Medicare Advantage

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H0504_20_984A_C 10262020

2024 Summary of Benefits

Blue Shield 65 Plus (HMO)

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

Effective January 1, 2024 – December 31, 2024

blueshieldca.com/medicare

H0504_23_780C_M 10262023

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 • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$0 copay for each visit to an outpatient hospital facility $0 copay for Medicare-covered observation services $50 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)	**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.

Premiums and Benefits	You Pay	What you should know
Outpatient surgery	$0 copay for each visit to an ambulatory surgical center $0 copay for each visit to an outpatient hospital facility	**A referral and prior authorization from your doctor may be required.**
Doctor visits • Primary care physician • Specialists	 $0 copay per visit $0 copay per visit	 **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	$50 copay per visit $10,000 combined annual limit for emergency care and urgently needed services outside the United States and its territories	This copay is waived if you are admitted to a hospital within one day for the same condition.
Urgently needed services Worldwide coverage	$10 copay for each visit to a network urgent care center within your plan service area $10 copay for each visit to an urgent care center outside of your plan service area but within the United States and its territories $10 copay for each visit to an emergency room outside of your plan service area but within the United States and its territories $0 copay for each visit to an emergency room or $0 for each visit to an urgent care center that is outside of the United States and its territories You have a $10,000 combined annual limit for covered emergency care and urgently needed services outside the United States and its territories	These copays are waived if you are admitted to a hospital within one day for the same condition.

Premiums and Benefits	You Pay	What you should know
Diagnostic services, labs, and imaging • 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)	$0 copay for each diagnostic radiology service $0 copay $0 copay $0 copay $0 copay	**A referral from your doctor may be required for diagnostic services, labs and imaging services**. Covered according to Medicare guidelines; prior authorization is required.
Hearing services • Hearing exam (Medicare-covered) • Routine (non-Medicare covered) hearing exam	$0 copay per visit $0 copay	**A referral from your doctor may be required for hearing services.**
Dental services • Non-routine dental care	$0 copay per visit if performed by your PCP $0 copay per visit if performed by a specialist	This does not include services in connection with care, treatment, filling, removal, or replacement of teeth.
Vision services • Exam to diagnose and treat diseases and conditions of the eye • Yearly glaucoma screening • Eyeglasses or contact lenses after cataract surgery	$0 copay for each Medicare-covered visit $0 copay $0 copay	**A referral from your doctor may be required for an exam and treat diseases and conditions of the eye**. A referral from your doctor may be required for yearly glaucoma screenings.

Premiums and Benefits	You Pay	What you should know
Mental health services • Inpatient mental health care • Outpatient group therapy visit • Outpatient individual therapy visit	For each Medicare-covered stay you pay: • $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. $0 copay per visit $0 copay per visit	**A referral and/or prior authorization from your doctor may be required for mental health services.** 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.
Skilled nursing facility (SNF) care	For each stay in a Medicare-certified skilled nursing facility, you pay: • $0 copay per day for days 1 to 20 • $75 copay per day for days 21 to 100	**A referral from your doctor may be required for skilled nursing facility care.** If you go over the 100-day limit, you will be responsible for all costs; no prior authorization required with network provider.
Rehabilitation services • Cardiac (heart) rehabilitation services • Occupational therapy services • Physical therapy and speech and language therapy services	 $0 copay per visit $0 copay per visit $0 copay per visit	**A referral from your doctor may be required for rehabilitation services.**
Ambulance services	$125 copay for each Medicare-covered one way trip	
Transportation services (non-Medicare covered)	Not covered	

Premiums and Benefits	You Pay	What you should know
Medicare Part B drugs	$0 copay when administered by your PCP or by a specialist.	Some Part B drugs may require a prior authorization from our provider. 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. Insulin obtained under Part B (when taken with an insulin pump) should not exceed a $35 copay for a one-month supply.

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) • 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 • 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 • Durable medical equipment (e.g., wheelchairs, oxygen)	20% coinsurance	Prior authorization from the plan may be required for DME. See the plan EOC for more information.
Prosthetics/Medical Supplies		**Prior authorization from your doctor may be**

Premiums and Benefits	You Pay	What you should know
• Prosthetics (e.g., braces, artificial limbs) • Medical supplies (e.g., splints, casts)	$0 copay $0 copay	**required for prosthetics/medical supplies.**
Health and Wellness programs • 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	 $0 copay $0 copay $0 copay	

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 supplyNDS**
Tier 1: Generic Drugs	$10 copay	$20 copay	$10 copay	$30 copay
Tier 2: Preferred Brand Drugs	$30 copay	$60 copay	$30 copay	$90 copay
Tier 3: Non-Preferred Drugs	$60 copay	$120 copay	$60 copay	$180 copay
Tier 3: Covered Insulins**	$35 copay	$105 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(Low Option)-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:	★★★½☆
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**.

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).

Blue Shield of California is an independent member of the Blue Shield Association.

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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)	$30 copay	$30 copay	Mail service is not available for drugs in Tier 2.	$30 copay	$30 copay
Cost-Sharing Tier 3 (Non-Preferred Drugs)	$60 copay	$60 copay	Mail service is not available for drugs in Tier 3.	$60 copay	$60 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)	$90 copay	$60 copay	$60 copay
Cost-Sharing Tier 3: Non-Preferred Drugs (up to a 90-day supply)	$180 copay	$120 copay	$120 copay
Cost-Sharing Tier 3: (Covered Insulins*)	$105 copay	$105 copay	$105 copay
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

	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 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

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

OPIOID ANALGESICS, LONG-ACTING

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
buprenorphine (patch 5 mcg/hr, patch 7.5 mcg/hr, patch 10 mcg/hr, patch 15 mcg/hr, patch 20 mcg/hr)	gen	PA, QL (4 PER 28 OVER TIME), NDS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	gen	PA, QL (10 PER 30 OVER TIME), NDS
hydromorphone hcl (tab er 24hr 16 mg, tab er 24hr 32 mg, tab er 24hr 8 mg)	gen	PA, QL (30 PER 30 OVER TIME), NDS
hydromorphone hcl tab er 24hr 12 mg	gen	PA, QL (60 PER 30 OVER TIME), NDS
methadone hcl (10 mg/5ml solution, soln 10 mg/5ml)	gen	PA, QL (450 PER 30 OVER TIME), NDS
methadone hcl (10 mg/ml solution, inj 10 mg/ml)	inj	PA, NDS
methadone hcl (5 mg/5ml solution, soln 5 mg/5ml)	gen	PA, QL (900 PER 30 OVER TIME), NDS
methadone hcl (conc 10 mg/ml, tab 10 mg)	gen	PA, QL (90 PER 30 OVER TIME), NDS
methadone hcl tab 5 mg	gen	PA, QL (180 PER 30 OVER TIME), NDS
methadone hcl tab for oral susp 40 mg	gen	QL (1 PER 1 DAYS), NDS
morphine sulfate (tab er 60 mg, tab er 100 mg, tab er 200 mg)	gen	QL (60 PER 30 OVER TIME), NDS
morphine sulfate tab er 15 mg	gen	QL (180 PER 30 OVER TIME), NDS
morphine sulfate tab er 30 mg	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
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)	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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
morphine sulfate (20 mg/5ml solution, oral soln 20 mg/5ml)	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
morphine sulfate oral soln 10 mg/5ml	gen	QL (630 PER 30 OVER TIME), NDS
morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	gen	QL (70 PER 30 OVER TIME), NDS
oxycodone hcl (cap 5 mg, tab 5 mg)	gen	QL (168 PER 30 OVER TIME), NDS
oxycodone hcl (conc 100 mg/5ml (20 mg/ml), tab 20 mg)	gen	QL (120 PER 30 OVER TIME), NDS
oxycodone hcl (tab 15 mg, tab 30 mg)	gen	QL (56 PER 30 OVER TIME), NDS
oxycodone hcl soln 5 mg/5ml	gen	QL (840 PER 30 OVER TIME), NDS
oxycodone hcl tab 10 mg	gen	QL (84 PER 30 OVER TIME), NDS
oxycodone w/ acetaminophen (w/ tab 2.5-325 mg, w/ tab 5-325 mg)	gen	QL (168 PER 30 OVER TIME), NDS
oxycodone w/ acetaminophen tab 10-325 mg	gen	QL (84 PER 30 OVER TIME), NDS
oxycodone w/ acetaminophen tab 7.5-325 mg	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
oxymorphone hcl tab 10 mg	gen	PA, QL (120 PER 30 OVER TIME), NDS
oxymorphone hcl tab 5 mg	gen	PA, QL (180 PER 30 OVER TIME), NDS
pentazocine w/ naloxone tab 50-0.5 mg	gen	QL (12 PER 1 DAYS), NDS
tramadol hcl tab 100 mg	gen	QL (4 PER 1 DAYS), NDS
tramadol hcl tab 50 mg	gen	QL (8 PER 1 DAYS), NDS
tramadol-acetaminophen tab 37.5-325 mg	gen	QL (112 PER 30 OVER TIME), NDS

ANESTHETICS

LOCAL ANESTHETICS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
LIDOCAINE HCL 4 % SOLUTION	brd	
lidocaine hcl soln 4%	gen	
lidocaine hcl viscous soln 2%	gen	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lidocaine oint 5%	gen	QL (50 PER 30 OVER TIME)
lidocaine patch 5%	gen	PA, QL (3 PER 1 DAYS)
lidocaine-prilocaine cream 2.5-2.5%	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
acamprosate calcium tab delayed release 333 mg	gen	
disulfiram (tab 250 mg, tab 500 mg)	gen	

OPIOID DEPENDENCE

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
buprenorphine hcl sl tab 2 mg (base equiv)	gen	QL (12 PER 1 DAYS)
buprenorphine hcl sl tab 8 mg (base equiv)	gen	QL (3 PER 1 DAYS)
buprenorphine hcl-naloxone hcl dihydrate (-naloxone sl film 2-0.5 mg equiv), -naloxone sl film 4-1 mg equiv))	gen	QL (5 PER 1 DAYS)
buprenorphine hcl-naloxone hcl dihydrate (-naloxone sl film 8-2 mg equiv), -naloxone sl tab 8-2 mg equiv))	gen	QL (3 PER 1 DAYS)
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	gen	QL (2 PER 1 DAYS)
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
SMOKING CESSATION AGENTS		
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	gen	QL (2 PER 1 DAYS)
NICOTROL 10 MG INHALER	brd	
NICOTROL NS 10 MG/ML SOLUTION	brd	
varenicline tartrate (tab 0.5 mg equiv), tab 1 mg equiv))	gen	QL (2 PER 1 DAYS)
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	gen	QL (53 PER 30 OVER TIME)
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin sulfate inj 500 mg/2ml (250 mg/ml)	inj	
gentamicin sulfate (topical) (cream, oint)	gen	
gentamicin sulfate inj 40 mg/ml	inj	
neomycin sulfate tab 500 mg	gen	
paromomycin sulfate cap 250 mg	gen	
STREPTOMYCIN SULFATE 1 GM RECON SOLN	inj	
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))	inj	
ANTIBACTERIALS, OTHER		
acetic acid otic soln 2%	gen	
aztreonam (inj 1 gm, inj 2 gm)	inj	
CHLORAMPHENICOL SOD SUCCINATE 1 GM RECON SOLN	inj	
CLEOCIN 100 MG SUPPOS	brd	
clindamycin hcl (cap 75 mg, cap 150 mg, cap 300 mg)	gen	
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	gen	
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)	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
clindamycin phosphate in d5w (soln 300 mg/50ml, soln 600 mg/50ml, soln 900 mg/50ml)	inj	
CLINDAMYCIN PHOSPHATE IN NACL (300-0.9 MG/50ML-% SOLUTION, 600-0.9 MG/50ML-% SOLUTION, 900-0.9 MG/50ML-% SOLUTION)	inj	
clindamycin phosphate swab 1%	gen	
clindamycin phosphate vaginal cream 2%	gen	
CLINDESSE 2 % CREAM	brd	
colistimethate sod for inj 150 mg (colistin base activity)	inj	
daptomycin (350 mg recon soln, for iv soln 350 mg, 500 mg recon soln, for iv soln 500 mg)	spec	
fosfomycin tromethamine powd pack 3 gm (base equivalent)	gen	QL (1 PER 30 OVER TIME)
lincomycin hcl inj 300 mg/ml	inj	
linezolid (for susp 100 mg/5ml, tab 600 mg)	gen	PA
LINEZOLID IN SODIUM CHLORIDE 600-0.9 MG/300ML-% SOLUTION	spec	
linezolid iv soln 600 mg/300ml (2 mg/ml)	inj	
methenamine hippurate tab 1 gm	gen	
metronidazole (5 mg/ml solution, 500 mg/100ml solution, iv soln 500 mg/100ml)	inj	
metronidazole (cap 375 mg, tab 250 mg, tab 500 mg)	gen	
metronidazole (topical) (cream 0.75%, gel 0.75%, gel 1%, lotion 0.75%)	gen	
metronidazole vaginal gel 0.75%	gen	
nitrofurantoin macrocrystal (cap 25 mg, cap 50 mg, cap 100 mg)	gen	
nitrofurantoin monohydrate macrocrystalline cap 100 mg	gen	
nitrofurantoin susp 25 mg/5ml	gen	
polymyxin b sulfate for inj 500000 unit	inj	
SYNERCID 150-350 MG RECON SOLN	spec	
tigecycline (50 mg recon soln, for iv soln 50 mg)	spec	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
tinidazole (tab 250 mg, tab 500 mg)	gen	
trimethoprim (100 mg tab, tab 100 mg)	gen	
vancomycin hcl (cap 125 mg equivalent), cap 250 mg equivalent))	gen	
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))	inj	
vancomycin hcl for oral soln 50 mg/ml (base equivalent)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CEFACLOR (125 MG/5ML RECON SUSP, 250 MG CAP, 250 MG/5ML RECON SUSP, 375 MG/5ML RECON SUSP, 500 MG CAP)	gen	
CEFACLOR ER 500 MG TAB ER 12H	gen	
cefadroxil (1 gm tab, cap 500 mg, for susp 250 mg/5ml, for susp 500 mg/5ml, tab 1 gm)	gen	
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)	inj	
cefdinir (cap 300 mg, for susp 125 mg/5ml, for susp 250 mg/5ml)	gen	
CEFDITOREN PIVOXIL (200 MG TAB, 400 MG TAB)	gen	
cefepime hcl (1 gm/50ml solution, for inj 1 gm, 2 gm/100ml solution, for inj 2 gm, for iv soln 2 gm)	inj	
cefixime (cap 400 mg, for susp 100 mg/5ml, for susp 200 mg/5ml)	gen	
cefotaxime sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, 500 mg recon soln)	inj	
cefotetan disodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm)	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
cefoxitin sodium (soln 1 gm, soln 2 gm, soln 10 gm)	inj	
cefpodoxime proxetil (for susp 50 mg/5ml, for susp 100 mg/5ml, tab 100 mg, tab 200 mg)	gen	
cefprozil (for susp 125 mg/5ml, for susp 250 mg/5ml, tab 250 mg, tab 500 mg)	gen	
ceftazidime (inj 1 gm, inj 6 gm, iv soln 2 gm)	inj	
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)	inj	
cefuroxime axetil (tab 250 mg, tab 500 mg)	gen	
cefuroxime sodium (inj 7.5 gm, inj 750 mg, iv soln 1.5 gm)	inj	
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)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	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	
ampicillin & sulbactam sodium (inj 1.5 (1-0.5) gm, inj 3 (2-1) gm, iv soln 15 (10-5) gm)	inj	
AMPICILLIN 500 MG CAP	gen	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	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	
dicloxacillin sodium (cap 250 mg, cap 500 mg)	gen	
nafcillin sodium (1 gm recon soln, for inj 1 gm, 2 gm recon soln, for inj 2 gm)	inj	
nafcillin sodium for iv soln 10 gm	spec	
penicillin g potassium (inj 5000000, inj 20000000)	inj	
PENICILLIN G SODIUM 5000000 UNIT RECON SOLN	inj	
penicillin v potassium (125 mg/5ml recon soln, 250 mg/5ml recon soln, tab 250 mg, tab 500 mg)	gen	
PFIZERPEN (5000000 RECON SOLN, 20000000 RECON SOLN)	inj	
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))	inj	

CARBAPENEMS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ertapenem sodium for inj 1 gm (base equivalent)	inj	
imipenem-cilastatin (250 mg recon soln, intravenous for soln 250 mg, intravenous for soln 500 mg)	inj	
meropenem (soln 1 gm, soln 500 mg)	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		
azithromycin (1 gm packet, for susp 100 mg/5ml, for susp 200 mg/5ml, tab 250 mg, tab 500 mg, tab 600 mg)	gen	
azithromycin iv for soln 500 mg	inj	
clarithromycin (tab 250 mg, tab 500 mg, tab er 24hr 500 mg, 125 mg/5ml recon susp, 250 mg/5ml recon susp)	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	
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)	gen	
erythromycin ethylsuccinate (for susp 200 mg/5ml, 400 mg tab, for susp 400 mg/5ml)	gen	
erythromycin lactobionate for inj 500 mg	inj	
QUINOLONES		
BESIVANCE 0.6 % SUSPENSION	brd	
CILOXAN 0.3 % OINTMENT	brd	
ciprofloxacin (susp 250 mg/5ml (5%) (5 gm/100ml), susp 500 mg/5ml (10%) (10 gm/100ml))	gen	
ciprofloxacin 200 mg/100ml in d5w	inj	
ciprofloxacin hcl (100 mg tab, tab 250 mg (base equiv), tab 500 mg (base equiv), tab 750 mg (base equiv))	gen	
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	gen	
CIPROFLOXACIN-CIPROFLOX HCL ER (ER 500 MG TAB ER 24H, ER 1000 MG TAB ER 24H)	gen	
levofloxacin (25 mg/ml solution, iv soln 25 mg/ml)	inj	

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

SULFONAMIDES

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

TETRACYCLINES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
demeclocycline hcl (tab 150 mg, tab 300 mg)	gen	
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)	gen	
DOXYCYCLINE 40 MG CAP DR	gen	PA, QL (1 PER 1 DAYS)
doxycycline hyclate (cap 50 mg, cap 100 mg, tab 20 mg, tab 100 mg)	gen	
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)	gen	PA
doxycycline hyclate for inj 100 mg	npd	
minocycline hcl (cap 50 mg, cap 75 mg, cap 100 mg, tab 50 mg, tab 75 mg, tab 100 mg)	gen	
tetracycline hcl (cap 250 mg, cap 500 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

ANTICONVULSANTS

ANTICONVULSANTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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
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)	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
felbamate (susp 600 mg/5ml, tab 400 mg, tab 600 mg)	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
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)	gen	
lamotrigine (tab er 24hr 100 mg, tab er 24hr 200 mg)	gen	ST, QL (3 PER 1 DAYS)
lamotrigine (tab er 24hr 25 mg, tab er 24hr 50 mg)	gen	ST, QL (1 PER 1 DAYS)
lamotrigine (tab er 24hr 250 mg, tab er 24hr 300 mg)	gen	ST
levetiracetam (oral soln 100 mg/ml, tab 250 mg, tab 500 mg, tab 750 mg, tab 1000 mg)	gen	
levetiracetam tab er 24hr 500 mg	gen	QL (6 PER 1 DAYS)
levetiracetam tab er 24hr 750 mg	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
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)	gen	PA - FOR NEW STARTS ONLY
topiramate (sprinkle cap 15 mg, sprinkle cap 25 mg, tab 25 mg, tab 50 mg, tab 100 mg, tab 200 mg)	gen	
valproate sodium inj 100 mg/ml	inj	
valproate sodium oral soln 250 mg/5ml (base equiv)	gen	
valproic acid cap 250 mg	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ethosuximide (cap 250 mg, soln 250 mg/5ml)	gen	
methsuximide cap 300 mg	gen	

GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
clobazam suspension 2.5 mg/ml	gen	QL (16 PER 1 DAYS), PA - FOR NEW STARTS ONLY
clobazam tab 10 mg	gen	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
clobazam tab 20 mg	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)
gabapentin (tab 600 mg, tab 800 mg)	gen	QL (4 PER 1 DAYS)
gabapentin cap 100 mg	gen	QL (12 PER 1 DAYS)
gabapentin cap 300 mg	gen	QL (8 PER 1 DAYS)
gabapentin cap 400 mg	gen	QL (6 PER 1 DAYS)
gabapentin oral soln 250 mg/5ml	gen	QL (72 PER 1 DAYS)
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)	gen	PA - FOR NEW STARTS ONLY
primidone (tab 50 mg, 125 mg tab, tab 250 mg)	gen	
SYMPAZAN (5 MG FILM, 10 MG FILM, 20 MG FILM)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
tiagabine hcl (tab 2 mg, tab 4 mg, tab 12 mg, tab 16 mg)	gen	

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)
vigabatrin (powd pack 500 mg, tab 500 mg)	spec	LA, QL (6 PER 1 DAYS), PA - FOR NEW STARTS ONLY

SODIUM CHANNEL AGENTS

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

ANTIDEMENTIA AGENTS

ANTIDEMENTIA AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	gen	

ANTIDEPRESSANTS

ANTIDEPRESSANTS, OTHER

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bupropion hcl (tab er 12hr 150 mg, tab er 24hr 150 mg)	gen	QL (3 PER 1 DAYS)
bupropion hcl tab 75 mg	gen	QL (6 PER 1 DAYS)
bupropion hcl tab er 12hr 200 mg	gen	QL (2 PER 1 DAYS)
bupropion hcl tab er 24hr 300 mg	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	
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)	gen	
olanzapine-fluoxetine hcl (cap 3-25 mg, cap 6-25 mg, cap 6-50 mg, cap 12-25 mg, cap 12-50 mg)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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	
phenelzine sulfate (15 mg tab, tab 15 mg)	gen	
tranylcypromine sulfate tab 10 mg	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
citalopram hydrobromide (oral soln 10 mg/5ml, tab 10 mg (base equiv), tab 20 mg (base equiv), tab 40 mg (base equiv))	gen	
desvenlafaxine succinate (tab er 24hr 25 mg equiv), tab er 24hr 50 mg equiv))	gen	QL (1 PER 1 DAYS)
desvenlafaxine succinate tab er 24hr 100 mg (base equiv)	gen	QL (4 PER 1 DAYS)
escitalopram oxalate (soln 5 mg/5ml equiv), tab 5 mg equiv), tab 10 mg equiv), tab 20 mg equiv))	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
fluoxetine hcl (cap 10 mg, cap 20 mg, cap 40 mg, solution 20 mg/5ml, tab 10 mg, tab 20 mg)	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)
fluvoxamine maleate (cap er 24hr 100 mg, cap er 24hr 150 mg)	gen	ST, QL (2 PER 1 DAYS)
fluvoxamine maleate tab 100 mg	gen	QL (3 PER 1 DAYS)
fluvoxamine maleate tab 25 mg	gen	QL (12 PER 1 DAYS)
fluvoxamine maleate tab 50 mg	gen	QL (6 PER 1 DAYS)
NEFAZODONE HCL (50 MG TAB, 100 MG TAB, 150 MG TAB, 200 MG TAB, 250 MG TAB)	gen	
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)	gen	
paroxetine hcl oral susp 10 mg/5ml (base equiv)	gen	QL (30 PER 1 DAYS)
paroxetine mesylate cap 7.5 mg (base equiv)	gen	QL (1 PER 1 DAYS)
sertraline hcl (oral concentrate for solution 20 mg/ml, tab 25 mg, tab 50 mg, tab 100 mg)	gen	
trazodone hcl (tab 50 mg, tab 100 mg, tab 150 mg, tab 300 mg)	gen	
TRINTELLIX (5 MG TAB, 10 MG TAB, 20 MG TAB)	npd	ST, QL (1 PER 1 DAYS)
venlafaxine hcl (cap er 24hr 150 mg equivalent), cap er 24hr 37.5 mg equivalent))	gen	QL (2 PER 1 DAYS)
venlafaxine hcl (cap er 24hr 75 mg equivalent), tab er 24hr 75 mg equivalent))	gen	QL (3 PER 1 DAYS)
venlafaxine hcl (tab 25 mg equivalent), tab 37.5 mg equivalent), tab 50 mg equivalent), tab 75 mg equivalent), tab 100 mg equivalent))	gen	
venlafaxine hcl tab er 24hr 150 mg (base equivalent)	gen	QL (1 PER 1 DAYS)
venlafaxine hcl tab er 24hr 37.5 mg (base equivalent)	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
vilazodone hcl (tab 10 mg, tab 20 mg, tab 40 mg)	gen	ST, QL (1 PER 1 DAYS)

TRICYCLICS

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

ANTIEMETICS

ANTIEMETICS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxylamine-pyridoxine tab delayed release 10-10 mg	gen	QL (4 PER 1 DAYS)
meclizine hcl (tab 12.5 mg, tab 25 mg)	gen	
metoclopramide hcl (soln 5 mg/5ml (10 mg/10ml) equiv), tab 5 mg equivalent), tab 10 mg equivalent))	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)
metoclopramide hcl inj 5 mg/ml (base equivalent)	inj	
perphenazine (tab 2 mg, tab 4 mg, tab 8 mg, tab 16 mg)	gen	
prochlorperazine maleate (tab 5 mg equivalent), tab 10 mg equivalent))	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
prochlorperazine suppos 25 mg	gen	
promethazine hcl (suppos 25 mg, tab 12.5 mg, tab 25 mg, tab 50 mg)	gen	PA
promethazine hcl suppos 12.5 mg	gen	PA, ED
scopolamine td patch 72hr 1 mg/3days	gen	
trimethobenzamide hcl cap 300 mg	gen	

EMETOGENIC THERAPY ADJUNCTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
aprepitant (capsule 80 mg, capsule 125 mg, capsule therapy pack 80 & 125 mg)	gen	PA - PART B VS D DETERMINATION
aprepitant capsule 40 mg	gen	PA, QL (1 PER 30 OVER TIME)
dronabinol (cap 2.5 mg, cap 5 mg, cap 10 mg)	gen	PA, QL (6 PER 1 DAYS)
granisetron hcl (inj 1 mg/ml, inj 4 mg/4ml (1 mg/ml))	inj	PA - PART B VS D DETERMINATION
granisetron hcl tab 1 mg	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
ondansetron hcl oral soln 4 mg/5ml	gen	QL (30 PER 1 DAYS), PA - PART B VS D DETERMINATION
ondansetron hcl tab 4 mg	gen	QL (6 PER 1 DAYS), PA - PART B VS D DETERMINATION
ondansetron hcl tab 8 mg	gen	QL (3 PER 1 DAYS), PA - PART B VS D DETERMINATION
ondansetron orally disintegrating tab 4 mg	gen	QL (6 PER 1 DAYS), PA - PART B VS D DETERMINATION
ondansetron orally disintegrating tab 8 mg	gen	QL (3 PER 1 DAYS), PA - PART B VS D DETERMINATION

ANTIFUNGALS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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
amphotericin b liposome iv for susp 50 mg	spec	PA - PART B VS D DETERMINATION
caspofungin acetate (50 mg recon soln, for iv soln 50 mg)	spec	PA
caspofungin acetate (70 mg recon soln, for iv soln 70 mg)	inj	PA
ciclopirox olamine (cream equiv), susp equiv))	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
clotrimazole (topical) (cream, soln)	gen	
clotrimazole troche 10 mg	gen	
CRESEMBA (74.5 MG CAP, 186 MG CAP, 372 MG RECON SOLN)	spec	PA
econazole nitrate cream 1%	gen	
fluconazole (for susp 10 mg/ml, for susp 40 mg/ml, tab 50 mg, tab 100 mg, tab 150 mg, tab 200 mg)	gen	
fluconazole in nacl (inj 200 mg/100ml, inj 400 mg/200ml)	inj	
flucytosine (cap 250 mg, cap 500 mg)	gen	
griseofulvin microsize (susp 125 mg/5ml, tab 500 mg)	gen	
griseofulvin ultramicrosize (tab 125 mg, tab 250 mg)	gen	
GYNAZOLE-1 2 % CREAM	gen	
itraconazole cap 100 mg	gen	
itraconazole oral soln 10 mg/ml	gen	PA
ketoconazole (topical) (cream, shampoo)	gen	
ketoconazole foam 2%	gen	ST
ketoconazole tab 200 mg	gen	
LULICONAZOLE 1 % CREAM	gen	ST
micafungin sodium (50 mg recon soln, for iv soln 50 mg, 100 mg recon soln, for iv soln 100 mg)	spec	
MICONAZOLE 3 200 MG SUPPOS	gen	
MICONAZOLE-ZINC OXIDE-PETROLAT 0.25-15-81.35 % OINTMENT	gen	ST
naftifine hcl (1 % cream, cream 1%, cream 2%, gel 1%)	gen	ST
nystatin (topical) (cream 100000 unit/gm, oint 100000 unit/gm, topical powder 100000 unit/gm)	gen	
nystatin susp 100000 unit/ml	gen	
nystatin tab 500000 unit	gen	
oxiconazole nitrate cream 1%	gen	ST
posaconazole susp 40 mg/ml	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
posaconazole tab delayed release 100 mg	gen	PA, QL (3 PER 1 DAYS)
terbinafine hcl tab 250 mg	gen	QL (1 PER 1 DAYS)
terconazole vaginal (cream 0.4%, cream 0.8%, suppos 80 mg)	gen	
voriconazole (200 mg recon soln, for inj 200 mg)	inj	PA - PART B VS D DETERMINATION
voriconazole (for susp 40 mg/ml, tab 50 mg, tab 200 mg)	gen	PA

ANTIGOUT AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
allopurinol (tab 100 mg, tab 300 mg)	gen	
colchicine (0.6 mg cap, tab 0.6 mg)	gen	QL (4 PER 1 DAYS)
colchicine w/ probenecid tab 0.5-500 mg	gen	
febuxostat (tab 40 mg, tab 80 mg)	gen	ST, QL (1 PER 1 DAYS)
probenecid tab 500 mg	gen	

ANTIMIGRAINE AGENTS

ANTIMIGRAINE AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

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

PROPHYLACTIC

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AIMOVIG (70 MG/ML SOLN A-INJ, 140 MG/ML SOLN A-INJ)	brd	PA, QL (1 PER 28 OVER TIME)
timolol maleate (tab 5 mg, tab 10 mg, tab 20 mg)	gen	

SEROTONIN (5-HT) RECEPTOR AGONIST

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
naratriptan hcl (tab 1 mg equiv), tab 2.5 mg equiv))	gen	QL (18 PER 30 OVER TIME)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
rizatriptan benzoate (oral disintegrating tab 5 mg eq), oral disintegrating tab 10 mg eq), tab 5 mg equivalent), tab 10 mg equivalent))	gen	QL (24 PER 30 OVER TIME)
sumatriptan (5 mg/act, 20 mg/act)	gen	QL (18 PER 30 OVER TIME)
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)	gen	QL (8 PER 30 OVER TIME)
sumatriptan succinate (tab 25 mg, tab 50 mg, tab 100 mg)	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)
zolmitriptan (orally disintegrating tab 2.5 mg, orally disintegrating tab 5 mg, tab 2.5 mg, tab 5 mg)	gen	QL (18 PER 30 OVER TIME)

ANTIMYASTHENIC AGENTS

PARASYMPATHOMIMETICS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
GUANIDINE HCL 125 MG TAB	gen	
pyridostigmine bromide (30 mg tab, oral soln 60 mg/5ml, tab 60 mg, tab er 180 mg)	gen	

ANTIMYCOBACTERIALS

ANTIMYCOBACTERIALS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
dapsone (tab 25 mg, tab 100 mg)	gen	
rifabutin cap 150 mg	gen	

ANTITUBERCULARS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CAPASTAT SULFATE 1 GM RECON SOLN	inj	
ethambutol hcl (tab 100 mg, tab 400 mg)	gen	
isoniazid (syrup 50 mg/5ml, 100 mg tab, tab 100 mg, tab 300 mg)	gen	
ISONIAZID 100 MG/ML SOLUTION	inj	
PASER 4 GM PACKET	npd	
PRIFTIN 150 MG TAB	brd	
pyrazinamide tab 500 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
rifampin (cap 150 mg, cap 300 mg)	gen	
rifampin for inj 600 mg	inj	
RIFATER 50-120-300 MG TAB	npd	
SIRTURO (20 MG TAB, 100 MG TAB)	spec	PA
TRECATOR 250 MG TAB	npd	

ANTINEOPLASTICS

ALKYLATING AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ALKERAN 2 MG TAB	gen	PA - PART B VS D DETERMINATION
cyclophosphamide (25 mg cap, 25 mg tab, cap 25 mg, 50 mg cap, 50 mg tab, cap 50 mg)	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
thiotepa (inj 15 mg, inj 100 mg)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
abiraterone acetate tab 250 mg	spec	QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
abiraterone acetate tab 500 mg	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
bicalutamide tab 50 mg	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
flutamide (125 mg cap, cap 125 mg)	gen	
nilutamide tab 150 mg	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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
lenalidomide (cap 5 mg, cap 10 mg, cap 15 mg, cap 20 mg, cap 25 mg, caps 2.5 mg)	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

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

ANTIMETABOLITES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
DROXIA (200 MG CAP, 300 MG CAP, 400 MG CAP)	brd	
hydroxyurea cap 500 mg	gen	
INQOVI 35-100 MG TAB	spec	LA, QL (5 PER 28 OVER TIME), PA - FOR NEW STARTS ONLY
mercaptopurine tab 50 mg	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
leucovorin calcium (inj 100 mg, inj 350 mg)	inj	
leucovorin calcium (tab 5 mg, tab 10 mg, tab 15 mg, tab 25 mg)	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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
anastrozole tab 1 mg	gen	
exemestane tab 25 mg	gen	
letrozole tab 2.5 mg	gen	

MOLECULAR TARGET INHIBITORS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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
erlotinib hcl (tab 100 mg equivalent), tab 150 mg equivalent))	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
erlotinib hcl tab 25 mg (base equivalent)	spec	QL (3 PER 1 DAYS), PA - FOR NEW STARTS ONLY
everolimus (tab 2.5 mg, tab 5 mg)	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
everolimus (tab 7.5 mg, tab 10 mg)	spec	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY
everolimus (tab susp 2 mg, tab susp 3 mg, tab susp 5 mg)	spec	PA - FOR NEW STARTS ONLY
GAVRETO 100 MG CAP	spec	LA, QL (4 PER 1 DAYS), PA - FOR NEW STARTS ONLY
gefitinib tab 250 mg	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
imatinib mesylate tab 100 mg (base equivalent)	spec	QL (8 PER 1 DAYS), PA - FOR NEW STARTS ONLY

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
imatinib mesylate tab 400 mg (base equivalent)	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
lapatinib ditosylate tab 250 mg (base equiv)	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

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
sorafenib tosylate tab 200 mg (base equivalent)	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
sunitinib malate (cap 37.5 mg equivalent), cap 50 mg equivalent))	spec	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
sunitinib malate cap 12.5 mg (base equivalent)	spec	QL (7 PER 1 DAYS), PA - FOR NEW STARTS ONLY
sunitinib malate cap 25 mg (base equivalent)	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
TAGRISSO (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

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

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

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

ANTIPARASITICS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANTHELMINTHICS		
albendazole tab 200 mg	npd	
ivermectin tab 3 mg	gen	QL (16 PER 365 OVER TIME)
praziquantel tab 600 mg	gen	
ANTIPROTOZOALS		
ALINIA 100 MG/5ML RECON SUSP	npd	PA, QL (180 PER 3 OVER TIME)
atovaquone susp 750 mg/5ml	gen	PA
atovaquone-proguanil hcl (tab 62.5-25 mg, tab 250-100 mg)	gen	
BENZNIDAZOLE 100 MG TAB	npd	QL (240 PER 365 OVER TIME)
BENZNIDAZOLE 12.5 MG TAB	npd	QL (720 PER 365 OVER TIME)
chloroquine phosphate tab 250 mg	gen	QL (50 PER 30 OVER TIME)
chloroquine phosphate tab 500 mg	gen	QL (25 PER 30 OVER TIME)
COARTEM 20-120 MG TAB	brd	QL (24 PER 2 OVER TIME)
hydroxychloroquine sulfate tab 100 mg	gen	QL (4 PER 1 DAYS)
hydroxychloroquine sulfate tab 200 mg	gen	QL (3 PER 1 DAYS)
hydroxychloroquine sulfate tab 300 mg	gen	QL (2 PER 1 DAYS)
hydroxychloroquine sulfate tab 400 mg	gen	QL (1 PER 1 DAYS)
mefloquine hcl tab 250 mg	gen	
nitazoxanide tab 500 mg	gen	PA, QL (6 PER 3 OVER TIME)
pentamidine isethionate (inj soln 300 mg, soln 300 mg)	gen	
pentamidine isethionate for nebulization soln 300 mg	npd	PA - PART B VS D DETERMINATION
primaquine phosphate (26.3 base) mg tab, tab 26.3 mg mg base))	gen	

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

ANTIPARKINSON AGENTS

ANTICHOLINERGICS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
benztropine mesylate (tab 0.5 mg, tab 1 mg, tab 2 mg)	gen	
benztropine mesylate inj 1 mg/ml	inj	
trihexyphenidyl hcl (0.4 mg/ml solution, oral soln 0.4 mg/ml, tab 2 mg, tab 5 mg)	gen	

ANTIPARKINSON AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amantadine hcl (cap 100 mg, soln 50 mg/5ml, tab 100 mg)	gen	
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)	gen	
entacapone tab 200 mg	gen	QL (8 PER 1 DAYS)

DOPAMINE AGONISTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
apomorphine hcl soln cartridge 30 mg/3ml	spec	PA
bromocriptine mesylate (cap 5 mg equivalent), tab 2.5 mg equivalent))	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)
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)	gen	
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)	gen	QL (1 PER 1 DAYS)
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)	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
ropinirole hydrochloride (tab er 24hr 2 mg equivalent), tab er 24hr 4 mg equivalent), tab er 24hr 6 mg equivalent))	gen	QL (1 PER 1 DAYS)
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)	gen	QL (2 PER 1 DAYS)
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)	gen	QL (3 PER 1 DAYS)

DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
carbidopa tab 25 mg	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
rasagiline mesylate (tab 0.5 mg equiv), tab 1 mg equiv))	gen	QL (1 PER 1 DAYS)
selegiline hcl (cap 5 mg, tab 5 mg)	gen	

ANTIPSYCHOTICS

1ST GENERATION/TYPICAL

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
chlorpromazine hcl (inj 25 mg/ml, inj 50 mg/2ml)	inj	
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)	gen	
fluphenazine decanoate inj 25 mg/ml	inj	
fluphenazine hcl (tab 1 mg, 2.5 mg/5ml elixir, tab 2.5 mg, 5 mg/ml conc, tab 5 mg, tab 10 mg)	gen	
FLUPHENAZINE HCL 2.5 MG/ML SOLUTION	inj	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
haloperidol (tab 0.5 mg, tab 1 mg, tab 2 mg, tab 5 mg, tab 10 mg, tab 20 mg)	gen	
haloperidol decanoate (soln 50 mg/ml, soln 100 mg/ml)	inj	
haloperidol lactate inj 5 mg/ml	inj	
haloperidol lactate oral conc 2 mg/ml	gen	
loxapine succinate (cap 5 mg, cap 10 mg, cap 25 mg, cap 50 mg)	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	
thioridazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)	gen	PA - FOR NEW STARTS ONLY
thiothixene (cap 1 mg, cap 2 mg, cap 5 mg, cap 10 mg)	gen	
trifluoperazine hcl (tab 1 mg equivalent), tab 2 mg equivalent), tab 5 mg equivalent), tab 10 mg equivalent))	gen	

2ND GENERATION/ATYPICAL

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ABILIFY ASIMTUFII (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
aripiprazole (orally disintegrating tab 10 mg, orally disintegrating tab 15 mg, tab 5 mg)	gen	QL (2 PER 1 DAYS)
aripiprazole (tab 10 mg, tab 15 mg, tab 20 mg, tab 30 mg)	gen	QL (1 PER 1 DAYS)
aripiprazole oral solution 1 mg/ml	gen	QL (25 PER 1 DAYS)
aripiprazole tab 2 mg	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
asenapine maleate (sl tab 2.5 mg equiv), sl tab 5 mg equiv), sl tab 10 mg equiv))	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
lurasidone hcl (tab 20 mg, tab 40 mg, tab 60 mg)	gen	QL (1 PER 1 DAYS)
lurasidone hcl (tab 80 mg, tab 120 mg)	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
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)	gen	
olanzapine for im inj 10 mg	inj	
paliperidone (tab er 24hr 1.5 mg, tab er 24hr 3 mg, tab er 24hr 9 mg)	gen	QL (1 PER 1 DAYS), PA - FOR NEW STARTS ONLY
paliperidone tab er 24hr 6 mg	gen	QL (2 PER 1 DAYS), PA - FOR NEW STARTS ONLY

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
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)	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
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)	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
ziprasidone hcl (cap 20 mg, cap 40 mg, cap 60 mg, cap 80 mg)	gen	
ziprasidone mesylate for inj 20 mg (base equivalent)	inj	
ZYPREXA RELPREVV (210 MG RECON SUSP, 300 MG RECON SUSP, 405 MG RECON SUSP)	inj	PA - PART B VS D DETERMINATION

TREATMENT-RESISTANT

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	gen	
VERSACLOZ 50 MG/ML SUSPENSION	spec	QL (18 PER 1 DAYS), PA - FOR NEW STARTS ONLY

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS

ANTISPASTICITY AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
baclofen tab 10 mg	gen	QL (8 PER 1 DAYS)
baclofen tab 20 mg	gen	QL (4 PER 1 DAYS)
baclofen tab 5 mg	gen	QL (16 PER 1 DAYS)
dantrolene sodium (cap 25 mg, cap 50 mg, cap 100 mg)	gen	
tizanidine hcl (cap 2 mg equivalent), cap 4 mg equivalent), cap 6 mg equivalent), tab 2 mg equivalent), tab 4 mg equivalent))	gen	

ANTIVIRALS

ANTI-CYTOMEGALOVIRUS (CMV) AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
PREVYMIS 240 MG TAB	spec	QL (200 PER 365 OVER TIME)
PREVYMIS 480 MG TAB	spec	QL (100 PER 365 OVER TIME)
valganciclovir hcl for soln 50 mg/ml (base equiv)	gen	QL (18 PER 1 DAYS)
valganciclovir hcl tab 450 mg (base equivalent)	gen	QL (2 PER 1 DAYS)
ZIRGAN 0.15 % GEL	npd	QL (5 PER 30 OVER TIME)

ANTI-HEPATITIS B (HBV) AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
adefovir dipivoxil tab 10 mg	gen	QL (1 PER 1 DAYS)
BARACLUDE 0.05 MG/ML SOLUTION	brd	QL (21 PER 1 DAYS)
entecavir (tab 0.5 mg, tab 1 mg)	gen	QL (1 PER 1 DAYS)
EPIVIR HBV 5 MG/ML SOLUTION	brd	
lamivudine tab 100 mg (hbv)	gen	

ANTI-HEPATITIS C (HCV) AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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	
ribavirin (hepatitis c) (cap 200 mg, tab 200 mg)	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)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
efavirenz tab 600 mg	gen	QL (1 PER 1 DAYS)
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	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
efavirenz-lamivudine-tenofovir disoproxil fumarate (tab 400-300-300 mg, tab 600-300-300 mg)	gen	QL (1 PER 1 DAYS)
etravirine tab 100 mg	gen	QL (4 PER 1 DAYS)
etravirine tab 200 mg	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)
nevirapine tab 200 mg	gen	QL (2 PER 1 DAYS)
nevirapine tab er 24hr 100 mg	gen	QL (3 PER 1 DAYS)
nevirapine tab er 24hr 400 mg	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)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
abacavir sulfate soln 20 mg/ml (base equiv)	gen	QL (30 PER 1 DAYS)
abacavir sulfate tab 300 mg (base equiv)	gen	QL (2 PER 1 DAYS)
abacavir sulfate-lamivudine tab 600-300 mg	gen	QL (1 PER 1 DAYS)
abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg	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)
emtricitabine caps 200 mg	gen	QL (1 PER 1 DAYS)
emtricitabine-tenofovir disoproxil fumarate (tab 100-150 mg, tab 133-200 mg, tab 167-250 mg, tab 200-300 mg)	gen	QL (1 PER 1 DAYS)
EMTRIVA 10 MG/ML SOLUTION	brd	QL (24 PER 1 DAYS)
lamivudine oral soln 10 mg/ml	gen	QL (30 PER 1 DAYS)
lamivudine tab 150 mg	gen	QL (2 PER 1 DAYS)
lamivudine tab 300 mg	gen	QL (1 PER 1 DAYS)
lamivudine-zidovudine tab 150-300 mg	gen	QL (2 PER 1 DAYS)
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)	gen	QL (2 PER 1 DAYS)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
TEMIXYS 300-300 MG TAB	brd	QL (1 PER 1 DAYS)
tenofovir disoproxil fumarate tab 300 mg	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)
zidovudine cap 100 mg	gen	QL (6 PER 1 DAYS)
zidovudine syrup 10 mg/ml	gen	QL (60 PER 1 DAYS)
zidovudine tab 300 mg	gen	QL (2 PER 1 DAYS)

ANTI-HIV AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
maraviroc tab 150 mg	gen	QL (2 PER 1 DAYS)
maraviroc tab 300 mg	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)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
APTIVUS 100 MG/ML SOLUTION	brd	QL (10 PER 1 DAYS)
APTIVUS 250 MG CAP	brd	QL (4 PER 1 DAYS)
atazanavir sulfate (cap 150 mg equiv), cap 200 mg equiv))	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
atazanavir sulfate cap 300 mg (base equiv)	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)
darunavir tab 600 mg	gen	QL (2 PER 1 DAYS)
darunavir tab 800 mg	gen	QL (1 PER 1 DAYS)
EVOTAZ 300-150 MG TAB	npd	QL (1 PER 1 DAYS)
fosamprenavir calcium tab 700 mg (base equiv)	gen	QL (4 PER 1 DAYS)
LEXIVA 50 MG/ML SUSPENSION	brd	QL (56 PER 1 DAYS)
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	gen	QL (13 PER 1 DAYS)
lopinavir-ritonavir tab 100-25 mg	gen	QL (10 PER 1 DAYS)
lopinavir-ritonavir tab 200-50 mg	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)
ritonavir tab 100 mg	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
oseltamivir phosphate cap 30 mg (base equiv)	gen	QL (120 PER 180 OVER TIME)
oseltamivir phosphate cap 45 mg (base equiv)	gen	QL (42 PER 180 OVER TIME)
oseltamivir phosphate cap 75 mg (base equiv)	gen	QL (60 PER 180 OVER TIME)
oseltamivir phosphate for susp 6 mg/ml (base equiv)	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	

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

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

ANXIOLYTICS

ANXIOLYTICS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
buspirone hcl (tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg, tab 30 mg)	gen	
meprobamate (tab 200 mg, tab 400 mg)	gen	

BENZODIAZEPINES

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

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

BIPOLAR AGENTS

MOOD STABILIZERS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
EQUETRO (100 MG CAP ER 12H, 200 MG CAP ER 12H, 300 MG CAP ER 12H)	brd	
LITHIUM 8 MEQ/5ML SOLUTION	gen	
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)	gen	

BLOOD GLUCOSE REGULATORS

ANTIDIABETIC AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
acarbose (tab 25 mg, tab 50 mg, tab 100 mg)	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)
glimepiride (tab 1 mg, tab 2 mg, tab 4 mg)	gen	
glipizide (tab 5 mg, tab 10 mg, tab er 24hr 10 mg, tab er 24hr 2.5 mg, tab er 24hr 5 mg)	gen	
glipizide-metformin hcl (tab 2.5-250 mg, tab 2.5-500 mg, tab 5-500 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
glyburide (tab 1.25 mg, tab 2.5 mg, tab 5 mg)	gen	
glyburide micronized (tab 1.5 mg, tab 3 mg, tab 6 mg)	gen	
glyburide-metformin (tab 1.25-250 mg, tab 2.5-500 mg, tab 5-500 mg)	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)
metformin hcl (tab 500 mg, tab 850 mg, tab 1000 mg, tab er 24hr 500 mg, tab er 24hr 750 mg)	gen	
miglitol (25 mg tab, tab 25 mg, 50 mg tab, tab 50 mg, 100 mg tab, tab 100 mg)	gen	QL (3 PER 1 DAYS)
nateglinide (tab 60 mg, tab 120 mg)	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)
pioglitazone hcl (tab 15 mg equiv), tab 30 mg equiv), tab 45 mg equiv))	gen	
pioglitazone hcl-glimepiride (tab 30-2 mg, tab 30-4 mg)	gen	QL (1 PER 1 DAYS)
pioglitazone hcl-metformin hcl (-metformin tab 15-500 mg, -metformin tab 15-850 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
repaglinide (tab 0.5 mg, tab 1 mg, tab 2 mg)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
diazoxide susp 50 mg/ml	gen	
GLUCAGEN HYPOKIT 1 MG RECON SOLN	brd	QL (2 PER 2 OVER TIME)
glucagon (rdna) for inj kit 1 mg	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS

BLOOD PRODUCTS AND MODIFIERS

ANTICOAGULANTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
dabigatran etexilate mesylate (cap 75 mg (eq), cap 150 mg (eq))	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)
enoxaparin sodium (inj 300 mg/3ml, inj soln pref syr 100 mg/ml, 150 mg/ml solution, inj soln pref syr 150 mg/ml)	inj	QL (60 PER 30 OVER TIME)
enoxaparin sodium (inj soln pref 80 mg/0.8ml, inj soln pref 120 mg/0.8ml)	inj	QL (48 PER 30 OVER TIME)
enoxaparin sodium inj soln pref syr 30 mg/0.3ml	inj	QL (18 PER 30 OVER TIME)
enoxaparin sodium inj soln pref syr 40 mg/0.4ml	inj	QL (24 PER 30 OVER TIME)
enoxaparin sodium inj soln pref syr 60 mg/0.6ml	inj	QL (36 PER 30 OVER TIME)
fondaparinux sodium subcutaneous inj 10 mg/0.8ml	spec	QL (24 PER 30 OVER TIME)
fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml	inj	QL (15 PER 30 OVER TIME)
fondaparinux sodium subcutaneous inj 5 mg/0.4ml	spec	QL (12 PER 30 OVER TIME)
fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml	spec	QL (18 PER 30 OVER TIME)
heparin sodium (porcine) ((porcine) inj 1000 unit/ml, (porcine) inj 5000 unit/ml, (porcine) inj 10000 unit/ml, (porcine) inj 20000 unit/ml)	gen	PA - PART B VS D DETERMINATION
PRADAXA 110 MG CAP	npd	QL (2 PER 1 DAYS)
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)	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)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ZONTIVITY 2.08 MG TAB	npd	QL (1 PER 1 DAYS)

BLOOD PRODUCTS AND MODIFIERS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
anagrelide hcl (cap 0.5 mg, cap 1 mg)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
MEPHYTON 5 MG TAB	brd	QL (5 PER 7 OVER TIME), ED
phytonadione tab 5 mg	gen	QL (5 PER 7 OVER TIME), ED
tranexamic acid tab 650 mg	gen	QL (1 PER 1 DAYS)

PLATELET MODIFYING AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
aspirin-dipyridamole cap er 12hr 25-200 mg	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)
cilostazol (tab 50 mg, tab 100 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
clopidogrel bisulfate tab 75 mg (base equiv)	gen	QL (1 PER 1 DAYS)
dipyridamole (tab 25 mg, tab 50 mg, tab 75 mg)	gen	
prasugrel hcl (tab 5 mg equiv), tab 10 mg equiv))	gen	QL (1 PER 1 DAYS)

CARDIOVASCULAR AGENTS

ALPHA-ADRENERGIC AGONISTS

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

ALPHA-ADRENERGIC BLOCKING AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
doxazosin mesylate (tab 1 mg, tab 2 mg, tab 4 mg, tab 8 mg)	gen	
prazosin hcl (cap 1 mg, cap 2 mg, cap 5 mg)	gen	
terazosin hcl (cap 1 mg equivalent), cap 2 mg equivalent), cap 5 mg equivalent), cap 10 mg equivalent))	gen	

ANGIOTENSIN II RECEPTOR ANTAGONISTS

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

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

ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

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

ANTIARRHYTHMICS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amiodarone hcl (tab 100 mg, tab 200 mg, tab 400 mg)	gen	
disopyramide phosphate (cap 100 mg, cap 150 mg)	gen	
dofetilide (cap 125 mcg (0.125 mg), cap 250 mcg (0.25 mg), cap 500 mcg (0.5 mg))	gen	
flecainide acetate (tab 50 mg, tab 100 mg, tab 150 mg)	gen	
mexiletine hcl (cap 150 mg, cap 200 mg, cap 250 mg)	gen	
MULTAQ 400 MG TAB	brd	QL (2 PER 1 DAYS)
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)	gen	

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

BETA-ADRENERGIC BLOCKING AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
acebutolol hcl (cap 200 mg, cap 400 mg)	gen	
atenolol (tab 25 mg, tab 50 mg, tab 100 mg)	gen	
betaxolol hcl (tab 10 mg, tab 20 mg)	gen	
bisoprolol fumarate (tab 5 mg, tab 10 mg)	gen	
carvedilol (tab 3.125 mg, tab 6.25 mg, tab 12.5 mg, tab 25 mg)	gen	
carvedilol phosphate (cap er 24hr 10 mg, cap er 24hr 20 mg, cap er 24hr 40 mg, cap er 24hr 80 mg)	gen	ST
labetalol hcl (tab 100 mg, tab 200 mg, tab 300 mg)	gen	
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))	gen	
metoprolol tartrate (tab 25 mg, tab 37.5 mg, tab 50 mg, tab 75 mg, tab 100 mg)	gen	
nadolol (tab 20 mg, tab 40 mg, tab 80 mg)	gen	
nebivolol hcl (tab 2.5 mg equivalent), tab 5 mg equivalent), tab 10 mg equivalent), tab 20 mg equivalent))	gen	
pindolol (tab 5 mg, tab 10 mg)	gen	
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)	gen	

CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amlodipine besylate (tab 2.5 mg equivalent), tab 5 mg equivalent), tab 10 mg equivalent))	gen	
felodipine (tab er 24hr 10 mg, tab er 24hr 2.5 mg, tab er 24hr 5 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
isradipine (cap 2.5 mg, cap 5 mg)	gen	
nicardipine hcl (cap 20 mg, cap 30 mg)	gen	
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)	gen	
nimodipine cap 30 mg	gen	
nisoldipine (tab er 24hr 17 mg, tab er 24hr 34 mg, tab er 24hr 8.5 mg)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	gen	
diltiazem hcl 120 mg extended release 24hr capsule	gen	
diltiazem hcl 180 mg extended release 24hr capsule	gen	
diltiazem hcl 240 mg extended release 24hr capsule	gen	
diltiazem hcl 300 mg extended release 24hr capsule	gen	
diltiazem hcl 360 mg extended release 24hr capsule	gen	
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)	gen	
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)	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
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)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
acetazolamide (tab 125 mg, tab 250 mg)	gen	
aliskiren fumarate (tab 150 mg equivalent), tab 300 mg equivalent))	gen	PA
amiloride & hydrochlorothiazide tab 5-50 mg	gen	
AMILORIDE-HYDROCHLOROTHIAZIDE 5-50 MG TAB	gen	
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)	gen	
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)	gen	
amlodipine besylate-olmesartan medoxomil (tab 5-20 mg, tab 5-40 mg, tab 10-20 mg, tab 10-40 mg)	gen	
amlodipine besylate-valsartan (tab 5-160 mg, tab 5-320 mg, tab 10-160 mg, tab 10-320 mg)	gen	
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)	gen	
atenolol & chlorthalidone (tab 50-25 mg, tab 100-25 mg)	gen	
benazepril & hydrochlorothiazide (tab 5-6.25 mg, tab 10-12.5 mg, tab 20-12.5 mg, tab 20-25 mg)	gen	
bisoprolol & hydrochlorothiazide (tab 2.5-6.25 mg, tab 5-6.25 mg, tab 10-6.25 mg)	gen	
candesartan cilexetil-hydrochlorothiazide (tab 16-12.5 mg, tab 32-12.5 mg, tab 32-25 mg)	gen	
CAPTOPRIL-HYDROCHLOROTHIAZIDE (25-15 MG TAB, 25-25 MG TAB, 50-15 MG TAB, 50-25 MG TAB)	gen	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	gen	
telmisartan-hydrochlorothiazide (tab 40-12.5 mg, tab 80-12.5 mg, tab 80-25 mg)	gen	
trandolapril-verapamil hcl (tab er 2-180 mg, tab er 2-240 mg, tab er 4-240 mg)	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	
triamterene & hydrochlorothiazide (cap 37.5-25 mg, tab 37.5-25 mg, tab 75-50 mg)	gen	
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)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bumetanide (tab 0.5 mg, tab 1 mg, tab 2 mg)	gen	
bumetanide inj 0.25 mg/ml	inj	
furosemide (8 mg/ml solution, oral soln 10 mg/ml, tab 20 mg, tab 40 mg, tab 80 mg)	gen	
furosemide inj 10 mg/ml	inj	
torsemide (tab 5 mg, tab 10 mg, tab 20 mg, tab 100 mg)	gen	

DIURETICS, POTASSIUM-SPARING

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amiloride hcl tab 5 mg	gen	
eplerenone (tab 25 mg, tab 50 mg)	gen	
spironolactone (tab 25 mg, tab 50 mg, tab 100 mg)	gen	
triamterene (cap 50 mg, cap 100 mg)	gen	ST

DIURETICS, THIAZIDE

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CHLOROTHIAZIDE (250 MG TAB, 500 MG TAB)	gen	
chlorthalidone (tab 25 mg, tab 50 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
DIURIL 250 MG/5ML SUSPENSION	npd	
hydrochlorothiazide (cap 12.5 mg, tab 12.5 mg, tab 25 mg, tab 50 mg)	gen	
indapamide (tab 1.25 mg, tab 2.5 mg)	gen	
metolazone (tab 2.5 mg, tab 5 mg, tab 10 mg)	gen	

DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
choline fenofibrate (cap dr 45 mg equiv), cap dr 135 mg equiv))	gen	
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)	gen	
fenofibrate micronized (cap 43 mg, cap 67 mg, cap 130 mg, cap 134 mg, cap 200 mg)	gen	
gemfibrozil tab 600 mg	gen	

DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
atorvastatin calcium (tab 10 mg equivalent), tab 20 mg equivalent), tab 40 mg equivalent), tab 80 mg equivalent))	gen	
fluvastatin sodium (cap 20 mg equivalent), cap 40 mg equivalent), tab er 24 hr 80 mg equivalent))	gen	
lovastatin (tab 10 mg, tab 20 mg, tab 40 mg)	gen	
pravastatin sodium (tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)	gen	
rosuvastatin calcium (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg)	gen	
simvastatin (tab 5 mg, tab 10 mg, tab 20 mg, tab 40 mg, tab 80 mg)	gen	

DYSLIPIDEMICS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cholestyramine (powder 4 gm/dose, powder packets 4 gm)	gen	
cholestyramine light (powder 4 gm/dose, powder packets 4 gm)	gen	
colesevelam hcl (packet for susp 3.75 gm, tab 625 mg)	gen	
colestipol hcl (granule packets 5 gm, granules 5 gm, tab 1 gm)	gen	
ezetimibe tab 10 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
ezetimibe-simvastatin (tab 10-10 mg, tab 10-20 mg, tab 10-40 mg, tab 10-80 mg)	gen	
icosapent ethyl cap 0.5 gm	gen	QL (8 PER 1 DAYS)
icosapent ethyl cap 1 gm	gen	QL (4 PER 1 DAYS)
niacin (antihyperlipidemic) (tab er 750 mg (antihyperlipidemic), tab er 1000 mg (antihyperlipidemic))	gen	QL (2 PER 1 DAYS)
NIACIN (ANTIHYPERLIPIDEMIC) 500 MG TAB	gen	
niacin tab er 500 mg (antihyperlipidemic)	gen	QL (4 PER 1 DAYS)
NIACOR 500 MG TAB	gen	
omega-3-acid ethyl esters cap 1 gm	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydralazine hcl (tab 10 mg, tab 25 mg, tab 50 mg, tab 100 mg)	gen	
minoxidil (tab 2.5 mg, tab 10 mg)	gen	

VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
isosorbide dinitrate (tab 5 mg, tab 10 mg, tab 20 mg, tab 30 mg, tab 40 mg)	gen	
ISOSORBIDE DINITRATE ER 40 MG TAB ER	gen	
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)	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	
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))	gen	
NITROSTAT (0.3 MG SL TAB, 0.4 MG SL TAB, 0.6 MG SL TAB)	brd	

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
amphetamine sulfate tab 10 mg	gen	ST, QL (6 PER 1 DAYS)
amphetamine sulfate tab 5 mg	gen	ST, QL (8 PER 1 DAYS)
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)	gen	QL (2 PER 1 DAYS)
amphetamine-dextroamphetamine (tab 5 mg, tab 7.5 mg, tab 10 mg, tab 15 mg)	gen	QL (4 PER 1 DAYS)
amphetamine-dextroamphetamine tab 12.5 mg	gen	QL (5 PER 1 DAYS)
amphetamine-dextroamphetamine tab 20 mg	gen	QL (3 PER 1 DAYS)
dextroamphetamine sulfate (cap er 24hr 10 mg, tab 5 mg, tab 10 mg)	gen	QL (6 PER 1 DAYS)
dextroamphetamine sulfate (cap er 24hr 15 mg, tab 15 mg)	gen	QL (4 PER 1 DAYS)
dextroamphetamine sulfate cap er 24hr 5 mg	gen	QL (12 PER 1 DAYS)
dextroamphetamine sulfate oral solution 5 mg/5ml	gen	QL (60 PER 1 DAYS)
dextroamphetamine sulfate tab 20 mg	gen	QL (3 PER 1 DAYS)
dextroamphetamine sulfate tab 30 mg	gen	QL (2 PER 1 DAYS)
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)	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

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

CENTRAL NERVOUS SYSTEM, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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
butalbital-acetaminophen (50-300 mg cap, cap 50-300 mg, tab 50-325 mg)	gen	PA, QL (48 PER 30 OVER TIME), NDS
butalbital-acetaminophen-caffeine (cap 50-300-40 mg, cap 50-325-40 mg, tab 50-325-40 mg)	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)
riluzole tab 50 mg	gen	
TENCON 50-325 MG TAB	gen	PA, QL (48 PER 30 OVER TIME), NDS
tetrabenazine tab 12.5 mg	spec	PA, LA, QL (8 PER 1 DAYS)
tetrabenazine tab 25 mg	spec	PA, LA, QL (4 PER 1 DAYS)

FIBROMYALGIA AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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
duloxetine hcl (cap 20 mg eq), cap 40 mg eq), cap 60 mg eq))	gen	QL (2 PER 1 DAYS)
duloxetine hcl enteric coated pellets cap 30 mg (base eq)	gen	QL (3 PER 1 DAYS)
pregabalin (cap 200 mg, cap 225 mg, cap 300 mg)	gen	QL (2 PER 1 DAYS)
pregabalin (cap 25 mg, cap 50 mg, cap 75 mg, cap 100 mg, cap 150 mg)	gen	QL (3 PER 1 DAYS)
pregabalin soln 20 mg/ml	gen	QL (30 PER 1 DAYS)

MULTIPLE SCLEROSIS AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
dalfampridine tab er 12hr 10 mg	brd	PA, QL (2 PER 1 DAYS)
dimethyl fumarate (capsule delayed release 120 mg, capsule delayed release 240 mg, capsule dr starter pack 120 mg & 240 mg)	spec	PA, QL (2 PER 1 DAYS)
fingolimod hcl cap 0.5 mg (base equiv)	spec	PA, QL (1 PER 1 DAYS)

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

DENTAL AND ORAL AGENTS

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

DERMATOLOGICAL AGENTS

ACNE AND ROSACEA AGENTS

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

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

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

DERMATOLOGICAL AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANALPRAM-HC 2.5-1 % LOTION	brd	
calcipotriene (cream, oint, soln (50 mcg/ml))	gen	
calcipotriene-betamethasone dipropionate oint 0.005-0.064%	gen	PA
CALCITRIOL 3 MCG/GM OINTMENT	gen	
clotrimazole w/ betamethasone (w/ cream 1-0.05%, w/ lotion 1-0.05%)	gen	
diclofenac sodium (actinic keratoses) gel 3%	gen	PA, QL (100 PER 30 OVER TIME)
EPIFOAM 1-1 % FOAM	brd	
FLUOROURACIL (2 % SOLUTION, 5 % SOLUTION)	gen	
fluorouracil cream 5%	gen	
hydrocortisone acetate w/ pramoxine perianal cream 1-1%	gen	
imiquimod cream 5%	gen	QL (24 PER 30 OVER TIME)
methoxsalen rapid (10 mg cap, cap 10 mg)	gen	
nystatin-triamcinolone (cream 100000-0.1 unit/gm-%, oint 100000-0.1 unit/gm-%)	gen	
OTEZLA 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
podofilox (0.5 % solution, soln 0.5%)	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)
silver sulfadiazine cream 1%	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)
sulfacetamide sodium w/ sulfur cream 10-5%	gen	ED
SULFACETAMIDE SODIUM-SULFUR (10-5 % LOTION, 10-5 % SUSPENSION)	gen	ED
TOLAK 4 % CREAM	brd	

PEDICULICIDES/SCABICIDES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
IVERMECTIN 1 % CREAM	gen	PA, QL (45 PER 30 OVER TIME)
ivermectin cream 1%	gen	PA, QL (45 PER 30 OVER TIME)
LINDANE 1 % SHAMPOO	gen	
malathion lotion 0.5%	gen	
permethrin cream 5%	gen	
SPINOSAD 0.9 % SUSPENSION	gen	QL (240 PER 30 OVER TIME)

TOPICAL ANTI-INFECTIVES

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

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

ELECTROLYTES/MINERALS/METALS/VITAMINS

ELECTROLYTE/MINERAL REPLACEMENT

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AMINOSYN II 10 % SOLUTION	inj	PA - PART B VS D DETERMINATION
AMINOSYN-PF 10 % SOLUTION	inj	PA - PART B VS D DETERMINATION
carglumic acid soluble tab 200 mg	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 NACL 20-0.9 MEQ/L-% SOLUTION	inj	
KCL (0.298%) IN NACL 40-0.9 MEQ/L-% SOLUTION	inj	
KCL IN DEXTROSE-NACL (20-5-0.225 MEQ/L-%-% SOLUTION, 20-5-0.33 MEQ/L-%-% SOLUTION, 40-5-0.9 MEQ/L-%-% SOLUTION)	inj	
magnesium sulfate (50 % solution, inj 50%)	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
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))	gen	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	inj	
POTASSIUM CHLORIDE ER 8 MEQ TAB ER	gen	
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)	inj	
POTASSIUM CHLORIDE IN NACL (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	
potassium chloride microencapsulated crystals er (crys er tab 10, crys er tab 15, crys er tab 20)	gen	
potassium citrate (alkalinizer) (tab er 5 (540 mg), tab er 10 (1080 mg), tab er 15 (1620 mg))	gen	
PREMASOL 10 % SOLUTION	inj	PA - PART B VS D DETERMINATION
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%)	inj	

ELECTROLYTE/MINERAL/METAL MODIFIERS

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

PHOSPHATE BINDERS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
AURYXIA 1 GM 210 MG(FE) TAB	npd	PA, QL (12 PER 1 DAYS)
calcium acetate (phosphate binder) (binder) cap 667 mg (169 mg ca), binder) tab 667 mg)	gen	

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

POTASSIUM BINDERS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
*sodium polystyrene sulfonate (*sodium powder**, sodium oral susp 15 gm/60ml)*	gen	
SPS 15 GM/60ML SUSPENSION	gen	
VELTASSA (8.4 GM PACKET, 16.8 GM PACKET, 25.2 GM PACKET)	brd	

VITAMINS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
pediatric multiple vitamins w/ fl-fe drops 0.25-10 mg/ml*	gen	ED
cyanocobalamin inj 1000 mcg/ml	gen	ED
dextrose (inj 5%, inj 10%)	inj	
dextrose 5% in lactated ringers	inj	
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%)	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	
folic acid tab 1 mg	gen	ED
KCL-LACTATED RINGERS-D5W 20 MEQ/L SOLUTION	inj	
lactated ringer's for irrigation	gen	
lactated ringer's solution	inj	
LACTATED RINGERS SOLUTION	inj	
levocarnitine (metabolic modifiers) (oral soln 1 gm/10ml (10%), tab 330 mg)	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
*pediatric multivitamins w/fl (w/ chew tab 0.5 mg***, w/ soln 0.25 mg/ml***)*	gen	ED
*pediatric vitamins acd w/ fluoride (w/ soln 0.25 mg/ml***, w/ soln 0.5 mg/ml***)*	gen	
POLY-VI-FLOR (0.25 MG CHEW TAB, 0.5 MG CHEW TAB, 1 MG CHEW TAB)	gen	ED
potassium bicarbonate effer tab 25 meq	gen	ED
POTASSIUM CHLORIDE IN DEXTROSE (20 MEQ/L (0.15%)5% INJ, 40-5 MEQ/L-% SOLUTION)	inj	
prenatal vitamins	brd	
QUFLORA PEDIATRIC (0.25 MG CHEW TAB, 0.5 MG CHEW TAB, 1 MG CHEW TAB)	gen	ED
ringer's solution	inj	
ringer's solution for irrigation	gen	
SMOFLIPID 20 % EMULSION	inj	PA - PART B VS D DETERMINATION
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))	gen	
TPN ELECTROLYTES CONC	inj	PA - PART B VS D DETERMINATION

GASTROINTESTINAL AGENTS

ANTI-CONSTIPATION AGENTS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
NULYTELY LEMON-LIME 420 GM RECON SOLN	brd	
NULYTELY WITH FLAVOR PACKS 420 GM RECON SOLN	brd	
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm	gen	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	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
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	gen	

ANTI-DIARRHEAL AGENTS

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

ANTISPASMODICS, GASTROINTESTINAL

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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))	inj	
chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg	gen	QL (8 PER 1 DAYS), ED
dicyclomine hcl (cap 10 mg, oral soln 10 mg/5ml, tab 20 mg)	gen	PA
glycopyrrolate (tab 1 mg, tab 2 mg)	gen	
glycopyrrolate oral soln 1 mg/5ml	gen	PA
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)	gen	ED
methscopolamine bromide (tab 2.5 mg, tab 5 mg)	gen	
pb-hyoscy-atrop-scopol elix 16.2-0.1037-0.0194-0.0065 mg/5ml	gen	QL (40 PER 1 DAYS), ED

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

GASTROINTESTINAL AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
peg 3350-kcl-sod bicarb-sod chloride-sod sulfate (soln 236 gm, soln 240 gm)	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)
ursodiol (cap 300 mg, tab 250 mg, tab 500 mg)	gen	

HISTAMINE2 (H2) RECEPTOR ANTAGONISTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cimetidine (tab 200 mg, tab 300 mg, tab 400 mg, tab 800 mg)	gen	
cimetidine hcl (300 mg/5ml solution, soln 300 mg/5ml)	gen	
famotidine (for susp 40 mg/5ml, tab 20 mg, tab 40 mg)	gen	
nizatidine (15 mg/ml solution, 150 mg cap, cap 150 mg, 300 mg cap, cap 300 mg)	gen	

PROTECTANTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
misoprostol (tab 100 mcg, tab 200 mcg)	gen	
sucralfate (susp 1 gm/10ml, tab 1 gm)	gen	

PROTON PUMP INHIBITORS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
esomeprazole magnesium cap delayed release 20 mg (base eq)	gen	
esomeprazole magnesium cap delayed release 40 mg (base eq)	gen	QL (2 PER 1 DAYS)
lansoprazole cap delayed release 15 mg	gen	
lansoprazole cap delayed release 30 mg	gen	QL (2 PER 1 DAYS)
omeprazole (cap 10 mg, cap 20 mg)	gen	
omeprazole cap delayed release 40 mg	gen	QL (2 PER 1 DAYS)

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
betaine powder for oral solution**	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	
cromolyn sodium oral conc 100 mg/5ml	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)
miglustat cap 100 mg	spec	PA, LA, QL (3 PER 1 DAYS)
NAGLAZYME 1 MG/ML SOLUTION	spec	LA, PA - PART B VS D DETERMINATION
nitisinone (cap 2 mg, cap 5 mg, cap 10 mg)	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
sapropterin dihydrochloride (powder packet 100 mg, powder packet 500 mg, tab 100 mg)	spec	PA
sodium phenylbutyrate (oral powder 3 gm/teaspoonful, tab 500 mg)	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

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

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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
methylprednisolone sod succ for inj 40 mg (base equiv)	inj	
mometasone furoate (cream, oint)	gen	
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))	gen	
prednisolone soln 15 mg/5ml	gen	
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))	gen	
PREDNISONE INTENSOL 5 MG/ML CONC	gen	

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
desmopressin acetate (inj 4 mcg/ml, preservative free (pf) inj 4 mcg/ml)	inj	
desmopressin acetate (tab 0.1 mg, tab 0.2 mg)	gen	
desmopressin acetate nasal spray soln 0.01%	gen	
desmopressin acetate nasal spray soln 0.01% (refrigerated)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)

ANABOLIC STEROIDS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ANADROL-50 50 MG TAB	npd	
oxandrolone (2.5 mg tab, tab 2.5 mg, 10 mg tab, tab 10 mg)	gen	

ANDROGENS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
drospirenone-ethinyl estradiol-levomefolate calcium (tab 3-0.02-0.451 mg, tab 3-0.03-0.451 mg)	gen	
esterified estrogens & methyltestosterone (tab 0.625-1.25 mg, tab 1.25-2.5 mg)	gen	ED
estradiol & norethindrone acetate (tab 0.5-0.1 mg, tab 1-0.5 mg)	gen	
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)	gen	QL (8 PER 28 OVER TIME)
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)	gen	QL (16 PER 28 OVER TIME)
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%))	gen	
estradiol vaginal (cream 0.1 mg/gm, tab 10 mcg)	gen	
estradiol valerate (oil 10 mg/ml, oil 20 mg/ml, oil 40 mg/ml)	gen	
ESTRING (2 MG RING, 7.5 MCG/24HR RING)	brd	QL (1 PER 84 OVER TIME)
ethynodiol diacet & eth estrad (tab 1 mg-35 mcg, tab 1 mg-50 mcg)	gen	
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	gen	QL (1 PER 28 OVER TIME)
levonorgestrel & eth estradiol (tab 0.1 mg-20 mcg, tab 0.15 mg-30 mcg)	gen	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	gen	
levonorgestrel-ethinyl estradiol (91-day) (levonor-eth tab 0.15-0.02/0.025/0.03 mg ð 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)	gen	
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	gen	
MENEST (0.3 MG TAB, 0.625 MG TAB, 1.25 MG TAB, 2.5 MG TAB)	npd	
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	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
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))	gen	
norethindrone & eth estradiol (tab 0.4 mcg, tab 0.5 mcg, tab 1 mcg)	gen	
norethindrone & ethinyl estradiol-fe (chew tab 0.4 mg-35 mcg, chew tab 0.8 mg-25 mcg)	gen	
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	gen	
norethindrone acet & eth estra (tab 1 mg-20 mcg, tab 1.5 mg-30 mcg)	gen	
norethindrone acetate-ethinyl estradiol (tab 0.5 mg-2.5 mcg, tab 1 mg-5 mcg)	gen	
norethindrone-eth estradiol (triphasic) (tab 0.5-35/0.75-35/1-35, tab 0.5-35/1-35/0.5-35)	gen	
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	gen	
norgestimate-ethinyl estradiol (triphasic) (tab 0.18-25/0.215-25/0.25-25, tab 0.18-35/0.215-35/0.25-35)	gen	
norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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	
medroxyprogesterone acetate (contraceptive) (susp 150 mg/ml, susp prefilled syr 150 mg/ml)	inj	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
medroxyprogesterone acetate (tab 2.5 mg, tab 5 mg, tab 10 mg)	gen	
megestrol acetate (susp 40 mg/ml, tab 20 mg, tab 40 mg)	gen	PA - FOR NEW STARTS ONLY
megestrol acetate susp 625 mg/5ml	gen	PA
norethindrone acetate tab 5 mg	gen	
norethindrone tab 0.35 mg	gen	
progesterone (cap 100 mg, cap 200 mg, im in oil 50 mg/ml)	gen	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
OSPHENA 60 MG TAB	npd	PA, QL (1 PER 1 DAYS)
raloxifene hcl tab 60 mg	gen	QL (1 PER 1 DAYS)

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)	brd	ED
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)	gen	
liothyronine sodium (tab 5 mcg, tab 25 mcg, tab 50 mcg)	gen	
NIVA THYROID (15 MG TAB, 30 MG TAB, 60 MG TAB, 90 MG TAB, 120 MG TAB)	brd	ED
NP THYROID (15 MG TAB, 30 MG TAB, 60 MG TAB, 90 MG TAB, 120 MG TAB)	brd	ED
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)	brd	
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))	brd	ED

HORMONAL AGENTS, SUPPRESSANT (PITUITARY)

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cabergoline tab 0.5 mg	gen	

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
leuprolide acetate inj kit 5 mg/ml	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	
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))	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
methimazole (tab 5 mg, tab 10 mg)	gen	
propylthiouracil tab 50 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

IMMUNOLOGICAL AGENTS

ANGIOEDEMA AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
HAEGARDA (2000 RECON SOLN, 3000 RECON SOLN)	spec	PA, LA
icatibant acetate subcutaneous soln pref syr 30 mg/3ml	spec	PA, QL (36 PER 60 OVER TIME)

IMMUNOGLOBULINS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
azathioprine (tab 50 mg, tab 75 mg, tab 100 mg)	gen	PA - PART B VS D DETERMINATION
AZATHIOPRINE SODIUM 100 MG RECON SOLN	inj	PA - PART B VS D DETERMINATION
cyclosporine (cap 25 mg, cap 100 mg)	gen	PA - PART B VS D DETERMINATION
cyclosporine iv soln 50 mg/ml	inj	PA - PART B VS D DETERMINATION
cyclosporine modified (for microemulsion) (cap 25 mg, cap 50 mg, cap 100 mg, oral soln 100 mg/ml)	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)
ENVARSUS XR (0.75 MG TAB ER 24H, 1 MG TAB ER 24H, 4 MG TAB ER 24H)	npd	PA - FOR NEW STARTS ONLY
everolimus (immunosuppressant) (tab 0.25 mg, tab 0.5 mg, tab 0.75 mg, tab 1 mg)	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)

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)
leflunomide (tab 10 mg, tab 20 mg)	gen	
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))	gen	PA - PART B VS D DETERMINATION
methotrexate sodium for inj 1 gm	inj	PA - PART B VS D DETERMINATION
methotrexate sodium tab 2.5 mg (base equiv)	gen	
mycophenolate mofetil (cap 250 mg, for oral susp 200 mg/ml, tab 500 mg)	gen	PA - PART B VS D DETERMINATION
mycophenolate mofetil hcl for iv soln 500 mg (base equiv)	inj	PA - PART B VS D DETERMINATION
mycophenolate sodium (tab dr 180 mg equiv), tab dr 360 mg equiv))	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
sirolimus (oral soln 1 mg/ml, tab 0.5 mg, tab 1 mg, tab 2 mg)	gen	PA - PART B VS D DETERMINATION
tacrolimus (cap 0.5 mg, cap 1 mg, cap 5 mg)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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

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

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

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

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

GLUCOCORTICOIDS

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

METABOLIC BONE DISEASE AGENTS

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

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
zoledronic acid (4 mg recon soln, 4 mg/100ml solution, inj conc for iv infusion 4 mg/5ml, iv soln 5 mg/100ml)	inj	PA - PART B VS D DETERMINATION

MISCELLANEOUS THERAPEUTIC AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
bacteriostatic sodium chloride inj soln 0.9%**	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	

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
gauze pads 2	gen	
GNP ISOPROPYL ALCOHOL WIPES 70 % MISC	gen	

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	
isopropyl alcohol wipes 70%	gen	
LITEAIRE DEVICE	brd	ED
methylergonovine maleate tab 0.2 mg	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
water for irrigation, sterile irrigation soln	gen	

OPHTHALMIC AGENTS

OPHTHALMIC AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ATROPINE SULFATE 1 % SOLUTION	gen	
atropine sulfate ophth soln 1%	gen	
bacitracin-polymyxin b ophth oint	gen	
bacitracin-polymyxin-neomycin-hc ophth oint 1%	gen	
BLEPHAMIDE 10-0.2 % SUSPENSION	brd	
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	gen	
DORZOLAMIDE HCL-TIMOLOL MAL 22.3-6.8 MG/ML SOLUTION	gen	
dorzolamide hcl-timolol maleate (pf soln 2-0.5%, sol 22.3-6.8 mg/ml pf, soln 22.3-6.8 mg/ml)	gen	
HOMATROPAIRE 5 % SOLUTION	gen	ED
homatropine hbr ophth soln 5%	gen	ED
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	gen	
neomycin-polymy-dexameth (oint, susp)	gen	
NEOMYCIN-POLYMYXIN-GRAMICIDIN 1.75-10000-.025 SOLUTION	gen	
NEOMYCIN-POLYMYXIN-HC 3.5-10000-1 SUSPENSION	gen	
phenylephrine hcl (mydriatic) (soln 2.5%, soln 10%)	gen	
proparacaine hcl ophth soln 0.5%	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	
tobramycin-dexamethasone ophth susp 0.3-0.1%	gen	
XIIDRA 5 % SOLUTION	brd	
ZYLET 0.5-0.3 % SUSPENSION	brd	

OPHTHALMIC ANTI-ALLERGY AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
azelastine hcl ophth soln 0.05%	gen	
bepotastine besilate ophth soln 1.5%	gen	
CROMOLYN SODIUM 4 % SOLUTION	gen	
cromolyn sodium ophth soln 4%	gen	
epinastine hcl ophth soln 0.05%	gen	
LASTACAFT 0.25 % SOLUTION	npd	
olopatadine hcl (soln 0.1% equivalent), soln 0.2% equivalent))	gen	
PAZEO 0.7 % SOLUTION	brd	QL (2.5 PER 30 OVER TIME)

OPHTHALMIC ANTI-INFECTIVES

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

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

OPHTHALMIC ANTI-INFLAMMATORIES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
ALREX 0.2 % SUSPENSION	brd	
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	gen	
DEXAMETHASONE SODIUM PHOSPHATE 0.1 % SOLUTION	gen	
diclofenac sodium ophth soln 0.1%	gen	
difluprednate ophth emulsion 0.05%	gen	
fluorometholone ophth susp 0.1%	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)
ketorolac tromethamine (ophth) (soln 0.4%, soln 0.5%)	gen	
loteprednol etabonate (0.5 % gel, ophth gel 0.5%, ophth susp 0.5%)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
BETAXOLOL HCL 0.5 % SOLUTION	gen	
betaxolol hcl ophth soln 0.5%	gen	
BETIMOL (0.25 % SOLUTION, 0.5 % SOLUTION)	brd	
BETOPTIC-S 0.25 % SUSPENSION	brd	
CARTEOLOL HCL 1 % SOLUTION	gen	
levobunolol hcl (0.5 % solution, ophth soln 0.5%)	gen	

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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))	gen	

OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER

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

OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS

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

OTIC AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
CIPRO HC 0.2-1 % SUSPENSION	npd	
CIPROFLOXACIN HCL 0.2 % SOLUTION	gen	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	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	
fluocinolone acetonide (otic) oil 0.01%	gen	
hydrocortisone w/ acetic acid otic soln 1-2%	gen	
HYDROCORTISONE-ACETIC ACID 1-2 % SOLUTION	gen	
neomycin-polymyxin-hc (otic) (soln 1%, susp 3.5 mg/ml-10000 unit/ml-1%)	gen	
ofloxacin otic soln 0.3%	gen	

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
budesonide (inhalation) (susp 0.25 mg/2ml, susp 0.5 mg/2ml, susp 1 mg/2ml)	gen	PA - PART B VS D DETERMINATION
flunisolide nasal soln 25 mcg/act (0.025%)	gen	QL (50 PER 30 DAYS)
fluticasone propionate nasal susp 50 mcg/act	gen	QL (16 PER 30 DAYS)
mometasone furoate nasal susp 50 mcg/act	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

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
hydroxyzine pamoate (cap 25 mg, cap 50 mg, 100 mg cap)	gen	PA
levocetirizine dihydrochloride tab 5 mg	gen	
olopatadine hcl nasal soln 0.6%	gen	QL (30.5 PER 30 DAYS)
promethazine hcl syrup 6.25 mg/5ml	gen	PA
ANTILEUKOTRIENES		
montelukast sodium (chew tab 4 mg equiv), chew tab 5 mg equiv), oral granules packet 4 mg equiv), tab 10 mg equiv))	gen	QL (1 PER 1 DAYS)
zafirlukast (tab 10 mg, tab 20 mg)	gen	QL (2 PER 1 DAYS)
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA 17 MCG/ACT AERO SOLN	brd	QL (25.8 PER 30 DAYS)
ipratropium bromide inhal soln 0.02%	gen	PA - PART B VS D DETERMINATION
ipratropium bromide nasal soln 0.03% (21 mcg/spray)	gen	QL (30 PER 30 DAYS)
ipratropium bromide nasal soln 0.06% (42 mcg/spray)	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		
albuterol 90mg hfa inhaler (generic proair)	gen	QL (17 PER 30 OVER TIME)
albuterol 90mg hfa inhaler (generic proventil)	gen	QL (13.4 PER 30 OVER TIME)
ALBUTEROL 90MG HFA INHALER (GENERIC VENTOLIN)	gen	QL (36 PER 30 OVER TIME)
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)	gen	PA - PART B VS D DETERMINATION
albuterol sulfate (syrup 2 mg/5ml, tab 2 mg, tab 4 mg)	gen	
ALBUTEROL SULFATE ER (ER 4 MG TAB ER 12H, ER 8 MG TAB ER 12H)	gen	
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	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
epinephrine (anaphylaxis) (solution 0.15 mg/0.3ml (1:2000), solution 0.3 mg/0.3ml (1:1000))	gen	QL (24 PER 365 OVER TIME)
EPINEPHRINE AUTOINJECTOR (GENERIC ADRENACLICK)	gen	QL (24 PER 365 OVER TIME)
formoterol fumarate soln nebu 20 mcg/2ml	gen	PA - PART B VS D DETERMINATION
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))	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)
terbutaline sulfate (tab 2.5 mg, tab 5 mg)	gen	
terbutaline sulfate inj 1 mg/ml	inj	

CYSTIC FIBROSIS AGENTS

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
tobramycin nebu soln 300 mg/4ml	spec	PA, QL (224 PER 28 OVER TIME)
tobramycin nebu soln 300 mg/5ml	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
cromolyn sodium soln nebu 20 mg/2ml	gen	PA - PART B VS D DETERMINATION

PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
roflumilast tab 500 mcg	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	
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)	gen	

PULMONARY ANTIHYPERTENSIVES

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
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)
ambrisentan (tab 5 mg, tab 10 mg)	spec	PA, LA, QL (1 PER 1 DAYS)
bosentan tab 125 mg	spec	PA, LA, QL (2 PER 1 DAYS)
bosentan tab 62.5 mg	spec	PA, LA, QL (4 PER 1 DAYS)
OPSUMIT 10 MG TAB	spec	PA, LA, QL (1 PER 1 DAYS)
sildenafil citrate for suspension 10 mg/ml	spec	PA, QL (6 PER 1 DAYS)
sildenafil citrate tab 20 mg	gen	PA, QL (3 PER 1 DAYS)
tadalafil tab 20 mg (pah)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
OFEV (100 MG CAP, 150 MG CAP)	spec	PA, LA, QL (2 PER 1 DAYS)
pirfenidone (cap 267 mg, tab 267 mg)	spec	PA, QL (9 PER 1 DAYS)
PIRFENIDONE 534 MG TAB	spec	PA, QL (5 PER 1 DAYS)
pirfenidone tab 801 mg	spec	PA, QL (3 PER 1 DAYS)

RESPIRATORY TRACT AGENTS, OTHER

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
acetylcysteine (soln 10%, soln 20%)	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)
benzonatate (cap 100 mg, cap 150 mg, cap 200 mg)	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)
budesonide-formoterol fumarate dihydrate (aerosol 80-4.5 mcg/act, aerosol 160-4.5 mcg/act)	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)
fluticasone-salmeterol (aer powder ba 100-50 mcg/act, aer powder ba 250-50 mcg/act, aer powder ba 500-50 mcg/act)	gen	QL (60 PER 30 DAYS)
guaifenesin-codeine soln 100-10 mg/5ml	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
hydrocod polst-chlorphen polst er susp 10-8 mg/5ml	gen	QL (70 PER 30 OVER TIME), NDS, ED
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	gen	QL (210 PER 30 OVER TIME), NDS, ED
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	gen	QL (42 PER 30 OVER TIME), NDS, ED
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	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)
promethazine & phenylephrine syrup 6.25-5 mg/5ml	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
promethazine w/ codeine syrup 6.25-10 mg/5ml	gen	PA, QL (240 PER 30 OVER TIME), NDS, ED
promethazine-dm syrup 6.25-15 mg/5ml	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
promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml	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
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	gen	ED
ribavirin for inhal soln 6 gm	spec	PA - PART B VS D DETERMINATION
sodium chloride (inhalant) (soln nebu 3%, soln nebu 7%, soln nebu 10%)	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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
carisoprodol tab 350 mg	gen	PA, QL (4 PER 1 DAYS)
cyclobenzaprine hcl (tab 5 mg, tab 10 mg)	gen	PA
metaxalone (tab 400 mg, tab 800 mg)	gen	PA, QL (4 PER 1 DAYS)
methocarbamol (tab 500 mg, tab 750 mg)	gen	PA

SLEEP DISORDER AGENTS

SLEEP PROMOTING AGENTS

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

DRUG NAME	DRUG TIER	REQUIREMENTS/LIMITS
WAKEFULNESS PROMOTING AGENTS		
armodafinil (tab 50 mg, tab 150 mg, tab 200 mg, tab 250 mg)	gen	PA, QL (1 PER 1 DAYS)
modafinil tab 100 mg	gen	PA, QL (3 PER 1 DAYS)
modafinil tab 200 mg	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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Discrimination is against the law. Blue Shield of California complies with applicable state laws and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Blue Shield of California provides:

- Aids and services at no cost to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

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

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

blue california

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.

Chinese Mandarin 我们提供免费的翻译服务， 帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务， 请致电 1-800-776-4466。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese 您對我們的健康或藥物保險可能存有疑問， 為此我們提供免費的翻譯 服務。如需翻譯服務， 請致電 1-800-776-4466。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-776-4466. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-776-4466. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-776-4466 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-776-4466. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-776-4466 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-776-4466. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن اي اسئلة تتعلق بالصحة او جدول الادوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-776-4466. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية

Hindi हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-776-4466 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian E disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-776-4466. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-776-4466. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-776-4466. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-776-4466. Ta usługa jest bezpłatna.

Japanese 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-776-4466 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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 1h1y3 47 doodago azee' bee aa 1h1y3 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'11 j77k'eh bee an1'1wo.

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

Khmer យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរនានា ដែលអ្នកអាចមានអំពីសុខភាព ឬគម្រោងឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ សូមទូរសព្ទមកយើងខ្ញុំតាមលេខ 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 ພວກເຮົາມີບໍລິການນາຍພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບຄໍາຖາມຕ່າງໆທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອໃຫ້ໄດ້ຮັບນາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-776-4466. ມີຜູ້ຮູ້ພາສາລາວ ສາມາດຊ່ວຍທ່ານ. ນີ້ແມ່ນບໍລິການໂດຍບໍ່ເສຍຄ່າ.

Armenian Մեզ մոտ հասանելի են անվճար թարգմանչական ծառայություններ՝ մեր առողջապահական կամ դեղերի պլանի հետ կապված Ձեր ցանկացած հարցին պատասխանելու համար: Թարգմանիչ ունենալու համար պարզապես զանգահարեք մեզ 1-800-776-4466 հեռախոսահամարով: Ձեզ կօգնի հայերեն իմացող թարգմանիչը: Ծառայությունն անվճար է:

Farsi ما خدمات مترجم شفاهی رایگان ارائه می‌دهیم تا به هر گونه سؤالی که در مورد طرح سلامت یا داروی ما دارید پاسخ دهیم. برای داشتن مترجم شفاهی، کافیست 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.

Thai ภาษาไทย เรามีบริการล่ามฟรีเพื่อตอบคำถามของคุณเกี่ยวกับสุขภาพหรือแผนด้านยาของคุณ หากต้องการบริการล่าม โปรดโทรหาเราที่ 1-800-776-4466 มีคนที่สามารถพูดภาษาไทยได้เพื่อช่วยเหลือคุณ บริการนี้เป็นบริการฟรี

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**.

Blue Shield of California's pharmacy network includes limited lower-cost, preferred pharmacies in certain counties within California. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call **(800) 776-4466 [TTY: 711]**, 8 a.m. to 8 p.m., seven days a week or consult the online pharmacy directory at **blueshieldca.com/medpharmacy2024**.

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。

6300 Canoga Avenue
Woodland Hills, CA 91367-2580

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