



Medicare Advantage

Take the first steps on your journey to a healthier, happier lifestyle.



2024 Summary of Benefits

Blue Shield 65 Plus (HMO)

Group Medicare Advantage Prescription Drug Plan for County of San Bernardino
(High Option)

Effective January 1, 2024 – December 31, 2024

2024 Summary of Benefits

Blue Shield 65 Plus (HMO)

January 1, 2024 – December 31, 2024

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, **please contact your former employer group/union or call Blue Shield 65 Plus Customer Service at (800) 776-4466** [TTY: 711], 8 a.m. to 8 p.m., seven days a week.

Blue Shield 65 Plus is a Medicare Advantage (Part C) plan that covers everything that Original Medicare (Part A and Part B) and includes Part D prescription drug coverage, offering you the convenience of having both your medical services and prescription drugs covered through one plan.

To join **Blue Shield 65 Plus** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, meet your former employer group/union's eligibility requirements, and live in our service area. Your Medicare-eligible dependents may also join Blue Shield 65 Plus (HMO) if they meet these requirements.

Our service area includes the following counties in California:

Alameda County, Contra Costa County*, Kern County, Los Angeles County, Merced County, Nevada County*, Orange County, Riverside County, Santa Barbara County, San Bernardino County, San Diego County, San Francisco County, San Joaquin County, San Luis Obispo County, San Mateo County, Santa Clara County, Santa Cruz County and Stanislaus County.

*Denotes partial county. Refer to the ZIP code listing on page 11 for details on the partial county service area coverage.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Our plan **Provider Directory** is located on our website at blueshieldca.com/medicare/providerdirectory. Our plan **Pharmacy Directory** is located on our website at blueshieldca.com/medpharmacy2024. To get the most complete and current information about which drugs are covered, you can visit our website at blueshieldca.com/medformulary2024.

Summary of Benefits

Effective January 1, 2024 – December 31, 2024

You pay the following:

Premiums and Benefits	You Pay	What you should know
Monthly plan premium	Your former employer group/union is responsible for paying premiums beyond your monthly Medicare Part B premium. If you are responsible for any contribution to the premiums, your benefits administrator will tell you the amount you and your former employer group/union contribute to the premium	You must continue to pay your Medicare Part B premium in addition to the plan premium, if applicable.
Deductible	\$0	
Annual maximum out-of-pocket	\$3,400	Does not include Part D prescription drugs. This is the most you would pay for the year for in-network covered Medicare Parts A and Part B services.
Inpatient hospital care	\$0 copay per admission	Prior authorization and a referral from your doctor may be required for inpatient hospital care. Our plan covers an unlimited number of days for a Medicare-covered inpatient hospital stay in a network hospital.
Outpatient hospital services <ul style="list-style-type: none"> Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery 	<p>\$0 copay for each visit to an outpatient hospital facility</p> <p>\$0 copay for Medicare-covered observation services</p> <p>\$20 copay for each visit to an emergency room (this copay is waived if you are admitted to the hospital within one day for the same condition)</p>	A referral and/or prior authorization may be required for outpatient hospital facility and observation services. Our plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Blue Shield 65 Plus (HMO)

Premiums and Benefits	You Pay	What you should know
Outpatient surgery	<p>\$0 copay for each visit to an ambulatory surgical center</p> <p>\$0 copay for each visit to an outpatient hospital facility</p>	A referral and prior authorization from your doctor may be required.
Doctor visits <ul style="list-style-type: none"> • Primary care physician • Specialists 	<p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	A referral from your doctor may be required for Specialist visits.
Preventive services	\$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care Worldwide coverage	<p>\$20 copay per visit</p> <p>\$10,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories</p>	This copay is waived if you are admitted to a hospital within one day for the same condition.
Urgently needed services Worldwide coverage	<p>\$20 copay for each visit to a network urgent care center within your plan service area</p> <p>\$20 copay for each visit to an urgent care center outside of your plan service area but within the United States and its territories</p> <p>\$20 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories</p> <p>\$20 copay for each visit to an emergency room or \$20 for each visit to an urgent care center that is outside of the United States and its territories</p> <p>You have a \$10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories</p>	These copays are waived if you are admitted to a hospital within one day for the same condition.

Blue Shield 65 Plus (HMO)

Premiums and Benefits	You Pay	What you should know
<p>Diagnostic services, labs, and imaging</p> <ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans, PET scans, etc.) • Lab services • Diagnostic tests and procedures • Outpatient X-rays • Therapeutic radiology services (such as radiation treatment for cancer) 	<p>\$0 copay for each diagnostic radiology service</p> <p>\$0 copay \$0 copay</p> <p>\$0 copay \$0 copay</p>	<p>A referral from your doctor may be required for diagnostic services, labs and imaging services.</p> <p>Covered according to Medicare guidelines; prior authorization is required.</p>
<p>Hearing services</p> <ul style="list-style-type: none"> • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam 	<p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>A referral from your doctor may be required for hearing services.</p>
<p>Dental services</p> <ul style="list-style-type: none"> • Non-routine dental care 	<p>\$10 copay per visit if performed by your PCP</p> <p>\$10 copay per visit if performed by a specialist</p>	<p>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.</p>
<p>Vision services</p> <ul style="list-style-type: none"> • Exam to diagnose and treat diseases and conditions of the eye • Yearly glaucoma screening • Eyeglasses or contact lenses after cataract surgery 	<p>\$10 copay for each Medicare-covered visit</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>A referral from your doctor may be required for an exam and treat diseases and conditions of the eye.</p> <p>A referral from your doctor may be required for yearly glaucoma screenings.</p>

Blue Shield 65 Plus (HMO)

Premiums and Benefits	You Pay	What you should know
Mental health services <ul style="list-style-type: none"> • Inpatient mental health care • Outpatient group therapy visit • Outpatient individual therapy visit 	<p>For each Medicare-covered stay you pay:</p> <ul style="list-style-type: none"> • \$0 copay per stay for days 1 through 150 • 100% of the cost of the hospital for days 151 and over unless new benefit period begins. <p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>A referral and/or prior authorization from your doctor may be required for mental health services.</p> <p>You are covered for 150 days per benefit period, up to the 190-day lifetime limit. If you go over the 150-day limit, you will be responsible for all costs.</p>
Skilled nursing facility (SNF) care	<p>For each stay in a Medicare-certified skilled nursing facility, you pay:</p> <ul style="list-style-type: none"> • \$0 copay per day for days 1 to 100 	<p>A referral from your doctor may be required for skilled nursing facility care.</p> <p>If you go over the 100-day limit, you will be responsible for all costs; no prior authorization required with network provider.</p>
Rehabilitation services <ul style="list-style-type: none"> • Cardiac (heart) rehabilitation services • Occupational therapy services • Physical therapy and speech and language therapy services 	<p>\$10 copay per visit</p> <p>\$0 copay per visit</p> <p>\$0 copay per visit</p>	<p>A referral from your doctor may be required for rehabilitation services.</p>
Ambulance services	<p>\$0 copay per trip (one way)</p>	
Transportation services (non-Medicare covered)	<p>Not covered</p>	

Blue Shield 65 Plus (HMO)

Premiums and Benefits	You Pay	What you should know
Medicare Part B drugs	\$10 copay when administered by your PCP or by a specialist.	<p>Some Part B drugs may require a prior authorization from our provider.</p> <p>If the drug listed on the Part B rebatable drug list and obtained at a retail pharmacy or your doctor's office, you will pay either the applicable tier copay or coinsurance, whichever amount is lesser.</p> <p>Insulin obtained under Part B (when taken with an insulin pump) should not exceed a \$35 copay for a one-month supply.</p>

Summary of Benefits

Effective January 1, 2024 – December 31, 2024

Additional benefits included in your plan:

Premiums and Benefits	You Pay	What you should know
Annual Physical Exam	\$0 copay	One every 12 months.
Opioid treatment program	\$0 copay	A referral and prior authorization from your doctor may be required for Opioid Treatment Program Services.
Additional Telehealth Services (Teladoc)	\$0 copay	Teladoc Physicians can diagnose and treat basic medical conditions and can also prescribe certain medication.
Foot care (podiatry services) <ul style="list-style-type: none"> Foot exams and treatment Routine (non-Medicare covered) foot care 	\$0 copay for each Medicare-covered visit \$0 copay	A referral from your doctor may be required for Medicare-covered foot care services. Limited to one visit per calendar month.
Diabetic Supplies & Services <ul style="list-style-type: none"> Blood glucose monitors Diabetes self-management training, diabetic services and supplies 	\$0 copay for ACCU-CHEK monitors and 20% coinsurance for blood glucose monitors from all other manufacturers \$0 copay for all training, services and supplies (except blood glucose monitors)	Prior authorization from the plan may be required for diabetic supplies and services (including blood glucose monitors). See the plan EOC for more information. Your copay for a month's supply of insulin will be capped at \$35.
Durable Medical Equipment (DME) and Related Supplies <ul style="list-style-type: none"> Durable medical equipment (e.g., wheelchairs, oxygen) 	\$0 copay	Prior authorization from the plan may be required for DME. See the plan EOC for more information.

Blue Shield 65 Plus (HMO)

Premiums and Benefits	You Pay	What you should know
<p>Prosthetics/Medical Supplies</p> <ul style="list-style-type: none"> • Prosthetics (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts) 	<p>\$0 copay</p> <p>\$0 copay</p>	<p>Prior authorization from your doctor may be required for prosthetics/medical supplies.</p>
<p>Health and Wellness programs</p> <ul style="list-style-type: none"> • NurseHelp 24/7SM (Telephone and online support) • LifeReferrals 24/7 – Access to counselors, consultations, information and referrals for a wide range of family and personal issue • Basic gym access through SilverSneakers Fitness 	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	

Part D Prescription Drug Coverage

Effective January 1, 2024 – December 31, 2024

You pay the following:

Annual Deductible Stage	This stage does not apply because there is no deductible.			
Initial Coverage Stage	You pay the following until your total out-of-pocket Part D drug costs reach \$8,000.			
What you pay:	Preferred retail cost-sharing (in-network)		Standard retail cost-sharing (in-network)^	
	30-day supply	90-day supply^{NDS}	30-day supply*	90-day supply^{NDS}
Tier 1: Generic Drugs	\$10 copay	\$20 copay	\$10 copay	\$30 copay
Tier 2: Preferred Brand Drugs	\$20 copay	\$40 copay	\$20 copay	\$60 copay
Tier 3: Non-Preferred Drugs	\$40 copay	\$80 copay	\$40 copay	\$120 copay
Tier 3: Covered Insulins**	\$35 copay	\$80 copay	\$35 copay	\$105 copay
Tier 4: Injectable Drugs	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$300 copay maximum)	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$300 copay maximum)
Tier 4: Covered Insulins**	\$35 copay	\$105 copay	\$35 copay	\$105 copay
Tier 5: Specialty Tier Drugs	20% coinsurance (up to a \$100 copay maximum)	Not covered	20% coinsurance (up to a \$100 copay maximum)	Not covered

** Covered Insulins are marked with the symbol INS on the drug list. This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (“Extra Help”).

^If you reside in a long-term care facility, you pay the same as at an in-network standard retail cost-sharing pharmacy. There are limited situations where you may be able to get drugs from an out-of-network pharmacy at the same cost as an in-network standard retail cost-sharing pharmacy.

* 90-day supply cost-sharing also applies to Blue Shield’s mail service pharmacy.

^{NDS} A long-term (up to a 90-day) supply is not available for select drugs. The drugs that are not available for a long-term supply are marked with the symbol ^{NDS} in our Drug List.

For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please refer to the plan EOC.

Part D Prescription Drug Coverage (cont'd)

Effective January 1, 2024 – December 31, 2024

Coverage Gap Stage

Because there is no coverage gap for the plan, this payment stage does not apply to you.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach \$8,000, the plan pays the full cost for your covered Part D drugs. For excluded drugs covered under our enhanced benefit, you pay the Tier 1: Generic Drugs copayments listed in the table shown above.

This stage **protects** you from any additional costs once you have paid your yearly out-of-pocket drug costs.

Important Message About What You Pay for Vaccines: Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Mail Service Pharmacy

CVS Caremark[®] is our network mail service pharmacy where you can get a 90-day supply of maintenance drugs at a lower cost share. Your order will be delivered to your home or office with no charge for standard shipping. After enrolling in your Blue Shield Medicare plan, you can log in to your Blue Shield of California member account at blueshieldca.com/login.

Tier 5 drugs are limited to a 30-day supply by mail service.

Network pharmacies that offer preferred cost-sharing

You may pay less when you visit one of our network pharmacies that offer preferred cost-sharing.

Here's just a few:

CVS/pharmacy[†] (including CVS pharmacy at Target)	(888) 607-4287 [TTY: 711]
Safeway and Vons pharmacies	(877) 723-3929 [TTY: 711]
Albertsons/Sav-on/Osco pharmacies	(877) 932-7948 [TTY: 711]
Costco (You do not have to be a member to use the pharmacy.)	(800) 955-2292 [TTY: 711]

Ralphs, Walmart, and other pharmacies are also available in our network

‡Accepts e-prescribing

Partial county service area zip code listing

Contra Costa County, the following ZIP codes only:

94506, 94507, 94526, 94528, 94583

Nevada County, the following ZIP codes only:

95602, 95712, 95924, 95945, 95946, 95949, 95959, 95960, 95975, 95977, 95986

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal. Blue Shield of California offers individual and employer group retiree plans to Medicare beneficiaries who have Part A and Part B. Individual plans are open to all Medicare beneficiaries who reside within a plan's specific service area. Employer group retiree plans are open only to Medicare beneficiaries who are eligible group retirees and who reside within a plan's specific service area. Individual and employer group retiree plans have different service areas, benefits and provider networks.

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Blue Shield of California is an independent member of the Blue Shield Association
MG00007-CountyofSanBernardino(HighOption)-GMAPD_1023

IMPORTANT INFORMATION: 2024 Medicare Star Ratings

Official U.S.
Government
Medicare
Information



Blue Shield of California - H0504

For 2024, Blue Shield of California - H0504 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★
Health Services Rating: ★★★★★
Drug Services Rating: ★★★★★



Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Blue Shield of California 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at **(800) 776-4466** (toll-free) or **711** (TTY). Current members please call **(800) 776-4466** (toll-free) or **711** (TTY).

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Blue Shield of California

Group Medicare Advantage–Prescription Drug Plans

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at **(800) 776-4466 [TTY: 711]**, 8 a.m. to 8 p.m., seven days a week. You may also contact your former employer group/union benefits administrator if you have questions and costs.

Understanding the benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Call Customer Service at **(800) 776-4466 [TTY: 711]**, 8 a.m. to 8 p.m., seven days a week. Or, contact your former employer group/union benefits administrator to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding important rules

- Your coverage is provided through a contract with your former employer group/union. Your former employer group/union is responsible for paying any monthly plan premium to the plan. Please contact your former employer group/union’s Benefits Administrator for information about your plan premium.** In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/co-insurance may change on January 1, 2025.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Effect on Current Coverage



If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

The company complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability. La compañía cumple con las leyes de derechos civiles federales y estatales aplicables, y no discrimina, ni excluye ni trata de manera diferente a las personas por su raza, color, país de origen, identificación con determinado grupo étnico, condición médica, información genética, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad, ni discapacidad física ni mental. 本公司遵守適用的州法律和聯邦民權法律，並且不會以種族、膚色、原國籍、族群認同、醫療狀況、遺傳資訊、血統、宗教、性別、婚姻狀況、性別認同、性取向、年齡、精神殘疾或身體殘疾而進行歧視、排斥或區別對待他人



Blue Shield 65 Plus (HMO)

2024 Formulary

(List of Covered Drugs)

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

Formulary ID 24335, Version **14**

This formulary was updated on **10/19/2023**. For more recent information or other questions, please contact Blue Shield of California Customer Service, at **(800) 776-4466** or, for TTY users, **711**, 8 a.m. to 8 p.m., seven days a week, or visit **blueshieldca.com/medformulary2024**.

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10/19/2023

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to “we,” “us”, or “our,” it means Blue Shield of California. When it refers to “plan” or “our plan,” it means Blue Shield 65 Plus.

This document includes a list of the drugs (formulary) for our plan which is current as of **10/19/2023** . 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, 2025 and from time to time during the year.

What is the Blue Shield 65 Plus Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan 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 our plan 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 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 Blue Shield 65 Plus’s Formulary?”

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary; or add new restrictions to the brand-name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Blue Shield 65 Plus's Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of **10/19/2023**. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages. If we make any other negative formulary changes during the year, the changes will be posted on our website at blueshieldca.com/medformulary2024.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. 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 Agents". If you know what your drug is used for, look for the category name in the list that begins on page number 1. 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 108. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, our plan provides 18 tablets per 30-day prescription for *sumatriptan* (generic for IMITREX). This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan 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 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Plan's formulary?" on page iv for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service and ask if your drug is covered.

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

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

How do I request an exception to the Blue Shield 65 Plus's Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at 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, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day 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.

Our transition policy applies to members who are stabilized on:

- Part D drugs not on the plan formulary, or
- Part D drugs previously covered by exception upon expiration of the exception, or
- Part D drugs on the plan formulary with a prior authorization, step therapy or a quantity limit requirement, or
- Part D drugs as listed above, where a distinction cannot be made at point of service whether it is a new or ongoing prescription drug

And are members in any of the following scenarios:

- new members following the annual coordinated election period,
- newly eligible members transitioning from other coverage at the beginning of a contract year,
- transitioning individuals who switch from one Blue Shield plan to another after the beginning of a contract year,
- members residing in long-term care (LTC) facilities, or
- in some cases, current members affected by formulary changes from one plan year to the next.

Members continuing coverage into a new plan year and experiencing negative formulary changes will have coverage continued for selected drugs in the new plan year, as determined by our plan and in accordance with the Centers for Medicare and Medicaid Services (CMS) guidance for Part D drugs. Plan members on drugs that were not selected for automatic continued coverage will be provided a transition process consistent with the transition process required for new members beginning in the new plan year. The transition policy will be extended across plan years if a member enrolls in a plan with an effective enrollment date of either November 1 or December 1 and needs access to a transition supply.

During the transitional stage, members may talk to their prescribers to decide whether they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug, if it is not on our formulary or has restrictions such as step therapy or prior authorization. Members may contact our plan Customer Service for assistance in initiating a prior authorization or exception request. Prior authorization or exception request forms are available on our website and are also provided upon request to members and prescribers, via mail, email or fax.

Per our transition policy, in conjunction with network pharmacies, a temporary supply of non-formulary Part D drugs or formulary drugs with coverage restrictions will be provided in order to prevent interruptions in continuing therapy. This temporary supply also provides sufficient time for members to work with their prescribers to switch to a therapeutically equivalent formulary medication, or to complete a formulary exception request based on medical necessity. Requests for prior authorization of formulary drugs are reviewed against the CMS approved coverage criteria and formulary exception requests are reviewed for medical necessity by Blue Shield pharmacy technicians, pharmacists and/or physicians. If a formulary exception request is denied, we will provide the prescriber a list of appropriate therapeutic alternatives. A letter will also be sent to you providing instructions on how to appeal the decision.

The transitional supply is a one-time, 30-day temporary supply (unless the prescription is written for fewer days in which case we will cover multiple fills to provide up to a total of 30 days of medication) of the non-formulary drug at a retail pharmacy during the first 90 days of new membership beginning on your effective date of coverage in our plan. Refills may be provided for transition prescriptions dispensed for less than the written amount, due to a plan quantity limit edit for safety or drug utilization edits that are based on approved product labeling, and for up to a total of a 30-day supply. If you are affected by a negative formulary change from one year to the next, we will provide up to a 30-day temporary supply of the non-formulary drug, if you need a refill for the drug during the first 90 days of the new plan year.

Retail and LTC pharmacies have the ability to provide a point-of-sale override for coverage of a transition supply of a drug that is non-formulary, requires prior authorization or step therapy unless the drug is subject to review for Part B vs. Part D determination, limits to prevent coverage of non-Part D drugs or limits that promote safe utilization of a Part D drug.

We will cover a 30-day supply (unless the prescription is written for fewer days in which case we will cover multiple fills to provide up to a total of 30 days of medication). The cost-sharing for low-income subsidy (LIS) eligible members for a temporary supply of drugs provided under the transition process will not exceed the statutory maximum co-payment amounts for LIS eligible members. For all other members (non-LIS members), we will apply the same cost-sharing for non-formulary Part D drugs provided during the transition that would apply for non-formulary drugs approved through a formulary exception and the same cost-sharing for formulary drugs subject to utilization management edits provided during the transition that would apply once the utilization management criteria are met. Members will not be required to pay additional cost-sharing associated with multiple fills of lesser quantities of Part D drugs based upon quantity limits for safety once the originally prescribed doses of Part D drugs have been determined to be medically necessary after an exception process has been completed.

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 send written notice within 3 business days of the transitional fill after we cover the temporary supply. This notice will contain an explanation of the temporary nature of the transition supply received, instructions for working with us and the prescriber to identify appropriate therapeutic alternatives that are on our formulary, an explanation of your right to request a formulary exception, and a description of the procedures for requesting a formulary exception. If a transition supply has been provided once and you are currently in the process of receiving a coverage determination, the transition supply may be extended by one additional 30-day prescription fill beyond the initial 30-day supply, unless you present with a prescription written for less than 30 days. The extension of the transition period is on a case-by-case basis, to the extent that your exception request or appeal has not been processed by the end of the minimum day transition period and until such time as a transition has been made (either through a switch to an appropriate formulary drug or a decision on an exception request).

If you are a resident of a long-term-care facility (like a nursing home), we will cover supplies of Part D drugs in increments of 14 days or less for a temporary 31-day transition supply unless the prescription is written for fewer days during the first 90 days you are enrolled in our Plan, beginning on your effective date of coverage.

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 can't 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 <http://www.medicare.gov>.

Plan Formulary

The formulary below provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 108 .

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

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

**Please keep this summary with your 2024 Blue Shield 65 Plus (HMO) Formulary
(List of Covered Drugs)**

Tier	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Preferred retail cost-sharing (in-network) (up to a 30-day supply)	Mail service cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Generic Drugs)	\$10 copay	\$10 copay	Mail service is not available for drugs in Tier 1.	\$10 copay	\$10 copay
Cost-Sharing Tier 2 (Preferred Brand Drugs)	\$20 copay	\$20 copay	Mail service is not available for drugs in Tier 2.	\$20 copay	\$20 copay
Cost-Sharing Tier 3 (Non-Preferred Drugs)	\$40 copay	\$40 copay	Mail service is not available for drugs in Tier 3.	\$40 copay	\$40 copay
Cost-Sharing Tier 3: (Covered Insulins*)	\$35 copay	\$35 copay	Mail service is not available for drugs in Tier 3.	\$35 copay	\$35 copay
Cost-Sharing Tier 4: (Injectable Drugs)	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$100 copay maximum)	Mail service is not available for drugs in Tier 4.	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$100 copay maximum)
Cost-Sharing Tier 4: (Covered Insulins*)	\$35 copay	\$35 copay	Mail service is not available for drugs in Tier 4.	\$35 copay	\$35 copay

Tier	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Preferred retail cost-sharing (in-network) (up to a 30-day supply)	Mail service cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 5: (Specialty Tier Drugs)	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$100 copay maximum)	20% coinsurance (up to a \$100 copay maximum)

*Covered insulins are marked with the symbol **INS** on the “Drug List.” This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (“Extra Help”).

You won’t pay more than \$35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Mail service cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1: Generic Drugs (up to a 90-day supply)	\$30 copay	\$20 copay	\$20 copay
Cost-Sharing Tier 2: Preferred Brand Drugs (up to a 90-day supply)	\$60 copay	\$40 copay	\$40 copay
Cost-Sharing Tier 3: Non-Preferred Drugs (up to a 90-day supply)	\$120 copay	\$80 copay	\$80 copay
Cost-Sharing Tier 3: (Covered Insulins*)	\$105 copay	\$80 copay	\$80 copay

	Standard retail cost sharing (in-network) (up to a 90-day supply)	Preferred retail cost sharing (in-network) (up to a 90-day supply)	Mail service cost sharing (up to a 90-day supply)
Cost-Sharing Tier 4: Injectable Drugs (up to a 90-day supply)	20% coinsurance (up to a \$300 copay maximum)	20% coinsurance (up to a \$300 copay maximum)	20% coinsurance (up to a \$300 copay maximum)
Cost-Sharing Tier 4: (Covered Insulins*)	\$105 copay	\$105 copay	\$105 copay
Cost-Sharing Tier 5: (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

*Covered insulins are marked with the symbol **INS** on the “Drug List.” This cost-sharing only applies to beneficiaries who do not qualify for a program that helps pay for your drugs (“Extra Help”).

You won’t pay more than \$105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Cost-sharing for network long-term care pharmacies (31-day supply) is the same as the in-network standard retail (30-day supply) and preferred retail (30-day supply) cost-sharing.

Refer to Chapter 6 of your *Evidence of Coverage*, “What you pay for your Part D prescription drugs” for further benefit details.

LEGEND

TIER	NAME	
gen	Generic Drugs	
brd	Preferred Brand Drugs	
npd	Non-Preferred Drugs	
inj	Injectable Drugs	
spec	Specialty Tier Drugs	

SYMBOL	NAME	DESCRIPTION
ED	Excluded Part D Drug	This prescription drug is not normally covered in a Medicare Prescription Drug Plan; however, Blue Shield covers this drug as a supplemental benefit. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help from Medicare or Social Security to pay for your prescriptions, you will not get any extra help to pay for this drug.
LA	Limited Access	This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call our Customer Service.
PA	Prior Authorization	Coverage for this prescription requires prior authorization from Blue Shield. Call Blue Shield to provide the necessary information to determine coverage. Some drugs may require Part B or Part D coverage determination, based on Medicare coverage rules. These drugs are noted with "PA – Part B vs. D Determination"
QL	Quantity Limit	This medication has a dosing or prescription quantity limit. Maximum daily dose limits are defined by the FDA and listed in the drug package insert. Other quantity limits encourage consolidated dosing when possible.
ST	Step Therapy	Coverage for this prescription is provided when other first-line or preferred drug therapies have been tried (step therapy).
NDS	Non-Extended Day Supply	Medication is NOT available for long-term supply.

SYMBOL	NAME	DESCRIPTION
INS	Covered Insulin	You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.
VAC	\$0 Vaccine	Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALGESICS		
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
<i>butalbital-aspirin-caffeine (50-325-40 mg tab, cap 50-325-40 mg)</i>	gen	PA, QL (48 PER 30 OVER TIME), NDS
<i>celecoxib (cap 50 mg, cap 100 mg, cap 200 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>celecoxib cap 400 mg</i>	gen	QL (1 PER 1 DAYS)
<i>diclofenac potassium tab 50 mg</i>	gen	
<i>diclofenac sodium (tab delayed release 25 mg, tab delayed release 50 mg, tab delayed release 75 mg, tab er 24hr 100 mg)</i>	gen	
<i>diclofenac sodium (topical) (gel 1%, gel 1% (1.16% diethylamine equiv), soln 1.5%)</i>	gen	
<i>diclofenac w/ misoprostol (w/ tab 50-0.2 mg, w/ tab 75-0.2 mg)</i>	gen	
<i>diflunisal tab 500 mg</i>	gen	
<i>etodolac (cap 200 mg, cap 300 mg, tab 400 mg, tab 500 mg, tab er 24hr 400 mg, tab er 24hr 500 mg, tab er 24hr 600 mg)</i>	gen	
<i>flurbiprofen (50 mg tab, tab 50 mg, tab 100 mg)</i>	gen	
<i>ibuprofen (tab 400 mg, tab 600 mg, tab 800 mg)</i>	gen	
<i>indomethacin (cap 25 mg, cap 50 mg, cap er 75 mg)</i>	gen	
<i>meloxicam (tab 7.5 mg, tab 15 mg)</i>	gen	
<i>nabumetone (tab 500 mg, tab 750 mg)</i>	gen	
<i>naproxen (tab 250 mg, tab 375 mg, tab 500 mg, tab ec 375 mg, tab ec 500 mg)</i>	gen	
<i>naproxen sodium (tab 275 mg, tab 550 mg)</i>	gen	
<i>oxaprozin tab 600 mg</i>	gen	
<i>piroxicam (cap 10 mg, cap 20 mg)</i>	gen	
<i>salsalate (tab 500 mg, tab 750 mg)</i>	gen	
<i>sulindac (tab 150 mg, tab 200 mg)</i>	gen	
OPIOID ANALGESICS, LONG-ACTING		
<i>buprenorphine (patch 5 mcg/hr, patch 7.5 mcg/hr, patch 10 mcg/hr, patch 15 mcg/hr, patch 20 mcg/hr)</i>	gen	PA, QL (4 PER 28 OVER TIME), NDS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>fentanyl (patch 72hr 100 mcg/hr, patch 72hr 12 mcg/hr, patch 72hr 25 mcg/hr, patch 72hr 50 mcg/hr, patch 72hr 75 mcg/hr)</i>	gen	PA, QL (10 PER 30 OVER TIME), NDS
<i>hydromorphone hcl (tab er 24hr 16 mg, tab er 24hr 32 mg, tab er 24hr 8 mg)</i>	gen	PA, QL (30 PER 30 OVER TIME), NDS
<i>hydromorphone hcl tab er 24hr 12 mg</i>	gen	PA, QL (60 PER 30 OVER TIME), NDS
<i>methadone hcl (10 mg/5ml solution, soln 10 mg/5ml)</i>	gen	PA, QL (450 PER 30 OVER TIME), NDS
<i>methadone hcl (10 mg/ml solution, inj 10 mg/ml)</i>	inj	PA, NDS
<i>methadone hcl (5 mg/5ml solution, soln 5 mg/5ml)</i>	gen	PA, QL (900 PER 30 OVER TIME), NDS
<i>methadone hcl (conc 10 mg/ml, tab 10 mg)</i>	gen	PA, QL (90 PER 30 OVER TIME), NDS
<i>methadone hcl tab 5 mg</i>	gen	PA, QL (180 PER 30 OVER TIME), NDS
<i>methadone hcl tab for oral susp 40 mg</i>	gen	QL (1 PER 1 DAYS), NDS
<i>morphine sulfate (tab er 60 mg, tab er 100 mg, tab er 200 mg)</i>	gen	QL (60 PER 30 OVER TIME), NDS
<i>morphine sulfate tab er 15 mg</i>	gen	QL (180 PER 30 OVER TIME), NDS
<i>morphine sulfate tab er 30 mg</i>	gen	QL (90 PER 30 OVER TIME), NDS
OXYCODONE HCL ER (ER 10 MG TB12 DETER, ER 15 MG TB12 DETER, ER 20 MG TB12 DETER, ER 30 MG TB12 DETER, ER 40 MG TB12 DETER, ER 60 MG TB12 DETER, ER 80 MG TB12 DETER)	gen	PA, QL (2 PER 1 DAYS), NDS
OXYMORPHONE HCL ER (ER 5 MG TAB ER 12H, ER 7.5 MG TAB ER 12H, ER 10 MG TAB ER 12H, ER 15 MG TAB ER 12H, ER 20 MG TAB ER 12H, ER 30 MG TAB ER 12H, ER 40 MG TAB ER 12H)	gen	PA, QL (2 PER 1 DAYS), NDS
<i>tramadol hcl (tab er 24hr 100 mg, tab er 24hr 200 mg, tab er 24hr 300 mg, tab er 24hr biphasic release 100 mg, tab er 24hr biphasic release 200 mg, tab er 24hr biphasic release 300 mg)</i>	gen	PA, QL (1 PER 1 DAYS), NDS
TRAMADOL HCL ER (BIPHASIC) (ER (BIPHASIC) 100 MG TAB ER 24H, ER (BIPHASIC) 200 MG TAB ER 24H, ER (BIPHASIC) 300 MG TAB ER 24H)	gen	PA, QL (1 PER 1 DAYS), NDS

OPIOID ANALGESICS, SHORT-ACTING

<i>acetaminophen w/ codeine (w/ tab 300-15 mg, w/ tab 300-30 mg)</i>	gen	QL (12 PER 1 DAYS), NDS
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You can find information on what the symbols and abbreviations on this table mean by going to page ix.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	gen	QL (1800 PER 30 OVER TIME), NDS
<i>acetaminophen w/ codeine tab 300-60 mg</i>	gen	QL (6 PER 1 DAYS), NDS
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	gen	PA, QL (10 PER 1 DAYS), NDS
APAP-CAFF-DIHYDROCODEINE 325-30-16 MG TAB	gen	PA, QL (10 PER 1 DAYS), NDS
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	gen	PA, QL (48 PER 30 OVER TIME), NDS
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	gen	PA, QL (48 PER 30 OVER TIME), NDS
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	gen	QL (15 PER 28 OVER TIME), NDS
<i>codeine sulfate (30 mg tab, tab 30 mg)</i>	gen	QL (168 PER 30 OVER TIME), NDS
CODEINE SULFATE 15 MG TAB	gen	QL (336 PER 30 OVER TIME), NDS
CODEINE SULFATE 60 MG TAB	gen	QL (84 PER 30 OVER TIME), NDS
<i>fentanyl citrate (100 mcg tab, 200 mcg tab, lozenge on a handle 200 mcg, 400 mcg tab, lozenge on a handle 400 mcg, 600 mcg tab, lozenge on a handle 600 mcg, 800 mcg tab, lozenge on a handle 800 mcg, lozenge on a handle 1200 mcg, lozenge on a handle 1600 mcg)</i>	gen	PA, QL (120 PER 30 OVER TIME), NDS
<i>hydrocodone-acetaminophen (tab 7.5-300 mg, tab 10-300 mg)</i>	gen	PA, QL (6 PER 1 DAYS), NDS
<i>hydrocodone-acetaminophen (tab 7.5-325 mg, tab 10-325 mg)</i>	gen	QL (6 PER 1 DAYS), NDS
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	gen	QL (2520 PER 30 OVER TIME), NDS
<i>hydrocodone-acetaminophen tab 5-300 mg</i>	gen	PA, QL (8 PER 1 DAYS), NDS
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	gen	QL (8 PER 1 DAYS), NDS
<i>hydrocodone-ibuprofen (5-200 mg tab, tab 5-200 mg, tab 7.5-200 mg, 10-200 mg tab, tab 10-200 mg)</i>	gen	QL (5 PER 1 DAYS), NDS
HYDROMORPHONE HCL 3 MG SUPPOS	gen	QL (240 PER 30 OVER TIME), NDS, ED
<i>hydromorphone hcl liqd 1 mg/ml</i>	gen	QL (675 PER 30 OVER TIME), NDS
<i>hydromorphone hcl tab 2 mg</i>	gen	QL (154 PER 30 OVER TIME), NDS
<i>hydromorphone hcl tab 4 mg</i>	gen	QL (84 PER 30 OVER TIME), NDS
<i>hydromorphone hcl tab 8 mg</i>	gen	QL (42 PER 30 OVER TIME), NDS
<i>morphine sulfate (15 mg tab, tab 15 mg, 30 mg tab, tab 30 mg)</i>	gen	QL (120 PER 30 OVER TIME), NDS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>morphine sulfate (20 mg/5ml solution, oral soln 20 mg/5ml)</i>	gen	QL (315 PER 30 OVER TIME), NDS
MORPHINE SULFATE (5 MG SUPPOS, 10 MG SUPPOS, 20 MG SUPPOS, 30 MG SUPPOS)	gen	QL (84 PER 30 OVER TIME), NDS, ED
<i>morphine sulfate oral soln 10 mg/5ml</i>	gen	QL (630 PER 30 OVER TIME), NDS
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	gen	QL (70 PER 30 OVER TIME), NDS
<i>oxycodone hcl (cap 5 mg, tab 5 mg)</i>	gen	QL (168 PER 30 OVER TIME), NDS
<i>oxycodone hcl (conc 100 mg/5ml (20 mg/ml), tab 20 mg)</i>	gen	QL (120 PER 30 OVER TIME), NDS
<i>oxycodone hcl (tab 15 mg, tab 30 mg)</i>	gen	QL (56 PER 30 OVER TIME), NDS
<i>oxycodone hcl soln 5 mg/5ml</i>	gen	QL (840 PER 30 OVER TIME), NDS
<i>oxycodone hcl tab 10 mg</i>	gen	QL (84 PER 30 OVER TIME), NDS
<i>oxycodone w/ acetaminophen (w/ tab 2.5-325 mg, w/ tab 5-325 mg)</i>	gen	QL (168 PER 30 OVER TIME), NDS
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	gen	QL (84 PER 30 OVER TIME), NDS
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	gen	QL (112 PER 30 OVER TIME), NDS
OXYCODONE-ACETAMINOPHEN 5-325 MG/5ML SOLUTION	gen	QL (840 PER 30 OVER TIME), NDS
OXYCODONE-ASPIRIN 4.8355-325 MG TAB	gen	QL (168 PER 30 OVER TIME), NDS
OXYCODONE-IBUPROFEN 5-400 MG TAB	gen	QL (56 PER 30 OVER TIME), NDS
<i>oxymorphone hcl tab 10 mg</i>	gen	PA, QL (120 PER 30 OVER TIME), NDS
<i>oxymorphone hcl tab 5 mg</i>	gen	PA, QL (180 PER 30 OVER TIME), NDS
<i>pentazocine w/ naloxone tab 50-0.5 mg</i>	gen	QL (12 PER 1 DAYS), NDS
<i>tramadol hcl tab 100 mg</i>	gen	QL (4 PER 1 DAYS), NDS
<i>tramadol hcl tab 50 mg</i>	gen	QL (8 PER 1 DAYS), NDS
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	gen	QL (112 PER 30 OVER TIME), NDS

ANESTHETICS

LOCAL ANESTHETICS

LIDOCAINE HCL 4 % SOLUTION	brd
<i>lidocaine hcl soln 4%</i>	gen
<i>lidocaine hcl viscous soln 2%</i>	gen

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lidocaine oint 5%</i>	gen	QL (50 PER 30 OVER TIME)
<i>lidocaine patch 5%</i>	gen	PA, QL (3 PER 1 DAYS)
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	gen	QL (30 PER 30 OVER TIME)
NAYZILAM 5 MG/0.1ML SOLUTION	spec	QL (10 PER 30 OVER TIME)

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

ALCOHOL DETERRENTS/ANTI-CRAVING

<i>acamprosate calcium tab delayed release 333 mg</i>	gen	
<i>disulfiram (tab 250 mg, tab 500 mg)</i>	gen	

OPIOID DEPENDENCE

<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	gen	QL (12 PER 1 DAYS)
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	gen	QL (3 PER 1 DAYS)
<i>buprenorphine hcl-naloxone hcl dihydrate (-naloxone sl film 2-0.5 mg equiv), -naloxone sl film 4-1 mg equiv))</i>	gen	QL (5 PER 1 DAYS)
<i>buprenorphine hcl-naloxone hcl dihydrate (-naloxone sl film 8-2 mg equiv), -naloxone sl tab 8-2 mg equiv))</i>	gen	QL (3 PER 1 DAYS)
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	gen	QL (2 PER 1 DAYS)
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	gen	QL (12 PER 1 DAYS)
ZUBSOLV (0.7-0.18 MG SL TAB, 1.4-0.36 MG SL TAB, 5.7-1.4 MG SL TAB)	npd	QL (3 PER 1 DAYS)
ZUBSOLV (2.9-0.71 MG SL TAB, 11.4-2.9 MG SL TAB)	npd	QL (1 PER 1 DAYS)
ZUBSOLV 8.6-2.1 MG SL TAB	npd	QL (2 PER 1 DAYS)

OPIOID REVERSAL AGENTS

<i>naloxone hcl (0.4 mg/ml soln cart, inj 0.4 mg/ml, inj 4 mg/10ml, soln prefilled syringe 2 mg/2ml)</i>	gen	
NALOXONE HCL 2 MG/0.4ML SOLN A-INJ	gen	PA, QL (0.8 PER 30 OVER TIME)
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	gen	QL (2 PER 30 OVER TIME)
<i>naltrexone hcl tab 50 mg</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SMOKING CESSATION AGENTS		
<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	gen	QL (2 PER 1 DAYS)
NICOTROL 10 MG INHALER	brd	
NICOTROL NS 10 MG/ML SOLUTION	brd	
<i>varenicline tartrate (tab 0.5 mg equiv), tab 1 mg equiv))</i>	gen	QL (2 PER 1 DAYS)
<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	gen	QL (53 PER 30 OVER TIME)

ANTIBACTERIALS

AMINOGLYCOSIDES

<i>amikacin sulfate inj 500 mg/2ml (250 mg/ml)</i>	inj	
<i>gentamicin sulfate (topical) (cream, oint)</i>	gen	
<i>gentamicin sulfate inj 40 mg/ml</i>	inj	
<i>neomycin sulfate tab 500 mg</i>	gen	
<i>paromomycin sulfate cap 250 mg</i>	gen	
STREPTOMYCIN SULFATE 1 GM RECON SOLN	inj	
<i>tobramycin sulfate (for inj 1.2 gm, inj 1.2 gm/30ml (40 mg/ml) (base equiv), 2 gm/50ml solution, 10 mg/ml solution, inj 80 mg/2ml (40 mg/ml) (base equiv))</i>	inj	

ANTIBACTERIALS, OTHER

<i>acetic acid otic soln 2%</i>	gen	
<i>aztreonam (inj 1 gm, inj 2 gm)</i>	inj	
CHLORAMPHENICOL SOD SUCCINATE 1 GM RECON SOLN	inj	
CLEOCIN 100 MG SUPPOS	brd	
<i>clindamycin hcl (cap 75 mg, cap 150 mg, cap 300 mg)</i>	gen	
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)</i>	gen	
<i>clindamycin phosphate (inj 9 gm/60ml, inj 300 mg/2ml, inj 600 mg/4ml, inj 900 mg/6ml, iv soln 300 mg/2ml, iv soln 600 mg/4ml, iv soln 900 mg/6ml)</i>	inj	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clindamycin phosphate in d5w (soln 300 mg/50ml, soln 600 mg/50ml, soln 900 mg/50ml)</i>	inj	
CLINDAMYCIN PHOSPHATE IN NAACL (300-0.9 MG/50ML-% SOLUTION, 600-0.9 MG/50ML-% SOLUTION, 900-0.9 MG/50ML-% SOLUTION)	inj	
<i>clindamycin phosphate swab 1%</i>	gen	
<i>clindamycin phosphate vaginal cream 2%</i>	gen	
CLINDESSE 2 % CREAM	brd	
<i>colistimethate sod for inj 150 mg (colistin base activity)</i>	inj	
<i>daptomycin (350 mg recon soln, for iv soln 350 mg, 500 mg recon soln, for iv soln 500 mg)</i>	spec	
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	gen	QL (1 PER 30 OVER TIME)
<i>lincomycin hcl inj 300 mg/ml</i>	inj	
<i>linezolid (for susp 100 mg/5ml, tab 600 mg)</i>	gen	PA
LINEZOLID IN SODIUM CHLORIDE 600-0.9 MG/300ML-% SOLUTION	spec	
<i>linezolid iv soln 600 mg/300ml (2 mg/ml)</i>	inj	
<i>methenamine hippurate tab 1 gm</i>	gen	
<i>metronidazole (5 mg/ml solution, 500 mg/100ml solution, iv soln 500 mg/100ml)</i>	inj	
<i>metronidazole (cap 375 mg, tab 250 mg, tab 500 mg)</i>	gen	
<i>metronidazole (topical) (cream 0.75%, gel 0.75%, gel 1%, lotion 0.75%)</i>	gen	
<i>metronidazole vaginal gel 0.75%</i>	gen	
<i>nitrofurantoin macrocrystal (cap 25 mg, cap 50 mg, cap 100 mg)</i>	gen	
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i>	gen	
<i>nitrofurantoin susp 25 mg/5ml</i>	gen	
<i>polymyxin b sulfate for inj 500000 unit</i>	inj	
SYNERCID 150-350 MG RECON SOLN	spec	
<i>tigecycline (50 mg recon soln, for iv soln 50 mg)</i>	spec	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>tinidazole (tab 250 mg, tab 500 mg)</i>	gen	
<i>trimethoprim (100 mg tab, tab 100 mg)</i>	gen	
<i>vancomycin hcl (cap 125 mg equivalent), cap 250 mg equivalent))</i>	gen	
<i>vancomycin hcl (for iv soln 1 gm (base equivalent), 1.25 gm recon soln, for iv soln 1.25 gm (base equivalent), 1.5 gm recon soln, for iv soln 1.5 gm (base equivalent), for iv soln 10 gm (base equivalent), 100 gm recon soln, 250 mg recon soln, for iv soln 500 mg (base equivalent), 750 mg recon soln, for iv soln 750 mg (base equivalent))</i>	inj	
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	gen	PA, QL (450 PER 30 OVER TIME)
VANDAZOLE 0.75 % GEL	brd	
XIFAXAN 200 MG TAB	npd	PA, QL (9 PER 30 OVER TIME)
XIFAXAN 550 MG TAB	npd	PA, QL (3 PER 1 DAYS)

BETA-LACTAM, CEPHALOSPORINS

<i>CEFACLOR (125 MG/5ML RECON SUSP, 250 MG CAP, 250 MG/5ML RECON SUSP, 375 MG/5ML RECON SUSP, 500 MG CAP)</i>	gen	
<i>CEFACLOR ER 500 MG TAB ER 12H</i>	gen	
<i>cefadroxil (1 gm tab, cap 500 mg, for susp 250 mg/5ml, for susp 500 mg/5ml, tab 1 gm)</i>	gen	
<i>cefazolin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, 3 gm recon soln, for inj 10 gm, 100 gm recon soln, 300 gm recon soln, for inj 500 mg)</i>	inj	
<i>cefdinir (cap 300 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)</i>	gen	
<i>CEFDITOREN PIVOXIL (200 MG TAB, 400 MG TAB)</i>	gen	
<i>cefepime hcl (1 gm/50ml solution, for inj 1 gm, 2 gm/100ml solution, for inj 2 gm, for iv soln 2 gm)</i>	inj	
<i>cefixime (cap 400 mg, for susp 100 mg/5ml, for susp 200 mg/5ml)</i>	gen	
<i>cefotaxime sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, 500 mg recon soln)</i>	inj	
<i>cefotetan disodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm)</i>	npd	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>cefepime sodium (soln 1 gm, soln 2 gm, soln 10 gm)</i>	inj	
<i>cefepodoxime proxetil (for susp 50 mg/5ml, for susp 100 mg/5ml, tab 100 mg, tab 200 mg)</i>	gen	
<i>cefprozil (for susp 125 mg/5ml, for susp 250 mg/5ml, tab 250 mg, tab 500 mg)</i>	gen	
<i>ceftazidime (inj 1 gm, inj 6 gm, iv soln 2 gm)</i>	inj	
<i>ceftriaxone sodium (inj 1 gm, inj 2 gm, inj 10 gm, inj 250 mg, inj 500 mg, iv soln 1 gm, iv soln 2 gm)</i>	inj	
<i>cefuroxime axetil (tab 250 mg, tab 500 mg)</i>	gen	
<i>cefuroxime sodium (inj 7.5 gm, inj 750 mg, iv soln 1.5 gm)</i>	inj	
<i>cephalexin (250 mg tab, cap 250 mg, cap 500 mg, 750 mg cap, cap 750 mg, for susp 125 mg/5ml, for susp 250 mg/5ml, 500 mg tab)</i>	gen	
SUPRAX (100 MG CHEW TAB, 200 MG CHEW TAB, 500 MG/5ML RECON SUSP)	npd	
TAZICEF (1 GM RECON SOLN, 6 GM RECON SOLN)	inj	
TEFLARO (400 MG RECON SOLN, 600 MG RECON SOLN)	spec	

BETA-LACTAM, PENICILLINS

<i>amoxicillin & pot clavulanate (for susp 200-28.5 mg/5ml, for susp 250-62.5 mg/5ml, for susp 400-57 mg/5ml, for susp 600-42.9 mg/5ml, tab 250-125 mg, tab 500-125 mg, tab 875-125 mg)</i>	gen	
AMOXICILLIN (125 MG CHEW TAB, (TRIHYDRATE) CAP 250 MG, (TRIHYDRATE) CAP 500 MG, (TRIHYDRATE) FOR SUSP 125 MG/5ML, (TRIHYDRATE) FOR SUSP 200 MG/5ML, (TRIHYDRATE) FOR SUSP 250 MG/5ML, 250 MG CHEW TAB, (TRIHYDRATE) FOR SUSP 400 MG/5ML, (TRIHYDRATE) TAB 500 MG, (TRIHYDRATE) TAB 875 MG)	gen	
AMOXICILLIN-POT CLAVULANATE (200-28.5 MG CHEW TAB, 400-57 MG CHEW TAB)	gen	
AMOXICILLIN-POT CLAVULANATE ER 1000-62.5 MG TAB ER 12H	gen	
<i>ampicillin & sulbactam sodium (inj 1.5 (1-0.5) gm, inj 3 (2-1) gm, iv soln 15 (10-5) gm)</i>	inj	
AMPICILLIN 500 MG CAP	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ampicillin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm, for iv soln 2 gm, 125 mg recon soln, for inj 250 mg, for inj 500 mg, for iv soln 10 gm)</i>	inj	
AMPICILLIN-SULBACTAM SODIUM (1.5 (1-0.5) GM RECON SOLN, 3 (2-1) GM RECON SOLN)	inj	
AUGMENTIN 125-31.25 MG/5ML RECON SUSP	brd	
BICILLIN C-R 1200000 UNIT/2ML SUSPENSION	inj	
BICILLIN C-R 900/300 900000-300000 UNIT/2ML SUSPENSION	inj	
BICILLIN L-A (600000 UNIT/ML SUSP PRSYR, 1200000 UNIT/2ML SUSP PRSYR, 2400000 UNIT/4ML SUSP PRSYR)	inj	
<i>dicloxacillin sodium (cap 250 mg, cap 500 mg)</i>	gen	
<i>nafcillin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm)</i>	inj	
<i>nafcillin sodium for iv soln 10 gm</i>	spec	
<i>penicillin g potassium (inj 5000000, inj 20000000)</i>	inj	
PENICILLIN G SODIUM 5000000 UNIT RECON SOLN	inj	
<i>penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, tab 250 mg, tab 500 mg)</i>	gen	
PFIZERPEN (5000000 RECON SOLN, 20000000 RECON SOLN)	inj	
<i>piperacillin sodium-tazobactam sodium (na inj 3.375 gm (3-0.375 gm), sod inj 2.25 gm (2-0.25 gm), sod inj 4.5 gm (4-0.5 gm), sod inj 13.5 gm (12-1.5 gm), sod inj 40.5 gm (36-4.5 gm))</i>	inj	

CARBAPENEMS

<i>ertapenem sodium for inj 1 gm (base equivalent)</i>	inj	
<i>imipenem-cilastatin (250 mg recon soln, intravenous for soln 250 mg, intravenous for soln 500 mg)</i>	inj	
<i>meropenem (soln 1 gm, soln 500 mg)</i>	inj	
MEROPENEM-SODIUM CHLORIDE (1 GM/50ML RECON SOLN, 500 MG/50ML RECON SOLN)	inj	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MACROLIDES		
<i>azithromycin (1 gm packet, for susp 100 mg/5ml, for susp 200 mg/5ml, tab 250 mg, tab 500 mg, tab 600 mg)</i>	gen	
<i>azithromycin iv for soln 500 mg</i>	inj	
<i>clarithromycin (tab 250 mg, tab 500 mg, tab er 24hr 500 mg, 125 mg/5ml recon susp, 250 mg/5ml recon susp)</i>	gen	
DIFICID 200 MG TAB	spec	PA, QL (20 PER 10 OVER TIME)
DIFICID 40 MG/ML RECON SUSP	spec	PA, QL (136 PER 10 OVER TIME)
E.E.S. 400 400 MG TAB	gen	
ERYTHROCIN LACTOBIONATE 500 MG RECON SOLN	inj	
ERYTHROCIN STEARATE 250 MG TAB	brd	
<i>erythromycin base (base 250 mg cp dr part, tab 250 mg, tab 500 mg, tab delayed release 250 mg, tab delayed release 333 mg, tab delayed release 500 mg, w/ delayed release particles cap 250 mg)</i>	gen	
<i>erythromycin ethylsuccinate (for susp 200 mg/5ml, 400 mg tab, for susp 400 mg/5ml)</i>	gen	
<i>erythromycin lactobionate for inj 500 mg</i>	inj	
QUINOLONES		
BESIVANCE 0.6 % SUSPENSION	brd	
CILOXAN 0.3 % OINTMENT	brd	
<i>ciprofloxacin (susp 250 mg/5ml (5%) (5 gm/100ml), susp 500 mg/5ml (10%) (10 gm/100ml))</i>	gen	
<i>ciprofloxacin 200 mg/100ml in d5w</i>	inj	
<i>ciprofloxacin hcl (100 mg tab, tab 250 mg (base equiv), tab 500 mg (base equiv), tab 750 mg (base equiv))</i>	gen	
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	gen	
CIPROFLOXACIN-CIPROFLOX HCL ER (ER 500 MG TAB ER 24H, ER 1000 MG TAB ER 24H)	gen	
<i>levofloxacin (25 mg/ml solution, iv soln 25 mg/ml)</i>	inj	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>levofloxacin (oral soln 25 mg/ml, tab 250 mg, tab 500 mg, tab 750 mg)</i>	gen	
<i>levofloxacin in d5w (soln 500 mg/100ml, soln 750 mg/150ml)</i>	inj	
MOXIFLOXACIN HCL 400 MG/250ML SOLUTION	inj	PA - PART B VS D DETERMINATION
MOXIFLOXACIN HCL IN NAACL 400 MG/250ML SOLUTION	inj	PA - PART B VS D DETERMINATION
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	gen	
<i>ofloxacin (300 mg tab, tab 400 mg)</i>	gen	

SULFONAMIDES

AVC VAGINAL 15 % CREAM	brd	
<i>sulfacetamide sodium lotion 10% (acne)</i>	gen	
<i>sulfadiazine (500 mg tab, tab 500 mg)</i>	gen	
<i>sulfamethoxazole-trimethoprim (susp 200-40 mg/5ml, tab 400-80 mg, tab 800-160 mg)</i>	gen	
<i>sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml</i>	inj	

TETRACYCLINES

<i>demeclocycline hcl (tab 150 mg, tab 300 mg)</i>	gen	
<i>doxycycline (monohydrate) (cap 50 mg, cap 100 mg, for susp 25 mg/5ml, tab 50 mg, tab 75 mg, tab 100 mg, tab 150 mg)</i>	gen	
DOXYCYCLINE 40 MG CAP DR	gen	PA, QL (1 PER 1 DAYS)
<i>doxycycline hyclate (cap 50 mg, cap 100 mg, tab 20 mg, tab 100 mg)</i>	gen	
<i>doxycycline hyclate (tab 75 mg, tab 150 mg, tab delayed release 50 mg, tab delayed release 75 mg, tab delayed release 100 mg, tab delayed release 150 mg, tab delayed release 200 mg)</i>	gen	PA
<i>doxycycline hyclate for inj 100 mg</i>	npd	
<i>minocycline hcl (cap 50 mg, cap 75 mg, cap 100 mg, tab 50 mg, tab 75 mg, tab 100 mg)</i>	gen	
<i>tetracycline hcl (cap 250 mg, cap 500 mg)</i>	gen	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT (10 MG TAB, 25 MG TAB, 50 MG TAB, 75 MG TAB, 100 MG TAB)	spec	ST, QL (2 PER 1 DAYS)
BRIVIACT 10 MG/ML SOLUTION	npd	ST, QL (20 PER 1 DAYS)
DIACOMIT (250 MG CAP, 250 MG PACKET)	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
DIACOMIT (500 MG CAP, 500 MG PACKET)	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>divalproex sodium (cap delayed release sprinkle 125 mg, tab delayed release 125 mg, tab delayed release 250 mg, tab delayed release 500 mg, tab er 24 hr 250 mg, tab er 24 hr 500 mg)</i>	gen	
EPIDIOLEX 100 MG/ML SOLUTION	spec	LA, PA - FOR NEW STARTS ONLY
EPRONTIA 25 MG/ML SOLUTION	npd	QL (16 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>felbamate (susp 600 mg/5ml, tab 400 mg, tab 600 mg)</i>	gen	
FINTEPLA 2.2 MG/ML SOLUTION	spec	LA, QL (12 PER 1 DAYS), PA - FOR NEW STARTS ONLY
FYCOMPA (4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	npd	QL (1 PER 1 DAYS)
FYCOMPA 0.5 MG/ML SUSPENSION	npd	QL (24 PER 1 DAYS)
FYCOMPA 2 MG TAB	npd	QL (3 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lamotrigine (orally disintegrating tab 25 mg, orally disintegrating tab 50 mg, orally disintegrating tab 100 mg, orally disintegrating tab 200 mg, tab 25 mg, tab 25 mg (42) & 100 mg (7) starter kit, tab 35 x 25 mg starter kit, tab 84 x 25 mg & 14 x 100 mg starter kit, tab 100 mg, tab 150 mg, tab 200 mg, tab chewable dispersible 5 mg, tab chewable dispersible 25 mg, tab disint 21 x 25 mg & 7 x 50 mg titration kit, tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit, tab disint 42 x 50mg & 14 x 100mg titration kit)</i>	gen	
<i>lamotrigine (tab er 24hr 100 mg, tab er 24hr 200 mg)</i>	gen	ST, QL (3 PER 1 DAYS)
<i>lamotrigine (tab er 24hr 25 mg, tab er 24hr 50 mg)</i>	gen	ST, QL (1 PER 1 DAYS)
<i>lamotrigine (tab er 24hr 250 mg, tab er 24hr 300 mg)</i>	gen	ST
<i>levetiracetam (oral soln 100 mg/ml, tab 250 mg, tab 500 mg, tab 750 mg, tab 1000 mg)</i>	gen	
<i>levetiracetam tab er 24hr 500 mg</i>	gen	QL (6 PER 1 DAYS)
<i>levetiracetam tab er 24hr 750 mg</i>	gen	QL (4 PER 1 DAYS)
SPRITAM (250 MG TAB, 500 MG TAB)	npd	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SPRITAM 1000 MG TAB	npd	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SPRITAM 750 MG TAB	npd	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>topiramate (cap er 24hr 100 mg, cap er 24hr 150 mg, cap er 24hr 200 mg, cap er 24hr 25 mg, cap er 24hr 50 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>topiramate (sprinkle cap 15 mg, sprinkle cap 25 mg, tab 25 mg, tab 50 mg, tab 100 mg, tab 200 mg)</i>	gen	
<i>valproate sodium inj 100 mg/ml</i>	inj	
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	gen	
<i>valproic acid cap 250 mg</i>	gen	
XCOPRI (150 MG TAB, 200 MG TAB)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XCOPRI (250 MG DAILY DOSE) (MG DOSE) 50 200 MG TAB THPK, (MG DOSE) 100 150 MG TAB THPK)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XCOPRI (350 MG DAILY DOSE) 150 & 200 MG TAB THPK	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XCOPRI (50 MG TAB, 100 MG TAB)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XCOPRI (COPRI 14 150 MG 14 200 MG TAB THPK, COPRI 14 50 MG 14 100 MG TAB THPK)	spec	QL (28 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XCOPRI 14 X 12.5 MG & 14 X 25 MG TAB THPK	npd	QL (28 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
ZTALMY 50 MG/ML SUSPENSION	spec	LA, QL (36 PER 1 DAYS), PA - FOR NEW STARTS ONLY

CALCIUM CHANNEL MODIFYING AGENTS

<i>ethosuximide (cap 250 mg, soln 250 mg/5ml)</i>	gen	
<i>methsuximide cap 300 mg</i>	gen	

GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS

<i>clobazam suspension 2.5 mg/ml</i>	gen	QL (16 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>clobazam tab 10 mg</i>	gen	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>clobazam tab 20 mg</i>	gen	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
DIAZEPAM 10 MG GEL	gen	QL (20 PER 30 OVER TIME)
DIAZEPAM 2.5 MG GEL	gen	QL (5 PER 30 OVER TIME)
DIAZEPAM 20 MG GEL	gen	QL (40 PER 30 OVER TIME)
<i>gabapentin (tab 600 mg, tab 800 mg)</i>	gen	QL (4 PER 1 DAYS)
<i>gabapentin cap 100 mg</i>	gen	QL (12 PER 1 DAYS)
<i>gabapentin cap 300 mg</i>	gen	QL (8 PER 1 DAYS)
<i>gabapentin cap 400 mg</i>	gen	QL (6 PER 1 DAYS)
<i>gabapentin oral soln 250 mg/5ml</i>	gen	QL (72 PER 1 DAYS)
<i>phenobarbital (elixir 20 mg/5ml, tab 15 mg, tab 16.2 mg, tab 30 mg, tab 32.4 mg, tab 60 mg, tab 64.8 mg, tab 97.2 mg, tab 100 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>primidone (tab 50 mg, 125 mg tab, tab 250 mg)</i>	gen	
SYMPAZAN (5 MG FILM, 10 MG FILM, 20 MG FILM)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>tiagabine hcl (tab 2 mg, tab 4 mg, tab 12 mg, tab 16 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VALTOCO 10 MG DOSE 10 MG/0.1ML LIQUID	spec	QL (10 PER 30 OVER TIME)
VALTOCO 15 MG DOSE 7.5 MG/0.1ML LIQD THPK	spec	QL (10 PER 30 OVER TIME)
VALTOCO 20 MG DOSE 10 MG/0.1ML LIQD THPK	spec	QL (10 PER 30 OVER TIME)
VALTOCO 5 MG DOSE 5 MG/0.1ML LIQUID	spec	QL (10 PER 30 OVER TIME)
<i>vigabatrin (powd pack 500 mg, tab 500 mg)</i>	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY

SODIUM CHANNEL AGENTS

APTIOM (200 MG TAB, 400 MG TAB)	npd	QL (1 PER 1 DAYS)
APTIOM (600 MG TAB, 800 MG TAB)	npd	QL (2 PER 1 DAYS)
<i>carbamazepine (cap er 12hr 100 mg, cap er 12hr 200 mg, cap er 12hr 300 mg, chew tab 100 mg, susp 100 mg/5ml, tab 200 mg, tab er 12hr 100 mg, tab er 12hr 200 mg, tab er 12hr 400 mg)</i>	gen	
DILANTIN (30 MG CAP, 100 MG CAP, 125 MG/5ML SUSPENSION)	brd	
DILANTIN INFATABS 50 MG CHEW TAB	brd	
<i>lacosamide (tab 50 mg, tab 100 mg, tab 150 mg, tab 200 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>lacosamide iv inj 200 mg/20ml (10 mg/ml)</i>	inj	PA - PART B VS D DETERMINATION
<i>lacosamide oral solution 10 mg/ml</i>	gen	QL (40 PER 1 DAYS)
<i>oxcarbazepine (susp 300 mg/5ml (60 mg/ml), tab 150 mg, tab 300 mg, tab 600 mg)</i>	gen	
PEGANONE 250 MG TAB	npd	
<i>phenytoin (chew tab 50 mg, susp 125 mg/5ml)</i>	gen	
<i>phenytoin sodium extended (cap 100 mg, cap 200 mg, cap 300 mg)</i>	gen	
<i>rufinamide susp 40 mg/ml</i>	gen	ST, QL (80 PER 1 DAYS)
<i>rufinamide tab 200 mg</i>	gen	ST, QL (16 PER 1 DAYS)
<i>rufinamide tab 400 mg</i>	gen	ST, QL (8 PER 1 DAYS)
ZONISADE 100 MG/5ML SUSPENSION	npd	
<i>zonisamide (cap 25 mg, cap 50 mg, cap 100 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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ANTIDEMENTIA AGENTS

ANTIDEMENTIA AGENTS, OTHER

ERGOLOID MESYLATES 1 MG TAB	gen	
NAMZARIC (7-10 MG CAP ER 24H, 14-10 MG CAP ER 24H, 21-10 MG CAP ER 24H, 28-10 MG CAP ER 24H)	brd	QL (1 PER 1 DAYS)
NAMZARIC 7 & 14 & 21 & 28 -10 MG CP24 THPK	brd	QL (28 PER 28 OVER TIME)

CHOLINESTERASE INHIBITORS

<i>donepezil hydrochloride (tab 5 mg, tab 10 mg)</i>	gen	
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	gen	
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	gen	
<i>donepezil hydrochloride tab 23 mg</i>	gen	ST
<i>galantamine hydrobromide (4 mg/ml solution, tab 4 mg, tab 8 mg, tab 12 mg)</i>	gen	
<i>galantamine hydrobromide (cap er 24hr 16 mg, cap er 24hr 24 mg, cap er 24hr 8 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>rivastigmine (patch 24hr 13.3 mg/24hr, patch 24hr 4.6 mg/24hr, patch 24hr 9.5 mg/24hr)</i>	gen	QL (30 PER 30 OVER TIME)
<i>rivastigmine tartrate (cap 1.5 mg equivalent), cap 3 mg equivalent), cap 4.5 mg equivalent), cap 6 mg equivalent))</i>	gen	

N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST

<i>memantine hcl (cap er 24hr 14 mg, cap er 24hr 21 mg, cap er 24hr 28 mg, cap er 24hr 7 mg, oral solution 2 mg/ml, tab 5 mg, tab 10 mg, tab 28 x 5 mg & 21 x 10 mg titration pack)</i>	gen	
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ANTIDEPRESSANTS

ANTIDEPRESSANTS, OTHER

AUVELITY 45-105 MG TAB ER	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	gen	QL (3 PER 1 DAYS)
<i>bupropion hcl (tab 100 mg, tab er 12hr 100 mg)</i>	gen	QL (4 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>bupropion hcl (tab er 12hr 150 mg, tab er 24hr 150 mg)</i>	gen	QL (3 PER 1 DAYS)
<i>bupropion hcl tab 75 mg</i>	gen	QL (6 PER 1 DAYS)
<i>bupropion hcl tab er 12hr 200 mg</i>	gen	QL (2 PER 1 DAYS)
<i>bupropion hcl tab er 24hr 300 mg</i>	gen	QL (1 PER 1 DAYS)
LYBALVI (5-10 MG TAB, 10-10 MG TAB, 15-10 MG TAB, 20-10 MG TAB)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
MAPROTILINE HCL (25 MG TAB, 50 MG TAB, 75 MG TAB)	gen	
<i>mirtazapine (orally disintegrating tab 15 mg, orally disintegrating tab 30 mg, orally disintegrating tab 45 mg, tab 7.5 mg, tab 15 mg, tab 30 mg, tab 45 mg)</i>	gen	
<i>olanzapine-fluoxetine hcl (cap 3-25 mg, cap 6-25 mg, cap 6-50 mg, cap 12-25 mg, cap 12-50 mg)</i>	gen	
PERPHENAZINE-AMITRIPTYLINE (2-10 MG TAB, 2-25 MG TAB, 4-10 MG TAB, 4-25 MG TAB, 4-50 MG TAB)	gen	PA - FOR NEW STARTS ONLY

MONOAMINE OXIDASE INHIBITORS

EMSAM (6 MG/24HR PATCH 24HR, 9 MG/24HR PATCH 24HR, 12 MG/24HR PATCH 24HR)	npd	PA - FOR NEW STARTS ONLY
MARPLAN 10 MG TAB	npd	
<i>phenelzine sulfate (15 mg tab, tab 15 mg)</i>	gen	
<i>tranylcypromine sulfate tab 10 mg</i>	gen	

SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITOR/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITOR)

<i>citalopram hydrobromide (oral soln 10 mg/5ml, tab 10 mg (base equiv), tab 20 mg (base equiv), tab 40 mg (base equiv))</i>	gen	
<i>desvenlafaxine succinate (tab er 24hr 25 mg equiv), tab er 24hr 50 mg equiv))</i>	gen	QL (1 PER 1 DAYS)
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	gen	QL (4 PER 1 DAYS)
<i>escitalopram oxalate (soln 5 mg/5ml equiv), tab 5 mg equiv), tab 10 mg equiv), tab 20 mg equiv))</i>	gen	
FETZIMA (20 MG CAP ER 24H, 40 MG CAP ER 24H, 80 MG CAP ER 24H, 120 MG CAP ER 24H)	npd	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FETZIMA TITRATION 20 & 40 MG CP24 THPK	npd	QL (28 PER 30 OVER TIME), PA - FOR NEW STARTS ONLY
<i>fluoxetine hcl (cap 10 mg, cap 20 mg, cap 40 mg, solution 20 mg/5ml, tab 10 mg, tab 20 mg)</i>	gen	
FLUOXETINE HCL (PMDD) ((PMDD) 10 MG CAP, (PMDD) 10 MG TAB, (PMDD) 20 MG CAP, (PMDD) 20 MG TAB)	gen	
FLUOXETINE HCL 90 MG CAP DR	gen	QL (4 PER 28 OVER TIME)
<i>fluvoxamine maleate (cap er 24hr 100 mg, cap er 24hr 150 mg)</i>	gen	ST, QL (2 PER 1 DAYS)
<i>fluvoxamine maleate tab 100 mg</i>	gen	QL (3 PER 1 DAYS)
<i>fluvoxamine maleate tab 25 mg</i>	gen	QL (12 PER 1 DAYS)
<i>fluvoxamine maleate tab 50 mg</i>	gen	QL (6 PER 1 DAYS)
NEFAZODONE HCL (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB, 250 MG TAB)	gen	
<i>paroxetine hcl (tab 10 mg, tab 20 mg, tab 30 mg, tab 40 mg, tab er 24hr 12.5 mg, tab er 24hr 25 mg, tab er 24hr 37.5 mg)</i>	gen	
<i>paroxetine hcl oral susp 10 mg/5ml (base equiv)</i>	gen	QL (30 PER 1 DAYS)
<i>paroxetine mesylate cap 7.5 mg (base equiv)</i>	gen	QL (1 PER 1 DAYS)
<i>sertraline hcl (oral concentrate for solution 20 mg/ml, tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	
<i>trazodone hcl (tab 50 mg, tab 100 mg, tab 150 mg, tab 300 mg)</i>	gen	
TRINTELLIX (5 MG TAB, 10 MG TAB, 20 MG TAB)	npd	ST, QL (1 PER 1 DAYS)
<i>venlafaxine hcl (cap er 24hr 150 mg equivalent), cap er 24hr 37.5 mg equivalent))</i>	gen	QL (2 PER 1 DAYS)
<i>venlafaxine hcl (cap er 24hr 75 mg equivalent), tab er 24hr 75 mg equivalent))</i>	gen	QL (3 PER 1 DAYS)
<i>venlafaxine hcl (tab 25 mg equivalent), tab 37.5 mg equivalent), tab 50 mg equivalent), tab 75 mg equivalent), tab 100 mg equivalent))</i>	gen	
<i>venlafaxine hcl tab er 24hr 150 mg (base equivalent)</i>	gen	QL (1 PER 1 DAYS)
<i>venlafaxine hcl tab er 24hr 37.5 mg (base equivalent)</i>	gen	QL (6 PER 1 DAYS)
VIIBRYD STARTER PACK 10 & 20 MG KIT	npd	ST, QL (30 PER 30 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>vilazodone hcl (tab 10 mg, tab 20 mg, tab 40 mg)</i>	gen	ST, QL (1 PER 1 DAYS)

TRICYCLICS

<i>amitriptyline hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 75 mg, tab 100 mg, tab 150 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>amoxapine (tab 25 mg, tab 50 mg, tab 100 mg, tab 150 mg)</i>	gen	
<i>clomipramine hcl (cap 25 mg, cap 50 mg, cap 75 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>desipramine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 75 mg, tab 100 mg, tab 150 mg)</i>	gen	
<i>doxepin hcl (cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg, conc 10 mg/ml)</i>	gen	PA - FOR NEW STARTS ONLY
<i>imipramine hcl (tab 10 mg, tab 25 mg, tab 50 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>nortriptyline hcl (10 mg/5ml solution, cap 10 mg, cap 25 mg, cap 50 mg, cap 75 mg)</i>	gen	
<i>protriptyline hcl (tab 5 mg, tab 10 mg)</i>	gen	
<i>trimipramine maleate (cap 25 mg, cap 50 mg, cap 100 mg)</i>	gen	PA - FOR NEW STARTS ONLY

ANTIEMETICS

ANTIEMETICS, OTHER

<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i>	gen	QL (4 PER 1 DAYS)
<i>meclizine hcl (tab 12.5 mg, tab 25 mg)</i>	gen	
<i>metoclopramide hcl (soln 5 mg/5ml (10 mg/10ml) equiv), tab 5 mg equivalent), tab 10 mg equivalent))</i>	gen	
METOCLOPRAMIDE HCL 10 MG TAB DISP	gen	PA, QL (4 PER 1 DAYS)
METOCLOPRAMIDE HCL 5 MG TAB DISP	gen	PA, QL (12 PER 1 DAYS)
<i>metoclopramide hcl inj 5 mg/ml (base equivalent)</i>	inj	
<i>perphenazine (tab 2 mg, tab 4 mg, tab 8 mg, tab 16 mg)</i>	gen	
<i>prochlorperazine maleate (tab 5 mg equivalent), tab 10 mg equivalent))</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>prochlorperazine suppos 25 mg</i>	gen	
<i>promethazine hcl (suppos 25 mg, tab 12.5 mg, tab 25 mg, tab 50 mg)</i>	gen	PA
<i>promethazine hcl suppos 12.5 mg</i>	gen	PA, ED
<i>scopolamine td patch 72hr 1 mg/3days</i>	gen	
<i>trimethobenzamide hcl cap 300 mg</i>	gen	

EMETOGENIC THERAPY ADJUNCTS

<i>aprepitant (capsule 80 mg, capsule 125 mg, capsule therapy pack 80 & 125 mg)</i>	gen	PA - PART B VS D DETERMINATION
<i>aprepitant capsule 40 mg</i>	gen	PA, QL (1 PER 30 OVER TIME)
<i>dronabinol (cap 2.5 mg, cap 5 mg, cap 10 mg)</i>	gen	PA, QL (6 PER 1 DAYS)
<i>granisetron hcl (inj 1 mg/ml, inj 4 mg/4ml (1 mg/ml))</i>	inj	PA - PART B VS D DETERMINATION
<i>granisetron hcl tab 1 mg</i>	gen	QL (2 PER 1 DAYS), PA - PART B VS D DETERMINATION
ONDANSETRON HCL 24 MG TAB	gen	QL (15 PER 30 OVER TIME), PA - PART B VS D DETERMINATION
<i>ondansetron hcl oral soln 4 mg/5ml</i>	gen	QL (30 PER 1 DAYS), PA - PART B VS D DETERMINATION
<i>ondansetron hcl tab 4 mg</i>	gen	QL (6 PER 1 DAYS), PA - PART B VS D DETERMINATION
<i>ondansetron hcl tab 8 mg</i>	gen	QL (3 PER 1 DAYS), PA - PART B VS D DETERMINATION
<i>ondansetron orally disintegrating tab 4 mg</i>	gen	QL (6 PER 1 DAYS), PA - PART B VS D DETERMINATION
<i>ondansetron orally disintegrating tab 8 mg</i>	gen	QL (3 PER 1 DAYS), PA - PART B VS D DETERMINATION

ANTIFUNGALS

ABELCET 5 MG/ML SUSPENSION	npd	PA - PART B VS D DETERMINATION
AMPHOTERICIN B 50 MG RECON SOLN	npd	PA - PART B VS D DETERMINATION
<i>amphotericin b liposome iv for susp 50 mg</i>	spec	PA - PART B VS D DETERMINATION
<i>caspofungin acetate (50 mg recon soln, for iv soln 50 mg)</i>	spec	PA
<i>caspofungin acetate (70 mg recon soln, for iv soln 70 mg)</i>	inj	PA
<i>ciclopirox olamine (cream equiv), susp equiv))</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clotrimazole (topical) (cream, soln)</i>	gen	
<i>clotrimazole troche 10 mg</i>	gen	
CRESEMBA (74.5 MG CAP, 186 MG CAP, 372 MG RECON SOLN)	spec	PA
<i>econazole nitrate cream 1%</i>	gen	
<i>fluconazole (for susp 10 mg/ml, for susp 40 mg/ml, tab 50 mg, tab 100 mg, tab 150 mg, tab 200 mg)</i>	gen	
<i>fluconazole in nacl (inj 200 mg/100ml, inj 400 mg/200ml)</i>	inj	
<i>flucytosine (cap 250 mg, cap 500 mg)</i>	gen	
<i>griseofulvin microsize (susp 125 mg/5ml, tab 500 mg)</i>	gen	
<i>griseofulvin ultramicrosize (tab 125 mg, tab 250 mg)</i>	gen	
GYNAZOLE-1 2 % CREAM	gen	
<i>itraconazole cap 100 mg</i>	gen	
<i>itraconazole oral soln 10 mg/ml</i>	gen	PA
<i>ketoconazole (topical) (cream, shampoo)</i>	gen	
<i>ketoconazole foam 2%</i>	gen	ST
<i>ketoconazole tab 200 mg</i>	gen	
LULICONAZOLE 1 % CREAM	gen	ST
<i>miconazole sodium (50 mg recon soln, for iv soln 50 mg, 100 mg recon soln, for iv soln 100 mg)</i>	spec	
MICONAZOLE 3 200 MG SUPPOS	gen	
MICONAZOLE-ZINC OXIDE-PETROLAT 0.25-15-81.35 % OINTMENT	gen	ST
<i>naftifine hcl (1 % cream, cream 1%, cream 2%, gel 1%)</i>	gen	ST
<i>nystatin (topical) (cream 100000 unit/gm, oint 100000 unit/gm, topical powder 100000 unit/gm)</i>	gen	
<i>nystatin susp 100000 unit/ml</i>	gen	
<i>nystatin tab 500000 unit</i>	gen	
<i>oxiconazole nitrate cream 1%</i>	gen	ST
<i>posaconazole susp 40 mg/ml</i>	gen	PA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>posaconazole tab delayed release 100 mg</i>	gen	PA, QL (3 PER 1 DAYS)
<i>terbinafine hcl tab 250 mg</i>	gen	QL (1 PER 1 DAYS)
<i>terconazole vaginal (cream 0.4%, cream 0.8%, suppos 80 mg)</i>	gen	
<i>voriconazole (200 mg recon soln, for inj 200 mg)</i>	inj	PA - PART B VS D DETERMINATION
<i>voriconazole (for susp 40 mg/ml, tab 50 mg, tab 200 mg)</i>	gen	PA

ANTIGOUT AGENTS

<i>allopurinol (tab 100 mg, tab 300 mg)</i>	gen	
<i>colchicine (0.6 mg cap, tab 0.6 mg)</i>	gen	QL (4 PER 1 DAYS)
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	gen	
<i>febuxostat (tab 40 mg, tab 80 mg)</i>	gen	ST, QL (1 PER 1 DAYS)
<i>probenecid tab 500 mg</i>	gen	

ANTIMIGRAINE AGENTS

ANTIMIGRAINE AGENTS, OTHER

NURTEC 75 MG TAB DISP	spec	PA, QL (16 PER 30 OVER TIME)
UBRELVY (50 MG TAB, 100 MG TAB)	spec	PA, QL (16 PER 30 OVER TIME)

ERGOT ALKALOIDS

<i>dihydroergotamine mesylate inj 1 mg/ml</i>	gen	PA
<i>dihydroergotamine mesylate nasal spray 4 mg/ml</i>	gen	PA, QL (8 PER 30 OVER TIME)
<i>ergotamine w/ caffeine tab 1-100 mg</i>	gen	QL (40 PER 28 OVER TIME)
MIGERGOT 2-100 MG SUPPOS	npd	QL (20 PER 30 OVER TIME)

PROPHYLACTIC

AIMOVIG (70 MG/ML SOLN A-INJ, 140 MG/ML SOLN A-INJ)	brd	PA, QL (1 PER 28 OVER TIME)
<i>timolol maleate (tab 5 mg, tab 10 mg, tab 20 mg)</i>	gen	

SEROTONIN (5-HT) RECEPTOR AGONIST

<i>naratriptan hcl (tab 1 mg equiv), tab 2.5 mg equiv)</i>	gen	QL (18 PER 30 OVER TIME)
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You can find information on what the symbols and abbreviations on this table mean by going to page ix.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>rizatriptan benzoate (oral disintegrating tab 5 mg eq), oral disintegrating tab 10 mg eq, tab 5 mg equivalent), tab 10 mg equivalent))</i>	gen	QL (24 PER 30 OVER TIME)
<i>sumatriptan (5 mg/act, 20 mg/act)</i>	gen	QL (18 PER 30 OVER TIME)
<i>sumatriptan succinate (solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml soln prsyr, inj 6 mg/0.5ml, solution auto-injector 6 mg/0.5ml, solution cartridge 4 mg/0.5ml, solution cartridge 6 mg/0.5ml)</i>	gen	QL (8 PER 30 OVER TIME)
<i>sumatriptan succinate (tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	QL (18 PER 30 OVER TIME)
SUMATRIPTAN SUCCINATE REFILL (4 MG/0.5ML SOLN CART, 6 MG/0.5ML SOLN CART)	gen	QL (8 PER 30 OVER TIME)
<i>zolmitriptan (orally disintegrating tab 2.5 mg, orally disintegrating tab 5 mg, tab 2.5 mg, tab 5 mg)</i>	gen	QL (18 PER 30 OVER TIME)

ANTIMYASTHENIC AGENTS

PARASYMPATHOMIMETICS

GUANIDINE HCL 125 MG TAB	gen
<i>pyridostigmine bromide (30 mg tab, oral soln 60 mg/5ml, tab 60 mg, tab er 180 mg)</i>	gen

ANTIMYCOBACTERIALS

ANTIMYCOBACTERIALS, OTHER

<i>dapsone (tab 25 mg, tab 100 mg)</i>	gen
<i>rifabutin cap 150 mg</i>	gen

ANTITUBERCULARS

CAPASTAT SULFATE 1 GM RECON SOLN	inj
<i>ethambutol hcl (tab 100 mg, tab 400 mg)</i>	gen
<i>isoniazid (syrup 50 mg/5ml, 100 mg tab, tab 100 mg, tab 300 mg)</i>	gen
ISONIAZID 100 MG/ML SOLUTION	inj
PASER 4 GM PACKET	npd
PRIFTIN 150 MG TAB	brd
<i>pyrazinamide tab 500 mg</i>	gen

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>rifampin (cap 150 mg, cap 300 mg)</i>	gen	
<i>rifampin for inj 600 mg</i>	inj	
RIFATER 50-120-300 MG TAB	npd	
SIRTURO (20 MG TAB, 100 MG TAB)	spec	PA
TRECTOR 250 MG TAB	npd	

ANTINEOPLASTICS

ALKYLATING AGENTS

ALKERAN 2 MG TAB	gen	PA - PART B VS D DETERMINATION
<i>cyclophosphamide (25 mg cap, 25 mg tab, cap 25 mg, 50 mg cap, 50 mg tab, cap 50 mg)</i>	brd	PA - PART B VS D DETERMINATION
GLEOSTINE (10 MG CAP, 40 MG CAP, 100 MG CAP)	brd	
LEUKERAN 2 MG TAB	brd	
MATULANE 50 MG CAP	brd	LA
MELPHALAN 2 MG TAB	gen	PA - PART B VS D DETERMINATION
<i>thiotepa (inj 15 mg, inj 100 mg)</i>	spec	PA - PART B VS D DETERMINATION
VALCHLOR 0.016 % GEL	spec	LA, QL (60 PER 30 OVER TIME), PA - FOR NEW STARTS ONLY

ANTIANDROGENS

<i>abiraterone acetate tab 250 mg</i>	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>abiraterone acetate tab 500 mg</i>	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>bicalutamide tab 50 mg</i>	gen	
ERLEADA 240 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ERLEADA 60 MG TAB	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>flutamide (125 mg cap, cap 125 mg)</i>	gen	
<i>nilutamide tab 150 mg</i>	spec	QL (1 PER 1 DAYS)
NUBEQA 300 MG TAB	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ORSERDU 345 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ORSERDU 86 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XTANDI (40 MG CAP, 40 MG TAB)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XTANDI 80 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

ANTIANGIOGENIC AGENTS

<i>lenalidomide (cap 5 mg, cap 10 mg, cap 15 mg, cap 20 mg, cap 25 mg, caps 2.5 mg)</i>	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
POMALYST (1 MG CAP, 2 MG CAP, 3 MG CAP, 4 MG CAP)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
REVLIMID (2.5 MG CAP, 5 MG CAP, 10 MG CAP, 15 MG CAP, 20 MG CAP, 25 MG CAP)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
THALOMID (150 MG CAP, 200 MG CAP)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
THALOMID (50 MG CAP, 100 MG CAP)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY

ANTIESTROGENS/MODIFIERS

EMCYT 140 MG CAP	brd	
<i>fulvestrant (250 mg/5ml soln prsyr, inj soln pref syr 250 mg/5ml)</i>	spec	
SOLTAMOX 10 MG/5ML SOLUTION	npd	
<i>tamoxifen citrate (tab 10 mg equivalent), tab 20 mg equivalent))</i>	gen	
<i>toremifene citrate tab 60 mg (base equivalent)</i>	gen	

ANTIMETABOLITES

DROXIA (200 MG CAP, 300 MG CAP, 400 MG CAP)	brd	
<i>hydroxyurea cap 500 mg</i>	gen	
INQOVI 35-100 MG TAB	spec	LA, QL (5 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
<i>mercaptopurine tab 50 mg</i>	gen	
PURIXAN 2000 MG/100ML SUSPENSION	spec	LA, PA - FOR NEW STARTS ONLY
TABLOID 40 MG TAB	brd	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTINEOPLASTICS, OTHER		
AYVAKIT (25 MG TAB, 50 MG TAB, 100 MG TAB, 200 MG TAB, 300 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BESREMI 500 MCG/ML SOLN PRSYR	spec	LA, QL (2 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
BRUKINSA 80 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
EXKIVITY 40 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
FOTIVDA (0.89 MG CAP, 1.34 MG CAP)	spec	LA, QL (21 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
IDHIFA (50 MG TAB, 100 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
INREBIC 100 MG CAP	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
KISQALI FEMARA (400 MG DOSE) 200 & 2.5 MG TAB THPK	spec	QL (70 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
KISQALI FEMARA (600 MG DOSE) 200 & 2.5 MG TAB THPK	spec	QL (91 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
KISQALI FEMARA(200 MG DOSE) 200 & 2.5 MG TAB THPK	spec	QL (49 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
KOSELUGO 10 MG CAP	spec	LA, QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
KOSELUGO 25 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
KRAZATI 200 MG TAB	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>leucovorin calcium (inj 100 mg, inj 350 mg)</i>	inj	
<i>leucovorin calcium (tab 5 mg, tab 10 mg, tab 15 mg, tab 25 mg)</i>	gen	
LONSURF 15-6.14 MG TAB	spec	LA, QL (100 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
LONSURF 20-8.19 MG TAB	spec	LA, QL (80 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
LUMAKRAS 120 MG TAB	spec	QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LUMAKRAS 320 MG TAB	spec	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LYSODREN 500 MG TAB	brd	
NINLARO (2.3 MG CAP, 3 MG CAP, 4 MG CAP)	spec	QL (3 PER 21 OVER TIME), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ONUREG (200 MG TAB, 300 MG TAB)	spec	QL (14 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
QINLOCK 50 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
RETEVMO 40 MG CAP	spec	QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
RETEVMO 80 MG CAP	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ROZLYTREK 100 MG CAP	spec	QL (5 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ROZLYTREK 200 MG CAP	spec	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SYNRIBO 3.5 MG RECON SOLN	spec	PA - PART B VS D DETERMINATION
TABRECTA (150 MG TAB, 200 MG TAB)	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TAZVERIK 200 MG TAB	spec	LA, QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VANFLYTA 17.7 MG TAB	spec	LA, QL (28 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
VANFLYTA 26.5 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
WELIREG 40 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XPOVIO (100 MG ONCE WEEKLY) 20 MG TAB THPK	spec	LA, QL (20 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (100 MG ONCE WEEKLY) 50 MG TAB THPK	spec	LA, QL (8 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (40 MG ONCE WEEKLY) 20 MG TAB THPK	spec	LA, QL (8 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (40 MG ONCE WEEKLY) 40 MG TAB THPK	spec	LA, QL (4 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (40 MG TWICE WEEKLY) 20 MG TAB THPK	spec	LA, QL (16 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (40 MG TWICE WEEKLY) 40 MG TAB THPK	spec	LA, QL (8 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (60 MG ONCE WEEKLY) 20 MG TAB THPK	spec	LA, QL (12 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (60 MG ONCE WEEKLY) 60 MG TAB THPK	spec	LA, QL (4 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (60 MG TWICE WEEKLY) 20 MG TAB THPK	spec	LA, QL (24 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XPOVIO (80 MG ONCE WEEKLY) 20 MG TAB THPK	spec	LA, QL (16 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (80 MG ONCE WEEKLY) 40 MG TAB THPK	spec	LA, QL (8 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
XPOVIO (80 MG TWICE WEEKLY) 20 MG TAB THPK	spec	LA, QL (32 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
ZOLINZA 100 MG CAP	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY

AROMATASE INHIBITORS, 3RD GENERATION

<i>anastrozole tab 1 mg</i>	gen	
<i>exemestane tab 25 mg</i>	gen	
<i>letrozole tab 2.5 mg</i>	gen	

MOLECULAR TARGET INHIBITORS

ALECENSA 150 MG CAP	spec	LA, QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ALUNBRIG (90 MG TAB, 180 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ALUNBRIG 30 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ALUNBRIG 90 & 180 MG TAB THPK	spec	LA, QL (30 PER 30 OVER TIME), PA - FOR NEW STARTS ONLY
BALVERSA 3 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BALVERSA 4 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BALVERSA 5 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BOSULIF (400 MG TAB, 500 MG TAB)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BOSULIF 100 MG TAB	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BRAFTOVI 50 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
BRAFTOVI 75 MG CAP	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
CABOMETYX (20 MG TAB, 40 MG TAB, 60 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
CALQUENCE (100 MG CAP, 100 MG TAB)	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CAPRELSA 100 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
CAPRELSA 300 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
COMETRIQ (100 MG DAILY DOSE) 80 & 20 MG KIT	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
COMETRIQ (140 MG DAILY DOSE) 3 X 20 MG & 80 MG KIT	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
COMETRIQ (60 MG DAILY DOSE) 20 MG KIT	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
COPIKTRA (15 MG CAP, 25 MG CAP)	spec	LA, QL (56 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
COTELLIC 20 MG TAB	spec	LA, QL (63 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
DAURISMO 100 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
DAURISMO 25 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ERIVEDGE 150 MG CAP	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>erlotinib hcl (tab 100 mg equivalent), tab 150 mg equivalent))</i>	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	spec	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>everolimus (tab 2.5 mg, tab 5 mg)</i>	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>everolimus (tab 7.5 mg, tab 10 mg)</i>	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>everolimus (tab susp 2 mg, tab susp 3 mg, tab susp 5 mg)</i>	spec	PA - FOR NEW STARTS ONLY
GAVRETO 100 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>gefitinib tab 250 mg</i>	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
GILOTRIF (20 MG TAB, 30 MG TAB, 40 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
IBRANCE (75 MG CAP, 75 MG TAB, 100 MG CAP, 100 MG TAB, 125 MG CAP, 125 MG TAB)	spec	LA, QL (21 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
ICLUSIG (10 MG TAB, 15 MG TAB, 30 MG TAB, 45 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	spec	QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
IMBRUVICA (70 MG CAP, 280 MG TAB, 420 MG TAB, 560 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
IMBRUVICA 140 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
IMBRUVICA 70 MG/ML SUSPENSION	spec	LA, QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
INLYTA 1 MG TAB	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
INLYTA 5 MG TAB	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
JAKAFI (5 MG TAB, 10 MG TAB, 15 MG TAB, 20 MG TAB, 25 MG TAB)	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
JAYPIRCA 100 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
JAYPIRCA 50 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
KISQALI (200 MG DOSE) 200 MG TAB THPK	spec	QL (21 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
KISQALI (400 MG DOSE) 200 MG TAB THPK	spec	QL (42 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
KISQALI (600 MG DOSE) 200 MG TAB THPK	spec	QL (63 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (10 MG DAILY DOSE) 10 MG CAP THPK	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (12 MG DAILY DOSE) 3 X 4 MG CAP THPK	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (14 MG DAILY DOSE) 10 & 4 MG CAP THPK	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (18 MG DAILY DOSE) 10 MG & 2 X 4 MG CAP THPK	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (20 MG DAILY DOSE) 2 X 10 MG CAP THPK	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (24 MG DAILY DOSE) 2 X 10 MG & 4 MG CAP THPK	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (4 MG DAILY DOSE) 4 MG CAP THPK	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LENVIMA (8 MG DAILY DOSE) 2 X 4 MG CAP THPK	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LORBRENA 100 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LORBRENA 25 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LYNPARZA (100 MG TAB, 150 MG TAB)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
LYTGOBI (12 MG DAILY DOSE) 4 MG TAB THPK	spec	LA, QL (84 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
LYTGOBI (16 MG DAILY DOSE) 4 MG TAB THPK	spec	LA, QL (112 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
LYTGOBI (20 MG DAILY DOSE) 4 MG TAB THPK	spec	LA, QL (140 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
MEKINIST 0.05 MG/ML RECON SOLN	spec	LA, QL (40 PER 1 DAYS), PA - FOR NEW STARTS ONLY
MEKINIST 0.5 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
MEKINIST 2 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
MEKTOVI 15 MG TAB	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
NERLYNX 40 MG TAB	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ODOMZO 200 MG CAP	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
PEMAZYRE (4.5 MG TAB, 9 MG TAB, 13.5 MG TAB)	spec	LA, QL (14 PER 21 OVER TIME), PA - FOR NEW STARTS ONLY
PIQRAY (200 MG DAILY DOSE) 200 MG TAB THPK	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
PIQRAY (250 MG DAILY DOSE) 200 & 50 MG TAB THPK	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
PIQRAY (300 MG DAILY DOSE) 2 X 150 MG TAB THPK	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
REZLIDHIA 150 MG CAP	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
RUBRACA (200 MG TAB, 250 MG TAB, 300 MG TAB)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
RYDAPT 25 MG CAP	spec	QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SCEMBLIX 20 MG TAB	spec	QL (20 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SCEMBLIX 40 MG TAB	spec	QL (10 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SPRYCEL (100 MG TAB, 140 MG TAB)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SPRYCEL (70 MG TAB, 80 MG TAB)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SPRYCEL 20 MG TAB	spec	QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SPRYCEL 50 MG TAB	spec	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
STIVARGA 40 MG TAB	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>sunitinib malate (cap 37.5 mg equivalent), cap 50 mg equivalent))</i>	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	spec	QL (7 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>sunitinib malate cap 25 mg (base equivalent)</i>	spec	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TAFINLAR (50 MG CAP, 75 MG CAP)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TAFINLAR 10 MG TAB SOL	spec	LA, QL (30 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TAGRISO (40 MG TAB, 80 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TALZENNA (0.1 MG CAP, 0.35 MG CAP, 0.5 MG CAP, 0.75 MG CAP, 1 MG CAP)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TALZENNA 0.25 MG CAP	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TASIGNA (50 MG CAP, 150 MG CAP, 200 MG CAP)	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TEPMETKO 225 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TIBSOVO 250 MG TAB	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TUKYSA (50 MG TAB, 150 MG TAB)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
TURALIO (125 MG CAP, 200 MG CAP)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
UKONIQ 200 MG TAB	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VENCLEXTA 10 MG TAB	brd	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VENCLEXTA 100 MG TAB	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VENCLEXTA 50 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VENCLEXTA STARTING PACK 10 & 50 & 100 MG TAB THPK	spec	LA, QL (84 PER 365 OVER TIME), PA - FOR NEW STARTS ONLY
VERZENIO (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB)	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VITRAKVI 100 MG CAP	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VITRAKVI 20 MG/ML SOLUTION	spec	LA, QL (10 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VITRAKVI 25 MG CAP	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VIZIMPRO (15 MG TAB, 30 MG TAB, 45 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VOTRIENT 200 MG TAB	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XALKORI (200 MG CAP, 250 MG CAP)	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
XOSPATA 40 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ZEJULA (100 MG TAB, 200 MG TAB, 300 MG TAB)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ZEJULA 100 MG CAP	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ZELBORAF 240 MG TAB	spec	LA, QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ZYDELIG (100 MG TAB, 150 MG TAB)	spec	LA, QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
ZYKADIA 150 MG TAB	spec	LA, QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY

RETINOIDS

<i>bexarotene cap 75 mg</i>	spec	QL (10 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>bexarotene gel 1%</i>	spec	QL (60 PER 30 OVER TIME), PA - FOR NEW STARTS ONLY
PANRETIN 0.1 % GEL	npd	PA - FOR NEW STARTS ONLY
<i>tretinoin cap 10 mg</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TREATMENT ADJUNCTS		
<i>mesna inj 100 mg/ml</i>	inj	
MESNEX 400 MG TAB	brd	
VONJO 100 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY

ANTIPARASITICS

ANTHELMINTHICS

<i>albendazole tab 200 mg</i>	npd	
<i>ivermectin tab 3 mg</i>	gen	QL (16 PER 365 OVER TIME)
<i>praziquantel tab 600 mg</i>	gen	

ANTIPROTOZOALS

ALINIA 100 MG/5ML RECON SUSP	npd	PA, QL (180 PER 3 OVER TIME)
<i>atovaquone susp 750 mg/5ml</i>	gen	PA
<i>atovaquone-proguanil hcl (tab 62.5-25 mg, tab 250-100 mg)</i>	gen	
BENZNIDAZOLE 100 MG TAB	npd	QL (240 PER 365 OVER TIME)
BENZNIDAZOLE 12.5 MG TAB	npd	QL (720 PER 365 OVER TIME)
<i>chloroquine phosphate tab 250 mg</i>	gen	QL (50 PER 30 OVER TIME)
<i>chloroquine phosphate tab 500 mg</i>	gen	QL (25 PER 30 OVER TIME)
COARTEM 20-120 MG TAB	brd	QL (24 PER 2 OVER TIME)
<i>hydroxychloroquine sulfate tab 100 mg</i>	gen	QL (4 PER 1 DAYS)
<i>hydroxychloroquine sulfate tab 200 mg</i>	gen	QL (3 PER 1 DAYS)
<i>hydroxychloroquine sulfate tab 300 mg</i>	gen	QL (2 PER 1 DAYS)
<i>hydroxychloroquine sulfate tab 400 mg</i>	gen	QL (1 PER 1 DAYS)
<i>mefloquine hcl tab 250 mg</i>	gen	
<i>nitazoxanide tab 500 mg</i>	gen	PA, QL (6 PER 3 OVER TIME)
<i>pentamidine isethionate (inj soln 300 mg, soln 300 mg)</i>	gen	
<i>pentamidine isethionate for nebulization soln 300 mg</i>	npd	PA - PART B VS D DETERMINATION
<i>primaquine phosphate (26.3 base) mg tab, tab 26.3 mg mg base))</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pyrimethamine tab 25 mg</i>	spec	PA
<i>quinine sulfate cap 324 mg</i>	gen	QL (6 PER 1 DAYS)

ANTIPARKINSON AGENTS

ANTICHOLINERGICS

<i>benztropine mesylate (tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	gen	
<i>benztropine mesylate inj 1 mg/ml</i>	inj	
<i>trihexyphenidyl hcl (0.4 mg/ml solution, oral soln 0.4 mg/ml, tab 2 mg, tab 5 mg)</i>	gen	

ANTIPARKINSON AGENTS, OTHER

<i>amantadine hcl (cap 100 mg, soln 50 mg/5ml, tab 100 mg)</i>	gen	
<i>carbidopa-levodopa-entacapone (12.5-50-200 mg tab, tabs 12.5-50-200 mg, 18.75-75-200 mg tab, tabs 18.75-75-200 mg, tabs 25-100-200 mg, tabs 31.25-125-200 mg, 37.5-150-200 mg tab, tabs 37.5-150-200 mg, tabs 50-200-200 mg)</i>	gen	
<i>entacapone tab 200 mg</i>	gen	QL (8 PER 1 DAYS)

DOPAMINE AGONISTS

<i>apomorphine hcl soln cartridge 30 mg/3ml</i>	spec	PA
<i>bromocriptine mesylate (cap 5 mg equivalent), tab 2.5 mg equivalent)</i>	gen	
NEUPRO (1 MG/24HR PATCH 24HR, 2 MG/24HR PATCH 24HR, 3 MG/24HR PATCH 24HR, 4 MG/24HR PATCH 24HR, 6 MG/24HR PATCH 24HR, 8 MG/24HR PATCH 24HR)	npd	QL (30 PER 30 OVER TIME)
<i>pramipexole dihydrochloride (tab 0.125 mg, tab 0.25 mg, tab 0.5 mg, tab 0.75 mg, tab 1 mg, tab 1.5 mg)</i>	gen	
<i>pramipexole dihydrochloride (tab er 24hr 0.375 mg, tab er 24hr 0.75 mg, tab er 24hr 1.5 mg, tab er 24hr 2.25 mg, tab er 24hr 3 mg, tab er 24hr 3.75 mg, tab er 24hr 4.5 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>ropinirole hydrochloride (tab 0.25 mg, tab 0.5 mg, tab 1 mg, tab 2 mg, tab 3 mg, tab 4 mg, tab 5 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ropinirole hydrochloride (tab er 24hr 2 mg equivalent), tab er 24hr 4 mg equivalent), tab er 24hr 6 mg equivalent))</i>	gen	QL (1 PER 1 DAYS)
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	gen	QL (2 PER 1 DAYS)
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	gen	QL (3 PER 1 DAYS)

DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS

<i>carbidopa tab 25 mg</i>	gen	
CARBIDOPA-LEVODOPA (CARBIDOPA & LEVODOPA ORALLY DISINTEGRATING TAB 10-100 MG, CARBIDOPA & LEVODOPA ORALLY DISINTEGRATING TAB 25-100 MG, CARBIDOPA & LEVODOPA ORALLY DISINTEGRATING TAB 25-250 MG, CARBIDOPA & LEVODOPA TAB 10-100 MG, CARBIDOPA & LEVODOPA TAB 25-100 MG, CARBIDOPA & LEVODOPA TAB 25-250 MG, CARBIDOPA & LEVODOPA TAB ER 25-100 MG, CARBIDOPA & LEVODOPA TAB ER 50-200 MG, CARBIDOPA-LEVODOPA 10-100 MG TAB DISP, CARBIDOPA-LEVODOPA 25-100 MG TAB DISP, CARBIDOPA-LEVODOPA 25-250 MG TAB DISP)	gen	

MONOAMINE OXIDASE B (MAO-B) INHIBITORS

<i>rasagiline mesylate (tab 0.5 mg equiv), tab 1 mg equiv))</i>	gen	QL (1 PER 1 DAYS)
<i>selegiline hcl (cap 5 mg, tab 5 mg)</i>	gen	

ANTIPSYCHOTICS

1ST GENERATION/TYPICAL

<i>chlorpromazine hcl (inj 25 mg/ml, inj 50 mg/2ml)</i>	inj	
<i>chlorpromazine hcl (tab 10 mg, tab 25 mg, 30 mg/ml conc, tab 50 mg, 100 mg/ml conc, tab 100 mg, tab 200 mg)</i>	gen	
<i>fluphenazine decanoate inj 25 mg/ml</i>	inj	
<i>fluphenazine hcl (tab 1 mg, 2.5 mg/5ml elixir, tab 2.5 mg, 5 mg/ml conc, tab 5 mg, tab 10 mg)</i>	gen	
FLUPHENAZINE HCL 2.5 MG/ML SOLUTION	inj	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>haloperidol (tab 0.5 mg, tab 1 mg, tab 2 mg, tab 5 mg, tab 10 mg, tab 20 mg)</i>	gen	
<i>haloperidol decanoate (soln 50 mg/ml, soln 100 mg/ml)</i>	inj	
<i>haloperidol lactate inj 5 mg/ml</i>	inj	
<i>haloperidol lactate oral conc 2 mg/ml</i>	gen	
<i>loxapine succinate (cap 5 mg, cap 10 mg, cap 25 mg, cap 50 mg)</i>	gen	
MOLINDONE HCL 10 MG TAB	gen	QL (8 PER 1 DAYS)
MOLINDONE HCL 25 MG TAB	gen	QL (9 PER 1 DAYS)
MOLINDONE HCL 5 MG TAB	gen	QL (12 PER 1 DAYS)
PIMOZIDE (1 MG TAB, 2 MG TAB)	gen	
<i>thioridazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>thiothixene (cap 1 mg, cap 2 mg, cap 5 mg, cap 10 mg)</i>	gen	
<i>trifluoperazine hcl (tab 1 mg equivalent), tab 2 mg equivalent), tab 5 mg equivalent), tab 10 mg equivalent))</i>	gen	

2ND GENERATION/ATYPICAL

ABILIFY ASIMTUFI (720 MG/2.4ML PRSYR, 960 MG/3.2ML PRSYR)	spec	PA - PART B VS D DETERMINATION
ABILIFY MAINTENA (300 MG PRSYR, 300 MG SRER, 400 MG PRSYR, 400 MG SRER)	spec	PA - PART B VS D DETERMINATION
<i>aripiprazole (orally disintegrating tab 10 mg, orally disintegrating tab 15 mg, tab 5 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>aripiprazole (tab 10 mg, tab 15 mg, tab 20 mg, tab 30 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>aripiprazole oral solution 1 mg/ml</i>	gen	QL (25 PER 1 DAYS)
<i>aripiprazole tab 2 mg</i>	gen	QL (4 PER 1 DAYS)
ARISTADA (441 MG/1.6ML PRSYR, 662 MG/2.4ML PRSYR, 882 MG/3.2ML PRSYR, 1064 MG/3.9ML PRSYR)	spec	PA - PART B VS D DETERMINATION
ARISTADA INITIO 675 MG/2.4ML PRSYR	spec	QL (2.4 PER 42 OVER TIME), PA - PART B VS D DETERMINATION
<i>asenapine maleate (sl tab 2.5 mg equiv), sl tab 5 mg equiv), sl tab 10 mg equiv))</i>	gen	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
CAPLYTA (10.5 MG CAP, 21 MG CAP, 42 MG CAP)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FANAPT (1 MG TAB, 2 MG TAB, 4 MG TAB, 6 MG TAB, 8 MG TAB, 10 MG TAB, 12 MG TAB)	npd	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
FANAPT TITRATION PACK 1 & 2 & 4 & 6 MG TAB	npd	QL (8 PER 30 OVER TIME), PA - FOR NEW STARTS ONLY
INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	spec	QL (3.5 PER 180 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	spec	QL (5 PER 180 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR	spec	QL (0.75 PER 28 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA SUSTENNA 156 MG/ML SUSP PRSYR	spec	QL (1 PER 28 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR	spec	QL (1.5 PER 28 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA SUSTENNA 39 MG/0.25ML SUSP PRSYR	inj	QL (0.25 PER 28 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR	spec	QL (0.5 PER 28 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA TRINZA 273 MG/0.88ML SUSP PRSYR	spec	QL (0.88 PER 84 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA TRINZA 410 MG/1.32ML SUSP PRSYR	spec	QL (1.32 PER 84 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA TRINZA 546 MG/1.75ML SUSP PRSYR	spec	QL (1.75 PER 84 OVER TIME), PA - PART B VS D DETERMINATION
INVEGA TRINZA 819 MG/2.63ML SUSP PRSYR	spec	QL (2.63 PER 84 OVER TIME), PA - PART B VS D DETERMINATION
<i>lurasidone hcl (tab 20 mg, tab 40 mg, tab 60 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>lurasidone hcl (tab 80 mg, tab 120 mg)</i>	gen	QL (2 PER 1 DAYS)
NUPLAZID (10 MG TAB, 34 MG CAP)	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>olanzapine (orally disintegrating tab 5 mg, orally disintegrating tab 10 mg, orally disintegrating tab 15 mg, orally disintegrating tab 20 mg, tab 2.5 mg, tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg, tab 20 mg)</i>	gen	
<i>olanzapine for im inj 10 mg</i>	inj	
<i>paliperidone (tab er 24hr 1.5 mg, tab er 24hr 3 mg, tab er 24hr 9 mg)</i>	gen	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>paliperidone tab er 24hr 6 mg</i>	gen	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PERSERIS (90 MG PRSYR, 120 MG PRSYR)	spec	QL (1 PER 28 OVER TIME), PA - PART B VS D DETERMINATION
<i>quetiapine fumarate (tab 25 mg, tab 50 mg, tab 100 mg, tab 200 mg, tab 300 mg, tab 400 mg, tab er 24hr 150 mg, tab er 24hr 200 mg, tab er 24hr 300 mg, tab er 24hr 400 mg, tab er 24hr 50 mg, 150 mg tab)</i>	gen	
REXULTI (0.25 MG TAB, 0.5 MG TAB, 1 MG TAB, 2 MG TAB, 3 MG TAB, 4 MG TAB)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
RISPERDAL CONSTA (25 MG, 37.5 MG, 50 MG)	spec	PA - PART B VS D DETERMINATION
RISPERDAL CONSTA 12.5 MG SRER	inj	PA - PART B VS D DETERMINATION
<i>risperidone (0.25 mg tab disp, orally disintegrating tab 0.5 mg, orally disintegrating tab 1 mg, orally disintegrating tab 2 mg, orally disintegrating tab 3 mg, orally disintegrating tab 4 mg, soln 1 mg/ml, tab 0.25 mg, tab 0.5 mg, tab 1 mg, tab 2 mg, tab 3 mg, tab 4 mg)</i>	gen	
SECUADO (3.8 MG/24HR PATCH 24HR, 5.7 MG/24HR PATCH 24HR, 7.6 MG/24HR PATCH 24HR)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VRAYLAR (1.5 MG CAP, 3 MG CAP, 4.5 MG CAP, 6 MG CAP)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
VRAYLAR 1.5 & 3 MG CAP THPK	npd	QL (7 PER 30 OVER TIME), PA - FOR NEW STARTS ONLY
<i>ziprasidone hcl (cap 20 mg, cap 40 mg, cap 60 mg, cap 80 mg)</i>	gen	
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	inj	
ZYPREXA RELPREVV (210 MG RECON SUSP, 300 MG RECON SUSP, 405 MG RECON SUSP)	inj	PA - PART B VS D DETERMINATION

TREATMENT-RESISTANT

<i>clozapine (12.5 mg tab disp, orally disintegrating tab 25 mg, orally disintegrating tab 100 mg, orally disintegrating tab 150 mg, orally disintegrating tab 200 mg, tab 25 mg, tab 50 mg, tab 100 mg, 150 mg tab disp, 200 mg tab disp, tab 200 mg)</i>	gen	
VERSACLOZ 50 MG/ML SUSPENSION	spec	QL (18 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTISPASTICITY AGENTS		
<i>baclofen tab 10 mg</i>	gen	QL (8 PER 1 DAYS)
<i>baclofen tab 20 mg</i>	gen	QL (4 PER 1 DAYS)
<i>baclofen tab 5 mg</i>	gen	QL (16 PER 1 DAYS)
<i>dantrolene sodium (cap 25 mg, cap 50 mg, cap 100 mg)</i>	gen	
<i>tizanidine hcl (cap 2 mg equivalent), cap 4 mg equivalent), cap 6 mg equivalent), tab 2 mg equivalent), tab 4 mg equivalent))</i>	gen	
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
PREVYMIS 240 MG TAB	spec	QL (200 PER 365 OVER TIME)
PREVYMIS 480 MG TAB	spec	QL (100 PER 365 OVER TIME)
<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i>	gen	QL (18 PER 1 DAYS)
<i>valganciclovir hcl tab 450 mg (base equivalent)</i>	gen	QL (2 PER 1 DAYS)
ZIRGAN 0.15 % GEL	npd	QL (5 PER 30 OVER TIME)
ANTI-HEPATITIS B (HBV) AGENTS		
<i>adefovir dipivoxil tab 10 mg</i>	gen	QL (1 PER 1 DAYS)
BARACLUDE 0.05 MG/ML SOLUTION	brd	QL (21 PER 1 DAYS)
<i>entecavir (tab 0.5 mg, tab 1 mg)</i>	gen	QL (1 PER 1 DAYS)
EPIVIR HBV 5 MG/ML SOLUTION	brd	
<i>lamivudine tab 100 mg (hbv)</i>	gen	
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA (150-37.5 MG PACKET, 200-50 MG TAB, 400-100 MG TAB)	spec	PA, QL (1 PER 1 DAYS)
EPCLUSA 200-50 MG PACKET	spec	PA, QL (2 PER 1 DAYS)
HARVONI (33.75-150 MG PACKET, 45-200 MG TAB, 90-400 MG TAB)	spec	PA, QL (1 PER 1 DAYS)
HARVONI 45-200 MG PACKET	spec	PA, QL (2 PER 1 DAYS)
LEDIPASVIR-SOFOSBUVIR 90-400 MG TAB	spec	PA, QL (1 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MAVYRET 100-40 MG TAB	spec	PA, QL (3 PER 1 DAYS)
MAVYRET 50-20 MG PACKET	spec	PA, QL (6 PER 1 DAYS)
RIBAVIRIN (200 MG CAP, 200 MG TAB)	gen	
<i>ribavirin (hepatitis c) (cap 200 mg, tab 200 mg)</i>	gen	
SOFOSBUVIR-VELPATASVIR 400-100 MG TAB	spec	PA, QL (1 PER 1 DAYS)
VOSEVI 400-100-100 MG TAB	spec	PA, QL (1 PER 1 DAYS)

ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)

APRETUDE 600 MG/3ML SUSP	spec	QL (21 PER 365 OVER TIME), PA - PART B VS D DETERMINATION
BIKTARVY (30-120-15 MG TAB, 50-200-25 MG TAB)	brd	QL (1 PER 1 DAYS)
DOVATO 50-300 MG TAB	npd	QL (1 PER 1 DAYS)
GENVOYA 150-150-200-10 MG TAB	npd	QL (1 PER 1 DAYS)
ISENTRESS (25 MG CHEW TAB, 100 MG CHEW TAB)	brd	QL (6 PER 1 DAYS)
ISENTRESS 100 MG PACKET	brd	QL (2 PER 1 DAYS)
ISENTRESS 400 MG TAB	brd	QL (4 PER 1 DAYS)
ISENTRESS HD 600 MG TAB	brd	QL (2 PER 1 DAYS)
JULUCA 50-25 MG TAB	npd	QL (1 PER 1 DAYS)
STRIBILD 150-150-200-300 MG TAB	brd	QL (1 PER 1 DAYS)
TIVICAY (10 MG TAB, 25 MG TAB, 50 MG TAB)	brd	QL (2 PER 1 DAYS)
TIVICAY PD 5 MG TAB SOL	brd	QL (6 PER 1 DAYS)

ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)

COMPLERA 200-25-300 MG TAB	brd	QL (1 PER 1 DAYS)
DELSTRIGO 100-300-300 MG TAB	npd	QL (1 PER 1 DAYS)
EDURANT 25 MG TAB	brd	QL (2 PER 1 DAYS)
EFAVIRENZ 200 MG CAP	gen	QL (3 PER 1 DAYS)
EFAVIRENZ 50 MG CAP	gen	QL (6 PER 1 DAYS)
<i>efavirenz tab 600 mg</i>	gen	QL (1 PER 1 DAYS)
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	gen	QL (1 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate (tab 400-300-300 mg, tab 600-300-300 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>etravirine tab 100 mg</i>	gen	QL (4 PER 1 DAYS)
<i>etravirine tab 200 mg</i>	gen	QL (2 PER 1 DAYS)
INTELENCE 25 MG TAB	brd	QL (12 PER 1 DAYS)
NEVIRAPINE 50 MG/5ML SUSPENSION	gen	QL (40 PER 1 DAYS)
NEVIRAPINE ER 100 MG TAB ER 24H	gen	QL (3 PER 1 DAYS)
<i>nevirapine tab 200 mg</i>	gen	QL (2 PER 1 DAYS)
<i>nevirapine tab er 24hr 100 mg</i>	gen	QL (3 PER 1 DAYS)
<i>nevirapine tab er 24hr 400 mg</i>	gen	QL (1 PER 1 DAYS)
ODEFSEY 200-25-25 MG TAB	brd	QL (1 PER 1 DAYS)
PIFELTRO 100 MG TAB	npd	QL (2 PER 1 DAYS)
RESCRIPTOR 200 MG TAB	brd	QL (6 PER 1 DAYS)

ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)

<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	gen	QL (30 PER 1 DAYS)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	gen	QL (2 PER 1 DAYS)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	gen	QL (1 PER 1 DAYS)
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	gen	QL (2 PER 1 DAYS)
CIMDUO 300-300 MG TAB	brd	QL (1 PER 1 DAYS)
DESCOVY (120-15 MG TAB, 200-25 MG TAB)	brd	QL (1 PER 1 DAYS)
DIDANOSINE (200 MG CAP DR, 250 MG CAP DR, 400 MG CAP DR)	gen	QL (1 PER 1 DAYS)
<i>emtricitabine caps 200 mg</i>	gen	QL (1 PER 1 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate (tab 100-150 mg, tab 133-200 mg, tab 167-250 mg, tab 200-300 mg)</i>	gen	QL (1 PER 1 DAYS)
EMTRIVA 10 MG/ML SOLUTION	brd	QL (24 PER 1 DAYS)
<i>lamivudine oral soln 10 mg/ml</i>	gen	QL (30 PER 1 DAYS)
<i>lamivudine tab 150 mg</i>	gen	QL (2 PER 1 DAYS)
<i>lamivudine tab 300 mg</i>	gen	QL (1 PER 1 DAYS)
<i>lamivudine-zidovudine tab 150-300 mg</i>	gen	QL (2 PER 1 DAYS)
<i>stavudine (15 mg cap, cap 15 mg, 20 mg cap, cap 20 mg, 30 mg cap, cap 30 mg, 40 mg cap, cap 40 mg)</i>	gen	QL (2 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TEMIXYS 300-300 MG TAB	brd	QL (1 PER 1 DAYS)
<i>tenofovir disoproxil fumarate tab 300 mg</i>	gen	QL (1 PER 1 DAYS)
TRIUMEQ 600-50-300 MG TAB	npd	QL (1 PER 1 DAYS)
TRIUMEQ PD 60-5-30 MG TAB SOL	npd	QL (6 PER 1 DAYS)
TRIZIVIR 300-150-300 MG TAB	brd	QL (2 PER 1 DAYS)
VIDEX 2 GM RECON SOLN	brd	
VIDEX EC 125 MG CAP DR	brd	QL (1 PER 1 DAYS)
VIREAD (200 MG TAB, 250 MG TAB)	brd	QL (1 PER 1 DAYS)
VIREAD 150 MG TAB	brd	QL (2 PER 1 DAYS)
VIREAD 40 MG/GM POWDER	brd	QL (240 PER 30 OVER TIME)
<i>zidovudine cap 100 mg</i>	gen	QL (6 PER 1 DAYS)
<i>zidovudine syrup 10 mg/ml</i>	gen	QL (60 PER 1 DAYS)
<i>zidovudine tab 300 mg</i>	gen	QL (2 PER 1 DAYS)

ANTI-HIV AGENTS, OTHER

CABENUVA 400 & 600 MG/2ML SUSP	spec	QL (4 PER 30 OVER TIME), PA - PART B VS D DETERMINATION
CABENUVA 600 & 900 MG/3ML SUSP	spec	QL (6 PER 30 OVER TIME), PA - PART B VS D DETERMINATION
FUZEON 90 MG RECON SOLN	spec	QL (60 PER 30 OVER TIME)
<i>maraviroc tab 150 mg</i>	gen	QL (2 PER 1 DAYS)
<i>maraviroc tab 300 mg</i>	gen	QL (4 PER 1 DAYS)
RUKOBIA 600 MG TAB ER 12H	npd	QL (2 PER 1 DAYS)
SELZENTRY (25 MG TAB, 75 MG TAB)	brd	QL (8 PER 1 DAYS)
SELZENTRY 20 MG/ML SOLUTION	brd	QL (60 PER 1 DAYS)
SUNLENCA 4 X 300 MG TAB THPK	spec	QL (4 PER 180 OVER TIME)
SUNLENCA 463.5 MG/1.5ML SOLUTION	spec	QL (3 PER 180 OVER TIME), PA - PART B VS D DETERMINATION
SUNLENCA 5 X 300 MG TAB THPK	spec	QL (5 PER 180 OVER TIME)
TYBOST 150 MG TAB	brd	QL (1 PER 1 DAYS)

ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)

APTIVUS 100 MG/ML SOLUTION	brd	QL (10 PER 1 DAYS)
APTIVUS 250 MG CAP	brd	QL (4 PER 1 DAYS)
<i>atazanavir sulfate (cap 150 mg equiv), cap 200 mg equiv)</i>	gen	QL (2 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>atazanavir sulfate cap 300 mg (base equiv)</i>	gen	QL (1 PER 1 DAYS)
CRIXIVAN 200 MG CAP	brd	QL (9 PER 1 DAYS)
CRIXIVAN 400 MG CAP	brd	QL (6 PER 1 DAYS)
<i>darunavir tab 600 mg</i>	gen	QL (2 PER 1 DAYS)
<i>darunavir tab 800 mg</i>	gen	QL (1 PER 1 DAYS)
EVOTAZ 300-150 MG TAB	npd	QL (1 PER 1 DAYS)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	gen	QL (4 PER 1 DAYS)
LEXIVA 50 MG/ML SUSPENSION	brd	QL (56 PER 1 DAYS)
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	gen	QL (13 PER 1 DAYS)
<i>lopinavir-ritonavir tab 100-25 mg</i>	gen	QL (10 PER 1 DAYS)
<i>lopinavir-ritonavir tab 200-50 mg</i>	gen	QL (4 PER 1 DAYS)
NORVIR 100 MG PACKET	brd	QL (12 PER 1 DAYS)
NORVIR 80 MG/ML SOLUTION	brd	QL (15 PER 1 DAYS)
PREZCOBIX 800-150 MG TAB	brd	QL (1 PER 1 DAYS)
PREZISTA 100 MG/ML SUSPENSION	brd	QL (12 PER 1 DAYS)
PREZISTA 150 MG TAB	brd	QL (8 PER 1 DAYS)
PREZISTA 75 MG TAB	brd	QL (10 PER 1 DAYS)
REYATAZ 50 MG PACKET	brd	QL (8 PER 1 DAYS)
<i>ritonavir tab 100 mg</i>	gen	QL (12 PER 1 DAYS)
SYMTUZA 800-150-200-10 MG TAB	npd	QL (1 PER 1 DAYS)
VIRACEPT 250 MG TAB	brd	QL (9 PER 1 DAYS)
VIRACEPT 625 MG TAB	brd	QL (4 PER 1 DAYS)

ANTI-INFLUENZA AGENTS

<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	gen	QL (120 PER 180 OVER TIME)
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	gen	QL (42 PER 180 OVER TIME)
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	gen	QL (60 PER 180 OVER TIME)
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	gen	QL (1080 PER 365 OVER TIME)
RELENZA DISKHALER 5 MG/ACT AER POW BA	brd	QL (60 PER 180 OVER TIME)
RIMANTADINE HCL 100 MG TAB	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
XOFLUZA (40 MG DOSE) (OFLUZA MG DOSE) 1 40 MG TAB THPK, OFLUZA MG DOSE) 2 20 MG TAB THPK)	npd	QL (2 PER 30 OVER TIME)
XOFLUZA (80 MG DOSE) 1 X 80 MG TAB THPK	npd	QL (1 PER 30 OVER TIME)
XOFLUZA (80 MG DOSE) 2 X 40 MG TAB THPK	npd	QL (2 PER 30 OVER TIME)

ANTIHERPETIC AGENTS

<i>acyclovir (cap 200 mg, susp 200 mg/5ml, tab 400 mg, tab 800 mg)</i>	gen	
<i>acyclovir sodium iv soln 50 mg/ml</i>	inj	PA - PART B VS D DETERMINATION
<i>famciclovir (tab 125 mg, tab 250 mg, tab 500 mg)</i>	gen	
TRIFLURIDINE 1% SOLUTION	gen	
<i>valacyclovir hcl (tab 1 gm, tab 500 mg)</i>	gen	

ANXIOLYTICS

ANXIOLYTICS, OTHER

<i>bupirone hcl (tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg, tab 30 mg)</i>	gen	
<i>meprobamate (tab 200 mg, tab 400 mg)</i>	gen	

BENZODIAZEPINES

<i>alprazolam (orally disintegrating tab 0.25 mg, orally disintegrating tab 0.5 mg, orally disintegrating tab 1 mg, tab 0.25 mg, tab 0.5 mg, tab 1 mg)</i>	gen	QL (4 PER 1 DAYS)
<i>alprazolam (orally disintegrating tab 2 mg, tab 2 mg, tab er 24hr 2 mg)</i>	gen	QL (5 PER 1 DAYS)
<i>alprazolam (tab er 24hr 0.5 mg, tab er 24hr 1 mg, tab er 24hr 3 mg)</i>	gen	QL (1 PER 1 DAYS)
ALPRAZOLAM INTENSOL 1 MG/ML CONC	gen	QL (10 PER 1 DAYS)
<i>clonazepam (orally disintegrating tab 0.125 mg, orally disintegrating tab 0.25 mg, orally disintegrating tab 0.5 mg, tab 0.5 mg)</i>	gen	QL (40 PER 1 DAYS)
<i>clonazepam (orally disintegrating tab 1 mg, tab 1 mg)</i>	gen	QL (20 PER 1 DAYS)
<i>clonazepam (orally disintegrating tab 2 mg, tab 2 mg)</i>	gen	QL (10 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clorazepate dipotassium tab 15 mg</i>	gen	QL (6 PER 1 DAYS)
<i>clorazepate dipotassium tab 3.75 mg</i>	gen	QL (24 PER 1 DAYS)
<i>clorazepate dipotassium tab 7.5 mg</i>	gen	QL (12 PER 1 DAYS)
<i>diazepam (conc 5 mg/ml, tab 5 mg)</i>	gen	QL (12 PER 1 DAYS)
<i>diazepam oral soln 1 mg/ml</i>	gen	QL (60 PER 1 DAYS)
<i>diazepam tab 10 mg</i>	gen	QL (6 PER 1 DAYS)
<i>diazepam tab 2 mg</i>	gen	QL (30 PER 1 DAYS)
<i>lorazepam (conc 2 mg/ml, tab 2 mg)</i>	gen	QL (5 PER 1 DAYS)
<i>lorazepam tab 0.5 mg</i>	gen	QL (20 PER 1 DAYS)
<i>lorazepam tab 1 mg</i>	gen	QL (10 PER 1 DAYS)
<i>oxazepam (cap 10 mg, cap 15 mg, cap 30 mg)</i>	gen	QL (4 PER 1 DAYS)

BIPOLAR AGENTS

MOOD STABILIZERS

EQUETRO (100 MG CAP ER 12H, 200 MG CAP ER 12H, 300 MG CAP ER 12H)	brd	
LITHIUM 8 MEQ/5ML SOLUTION	gen	
<i>lithium carbonate (150 mg cap, cap 150 mg, 300 mg cap, cap 300 mg, cap 600 mg, tab 300 mg, tab er 300 mg, tab er 450 mg, 600 mg cap)</i>	gen	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

<i>acarbose (tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	
BYETTA 10 MCG PEN 10 MCG/0.04ML SOLN PEN	npd	PA, QL (2.4 PER 28 OVER TIME)
BYETTA 5 MCG PEN 5 MCG/0.02ML SOLN PEN	npd	PA, QL (1.2 PER 28 OVER TIME)
FARXIGA (5 MG TAB, 10 MG TAB)	brd	QL (1 PER 1 DAYS)
<i>glimepiride (tab 1 mg, tab 2 mg, tab 4 mg)</i>	gen	
<i>glipizide (tab 5 mg, tab 10 mg, tab er 24hr 10 mg, tab er 24hr 2.5 mg, tab er 24hr 5 mg)</i>	gen	
<i>glipizide-metformin hcl (tab 2.5-250 mg, tab 2.5-500 mg, tab 5-500 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>glyburide (tab 1.25 mg, tab 2.5 mg, tab 5 mg)</i>	gen	
<i>glyburide micronized (tab 1.5 mg, tab 3 mg, tab 6 mg)</i>	gen	
<i>glyburide-metformin (tab 1.25-250 mg, tab 2.5-500 mg, tab 5-500 mg)</i>	gen	
GLYXAMBI (10-5 MG TAB, 25-5 MG TAB)	brd	QL (1 PER 1 DAYS)
JANUMET (50-1000 MG TAB, 50-500 MG TAB)	brd	QL (2 PER 1 DAYS)
JANUMET XR (50-500 MG TAB ER 24H, 100-1000 MG TAB ER 24H)	brd	QL (1 PER 1 DAYS)
JANUMET XR 50-1000 MG TAB ER 24H	brd	QL (2 PER 1 DAYS)
JANUVIA (25 MG TAB, 50 MG TAB, 100 MG TAB)	brd	QL (1 PER 1 DAYS)
JARDIANCE (10 MG TAB, 25 MG TAB)	brd	QL (1 PER 1 DAYS)
JENTADUETO (2.5-1000 MG TAB, 2.5-500 MG TAB, 2.5-850 MG TAB)	brd	QL (2 PER 1 DAYS)
JENTADUETO XR 2.5-1000 MG TAB ER 24H	brd	QL (2 PER 1 DAYS)
JENTADUETO XR 5-1000 MG TAB ER 24H	brd	QL (1 PER 1 DAYS)
KERENDIA (10 MG TAB, 20 MG TAB)	npd	PA, QL (1 PER 1 DAYS)
<i>metformin hcl (tab 500 mg, tab 850 mg, tab 1000 mg, tab er 24hr 500 mg, tab er 24hr 750 mg)</i>	gen	
<i>miglitol (25 mg tab, tab 25 mg, 50 mg tab, tab 50 mg, 100 mg tab, tab 100 mg)</i>	gen	QL (3 PER 1 DAYS)
<i>nateglinide (tab 60 mg, tab 120 mg)</i>	gen	
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML SOLN PEN	brd	PA, QL (1.5 PER 28 OVER TIME)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	brd	PA, QL (3 PER 28 OVER TIME)
OZEMPIC (1 MG/DOSE) (MG/DOSE) 2 MG/1.5ML SOLN PEN, (MG/DOSE) 4 MG/3ML SOLN PEN)	brd	PA, QL (3 PER 28 OVER TIME)
OZEMPIC (2 MG/DOSE) 8 MG/3ML SOLN PEN	brd	PA, QL (3 PER 28 OVER TIME)
<i>pioglitazone hcl (tab 15 mg equiv), tab 30 mg equiv, tab 45 mg equiv)</i>	gen	
<i>pioglitazone hcl-glimepiride (tab 30-2 mg, tab 30-4 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>pioglitazone hcl-metformin hcl (-metformin tab 15-500 mg, -metformin tab 15-850 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>repaglinide (tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	gen	
REPAGLINIDE-METFORMIN HCL (1-500 MG TAB, 2-500 MG TAB)	gen	
RYBELSUS (3 MG TAB, 7 MG TAB, 14 MG TAB)	brd	PA, QL (1 PER 1 DAYS)
SYNJARDY (5-1000 MG TAB, 5-500 MG TAB, 12.5-1000 MG TAB, 12.5-500 MG TAB)	brd	QL (2 PER 1 DAYS)
SYNJARDY XR (5-1000 MG TAB ER 24H, 10-1000 MG TAB ER 24H, 12.5-1000 MG TAB ER 24H)	brd	QL (2 PER 1 DAYS)
SYNJARDY XR 25-1000 MG TAB ER 24H	brd	QL (1 PER 1 DAYS)
TOLAZAMIDE (250 MG TAB, 500 MG TAB)	gen	
TOLBUTAMIDE 500 MG TAB	gen	
TRADJENTA 5 MG TAB	brd	QL (1 PER 1 DAYS)
TRULICITY (0.75 MG/0.5ML SOLN PEN, 1.5 MG/0.5ML SOLN PEN, 3 MG/0.5ML SOLN PEN, 4.5 MG/0.5ML SOLN PEN)	brd	PA, QL (2 PER 28 OVER TIME)
VICTOZA 18 MG/3ML SOLN PEN	brd	PA, QL (9 PER 30 OVER TIME)
XIGDUO XR (2.5-1000 MG TAB ER 24H, 5-1000 MG TAB ER 24H, 10-1000 MG TAB ER 24H)	brd	QL (2 PER 1 DAYS)
XIGDUO XR (5-500 MG TAB ER 24H, 10-500 MG TAB ER 24H)	brd	QL (1 PER 1 DAYS)

GLYCEMIC AGENTS

BAQSIMI ONE PACK 3 MG/DOSE POWDER	brd	QL (2 PER 30 OVER TIME)
BAQSIMI TWO PACK 3 MG/DOSE POWDER	brd	QL (2 PER 30 OVER TIME)
<i>diazoxide susp 50 mg/ml</i>	gen	
GLUCAGEN HYPOKIT 1 MG RECON SOLN	brd	QL (2 PER 2 OVER TIME)
<i>glucagon (rdna) for inj kit 1 mg</i>	brd	QL (2 PER 2 OVER TIME)
GLUCAGON EMERGENCY (1 MG KIT, 1 MG/ML RECON SOLN)	brd	QL (2 PER 2 OVER TIME)

INSULINS

HUMALOG 100 UNIT/ML SOLN CART	brd	INS
HUMALOG JUNIOR KWIKPEN 100 UNIT/ML SOLN PEN	brd	INS
HUMALOG KWIKPEN (100 UNIT/ML SOLN PEN, 200 UNIT/ML SOLN PEN)	brd	INS
HUMALOG MIX 50/50 (50-50) 100 UNIT/ML SUSPENSION	brd	INS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMALOG MIX 50/50 KWIKPEN (50-50) 100 UNIT/ML SUSP PEN	brd	INS
HUMALOG MIX 75/25 (75-25) 100 UNIT/ML SUSPENSION	brd	INS
HUMALOG MIX 75/25 KWIKPEN (75-25) 100 UNIT/ML SUSP PEN	brd	INS
HUMULIN 70/30 (70-30) 100 UNIT/ML SUSPENSION	brd	INS
HUMULIN 70/30 KWIKPEN (70-30) 100 UNIT/ML SUSP PEN	brd	INS
HUMULIN N 100 UNIT/ML SUSPENSION	brd	INS
HUMULIN N KWIKPEN 100 UNIT/ML SUSP PEN	brd	INS
HUMULIN R 100 UNIT/ML SOLUTION	brd	INS
HUMULIN R U-500 (CONCENTRATED) 500 UNIT/ML SOLUTION	brd	PA - PART B VS D DETERMINATION, INS
HUMULIN R U-500 KWIKPEN 500 UNIT/ML SOLN PEN	brd	INS
INSULIN LISPRO (1 UNIT DIAL) 100 UNIT/ML SOLN PEN	brd	INS
INSULIN LISPRO 100 UNIT/ML SOLUTION	brd	INS
INSULIN LISPRO JUNIOR KWIKPEN 100 UNIT/ML SOLN PEN	brd	INS
INSULIN LISPRO PROT & LISPRO (75-25) 100 UNIT/ML SUSP PEN	brd	INS
LANTUS 100 UNIT/ML SOLUTION	brd	QL (40 PER 30 OVER TIME), INS
LANTUS SOLOSTAR 100 UNIT/ML SOLN PEN	brd	QL (45 PER 30 OVER TIME), INS
TOUJEO MAX SOLOSTAR 300 UNIT/ML SOLN PEN	brd	QL (18 PER 28 OVER TIME), INS
TOUJEO SOLOSTAR 300 UNIT/ML SOLN PEN	brd	QL (18 PER 28 OVER TIME), INS
TRESIBA 100 UNIT/ML SOLUTION	brd	QL (30 PER 30 OVER TIME), INS
TRESIBA FLEXTOUCH 100 UNIT/ML SOLN PEN	brd	QL (30 PER 30 OVER TIME), INS
TRESIBA FLEXTOUCH 200 UNIT/ML SOLN PEN	brd	QL (27 PER 30 OVER TIME), INS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BLOOD PRODUCTS AND MODIFIERS		
ANTICOAGULANTS		
<i>dabigatran etexilate mesylate (cap 75 mg (eq), cap 150 mg (eq))</i>	gen	QL (2 PER 1 DAYS)
ELIQUIS (2.5 MG TAB, 5 MG TAB)	brd	QL (2 PER 1 DAYS)
ELIQUIS DVT/PE STARTER PACK 5 MG TAB THPK	brd	QL (74 PER 180 OVER TIME)
<i>enoxaparin sodium (inj 300 mg/3ml, inj soln pref syr 100 mg/ml, 150 mg/ml solution, inj soln pref syr 150 mg/ml)</i>	inj	QL (60 PER 30 OVER TIME)
<i>enoxaparin sodium (inj soln pref 80 mg/0.8ml, inj soln pref 120 mg/0.8ml)</i>	inj	QL (48 PER 30 OVER TIME)
<i>enoxaparin sodium inj soln pref syr 30 mg/0.3ml</i>	inj	QL (18 PER 30 OVER TIME)
<i>enoxaparin sodium inj soln pref syr 40 mg/0.4ml</i>	inj	QL (24 PER 30 OVER TIME)
<i>enoxaparin sodium inj soln pref syr 60 mg/0.6ml</i>	inj	QL (36 PER 30 OVER TIME)
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml</i>	spec	QL (24 PER 30 OVER TIME)
<i>fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml</i>	inj	QL (15 PER 30 OVER TIME)
<i>fondaparinux sodium subcutaneous inj 5 mg/0.4ml</i>	spec	QL (12 PER 30 OVER TIME)
<i>fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml</i>	spec	QL (18 PER 30 OVER TIME)
<i>heparin sodium (porcine) ((porcine) inj 1000 unit/ml, (porcine) inj 5000 unit/ml, (porcine) inj 10000 unit/ml, (porcine) inj 20000 unit/ml)</i>	gen	PA - PART B VS D DETERMINATION
PRADAXA 110 MG CAP	npd	QL (2 PER 1 DAYS)
<i>warfarin sodium (tab 1 mg, tab 2 mg, tab 2.5 mg, tab 3 mg, tab 4 mg, tab 5 mg, tab 6 mg, tab 7.5 mg, tab 10 mg)</i>	gen	
XARELTO (10 MG TAB, 15 MG TAB, 20 MG TAB)	brd	QL (1 PER 1 DAYS)
XARELTO 1 MG/ML RECON SUSP	brd	QL (20 PER 1 DAYS)
XARELTO 2.5 MG TAB	brd	QL (2 PER 1 DAYS)
XARELTO STARTER PACK 15 & 20 MG TAB THPK	brd	QL (51 PER 180 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZONTIVITY 2.08 MG TAB	npd	QL (1 PER 1 DAYS)
BLOOD PRODUCTS AND MODIFIERS, OTHER		
<i>anagrelide hcl (cap 0.5 mg, cap 1 mg)</i>	gen	
ARANESP (ALBUMIN FREE) (FREE) 10 MCG/0.4ML SOLN PRSYR, (FREE) 25 MCG/0.42ML SOLN PRSYR, (FREE) 25 MCG/ML SOLUTION, (FREE) 40 MCG/0.4ML SOLN PRSYR, (FREE) 40 MCG/ML SOLUTION, (FREE) 60 MCG/0.3ML SOLN PRSYR, (FREE) 60 MCG/ML SOLUTION, (FREE) 100 MCG/ML SOLUTION)	inj	PA
ARANESP (ALBUMIN FREE) (FREE) 100 MCG/0.5ML SOLN PRSYR, (FREE) 150 MCG/0.3ML SOLN PRSYR, (FREE) 200 MCG/0.4ML SOLN PRSYR, (FREE) 200 MCG/ML SOLUTION, (FREE) 300 MCG/0.6ML SOLN PRSYR, (FREE) 300 MCG/ML SOLUTION, (FREE) 500 MCG/ML SOLN PRSYR)	spec	PA
PROMACTA (12.5 MG PACKET, 12.5 MG TAB)	spec	PA, LA, QL (1 PER 1 DAYS)
PROMACTA (25 MG TAB, 50 MG TAB)	spec	PA, LA, QL (3 PER 1 DAYS)
PROMACTA 25 MG PACKET	spec	PA, LA, QL (6 PER 1 DAYS)
PROMACTA 75 MG TAB	spec	PA, LA, QL (2 PER 1 DAYS)
RETACRIT (2000 UNIT/ML SOLUTION, 3000 UNIT/ML SOLUTION, 4000 UNIT/ML SOLUTION, 10000 UNIT/ML SOLUTION, 20000 UNIT/ML SOLUTION)	npd	PA
RETACRIT 40000 UNIT/ML SOLUTION	spec	PA
ZARXIO (300 MCG/0.5ML SOLN PRSYR, 480 MCG/0.8ML SOLN PRSYR)	spec	PA
HEMOSTASIS AGENTS		
MEPHYTON 5 MG TAB	brd	QL (5 PER 7 OVER TIME), ED
<i>phytonadione tab 5 mg</i>	gen	QL (5 PER 7 OVER TIME), ED
<i>tranexamic acid tab 650 mg</i>	gen	QL (1 PER 1 DAYS)
PLATELET MODIFYING AGENTS		
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	gen	
BRILINTA (60 MG TAB, 90 MG TAB)	brd	QL (2 PER 1 DAYS)
CABLIVI 11 MG KIT	spec	PA, LA, QL (1 PER 1 DAYS)
<i>cilostazol (tab 50 mg, tab 100 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	gen	QL (1 PER 1 DAYS)
<i>dipyridamole (tab 25 mg, tab 50 mg, tab 75 mg)</i>	gen	
<i>prasugrel hcl (tab 5 mg equiv), tab 10 mg equiv))</i>	gen	QL (1 PER 1 DAYS)

CARDIOVASCULAR AGENTS

ALPHA-ADRENERGIC AGONISTS

<i>clonidine (patch 0.1 mg/24hr, patch 0.2 mg/24hr, patch 0.3 mg/24hr)</i>	gen	
<i>clonidine hcl (tab 0.1 mg, tab 0.2 mg, tab 0.3 mg)</i>	gen	
<i>droxidopa cap 100 mg</i>	spec	PA, QL (252 PER 90 OVER TIME)
<i>droxidopa cap 200 mg</i>	spec	PA, QL (120 PER 30 OVER TIME)
<i>droxidopa cap 300 mg</i>	spec	PA, QL (84 PER 90 OVER TIME)
<i>guanfacine hcl (tab 1 mg, tab 2 mg)</i>	gen	
<i>methyldopa (250 mg tab, tab 250 mg, 500 mg tab, tab 500 mg)</i>	gen	
<i>midodrine hcl (tab 2.5 mg, tab 5 mg, tab 10 mg)</i>	gen	

ALPHA-ADRENERGIC BLOCKING AGENTS

<i>doxazosin mesylate (tab 1 mg, tab 2 mg, tab 4 mg, tab 8 mg)</i>	gen	
<i>prazosin hcl (cap 1 mg, cap 2 mg, cap 5 mg)</i>	gen	
<i>terazosin hcl (cap 1 mg equivalent), cap 2 mg equivalent), cap 5 mg equivalent), cap 10 mg equivalent))</i>	gen	

ANGIOTENSIN II RECEPTOR ANTAGONISTS

<i>candesartan cilexetil (tab 4 mg, tab 8 mg, tab 16 mg, tab 32 mg)</i>	gen	
EPROSARTAN MESYLATE 600 MG TAB	gen	QL (1 PER 1 DAYS)
<i>irbesartan (tab 75 mg, tab 150 mg, tab 300 mg)</i>	gen	
<i>losartan potassium (tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	
<i>olmesartan medoxomil (tab 5 mg, tab 20 mg, tab 40 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>telmisartan (tab 20 mg, tab 40 mg, tab 80 mg)</i>	gen	
<i>valsartan (tab 40 mg, tab 80 mg, tab 160 mg, tab 320 mg)</i>	gen	

ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

<i>benazepril hcl (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)</i>	gen	
<i>captopril (tab 12.5 mg, tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	
<i>enalapril maleate (tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg)</i>	gen	
<i>enalapril maleate oral soln 1 mg/ml</i>	gen	QL (40 PER 1 DAYS)
<i>fosinopril sodium (tab 10 mg, tab 20 mg, tab 40 mg)</i>	gen	
<i>lisinopril (tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg, tab 30 mg, tab 40 mg)</i>	gen	
<i>moexipril hcl (tab 7.5 mg, tab 15 mg)</i>	gen	
<i>perindopril erbumine (tab 2 mg, tab 4 mg, 8 mg tab, tab 8 mg)</i>	gen	
<i>quinapril hcl (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)</i>	gen	
<i>ramipril (cap 1.25 mg, cap 2.5 mg, cap 5 mg, cap 10 mg)</i>	gen	
<i>trandolapril (tab 1 mg, tab 2 mg, tab 4 mg)</i>	gen	

ANTIARRHYTHMICS

<i>amiodarone hcl (tab 100 mg, tab 200 mg, tab 400 mg)</i>	gen	
<i>disopyramide phosphate (cap 100 mg, cap 150 mg)</i>	gen	
<i>dofetilide (cap 125 mcg (0.125 mg), cap 250 mcg (0.25 mg), cap 500 mcg (0.5 mg))</i>	gen	
<i>flecainide acetate (tab 50 mg, tab 100 mg, tab 150 mg)</i>	gen	
<i>mexiletine hcl (cap 150 mg, cap 200 mg, cap 250 mg)</i>	gen	
MULTAQ 400 MG TAB	brd	QL (2 PER 1 DAYS)
<i>propafenone hcl (cap er 12hr 225 mg, cap er 12hr 325 mg, cap er 12hr 425 mg, tab 150 mg, tab 225 mg, tab 300 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>quinidine gluconate tab er 324 mg</i>	gen	
<i>quinidine sulfate (200 mg tab, tab 200 mg, 300 mg tab, tab 300 mg)</i>	gen	
<i>sotalol hcl (afib/af) ((afib/af) tab 80 mg, (afib/af) tab 120 mg, (afib/af) tab 160 mg)</i>	gen	
<i>sotalol hcl (tab 80 mg, tab 120 mg, tab 160 mg, tab 240 mg)</i>	gen	

BETA-ADRENERGIC BLOCKING AGENTS

<i>acebutolol hcl (cap 200 mg, cap 400 mg)</i>	gen	
<i>atenolol (tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	
<i>betaxolol hcl (tab 10 mg, tab 20 mg)</i>	gen	
<i>bisoprolol fumarate (tab 5 mg, tab 10 mg)</i>	gen	
<i>carvedilol (tab 3.125 mg, tab 6.25 mg, tab 12.5 mg, tab 25 mg)</i>	gen	
<i>carvedilol phosphate (cap er 24hr 10 mg, cap er 24hr 20 mg, cap er 24hr 40 mg, cap er 24hr 80 mg)</i>	gen	ST
<i>labetalol hcl (tab 100 mg, tab 200 mg, tab 300 mg)</i>	gen	
<i>metoprolol succinate (tab er 24hr 100 mg equiv), tab er 24hr 200 mg equiv), tab er 24hr 25 mg equiv), tab er 24hr 50 mg equiv))</i>	gen	
<i>metoprolol tartrate (tab 25 mg, tab 37.5 mg, tab 50 mg, tab 75 mg, tab 100 mg)</i>	gen	
<i>nadolol (tab 20 mg, tab 40 mg, tab 80 mg)</i>	gen	
<i>nebivolol hcl (tab 2.5 mg equivalent), tab 5 mg equivalent), tab 10 mg equivalent), tab 20 mg equivalent))</i>	gen	
<i>pindolol (tab 5 mg, tab 10 mg)</i>	gen	
<i>propranolol hcl (cap er 24hr 120 mg, cap er 24hr 160 mg, cap er 24hr 60 mg, cap er 24hr 80 mg, oral soln 20 mg/5ml, tab 10 mg, tab 20 mg, 40 mg/5ml solution, tab 40 mg, tab 60 mg, tab 80 mg)</i>	gen	

CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES

<i>amlodipine besylate (tab 2.5 mg equivalent), tab 5 mg equivalent), tab 10 mg equivalent))</i>	gen	
<i>felodipine (tab er 24hr 10 mg, tab er 24hr 2.5 mg, tab er 24hr 5 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>isradipine (cap 2.5 mg, cap 5 mg)</i>	gen	
<i>nicardipine hcl (cap 20 mg, cap 30 mg)</i>	gen	
<i>nifedipine (cap 10 mg, cap 20 mg, tab er 24hr 30 mg, tab er 24hr 60 mg, tab er 24hr 90 mg, tab er 24hr osmotic release 30 mg, tab er 24hr osmotic release 60 mg, tab er 24hr osmotic release 90 mg)</i>	gen	
<i>nimodipine cap 30 mg</i>	gen	
<i>nisoldipine (tab er 24hr 17 mg, tab er 24hr 34 mg, tab er 24hr 8.5 mg)</i>	gen	
NISOLDIPINE ER (ER 20 MG TAB ER 24H, ER 25.5 MG TAB ER 24H, ER 30 MG TAB ER 24H, ER 40 MG TAB ER 24H)	gen	
NYMALIZE 6 MG/ML SOLUTION	spec	QL (1260 PER 21 OVER TIME)

CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES

<i>diltiazem hcl (cap er 12hr 120 mg, cap er 12hr 60 mg, cap er 12hr 90 mg, cap er 24hr 120 mg, cap er 24hr 180 mg, cap er 24hr 240 mg, tab 30 mg, tab 60 mg, tab 90 mg, tab 120 mg, tab er 24hr 120 mg, tab er 24hr 180 mg, tab er 24hr 240 mg, tab er 24hr 300 mg, tab er 24hr 360 mg, tab er 24hr 420 mg)</i>	gen	
<i>diltiazem hcl 120 mg extended release 24hr capsule</i>	gen	
<i>diltiazem hcl 180 mg extended release 24hr capsule</i>	gen	
<i>diltiazem hcl 240 mg extended release 24hr capsule</i>	gen	
<i>diltiazem hcl 300 mg extended release 24hr capsule</i>	gen	
<i>diltiazem hcl 360 mg extended release 24hr capsule</i>	gen	
<i>diltiazem hcl coated beads (beads cap er 24hr 120 mg, beads cap er 24hr 180 mg, beads cap er 24hr 240 mg, beads cap er 24hr 300 mg)</i>	gen	
<i>diltiazem hcl extended release beads (beads cap er 24hr 120 mg, beads cap er 24hr 180 mg, beads cap er 24hr 240 mg, beads cap er 24hr 300 mg, beads cap er 24hr 360 mg, beads cap er 24hr 420 mg)</i>	gen	

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DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>verapamil hcl (cap er 24hr 120 mg, cap er 24hr 180 mg, cap er 24hr 200 mg, cap er 24hr 240 mg, tab 40 mg, tab 80 mg, tab 120 mg, tab er 120 mg, tab er 180 mg, tab er 240 mg)</i>	gen	
VERAPAMIL HCL ER (ER 100 MG CAP ER 24H, ER 200 MG CAP ER 24H, ER 300 MG CAP ER 24H, ER 360 MG CAP ER 24H)	gen	

CARDIOVASCULAR AGENTS, OTHER

<i>acetazolamide (tab 125 mg, tab 250 mg)</i>	gen	
<i>aliskiren fumarate (tab 150 mg equivalent), tab 300 mg equivalent))</i>	gen	PA
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	gen	
AMILORIDE-HYDROCHLOROTHIAZIDE 5-50 MG TAB	gen	
<i>amlodipine besylate-atorvastatin calcium (tab 2.5-10 mg, tab 2.5-20 mg, tab 2.5-40 mg, tab 5-10 mg, tab 5-20 mg, tab 5-40 mg, tab 5-80 mg, tab 10-10 mg, tab 10-20 mg, tab 10-40 mg, tab 10-80 mg)</i>	gen	
<i>amlodipine besylate-benazepril hcl (cap 2.5-10 mg, cap 5-10 mg, cap 5-20 mg, cap 5-40 mg, cap 10-20 mg, cap 10-40 mg)</i>	gen	
<i>amlodipine besylate-olmesartan medoxomil (tab 5-20 mg, tab 5-40 mg, tab 10-20 mg, tab 10-40 mg)</i>	gen	
<i>amlodipine besylate-valsartan (tab 5-160 mg, tab 5-320 mg, tab 10-160 mg, tab 10-320 mg)</i>	gen	
<i>amlodipine-valsartan-hydrochlorothiazide (tab 5-160-12.5 mg, tab 5-160-25 mg, tab 10-160-12.5 mg, tab 10-160-25 mg, tab 10-320-25 mg)</i>	gen	
<i>atenolol & chlorthalidone (tab 50-25 mg, tab 100-25 mg)</i>	gen	
<i>benazepril & hydrochlorothiazide (tab 5-6.25 mg, tab 10-12.5 mg, tab 20-12.5 mg, tab 20-25 mg)</i>	gen	
<i>bisoprolol & hydrochlorothiazide (tab 2.5-6.25 mg, tab 5-6.25 mg, tab 10-6.25 mg)</i>	gen	
<i>candesartan cilexetil-hydrochlorothiazide (tab 16-12.5 mg, tab 32-12.5 mg, tab 32-25 mg)</i>	gen	
CAPTOPRIL-HYDROCHLOROTHIAZIDE (25-15 MG TAB, 25-25 MG TAB, 50-15 MG TAB, 50-25 MG TAB)	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CORLANOR (5 MG TAB, 7.5 MG TAB)	npd	PA, QL (2 PER 1 DAYS)
CORLANOR 5 MG/5ML SOLUTION	npd	PA, QL (20 PER 1 DAYS)
<i>digoxin (tab 125 mcg (0.125 mg), tab 250 mcg (0.25 mg))</i>	gen	QL (1 PER 1 DAYS)
<i>digoxin tab 62.5 mcg (0.0625 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>enalapril maleate & hydrochlorothiazide (tab 5-12.5 mg, tab 10-25 mg)</i>	gen	
ENTRESTO (24-26 MG TAB, 49-51 MG TAB, 97-103 MG TAB)	brd	QL (2 PER 1 DAYS)
<i>fosinopril sodium & hydrochlorothiazide (tab 10-12.5 mg, tab 20-12.5 mg)</i>	gen	
<i>irbesartan-hydrochlorothiazide (tab 150-12.5 mg, tab 300-12.5 mg)</i>	gen	
<i>isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg</i>	gen	QL (6 PER 1 DAYS)
<i>lisinopril & hydrochlorothiazide (tab 10-12.5 mg, tab 20-12.5 mg, tab 20-25 mg)</i>	gen	
<i>losartan potassium & hydrochlorothiazide (tab 50-12.5 mg, tab 100-12.5 mg, tab 100-25 mg)</i>	gen	
METHYLDOPA-HYDROCHLOROTHIAZIDE (250-15 MG TAB, 250-25 MG TAB)	gen	
<i>metoprolol & hydrochlorothiazide (tab 50-25 mg, tab 100-25 mg, tab 100-50 mg)</i>	gen	
<i>metyrosine cap 250 mg</i>	spec	
<i>olmesartan medoxomil-amlodipine-hydrochlorothiazide (tab 20-5-12.5 mg, tab 40-10-12.5 mg, tab 40-10-25 mg, tab 40-5-12.5 mg, tab 40-5-25 mg)</i>	gen	
<i>olmesartan medoxomil-hydrochlorothiazide (tab 20-12.5 mg, tab 40-12.5 mg, tab 40-25 mg)</i>	gen	
<i>pentoxifylline tab er 400 mg</i>	gen	
PROPRANOLOL-HCTZ (40-25 MG TAB, 80-25 MG TAB)	gen	
<i>quinapril-hydrochlorothiazide (tab 10-12.5 mg, 20-12.5 mg tab, 20-25 mg tab, tab 20-12.5 mg, tab 20-25 mg)</i>	gen	
<i>ranolazine (tab er 500 mg, tab er 1000 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>telmisartan-amlodipine (40-10 mg tab, 40-5 mg tab, tab 40-10 mg, tab 40-5 mg, 80-10 mg tab, 80-5 mg tab, tab 80-10 mg, tab 80-5 mg)</i>	gen	
<i>telmisartan-hydrochlorothiazide (tab 40-12.5 mg, tab 80-12.5 mg, tab 80-25 mg)</i>	gen	
<i>trandolapril-verapamil hcl (tab er 2-180 mg, tab er 2-240 mg, tab er 4-240 mg)</i>	gen	
TRANDOLAPRIL-VERAPAMIL HCL ER (ER 1-240 MG TAB ER, ER 2-180 MG TAB ER, ER 2-240 MG TAB ER, ER 4-240 MG TAB ER)	gen	
<i>triamterene & hydrochlorothiazide (cap 37.5-25 mg, tab 37.5-25 mg, tab 75-50 mg)</i>	gen	
<i>valsartan-hydrochlorothiazide (tab 80-12.5 mg, tab 160-12.5 mg, tab 160-25 mg, tab 320-12.5 mg, tab 320-25 mg)</i>	gen	
VECAMYL 2.5 MG TAB	gen	
VERQUVO (2.5 MG TAB, 5 MG TAB, 10 MG TAB)	npd	PA, QL (1 PER 1 DAYS)
VYNDAMAX 61 MG CAP	spec	PA, LA, QL (1 PER 1 DAYS)

DIURETICS, LOOP

<i>bumetanide (tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	gen	
<i>bumetanide inj 0.25 mg/ml</i>	inj	
<i>furosemide (8 mg/ml solution, oral soln 10 mg/ml, tab 20 mg, tab 40 mg, tab 80 mg)</i>	gen	
<i>furosemide inj 10 mg/ml</i>	inj	
<i>torseamide (tab 5 mg, tab 10 mg, tab 20 mg, tab 100 mg)</i>	gen	

DIURETICS, POTASSIUM-SPARING

<i>amiloride hcl tab 5 mg</i>	gen	
<i>eplerenone (tab 25 mg, tab 50 mg)</i>	gen	
<i>spironolactone (tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	
<i>triamterene (cap 50 mg, cap 100 mg)</i>	gen	ST

DIURETICS, THIAZIDE

CHLOROTHIAZIDE (250 MG TAB, 500 MG TAB)	gen	
<i>chlorthalidone (tab 25 mg, tab 50 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DIURIL 250 MG/5ML SUSPENSION	npd	
<i>hydrochlorothiazide (cap 12.5 mg, tab 12.5 mg, tab 25 mg, tab 50 mg)</i>	gen	
<i>indapamide (tab 1.25 mg, tab 2.5 mg)</i>	gen	
<i>metolazone (tab 2.5 mg, tab 5 mg, tab 10 mg)</i>	gen	

DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES

<i>choline fenofibrate (cap dr 45 mg equiv), cap dr 135 mg equiv))</i>	gen	
<i>fenofibrate (tab 40 mg, tab 48 mg, 50 mg cap, tab 54 mg, tab 120 mg, tab 145 mg, 150 mg cap, tab 160 mg)</i>	gen	
<i>fenofibrate micronized (cap 43 mg, cap 67 mg, cap 130 mg, cap 134 mg, cap 200 mg)</i>	gen	
<i>gemfibrozil tab 600 mg</i>	gen	

DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS

<i>atorvastatin calcium (tab 10 mg equivalent), tab 20 mg equivalent), tab 40 mg equivalent), tab 80 mg equivalent))</i>	gen	
<i>fluvastatin sodium (cap 20 mg equivalent), cap 40 mg equivalent), tab er 24 hr 80 mg equivalent))</i>	gen	
<i>lovastatin (tab 10 mg, tab 20 mg, tab 40 mg)</i>	gen	
<i>pravastatin sodium (tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)</i>	gen	
<i>rosuvastatin calcium (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)</i>	gen	
<i>simvastatin (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)</i>	gen	

DYSLIPIDEMICS, OTHER

<i>cholestyramine (powder 4 gm/dose, powder packets 4 gm)</i>	gen	
<i>cholestyramine light (powder 4 gm/dose, powder packets 4 gm)</i>	gen	
<i>colesevelam hcl (packet for susp 3.75 gm, tab 625 mg)</i>	gen	
<i>colestipol hcl (granule packets 5 gm, granules 5 gm, tab 1 gm)</i>	gen	
<i>ezetimibe tab 10 mg</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>ezetimibe-simvastatin (tab 10-10 mg, tab 10-20 mg, tab 10-40 mg, tab 10-80 mg)</i>	gen	
<i>icosapent ethyl cap 0.5 gm</i>	gen	QL (8 PER 1 DAYS)
<i>icosapent ethyl cap 1 gm</i>	gen	QL (4 PER 1 DAYS)
<i>niacin (antihyperlipidemic) (tab er 750 mg (antihyperlipidemic), tab er 1000 mg (antihyperlipidemic))</i>	gen	QL (2 PER 1 DAYS)
NIACIN (ANTIHYPERSLIPIDEMIC) 500 MG TAB	gen	
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	gen	QL (4 PER 1 DAYS)
NIACOR 500 MG TAB	gen	
<i>omega-3-acid ethyl esters cap 1 gm</i>	gen	QL (4 PER 1 DAYS)
REPATHA 140 MG/ML SOLN PRSYR	brd	PA, QL (2 PER 28 OVER TIME)
REPATHA PUSHTRONEX SYSTEM 420 MG/3.5ML SOLN CART	brd	PA, QL (3.5 PER 28 OVER TIME)
REPATHA SURECLICK 140 MG/ML SOLN A-INJ	brd	PA, QL (2 PER 28 OVER TIME)

VASODILATORS, DIRECT-ACTING ARTERIAL

<i>hydralazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen
<i>minoxidil (tab 2.5 mg, tab 10 mg)</i>	gen

VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS

<i>isosorbide dinitrate (tab 5 mg, tab 10 mg, tab 20 mg, tab 30 mg, tab 40 mg)</i>	gen
ISOSORBIDE DINITRATE ER 40 MG TAB ER	gen
<i>isosorbide mononitrate (10 mg tab, tab 10 mg, 20 mg tab, tab 20 mg, tab er 24hr 120 mg, tab er 24hr 30 mg, tab er 24hr 60 mg)</i>	gen
NITRO-BID 2 % OINTMENT	brd
NITRO-DUR (0.3 MG/HR PATCH 24HR, 0.8 MG/HR PATCH 24HR)	brd
NITRO-TIME (2.5 MG CAP ER, 6.5 MG CAP ER, 9 MG CAP ER)	gen
<i>nitroglycerin (cap er 2.5 mg, sl tab 0.3 mg, sl tab 0.4 mg, sl tab 0.6 mg, td patch 24hr 0.1 mg/hr, td patch 24hr 0.2 mg/hr, td patch 24hr 0.4 mg/hr, td patch 24hr 0.6 mg/hr, tl soln 0.4 mg/spray (400 mcg/spray))</i>	gen
NITROSTAT (0.3 MG SL TAB, 0.4 MG SL TAB, 0.6 MG SL TAB)	brd

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
RECTIV 0.4 % OINTMENT	npd	QL (30 PER 30 OVER TIME)

CENTRAL NERVOUS SYSTEM AGENTS

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES

<i>amphetamine sulfate tab 10 mg</i>	gen	ST, QL (6 PER 1 DAYS)
<i>amphetamine sulfate tab 5 mg</i>	gen	ST, QL (8 PER 1 DAYS)
<i>amphetamine-dextroamphetamine (cap er 24hr 10 mg, cap er 24hr 15 mg, cap er 24hr 20 mg, cap er 24hr 25 mg, cap er 24hr 30 mg, cap er 24hr 5 mg, tab 30 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>amphetamine-dextroamphetamine (tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg)</i>	gen	QL (4 PER 1 DAYS)
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	gen	QL (5 PER 1 DAYS)
<i>amphetamine-dextroamphetamine tab 20 mg</i>	gen	QL (3 PER 1 DAYS)
<i>dextroamphetamine sulfate (cap er 24hr 10 mg, tab 5 mg, tab 10 mg)</i>	gen	QL (6 PER 1 DAYS)
<i>dextroamphetamine sulfate (cap er 24hr 15 mg, tab 15 mg)</i>	gen	QL (4 PER 1 DAYS)
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	gen	QL (12 PER 1 DAYS)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	gen	QL (60 PER 1 DAYS)
<i>dextroamphetamine sulfate tab 20 mg</i>	gen	QL (3 PER 1 DAYS)
<i>dextroamphetamine sulfate tab 30 mg</i>	gen	QL (2 PER 1 DAYS)
<i>lisdexamfetamine dimesylate (cap 10 mg, cap 20 mg, cap 30 mg, cap 40 mg, cap 50 mg, cap 60 mg, cap 70 mg, chew tab 10 mg, chew tab 20 mg, chew tab 30 mg, chew tab 40 mg, chew tab 50 mg, chew tab 60 mg)</i>	gen	QL (1 PER 1 DAYS)
VYVANSE (10 MG CAP, 10 MG CHEW TAB, 20 MG CAP, 20 MG CHEW TAB, 30 MG CAP, 30 MG CHEW TAB, 40 MG CAP, 40 MG CHEW TAB, 50 MG CAP, 50 MG CHEW TAB, 60 MG CAP, 60 MG CHEW TAB, 70 MG CAP)	npd	QL (1 PER 1 DAYS)

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES

<i>atomoxetine hcl (cap 10 mg equiv), cap 18 mg equiv, cap 25 mg equiv)</i>	gen	QL (4 PER 1 DAYS)
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You can find information on what the symbols and abbreviations on this table mean by going to page ix.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>atomoxetine hcl (cap 60 mg equiv), cap 80 mg equiv), cap 100 mg equiv))</i>	gen	QL (1 PER 1 DAYS)
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	gen	QL (2 PER 1 DAYS)
<i>clonidine hcl tab er 12hr 0.1 mg</i>	gen	
<i>dexmethylphenidate hcl (cap er 24 hr 10 mg, cap er 24 hr 15 mg, cap er 24 hr 20 mg, cap er 24 hr 25 mg, cap er 24 hr 30 mg, cap er 24 hr 35 mg, cap er 24 hr 40 mg, cap er 24 hr 5 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>dexmethylphenidate hcl (tab 2.5 mg, tab 5 mg, tab 10 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>guanfacine hcl (adhd) (tab er 24hr 1 mg equiv), tab er 24hr 2 mg equiv), tab er 24hr 3 mg equiv), tab er 24hr 4 mg equiv))</i>	gen	QL (1 PER 1 DAYS)
<i>methylphenidate hcl (cap er 10 mg (cd), cap er 20 mg (cd), cap er 24hr 20 mg (la), cap er 24hr 30 mg (la), cap er 24hr 40 mg (la), cap er 24hr 60 mg (la), cap er 40 mg (cd), cap er 50 mg (cd), cap er 60 mg (cd), tab er 24hr 27 mg, tab er 24hr 54 mg, tab er osmotic release (osm) 18 mg, tab er osmotic release (osm) 27 mg, tab er osmotic release (osm) 54 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>methylphenidate hcl (cap er 24hr 10 mg (la), chew tab 10 mg, tab 10 mg, tab er 10 mg)</i>	gen	QL (6 PER 1 DAYS)
<i>methylphenidate hcl (cap er 30 mg (cd), tab er 24hr 36 mg, tab er osmotic release (osm) 36 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>methylphenidate hcl (chew tab 2.5 mg, chew tab 5 mg, tab 20 mg, tab er 20 mg)</i>	gen	QL (3 PER 1 DAYS)
METHYLPHENIDATE HCL ER 18 MG TAB ER 24H	gen	QL (1 PER 1 DAYS)
<i>methylphenidate hcl soln 10 mg/5ml</i>	gen	QL (30 PER 1 DAYS)
<i>methylphenidate hcl soln 5 mg/5ml</i>	gen	QL (60 PER 1 DAYS)
<i>methylphenidate hcl tab 5 mg</i>	gen	QL (12 PER 1 DAYS)

CENTRAL NERVOUS SYSTEM, OTHER

AUSTEDO (9 MG TAB, 12 MG TAB)	spec	PA, QL (4 PER 1 DAYS)
AUSTEDO 6 MG TAB	spec	PA, QL (8 PER 1 DAYS)
AUSTEDO XR (6 MG TAB ER 24H, 12 MG TAB ER 24H)	spec	PA, QL (1 PER 1 DAYS)
AUSTEDO XR 24 MG TAB ER 24H	spec	PA, QL (2 PER 1 DAYS)
AUSTEDO XR PATIENT TITRATION 6 & 12 & 24 MG TBER THPK	spec	PA, QL (42 PER 30 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>butalbital-acetaminophen (50-300 mg cap, cap 50-300 mg, tab 50-325 mg)</i>	gen	PA, QL (48 PER 30 OVER TIME), NDS
<i>butalbital-acetaminophen-caffeine (cap 50-300-40 mg, cap 50-325-40 mg, tab 50-325-40 mg)</i>	gen	PA, QL (48 PER 30 OVER TIME), NDS
INGREZZA (60 MG CAP, 80 MG CAP)	spec	PA, LA, QL (1 PER 1 DAYS)
INGREZZA 40 & 80 MG CAP THPK	spec	PA, LA, QL (28 PER 28 OVER TIME)
INGREZZA 40 MG CAP	spec	PA, LA, QL (2 PER 1 DAYS)
NUEDEXTA 20-10 MG CAP	brd	PA, QL (2 PER 1 DAYS)
<i>riluzole tab 50 mg</i>	gen	
TENCON 50-325 MG TAB	gen	PA, QL (48 PER 30 OVER TIME), NDS
<i>tetrabenazine tab 12.5 mg</i>	spec	PA, LA, QL (8 PER 1 DAYS)
<i>tetrabenazine tab 25 mg</i>	spec	PA, LA, QL (4 PER 1 DAYS)

FIBROMYALGIA AGENTS

DRIZALMA SPRINKLE (20 MG CAP DR, 30 MG CAP DR)	npd	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
DRIZALMA SPRINKLE (40 MG CAP DR, 60 MG CAP DR)	npd	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>duloxetine hcl (cap 20 mg eq), cap 40 mg eq, cap 60 mg eq))</i>	gen	QL (2 PER 1 DAYS)
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</i>	gen	QL (3 PER 1 DAYS)
<i>pregabalin (cap 200 mg, cap 225 mg, cap 300 mg)</i>	gen	QL (2 PER 1 DAYS)
<i>pregabalin (cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg)</i>	gen	QL (3 PER 1 DAYS)
<i>pregabalin soln 20 mg/ml</i>	gen	QL (30 PER 1 DAYS)

MULTIPLE SCLEROSIS AGENTS

BETASERON 0.3 MG KIT	spec	PA, QL (15 PER 30 OVER TIME)
COPAXONE 20 MG/ML SOLN PRSYR	spec	PA, QL (30 PER 30 OVER TIME)
COPAXONE 40 MG/ML SOLN PRSYR	spec	PA, QL (12 PER 28 OVER TIME)
<i>dalfampridine tab er 12hr 10 mg</i>	brd	PA, QL (2 PER 1 DAYS)
<i>dimethyl fumarate (capsule delayed release 120 mg, capsule delayed release 240 mg, capsule dr starter pack 120 mg & 240 mg)</i>	spec	PA, QL (2 PER 1 DAYS)
<i> fingolimod hcl cap 0.5 mg (base equiv)</i>	spec	PA, QL (1 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>teriflunomide (tab 7 mg, tab 14 mg)</i>	npd	PA, QL (1 PER 1 DAYS)
TYSABRI 300 MG/15ML CONC	spec	PA, LA

DENTAL AND ORAL AGENTS

<i>cevimeline hcl cap 30 mg</i>	gen	
<i>chlorhexidine gluconate soln 0.12%</i>	gen	
KEPIVANCE 6.25 MG RECON SOLN	spec	PA - PART B VS D DETERMINATION
<i>pilocarpine hcl (oral) (tab 5 mg, tab 7.5 mg)</i>	gen	
<i>triamcinolone acetonide dental paste 0.1%</i>	gen	

DERMATOLOGICAL AGENTS

ACNE AND ROSACEA AGENTS

<i>acitretin (cap 10 mg, cap 17.5 mg, cap 25 mg)</i>	gen	
<i>adapalene (cream 0.1%, gel 0.1%, gel 0.3%)</i>	gen	PA
ADAPALENE 0.1 % LOTION	gen	
<i>adapalene-benzoyl peroxide (gel 0.1-2.5%, gel 0.3-2.5%)</i>	gen	ST
<i>azelaic acid gel 15%</i>	gen	QL (50 PER 30 OVER TIME)
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	gen	
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	gen	
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	gen	
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i>	gen	ST
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>	gen	ST
<i>isotretinoin (cap 10 mg, cap 20 mg, cap 25 mg, cap 30 mg, cap 35 mg, cap 40 mg)</i>	gen	
<i>tazarotene cream 0.1%</i>	gen	
TAZORAC 0.05 % CREAM	npd	
<i>tretinoin (cream 0.025%, cream 0.05%, cream 0.1%, gel 0.01%, gel 0.025%, gel 0.05%)</i>	gen	PA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DERMATITIS AND PRURITUS AGENTS		
<i>alclometasone dipropionate oint 0.05%</i>	gen	
ANUSOL-HC 2.5 % CREAM	gen	
<i>betamethasone dipropionate (topical) (cream, lotion)</i>	gen	
BETAMETHASONE DIPROPIONATE AUG 0.05 % GEL	gen	
<i>betamethasone dipropionate augmented oint 0.05%</i>	gen	
<i>betamethasone valerate (cream equivalent), lotion equivalent), oint equivalent))</i>	gen	
CAPEX 0.01 % SHAMPOO	npd	
<i>clobetasol propionate (cream, gel, lotion, oint, shampoo, soln)</i>	gen	
<i>clobetasol propionate emollient base cream 0.05%</i>	gen	
<i>clobetasol propionate emulsion foam 0.05%</i>	gen	PA
<i>clobetasol propionate foam 0.05%</i>	gen	PA
<i>desonide (cream, oint)</i>	gen	
<i>desonide gel 0.05%</i>	gen	PA
<i>desoximetasone (cream 0.05%, cream 0.25%, oint 0.25%)</i>	gen	
<i>desoximetasone (gel 0.05%, oint 0.05%, spray 0.25%)</i>	gen	ST
DIFLORASONE DIACETATE 0.05 % CREAM	gen	
<i>fluocinolone acetonide (cream 0.01%, cream 0.025%, oil 0.01% (body oil), oil 0.01% (scalp oil), oint 0.025%, soln 0.01%)</i>	gen	
<i>fluocinonide (cream, gel, oint, soln)</i>	gen	
<i>fluocinonide cream 0.1%</i>	gen	ST
<i>fluocinonide emulsified base cream 0.05%</i>	gen	
<i>flurandrenolide (lotion, oint)</i>	gen	PA
<i>fluticasone propionate (cream 0.05%, oint 0.005%)</i>	gen	
<i>halobetasol propionate (cream, oint)</i>	gen	QL (200 PER 28 OVER TIME)
<i>hydrocortisone (rectal) (cream 1%, cream 2.5%)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>hydrocortisone (topical) (cream 1%, cream 2.5%, lotion 2.5%, oint 1%, oint 2.5%)</i>	gen	
<i>hydrocortisone butyrate (0.1 % cream, 0.1 % solution, cream 0.1%, soln 0.1%)</i>	gen	ST
<i>hydrocortisone valerate cream 0.2%</i>	gen	ST
<i>lactic acid (ammonium lactate) (lactate cream, lactate) lotion)</i>	gen	
<i>mometasone furoate solution 0.1% (lotion)</i>	gen	
<i>pimecrolimus cream 1%</i>	gen	QL (100 PER 30 OVER TIME)
<i>selenium sulfide lotion 2.5%</i>	gen	
<i>tacrolimus (topical) (ointment 0.03%, oint 0.1%)</i>	gen	QL (100 PER 30 OVER TIME)
<i>triamcinolone acetonide (topical) (cream 0.025%, cream 0.1%, cream 0.5%, lotion 0.025%, lotion 0.1%, oint 0.025%, oint 0.1%, oint 0.5%)</i>	gen	
<i>triamcinolone acetonide aerosol soln 0.147 mg/gm</i>	gen	PA

DERMATOLOGICAL AGENTS, OTHER

ANALPRAM-HC 2.5-1 % LOTION	brd	
<i>calcipotriene (cream, oint, soln (50 mcg/ml))</i>	gen	
<i>calcipotriene-betamethasone dipropionate oint 0.005-0.064%</i>	gen	PA
CALCITRIOL 3 MCG/GM OINTMENT	gen	
<i>clotrimazole w/ betamethasone (w/ cream 1-0.05%, w/ lotion 1-0.05%)</i>	gen	
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	gen	PA, QL (100 PER 30 OVER TIME)
EPIFOAM 1-1 % FOAM	brd	
FLUOROURACIL (2 % SOLUTION, 5 % SOLUTION)	gen	
<i>fluorouracil cream 5%</i>	gen	
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	gen	
<i>imiquimod cream 5%</i>	gen	QL (24 PER 30 OVER TIME)
<i>methoxsalen rapid (10 mg cap, cap 10 mg)</i>	gen	
<i>nystatin-triamcinolone (cream 100000-0.1 unit/gm-%, oint 100000-0.1 unit/gm-%)</i>	gen	
OTZLA 30 MG TAB	spec	PA, QL (2 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>podofilox (0.5 % solution, soln 0.5%)</i>	gen	
PRAMOSONE (1-1 % LOTION, 1-2.5 % LOTION)	brd	
PROCTOFOAM HC 1-1 % FOAM	brd	
REGRANEX 0.01 % GEL	brd	PA, QL (15 PER 2 OVER TIME)
SANTYL 250 UNIT/GM OINTMENT	brd	QL (180 PER 30 OVER TIME)
<i>silver sulfadiazine cream 1%</i>	gen	
SKYRIZI 600 MG/10ML SOLUTION	spec	PA, QL (30 PER 365 OVER TIME)
SODIUM SULFACETAMIDE-BAKUCHIOL 10 % LIQUID	gen	ED
SSS 10-5 10-5 % FOAM	gen	ED
STELARA 130 MG/26ML SOLUTION	spec	PA, QL (104 PER 365 OVER TIME)
<i>sulfacetamide sodium w/ sulfur cream 10-5%</i>	gen	ED
SULFACETAMIDE SODIUM-SULFUR (10-5 % LOTION, 10-5 % SUSPENSION)	gen	ED
TOLAK 4 % CREAM	brd	

PEDICULICIDES/SCABICIDES

IVERMECTIN 1 % CREAM	gen	PA, QL (45 PER 30 OVER TIME)
<i>ivermectin cream 1%</i>	gen	PA, QL (45 PER 30 OVER TIME)
LINDANE 1 % SHAMPOO	gen	
<i>malathion lotion 0.5%</i>	gen	
<i>permethrin cream 5%</i>	gen	
SPINOSAD 0.9 % SUSPENSION	gen	QL (240 PER 30 OVER TIME)

TOPICAL ANTI-INFECTIVES

<i>acyclovir cream 5%</i>	gen	PA, QL (5 PER 30 OVER TIME)
<i>acyclovir oint 5%</i>	gen	PA, QL (30 PER 30 OVER TIME)
<i>ciclopirox (gel 0.77%, shampoo 1%, solution 8%)</i>	gen	
<i>clindamycin phosphate (topical) (foam, gel, lotion, soln)</i>	gen	
<i>dapsone (topical) (gel 5%, gel 7.5%)</i>	gen	PA, QL (90 PER 30 OVER TIME)
ERY 2 % PAD	gen	
<i>erythromycin (acne aid) (gel, pads, soln)</i>	gen	
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>mupirocin oint 2%</i>	gen	
<i>penciclovir cream 1%</i>	gen	PA, QL (5 PER 30 OVER TIME)
SULFAMYLON 85 MG/GM CREAM	npd	

ELECTROLYTES/MINERALS/METALS/VITAMINS

ELECTROLYTE/MINERAL REPLACEMENT

AMINOSYN II 10 % SOLUTION	inj	PA - PART B VS D DETERMINATION
AMINOSYN-PF 10 % SOLUTION	inj	PA - PART B VS D DETERMINATION
<i>carglumic acid soluble tab 200 mg</i>	spec	PA, LA
CRYSVITA 10 MG/ML SOLUTION	spec	PA, LA, QL (2 PER 28 OVER TIME)
CRYSVITA 20 MG/ML SOLUTION	spec	PA, LA, QL (8 PER 28 OVER TIME)
CRYSVITA 30 MG/ML SOLUTION	spec	PA, LA, QL (6 PER 28 OVER TIME)
HEPATAMINE 8 % SOLUTION	inj	PA - PART B VS D DETERMINATION
INTRALIPID (20 % EMULSION, 30 % EMULSION)	inj	PA - PART B VS D DETERMINATION
KCL (0.149%) IN NAACL 20-0.9 MEQ/L-% SOLUTION	inj	
KCL (0.298%) IN NAACL 40-0.9 MEQ/L-% SOLUTION	inj	
KCL IN DEXTROSE-NAACL (20-5-0.225 MEQ/L-%-% SOLUTION, 20-5-0.33 MEQ/L-%-% SOLUTION, 40-5-0.9 MEQ/L-%-% SOLUTION)	inj	
<i>magnesium sulfate (50 % solution, inj 50%)</i>	inj	
MULTIVITAMIN/FLUORIDE (MULTIVITAMIN/FLUORIDE 0.25 MG CHEW TAB, MULTIVITAMIN/FLUORIDE 0.5 MG CHEW TAB, MULTIVITAMIN/FLUORIDE 1 MG CHEW TAB)	gen	ED
NORMOSOL-M IN D5W SOLUTION	inj	
NUTRILIPID 20 % EMULSION	inj	PA - PART B VS D DETERMINATION
<i>potassium chloride (cap er 8 meq, cap er 10 meq, oral soln 10% (20 meq/15ml), oral soln 20% (40 meq/15ml), powder packet 20 meq, tab er 8 meq (600 mg), tab er 10 meq, tab er 20 meq (1500 mg))</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>potassium chloride (inj 2 meq/ml, 10 meq/100ml solution, inj 10 meq/100ml, 20 meq/100ml solution, inj 20 meq/100ml, 40 meq/100ml solution, inj 40 meq/100ml)</i>	inj	
POTASSIUM CHLORIDE ER 8 MEQ TAB ER	gen	
<i>potassium chloride in dextrose & sodium chloride (20 meq/l (0.1)0.2% inj, 20 meq/l (0.1)0.4inj, 20 meq/l (0.1)0.9% inj, 40 meq/l (0.3%)0.9% inj)</i>	inj	
POTASSIUM CHLORIDE IN NAACL (KCL 20 MEQ/L (0.15%)0.9% INJ, KCL 40 MEQ/L (0.3%)0.9% INJ, POTASSIUM CHLORIDE20-0.9 MEQ/L-% SOLUTION, POTASSIUM CHLORIDE40-0.9 MEQ/L-% SOLUTION)	inj	
<i>potassium chloride microencapsulated crystals er (crys er tab 10, crys er tab 15, crys er tab 20)</i>	gen	
<i>potassium citrate (alkalinizer) (tab er 5 (540 mg), tab er 10 (1080 mg), tab er 15 (1620 mg))</i>	gen	
PREMASOL 10 % SOLUTION	inj	PA - PART B VS D DETERMINATION
<i>sodium chloride (iv soln 0.45%, 0.9 % solution, inj 2.5 meq/ml (14.6%), iv soln 0.9%, iv soln 3%, iv soln 5%, preservative free (pf) inj 0.9%)</i>	inj	

ELECTROLYTE/MINERAL/METAL MODIFIERS

CHEMET 100 MG CAP	brd	
<i>deferasirox (tab 180 mg, tab 360 mg, tab for oral susp 250 mg, tab for oral susp 500 mg)</i>	spec	
<i>deferasirox tab 90 mg</i>	npd	
<i>deferasirox tab for oral susp 125 mg</i>	brd	
<i>deferiprone tab 1000 mg</i>	spec	PA
<i>deferiprone tab 500 mg</i>	spec	PA, LA
FERRIPROX 100 MG/ML SOLUTION	spec	PA, LA
TRIENTINE HCL 500 MG CAP	spec	PA, QL (4 PER 1 DAYS)
<i>trientine hcl cap 250 mg</i>	spec	PA, QL (8 PER 1 DAYS)

PHOSPHATE BINDERS

AURYXIA 1 GM 210 MG(FE) TAB	npd	PA, QL (12 PER 1 DAYS)
<i>calcium acetate (phosphate binder) (binder) cap 667 mg (169 mg ca), binder) tab 667 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>lanthanum carbonate (chew tab 500 mg (elemental), chew tab 750 mg (elemental), chew tab 1000 mg (elemental))</i>	gen	
<i>sevelamer carbonate (packet 0.8 gm, packet 2.4 gm, tab 800 mg)</i>	gen	
<i>sevelamer hcl (400 mg tab, tab 800 mg)</i>	gen	

POTASSIUM BINDERS

<i>sodium polystyrene sulfonate (*sodium powder**, sodium oral susp 15 gm/60ml)</i>	gen	
SPS 15 GM/60ML SUSPENSION	gen	
VELTASSA (8.4 GM PACKET, 16.8 GM PACKET, 25.2 GM PACKET)	brd	

VITAMINS

<i>*pediatric multiple vitamins w/ fl-fe drops 0.25-10 mg/ml**</i>	gen	ED
<i>cyanocobalamin inj 1000 mcg/ml</i>	gen	ED
<i>dextrose (inj 5%, inj 10%)</i>	inj	
<i>dextrose 5% in lactated ringers</i>	inj	
<i>dextrose w/ sodium chloride (2.5% w/ 0.45%, 5% w/ 0.2%, 5% w/ 0.225%, 5% w/ 0.3%, 5% w/ 0.33%, 5% w/ 0.45%, 5% w/ 0.9%)</i>	inj	
DEXTROSE-NACL (2.5-0.45 % SOLUTION, 5-0.225 % SOLUTION, 5-0.3 % SOLUTION, 5-0.33 % SOLUTION, 10-0.2 % SOLUTION, 10-0.45 % SOLUTION)	inj	
DEXTROSE-SODIUM CHLORIDE (5-0.225 % SOLUTION, 5-0.3 % SOLUTION)	inj	
<i>folic acid tab 1 mg</i>	gen	ED
KCL-LACTATED RINGERS-D5W 20 MEQ/L SOLUTION	inj	
<i>lactated ringer's for irrigation</i>	gen	
<i>lactated ringer's solution</i>	inj	
LACTATED RINGERS SOLUTION	inj	
<i>levocarnitine (metabolic modifiers) (oral soln 1 gm/10ml (10%), tab 330 mg)</i>	gen	
MULTI-VIT-FLOR (0.25 MG CHEW TAB, 0.5 MG CHEW TAB, 1 MG CHEW TAB)	gen	ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MULTIVITAMIN W/FLUORIDE (W/FLUORIDE 0.25 MG CHEW TAB, W/FLUORIDE 0.5 MG CHEW TAB, W/FLUORIDE 1 MG CHEW TAB)	gen	ED
MULTIVITAMIN/FLUORIDE (MULTIVITAMIN/FLUORIDE 0.25 MG CHEW TAB, MULTIVITAMIN/FLUORIDE 0.5 MG CHEW TAB, MULTIVITAMIN/FLUORIDE 1 MG CHEW TAB)	gen	ED
<i>pediatric multivitamins w/fl (w/ chew tab 0.5 mg***, w/ soln 0.25 mg/ml***)</i>	gen	ED
<i>pediatric vitamins acd w/ fluoride (w/ soln 0.25 mg/ml***, w/ soln 0.5 mg/ml***)</i>	gen	
POLY-VI-FLOR (0.25 MG CHEW TAB, 0.5 MG CHEW TAB, 1 MG CHEW TAB)	gen	ED
<i>potassium bicarbonate effer tab 25 meq</i>	gen	ED
POTASSIUM CHLORIDE IN DEXTROSE (20 MEQ/L (0.15%)5% INJ, 40-5 MEQ/L-% SOLUTION)	inj	
<i>prenatal vitamins</i>	brd	
QUFLORA PEDIATRIC (0.25 MG CHEW TAB, 0.5 MG CHEW TAB, 1 MG CHEW TAB)	gen	ED
<i>ringer's solution</i>	inj	
<i>ringer's solution for irrigation</i>	gen	
SMOFLIPID 20 % EMULSION	inj	PA - PART B VS D DETERMINATION
<i>sodium fluoride (chew tab 0.25 mg f 0.55 mg naf), chew tab 0.5 mg f 1.1 mg naf), chew tab 1 mg f 2.2 mg naf), soln 0.5 mg/ml f 1.1 mg/ml naf))</i>	gen	
TPN ELECTROLYTES CONC	inj	PA - PART B VS D DETERMINATION

GASTROINTESTINAL AGENTS

ANTI-CONSTIPATION AGENTS

<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	gen	
<i>lactulose solution 10 gm/15ml</i>	gen	
LINZESS (72 MCG CAP, 145 MCG CAP, 290 MCG CAP)	brd	QL (1 PER 1 DAYS)
<i>lubiprostone (cap 8 mcg, cap 24 mcg)</i>	gen	QL (2 PER 1 DAYS)
MOVANTIK (12.5 MG TAB, 25 MG TAB)	brd	QL (1 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NULYTELY LEMON-LIME 420 GM RECON SOLN	brd	
NULYTELY WITH FLAVOR PACKS 420 GM RECON SOLN	brd	
<i>peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm</i>	gen	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	gen	
PEG-PREP 5-210 MG-GM KIT	gen	
PLENVU 140 GM RECON SOLN	brd	
RELISTOR (8 MG/0.4ML SOLUTION, 12 MG/0.6ML SOLUTION)	spec	PA
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	gen	

ANTI-DIARRHEAL AGENTS

<i>alosetron hcl (tab 0.5 mg equiv), tab 1 mg equiv))</i>	npd	PA
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	gen	
DIPHENOXYLATE-ATROPINE 2.5-0.025 MG/5ML LIQUID	gen	
<i>loperamide hcl cap 2 mg</i>	gen	
XERMELO 250 MG TAB	spec	PA, LA, QL (3 PER 1 DAYS)

ANTISPASMODICS, GASTROINTESTINAL

<i>atropine sulfate (0.5 mg/5ml soln prsyr, soln prefill syr 0.5 mg/5ml (0.1 mg/ml), 1 mg/10ml soln prsyr, soln prefill syr 1 mg/10ml (0.1 mg/ml))</i>	inj	
<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	gen	QL (8 PER 1 DAYS), ED
<i>dicyclomine hcl (cap 10 mg, oral soln 10 mg/5ml, tab 20 mg)</i>	gen	PA
<i>glycopyrrolate (tab 1 mg, tab 2 mg)</i>	gen	
<i>glycopyrrolate oral soln 1 mg/5ml</i>	gen	PA
<i>hyoscyamine sulfate (elixir 0.125 mg/5ml, sl tab 0.125 mg, soln 0.125 mg/ml, tab 0.125 mg, tab disint 0.125 mg, tab er 12hr 0.375 mg)</i>	gen	ED
<i>methscopolamine bromide (tab 2.5 mg, tab 5 mg)</i>	gen	
<i>pb-hyoscy-atrop-scopol elix 16.2-0.1037-0.0194-0.0065 mg/5ml</i>	gen	QL (40 PER 1 DAYS), ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pb-hyoscy-atrop-scopol tab 16.2-0.1037-0.0194-0.0065 mg</i>	gen	ED

GASTROINTESTINAL AGENTS, OTHER

GATTEX 5 MG KIT	spec	PA, LA
GAVILYTE-C 240 GM RECON SOLN	gen	
GOLYTELY (227.1 GM RECON SOLN, 236 GM RECON SOLN)	brd	
MYALEPT 11.3 MG RECON SOLN	spec	PA, LA, QL (60 PER 30 OVER TIME)
<i>peg 3350-kcl-sod bicarb-sod chloride-sod sulfate (soln 236 gm, soln 240 gm)</i>	gen	
SKYRIZI 180 MG/1.2ML SOLN CART	spec	PA, QL (1.2 PER 56 OVER TIME)
SKYRIZI 360 MG/2.4ML SOLN CART	spec	PA, QL (2.4 PER 56 OVER TIME)
<i>ursodiol (cap 300 mg, tab 250 mg, tab 500 mg)</i>	gen	

HISTAMINE2 (H2) RECEPTOR ANTAGONISTS

<i>cimetidine (tab 200 mg, tab 300 mg, tab 400 mg, tab 800 mg)</i>	gen	
<i>cimetidine hcl (300 mg/5ml solution, soln 300 mg/5ml)</i>	gen	
<i>famotidine (for susp 40 mg/5ml, tab 20 mg, tab 40 mg)</i>	gen	
<i>nizatidine (15 mg/ml solution, 150 mg cap, cap 150 mg, 300 mg cap, cap 300 mg)</i>	gen	

PROTECTANTS

<i>misoprostol (tab 100 mcg, tab 200 mcg)</i>	gen	
<i>sucralfate (susp 1 gm/10ml, tab 1 gm)</i>	gen	

PROTON PUMP INHIBITORS

<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	gen	
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	gen	QL (2 PER 1 DAYS)
<i>lansoprazole cap delayed release 15 mg</i>	gen	
<i>lansoprazole cap delayed release 30 mg</i>	gen	QL (2 PER 1 DAYS)
<i>omeprazole (cap 10 mg, cap 20 mg)</i>	gen	
<i>omeprazole cap delayed release 40 mg</i>	gen	QL (2 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	gen	
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	gen	QL (2 PER 1 DAYS)
<i>pantoprazole sodium for iv soln 40 mg (base equiv)</i>	inj	
<i>rabeprazole sodium ec tab 20 mg</i>	gen	

GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT

<i>*betaine powder for oral solution***</i>	spec	
ALDURAZYME 2.9 MG/5ML SOLUTION	spec	LA, PA - PART B VS D DETERMINATION
ARALAST NP (500 MG RECON SOLN, 1000 MG RECON SOLN)	spec	LA, PA - PART B VS D DETERMINATION
BYLVAY (PELLETS) 200 MCG CAP SPRINK	spec	PA, LA, QL (30 PER 1 DAYS)
BYLVAY (PELLETS) 600 MCG CAP SPRINK	spec	PA, LA, QL (10 PER 1 DAYS)
BYLVAY 1200 MCG CAP	spec	PA, LA, QL (6 PER 1 DAYS)
BYLVAY 400 MCG CAP	spec	PA, LA, QL (18 PER 1 DAYS)
CERDELGA 84 MG CAP	spec	PA, LA, QL (2 PER 1 DAYS)
CEREZYME 400 UNIT RECON SOLN	spec	PA, LA
CHOLBAM 250 MG CAP	spec	PA, QL (5 PER 1 DAYS)
CHOLBAM 50 MG CAP	spec	PA, QL (4 PER 1 DAYS)
CREON (3000-9500 CP DR PART, 6000 CP DR PART, 12000 CP DR PART, 24000-76000 CP DR PART, 36000 CP DR PART)	brd	
<i>cromolyn sodium oral conc 100 mg/5ml</i>	gen	
CYSTAGON (50 MG CAP, 150 MG CAP)	npd	PA, LA
CYSTARAN 0.44 % SOLUTION	spec	PA, LA, QL (60 PER 28 OVER TIME)
ELAPRASE 6 MG/3ML SOLUTION	spec	LA, PA - PART B VS D DETERMINATION
ENDARI 5 GM PACKET	spec	PA, LA, QL (6 PER 1 DAYS)
<i>miglustat cap 100 mg</i>	spec	PA, LA, QL (3 PER 1 DAYS)
NAGLAZYME 1 MG/ML SOLUTION	spec	LA, PA - PART B VS D DETERMINATION
<i>nitisinone (cap 2 mg, cap 5 mg, cap 10 mg)</i>	spec	PA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PROCYSBI (25 MG CAP DR, 75 MG CAP DR)	spec	PA, LA
PROLASTIN-C (1000 MG RECON SOLN, 1000 MG/20ML SOLUTION)	spec	LA, PA - PART B VS D DETERMINATION
<i>sapropterin dihydrochloride (powder packet 100 mg, powder packet 500 mg, tab 100 mg)</i>	spec	PA
<i>sodium phenylbutyrate (oral powder 3 gm/teaspoonful, tab 500 mg)</i>	spec	PA
STRENSIQ (18 MG/0.45ML SOLUTION, 28 MG/0.7ML SOLUTION, 40 MG/ML SOLUTION)	spec	PA, LA
STRENSIQ 80 MG/0.8ML SOLUTION	spec	PA, LA, QL (38.4 PER 28 OVER TIME)
SUCRAID 8500 UNIT/ML SOLUTION	spec	PA, LA
VYNDAQEL 20 MG CAP	spec	PA, LA, QL (4 PER 1 DAYS)
ZENPEP (3000-10000 CP DR PART, 5000-24000 CP DR PART, 10000-32000 CP DR PART, 15000-47000 CP DR PART, 20000-63000 CP DR PART, 25000-79000 CP DR PART, 40000-126000 CP DR PART)	npd	

GENITOURINARY AGENTS

ANTISPASMODICS, URINARY

<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	gen	ST, QL (1 PER 1 DAYS)
<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	gen	ST, QL (2 PER 1 DAYS)
<i>fesoterodine fumarate (tab er 24hr 4 mg, tab er 24hr 8 mg)</i>	gen	
<i>flavoxate hcl tab 100 mg</i>	gen	
GEMTESA 75 MG TAB	brd	QL (1 PER 1 DAYS)
MYRBETRIQ (25 MG TAB ER 24H, 50 MG TAB ER 24H)	brd	
<i>oxybutynin chloride (solution 5 mg/5ml, tab 5 mg, tab er 24hr 10 mg, tab er 24hr 15 mg, tab er 24hr 5 mg)</i>	gen	
<i>solifenacin succinate (tab 5 mg, tab 10 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>tolterodine tartrate (cap er 24hr 2 mg, cap er 24hr 4 mg, tab 1 mg, tab 2 mg)</i>	gen	ST
<i>tropium chloride (cap er 24hr 60 mg, tab 20 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BENIGN PROSTATIC HYPERTROPHY AGENTS		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	gen	
<i>dutasteride cap 0.5 mg</i>	gen	QL (1 PER 1 DAYS)
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	gen	QL (1 PER 1 DAYS)
<i>finasteride tab 5 mg</i>	gen	
<i>silodosin (cap 4 mg, cap 8 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>tadalafil (tab 10 mg, tab 20 mg)</i>	gen	PA, QL (6 PER 30 OVER TIME), ED
<i>tadalafil tab 2.5 mg</i>	gen	PA, QL (2 PER 1 DAYS)
<i>tadalafil tab 5 mg</i>	gen	PA, QL (1 PER 1 DAYS)
<i>tamsulosin hcl cap 0.4 mg</i>	gen	
GENITOURINARY AGENTS, OTHER		
<i>bethanechol chloride (tab 5 mg, tab 10 mg, tab 25 mg, tab 50 mg)</i>	gen	
CYTRA K CRYSTALS 3300-1002 MG PACKET	gen	ED
ELMIRON 100 MG CAP	brd	
MUSE (125 MCG PELLETT, 250 MCG PELLETT, 500 MCG PELLETT, 1000 MCG PELLETT)	brd	PA, QL (6 PER 30 OVER TIME), ED
<i>penicillamine tab 250 mg</i>	spec	PA
<i>phenazopyridine hcl (tab 100 mg, tab 200 mg)</i>	gen	ED
<i>pot & sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	gen	ED
<i>potassium citrate-citric acid (powder pack 3300-1002 mg, soln 1100-334 mg/5ml)</i>	gen	ED
<i>potassium phosphate monobasic tab 500 mg</i>	gen	ED
<i>sildenafil citrate (tab 25 mg, tab 50 mg, tab 100 mg)</i>	gen	PA, QL (6 PER 30 OVER TIME), ED
<i>sodium citrate & citric acid soln 500-334 mg/5ml</i>	gen	ED
THIOLA EC (EC 100 MG TAB DR, EC 300 MG TAB DR)	spec	PA, LA
<i>tiopronin tab 100 mg</i>	spec	PA
<i>vardenafil hcl (orally disintegrating tab 10 mg, tab 2.5 mg, tab 5 mg, tab 10 mg, tab 20 mg)</i>	gen	PA, QL (6 PER 30 OVER TIME), ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
<i>alclometasone dipropionate cream 0.05%</i>	gen	
<i>betamethasone dipropionate augmented (cream, lotion)</i>	gen	
<i>betamethasone dipropionate oint 0.05%</i>	gen	
<i>clobetasol propionate emollient base cream 0.05%</i>	gen	
CORTISONE ACETATE 25 MG TAB	gen	
CORTROPHIN 80 UNIT/ML GEL	spec	PA, LA
<i>desonide lotion 0.05%</i>	gen	
<i>dexamethasone (0.5 mg tab, 0.5 mg/5ml solution, elixir 0.5 mg/5ml, tab 0.5 mg, 0.75 mg tab, tab 0.75 mg, 1 mg tab, tab 1.5 mg, tab 2 mg, tab 4 mg, tab 6 mg)</i>	gen	
DEXAMETHASONE INTENSOL 1 MG/ML CONC	gen	
<i>dexamethasone sodium phosphate (4 mg/ml solution, inj 4 mg/ml, inj 20 mg/5ml, inj 120 mg/30ml)</i>	inj	
<i>dexamethasone sodium phosphate (sod preservative free inj 10 mg/ml, sodium inj 10 mg/ml, sodium inj 100 mg/10ml)</i>	inj	PA - PART B VS D DETERMINATION
<i>fludrocortisone acetate tab 0.1 mg</i>	gen	
HEMADY 20 MG TAB	npd	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
<i>hydrocortisone acetate suppos 25 mg</i>	gen	ED
<i>hydrocortisone butyrate oint 0.1%</i>	gen	ST
<i>hydrocortisone valerate oint 0.2%</i>	gen	
KORLYM 300 MG TAB	spec	PA, LA, QL (4 PER 1 DAYS)
MEDROL 2 MG TAB	brd	
<i>methylprednisolone (tab 4 mg, tab 8 mg, tab 16 mg, tab 32 mg, tab therapy pack 4 mg (21))</i>	gen	
<i>methylprednisolone acetate (40 mg/ml suspension, inj susp 40 mg/ml, inj susp 80 mg/ml)</i>	inj	
<i>methylprednisolone sod succ for inj 125 mg (base equiv)</i>	inj	PA - PART B VS D DETERMINATION

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>methylprednisolone sod succ for inj 40 mg (base equiv)</i>	inj	
<i>mometasone furoate (cream, oint)</i>	gen	
<i>prednisolone sodium phosphate (sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base), sod phosphate oral soln 10 mg/5ml (base equiv), sod phosphate oral soln 15 mg/5ml (base equiv), sod phosphate oral soln 20 mg/5ml (base equiv), sodium phosphate 25 mg/5ml solution, sodium phosphate oral soln 25 mg/5ml (base eq))</i>	gen	
<i>prednisolone soln 15 mg/5ml</i>	gen	
<i>prednisone (tab 1 mg, tab 2.5 mg, 5 mg/5ml solution, tab 5 mg, tab 10 mg, tab 20 mg, tab 50 mg, tab therapy pack 5 mg (21), tab therapy pack 5 mg (48), tab therapy pack 10 mg (21), tab therapy pack 10 mg (48))</i>	gen	
PREDNISONE INTENSOL 5 MG/ML CONC	gen	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)

<i>desmopressin acetate (inj 4 mcg/ml, preservative free (pf) inj 4 mcg/ml)</i>	inj	
<i>desmopressin acetate (tab 0.1 mg, tab 0.2 mg)</i>	gen	
<i>desmopressin acetate nasal spray soln 0.01%</i>	gen	
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	gen	
EGRIFTA 1 MG RECON SOLN	spec	PA, LA, QL (60 PER 30 OVER TIME)
EGRIFTA SV 2 MG RECON SOLN	spec	PA, LA, QL (30 PER 30 OVER TIME)
GENOTROPIN (5 MG CARTRIDGE, 12 MG CARTRIDGE)	spec	PA
GENOTROPIN MINIQUICK (0.2 MG PRSYR, 0.4 MG PRSYR, 0.6 MG PRSYR, 0.8 MG PRSYR, 1 MG PRSYR, 1.2 MG PRSYR, 1.4 MG PRSYR, 1.6 MG PRSYR, 1.8 MG PRSYR, 2 MG PRSYR)	spec	PA
INCRELEX 40 MG/4ML SOLUTION	spec	PA, LA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
ANABOLIC STEROIDS		
ANADROL-50 50 MG TAB	npd	
oxandrolone (2.5 mg tab, tab 2.5 mg, 10 mg tab, tab 10 mg)	gen	
ANDROGENS		
danazol (cap 50 mg, cap 100 mg, cap 200 mg)	gen	
methyltestosterone cap 10 mg	gen	PA
testosterone (12.5 mg/act (1%) gel, td gel 12.5 mg/act (1%), 25 mg/2.5gm (1%) gel, td gel 25 mg/2.5gm (1%), 50 mg/5gm (1%) gel, td gel 50 mg/5gm (1%))	gen	PA, QL (300 PER 30 OVER TIME)
testosterone (gel 20.25 mg/act (1.62%), gel 40.5 mg/2.5gm (1.62%))	gen	PA, QL (150 PER 30 OVER TIME)
testosterone cypionate (im inj in oil 100 mg/ml, 200 mg/ml solution, im inj in oil 200 mg/ml)	gen	
testosterone enanthate (200 mg/ml solution, im inj in oil 200 mg/ml)	gen	QL (5 PER 30 OVER TIME)
testosterone td gel 10mg/act (2%)	gen	PA, QL (120 PER 30 OVER TIME)
testosterone td gel 20.25 mg/1.25gm (1.62%)	gen	PA, QL (37.5 PER 30 OVER TIME)
testosterone td soln 30 mg/act	gen	PA, QL (180 PER 30 OVER TIME)
ESTROGENS		
CLIMARA PRO 0.045-0.015 MG/DAY PATCH WK	brd	QL (4 PER 28 OVER TIME)
DEPO-ESTRADIOL 5 MG/ML OIL	inj	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	gen	
desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg	gen	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	gen	
drospirenone-ethinyl estradiol (tab 3-0.02 mg, tab 3-0.03 mg)	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>drospirenone-ethinyl estradiol-levomefolate calcium (tab 3-0.02-0.451 mg, tab 3-0.03-0.451 mg)</i>	gen	
<i>esterified estrogens & methyltestosterone (tab 0.625-1.25 mg, tab 1.25-2.5 mg)</i>	gen	ED
<i>estradiol & norethindrone acetate (tab 0.5-0.1 mg, tab 1-0.5 mg)</i>	gen	
<i>estradiol (patch 0.025 mg/24hr, patch 0.0375 mg/24hr (37.5 mcg/24hr), patch 0.05 mg/24hr, patch 0.06 mg/24hr, patch 0.075 mg/24hr, patch 0.1 mg/24hr)</i>	gen	QL (8 PER 28 OVER TIME)
<i>estradiol (patch 0.025 mg/24hr, patch 0.0375 mg/24hr, patch 0.05 mg/24hr, patch 0.075 mg/24hr, patch 0.1 mg/24hr)</i>	gen	QL (16 PER 28 OVER TIME)
<i>estradiol (tab 0.5 mg, tab 1 mg, tab 2 mg, td gel 0.25 mg/0.25gm (0.1%), td gel 0.5 mg/0.5gm (0.1%), td gel 0.75 mg/0.75gm (0.1%), td gel 1 mg/gm (0.1%), td gel 1.25 mg/1.25gm (0.1%))</i>	gen	
<i>estradiol vaginal (cream 0.1 mg/gm, tab 10 mcg)</i>	gen	
<i>estradiol valerate (oil 10 mg/ml, oil 20 mg/ml, oil 40 mg/ml)</i>	gen	
ESTRING (2 MG RING, 7.5 MCG/24HR RING)	brd	QL (1 PER 84 OVER TIME)
<i>ethynodiol diacet & eth estrad (tab 1 mg-35 mcg, tab 1 mg-50 mcg)</i>	gen	
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	gen	QL (1 PER 28 OVER TIME)
<i>levonorgestrel & eth estradiol (tab 0.1 mg-20 mcg, tab 0.15 mg-30 mcg)</i>	gen	
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	gen	
<i>levonorgestrel-ethinyl estradiol (91-day) (levonor-eth tab 0.15-0.02/0.025/0.03 mg & eth 0.01 mg, levonorg-eth tab 0.1-0.02mg(84) & eth tab 0.01mg(7), levonorg-eth tab 0.15-0.03mg(84) & eth tab 0.01mg(7), levonorgrel & ethinyl radiol (91-day) tab 0.15-0.03 mg)</i>	gen	
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	gen	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB, 2.5 MG TAB)	npd	
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>norethin acet & estrad-fe (ace & ethinyl tab 1 mg-20 mcg, ace & ethinyl tab 1.5 mg-30 mcg, ace-eth chew tab 1 mg-20 mcg (24), ace-ethinyl cap 1 mg-20 mcg (24), ace-ethinyl tab 1 mg-20 mcg (24))</i>	gen	
<i>norethindrone & eth estradiol (tab 0.4 mcg, tab 0.5 mcg, tab 1 mcg)</i>	gen	
<i>norethindrone & ethinyl estradiol-fe (chew tab 0.4 mg-35 mcg, chew tab 0.8 mg-25 mcg)</i>	gen	
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	gen	
<i>norethindrone acet & eth estra (tab 1 mg-20 mcg, tab 1.5 mg-30 mcg)</i>	gen	
<i>norethindrone acetate-ethinyl estradiol (tab 0.5 mg-2.5 mcg, tab 1 mg-5 mcg)</i>	gen	
<i>norethindrone-eth estradiol (triphasic) (tab 0.5-35/0.75-35/1-35, tab 0.5-35/1-35/0.5-35)</i>	gen	
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	gen	
<i>norgestimate-ethinyl estradiol (triphasic) (tab 0.18-25/0.215-25/0.25-25, tab 0.18-35/0.215-35/0.25-35)</i>	gen	
<i>norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg</i>	gen	
PREMARIN (0.3 MG TAB, 0.45 MG TAB, 0.625 MG TAB, 0.9 MG TAB, 1.25 MG TAB)	npd	
PREMARIN 0.625 MG/GM CREAM	brd	
PREMPHASE 0.625-5 MG TAB	brd	
PREMPRO (0.3-1.5 MG TAB, 0.45-1.5 MG TAB, 0.625-2.5 MG TAB, 0.625-5 MG TAB)	brd	
VELIVET 0.1/0.125/0.15 -0.025 MG TAB	gen	

PROGESTINS

DEPO-PROVERA 400 MG/ML SUSPENSION	inj	
DEPO-SUBQ PROVERA 104 104 MG/0.65ML SUSP PRSYR	inj	
HYDROXYPROGESTERONE CAPROATE 1.25 GM/5ML SOLUTION	spec	
<i>medroxyprogesterone acetate (contraceptive) (susp 150 mg/ml, susp prefilled syr 150 mg/ml)</i>	inj	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>medroxyprogesterone acetate (tab 2.5 mg, tab 5 mg, tab 10 mg)</i>	gen	
<i>megestrol acetate (susp 40 mg/ml, tab 20 mg, tab 40 mg)</i>	gen	PA - FOR NEW STARTS ONLY
<i>megestrol acetate susp 625 mg/5ml</i>	gen	PA
<i>norethindrone acetate tab 5 mg</i>	gen	
<i>norethindrone tab 0.35 mg</i>	gen	
<i>progesterone (cap 100 mg, cap 200 mg, im in oil 50 mg/ml)</i>	gen	

SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS

<i>OSPHENA 60 MG TAB</i>	npd	PA, QL (1 PER 1 DAYS)
<i>raloxifene hcl tab 60 mg</i>	gen	QL (1 PER 1 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)

<i>ARMOUR THYROID (15 MG TAB, 30 MG TAB, 60 MG TAB, 90 MG TAB, 120 MG TAB, 180 MG TAB, 240 MG TAB, 300 MG TAB)</i>	brd	ED
<i>levothyroxine sodium (tab 25 mcg, tab 50 mcg, tab 75 mcg, tab 88 mcg, tab 100 mcg, tab 112 mcg, tab 125 mcg, tab 137 mcg, tab 150 mcg, tab 175 mcg, tab 200 mcg, tab 300 mcg)</i>	gen	
<i>liothyronine sodium (tab 5 mcg, tab 25 mcg, tab 50 mcg)</i>	gen	
<i>NIVA THYROID (15 MG TAB, 30 MG TAB, 60 MG TAB, 90 MG TAB, 120 MG TAB)</i>	brd	ED
<i>NP THYROID (15 MG TAB, 30 MG TAB, 60 MG TAB, 90 MG TAB, 120 MG TAB)</i>	brd	ED
<i>SYNTHROID (25 MCG TAB, 50 MCG TAB, 75 MCG TAB, 88 MCG TAB, 100 MCG TAB, 112 MCG TAB, 125 MCG TAB, 137 MCG TAB, 150 MCG TAB, 175 MCG TAB, 200 MCG TAB, 300 MCG TAB)</i>	brd	
<i>thyroid (15 mg tab, tab 15 mg (1/4 grain), 30 mg tab, tab 30 mg (1/2 grain), 60 mg tab, tab 60 mg (1 grain), 90 mg tab, tab 90 mg (1 1/2 grain), 120 mg tab, tab 120 mg (2 grain))</i>	brd	ED

HORMONAL AGENTS, SUPPRESSANT (PITUITARY)

<i>cabergoline tab 0.5 mg</i>	gen	
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You can find information on what the symbols and abbreviations on this table mean by going to page ix.

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
FIRMAGON (240 MG DOSE) 120 MG/VIAL RECON SOLN	spec	
FIRMAGON 80 MG RECON SOLN	inj	
LANREOTIDE ACETATE 120 MG/0.5ML SOLUTION	spec	PA - FOR NEW STARTS ONLY
<i>leuprolide acetate inj kit 5 mg/ml</i>	spec	
LUPRON DEPOT (1-MONTH) ((1-MONTH) 3.75 MG KIT, (1-MONTH) 7.5 MG KIT)	spec	
LUPRON DEPOT (3-MONTH) ((3-MONTH) 11.25 MG KIT, (3-MONTH) 22.5 MG KIT)	spec	
LUPRON DEPOT (4-MONTH) 30 MG KIT	spec	
LUPRON DEPOT (6-MONTH) 45 MG KIT	spec	
<i>octreotide acetate (50 mcg/ml soln prsyr, inj 50 mcg/ml (0.05 mg/ml), 100 mcg/ml soln prsyr, inj 100 mcg/ml (0.1 mg/ml), inj 200 mcg/ml (0.2 mg/ml), inj 500 mcg/ml (0.5 mg/ml), inj 1000 mcg/ml (1 mg/ml))</i>	inj	PA
OCTREOTIDE ACETATE 500 MCG/ML SOLN PRSYR	spec	PA
ORGOVYX 120 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
SANDOSTATIN LAR DEPOT (10 MG KIT, 20 MG KIT, 30 MG KIT)	spec	PA
SIGNIFOR (0.3 MG/ML SOLUTION, 0.6 MG/ML SOLUTION, 0.9 MG/ML SOLUTION)	spec	PA, LA, QL (60 PER 30 OVER TIME)
SOMATULINE DEPOT (60 MG/0.2ML SOLUTION, 90 MG/0.3ML SOLUTION)	spec	PA - FOR NEW STARTS ONLY
SOMAVERT (10 MG RECON SOLN, 15 MG RECON SOLN, 20 MG RECON SOLN, 25 MG RECON SOLN, 30 MG RECON SOLN)	spec	PA, QL (1 PER 1 DAYS)
SYNAREL 2 MG/ML SOLUTION	spec	
TRELSTAR MIXJECT (3.75 MG RECON SUSP, 11.25 MG RECON SUSP, 22.5 MG RECON SUSP)	inj	PA - PART B VS D DETERMINATION

HORMONAL AGENTS, SUPPRESSANT (THYROID)

ANTITHYROID AGENTS

<i>methimazole (tab 5 mg, tab 10 mg)</i>	gen
<i>propylthiouracil tab 50 mg</i>	gen

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
HAEGARDA (2000 RECON SOLN, 3000 RECON SOLN)	spec	PA, LA
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>	spec	PA, QL (36 PER 60 OVER TIME)
IMMUNOGLOBULINS		
BIVIGAM (5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION)	spec	PA, LA
CARIMUNE NF (6 GM RECON SOLN, 12 GM RECON SOLN)	spec	PA
FLEBOGAMMA DIF (0.5 GM/10ML SOLUTION, 2.5 GM/50ML SOLUTION, 5 GM/100ML SOLUTION, 5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 10 GM/200ML SOLUTION, 20 GM/200ML SOLUTION, 20 GM/400ML SOLUTION)	spec	PA
GAMMAGARD (1 GM/10ML SOLUTION, 2.5 GM/25ML SOLUTION, 5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 20 GM/200ML SOLUTION, 30 GM/300ML SOLUTION)	spec	PA
GAMMAGARD S/D LESS IGA (S/D 5 GM RECON SOLN, S/D 10 GM RECON SOLN)	spec	PA
GAMMAKED (1 GM/10ML SOLUTION, 5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 20 GM/200ML SOLUTION)	spec	PA
GAMMAPLEX (5 GM/100ML SOLUTION, 5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 10 GM/200ML SOLUTION, 20 GM/200ML SOLUTION, 20 GM/400ML SOLUTION)	spec	PA, LA
GAMUNEX-C (1 GM/10ML SOLUTION, 2.5 GM/25ML SOLUTION, 5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 20 GM/200ML SOLUTION, 40 GM/400ML SOLUTION)	spec	PA
HIZENTRA (1 GM/5ML SOLN PRSYR, 1 GM/5ML SOLUTION, 2 GM/10ML SOLN PRSYR, 2 GM/10ML SOLUTION, 4 GM/20ML SOLN PRSYR, 4 GM/20ML SOLUTION, 10 GM/50ML SOLUTION)	spec	PA, LA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PRIVIGEN (5 GM/50ML SOLUTION, 10 GM/100ML SOLUTION, 20 GM/200ML SOLUTION, 40 GM/400ML SOLUTION)	spec	PA

IMMUNOLOGICAL AGENTS, OTHER

ARCALYST 220 MG RECON SOLN	spec	PA, LA
BENLYSTA (200 MG/ML SOLN A-INJ, 200 MG/ML SOLN PRSYR)	spec	PA, LA, QL (4 PER 28 OVER TIME)
BEYFORTUS (50 MG/0.5ML SOLN PRSYR, 100 MG/ML SOLN PRSYR)	inj	
DUPIXENT (100 MG/0.67ML SOLN PRSYR, 200 MG/1.14ML SOLN PEN, 200 MG/1.14ML SOLN PRSYR, 300 MG/2ML SOLN PEN, 300 MG/2ML SOLN PRSYR)	spec	PA
ILARIS 150 MG/ML SOLUTION	spec	PA, LA
OTEZLA 10 & 20 & 30 MG TAB THPK	spec	PA, QL (55 PER 28 OVER TIME)
RIDAURA 3 MG CAP	brd	
SKYRIZI (150 MG DOSE) 75 MG/0.83ML PREF SY KT	spec	PA, QL (6 PER 365 OVER TIME)
SKYRIZI 150 MG/ML SOLN PRSYR	spec	PA, QL (6 PER 365 OVER TIME)
SKYRIZI PEN 150 MG/ML SOLN A-INJ	spec	PA, QL (6 PER 365 OVER TIME)
STELARA (45 MG/0.5ML SOLN PRSYR, 45 MG/0.5ML SOLUTION)	spec	PA, QL (0.5 PER 28 OVER TIME)
STELARA 90 MG/ML SOLN PRSYR	spec	PA, QL (1 PER 28 OVER TIME)
TALTZ (80 MG/ML SOLN A-INJ, 80 MG/ML SOLN PRSYR)	spec	PA, LA, QL (1 PER 28 OVER TIME)
XELJANZ (5 MG TAB, 10 MG TAB)	spec	PA, QL (2 PER 1 DAYS)
XELJANZ 1 MG/ML SOLUTION	spec	PA, QL (10 PER 1 DAYS)
XOLAIR (150 MG RECON SOLN, 150 MG/ML SOLN PRSYR)	spec	PA, LA, QL (8 PER 28 OVER TIME)
XOLAIR 75 MG/0.5ML SOLN PRSYR	spec	PA, LA, QL (2 PER 28 OVER TIME)

IMMUNOSTIMULANTS

ACTIMMUNE 2000000 UNIT/0.5ML SOLUTION	spec	LA, PA - FOR NEW STARTS ONLY
INTRON A (6000000 UNIT/ML SOLUTION, 10000000 UNIT RECON SOLN, 10000000 UNIT/ML SOLUTION, 18000000 UNIT RECON SOLN, 50000000 UNIT RECON SOLN)	spec	LA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PEGASYS 180 MCG/0.5ML SOLN PRSYR	spec	PA, QL (2 PER 30 OVER TIME)
PEGASYS 180 MCG/ML SOLUTION	spec	PA, QL (4 PER 30 OVER TIME)
PEGASYS PROCLICK 180 MCG/0.5ML SOLN A-INJ	spec	PA, QL (2 PER 30 OVER TIME)

IMMUNOSUPPRESSANTS

<i>azathioprine (tab 50 mg, tab 75 mg, tab 100 mg)</i>	gen	PA - PART B VS D DETERMINATION
AZATHIOPRINE SODIUM 100 MG RECON SOLN	inj	PA - PART B VS D DETERMINATION
<i>cyclosporine (cap 25 mg, cap 100 mg)</i>	gen	PA - PART B VS D DETERMINATION
<i>cyclosporine iv soln 50 mg/ml</i>	inj	PA - PART B VS D DETERMINATION
<i>cyclosporine modified (for microemulsion) (cap 25 mg, cap 50 mg, cap 100 mg, oral soln 100 mg/ml)</i>	gen	PA - PART B VS D DETERMINATION
ENBREL (25 MG RECON SOLN, 50 MG/ML SOLN PRSYR)	spec	PA, QL (8 PER 28 OVER TIME)
ENBREL 25 MG/0.5ML SOLN PRSYR	spec	PA, QL (4.08 PER 28 OVER TIME)
ENBREL 25 MG/0.5ML SOLUTION	spec	PA, QL (4 PER 28 OVER TIME)
ENBREL SURECLICK 50 MG/ML SOLN A-INJ	spec	PA, QL (8 PER 28 OVER TIME)
ENVARUSUS XR (0.75 MG TAB ER 24H, 1 MG TAB ER 24H, 4 MG TAB ER 24H)	npd	PA - FOR NEW STARTS ONLY
<i>everolimus (immunosuppressant) (tab 0.25 mg, tab 0.5 mg, tab 0.75 mg, tab 1 mg)</i>	gen	PA - PART B VS D DETERMINATION
HUMIRA (10 MG/0.1ML PREF SY KT, 10 MG/0.2ML PREF SY KT, 20 MG/0.2ML PREF SY KT, 20 MG/0.4ML PREF SY KT)	spec	PA, QL (2 PER 28 OVER TIME)
HUMIRA (40 MG/0.4ML PREF SY KT, 40 MG/0.8ML PREF SY KT)	spec	PA, QL (4 PER 28 OVER TIME)
HUMIRA PEDIATRIC CROHNS START (40 MG/0.8ML PREF SY KT, 80 MG/0.8ML PREF SY KT)	spec	PA, QL (6 PER 365 OVER TIME)
HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML & 40MG/0.4ML PREF SY KT	spec	PA, QL (4 PER 365 OVER TIME)
HUMIRA PEN (PEN 40 MG/0.4ML PEN KIT, PEN 40 MG/0.8ML PEN KIT)	spec	PA, QL (4 PER 28 OVER TIME)
HUMIRA PEN 80 MG/0.8ML PEN KIT	spec	PA, QL (2 PER 28 OVER TIME)
HUMIRA PEN-CD/UC/HS STARTER 40 MG/0.8ML PEN KIT	spec	PA, QL (12 PER 365 OVER TIME)
HUMIRA PEN-CD/UC/HS STARTER 80 MG/0.8ML PEN KIT	spec	PA, QL (6 PER 365 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HUMIRA PEN-PEDIATRIC UC START 80 MG/0.8ML PEN KIT	spec	PA, QL (8 PER 365 OVER TIME)
HUMIRA PEN-PS/UV/ADOL HS START 40 MG/0.8ML PEN KIT	spec	PA, QL (8 PER 365 OVER TIME)
HUMIRA PEN-PSOR/UVEIT STARTER 80 MG/0.8ML & 40MG/0.4ML PEN KIT	spec	PA, QL (6 PER 365 OVER TIME)
<i>leflunomide (tab 10 mg, tab 20 mg)</i>	gen	
<i>methotrexate sodium (inj 50 mg/2ml (25 mg/ml), inj pf 50 mg/2ml (25 mg/ml), 250 mg/10ml solution, inj pf 250 mg/10ml (25 mg/ml), inj pf 1000 mg/40ml (25 mg/ml))</i>	gen	PA - PART B VS D DETERMINATION
<i>methotrexate sodium for inj 1 gm</i>	inj	PA - PART B VS D DETERMINATION
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	gen	
<i>mycophenolate mofetil (cap 250 mg, for oral susp 200 mg/ml, tab 500 mg)</i>	gen	PA - PART B VS D DETERMINATION
<i>mycophenolate mofetil hcl for iv soln 500 mg (base equiv)</i>	inj	PA - PART B VS D DETERMINATION
<i>mycophenolate sodium (tab dr 180 mg equiv), tab dr 360 mg equiv)</i>	gen	PA - PART B VS D DETERMINATION
PROGRAF (0.2 MG PACKET, 1 MG PACKET)	npd	PA - FOR NEW STARTS ONLY
REZUROCK 200 MG TAB	spec	LA, QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
RINVOQ (15 MG TAB ER 24H, 30 MG TAB ER 24H)	spec	PA, QL (1 PER 1 DAYS)
RINVOQ 45 MG TAB ER 24H	spec	PA, QL (168 PER 365 OVER TIME)
SANDIMMUNE 100 MG/ML SOLUTION	brd	PA - PART B VS D DETERMINATION
<i>sirolimus (oral soln 1 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)</i>	gen	PA - PART B VS D DETERMINATION
<i>tacrolimus (cap 0.5 mg, cap 1 mg, cap 5 mg)</i>	gen	PA - PART B VS D DETERMINATION
TREXALL (5 MG TAB, 7.5 MG TAB, 10 MG TAB, 15 MG TAB)	npd	
XATMEP 2.5 MG/ML SOLUTION	npd	PA - FOR NEW STARTS ONLY
XELJANZ XR (11 MG TAB ER 24H, 22 MG TAB ER 24H)	spec	PA, QL (1 PER 1 DAYS)

VACCINES

ABRYSVO 120 MCG/0.5ML RECON SOLN	brd	VAC
ACTHIB RECON SOLN	brd	
ADACEL 5-2-15.5 LF-MCG/0.5 SUSPENSION	brd	VAC

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AREXVY 120 MCG/0.5ML RECON SUSP	brd	VAC
BCG VACCINE 50 MG RECON SOLN	brd	VAC
BEXSERO SUSP PRSYR	brd	VAC
BOOSTRIX (5-2.5-18.5 LF-MCG/0.5 SUSP PRSYR, 5-2.5-18.5 LF-MCG/0.5 SUSPENSION)	brd	VAC
DAPTACEL 23-15-5 SUSPENSION	brd	
DENGVAXIA RECON SUSP	brd	
DIPHTHERIA-TETANUS TOXOIDS DT 25-5 LFU/0.5ML SUSPENSION	brd	
ENGERIX-B (10 MCG/0.5ML SUSP PRSYR, 20 MCG/ML SUSP PRSYR, 20 MCG/ML SUSPENSION)	brd	PA - PART B VS D DETERMINATION, VAC
GARDASIL 9 (9 SUSP PRSYR, 9 SUSPENSION)	brd	VAC
HAVRIX 1440 EL U/ML SUSPENSION	brd	VAC
HAVRIX 720 EL U/0.5ML SUSPENSION	brd	
HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	brd	PA - PART B VS D DETERMINATION, VAC
HEPLISAV-B 20 MCG/0.5ML SOLUTION	brd	PA - PART B VS D DETERMINATION
HIBERIX 10 MCG RECON SOLN	brd	
IMOVAX RABIES 2.5 UNIT/ML RECON SUSP	brd	VAC
INFANRIX 25-58-10 SUSPENSION	brd	
IPOL INJECTABLE	brd	VAC
IXIARO SUSPENSION	inj	VAC
JYNNEOS 0.5 ML SUSPENSION	brd	VAC
KINRIX (0.5 ML SUSP PRSYR, SUSPENSION)	brd	
M-M-R II RECON SOLN	brd	VAC
MENACTRA SOLUTION	brd	VAC
MENQUADFI SOLUTION	brd	VAC
MENVEO (RECON SOLN, SOLUTION)	brd	VAC
PEDIARIX SUSP PRSYR	brd	
PEDVAX HIB 7.5 MCG/0.5ML SUSPENSION	brd	
PENTACEL RECON SUSP	brd	
PREHEVBRIO 10 MCG/ML SUSPENSION	brd	PA - PART B VS D DETERMINATION, VAC

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PRIORIX RECON SUSP	brd	VAC
PROQUAD RECON SUSP	brd	
QUADRACEL (0.5 ML SUSP PRSYR, SUSPENSION)	brd	
RABAVERT RECON SUSP	brd	VAC
RECOMBIVAX HB (5 MCG/0.5ML SUSP PRSYR, 5 MCG/0.5ML SUSPENSION, 10 MCG/ML SUSP PRSYR, 10 MCG/ML SUSPENSION, 40 MCG/ML SUSPENSION)	brd	PA - PART B VS D DETERMINATION, VAC
ROTARIX (RECON SUSP, SUSPENSION)	brd	
ROTATEQ SOLUTION	brd	
SHINGRIX 50 MCG/0.5ML RECON SUSP	brd	QL (2 PER 365 OVER TIME), VAC
TDVAX 2-2 LF/0.5ML SUSPENSION	brd	VAC
TENIVAC 5-2 LFU INJECTABLE	brd	VAC
TICOVAC (1.2 MCG/0.25ML SUSP PRSYR, 2.4 MCG/0.5ML SUSP PRSYR)	brd	
TRUMENBA SUSP PRSYR	brd	VAC
TWINRIX 720-20 ELU-MCG/ML SUSP PRSYR	brd	PA - PART B VS D DETERMINATION, VAC
TYPHIM VI (25 MCG/0.5ML SOLN PRSYR, 25 MCG/0.5ML SOLUTION)	inj	VAC
VAQTA 25 UNIT/0.5ML SUSPENSION	brd	
VAQTA 50 UNIT/ML SUSPENSION	brd	VAC
VARIVAX 1350 PFU/0.5ML INJECTABLE	brd	VAC
YF-VAX INJECTABLE	inj	VAC

INFLAMMATORY BOWEL DISEASE AGENTS

AMINOSALICYLATES

<i>balsalazide disodium cap 750 mg</i>	gen	
DIPENTUM 250 MG CAP	npd	PA
<i>mesalamine (cap dr 400 mg, 800 mg tab dr, tab delayed release 800 mg)</i>	gen	ST, QL (6 PER 1 DAYS)
<i>mesalamine (cap er 24hr 0.375 gm, tab delayed release 1.2 gm)</i>	gen	QL (4 PER 1 DAYS)
<i>mesalamine (enema 4 gm, suppos 1000 mg)</i>	gen	
<i>mesalamine cap er 500 mg</i>	gen	ST, QL (8 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>sulfasalazine (tab 500 mg, tab delayed release 500 mg)</i>	gen	

GLUCOCORTICOIDS

<i>budesonide delayed release particles cap 3 mg</i>	gen	PA, QL (3 PER 1 DAYS)
<i>budesonide tab er 24hr 9 mg</i>	gen	PA, QL (1 PER 1 DAYS)
CORTIFOAM 10 % FOAM	brd	
<i>hydrocortisone (tab 5 mg, tab 10 mg, tab 20 mg)</i>	gen	
<i>hydrocortisone enema 100 mg/60ml</i>	gen	

METABOLIC BONE DISEASE AGENTS

<i>alendronate sodium (5 mg tab, oral soln 70 mg/75ml, tab 10 mg, tab 35 mg, 40 mg tab, tab 70 mg)</i>	gen	
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	gen	QL (3.7 PER 30 OVER TIME)
<i>calcitriol (cap 0.25 mcg, cap 0.5 mcg, oral soln 1 mcg/ml)</i>	gen	PA - PART B VS D DETERMINATION
CALCITRIOL 1 MCG/ML SOLUTION	inj	PA - PART B VS D DETERMINATION
<i>cinacalcet hcl (tab 30 mg equiv), tab 60 mg equiv), tab 90 mg equiv))</i>	gen	PA - PART B VS D DETERMINATION
<i>doxercalciferol (cap 0.5 mcg, cap 1 mcg, cap 2.5 mcg)</i>	gen	PA - PART B VS D DETERMINATION
<i>doxercalciferol inj 4 mcg/2ml (2 mcg/ml)</i>	inj	PA - PART B VS D DETERMINATION
<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	gen	ED
FORTEO 600 MCG/2.4ML SOLN PEN	spec	PA
<i>ibandronate sodium iv soln 3 mg/3ml (base equivalent)</i>	inj	PA - PART B VS D DETERMINATION
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	gen	
NATPARA (25 MCG CARTRIDGE, 50 MCG CARTRIDGE, 75 MCG CARTRIDGE, 100 MCG CARTRIDGE)	spec	PA, LA, QL (2 PER 28 OVER TIME)
<i>paricalcitol (cap 1 mcg, cap 2 mcg, cap 4 mcg)</i>	gen	PA - PART B VS D DETERMINATION
<i>paricalcitol (soln 2 mcg/ml, soln 5 mcg/ml)</i>	inj	PA - PART B VS D DETERMINATION
PROLIA 60 MG/ML SOLN PRSYR	inj	PA
<i>risedronate sodium (tab 5 mg, tab 30 mg, tab 35 mg, tab 150 mg, tab delayed release 35 mg)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TERIPARATIDE (RECOMBINANT) 620 MCG/2.48ML SOLN PEN	spec	PA
TYMLOS 3120 MCG/1.56ML SOLN PEN	spec	PA, QL (1.56 PER 28 OVER TIME)
XGEVA 120 MG/1.7ML SOLUTION	spec	QL (1.7 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
<i>zoledronic acid (4 mg recon soln, 4 mg/100ml solution, inj conc for iv infusion 4 mg/5ml, iv soln 5 mg/100ml)</i>	inj	PA - PART B VS D DETERMINATION

MISCELLANEOUS THERAPEUTIC AGENTS

<i>*bacteriostatic sodium chloride inj soln 0.9%***</i>	inj	
AEROCHAMBER MINI CHAMBER DEVICE	brd	ED
AEROCHAMBER MV MISC	brd	ED
AEROCHAMBER PLUS FLO-VU MISC	brd	ED
AEROCHAMBER PLUS FLO-VU LARGE MISC	brd	ED
AEROCHAMBER PLUS FLO-VU MEDIUM MISC	brd	ED
AEROCHAMBER PLUS FLO-VU SMALL MISC	brd	ED
AEROCHAMBER PLUS FLO-VU W/MASK MISC	brd	ED
AEROCHAMBER PLUS FLOW VU MISC	brd	ED
AEROCHAMBER W/FLOWSIGNAL MISC	brd	ED
AEROCHAMBER Z-STAT PLUS MISC	brd	ED
AEROCHAMBER Z-STAT PLUS CHAMBR MISC	brd	ED
AEROCHAMBER Z-STAT PLUS/LARGE MISC	brd	ED
AEROCHAMBER Z-STAT PLUS/MEDIUM MISC	brd	ED
AEROCHAMBER Z-STAT PLUS/SMALL MISC	brd	ED
AEROVENT PLUS DEVICE	brd	ED
AIRIAL CHAMBER DEVICE	brd	ED
ALCOHOL 70% PADS	gen	
ALCOHOL PREP PAD	gen	
ALCOHOL PREP PADS 70 % PAD	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ALCOHOL SWABSTICK PAD	gen	
AQ INSULIN SYRINGE (29G 1/2" 1 ML MISC, 30G 5/16" 0.5 ML MISC, 31G 5/16" 1 ML MISC)	brd	
AQINJECT PEN NEEDLE (PEN 31G 5 MISC, PEN 32G 4 MISC)	brd	
AUM INSULIN SAFETY PEN NEEDLE (PEN 4 MISC, PEN 5 MISC)	brd	
AUM PEN NEEDLE (PEN 32G 4 MISC, PEN 32G 5 MISC, PEN 32G 6 MISC, PEN 33G 4 MISC, PEN 33G 5 MISC, PEN 33G 6 MISC)	brd	
BD INSULIN SYRINGE 27.5G X 5/8" 2 ML MISC	brd	
BD PEN NEEDLE MINI U/F 31G X 5 MM MISC	brd	
BD PEN NEEDLE NANO U/F 32G X 4 MM MISC	brd	
BD PEN NEEDLE ORIGINAL U/F 29G X 12.7MM MISC	brd	
BD PEN NEEDLE SHORT U/F 31G X 8 MM MISC	brd	
BREATHE COMFORT CHAMBER/ADULT DEVICE	brd	ED
BREATHE COMFORT CHAMBER/CHILD DEVICE	brd	ED
BREATHE EASE LARGE DEVICE	brd	ED
BREATHE EASE MEDIUM DEVICE	brd	ED
BREATHE EASE SMALL DEVICE	brd	ED
BREATHERITE MISC	brd	ED
BREATHERITE COLL SPACER ADULT MISC	brd	ED
BREATHERITE COLL SPACER CHILD MISC	brd	ED
BREATHERITE COLL SPACER INFANT MISC	brd	ED
BREATHERITE RIGID SPACER/MASK MISC	brd	ED
BREATHERITE SPACER NEONATE MISC	brd	ED
BREATHERITE SPACER SMALL CHILD MISC	brd	ED
BREATHERITE VALVED MDI CHAMBER DEVICE	brd	ED
BREATHERITE/LARGE MASK MISC	brd	ED
BREATHERITE/MEDIUM MASK MISC	brd	ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BREATHERITE/SMALL MASK MISC	brd	ED
CLEVER CHOICE HOLDING CHAMBER DEVICE	brd	ED
COMPACT SPACE CHAMBER DEVICE	brd	ED
COMPACT SPACE CHAMBER/LG MASK DEVICE	brd	ED
COMPACT SPACE CHAMBER/MED MASK DEVICE	brd	ED
COMPACT SPACE CHAMBER/SM MASK DEVICE	brd	ED
CVS ALCOHOL PREP PADS 70 % PAD	gen	
DROPSAFE SAFETY SYRINGE/NEEDLE (SYRINGE/NEEDLE 29G 1/2" 1 ML MISC, SYRINGE/NEEDLE 31G 15/64" 0.3 ML MISC, SYRINGE/NEEDLE 31G 15/64" 0.5 ML MISC, SYRINGE/NEEDLE 31G 15/64" 1 ML MISC, SYRINGE/NEEDLE 31G 5/16" 0.3 ML MISC, SYRINGE/NEEDLE 31G 5/16" 0.5 ML MISC, SYRINGE/NEEDLE 31G 5/16" 1 ML MISC)	brd	
EASIVENT MISC	brd	ED
EASIVENT MASK LARGE MISC	brd	ED
EASIVENT MASK MEDIUM MISC	brd	ED
EASIVENT MASK SMALL MISC	brd	ED
EASY COMFORT INSULIN SYRINGE 31G X 1/2" 0.3 ML MISC	brd	
EMBRACE PEN NEEDLES (PEN 29G 12MM MISC, PEN 30G 5 MM MISC, PEN 30G 8 MM MISC, PEN 31G 5 MM MISC, PEN 31G 6 MM MISC, PEN 31G 8 MM MISC, PEN 32G 4 MM MISC)	brd	
EQ SPACE CHAMBER ANTI-STATIC DEVICE	brd	ED
EQ SPACE CHAMBER ANTI-STATIC L DEVICE	brd	ED
EQ SPACE CHAMBER ANTI-STATIC M DEVICE	brd	ED
EQ SPACE CHAMBER ANTI-STATIC S DEVICE	brd	ED
FLEXICHAMBER DEVICE	brd	ED
<i>gauze pads 2</i>	gen	
GNP ISOPROPYL ALCOHOL WIPES 70 % MISC	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
INSPIRACHAMBER/LARGE DEVICE	brd	ED
INSPIRACHAMBER/MEDIUM DEVICE	brd	ED
INSPIRACHAMBER/MOUTHPIECE DEVICE	brd	ED
INSPIRACHAMBER/SMALL DEVICE	brd	ED
INSPIREASE MISC	brd	ED
INSULIN PEN NEEDLES	brd	
INSULIN SYRINGE 0.3 ML	brd	
INSULIN SYRINGE 0.5 ML	brd	
INSULIN SYRINGE 1 ML	brd	
INSULIN SYRINGE-NEEDLE U-100 (27G 1/2" 0.5 ML MISC, 27G 1/2" 1 ML MISC, 28G 1/2" 0.5 ML MISC, 28G 1/2" 1 ML MISC, 29G 1/2" 0.5 ML MISC, 29G 1/2" 1 ML MISC, 30G 1/2" 1 ML MISC, 30G 5/16" 0.5 ML MISC, 31G 5/16" 0.5 ML MISC, 31G 5/16" 1 ML MISC)	brd	
INSUPEN PEN NEEDLES (PEN 31G 5 MISC, PEN 31G 8 MISC, PEN 32G 4 MISC)	brd	
<i>isopropyl alcohol wipes 70%</i>	gen	
LITEAIRE DEVICE	brd	ED
<i>methylergonovine maleate tab 0.2 mg</i>	gen	
MICROCHAMBER (DEVICE, MISC)	brd	ED
MICROSPACER MISC	brd	ED
NOVOFINE 32G X 6 MM MISC	brd	
NOVOTWIST 32G X 5 MM MISC	brd	
OPTICHAMBER ADVANTAGE-LG MASK MISC	brd	ED
OPTICHAMBER ADVANTAGE-MED MASK MISC	brd	ED
OPTICHAMBER ADVANTAGE-SM MASK MISC	brd	ED
OPTICHAMBER DIAMOND (DEVICE, MISC)	brd	ED
OPTICHAMBER DIAMOND-LG MASK DEVICE	brd	ED
OPTICHAMBER DIAMOND-MD MASK MISC	brd	ED
OPTICHAMBER DIAMOND-SM MASK MISC	brd	ED
OPTICHAMBER FACE MASK-LARGE MISC	brd	ED
OPTICHAMBER FACE MASK-MEDIUM MISC	brd	ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OPTICHAMBER FACE MASK-SMALL MISC	brd	ED
OPTIHALER (DEVICE, MISC)	brd	ED
OPVEE 2.7 MG/0.1ML SOLUTION	npd	QL (2 PER 30 OVER TIME)
PEN NEEDLES (PEN 30G 5 MISC, PEN 31G 5 MISC, PEN 31G 8 MISC, PEN 32G 4 MISC)	brd	
POCKET CHAMBER DEVICE	brd	ED
POCKET SPACER DEVICE	brd	ED
PRIMEAIRE HOLDING CHAMBER DEVICE	brd	ED
PRO COMFORT SPACER ADULT MISC	brd	ED
PRO COMFORT SPACER CHILD MISC	brd	ED
PRO COMFORT SPACER INFANT DEVICE	brd	ED
PROCARE SPACER/ADULT MASK DEVICE	brd	ED
PROCARE SPACER/CHILD MASK DEVICE	brd	ED
PURE COMFORT SAFETY PEN NEEDLE (PEN 31G 5 MISC, PEN 31G 6 MISC, PEN 32G 4 MISC)	brd	
PURE COMFORT SPACER CHAMBER DEVICE	brd	ED
RITEFLO DEVICE	brd	ED
SECURESAFE INSULIN SYRINGE (1/2" 0.5 ML MISC, 1/2" 1 ML MISC)	brd	
SILIGENTLE FOAM DRESSING 2"X2" PAD	gen	
SURE COMFORT PEN NEEDLES (PEN 31G 5 MISC, PEN 31G 8 MISC, PEN 32G 4 MISC)	brd	
VALVED HOLDING CHAMBER DEVICE	brd	ED
VERIFINE INSULIN PEN NEEDLE (PEN 29G 12MM MISC, PEN 31G 5 MM MISC, PEN 31G 8 MM MISC, PEN 32G 4 MM MISC, PEN 32G 6 MM MISC)	brd	
VERIFINE INSULIN SYRINGE (29G 1/2" 0.5 ML MISC, 29G 1/2" 1 ML MISC, 31G 5/16" 0.3 ML MISC, 31G 5/16" 0.5 ML MISC, 31G 5/16" 1 ML MISC)	brd	
VERIFINE PLUS PEN NEEDLE (PEN 5 MISC, PEN 8 MISC)	brd	
VORTEX HOLD CHMBR/MASK/CHILD DEVICE	brd	ED
VORTEX HOLD CHMBR/MASK/TODDLER DEVICE	brd	ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
VORTEX HOLDING CHAMBER/MASK DEVICE	brd	ED
VORTEX VALVED HOLDING CHAMBER DEVICE	brd	ED
WATCHHALER DEVICE	brd	ED
<i>water for irrigation, sterile irrigation soln</i>	gen	

OPHTHALMIC AGENTS

OPHTHALMIC AGENTS, OTHER

ATROPINE SULFATE 1 % SOLUTION	gen	
<i>atropine sulfate ophth soln 1%</i>	gen	
<i>bacitracin-polymyxin b ophth oint</i>	gen	
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	gen	
BLEPHAMIDE 10-0.2 % SUSPENSION	brd	
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	gen	
DORZOLAMIDE HCL-TIMOLOL MAL 22.3-6.8 MG/ML SOLUTION	gen	
<i>dorzolamide hcl-timolol maleate (pf soln 2-0.5%, sol 22.3-6.8 mg/ml pf, soln 22.3-6.8 mg/ml)</i>	gen	
HOMATROPAIRE 5 % SOLUTION	gen	ED
<i>homatropine hbr ophth soln 5%</i>	gen	ED
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	gen	
<i>neomycin-polymy-dexameth (oint, susp)</i>	gen	
NEOMYCIN-POLYMYXIN-GRAMICIDIN 1.75-10000-.025 SOLUTION	gen	
NEOMYCIN-POLYMYXIN-HC 3.5-10000-1 SUSPENSION	gen	
<i>phenylephrine hcl (mydriatic) (soln 2.5%, soln 10%)</i>	gen	
<i>proparacaine hcl ophth soln 0.5%</i>	gen	
RESTASIS 0.05 % EMULSION	brd	QL (60 PER 30 OVER TIME)
RESTASIS MULTIDOSE 0.05 % EMULSION	brd	QL (5.5 PER 30 OVER TIME)
ROCKLATAN 0.02-0.005 % SOLUTION	npd	QL (2.5 PER 25 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SULFACETAMIDE-PREDNISOLONE 10-0.23 % SOLUTION	gen	
TOBRADEX 0.3-0.1 % OINTMENT	brd	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	gen	
XIIDRA 5 % SOLUTION	brd	
ZYLET 0.5-0.3 % SUSPENSION	brd	

OPHTHALMIC ANTI-ALLERGY AGENTS

<i>azelastine hcl ophth soln 0.05%</i>	gen	
<i>bepotastine besilate ophth soln 1.5%</i>	gen	
CROMOLYN SODIUM 4 % SOLUTION	gen	
<i>cromolyn sodium ophth soln 4%</i>	gen	
<i>epinastine hcl ophth soln 0.05%</i>	gen	
LASTACFT 0.25 % SOLUTION	npd	
<i>olopatadine hcl (soln 0.1% equivalent), soln 0.2% equivalent))</i>	gen	
PAZEO 0.7 % SOLUTION	brd	QL (2.5 PER 30 OVER TIME)

OPHTHALMIC ANTI-INFECTIVES

BACITRACIN 500 UNIT/GM OINTMENT	gen	
<i>erythromycin ophth oint 5 mg/gm</i>	gen	
<i>gatifloxacin ophth soln 0.5%</i>	gen	QL (2.5 PER 30 OVER TIME)
GENTAK 0.3 % OINTMENT	gen	
<i>gentamicin sulfate ophth soln 0.3%</i>	gen	
LEVOFLOXACIN (0.5 % SOLUTION, 1.5 % SOLUTION)	gen	
<i>levofloxacin ophth soln 0.5%</i>	gen	
MOXIFLOXACIN HCL (2X DAY) 0.5 % SOLUTION	gen	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	gen	
NATACYN 5 % SUSPENSION	brd	
<i>ofloxacin ophth soln 0.3%</i>	gen	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	gen	
SULFACETAMIDE SODIUM 10 % OINTMENT	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>sulfacetamide sodium ophth soln 10%</i>	gen	
<i>tobramycin ophth soln 0.3%</i>	gen	
TOBREX 0.3 % OINTMENT	brd	

OPHTHALMIC ANTI-INFLAMMATORIES

ALREX 0.2 % SUSPENSION	brd	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	gen	
DEXAMETHASONE SODIUM PHOSPHATE 0.1 % SOLUTION	gen	
<i>diclofenac sodium ophth soln 0.1%</i>	gen	
<i>difluprednate ophth emulsion 0.05%</i>	gen	
<i>fluorometholone ophth susp 0.1%</i>	gen	
FLURBIPROFEN SODIUM 0.03 % SOLUTION	gen	
FML 0.1 % OINTMENT	npd	
FML FORTE 0.25 % SUSPENSION	npd	
ILEVRO 0.3 % SUSPENSION	brd	QL (3 PER 30 OVER TIME)
<i>ketorolac tromethamine (ophth) (soln 0.4%, soln 0.5%)</i>	gen	
<i>loteprednol etabonate (0.5 % gel, ophth gel 0.5%, ophth susp 0.5%)</i>	gen	
MAXIDEX 0.1 % SUSPENSION	npd	
PREDNISOLONE ACETATE 1 % SUSPENSION	gen	
PREDNISOLONE SODIUM PHOSPHATE 1 % SOLUTION	gen	
PROLENSA 0.07 % SOLUTION	brd	

OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS

BETAXOLOL HCL 0.5 % SOLUTION	gen	
<i>betaxolol hcl ophth soln 0.5%</i>	gen	
BETIMOL (0.25 % SOLUTION, 0.5 % SOLUTION)	brd	
BETOPTIC-S 0.25 % SUSPENSION	brd	
CARTEOLOL HCL 1 % SOLUTION	gen	
<i>levobunolol hcl (0.5 % solution, ophth soln 0.5%)</i>	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>timolol maleate (ophth) (gel forming soln 0.25%, gel forming soln 0.5%, preservative free soln 0.25%, preservative free soln 0.5%, soln 0.25%, soln 0.5%, soln 0.5% (once-daily))</i>	gen	

OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER

<i>acetazolamide cap er 12hr 500 mg</i>	gen	
ALPHAGAN P 0.1 % SOLUTION	brd	
<i>apraclonidine hcl (0.5 % solution, ophth soln 0.5% (base equivalent))</i>	gen	
<i>brimonidine tartrate (soln 0.1%, soln 0.15%, soln 0.2%)</i>	gen	
<i>brinzolamide ophth susp 1%</i>	gen	
<i>dorzolamide hcl (2 % solution, ophth soln 2%)</i>	gen	
<i>methazolamide (tab 25 mg, tab 50 mg)</i>	gen	
PHOSPHOLINE IODIDE 0.125 % RECON SOLN	npd	
<i>pilocarpine hcl (soln 1%, soln 2%, soln 4%)</i>	gen	
RHOPRESSA 0.02 % SOLUTION	brd	QL (2.5 PER 25 OVER TIME)
SIMBRINZA 1-0.2 % SUSPENSION	brd	

OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS

<i>bimatoprost ophth soln 0.03%</i>	gen	ST, QL (5 PER 30 DAYS)
<i>latanoprost (0.005 % solution, ophth soln 0.005%)</i>	gen	
LUMIGAN 0.01 % SOLUTION	brd	QL (5 PER 30 DAYS)
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	gen	ST, QL (1 PER 1 DAYS)
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	gen	QL (5 PER 30 DAYS)
VYZULTA 0.024 % SOLUTION	npd	

OTIC AGENTS

CIPRO HC 0.2-1 % SUSPENSION	npd	
CIPROFLOXACIN HCL 0.2 % SOLUTION	gen	
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	gen	
CIPROFLOXACIN-FLUOCINOLONE PF 0.3-0.025 % SOLUTION	gen	QL (2 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
COLY-MYCIN S 3.3-3-10-0.5 MG/ML SUSPENSION	brd	
CORTISPORIN-TC 3.3-3-10-0.5 MG/ML SUSPENSION	brd	
DERMOTIC 0.01 % OIL	brd	
<i>fluocinolone acetonide (otic) oil 0.01%</i>	gen	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	gen	
HYDROCORTISONE-ACETIC ACID 1-2 % SOLUTION	gen	
<i>neomycin-polymyxin-hc (otic) (soln 1%, susp 3.5 mg/ml-10000 unit/ml-1%)</i>	gen	
<i>ofloxacin otic soln 0.3%</i>	gen	

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

ARNUITY ELLIPTA (50 MCG/ACT AER POW BA, 100 MCG/ACT AER POW BA, 200 MCG/ACT AER POW BA)	brd	QL (30 PER 30 DAYS)
<i>budesonide (inhalation) (susp 0.25 mg/2ml, susp 0.5 mg/2ml, susp 1 mg/2ml)</i>	gen	PA - PART B VS D DETERMINATION
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	gen	QL (50 PER 30 DAYS)
<i>fluticasone propionate nasal susp 50 mcg/act</i>	gen	QL (16 PER 30 DAYS)
<i>mometasone furoate nasal susp 50 mcg/act</i>	gen	ST, QL (34 PER 30 DAYS)
PULMICORT FLEXHALER (90 MCG/ACT AER POW BA, 180 MCG/ACT AER POW BA)	brd	QL (2 PER 30 DAYS)

ANTIHISTAMINES

<i>azelastine hcl (0.1% (137 mcg/), 0.15% (205.5 mcg/))</i>	gen	QL (30 PER 25 DAYS)
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	gen	QL (23 PER 30 DAYS)
<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>	gen	
<i>cyproheptadine hcl tab 4 mg</i>	gen	PA
DESLORATADINE (2.5 MG TAB DISP, 5 MG TAB DISP)	gen	ST
<i>desloratadine tab 5 mg</i>	gen	
<i>hydroxyzine hcl (syrup 10 mg/5ml, tab 10 mg, tab 25 mg, tab 50 mg)</i>	gen	PA

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>hydroxyzine pamoate (cap 25 mg, cap 50 mg, 100 mg cap)</i>	gen	PA
<i>levocetirizine dihydrochloride tab 5 mg</i>	gen	
<i>olopatadine hcl nasal soln 0.6%</i>	gen	QL (30.5 PER 30 DAYS)
<i>promethazine hcl syrup 6.25 mg/5ml</i>	gen	PA

ANTILEUKOTRIENES

<i>montelukast sodium (chew tab 4 mg equiv), chew tab 5 mg equiv, oral granules packet 4 mg equiv, tab 10 mg equiv))</i>	gen	QL (1 PER 1 DAYS)
<i>zafirlukast (tab 10 mg, tab 20 mg)</i>	gen	QL (2 PER 1 DAYS)

BRONCHODILATORS, ANTICHOLINERGIC

ATROVENT HFA 17 MCG/ACT AERO SOLN	brd	QL (25.8 PER 30 DAYS)
<i>ipratropium bromide inhal soln 0.02%</i>	gen	PA - PART B VS D DETERMINATION
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	gen	QL (30 PER 30 DAYS)
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	gen	QL (45 PER 30 DAYS)
SPIRIVA HANDIHALER 18 MCG CAP	brd	QL (30 PER 30 DAYS)
SPIRIVA RESPIMAT (1.25 MCG/ACT AERO SOLN, 2.5 MCG/ACT AERO SOLN)	brd	QL (4 PER 30 DAYS)

BRONCHODILATORS, SYMPATHOMIMETIC

<i>albuterol 90mg hfa inhaler (generic proair)</i>	gen	QL (17 PER 30 OVER TIME)
<i>albuterol 90mg hfa inhaler (generic proventil)</i>	gen	QL (13.4 PER 30 OVER TIME)
ALBUTEROL 90MG HFA INHALER (GENERIC VENTOLIN)	gen	QL (36 PER 30 OVER TIME)
<i>albuterol sulfate (soln nebu 0.083% (2.5 mg/3ml), soln nebu 0.5% (5 mg/ml), soln nebu 0.63 mg/3ml (base equiv), soln nebu 1.25 mg/3ml (base equiv), 2.5 mg/0.5ml nebu soln, (5 mg/ml) 0.5% nebu soln)</i>	gen	PA - PART B VS D DETERMINATION
<i>albuterol sulfate (syrup 2 mg/5ml, tab 2 mg, tab 4 mg)</i>	gen	
ALBUTEROL SULFATE ER (ER 4 MG TAB ER 12H, ER 8 MG TAB ER 12H)	gen	
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	gen	PA - PART B VS D DETERMINATION
EPINEPHRINE (0.15 MG/0.15ML SOLN A-INJ, 0.3 MG/0.3ML SOLN A-INJ)	gen	QL (24 PER 365 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>epinephrine (anaphylaxis) (solution 0.15 mg/0.3ml (1:2000), solution 0.3 mg/0.3ml (1:1000))</i>	gen	QL (24 PER 365 OVER TIME)
EPINEPHRINE AUTOINJECTOR (GENERIC ADRENALCLIK)	gen	QL (24 PER 365 OVER TIME)
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	gen	PA - PART B VS D DETERMINATION
<i>levalbuterol hcl (soln nebu 0.31 mg/3ml equiv), soln nebu 0.63 mg/3ml equiv, soln nebu 1.25 mg/3ml equiv, soln nebu conc 1.25 mg/0.5ml equiv)</i>	gen	PA
LEVALBUTEROL TARTRATE 45 MCG/ACT AEROSOL	gen	QL (30 PER 30 DAYS)
SEREVENT DISKUS 50 MCG/ACT AER POW BA	brd	QL (60 PER 30 DAYS)
<i>terbutaline sulfate (tab 2.5 mg, tab 5 mg)</i>	gen	
<i>terbutaline sulfate inj 1 mg/ml</i>	inj	

CYSTIC FIBROSIS AGENTS

CAYSTON 75 MG RECON SOLN	spec	PA, LA, QL (84 PER 28 OVER TIME)
KALYDECO (5.8 MG PACKET, 13.4 MG PACKET, 25 MG PACKET, 50 MG PACKET, 75 MG PACKET, 150 MG TAB)	spec	PA, LA, QL (2 PER 1 DAYS)
PULMOZYME 2.5 MG/2.5ML SOLUTION	spec	QL (150 PER 30 OVER TIME), PA - PART B VS D DETERMINATION
SYMDEKO (50-75 75 MG TAB THPK, 100-150 150 MG TAB THPK)	spec	PA, LA, QL (2 PER 1 DAYS)
TOBI PODHALER 28 MG CAP	spec	PA, LA, QL (224 PER 28 OVER TIME)
<i>tobramycin nebu soln 300 mg/4ml</i>	spec	PA, QL (224 PER 28 OVER TIME)
<i>tobramycin nebu soln 300 mg/5ml</i>	spec	PA, QL (280 PER 56 OVER TIME)
TRIKAFTA (50-25-37.5 75 MG TAB THPK, 100-50-75 150 MG TAB THPK)	spec	PA, LA, QL (3 PER 1 DAYS)

MAST CELL STABILIZERS

<i>cromolyn sodium soln nebu 20 mg/2ml</i>	gen	PA - PART B VS D DETERMINATION
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PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE

<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	gen	
ELIXOPHYLLIN 80 MG/15ML ELIXIR	gen	
<i>roflumilast tab 250 mcg</i>	gen	PA, QL (28 PER 180 OVER TIME)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>roflumilast tab 500 mcg</i>	gen	PA, QL (1 PER 1 DAYS)
THEO-24 (100 MG CAP ER 24H, 200 MG CAP ER 24H, 300 MG CAP ER 24H, 400 MG CAP ER 24H)	brd	
<i>theophylline (elixir 80 mg/15ml, soln 80 mg/15ml, tab er 12hr 100 mg, tab er 12hr 200 mg, tab er 12hr 300 mg, tab er 12hr 450 mg, tab er 24hr 400 mg, tab er 24hr 600 mg)</i>	gen	

PULMONARY ANTIHYPERTENSIVES

ADEMPAS (0.5 MG TAB, 1 MG TAB, 1.5 MG TAB, 2 MG TAB, 2.5 MG TAB)	spec	PA, LA, QL (3 PER 1 DAYS)
<i>ambrisentan (tab 5 mg, tab 10 mg)</i>	spec	PA, LA, QL (1 PER 1 DAYS)
<i>bosentan tab 125 mg</i>	spec	PA, LA, QL (2 PER 1 DAYS)
<i>bosentan tab 62.5 mg</i>	spec	PA, LA, QL (4 PER 1 DAYS)
OPSUMIT 10 MG TAB	spec	PA, LA, QL (1 PER 1 DAYS)
<i>sildenafil citrate for suspension 10 mg/ml</i>	spec	PA, QL (6 PER 1 DAYS)
<i>sildenafil citrate tab 20 mg</i>	gen	PA, QL (3 PER 1 DAYS)
<i>tadalafil tab 20 mg (pah)</i>	spec	PA, QL (2 PER 1 DAYS)
TRACLEER 32 MG TAB SOL	spec	PA, LA, QL (4 PER 1 DAYS)
VENTAVIS 10 MCG/ML SOLUTION	spec	LA, QL (270 PER 30 OVER TIME), PA - PART B VS D DETERMINATION
VENTAVIS 20 MCG/ML SOLUTION	spec	LA, QL (90 PER 30 OVER TIME), PA - PART B VS D DETERMINATION

PULMONARY FIBROSIS AGENTS

OFEV (100 MG CAP, 150 MG CAP)	spec	PA, LA, QL (2 PER 1 DAYS)
<i>pirfenidone (cap 267 mg, tab 267 mg)</i>	spec	PA, QL (9 PER 1 DAYS)
PIRFENIDONE 534 MG TAB	spec	PA, QL (5 PER 1 DAYS)
<i>pirfenidone tab 801 mg</i>	spec	PA, QL (3 PER 1 DAYS)

RESPIRATORY TRACT AGENTS, OTHER

<i>acetylcysteine (soln 10%, soln 20%)</i>	gen	PA - PART B VS D DETERMINATION
ADVAIR HFA (45-21 MCG/ACT AEROSOL, 115-21 MCG/ACT AEROSOL, 230-21 MCG/ACT AEROSOL)	brd	QL (12 PER 30 DAYS)
ANORO ELLIPTA 62.5-25 MCG/ACT AER POW BA	brd	QL (60 PER 30 DAYS)
<i>benzonatate (cap 100 mg, cap 150 mg, cap 200 mg)</i>	gen	ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BEVESPI AEROSPHERE 9-4.8 MCG/ACT AEROSOL	brd	QL (10.7 PER 28 DAYS)
BREO ELLIPTA (50-25 MCG/INH AER POW BA, 100-25 MCG/ACT AER POW BA, 200-25 MCG/ACT AER POW BA)	brd	QL (60 PER 30 DAYS)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACT AEROSOL	brd	QL (10.7 PER 30 DAYS)
<i>budesonide-formoterol fumarate dihydrate (aerosol 80-4.5 mcg/act, aerosol 160-4.5 mcg/act)</i>	brd	QL (10.2 PER 30 DAYS)
COMBIVENT RESPIMAT 20-100 MCG/ACT AERO SOLN	brd	QL (4 PER 30 DAYS)
FLUTICASONE-SALMETEROL (55-14 MCG/ACT AER POW BA, 113-14 MCG/ACT AER POW BA, 232-14 MCG/ACT AER POW BA)	gen	QL (1 PER 30 DAYS)
<i>fluticasone-salmeterol (aer powder ba 100-50 mcg/act, aer powder ba 250-50 mcg/act, aer powder ba 500-50 mcg/act)</i>	gen	QL (60 PER 30 DAYS)
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	gen	QL (420 PER 30 OVER TIME), NDS, ED
HYDROCOD POLI-CHLORPHE POLI ER 10-8 MG/5ML SUSP	gen	QL (70 PER 30 OVER TIME), NDS, ED
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	gen	QL (70 PER 30 OVER TIME), NDS, ED
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	gen	QL (210 PER 30 OVER TIME), NDS, ED
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	gen	QL (42 PER 30 OVER TIME), NDS, ED
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	gen	PA - PART B VS D DETERMINATION
NUCALA (100 MG RECON SOLN, 100 MG/ML SOLN A-INJ, 100 MG/ML SOLN PRSYR)	spec	PA, LA, QL (3 PER 30 OVER TIME)
NUCALA 40 MG/0.4ML SOLN PRSYR	spec	PA, LA, QL (0.4 PER 28 OVER TIME)
<i>promethazine & phenylephrine syrup 6.25-5 mg/5ml</i>	gen	PA
PROMETHAZINE VC 6.25-5 MG/5ML SYRUP	gen	PA
PROMETHAZINE VC/CODEINE 6.25-5-10 MG/5ML SYRUP	gen	PA, QL (240 PER 30 OVER TIME), NDS, ED
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	gen	PA, QL (240 PER 30 OVER TIME), NDS, ED
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	gen	PA, ED

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
<i>promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml</i>	gen	PA, QL (240 PER 30 OVER TIME), NDS, ED
PSEUDOEPH-CHLORPHEN-HYDROCOD 60-4-5 MG/5ML SOLUTION	gen	QL (140 PER 30 OVER TIME), NDS, ED
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	gen	ED
<i>ribavirin for inhal soln 6 gm</i>	spec	PA - PART B VS D DETERMINATION
<i>sodium chloride (inhalant) (soln nebu 3%, soln nebu 7%, soln nebu 10%)</i>	gen	ED
TRELEGY ELLIPTA (100-62.5-25 MCG/ACT AER POW BA, 200-62.5-25 MCG/ACT AER POW BA)	brd	QL (60 PER 30 DAYS)

SKELETAL MUSCLE RELAXANTS

<i>carisoprodol tab 350 mg</i>	gen	PA, QL (4 PER 1 DAYS)
<i>cyclobenzaprine hcl (tab 5 mg, tab 10 mg)</i>	gen	PA
<i>metaxalone (tab 400 mg, tab 800 mg)</i>	gen	PA, QL (4 PER 1 DAYS)
<i>methocarbamol (tab 500 mg, tab 750 mg)</i>	gen	PA

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

<i>estazolam (tab 1 mg, tab 2 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>eszopiclone (tab 1 mg, tab 2 mg, tab 3 mg)</i>	gen	QL (1 PER 1 DAYS)
FLURAZEPAM HCL (15 MG CAP, 30 MG CAP)	gen	QL (1 PER 1 DAYS)
<i>ramelteon tab 8 mg</i>	gen	QL (1 PER 1 DAYS)
<i>tasimelteon capsule 20 mg</i>	spec	PA, QL (1 PER 1 DAYS)
<i>temazepam (cap 22.5 mg, cap 30 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>temazepam cap 15 mg</i>	gen	QL (2 PER 1 DAYS)
<i>temazepam cap 7.5 mg</i>	gen	QL (4 PER 1 DAYS)
<i>triazolam tab 0.125 mg</i>	gen	QL (4 PER 1 DAYS)
<i>triazolam tab 0.25 mg</i>	gen	QL (2 PER 1 DAYS)
<i>zaleplon cap 10 mg</i>	gen	QL (2 PER 1 DAYS)
<i>zaleplon cap 5 mg</i>	gen	QL (4 PER 1 DAYS)
<i>zolpidem tartrate (tab 10 mg, tab er 12.5 mg)</i>	gen	QL (1 PER 1 DAYS)
<i>zolpidem tartrate (tab 5 mg, tab er 6.25 mg)</i>	gen	QL (2 PER 1 DAYS)

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
WAKEFULNESS PROMOTING AGENTS		
<i>armodafinil (tab 50 mg, tab 150 mg, tab 200 mg, tab 250 mg)</i>	gen	PA, QL (1 PER 1 DAYS)
<i>modafinil tab 100 mg</i>	gen	PA, QL (3 PER 1 DAYS)
<i>modafinil tab 200 mg</i>	gen	PA, QL (2 PER 1 DAYS)
XYREM 500 MG/ML SOLUTION	spec	PA, LA, QL (540 PER 30 OVER TIME)

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

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DIFLORASONE DIACETATE.....	66	doxepin hcl.....	20
diflunisal.....	1	doxercalciferol.....	91
difluprednate.....	99	DOXYCYCLINE.....	12
digoxin.....	58	doxycycline (monohydrate).....	12
dihydroergotamine mesylate.....	23	doxycycline hyclate.....	12
DILANTIN.....	16	doxylamine-pyridoxine.....	20
DILANTIN INFATABS.....	16	DRIZALMA SPRINKLE.....	64
diltiazem hcl.....	56	dronabinol.....	21
diltiazem hcl 120 mg extended release 24hr capsule.....	56	DROPSAFE SAFETY SYRINGE/NEEDLE.....	94
diltiazem hcl 180 mg extended release 24hr capsule.....	56	drosiprenone-ethinyl estradiol.....	80
diltiazem hcl 240 mg extended release 24hr capsule.....	56	drosiprenone-ethinyl estradiol-levomefolate calcium.....	81
diltiazem hcl 300 mg extended release 24hr capsule.....	56	DROXIA.....	26
diltiazem hcl 360 mg extended release 24hr capsule.....	56	droxidopa.....	53
diltiazem hcl coated beads.....	56	duloxetine hcl.....	64
diltiazem hcl extended release beads.....	56	DUPIXENT.....	86
dimethyl fumarate.....	64	dutasteride.....	77
DIPENTUM.....	90	dutasteride-tamsulosin hcl.....	77
diphenoxylate w/ atropine.....	73	E	
DIPHENOXYLATE-ATROPINE.....	73	E.E.S. 400.....	11
DIPHThERIA-TETANUS TOXOIDS DT.....	89	EASIVENT.....	94
dipyridamole.....	53	EASIVENT MASK LARGE.....	94
disopyramide phosphate.....	54	EASIVENT MASK MEDIUM.....	94
disulfiram.....	5	EASIVENT MASK SMALL.....	94
DIURIL.....	60	EASY COMFORT INSULIN SYRINGE.....	94
divalproex sodium.....	13	econazole nitrate.....	22
dofetilide.....	54	EDURANT.....	42
donepezil hydrochloride.....	17	EFAVIRENZ.....	42
donepezil hydrochloride orally disintegrating tab 10 mg.....	17	efavirenz.....	42
donepezil hydrochloride orally disintegrating tab 5 mg.....	17	efavirenz-emtricitabine-tenofovir disoproxil fumarate.....	42
dorzolamide hcl.....	100	efavirenz-lamivudine-tenofovir disoproxil fumarate.....	43
DORZOLAMIDE HCL-TIMOLOL MAL.....	97	EGRIFTA.....	79
dorzolamide hcl-timolol maleate.....	97	EGRIFTA SV.....	79
DOVATO.....	42	ELAPRASE.....	75
doxazosin mesylate.....	53	ELIQUIS.....	51
		ELIQUIS DVT/PE STARTER PACK.....	51
		ELIXOPHYLLIN.....	103
		ELMIRON.....	77

EMBRACE PEN NEEDLES.....	94	ERY.....	68
EMCYT.....	26	ERYTHROCIN LACTOBIONATE.....	11
EMSAM.....	18	ERYTHROCIN STEARATE.....	11
emtricitabine.....	43	erythromycin (acne aid).....	68
emtricitabine-tenofovir disoproxil fumarate..	43	erythromycin (ophth).....	98
EMTRIVA.....	43	erythromycin base.....	11
enalapril maleate.....	54	erythromycin ethylsuccinate.....	11
enalapril maleate & hydrochlorothiazide....	58	erythromycin lactobionate.....	11
ENBREL.....	87	escitalopram oxalate.....	18
ENBREL SURECLICK.....	87	esomeprazole magnesium.....	74
ENDARI.....	75	estazolam.....	106
ENGERIX-B.....	89	esterified estrogens & methyltestosterone....	81
enoxaparin sodium.....	51	estradiol.....	81
entacapone.....	36	estradiol & norethindrone acetate.....	81
entecavir.....	41	estradiol vaginal.....	81
ENTRESTO.....	58	estradiol valerate.....	81
ENVARUSUS XR.....	87	ESTRING.....	81
EPCLUSA.....	41	eszopiclone.....	106
EPIDIOLEX.....	13	ethambutol hcl.....	24
EPIFOAM.....	67	ethosuximide.....	15
epinastine hcl (ophth).....	98	ethynodiol diacet & eth estrad.....	81
EPINEPHRINE.....	102	etodolac.....	1
epinephrine (anaphylaxis).....	103	etonogestrel-ethinyl estradiol.....	81
EPINEPHRINE AUTOINJECTOR (GENERIC ADRENACLICK).....	103	etravirine.....	43
EPIVIR HBV.....	41	everolimus.....	30
eplerenone.....	59	everolimus (immunosuppressant).....	87
EPRONTIA.....	13	EVOTAZ.....	45
EPROSARTAN MESYLATE.....	53	exemestane.....	29
EQ SPACE CHAMBER ANTI-STATIC.....	94	EXKIVITY.....	27
EQ SPACE CHAMBER ANTI-STATIC L.....	94	ezetimibe.....	60
EQ SPACE CHAMBER ANTI-STATIC M.....	94	ezetimibe-simvastatin.....	61
EQ SPACE CHAMBER ANTI-STATIC S.....	94		
EQUETRO.....	47	F	
ergocalciferol.....	91	famciclovir.....	46
ERGOLOID MESYLATES.....	17	famotidine.....	74
ergotamine w/ caffeine.....	23	FANAPT.....	39
ERIVEDGE.....	30	FANAPT TITRATION PACK.....	39
ERLEADA.....	25	FARXIGA.....	47
erlotinib hcl.....	30	febuxostat.....	23
ertapenem sodium.....	10	felbamate.....	13
		felodipine.....	55

fenofibrate	60	fluticasone propionate (nasal)	101
fenofibrate micronized	60	FLUTICASONE-SALMETEROL	105
fentanyl	2	fluticasone-salmeterol	105
fentanyl citrate	3	fluvastatin sodium	60
FERRIPROX	70	fluvoxamine maleate	19
fesoterodine fumarate	76	FML	99
FETZIMA	18	FML FORTE	99
FETZIMA TITRATION	19	folic acid	71
finasteride	77	fondaparinux sodium	51
fingolimod hcl	64	formoterol fumarate	103
FINTEPLA	13	FORTEO	91
FIRMAGON	84	fosamprenavir calcium	45
FIRMAGON (240 MG DOSE)	84	fosfomycin tromethamine	7
flavoxate hcl	76	fosinopril sodium	54
FLEBOGAMMA DIF	85	fosinopril sodium & hydrochlorothiazide	58
flecainide acetate	54	FOTIVDA	27
FLEXICHAMBER	94	fulvestrant	26
fluconazole	22	furosemide	59
fluconazole in nacl	22	FUZEON	44
flucytosine	22	FYCOMPA	13
fludrocortisone acetate	78		
flunisolide (nasal)	101	G	
fluocinolone acetonide	66	gabapentin	15
fluocinolone acetonide (otic)	101	galantamine hydrobromide	17
fluocinonide	66	GAMMAGARD	85
fluocinonide emulsified base	66	GAMMAGARD S/D LESS IGA	85
fluorometholone (ophth)	99	GAMMAKED	85
FLUOROURACIL	67	GAMMAPLEX	85
fluorouracil (topical)	67	GAMUNEX-C	85
fluoxetine hcl	19	GARDASIL 9	89
FLUOXETINE HCL	19	gatifloxacin (ophth)	98
FLUOXETINE HCL (PMDD)	19	GATTEX	74
fluphenazine decanoate	37	gauze pads 2	94
fluphenazine hcl	37	GAVILYTE-C	74
FLUPHENAZINE HCL	37	GAVRETO	30
flurandrenolide	66	gefitinib	30
FLURAZEPAM HCL	106	gemfibrozil	60
flurbiprofen	1	GEMTESA	76
FLURBIPROFEN SODIUM	99	GENOTROPIN	79
flutamide	25	GENOTROPIN MINIQUICK	79
fluticasone propionate	66	GENTAK	98

gentamicin sulfate	6	HIZENTRA	85
gentamicin sulfate (ophth)	98	HOMATROPAIRE	97
gentamicin sulfate (topical)	6	homatropine hbr	97
GENVOYA	42	HUMALOG	49
GILOTRIF	30	HUMALOG JUNIOR KWIKPEN	49
GLEOSTINE	25	HUMALOG KWIKPEN	49
glimepiride	47	HUMALOG MIX 50/50	49
glipizide	47	HUMALOG MIX 50/50 KWIKPEN	50
glipizide-metformin hcl	47	HUMALOG MIX 75/25	50
GLUCAGEN HYPOKIT	49	HUMALOG MIX 75/25 KWIKPEN	50
glucagon (rdna)	49	HUMIRA	87
GLUCAGON EMERGENCY	49	HUMIRA PEDIATRIC CROHNS START	87
glyburide	48	HUMIRA PEN	87
glyburide micronized	48	HUMIRA PEN-CD/UC/HS STARTER	87
glyburide-metformin	48	HUMIRA PEN-PEDIATRIC UC START	88
glycopyrrolate	73	HUMIRA PEN-PS/UV/ADOL HS START	88
GLYXAMBI	48	HUMIRA PEN-PSOR/UEIT STARTER	88
GNP ISOPROPYL ALCOHOL WIPES	94	HUMULIN 70/30	50
GOLYTELY	74	HUMULIN 70/30 KWIKPEN	50
granisetron hcl	21	HUMULIN N	50
griseofulvin microsize	22	HUMULIN N KWIKPEN	50
griseofulvin ultramicrosize	22	HUMULIN R	50
guaifenesin-codeine	105	HUMULIN R U-500 (CONCENTRATED)	50
guanfacine hcl	53	HUMULIN R U-500 KWIKPEN	50
guanfacine hcl (adhd)	63	hydralazine hcl	61
GUANIDINE HCL	24	hydrochlorothiazide	60
GYNAZOLE-1	22	HYDROCOD POLI-CHLORPHE POLI ER	105
H		hydrocodone bitartrate-homatropine methylbromide	105
HAEGARDA	85	hydrocodone polistirex-chlorpheniramine polistirex	105
halobetasol propionate	66	hydrocodone-acetaminophen	3
haloperidol	38	hydrocodone-ibuprofen	3
haloperidol decanoate	38	hydrocortisone	91
haloperidol lactate	38	hydrocortisone (intrarectal)	91
HARVONI	41	hydrocortisone (rectal)	66
HAVRIX	89	hydrocortisone (topical)	67
HEMADY	78	hydrocortisone acetate (rectal)	78
heparin sodium (porcine)	51	hydrocortisone acetate w/ pramoxine	67
HEPATAMINE	69	hydrocortisone butyrate	67,78
HEPLISAV-B	89	hydrocortisone valerate	67,78
HIBERIX	89		

hydrocortisone w/ acetic acid	101	INSULIN LISPRO (1 UNIT DIAL)	50
HYDROCORTISONE-ACETIC ACID	101	INSULIN LISPRO JUNIOR KWIKPEN	50
hydromorphone hcl	2,3	INSULIN LISPRO PROT & LISPRO	50
HYDROMORPHONE HCL	3	INSULIN PEN NEEDLES	95
hydroxychloroquine sulfate	35	INSULIN SYRINGE 0.3 ML	95
HYDROXYPROGESTERONE CAPROATE	82	INSULIN SYRINGE 0.5 ML	95
hydroxyurea	26	INSULIN SYRINGE 1 ML	95
hydroxyzine hcl	101	INSULIN SYRINGE-NEEDLE U-100	95
hydroxyzine pamoate	102	INSUPEN PEN NEEDLES	95
hyoscyamine sulfate	73	INTELENCE	43
I		INTRALIPID	69
ibandronate sodium	91	INTRON A	86
IBRANCE	30	INVEGA HAFYERA	39
ibuprofen	1	INVEGA SUSTENNA	39
icatibant acetate	85	INVEGA TRINZA	39
ICLUSIG	30	IPOL	89
icosapent ethyl	61	ipratropium bromide	102
IDHIFA	27	ipratropium bromide (nasal)	102
ILARIS	86	ipratropium-albuterol	105
ILEVRO	99	irbesartan	53
imatinib mesylate	30,31	irbesartan-hydrochlorothiazide	58
IMBRUVICA	31	ISENTRESS	42
imipenem-cilastatin	10	ISENTRESS HD	42
imipramine hcl	20	isoniazid	24
imiquimod	67	ISONIAZID	24
IMOVAX RABIES	89	isopropyl alcohol (skin cleanser)	95
INCRELEX	79	isosorbide dinitrate	61
indapamide	60	ISOSORBIDE DINITRATE ER	61
indomethacin	1	isosorbide dinitrate-hydralazine hcl	58
INFANRIX	89	isosorbide mononitrate	61
INGREZZA	64	isotretinoin	65
INLYTA	31	isradipine	56
INQOVI	26	itraconazole	22
INREBIC	27	ivermectin	35
INSPIRACHAMBER/LARGE	95	IVERMECTIN	68
INSPIRACHAMBER/MEDIUM	95	ivermectin (rosacea)	68
INSPIRACHAMBER/MOUTHPIECE	95	IXIARO	89
INSPIRACHAMBER/SMALL	95	J	
INSPIREASE	95	JAKAFI	31
INSULIN LISPRO	50	JANUMET	48

JANUMET XR	48
JANUVIA	48
JARDIANCE	48
JAYPIRCA	31
JENTADUETO	48
JENTADUETO XR	48
JULUCA	42
JYNNEOS	89

K

KALYDECO	103
KCL (0.149%) IN NAACL	69
KCL (0.298%) IN NAACL	69
KCL IN DEXTROSE-NAACL	69
KCL-LACTATED RINGERS-D5W	71
KEPIVANCE	65
KERENDIA	48
ketoconazole	22
ketoconazole (topical)	22
ketorolac tromethamine (ophth)	99
KINRIX	89
KISQALI (200 MG DOSE)	31
KISQALI (400 MG DOSE)	31
KISQALI (600 MG DOSE)	31
KISQALI FEMARA (400 MG DOSE)	27
KISQALI FEMARA (600 MG DOSE)	27
KISQALI FEMARA(200 MG DOSE)	27
KORLYM	78
KOSELUGO	27
KRAZATI	27

L

labetalol hcl	55
lacosamide	16
lactated ringer's	71
lactated ringer's (irrigation)	71
LACTATED RINGERS	71
lactic acid (ammonium lactate)	67
lactulose	72
lactulose (encephalopathy)	72
lamivudine	43

lamivudine (hbv)	41
lamivudine-zidovudine	43
lamotrigine	14
LANREOTIDE ACETATE	84
lansoprazole	74
lanthanum carbonate	71
LANTUS	50
LANTUS SOLOSTAR	50
lapatinib ditosylate	31
LASTACAPT	98
latanoprost	100
LEDIPASVIR-SOFOSBUVIR	41
leflunomide	88
lenalidomide	26
LENVIMA (10 MG DAILY DOSE)	31
LENVIMA (12 MG DAILY DOSE)	31
LENVIMA (14 MG DAILY DOSE)	31
LENVIMA (18 MG DAILY DOSE)	31
LENVIMA (20 MG DAILY DOSE)	31
LENVIMA (24 MG DAILY DOSE)	31
LENVIMA (4 MG DAILY DOSE)	31
LENVIMA (8 MG DAILY DOSE)	31
letrozole	29
leucovorin calcium	27
LEUKERAN	25
leuprolide acetate	84
levalbuterol hcl	103
LEVALBUTEROL TARTRATE	103
levetiracetam	14
levobunolol hcl	99
levocarnitine (metabolic modifiers)	71
levocetirizine dihydrochloride	102
levofloxacin	11,12
LEVOFLOXACIN	98
levofloxacin (ophth)	98
levofloxacin in d5w	12
levonorgestrel & eth estradiol	81
levonorgestrel-eth estradiol (triphasic)	81
levonorgestrel-ethinyl estradiol (91-day)	81
levonorgestrel-ethinyl estradiol (continuous)	81
levothyroxine sodium	83

LEXIVA	45	LYTGOBI (16 MG DAILY DOSE)	32
lidocaine	5	LYTGOBI (20 MG DAILY DOSE)	32
LIDOCAINE HCL	4	M	
lidocaine hcl	4	M-M-R II	89
lidocaine hcl (mouth-throat)	4	mafenide acetate	68
lidocaine-prilocaine	5	magnesium sulfate	69
lincomycin hcl	7	malathion	68
LINDANE	68	MAPROTILINE HCL	18
linezolid	7	maraviroc	44
LINEZOLID IN SODIUM CHLORIDE	7	MARPLAN	18
LINZESS	72	MATULANE	25
liothyronine sodium	83	MAVYRET	42
lisdexamfetamine dimesylate	62	MAXIDEX	99
lisinopril	54	meclizine hcl	20
lisinopril & hydrochlorothiazide	58	MEDROL	78
LITEAIRE	95	medroxyprogesterone acetate	83
LITHIUM	47	medroxyprogesterone acetate (contraceptive)	82
lithium carbonate	47	mefloquine hcl	35
LONSURF	27	megestrol acetate	83
loperamide hcl	73	megestrol acetate (appetite)	83
lopinavir-ritonavir	45	MEKINIST	32
lorazepam	47	MEKTOVI	32
LORBRENA	32	meloxicam	1
losartan potassium	53	MELPHALAN	25
losartan potassium & hydrochlorothiazide	58	memantine hcl	17
loteprednol etabonate	99	MENACTRA	89
lovastatin	60	MENEST	81
loxapine succinate	38	MENQUADFI	89
lubiprostone	72	MENVEO	89
LULICONAZOLE	22	MEPHYTON	52
LUMAKRAS	27	meprobamate	46
LUMIGAN	100	mercaptapurine	26
LUPRON DEPOT (1-MONTH)	84	meropenem	10
LUPRON DEPOT (3-MONTH)	84	MEROPENEM-SODIUM CHLORIDE	10
LUPRON DEPOT (4-MONTH)	84	mesalamine	90
LUPRON DEPOT (6-MONTH)	84	mesna	35
lurasidone hcl	39	MESNEX	35
LYBALVI	18	metaxalone	106
LYNPARZA	32	metformin hcl	48
LYSODREN	27		
LYTGOBI (12 MG DAILY DOSE)	32		

methadone hcl.....	2	misoprostol.....	74
methazolamide.....	100	modafinil.....	107
methenamine hippurate.....	7	moexipril hcl.....	54
methimazole.....	84	MOLINDONE HCL.....	38
methocarbamol.....	106	mometasone furoate.....	67,79
methotrexate sodium.....	88	mometasone furoate (nasal).....	101
methoxsalen rapid.....	67	montelukast sodium.....	102
methscopolamine bromide.....	73	morphine sulfate.....	2,3,4
methsuximide.....	15	MORPHINE SULFATE.....	4
methyl dopa.....	53	MOVANTIK.....	72
METHYLDOPA-HYDROCHLOROTHIAZIDE.....	58	MOXIFLOXACIN HCL.....	12
methylergonovine maleate.....	95	moxifloxacin hcl.....	12
methylphenidate hcl.....	63	MOXIFLOXACIN HCL (2X DAY).....	98
METHYLPHENIDATE HCL ER.....	63	moxifloxacin hcl (ophth).....	98
methylprednisolone.....	78	MOXIFLOXACIN HCL IN NAACL.....	12
methylprednisolone acetate.....	78	MULTAQ.....	54
methylprednisolone sod succ.....	78,79	MULTI-VIT-FLOR.....	71
methyltestosterone.....	80	MULTIVITAMIN W/FLUORIDE.....	72
metoclopramide hcl.....	20	MULTIVITAMIN/FLUORIDE.....	69,72
METOCLOPRAMIDE HCL.....	20	mupirocin.....	69
metolazone.....	60	MUSE.....	77
metoprolol & hydrochlorothiazide.....	58	MYALEPT.....	74
metoprolol succinate.....	55	mycophenolate mofetil.....	88
metoprolol tartrate.....	55	mycophenolate mofetil hcl.....	88
metronidazole.....	7	mycophenolate sodium.....	88
metronidazole (topical).....	7	MYRBETRIQ.....	76
metronidazole vaginal.....	7		
metyrosine.....	58	N	
mexiletine hcl.....	54	nabumetone.....	1
micafungin sodium.....	22	nadolol.....	55
MICONAZOLE 3.....	22	nafcillin sodium.....	10
MICONAZOLE-ZINC OXIDE-PETROLAT.....	22	naftifine hcl.....	22
MICROCHAMBER.....	95	NAGLAZYME.....	75
MICROSPACER.....	95	naloxone hcl.....	5
midodrine hcl.....	53	NALOXONE HCL.....	5
MIGERGOT.....	23	naltrexone hcl.....	5
miglitol.....	48	NAMZARIC.....	17
miglustat.....	75	naproxen.....	1
minocycline hcl.....	12	naproxen sodium.....	1
minoxidil.....	61	naratriptan hcl.....	23
mirtazapine.....	18	NATACYN.....	98

nateglinide	48	norethin acet & estrad-fe	82
NATPARA	91	norethindrone & eth estradiol	82
NAYZILAM	5	norethindrone & ethinyl estradiol-fe	82
nebivolol hcl	55	norethindrone (contraceptive)	83
NEFAZODONE HCL	19	norethindrone acet & eth estra	82
neomycin sulfate	6	norethindrone acetate	83
neomycin-bacitracin zn-polymyxin	97	norethindrone acetate-ethinyl estradiol	82
neomycin-polymy-dexameth	97	norethindrone acetate-ethinyl estradiol-fe	82
NEOMYCIN-POLYMYXIN-GRAMICIDIN	97	norethindrone-eth estradiol (triphasic)	82
NEOMYCIN-POLYMYXIN-HC	97	norgestimate-ethinyl estradiol	82
neomycin-polymyxin-hc (otic)	101	norgestimate-ethinyl estradiol (triphasic)	82
NERLYNX	32	norgestrel & ethinyl estradiol	82
NEUPRO	36	NORMOSOL-M IN D5W	69
NEVIRAPINE	43	nortriptyline hcl	20
nevirapine	43	NORVIR	45
NEVIRAPINE ER	43	NOVOFINE 32G X 6 MM MISC	95
niacin (antihyperlipidemic)	61	NOVOTWIST 32G X 5 MM MISC	95
NIACIN (ANTIHYPERLIPIDEMIC)	61	NP THYROID	83
NIACOR	61	NUBEQA	25
nicardipine hcl	56	NUCALA	105
NICOTROL	6	NUEDEXTA	64
NICOTROL NS	6	NULYTELY LEMON-LIME	73
nifedipine	56	NULYTELY WITH FLAVOR PACKS	73
nilutamide	25	NUPLAZID	39
nimodipine	56	NURTEC	23
NINLARO	27	NUTRILIPID	69
nisoldipine	56	NYMALIZE	56
NISOLDIPINE ER	56	nystatin	22
nitazoxanide	35	nystatin (mouth-throat)	22
nitisinone	75	nystatin (topical)	22
NITRO-BID	61	nystatin-triamcinolone	67
NITRO-DUR	61		
NITRO-TIME	61	O	
nitrofurantoin	7	octreotide acetate	84
nitrofurantoin macrocrystal	7	OCTREOTIDE ACETATE	84
nitrofurantoin monohyd macro	7	ODEFSEY	43
nitroglycerin	61	ODOMZO	32
NITROSTAT	61	OFEV	104
NIVA THYROID	83	ofloxacin	12
nizatidine	74	ofloxacin (ophth)	98
norelgestromin-ethinyl estradiol	81	ofloxacin (otic)	101

olanzapine	39
olanzapine-fluoxetine hcl	18
olmesartan medoxomil	53
olmesartan medoxomil-amlodipine- hydrochlorothiazide	58
olmesartan medoxomil-hydrochlorothiazide	58
olopatadine hcl	98
olopatadine hcl (nasal)	102
omega-3-acid ethyl esters	61
omeprazole	74
ondansetron	21
ONDANSETRON HCL	21
ondansetron hcl	21
ONUREG	28
OPSUMIT	104
OPTICHAMBER ADVANTAGE-LG MASK	95
OPTICHAMBER ADVANTAGE-MED MASK	95
OPTICHAMBER ADVANTAGE-SM MASK	95
OPTICHAMBER DIAMOND	95
OPTICHAMBER DIAMOND-LG MASK	95
OPTICHAMBER DIAMOND-MD MASK	95
OPTICHAMBER DIAMOND-SM MASK	95
OPTICHAMBER FACE MASK-LARGE	95
OPTICHAMBER FACE MASK-MEDIUM	95
OPTICHAMBER FACE MASK-SMALL	96
OPTIHALER	96
OPVEE	96
ORGOVYX	84
ORSERDU	25,26
oseltamivir phosphate	45
OSPHENA	83
OTEZLA	67,86
oxandrolone	80
oxaprozin	1
oxazepam	47
oxcarbazepine	16
oxiconazole nitrate	22
oxybutynin chloride	76
oxycodone hcl	4
OXYCODONE HCL ER	2
oxycodone w/ acetaminophen	4

OXYCODONE-ACETAMINOPHEN	4
OXYCODONE-ASPIRIN	4
OXYCODONE-IBUPROFEN	4
oxymorphone hcl	4
OXYMORPHONE HCL ER	2
OZEMPIC (0.25 OR 0.5 MG/DOSE)	48
OZEMPIC (1 MG/DOSE)	48
OZEMPIC (2 MG/DOSE)	48

P

paliperidone	39
PANRETIN	34
pantoprazole sodium	75
paricalcitol	91
paromomycin sulfate	6
paroxetine hcl	19
paroxetine mesylate (vasomotor)	19
PASER	24
PAZEO	98
ped multivitamins w/fl & iron	71
PEDIARIX	89
pediatric multivitamins w/fl	72
pediatric vitamins acid w/ fluoride	72
PEDVAX HIB	89
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Room 509F, HHH Building
Washington, D.C. 20201
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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 1-800-776-4466. Someone who speaks English 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 1-800-776-4466. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

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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 1-800-776-4466. Ta usługa jest bezpłatna.

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Hmong Peb muaj cov kev pab cuam txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog ntawm peb li kev noj qab haus huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais tus kws pab cuam txhais lus, tsuas yog hu rau peb ntawm 1-800-776-4466. Muaj cov paub lus Hmoob tuaj yeem pab tau koj. Qhov no yog pab dawb.

Ukrainian Ми надаємо безкоштовні послуги перекладача, щоб відповісти на будь-які запитання щодо нашого плану лікування чи надання лікарських засобів. Щоб скористатися послугами перекладача, просто зателефонуйте нам за номером 1-800-776-4466. Вам може допомогти хтось, хто розмовляє Українською. Це безкоштовна послуга.

Navajo D77 ats'77s baa lhly3 47 doodago aze'e bee aa lhly3 b7na'7d7[kidgo 47 n1 ata' hodoolnih77 h0l=. Ata' halne'4 biniiy4go, koj8' 1-800-776-4466 b44sh bee hod77lnih. Diné k'ehj7 y1[ti'i n7k1 adoolwo]. D77 t'1l j77k'eh bee an1'1wo.

Punjabi ਪੰਜਾਬੀ ਸਾਡੀ ਸਿਹਤ ਨਾਂ ਡਰੱਗ ਪਲਾਨ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫਤ ਦੁਬਾਸੀਏ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਇੱਕ ਦੁਬਾਸੀਆ ਲੈਣ ਲਈ, ਸਾਨੂੰ 1-800-776-4466 'ਤੇ ਕਾਲ ਕਰੋ। ਪੰਜਾਬੀ ਬੋਲਣ ਵਾਲਾ ਕੋਈ ਵੀ ਵਿਅਕਤੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫਤ ਸੇਵਾ ਹੈ।

Khmer យើងមានសេវាអ្នកបកប្រែផ្តល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរនានា ដែលអ្នកអាចមានអំពីសុខភាព ឬគម្រោងឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តល់មាត់ម្នាក់ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-800-776-4466។ អ្នកណាម្នាក់ដែលនិយាយភាសាខ្មែរអាចជួយអ្នកបាន។ សេវានេះមិនគិតថ្លៃនោះទេ។

Mien Yie mbuo mbenc duqv maaih tengx wang-henh nzie faan waac mienh liouh dau waac bun muangx dongh nzunc baav meih maaih waac naaic taux yie mbuo gorngv taux yie nyei heng-wangc jauv-louc a'fai ndie-daan. Liouh lorx zipv longc faan waac nor, douc waac lorx taux yie mbuo yiem njiec naaiv 1-800-776-4466. Maaih mienh gorngv benx Mienh waac haih tengx nzie duqv meih. Naaiv se benx wang-henh nzie weih jauv-louc oc.

Lao ພວກເຮົາມີນາຍພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບຄໍາຖາມຕ່າງໆທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອໃຫ້ໄດ້ຮັບນາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-776-4466. ມີຜູ້ຮູ້ພາສາລາວ ສາມາດຊ່ວຍທ່ານ. ນີ້ແມ່ນບໍລິການໂດຍບໍ່ເສຍຄ່າ.

Armenian Մեզ քոն հասանելի են անվճար թարգմանչական ծառայություններ՝ մեր առողջապահական կազմակերպության հետ կապված Ձեր ցանկացած հարցին պատասխանելու համար: Թարգմանիչ ծառայությունը համար կապակցված է 1-800-776-4466 հեռախոսահամարով: Ձեր կողմից հարցերին իմացող թարգմանիչը: Ծառայությունն անվճար է:

Farsi ما خدمات مترجم شفاهی رایگان ارائه می‌دهیم تا به هر گونه سوالی که در مورد طرح سلامت یا داروی ما دارید پاسخ دهید. برای داشتن مترجم شفاهی، کافایت با ما به شماره 1-800-776-4466 تماس بگیرید. کسی که فارسی صحبت می‌کند می‌تواند به شما کمک کند. این یک خدمت رایگان است.

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This formulary was updated on **10/19/2023** . For more recent information or other questions, please contact Blue Shield of California Customer Service, at **(800) 776-4466** or, for TTY users, **711**, 8 a.m. to 8 p.m., seven days a week, or visit **blueshieldca.com/medformulary2024**.

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