
RUBRACA	1	PA; MO; LA; QL (120 per 30 days)
RUXIENCE	1	PA; MO
RYBREVANT	1	PA; MO
RYDAPT	1	PA; MO
RYLAZE	1	PA
SANDIMMUNE ORAL SOLUTION	1	B/D PA; MO
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON	1	PA; MO
SARCLISA	1	PA; LA
SCEMBLIX ORAL TABLET 20 MG	1	PA; MO; QL (600 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	1	PA; MO; 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

Drug Name	Drug Tier	Requirements /Limits
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</i>	1	PA; MO; QL (30 per 30 days)
SYNRIBO	1	B/D PA
TABLOID	1	MO
TABRECTA	1	PA; MO
<i>tacrolimus oral</i>	1	B/D PA; MO
TAFINLAR	1	PA; MO; QL (120 per 30 days)
TAGRISSE	1	PA; MO; LA; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG	1	PA; MO; QL (90 per 30 days)
TALZENNA ORAL CAPSULE 0.5 MG, 0.75 MG, 1 MG	1	PA; MO; QL (30 per 30 days)
<i>tamoxifen</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
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
TECVAYLI	1	PA
TEMODAR INTRAVENOUS	1	B/D PA; MO
<i>temsirolimus</i>	1	B/D PA; MO
TEPMETKO	1	PA; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	1	PA; MO; QL (28 per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	1	PA; MO; QL (56 per 28 days)
<i>thiotepa injection recon soln 100 mg</i>	1	B/D PA
<i>thiotepa injection recon soln 15 mg</i>	1	B/D PA; MO
TIBSOVO	1	PA
TIVDAK	1	PA; MO
<i>toposar</i>	1	B/D PA; MO
<i>topotecan intravenous recon soln</i>	1	B/D PA; MO
<i>topotecan intravenous solution 4 mg/4 ml (1 mg/ml)</i>	1	B/D PA; MO
<i>toremifene</i>	1	MO
TRAZIMERA	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
TREANDA	1	B/D PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	B/D PA; MO
<i>tretinoin (antineoplastic)</i>	1	MO
TRODELVY	1	PA; LA
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)	1	PA; LA; QL (21 per 28 days)
TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)	1	PA; LA; QL (42 per 28 days)
TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)	1	PA; LA; QL (63 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 200 MG	1	PA; LA; QL (120 per 30 days)
UNITUXIN	1	B/D PA
<i>valrubicin</i>	1	B/D PA; MO
VECTIBIX	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements /Limits
VENCLEXTA ORAL TABLET 10 MG	1	PA; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	1	PA; LA; QL (120 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>vincasar pfs</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)
VOTRIENT	1	PA; MO; QL (120 per 30 days)
VYXEOS	1	B/D PA

Drug Name	Drug Tier	Requirements /Limits
WELIREG	1	PA; LA
XALKORI	1	PA; MO; QL (60 per 30 days)
XATMEP	1	B/D PA; MO
XERMELO	1	PA; LA; QL (90 per 30 days)
XOSPATA	1	PA; LA
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)	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
YONSA	1	PA; MO; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
ZALTRAP	1	B/D PA; MO
ZANOSAR	1	B/D PA; MO
ZEJULA	1	PA; MO; LA; QL (90 per 30 days)
ZELBORAF	1	PA; MO; QL (240 per 30 days)
ZEPZELCA	1	PA
ZIRABEV	1	B/D PA; MO
ZOLADEX	1	PA; MO
ZOLINZA	1	PA; MO
ZYDELIG	1	PA; MO; QL (60 per 30 days)
ZYKADIA	1	PA; MO; QL (90 per 30 days)
ZYNLONTA	1	PA; LA

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)

Drug Name	Drug Tier	Requirements /Limits
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	1	MO
<i>carbamazepine oral suspension 100 mg/5 ml</i>	1	MO
<i>carbamazepine oral suspension 200 mg/10 ml</i>	1	
<i>carbamazepine oral tablet</i>	1	MO
<i>carbamazepine oral tablet extended release 12 hr</i>	1	MO
<i>carbamazepine oral tablet, chewable</i>	1	MO
CELONTIN ORAL CAPSULE 300 MG	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

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Drug Name	Drug Tier	Requirements /Limits
DILANTIN 30 MG	1	MO
<i>divalproex oral capsule, delayed rel sprinkle</i>	1	
<i>divalproex oral tablet extended release 24 hr</i>	1	MO
<i>divalproex oral tablet, delayed release (dr/ec)</i>	1	MO
EPIDIOLEX	1	PA; MO; LA
<i>epitol</i>	1	MO
EPRONTIA	1	PA; MO
<i>ethosuximide</i>	1	MO
<i>felbamate oral suspension</i>	1	MO
<i>felbamate oral tablet</i>	1	MO
FINTEPLA	1	PA; LA; QL (360 per 30 days)
<i>fosphenytoin</i>	1	MO
FYCOMPA ORAL SUSPENSION	1	MO; QL (720 per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	1	MO; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG	1	MO; QL (60 per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG	1	MO; QL (60 per 30 days)
<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)

Drug Name	Drug Tier	Requirements /Limits
<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>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 extended release 24hr</i>	1	MO
<i>lamotrigine oral tablet, chewable dispersible</i>	1	MO
<i>lamotrigine oral tablet, disintegrating</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	

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

Drug Name	Drug Tier	Requirements /Limits
<i>phenytoin oral suspension 125 mg/5 ml</i>	1	MO
<i>phenytoin oral tablet, chewable</i>	1	MO
<i>phenytoin sodium extended</i>	1	MO
<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)
<i>primidone</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</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

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Drug Name	Drug Tier	Requirements /Limits
<i>topiramate oral capsule, sprinkle</i>	1	PA; MO
<i>topiramate oral tablet</i>	1	PA; MO
<i>valproate sodium</i>	1	MO
<i>valproic acid</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)</i>	1	
VALTOCO	1	PA; MO; QL (10 per 30 days)
<i>vigabatrin</i>	1	MO; LA
<i>vigadrone</i>	1	LA
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	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 50 MG	1	MO; QL (240 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	1	MO; QL (28 per 180 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	1	MO; QL (28 per 180 days)
ZONISADE	1	PA; MO
<i>zonisamide</i>	1	PA; MO
ZTALMY	1	PA; LA; QL (1080 per 30 days)

ANTIPARKINSONISM AGENTS

<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	MO
<i>carbidopa-levodopa-entacapone</i>	1	MO
<i>entacapone</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	1	PA; MO; QL (150 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>selegiline hcl</i>	1	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
<i>dihydroergotamine injection</i>	1	
<i>dihydroergotamine nasal</i>	1	QL (8 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)
<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)

Drug Name	Drug Tier	Requirements /Limits
<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</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	1	MO; QL (8 per 28 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUBAGIO	1	PA; MO; QL (30 per 30 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)

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Drug Name	Drug Tier	Requirements /Limits
<i>donepezil oral tablet 10 mg, 5 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
<i>galantamine oral tablet</i>	1	MO
GILENYA ORAL CAPSULE 0.5 MG	1	PA; MO; QL (30 per 30 days)
<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)
<i>memantine oral capsule, sprinkle, er 24hr</i>	1	PA; MO
<i>memantine oral solution</i>	1	PA; MO
<i>memantine oral tablet</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
NAMZARIC	1	PA; MO
NUEDEXTA	1	PA; MO
OCREVUS	1	PA; MO; LA; QL (20 per 180 days)
RADICAVA	1	PA
<i> rivastigmine</i>	1	MO
<i> rivastigmine tartrate</i>	1	MO
<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)
TYSABRI	1	PA; MO; LA; QL (15 per 28 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
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

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Drug Name	Drug Tier	Requirements /Limits
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	MO
<i>pyridostigmine bromide oral tablet extended release</i>	1	MO
<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)
<i>buprenorphine hcl injection syringe</i>	1	
<i>buprenorphine hcl sublingual</i>	1	MO
<i>endocet</i>	1	MO; QL (360 per 30 days)
<i>fentanyl citrate (pf) injection solution</i>	1	QL (400 per 30 days)
<i>fentanyl citrate (pf) intravenous syringe 100 mcg/2 ml (50 mcg/ml)</i>	1	QL (400 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	1	PA; MO; QL (120 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	1	PA; MO; QL (120 per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	1	PA; MO; QL (10 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	MO; QL (390 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	1	MO; QL (50 per 30 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	1	QL (240 per 30 days)
<i>hydromorphone (pf) injection solution 2 mg/ml</i>	1	QL (150 per 30 days)
<i>hydromorphone injection solution 1 mg/ml</i>	1	QL (300 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>hydromorphone injection solution 2 mg/ml</i>	1	MO; QL (150 per 30 days)
<i>hydromorphone injection syringe 1 mg/ml</i>	1	MO; QL (300 per 30 days)
<i>hydromorphone injection syringe 2 mg/ml</i>	1	QL (150 per 30 days)
<i>hydromorphone injection syringe 4 mg/ml</i>	1	MO; QL (75 per 30 days)
<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	QL (150 per 30 days)
<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)
<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)

Drug Name	Drug Tier	Requirements /Limits
<i>methadone oral concentrate</i>	1	PA; MO; QL (90 per 30 days)
<i>morphine (pf) injection solution 0.5 mg/ml</i>	1	QL (4000 per 30 days)
<i>morphine (pf) injection solution 1 mg/ml</i>	1	MO; QL (2000 per 30 days)
<i>morphine concentrate oral solution</i>	1	MO; QL (900 per 30 days)
<i>morphine injection syringe 4 mg/ml</i>	1	MO; QL (500 per 30 days)
<i>morphine injection syringe 8 mg/ml</i>	1	QL (250 per 30 days)
<i>morphine intravenous solution 10 mg/ml</i>	1	MO; QL (200 per 30 days)
<i>morphine intravenous solution 4 mg/ml</i>	1	MO; QL (500 per 30 days)
<i>morphine intravenous syringe 10 mg/ml</i>	1	QL (200 per 30 days)
<i>morphine intravenous syringe 2 mg/ml</i>	1	QL (1000 per 30 days)
<i>morphine intravenous syringe 4 mg/ml</i>	1	QL (500 per 30 days)
<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)

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Drug Name	Drug Tier	Requirements /Limits
<i>oxycodone oral capsule</i>	1	MO; QL (360 per 30 days)
<i>oxycodone oral concentrate</i>	1	MO; QL (180 per 30 days)
<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)

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)
<i>butorphanol injection solution 1 mg/ml</i>	1	MO; QL (857 per 30 days)
<i>butorphanol injection solution 2 mg/ml</i>	1	MO; QL (428 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<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>diflunisal</i>	1	MO
<i>ec-naproxen oral tablet, delayed release (dr/ec) 375 mg</i>	1	
<i>ec-naproxen oral tablet, delayed release (dr/ec) 500 mg</i>	1	MO
<i>etodolac oral capsule</i>	1	MO
<i>etodolac oral tablet</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 15 mg</i>	1	MO
<i>meloxicam oral tablet 7.5 mg</i>	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>nabumetone</i>	1	MO
<i>nalbuphine injection solution 10 mg/ml</i>	1	MO; QL (200 per 30 days)
<i>nalbuphine injection solution 20 mg/ml</i>	1	MO; QL (100 per 30 days)
<i>naloxone injection solution</i>	1	MO
<i>naloxone injection syringe</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) 375 mg</i>	1	MO
<i>naproxen oral tablet, delayed release (dr/ec) 500 mg</i>	1	
<i>oxaprozin</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
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY MAINTENA	1	MO; QL (1 per 28 days)
<i>amitriptyline</i>	1	MO
<i>amoxapine</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<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)
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)

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Drug Name	Drug Tier	Requirements /Limits
<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)
<i>bupropion hcl oral tablet</i>	1	MO
<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>bupirone</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)

Drug Name	Drug Tier	Requirements /Limits
<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	
<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

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Drug Name	Drug Tier	Requirements /Limits
<i>doxepin oral tablet</i>	1	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	1	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	MO; QL (90 per 30 days)
<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)
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	1	MO; QL (28 per 180 days)
FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24 HR	1	MO; QL (30 per 30 days)
<i>flumazenil</i>	1	
<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 solution</i>	1	MO
<i>fluphenazine decanoate</i>	1	MO
<i>fluphenazine hcl</i>	1	MO
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (60 per 30 days)
<i>haloperidol</i>	1	MO
<i>haloperidol decanoate intramuscular solution 100 mg/ml (1 ml), 50 mg/ml(1ml)</i>	1	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	1	MO
<i>haloperidol lactate injection</i>	1	MO
<i>haloperidol lactate intramuscular</i>	1	
<i>haloperidol lactate oral</i>	1	MO
HETLIOZ	1	PA; MO; QL (30 per 30 days)
<i>imipramine hcl</i>	1	MO
<i>imipramine pamoate</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	1	MO; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	1	MO; QL (5 per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	1	MO; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	1	MO; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	1	MO; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	1	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	1	MO; QL (0.5 per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	1	MO; QL (0.88 per 90 days)

Drug Name	Drug Tier	Requirements /Limits
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)
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	1	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	1	MO; QL (60 per 30 days)
<i>lithium carbonate</i>	1	MO
<i>lorazepam injection solution</i>	1	PA; MO
<i>lorazepam injection syringe 2 mg/ml</i>	1	PA; MO
<i>lorazepam intensol</i>	1	PA; QL (150 per 30 days)
<i>lorazepam oral concentrate</i>	1	PA; MO; QL (150 per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>lorazepam oral tablet 2 mg</i>	1	PA; MO; QL (150 per 30 days)
<i>loxapine succinate</i>	1	MO
MARPLAN	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<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</i>	1	MO
<i>nefazodone</i>	1	MO
<i>nortriptyline oral capsule</i>	1	MO
<i>nortriptyline oral solution</i>	1	MO
NUPLAZID	1	PA; MO; QL (30 per 30 days)
<i>olanzapine intramuscular</i>	1	MO
<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)

Drug Name	Drug Tier	Requirements /Limits
<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>perphenazine</i>	1	MO
PERSERIS	1	MO; QL (1 per 30 days)
<i>phenelzine</i>	1	MO
<i>pimozide</i>	1	MO
<i>protriptyline</i>	1	MO
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	MO; QL (90 per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)
<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)

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Drug Name	Drug Tier	Requirements /Limits
REXULTI	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 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)

Drug Name	Drug Tier	Requirements /Limits
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
<i>thioridazine</i>	1	MO
<i>thiothixene</i>	1	MO
<i>tranylcypromine</i>	1	MO
<i>trazodone</i>	1	MO
<i>trifluoperazine</i>	1	MO
<i>trimipramine</i>	1	MO
TRINTELLIX	1	MO; QL (30 per 30 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	
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	1	MO; QL (30 per 180 days)
<i>vilazodone</i>	1	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	1	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	1	MO; QL (7 per 180 days)
XYREM	1	PA; LA; QL (540 per 30 days)
<i>zaleplon oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)

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This drug list was last updated on 01/24/2023.

Drug Name	Drug Tier	Requirements /Limits
<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)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	1	MO; QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	1	MO; QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	1	MO; QL (1 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>amiodarone oral tablet 100 mg, 400 mg</i>	1	
<i>amiodarone oral tablet 200 mg</i>	1	MO
<i>dofetilide</i>	1	MO
<i>flecainide</i>	1	MO
<i>ibutilide fumarate</i>	1	
<i>lidocaine (pf) intravenous</i>	1	
<i>lidocaine in 5 % dextrose (pf) intravenous parenteral solution 4 mg/ml (0.4 %), 8 mg/ml (0.8 %)</i>	1	
<i>mexiletine</i>	1	MO
<i>pacerone oral tablet 100 mg, 400 mg</i>	1	MO
<i>pacerone oral tablet 200 mg</i>	1	MO
<i>procainamide injection</i>	1	
<i>propafenone oral capsule, extended release 12 hr</i>	1	MO
<i>propafenone oral tablet</i>	1	MO
<i>quinidine sulfate oral tablet</i>	1	MO
<i>sorine oral tablet 120 mg, 160 mg, 80 mg</i>	1	MO
<i>sorine oral tablet 240 mg</i>	1	
<i>sotalol af</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>sotalol oral</i>	1	MO
ANTIHYPERTENSIVE THERAPY		
<i>acebutolol</i>	1	MO
<i>aliskiren</i>	1	MO
<i>amiloride</i>	1	MO
<i>amiloride-hydrochlorothiazide</i>	1	MO
<i>amlodipine</i>	1	MO
<i>amlodipine-benazepril</i>	1	MO
<i>amlodipine-olmesartan</i>	1	MO
<i>amlodipine-valsartan</i>	1	MO
<i>amlodipine-valsartan-hcthiazid</i>	1	MO
<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>cartia xt</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>carvedilol</i>	1	MO
<i>chlorothiazide sodium</i>	1	MO
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	MO
<i>clonidine</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 capsule, ext. rel 24h degradable</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 24 hr</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 24hr</i>	1	MO
<i>diltiazem hcl oral tablet</i>	1	MO
<i>diltiazem hcl oral tablet extended release 24 hr</i>	1	
<i>dilt-xr</i>	1	MO
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	1	MO; QL (30 per 30 days)
<i>doxazosin oral tablet 8 mg</i>	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<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>epoprostenol (glycine)</i>	1	B/D PA; 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</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
KERENDIA	1	PA; QL (30 per 30 days)
<i>labetalol intravenous solution</i>	1	

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

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

Drug Name	Drug Tier	Requirements /Limits
<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>treprostinil sodium</i>	1	PA; MO; LA
<i>triamterene-hydrochlorothiazid</i>	1	MO
UPTRAVI ORAL	1	PA; MO; LA
<i>valsartan oral tablet</i>	1	MO
<i>valsartan-hydrochlorothiazide</i>	1	MO
<i>veletri</i>	1	B/D PA; MO
<i>verapamil intravenous</i>	1	
<i>verapamil oral capsule, 24 hr er pellet ct</i>	1	MO
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	1	MO
<i>verapamil oral tablet</i>	1	MO
<i>verapamil oral tablet extended release</i>	1	MO
COAGULATION THERAPY		
<i>aminocaproic acid intravenous</i>	1	MO
<i>aminocaproic acid oral</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>aspirin-dipyridamole</i>	1	MO
BRILINTA	1	MO
CABLIVI INJECTION KIT	1	PA; LA
CEPROTIN (BLUE BAR)	1	PA; MO
CEPROTIN (GREEN BAR)	1	PA; MO
<i>cilostazol</i>	1	MO
<i>clopidogrel oral tablet 300 mg</i>	1	MO
<i>clopidogrel oral tablet 75 mg</i>	1	MO; QL (30 per 30 days)
<i>dabigatran etexilate</i>	1	MO
<i>dipyridamole intravenous</i>	1	
<i>dipyridamole oral</i>	1	MO
DOPTELET (10 TAB PACK)	1	PA; MO; LA
DOPTELET (15 TAB PACK)	1	PA; MO; LA
DOPTELET (30 TAB PACK)	1	PA; MO; LA
ELIQUIS	1	MO
ELIQUIS DVT-PE TREAT 30D START	1	MO
<i>enoxaparin subcutaneous solution</i>	1	MO; QL (30 per 30 days)
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	1	MO; QL (28 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	1	MO; QL (22.4 per 28 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml</i>	1	MO; QL (16.8 per 28 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	1	MO; QL (11.2 per 28 days)
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	1	MO
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	1	MO
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml)</i>	1	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	1	MO
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml</i>	1	MO
<i>heparin (porcine) in nacl (pf) intravenous parenteral solution 2,000 unit/1,000 ml</i>	1	

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

Drug Name	Drug Tier	Requirements /Limits
<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>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</i>	1	MO
<i>ezetimibe</i>	1	MO
<i>ezetimibe-simvastatin</i>	1	MO; QL (30 per 30 days)
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	1	MO
<i>fenofibrate nanocrystallized</i>	1	MO
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	1	MO
<i>fenofibric acid</i>	1	MO
<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)

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Drug Name	Drug Tier	Requirements /Limits
<i>gemfibrozil</i>	1	MO
<i>icosapent ethyl</i>	1	MO
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	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)
<i>niacin oral tablet 500 mg</i>	1	MO
<i>niacin oral tablet extended release 24 hr</i>	1	MO
<i>omega-3 acid ethyl esters</i>	1	MO
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite</i>	1	MO
REPATHA	1	PA; QL (3 per 28 days)
REPATHA PUSHTRONEX	1	PA; QL (3.5 per 28 days)
REPATHA SURECLICK	1	PA; QL (3 per 28 days)
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
<i>simvastatin oral tablet</i>	1	MO; QL (30 per 30 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	1	MO
MISCELLANEOUS CARDIOVASCULAR AGENTS		
<i>cardioplegic soln</i>	1	

Drug Name	Drug Tier	Requirements /Limits
CORLANOR ORAL SOLUTION	1	QL (450 per 30 days)
CORLANOR ORAL TABLET	1	MO; QL (60 per 30 days)
<i>digitek oral tablet 250 mcg (0.25 mg)</i>	1	MO
<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 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>dobutamine intravenous solution 250 mg/20 ml (12.5 mg/ml)</i>	1	B/D PA
<i>dopamine in 5 % dextrose intravenous solution 200 mg/250 ml (800 mcg/ml), 400 mg/250 ml (1,600 mcg/ml), 400 mg/500 ml (800 mcg/ml), 800 mg/500 ml (1,600 mcg/ml)</i>	1	B/D PA
<i>dopamine in 5 % dextrose intravenous solution 800 mg/250 ml (3,200 mcg/ml)</i>	1	B/D PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>nitroglycerin transdermal patch 24 hour</i>	1	MO
<i>nitroglycerin translingual</i>	1	MO
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>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)
SKYRIZI SUBCUTANEOUS SYRINGE KIT	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)

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Drug Name	Drug Tier	Requirements /Limits
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
TALTZ AUTOINJECTOR	1	PA; MO; QL (1 per 28 days)
TALTZ AUTOINJECTOR (2 PACK)	1	PA; MO; QL (4 per 28 days)
TALTZ AUTOINJECTOR (3 PACK)	1	PA; MO; QL (3 per 180 days)
TALTZ SYRINGE	1	PA; MO; QL (1 per 28 days)
MISCELLANEOUS DERMATOLOGICALS		
<i>ammonium lactate</i>	1	MO
<i>chlorprocaine (pf)</i>	1	
DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	1	PA; MO; QL (1.34 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
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	MO
<i>lidocaine hcl mucous membrane jelly</i>	1	MO; QL (60 per 30 days)
<i>lidocaine hcl mucous membrane jelly in applicator</i>	1	MO; QL (60 per 30 days)
<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	MO

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Drug Name	Drug Tier	Requirements /Limits
<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>methoxsalen</i>	1	MO
PANRETIN	1	PA; MO
<i>pimecrolimus</i>	1	PA; MO; QL (100 per 30 days)
<i>podofilox</i>	1	MO
<i>polocaine injection solution 1 % (10 mg/ml)</i>	1	
<i>polocaine-mpf</i>	1	
REGRANEX	1	MO
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)
VALCHLOR	1	PA; MO
THERAPY FOR ACNE		
<i>acutane</i>	1	
<i>amnesteem</i>	1	
<i>avita topical cream</i>	1	PA; MO
<i>claravis</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<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 (60 per 30 days)
<i>metronidazole topical</i>	1	MO
<i>myorisan</i>	1	
<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 cream</i>	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>gentamicin topical ointment</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	MO; QL (6.6 per 28 days)
<i>ciclopirox topical cream</i>	1	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	1	MO; QL (45 per 28 days)
<i>ciclopirox topical shampoo</i>	1	MO; QL (120 per 28 days)
<i>ciclopirox topical solution</i>	1	MO; QL (6.6 per 28 days)
<i>ciclopirox topical suspension</i>	1	MO; QL (60 per 28 days)
<i>clotrimazole topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole topical solution</i>	1	MO; QL (30 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	1	MO; QL (60 per 28 days)
<i>econazole</i>	1	MO; QL (85 per 28 days)
<i>ketconazole topical cream</i>	1	MO; QL (60 per 28 days)
<i>ketconazole topical shampoo</i>	1	MO; QL (120 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<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	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)
DENAVIR	1	MO; QL (5 per 30 days)
<i>penciclovir</i>	1	MO; QL (5 per 30 days)
TOPICAL CORTICOSTEROIDS		
<i>ala-cort topical cream 1 %</i>	1	MO
<i>ala-cort topical cream 2.5 %</i>	1	
<i>alclometasone</i>	1	MO
<i>betamethasone dipropionate</i>	1	MO
<i>betamethasone valerate topical cream</i>	1	MO
<i>betamethasone valerate topical lotion</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<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	MO
<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	MO
TOPICAL SCABICIDES / PEDICULICIDES		
<i>crotan</i>	1	MO
<i>lindane topical shampoo</i>	1	MO
<i>malathion</i>	1	MO
<i>permethrin</i>	1	MO
DIAGNOSTICS / MISCELLANEOUS AGENTS		
ANTIDOTES		
<i>acetylcysteine intravenous</i>	1	
IRRIGATING SOLUTIONS		
<i>lactated ringers irrigation</i>	1	MO
<i>neomycin-polymyxin b gu</i>	1	MO
<i>ringer's irrigation</i>	1	
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
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	MO
<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 tablet 180 mg, 360 mg</i>	1	PA; MO
<i>deferasirox oral tablet 90 mg</i>	1	PA; MO
<i>deferiprone</i>	1	PA; MO
<i>deferoxamine</i>	1	B/D PA; MO
<i>dextrose 10 % and 0.2 % nacl</i>	1	
<i>dextrose 10 % in water (d10w)</i>	1	
<i>dextrose 25 % in water (d25w)</i>	1	
<i>dextrose 5 % in water (d5w)</i>	1	MO
<i>dextrose 5 %-lactated ringers</i>	1	MO
<i>dextrose 5%-0.2 % sod chloride</i>	1	
<i>dextrose 5%-0.3 % sod.chloride</i>	1	
<i>dextrose 50 % in water (d50w)</i>	1	MO
<i>dextrose 70 % in water (d70w)</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>disulfiram oral tablet 250 mg</i>	1	MO
<i>disulfiram oral tablet 500 mg</i>	1	
<i>droxidopa</i>	1	PA; MO
INCRELEX	1	MO; LA
<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	1	PA; LA
RAVICTI	1	PA; MO
REVCOVI	1	PA; LA
<i>riluzole</i>	1	PA; MO
<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

Drug Name	Drug Tier	Requirements /Limits
<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</i>	1	PA; MO
<i>water for irrigation, sterile</i>	1	MO
XIAFLEX	1	PA
<i>zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml</i>	1	PA; MO
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deter)</i>	1	MO
NICOTROL	1	MO
NICOTROL NS	1	MO
<i>varenicline</i>	1	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
<i>azelastine nasal</i>	1	MO; QL (60 per 30 days)
<i>chlorhexidine gluconate mucous membrane</i>	1	MO
<i>denta 5000 plus</i>	1	MO
<i>dentagel</i>	1	MO
<i>fluoride (sodium) dental cream</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<i>fluoride (sodium) dental gel</i>	1	
<i>fluoride (sodium) dental paste</i>	1	MO
<i>ipratropium bromide nasal</i>	1	MO; QL (30 per 30 days)
<i>oralone</i>	1	MO
<i>periogard</i>	1	MO
<i>sf</i>	1	MO
<i>sf 5000 plus</i>	1	MO
<i>sodium fluoride 5000 dry mouth</i>	1	MO
<i>sodium fluoride 5000 plus</i>	1	
<i>sodium fluoride-pot nitrate</i>	1	MO
<i>triamcinolone acetonide dental</i>	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetic acid otic (ear)</i>	1	MO
<i>ciprofloxacin hcl otic (ear)</i>	1	MO
<i>flac otic oil</i>	1	
<i>fluocinolone acetonide oil</i>	1	MO
<i>hydrocortisone-acetic acid</i>	1	MO
<i>ofloxacin otic (ear)</i>	1	MO
OTIC STEROID / ANTIBIOTIC		
<i>ciprofloxacin-dexamethasone</i>	1	MO
<i>neomycin-polymyxin-hc otic (ear)</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
<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</i>	1	MO
<i>dexamethasone sodium phosphate injection</i>	1	MO
<i>fludrocortisone</i>	1	MO
<i>hydrocortisone oral</i>	1	MO
<i>methylprednisolone acetate</i>	1	MO
<i>methylprednisolone oral tablet</i>	1	B/D PA; MO
<i>methylprednisolone oral tablets,dose pack</i>	1	MO
<i>methylprednisolone sodium succ injection recon soln 125 mg, 40 mg</i>	1	MO
<i>methylprednisolone sodium succ intravenous</i>	1	MO
<i>prednisolone oral solution</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<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</i>	1	MO
<i>prednisone intensol</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)
<i>alcohol pads</i>	1	MO
BYDUREON BCISE	1	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	1	PA; MO; QL (2.4 per 30 days)

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

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Drug Name	Drug Tier	Requirements /Limits
GVOKE	1	MO
GVOKE HYPOPEN 1-PACK	1	MO
GVOKE HYPOPEN 2-PACK	1	MO
GVOKE PFS 1-PACK SYRINGE	1	MO
GVOKE PFS 2-PACK SYRINGE	1	MO
HUMALOG JUNIOR KWIKPEN U-100	1	MO
HUMALOG KWIKPEN INSULIN	1	MO
HUMALOG MIX 50-50 INSULN U-100	1	MO
HUMALOG MIX 50-50 KWIKPEN	1	MO
HUMALOG MIX 75-25 KWIKPEN	1	MO
HUMALOG MIX 75-25(U-100)INSULN	1	MO
HUMALOG U-100 INSULIN	1	MO
HUMULIN 70/30 U-100 INSULIN	1	MO
HUMULIN 70/30 U-100 KWIKPEN	1	MO
HUMULIN N NPH INSULIN KWIKPEN	1	MO
HUMULIN N NPH U-100 INSULIN	1	MO

Drug Name	Drug Tier	Requirements /Limits
HUMULIN R REGULAR U-100 INSULN	1	MO
HUMULIN R U-500 (CONC) INSULIN	1	MO
HUMULIN R U-500 (CONC) KWIKPEN	1	MO
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)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	1	MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	1	MO; QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN	1	MO
LANTUS U-100 INSULIN	1	MO

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Drug Name	Drug Tier	Requirements /Limits
LYUMJEV KWIKPEN U-100 INSULIN	1	MO
LYUMJEV KWIKPEN U-200 INSULIN	1	MO
LYUMJEV 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)
<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)
ONGLYZA	1	MO; QL (30 per 30 days)
<i>pioglitazone</i>	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)
SOLIQUA 100/33	1	MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
SYNJARDY	1	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5- 1,000 MG	1	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	1	MO; QL (30 per 30 days)
TOUJEO MAX U- 300 SOLOSTAR	1	MO
TOUJEO SOLOSTAR U-300 INSULIN	1	MO
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 4.5 MG/0.5 ML	1	PA; MO; QL (2 per 28 days)
TRULICITY SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML	1	PA; 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)

MISCELLANEOUS HORMONES

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Drug Name	Drug Tier	Requirements /Limits
ALDURAZYME	1	PA; MO
<i>cabergoline</i>	1	MO
<i>calcitonin (salmon) injection</i>	1	MO
<i>calcitonin (salmon) nasal</i>	1	MO
<i>calcitriol intravenous solution 1 mcg/ml</i>	1	
<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	
<i>doxercalciferol oral</i>	1	MO
ELAPRASE	1	PA; MO
FABRAZYME	1	PA; MO
KANUMA	1	PA; MO
KORLYM	1	PA

Drug Name	Drug Tier	Requirements /Limits
LUMIZYME	1	PA; MO
MEPSEVII	1	PA; MO
MYALEPT	1	PA; MO; LA
NAGLAZYME	1	PA; MO; LA
NATPARA	1	PA; MO; LA
<i>oxandrolone oral tablet 10 mg</i>	1	PA; MO
<i>oxandrolone oral tablet 2.5 mg</i>	1	PA; MO
<i>pamidronate intravenous solution</i>	1	MO
<i>paricalcitol intravenous solution 2 mcg/ml</i>	1	
<i>paricalcitol intravenous solution 5 mcg/ml</i>	1	MO
<i>paricalcitol oral</i>	1	MO
<i>sapropterin</i>	1	PA; MO
SOMAVERT	1	PA; MO
SYNAREL	1	PA; MO
<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)

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Drug Name	Drug Tier	Requirements /Limits
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	1	PA; MO; QL (120 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	1	PA; MO; QL (300 per 30 days)
<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
<i>zoledronic acid-mannitol-water intravenous piggyback 4 mg/100 ml</i>	1	B/D PA; MO
THYROID HORMONES		
<i>euthyrox</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>levo-t</i>	1	
<i>levothyroxine intravenous recon soln</i>	1	MO
<i>levothyroxine oral tablet</i>	1	MO
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO
<i>liothyronine</i>	1	MO
<i>unithroid</i>	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
<i>atropine injection solution 0.4 mg/ml</i>	1	
<i>atropine injection syringe 0.05 mg/ml, 0.1 mg/ml</i>	1	
<i>dicyclomine intramuscular</i>	1	MO
<i>dicyclomine oral capsule</i>	1	MO
<i>dicyclomine oral solution</i>	1	MO
<i>dicyclomine oral tablet</i>	1	MO
<i>diphenoxylate-atropine oral liquid</i>	1	MO
<i>diphenoxylate-atropine oral tablet</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>glycopyrrolate (pf) in water intravenous syringe 0.4 mg/2 ml (0.2 mg/ml)</i>	1	MO
<i>glycopyrrolate injection</i>	1	MO
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	MO
<i>glycopyrrolate oral tablet 1.5 mg</i>	1	
<i>loperamide oral capsule</i>	1	MO
<i>opium tincture</i>	1	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
<i>alosetron</i>	1	PA; MO
<i>aprepitant</i>	1	B/D PA; MO
<i>balsalazide</i>	1	MO
<i>betaine</i>	1	MO
<i>budesonide oral capsule, delayed, extended release</i>	1	MO
<i>budesonide oral tablet, delayed and extended release</i>	1	
CHENODAL	1	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	1	PA
CHOLBAM ORAL CAPSULE 50 MG	1	PA; QL (120 per 30 days)
CINVANTI	1	MO
<i>compro</i>	1	MO
<i>constulose</i>	1	MO
CORTIFOAM	1	MO
CREON	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>cromolyn oral</i>	1	MO
<i>dimenhydrinate injection solution</i>	1	MO
<i>dronabinol</i>	1	B/D PA; MO
<i>droperidol injection solution</i>	1	MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	1	B/D PA
ENTYVIO	1	PA; MO; QL (2 per 28 days)
<i>enulose</i>	1	MO
<i>fosaprepitant</i>	1	MO
GATTEX 30-VIAL	1	PA; MO
GATTEX ONE-VIAL	1	PA; MO
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>generlac</i>	1	MO
<i>granisetron (pf) intravenous solution 1 mg/ml (1 ml)</i>	1	MO
<i>granisetron hcl intravenous</i>	1	MO
<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
INFLECTRA	1	PA; MO; QL (20 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>ondansetron</i>	1	B/D PA; MO
<i>ondansetron hcl (pf)</i>	1	MO
<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>palonosetron intravenous solution 0.25 mg/5 ml</i>	1	MO
<i>palonosetron intravenous syringe</i>	1	
<i>peg 3350-electrolytes</i>	1	MO
<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
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 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>procto-pak</i>	1	MO
<i>proctosol hc topical</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<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)
<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; 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</i>	1	MO
SUCRAID	1	PA
<i>sulfasalazine</i>	1	MO
TRULANCE	1	MO
<i>ursodiol oral capsule 300 mg</i>	1	MO
<i>ursodiol oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
VARUBI	1	B/D PA
VIOKACE	1	MO
ULCER THERAPY		
<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
<i>esomeprazole sodium intravenous recon soln 40 mg</i>	1	
<i>famotidine (pf)</i>	1	MO
<i>famotidine (pf)-nacl (iso-os)</i>	1	MO
<i>famotidine intravenous</i>	1	MO
<i>famotidine oral suspension</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
<i>misoprostol</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

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Drug Name	Drug Tier	Requirements /Limits
<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
<i>sucralfate oral suspension</i>	1	MO
<i>sucralfate oral tablet</i>	1	MO

IMMUNOLOGY, VACCINES / BIOTECHNOLOGY

BIOTECHNOLOGY DRUGS

ACTIMMUNE	1	B/D PA; MO
ARCALYST	1	PA; MO
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)
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
INTRON A INJECTION RECON SOLN 50 MILLION UNIT (1 ML)	1	B/D PA
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)
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

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Drug Name	Drug Tier	Requirements /Limits
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
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	1	MO
ADACEL(TDAP ADOLESN/ADULT)(PF)	1	MO
BCG VACCINE, LIVE (PF)	1	MO
BEXSERO	1	MO
BOOSTRIX TDAP	1	MO
BOTOX	1	PA; MO
DAPTACEL (DTAP PEDIATRIC) (PF)	1	MO
DENGVAXIA (PF)	1	
ENGERIX-B (PF)	1	B/D PA; MO
ENGERIX-B PEDIATRIC (PF)	1	B/D PA; MO
<i>fomepizole</i>	1	
GAMASTAN	1	MO
GAMASTAN S/D	1	
GARDASIL 9 (PF)	1	MO
HAVRIX (PF)	1	MO
HIBERIX (PF)	1	MO

Drug Name	Drug Tier	Requirements /Limits
HIZENTRA	1	B/D PA; MO
HYPERHEP B INTRAMUSCULAR SOLUTION 220 UNIT/ML	1	
HYPERHEP B INTRAMUSCULAR SOLUTION 220 UNIT/ML (5 ML)	1	MO
HYPERHEP B NEONATAL	1	
HYQVIA	1	B/D PA; MO
IMOVAX RABIES VACCINE (PF)	1	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	1	MO
IPOL	1	
IXIARO (PF)	1	
KINRIX (PF) INTRAMUSCULAR SYRINGE	1	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	1	MO
MENQUADFI (PF)	1	MO
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	1	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR SOLUTION	1	MO
M-M-R II (PF)	1	MO
PEDIARIX (PF)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
PEDVAX HIB (PF)	1	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF- 48MCG-62DU -10 MCG/0.5ML	1	
PREHEVBRIO (PF)	1	B/D PA; MO
PRIORIX (PF)	1	
PRIVIGEN	1	PA; MO
PROQUAD (PF)	1	
QUADRACEL (PF)	1	
RABAVERT (PF)	1	MO
RECOMBIVAX HB (PF)	1	B/D PA; MO
ROTARIX	1	
ROTATEQ VACCINE	1	MO
SHINGRIX (PF)	1	MO
STAMARIL (PF)	1	
TDVAX	1	MO
TENIVAC (PF)	1	MO
TETANUS,DIPHTE RIA TOX PED(PF)	1	MO
TICE BCG	1	B/D PA; MO
TICOVAC	1	MO
TRUMENBA	1	MO
TWINRIX (PF)	1	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	1	
TYPHIM VI INTRAMUSCULAR SYRINGE	1	MO

Drug Name	Drug Tier	Requirements /Limits
VAQTA (PF)	1	MO
VARIVAX (PF)	1	
VARIZIG	1	MO
YF-VAX (PF)	1	
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
BD AUTOSHIELD DUO PEN NEEDLE	1	MO
BD INSULIN SYRINGE (HALF UNIT)	1	MO
BD INSULIN SYRINGE U-500	1	MO
BD INSULIN ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2"	1	MO
BD NANO 2ND GEN PEN NEEDLE	1	MO
BD ULTRA-FINE MICRO PEN NEEDLE	1	MO
BD ULTRA-FINE MINI PEN NEEDLE	1	MO
BD ULTRA-FINE NANO PEN NEEDLE	1	MO
BD ULTRA-FINE SHORT PEN NEEDLE	1	MO
BD VEO INSULIN SYR (HALF UNIT)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
BD VEO INSULIN SYRINGE UF	1	MO
GAUZE PADS 2 X 2	1	MO
INSULIN PEN NEEDLE	1	MO
INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML	1	MO
NEEDLES, INSULIN DISP.,SAFETY	1	MO
NOVOFINE 32	1	MO
NOVOFINE PLUS	1	MO
OMNIPOD 5 G6 INTRO KIT (GEN 5)	1	MO; QL (1 per 720 days)
OMNIPOD 5 G6 PODS (GEN 5)	1	MO
OMNIPOD CLASSIC PODS (GEN 3)	1	MO
OMNIPOD DASH INTRO KIT (GEN 4)	1	MO; QL (1 per 720 days)
OMNIPOD DASH PODS (GEN 4)	1	MO
V-GO 20	1	MO
V-GO 30	1	MO
V-GO 40	1	MO

MUSCULOSKELETAL / RHEUMATOLOGY

GOUT THERAPY

Drug Name	Drug Tier	Requirements /Limits
<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
KRYSTEXXA	1	MO
<i>probenecid</i>	1	MO
<i>probenecid-colchicine</i>	1	MO
OSTEOPOROSIS THERAPY		
<i>alendronate oral tablet 10 mg, 5 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)
<i>ibandronate intravenous</i>	1	PA; MO
<i>ibandronate oral</i>	1	MO; QL (1 per 30 days)
PROLIA	1	PA; MO; QL (1 per 180 days)
<i>raloxifene</i>	1	MO
TERIPARATIDE	1	PA; MO; 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)

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Drug Name	Drug Tier	Requirements /Limits
ACTEMRA SUBCUTANEOUS	1	PA; MO; QL (3.6 per 28 days)
BENLYSTA	1	PA; MO
ENBREL MINI	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	1	PA; MO; QL (16 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 PEN	1	PA; MO; QL (4 per 28 days)
HUMIRA PEN CROHNS-UC-HS START	1	PA; MO; QL (6 per 180 days)
HUMIRA PEN PSOR-UEVITS-ADOL HS	1	PA; MO; QL (4 per 180 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	1	PA; MO; QL (3 per 180 days)

Drug Name	Drug Tier	Requirements /Limits
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	1	PA; MO; QL (2 per 180 days)
HUMIRA(CF) PEN CROHNS-UC-HS	1	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC	1	PA; MO; QL (4 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	1	PA; MO; QL (3 per 180 days)
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	1	PA; MO; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	1	PA; MO; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
<i>leflunomide</i>	1	MO; QL (30 per 30 days)
ORENCIA (WITH MALTOSE)	1	PA; MO; QL (12 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
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 (4)-30 MG (47)	1	PA; MO; QL (55 per 180 days)
<i>penicillamine oral tablet</i>	1	PA; MO
RIDAURA	1	MO
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	1	PA; MO; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	1	PA; MO; QL (56 per 180 days)
XELJANZ ORAL SOLUTION	1	PA; MO; QL (300 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
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>amabelz</i>	1	PA; MO
<i>camila</i>	1	MO
<i>deblitane</i>	1	MO
<i>dotti</i>	1	PA; MO; QL (8 per 28 days)
<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; QL (4 per 28 days)
<i>estradiol vaginal</i>	1	MO
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	1	MO
<i>estradiol-norethindrone acet</i>	1	PA; MO
<i>fyavolv</i>	1	PA; MO
<i>heather</i>	1	MO
<i>hydroxyprogesterone caproate</i>	1	
<i>incassia</i>	1	MO
<i>jencycla</i>	1	MO
<i>jinteli</i>	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
<i>lyleq</i>	1	MO
<i>lyllana</i>	1	PA; MO; QL (8 per 28 days)
<i>lyza</i>	1	
<i>medroxyprogesterone</i>	1	MO
MENEST	1	PA; MO
<i>mimvey</i>	1	PA; MO
<i>nora-be</i>	1	MO
<i>norethindrone (contraceptive)</i>	1	
<i>norethindrone acetate</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	1	PA
<i>norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg</i>	1	PA; MO
<i>progesterone</i>	1	MO
<i>progesterone micronized</i>	1	MO
<i>sharobel</i>	1	MO
<i>yuvafem</i>	1	MO
MISCELLANEOUS OB/GYN		
<i>clindamycin phosphate vaginal</i>	1	MO
<i>eluryng</i>	1	MO
<i>etonogestrel-ethinyl estradiol</i>	1	
<i>metronidazole vaginal</i>	1	MO
<i>mifepristone</i>	1	LA
<i>terconazole</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>tranexamic acid oral</i>	1	MO
<i>vandazole</i>	1	MO
<i>xulane</i>	1	MO
<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>apri</i>	1	MO
<i>aranelle (28)</i>	1	MO
<i>aubra</i>	1	
<i>aubra eq</i>	1	MO
<i>aviane</i>	1	MO
<i>azurette (28)</i>	1	MO
<i>cryselle (28)</i>	1	MO
<i>cyred</i>	1	
<i>cyred eq</i>	1	MO
<i>dasetta 1/35 (28)</i>	1	MO
<i>dasetta 7/7/7 (28)</i>	1	MO
<i>desog- e.estradiol/e.estradiol</i>	1	
<i>desogestrel-ethinyl estradiol</i>	1	
<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>emoquette</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<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>femynor</i>	1	MO
<i>introvale</i>	1	MO
<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	MO
<i>kariva (28)</i>	1	MO
<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)</i>	1	
<i>larin 1.5/30 (21)</i>	1	MO
<i>larin 1/20 (21)</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

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

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

Drug Name	Drug Tier	Requirements /Limits
<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>methergine</i>	1	PA
<i>methylergonovine oral</i>	1	PA
OPHTHALMOLOGY		
ANTIBIOTICS		
<i>ak-poly-bac</i>	1	MO
<i>bacitracin ophthalmic (eye)</i>	1	MO
<i>bacitracin-polymyxin b</i>	1	MO
<i>ciprofloxacin hcl ophthalmic (eye)</i>	1	MO
<i>erythromycin ophthalmic (eye)</i>	1	MO; QL (3.5 per 14 days)
<i>gentak ophthalmic (eye) ointment</i>	1	MO; QL (3.5 per 30 days)
<i>gentamicin ophthalmic (eye) drops</i>	1	MO; QL (70 per 30 days)
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	1	MO
<i>levofloxacin ophthalmic (eye) drops 1.5 %</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
<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	MO
<i>ofloxacin ophthalmic (eye)</i>	1	MO
<i>polycin</i>	1	MO
<i>polymyxin b sulf-trimethoprim</i>	1	MO
<i>tobramycin ophthalmic (eye)</i>	1	MO; QL (10 per 14 days)
ANTIVIRALS		
<i>trifluridine</i>	1	MO
ZIRGAN	1	MO
BETA-BLOCKERS		
<i>betaxolol ophthalmic (eye)</i>	1	MO
<i>carteolol</i>	1	MO
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	1	MO
<i>timolol maleate ophthalmic (eye) drops</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
<i>atropine ophthalmic (eye) drops</i>	1	MO
<i>azelastine ophthalmic (eye)</i>	1	MO
<i>balanced salt</i>	1	
<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
<i>olopatadine ophthalmic (eye)</i>	1	MO
OXERVATE	1	PA; MO
PHOSPHOLINE IODIDE	1	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	MO
<i>sulfacetamide sodium ophthalmic (eye)</i>	1	MO
<i>sulfacetamide-prednisolone</i>	1	MO
XIIDRA	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
<i>diclofenac sodium ophthalmic (eye)</i>	1	MO
<i>flurbiprofen sodium</i>	1	MO
<i>ketorolac ophthalmic (eye)</i>	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>dorzolamide</i>	1	MO
<i>dorzolamide-timolol</i>	1	MO
<i>latanoprost</i>	1	MO
<i>miostat</i>	1	
<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	MO
<i>tobramycin-dexamethasone</i>	1	MO; QL (10 per 14 days)
STERIODS		
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>fluorometholone</i>	1	MO
<i>loteprednol etabonate</i>	1	MO
OZURDEX	1	MO
<i>prednisolone acetate</i>	1	MO
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	1	MO
SYMPATHOMIMETICS		
ALPHAGAN P OPTHALMIC (EYE) DROPS 0.1 %	1	MO
<i>apraclonidine</i>	1	MO
<i>brimonidine ophthalmic (eye) drops 0.15 %</i>	1	
<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

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Drug Name	Drug Tier	Requirements /Limits
<i>diphenhydramine hcl oral elixir</i>	1	PA
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)</i>	1	MO; QL (2 per 30 days)
<i>epinephrine injection solution 1 mg/ml</i>	1	
<i>hydroxyzine hcl oral tablet</i>	1	PA; MO
<i>levocetirizine oral solution</i>	1	MO
<i>levocetirizine oral tablet</i>	1	MO; QL (30 per 30 days)
<i>promethazine injection solution</i>	1	MO
<i>promethazine oral</i>	1	PA; MO
SYMJEPI	1	MO; QL (2 per 30 days)
PULMONARY AGENTS		
<i>acetylcysteine</i>	1	B/D PA; MO
ADEMPAS	1	PA; MO; LA
<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</i>	1	B/D PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>albuterol sulfate oral syrup</i>	1	MO
<i>albuterol sulfate oral tablet</i>	1	MO
<i>alyq</i>	1	PA; QL (60 per 30 days)
<i>ambriasantan</i>	1	PA; MO; LA
<i>arformoterol</i>	1	B/D PA; MO
ASMANEX HFA	1	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	1	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	1	MO; QL (2 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (14)	1	QL (2 per 28 days)
ATROVENT HFA	1	MO; QL (25.8 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
<i>bosentan</i>	1	PA; MO; LA
BREZTRI AEROSPHERE	1	MO; QL (10.7 per 30 days)
<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)
CINRYZE	1	PA; MO
COMBIVENT RESPIMAT	1	MO; QL (8 per 30 days)
<i>cromolyn inhalation</i>	1	B/D PA; MO
DALIRESP	1	PA; MO; QL (30 per 30 days)
DULERA	1	MO; QL (13 per 30 days)
ESBRIET ORAL CAPSULE	1	PA; MO; QL (270 per 30 days)
<i>flunisolide</i>	1	MO; QL (50 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	1	ST; MO; QL (12 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	1	ST; MO; QL (24 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	1	ST; MO; QL (10.6 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	QL (60 per 30 days)
<i>formoterol fumarate</i>	1	B/D PA; MO
<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 ORAL GRANULES IN PACKET	1	PA; MO; QL (56 per 28 days)
KALYDECO ORAL TABLET	1	PA; MO; QL (60 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

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Drug Name	Drug Tier	Requirements /Limits
OFEV	1	PA; MO; QL (60 per 30 days)
OPSUMIT	1	PA; MO; LA
ORKAMBI ORAL GRANULES IN PACKET	1	PA; MO; QL (56 per 28 days)
ORKAMBI ORAL TABLET	1	PA; MO; QL (112 per 28 days)
ORLADEYO	1	PA; LA
<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)
PULMOZYME	1	B/D PA; MO
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	1	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	1	MO; QL (21.2 per 30 days)
<i>roflumilast</i>	1	PA; MO; QL (30 per 30 days)
<i>sajazir</i>	1	PA

Drug Name	Drug Tier	Requirements /Limits
<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)
SPIRIVA WITH HANDIHALER	1	MO; QL (90 per 90 days)
STIOLTO RESPIMAT	1	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	1	MO; QL (4 per 30 days)
SYMBICORT	1	MO; QL (10.2 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
<i>theophylline oral solution</i>	1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	1	MO

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Drug Name	Drug Tier	Requirements /Limits
<i>theophylline oral tablet extended release 24 hr</i>	1	MO
TRIKAFTA	1	PA; MO; QL (84 per 28 days)
<i>wixela inhub</i>	1	QL (60 per 30 days)
XOLAIR SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/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

MYRBETRIQ ORAL SUSPENSION, EXTENDED REL RECON	1	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	1	MO
<i>oxybutynin chloride</i>	1	MO
<i>tolterodine</i>	1	MO
<i>tropium oral tablet</i>	1	MO

BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY

Drug Name	Drug Tier	Requirements /Limits
<i>alfuzosin</i>	1	MO
<i>dutasteride</i>	1	MO
<i>finasteride oral tablet 5 mg</i>	1	MO
<i>tamsulosin</i>	1	MO
MISCELLANEOUS UROLOGICALS		
<i>alprostadil</i>	1	
<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	
<i>albutein 5 %</i>	1	
<i>plasbumin 25 %</i>	1	
<i>plasbumin 5 %</i>	1	

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Drug Name	Drug Tier	Requirements /Limits
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 sulfate in water</i>	1	
<i>magnesium sulfate injection solution</i>	1	MO
<i>magnesium sulfate injection syringe</i>	1	
<i>potassium acetate</i>	1	
<i>potassium chlorid-d5-0.45%nacl</i>	1	

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	MO
<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	

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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 parenteral solution</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		

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-48 in d5w</i>	1	
<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 148	1	
PLASMA-LYTE A	1	
<i>plasmanate</i>	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		

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Drug Name	Drug Tier	Requirements /Limits
<i>fluoride (sodium) oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>prenatal vitamin oral tablet</i>	1	MO
<i>wescap-pn dha</i>	1	

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This drug list was last updated on 01/24/2023.

Nondiscrimination Notice

Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate because of race, religion, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, religion, color, national origin, age, disability, or sex. The Plan:

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

If you need these services, contact The Health Plan Customer Service Department. If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, religion, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department 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:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

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

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.877.847.7907 (TTY: 711).

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.847.7907 (TTY: 711).

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.847.7907 (TTY: 711)。

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.847.7907 (TTY: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.877.847.7907 (ATS : 711).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.847.7907 (TTY: 711).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.847.7907 (TTY: 711).

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.847.7907 (TTY: 711)번으로 전화해 주십시오.

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.847.7907 (телетайп: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.847.7907 (رقم هاتف الصم والبكم: 711).

Hindi:

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.877.847.7907 (TTY: 711) पर कॉल करें।

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.847.7907 (TTY: 711).

Portugues:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.877.847.7907 (TTY: 711).

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.847.7907 (TTY: 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.847.7907 (TTY: 711).

Japanese:

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.877.847.7907（TTY: 711）まで、お電話にてご連絡ください。

Dutch:

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se tofogi, mo oe, Telefoni mai: 1.877.847.7907 (TTY: 711).

Pennsylvania Dutch:

Wann du (Deutsch (Pennsylvania German / Dutch)) schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.847.7907 (TTY: 711).

Ukranian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (1.877.847.7907) (TTY: 711).

Romanian:

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (1.877.847.7907) (TTY: 711).

Cushite:

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (1.877.847.7907) (TTY: 711).

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-847-7915. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-847-7915. 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 1-877-847-7915。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-847-7915。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-847-7915. 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 1-877-847-7915. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-847-7915 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-847-7915. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-847-7915번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-847-7915. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول بمساعدتك. على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-847-7915 سيقوم شخص ما يتحدث العربية بهذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-847-7915 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-847-7915. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-847-7915. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-847-7915. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-847-7915. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-877-847-7915にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。



This formulary was updated on

For more recent information or other questions, please contact The Health Plan at 1.877.847.7907 or, for TTY users, 711, or visit healthplan.org/medicare.

Hours of Operation:

- October 1 to March 31: 8:00 am to 8:00 pm, 7 days a week
- April 1 to September 30: 8:00 am to 8:00 pm, Monday through Friday