



**July - September 2023**

**Molina Healthcare of Illinois Medicaid**

**Preferred Drug List  
(Formulary)**

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# Molina Healthcare of Illinois Preferred Drug List (Formulary)

(07/01/2023)

## INTRODUCTION

We are pleased to provide the 2023 *Molina Healthcare of Illinois Preferred Drug List (Formulary)* as a useful reference and informational tool. This document can assist medical providers in selecting clinically-appropriate and cost-effective products for their patients.

This Formulary is up to date through its date of publication, January 1, 2023. Please notify Molina Healthcare of Illinois at [mhilpharmacy@molinahealthcare.com](mailto:mhilpharmacy@molinahealthcare.com) or 1-855-866-5462 with any mistakes in the formulary.

Molina Healthcare of Illinois only covers drugs made by a manufacturer that participates in the Federal Medicaid drug rebate program. Drugs obtained through the Molina Healthcare of Illinois prescription drug benefit are covered at no cost to the member.

The information contained in this document and its appendices is provided solely for the convenience of medical providers. We do not warrant or assure accuracy of such information nor is it intended to be comprehensive in nature. All the information in the document is provided as a reference for drug therapy selection.

The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

We assume no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

## PREFACE

The document is organized by sections. Each section is divided by therapeutic drug class primarily defined by mechanism of action.

## DRUG LIST PRODUCT DESCRIPTIONS

To assist in understanding which specific strengths and dosage forms on the document are covered, general principles are noted below:

- The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIPITOR). Generic drugs are listed in lowercase italics (e.g., *atorvastatin*).
- The second column (Requirements/Limits) contains any special requirements for coverage of the particular drug.
- If both the OTC and Prescription versions of the product are covered, then both are listed.
- Extended-release and delayed-release products require their own entry.
- Dosage forms on the document will be consistent with the category and use where listed.

## GENERIC SUBSTITUTION

Generic substitution is a pharmacy action whereby a generic version is dispensed rather than a prescribed brand-name product. In this document, *lowercase italicized* type indicates generic availability for the brand name product. In most instances, a brand-name drug for which a generic product becomes available will become non-formulary, with the generic product covered in its place, upon release of the generic product to the market. However, the document is subject to state specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drug.

- Manufactured in the same strength and dosage form as the brand-name drugs.

When a generic drug is substituted for a brand-name drug, you can expect the generic to produce the same clinical effect and safety profile as the brand-name drug (therapeutic equivalence).

## PLAN DESIGN

The document represents a closed formulary plan design. The medications listed on the document are covered by the plan as represented. Certain medications on the list are covered if utilization management criteria are met (i.e., Step Therapy, Prior Authorization, Quantity Limits, etc.); requests for use of such medications outside of their listed criteria will be reviewed for medical necessity. If a medication is not listed on the document, a formulary exception may be requested for coverage. Medical necessity or formulary exception requests will be reviewed based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria.

## CATEGORIES OF CONSIDERATION

### OPIOID ANALGESICS, BENZODIAZEPINES, MUSCLE RELAXANTS

- All Opioid Analgesics are subject to a Morphine Equivalent Dose of 90 mg per day, Acute Pain Duration Limits, and ER Opioid Step Therapy.
- Concurrent use of Opioid Analgesics, Benzodiazepines, and/or Muscle Relaxants may be subject to clinical review.

## NON-COVERED MEDICATIONS

Please note that certain medications are not covered. These include, but are not limited to:

- Appetite Suppressants / Anorexiants for weight loss
- Drugs for Cosmetic Purposes
- Drugs to treat infertility
- Drugs to treat erectile dysfunction
- Experimental or Investigational Medications
- Convenience Dosage Forms not listed on the Formulary
- Pharmaceuticals determined by the Federal Drug Administration (FDA) to be less than effective and identical, related or similar drugs (frequently referred to as “DESI 5 and 6” drugs)

## PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when formulary options have demonstrated ineffectiveness. When these exceptional situations arise, the physician may fax a completed drug prior authorization form to Molina at (855) 365-8112. The forms may be obtained by logging into the website [www.molinahealthcare.com](http://www.molinahealthcare.com). Trials of pharmaceutical samples will not be considered as rationale for approving a prior authorization request.

## PRIOR AUTHORIZATION HELPFUL HINTS

To ensure the quickest response possible from MHIL Pharmacy Department, please provide clinical documentation with the Prior Authorization request. The following are examples:

Class of Medication/Diagnosis	Requested Clinical Information
Cholesterol Lowering	Lipid Panel, Cardiovascular risk factors
Diabetes	A1c Report
Non-Formulary/Non-Preferred Medication	Medication Log and/or Progress Notes documenting previous use of Formulary medications

## LEGEND

AGE	Age Limit
OTC	Over-the-counter, covered benefit with a prescription
PA	Prior Authorization
PA, QL	Quantity Limit is applied after Prior Authorization approval
QL	Quantity Limit

<b>SP</b>	Specialty Drug; these drugs must be obtained through a specialty pharmacy
<b>ST</b>	Step Therapy
<b>Preferred</b>	Preferred product, may require Prior Authorization
<b>Non-preferred</b>	Non-Preferred product, requires Prior Authorization and documentation of medical necessity

## **URGENT AND AFTER-HOURS MEDICATION POLICY**

To prevent a member's condition from worsening in an urgent situation, it may be necessary to dispense a 72-hour supply of an acute medication before prior authorization may be obtained from Molina Healthcare. (e.g., a member is discharged from a hospital after regular business hours with a special antibiotic prescription). Pharmacies are instructed to use their professional judgment. Molina Healthcare will reimburse pharmacies for a 72-hour supply of an acute medication at contracted rates for these prescriptions. Pharmacies may contact CVS Caremark Help Desk at (800) 364-6331 to obtain an override for a 72-hour supply.

Pharmacies may call Molina Healthcare at (855) 866-5462 on the following business day to obtain authorization to allow the urgent or after-hours prescription to process on-line. It is advised and expected that the pharmacy will provide reasonable documentation of cases where medications were dispensed under these urgent circumstances.

## **NOTICE**

The information contained in this document is proprietary. The information may not be copied in whole or in part without written permission. ©2023. All rights reserved.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

## FORMULARY UPDATES

Please review the formulary changes which pertain to the Pharmacy Benefit unless denoted otherwise. If you have questions, contact Molina Health Plan's Pharmacy Help Desk.

Key			
AGE= Age Limit	ST= Step Therapy	OTC= Over the Counter	PA= Prior Authorization
PA, QL= Quantity Limit is applied after Prior Authorization approval	QL= Quantity Limit	SP= Specialty Drugs; these drugs must be obtained through a specialty pharmacy	

Date Effective	Product Name	Change	Notes
7/1/2023	ALBUTEROL SYP 2MG/5ML	Update to non-preferred with PA	
7/1/2023	EMGALITY INJ 100MG/ML	Update to preferred with PA	
7/1/2023	EMGALITY INJ 120MG/ML	Update to preferred with PA	
7/1/2023	EMGALITY INJ 120MG/ML	Update to preferred with PA	
7/1/2023	LURASIDONE TAB 120MG	Update to preferred, remove PA	
7/1/2023	LURASIDONE TAB 20MG	Update to preferred, remove PA	
7/1/2023	LURASIDONE TAB 40MG	Update to preferred, remove PA	
7/1/2023	LURASIDONE TAB 60MG	Update to preferred, remove PA	
7/1/2023	LURASIDONE TAB 80MG	Update to preferred, remove PA	
7/1/2023	MAVYRET PAK 50- 20MG	Remove PA	
7/1/2023	MAVYRET TAB 100- 40MG	Remove PA	
7/1/2023	SOFOS/VELPAT TAB 400-100	Remove PA	
7/1/2023	SUNLENCA INJ	Add, preferred with PA	
7/1/2023	SUNLENCA TAB 300MG	Add, preferred with PA	
7/1/2023	SUNLENCA TAB 300MG	Add, preferred with PA	

**Drug Name** **Drug Tier** **Requirements/Limits**  
**ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS**  
**TO TREAT NERVOUS SYSTEM DISORDERS**

**AMPHETAMINES**

ADDERALL TAB 5MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL TAB 7.5MG	Non Preferred	PA, QL (5 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL TAB 10MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL TAB 12.5MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL TAB 15MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL TAB 20MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL TAB 30MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 6, Max 18)
ADDERALL XR CAP 5MG	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
ADDERALL XR CAP 10MG	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
ADDERALL XR CAP 15MG	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
ADDERALL XR CAP 20MG	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
ADDERALL XR CAP 25MG	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
ADDERALL XR CAP 30MG	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
ADZENYS XR TAB 3.1MG	Non Preferred	PA; AGE (Min 6, Max 18)
ADZENYS XR TAB 6.3MG	Non Preferred	PA; AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ADZENYS XR TAB 9.4MG	Non Preferred	PA; AGE (Min 6, Max 18)
ADZENYS XR TAB 12.5MG	Non Preferred	PA; AGE (Min 6, Max 18)
ADZENYS XR TAB 15.7 MG	Non Preferred	PA; AGE (Min 6, Max 18)
ADZENYS XR TAB 18.8MG	Non Preferred	PA; AGE (Min 6, Max 18)
<i>amphetamine sulfate tab 5 mg (generic of EVEKEO)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>amphetamine sulfate tab 10 mg (generic of EVEKEO)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg (generic of ADDERALL XR)</i>	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg (generic of ADDERALL XR)</i>	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg (generic of ADDERALL XR)</i>	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg (generic of ADDERALL XR)</i>	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg (generic of ADDERALL XR)</i>	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg (generic of ADDERALL XR)</i>	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 5 mg (generic of ADDERALL)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 7.5 mg (generic of ADDERALL)</i>	Preferred	QL (5 tabs every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 10 mg (generic of ADDERALL)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 12.5 mg (generic of ADDERALL)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 15 mg (generic of ADDERALL)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 20 mg (generic of ADDERALL)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>amphetamine-dextroamphetamine tab 30 mg (generic of ADDERALL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 6, Max 18)
DEXEDRINE CAP 10MG CR	Non Preferred	PA, QL (4 caps every 1 day); AGE (Min 6, Max 18)
DEXEDRINE CAP 15MG CR	Non Preferred	PA, QL (2 caps every 1 day); AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	Non Preferred	PA, QL (4 caps every 1 day); AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dextroamphetamine sulfate cap er 24hr 10 mg (generic of DEXEDRINE)</i>	Non Preferred	PA, QL (4 caps every 1 day); AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate cap er 24hr 15 mg (generic of DEXEDRINE)</i>	Non Preferred	PA, QL (2 caps every 1 day); AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate tab 5 mg</i>	Non Preferred	PA, QL (6 tabs every 1 day); AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate tab 10 mg</i>	Non Preferred	PA, QL (6 tabs every 1 day); AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate tab 15 mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate tab 20 mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dextroamphetamine sulfate tab 30 mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
DYANAVEL XR CHW 5MG	Non Preferred	PA; AGE (Min 6, Max 18)
DYANAVEL XR CHW 10MG	Non Preferred	PA; AGE (Min 6, Max 18)
DYANAVEL XR CHW 15MG	Non Preferred	PA; AGE (Min 6, Max 18)
DYANAVEL XR CHW 20MG	Non Preferred	PA; AGE (Min 6, Max 18)
DYANAVEL XR SUS 2.5MG/ML	Preferred	PA; AGE (Min 6, Max 18)
EVEKEO ODT TAB 5MG	Non Preferred	PA; AGE (Min 6, Max 18)
EVEKEO ODT TAB 10MG	Non Preferred	PA; AGE (Min 6, Max 18)
EVEKEO ODT TAB 15MG	Non Preferred	PA; AGE (Min 6, Max 18)
EVEKEO ODT TAB 20MG	Non Preferred	PA; AGE (Min 6, Max 18)
EVEKEO TAB 5MG	Non Preferred	PA; AGE (Min 6, Max 18)
EVEKEO TAB 10MG	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methamphetamine hcl tab 5 mg (generic of DESOXYN)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
MYDAYIS CAP 12.5MG	Non Preferred	PA; AGE (Min 6, Max 18)
MYDAYIS CAP 25MG	Non Preferred	PA; AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MYDAYIS CAP 37.5MG	Non Preferred	PA; AGE (Min 6, Max 18)
MYDAYIS CAP 50MG	Non Preferred	PA; AGE (Min 6, Max 18)
<i>procentra sol 5mg/5ml</i>	Non Preferred	PA; AGE (Min 6, Max 18)
VYVANSE CAP 10MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CAP 20MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CAP 30MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CAP 40MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CAP 50MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CAP 60MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CAP 70MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CHW 10MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CHW 20MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CHW 30MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CHW 40MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CHW 50MG	Preferred	AGE (Min 6, Max 18)
VYVANSE CHW 60MG	Preferred	AGE (Min 6, Max 18)
XELSTRYM PAD 4.5MG/9H	Non Preferred	PA; AGE (Min 6, Max 18)
XELSTRYM PAD 9MG/9HR	Non Preferred	PA; AGE (Min 6, Max 18)
XELSTRYM PAD 13.5/9HR	Non Preferred	PA; AGE (Min 6, Max 18)
XELSTRYM PAD 18MG/9HR	Non Preferred	PA; AGE (Min 6, Max 18)
<i>zenzedi tab 2.5mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>zenzedi tab 5mg</i>	Non Preferred	PA, QL (6 tabs every 1 day); AGE (Min 6, Max 18)
<i>zenzedi tab 7.5mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>zenzedi tab 10mg</i>	Non Preferred	PA, QL (6 tabs every 1 day); AGE (Min 6, Max 18)
<i>zenzedi tab 15mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>zenzedi tab 20mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>zenzedi tab 30mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<b>ANALEPTICS</b>		
<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	Preferred	QL (40 vials in lifetime); AGE (Max 1)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS</b>		
<i>atomoxetine hcl cap 10 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>atomoxetine hcl cap 18 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>atomoxetine hcl cap 25 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>atomoxetine hcl cap 40 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>atomoxetine hcl cap 60 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>atomoxetine hcl cap 80 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>atomoxetine hcl cap 100 mg (base equiv)</i> (generic of STRATTERA)	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>clonidine hcl tab er 12hr 0.1 mg</i> (generic of KAPVAY)	Preferred	AGE (Min 6, Max 18)
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i> (generic of INTUNIV)	Preferred	QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i> (generic of INTUNIV)	Preferred	QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i> (generic of INTUNIV)	Preferred	QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i> (generic of INTUNIV)	Preferred	QL (1 tab every 1 day); AGE (Min 6, Max 18)
INTUNIV TAB 1MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
INTUNIV TAB 2MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
INTUNIV TAB 3MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
INTUNIV TAB 4MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
QELBREE CAP 100MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
QELBREE CAP 150MG ER	Non Preferred	PA; AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QELBREE CAP 200MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
STRATTERA CAP 10MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
STRATTERA CAP 18MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
STRATTERA CAP 25MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
STRATTERA CAP 40MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
STRATTERA CAP 60MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
STRATTERA CAP 80MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)
STRATTERA CAP 100MG	Preferred	QL (1 cap every 1 day); AGE (Min 6, Max 18)

**DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS  
(DNRIS)**

SUNOSI TAB 75MG	Non Preferred	PA; AGE (Min 6, Max 18)
SUNOSI TAB 150MG	Non Preferred	PA; AGE (Min 6, Max 18)

**HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS**

WAKIX TAB 4.45MG	Non Preferred	SP, PA; AGE (Min 18)
WAKIX TAB 17.8MG	Non Preferred	SP, PA; AGE (Min 18)

**STIMULANTS - MISC.**

APTENSIO XR CAP 10MG	Non Preferred	PA; AGE (Min 6, Max 18)
APTENSIO XR CAP 15MG	Non Preferred	PA; AGE (Min 6, Max 18)
APTENSIO XR CAP 20MG	Non Preferred	PA; AGE (Min 6, Max 18)
APTENSIO XR CAP 30MG	Non Preferred	PA; AGE (Min 6, Max 18)
APTENSIO XR CAP 40MG	Non Preferred	PA; AGE (Min 6, Max 18)
APTENSIO XR CAP 50MG	Non Preferred	PA; AGE (Min 6, Max 18)
APTENSIO XR CAP 60MG	Non Preferred	PA; AGE (Min 6, Max 18)
<i>armodafinil tab 50 mg (generic of NUVIGIL)</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
<i>armodafinil tab 150 mg (generic of NUVIGIL)</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>armodafinil tab 200 mg (generic of NUVIGIL)</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
<i>armodafinil tab 250 mg (generic of NUVIGIL)</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
AZSTARYS CAP 26.1-5.2	Non Preferred	PA; AGE (Min 6, Max 18)
AZSTARYS CAP 39.2-7.8	Non Preferred	PA; AGE (Min 6, Max 18)
AZSTARYS CAP 52.3-10.	Non Preferred	PA; AGE (Min 6, Max 18)
CONCERTA TAB 18MG	Preferred	AGE (Min 6, Max 18)
CONCERTA TAB 27MG	Preferred	AGE (Min 6, Max 18)
CONCERTA TAB 36MG	Preferred	AGE (Min 6, Max 18)
CONCERTA TAB 54MG	Preferred	AGE (Min 6, Max 18)
COTEMPLA XR TAB 8.6MG	Non Preferred	PA; AGE (Min 6, Max 18)
COTEMPLA XR TAB 17.3MG	Non Preferred	PA; AGE (Min 6, Max 18)
COTEMPLA XR TAB 25.9MG	Non Preferred	PA; AGE (Min 6, Max 18)
DAYTRANA DIS 10MG/9HR	Preferred	PA; AGE (Min 6, Max 18)
DAYTRANA DIS 15MG/9HR	Preferred	PA; AGE (Min 6, Max 18)
DAYTRANA DIS 20MG/9HR	Preferred	PA; AGE (Min 6, Max 18)
DAYTRANA DIS 30MG/9HR	Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 5 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 10 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 15 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 20 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 25 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 30 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 35 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl cap er 24 hr 40 mg (generic of FOCALIN XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl tab 2.5 mg (generic of FOCALIN)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl tab 5 mg (generic of FOCALIN)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 6, Max 18)
<i>dexmethylphenidate hcl tab 10 mg (generic of FOCALIN)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FOCALIN TAB 2.5MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 6, Max 18)
FOCALIN TAB 5MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 6, Max 18)
FOCALIN TAB 10MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 6, Max 18)
FOCALIN XR CAP 5MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 10MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 15MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 20MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 25MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 30MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 35MG	Preferred	AGE (Min 6, Max 18)
FOCALIN XR CAP 40MG	Preferred	AGE (Min 6, Max 18)
JORNAY PM CAP 20MG ER	Preferred	PA; AGE (Min 6, Max 18)
JORNAY PM CAP 40MG ER	Preferred	PA; AGE (Min 6, Max 18)
JORNAY PM CAP 60MG ER	Preferred	PA; AGE (Min 6, Max 18)
JORNAY PM CAP 80MG ER	Preferred	PA; AGE (Min 6, Max 18)
JORNAY PM CAP 100MG ER	Preferred	PA; AGE (Min 6, Max 18)
METHYLIN SOL 5MG/5ML	Non Preferred	PA, QL (15 mL every 1 day); AGE (Min 6, Max 18)
METHYLIN SOL 10MG/5ML	Non Preferred	PA, QL (30 mL every 1 day); AGE (Min 6, Max 18)
METHYLPHENID TAB 45MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
METHYLPHENID TAB 63MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
METHYLPHENID TAB 72MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 10 mg (cd)</i>	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 20 mg (cd)</i>	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 10 mg (la) (generic of RITALIN LA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 10 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 15 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl cap er 24hr 20 mg (la) (generic of RITALIN LA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 20 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 30 mg (la) (generic of RITALIN LA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 30 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 40 mg (la) (generic of RITALIN LA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 40 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 50 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 24hr 60 mg (xr) (generic of APTENSIO XR)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 30 mg (cd)</i>	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 40 mg (cd)</i>	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 50 mg (cd)</i>	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl cap er 60 mg (cd)</i>	Non Preferred	PA, QL (1 cap every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl chew tab 2.5 mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl chew tab 5 mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl chew tab 10 mg</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl soln 5 mg/5ml (generic of METHYLIN)</i>	Non Preferred	PA, QL (15 mL every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl soln 10 mg/5ml (generic of METHYLIN)</i>	Non Preferred	PA, QL (30 mL every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab 5 mg (generic of RITALIN)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab 10 mg (generic of RITALIN)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab 20 mg (generic of RITALIN)</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl tab er 10 mg</i>	Preferred	QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er 20 mg</i>	Preferred	QL (3 tabs every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er 24hr 18 mg</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er 24hr 27 mg</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er 24hr 36 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er 24hr 54 mg</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg (generic of CONCERTA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg (generic of CONCERTA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg (generic of CONCERTA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg (generic of CONCERTA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate td patch 10 mg/9hr (generic of DAYTRANA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate td patch 15 mg/9hr (generic of DAYTRANA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate td patch 20 mg/9hr (generic of DAYTRANA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>methylphenidate td patch 30 mg/9hr (generic of DAYTRANA)</i>	Non Preferred	PA; AGE (Min 6, Max 18)
<i>modafinil tab 100 mg (generic of PROVIGIL)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 17)
<i>modafinil tab 200 mg (generic of PROVIGIL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 17)
NUVIGIL TAB 50MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
NUVIGIL TAB 150MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
NUVIGIL TAB 200MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
NUVIGIL TAB 250MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
PROVIGIL TAB 100MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 17)
PROVIGIL TAB 200MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 17)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QUILLICHEW CHW 20MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
QUILLICHEW CHW 30MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
QUILLICHEW CHW 40MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
QUILLIVANT SUS 25MG/5ML	Non Preferred	PA; AGE (Min 6, Max 18)
RELEXXII TAB 45MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
RELEXXII TAB 63MG ER	Non Preferred	PA; AGE (Min 6, Max 18)
RELEXXII TAB 72MG	Non Preferred	PA; AGE (Min 6, Max 18)
RITALIN LA CAP 10MG	Non Preferred	PA; AGE (Min 6, Max 18)
RITALIN LA CAP 20MG	Non Preferred	PA; AGE (Min 6, Max 18)
RITALIN LA CAP 30MG	Non Preferred	PA; AGE (Min 6, Max 18)
RITALIN LA CAP 40MG	Non Preferred	PA; AGE (Min 6, Max 18)
RITALIN TAB 5MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
RITALIN TAB 10MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)
RITALIN TAB 20MG	Non Preferred	PA, QL (3 tabs every 1 day); AGE (Min 6, Max 18)

## **ALTERNATIVE MEDICINES - COMPLEMENTARY AND ALTERNATIVE MEDICINES**

### **ALTERNATIVE MEDICINE - M'S**

<i>melatonin tab 3 mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>melatonin tab 5 mg</i>	Preferred	QL (1 tab every 1 day), OTC

## **AMEBICIDES - DRUGS TO TREAT INFECTIONS**

### **AMEBICIDES - DRUGS TO TREAT INFECTIONS**

SOLOSEC GRA 2GM	Non Preferred	PA
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## **AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS**

### **AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS**

ARIKAYCE SUS	Non Preferred	PA
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BETHKIS NEB 300/4ML	Non Preferred	SP, PA
KITABIS PAK NEB 300/5ML	Preferred	SP
<i>neomycin sulfate tab 500 mg</i>	Preferred	
<i>paromomycin sulfate cap 250 mg (generic of HUMATIN)</i>	Preferred	
TOBI NEB 300/5ML	Non Preferred	SP, PA
TOBI PODHALR CAP 28MG	Non Preferred	SP, PA
<i>tobramycin nebu soln 300 mg/4ml (generic of BETHKIS)</i>	Non Preferred	SP, PA
<i>tobramycin nebu soln 300 mg/5ml (generic of KITABIS PAK)</i>	Non Preferred	SP, PA

## **ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION CONDITIONS**

### **ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES**

AMJEVITA INJ 20/0.4ML	Non Preferred	SP, PA
AMJEVITA INJ 40/0.8ML	Non Preferred	SP, PA
HUMIRA INJ 10/0.1ML	Preferred	SP, PA, QL (0.072 injections every 1 day)
HUMIRA INJ 20/0.2ML	Preferred	SP, PA, QL (0.072 injections every 1 day)
HUMIRA INJ 40/0.4ML	Preferred	SP, PA, QL (0.072 injections every 1 day)
HUMIRA KIT 40MG/0.8	Preferred	SP, PA
HUMIRA PEDIA INJ CROHNS	Preferred	SP, PA, QL (0.072 injections every 1 day)
HUMIRA PEN INJ 40/0.4ML	Preferred	SP, PA, QL (0.072 pens every 1 day)
HUMIRA PEN INJ 40MG/0.8	Preferred	SP, PA
HUMIRA PEN INJ 80/0.8ML	Preferred	SP, PA
HUMIRA PEN INJ CD/UC/HS	Preferred	SP, PA
HUMIRA PEN INJ PS/UV	Preferred	SP, PA
HUMIRA PEN KIT CD/UC/HS	Preferred	SP, PA
HUMIRA PEN KIT PED UC	Preferred	SP, PA
HUMIRA PEN KIT PS/UV	Preferred	SP, PA
SIMPONI ARIA SOL 50MG/4ML	Non Preferred	SP, PA
SIMPONI INJ 50/0.5ML	Non Preferred	SP, PA
SIMPONI INJ 100MG/ML	Non Preferred	SP, PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIRHEUMATIC - ENZYME INHIBITORS</b>		
OLUMIANT TAB 1MG	Non Preferred	SP, PA
OLUMIANT TAB 2MG	Non Preferred	SP, PA
OLUMIANT TAB 4MG	Non Preferred	SP, PA
RINVOQ TAB 15MG ER	Non Preferred	SP, PA
RINVOQ TAB 30MG ER	Non Preferred	SP, PA
RINVOQ TAB 45MG ER	Non Preferred	SP, PA
XELJANZ SOL 1MG/ML	Preferred	SP, PA
XELJANZ SOL 1MG/ML	Non Preferred	SP, PA
XELJANZ TAB 5MG	Preferred	SP, PA
XELJANZ TAB 10MG	Preferred	SP, PA
XELJANZ XR TAB 11MG	Preferred	SP, PA
XELJANZ XR TAB 22MG	Preferred	SP, PA

**ANTIRHEUMATIC ANTIMETABOLITES**

OTREXUP INJ 10MG	Non Preferred	PA
OTREXUP INJ 12.5/0.4	Non Preferred	PA
OTREXUP INJ 15MG	Non Preferred	PA
OTREXUP INJ 17.5/0.4	Non Preferred	PA
OTREXUP INJ 20MG	Non Preferred	PA
OTREXUP INJ 22.5/0.4	Non Preferred	PA
OTREXUP INJ 25MG	Non Preferred	PA
RASUVO INJ 7.5MG	Non Preferred	PA
RASUVO INJ 10MG	Non Preferred	PA
RASUVO INJ 12.5MG	Non Preferred	PA
RASUVO INJ 15MG	Non Preferred	PA
RASUVO INJ 17.5MG	Non Preferred	PA
RASUVO INJ 20MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RASUVO INJ 22.5MG	Non Preferred	PA
RASUVO INJ 25MG	Non Preferred	PA
RASUVO INJ 30MG	Non Preferred	PA
REDITREX INJ 7.5/.3ML	Non Preferred	SP, PA
REDITREX INJ 10/.4ML	Non Preferred	SP, PA
REDITREX INJ 12.5/0.5	Non Preferred	SP, PA
REDITREX INJ 15/.6ML	Non Preferred	SP, PA
REDITREX INJ 17.5/0.7	Non Preferred	SP, PA
REDITREX INJ 20/.8ML	Non Preferred	SP, PA
REDITREX INJ 22.5/0.9	Non Preferred	SP, PA
REDITREX INJ 25MG/ML	Non Preferred	SP, PA
<b><i>GOLD COMPOUNDS</i></b>		
RIDAURA CAP 3MG	Non Preferred	PA
<b><i>INTERLEUKIN-1 BLOCKERS</i></b>		
ARCALYST INJ 220MG	Non Preferred	SP, PA
<b><i>INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)</i></b>		
KINERET INJ	Non Preferred	SP, PA
<b><i>INTERLEUKIN-1BETA BLOCKERS</i></b>		
ILARIS INJ 150MG/ML	Non Preferred	SP, PA
<b><i>INTERLEUKIN-6 RECEPTOR INHIBITORS</i></b>		
ACTEMRA INJ 80MG/4ML	Non Preferred	SP, PA
ACTEMRA INJ 162/0.9	Non Preferred	SP, PA
ACTEMRA INJ 200/10ML	Non Preferred	SP, PA
ACTEMRA INJ 400/20ML	Non Preferred	SP, PA
ACTEMRA INJ ACTPEN	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KEVZARA INJ 150/1.14	Non Preferred	SP, PA
KEVZARA INJ 200/1.14	Non Preferred	SP, PA
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>		
ARTHROTEC 50 TAB	Non Preferred	PA
ARTHROTEC 75 TAB	Non Preferred	PA
CELEBREX CAP 50MG	Non Preferred	PA
CELEBREX CAP 100MG	Non Preferred	PA, QL (4 caps every 1 day)
CELEBREX CAP 200MG	Non Preferred	PA, QL (2 caps every 1 day)
CELEBREX CAP 400MG	Non Preferred	PA, QL (4 caps every 1 day)
<i>celecoxib cap 50 mg (generic of CELEBREX)</i>	Preferred	
<i>celecoxib cap 100 mg (generic of CELEBREX)</i>	Preferred	QL (4 caps every 1 day)
<i>celecoxib cap 200 mg (generic of CELEBREX)</i>	Preferred	QL (2 caps every 1 day)
<i>celecoxib cap 400 mg (generic of CELEBREX)</i>	Preferred	QL (4 caps every 1 day)
DAYPRO TAB 600MG	Non Preferred	PA, QL (3 tabs every 1 day)
<i>diclofenac potassium cap 25 mg (generic of ZIPSOR)</i>	Non Preferred	PA
<i>diclofenac potassium tab 25 mg</i>	Preferred	
<i>diclofenac potassium tab 50 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>diclofenac sodium tab delayed release 25 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>diclofenac sodium tab delayed release 50 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>diclofenac sodium tab delayed release 75 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>diclofenac sodium tab er 24hr 100 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg (generic of ARTHROTEC 50)</i>	Non Preferred	PA
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg (generic of ARTHROTEC 75)</i>	Non Preferred	PA
DUEXIS TAB 800-26.6	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ec-naproxen tab 375mg</i> (generic of EC-NAPROSYN)	Preferred	QL (3 tabs every 1 day)
<i>ec-naproxen tab 500mg</i> (generic of EC-NAPROSYN)	Preferred	QL (3 tabs every 1 day)
<i>etodolac cap 200 mg</i>	Preferred	
<i>etodolac cap 300 mg</i>	Preferred	
<i>etodolac tab 400 mg</i> (generic of LODINE)	Preferred	QL (3 tabs every 1 day)
<i>etodolac tab 500 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>etodolac tab er 24hr 400 mg</i>	Preferred	
<i>etodolac tab er 24hr 500 mg</i>	Preferred	
<i>etodolac tab er 24hr 600 mg</i>	Preferred	
FELDENE CAP 10MG	Non Preferred	PA, QL (4 caps every 1 day)
FELDENE CAP 20MG	Non Preferred	PA, QL (2 caps every 1 day)
<i>fenoprofen calcium cap 400 mg</i> (generic of NALFON)	Non Preferred	PA
<i>fenoprofen calcium tab 600 mg</i>	Non Preferred	PA
<i>flurbiprofen tab 100 mg</i>	Preferred	QL (4 tabs every 1 day)
IBUPAK KIT	Non Preferred	PA
<i>ibuprofen cap 200 mg</i>	Preferred	OTC
<i>ibuprofen chew tab 100 mg</i>	Preferred	OTC
<i>ibuprofen susp 40 mg/ml</i>	Preferred	OTC
<i>ibuprofen susp 100 mg/5ml</i>	Preferred	QL (160 mL every 1 day), OTC
<i>ibuprofen susp 100 mg/5ml</i>	Non Preferred	PA, QL (160 mL every 1 day)
<i>ibuprofen tab 100 mg</i>	Preferred	OTC
<i>ibuprofen tab 200 mg</i>	Preferred	OTC
<i>ibuprofen tab 400 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>ibuprofen tab 600 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>ibuprofen tab 800 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>ibuprofen-famotidine tab 800-26.6 mg</i> (generic of DUEXIS)	Non Preferred	PA
<i>indomethacin cap 25 mg</i>	Preferred	QL (4 caps every 1 day)
<i>indomethacin cap 50 mg</i>	Preferred	QL (4 caps every 1 day)
<i>indomethacin cap er 75 mg</i>	Preferred	
<i>ketoprofen cap er 24hr 200 mg</i>	Non Preferred	PA
KETOR TROMET SPR 15.75MG	Non Preferred	PA
<i>ketorolac tromethamine tab 10 mg</i>	Preferred	QL (20 tabs every 5 days)
<i>lofena tab 25mg</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>meclofenamate sodium cap 50 mg</i>	Non Preferred	PA
<i>meclofenamate sodium cap 100 mg</i>	Non Preferred	PA
<i>mefenamic acid cap 250 mg</i>	Non Preferred	PA
<i>meloxicam cap 5 mg</i>	Non Preferred	PA
<i>meloxicam cap 10 mg</i>	Non Preferred	PA
<i>meloxicam tab 7.5 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>meloxicam tab 15 mg</i>	Preferred	QL (1 tab every 1 day)
<i>nabumetone tab 500 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>nabumetone tab 750 mg</i>	Preferred	QL (4 tabs every 1 day)
NALFON CAP 400MG	Non Preferred	PA
NALFON TAB 600MG	Non Preferred	PA
NAPRELAN TAB 375MG CR	Non Preferred	PA
NAPRELAN TAB 500MG CR	Non Preferred	PA
NAPRELAN TAB 750MG CR	Non Preferred	PA
<i>naproxen sodium tab 220 mg</i>	Preferred	OTC
<i>naproxen sodium tab 275 mg</i>	Preferred	
<i>naproxen sodium tab 550 mg (generic of ANAPROX DS)</i>	Preferred	
<i>naproxen sodium tab er 24hr 375 mg (base equiv) (generic of NAPRELAN)</i>	Non Preferred	PA
<i>naproxen sodium tab er 24hr 375 mg (base equiv) (generic of NAPRELAN)</i>	Non Preferred	PA
<i>naproxen sodium tab er 24hr 500 mg (base equiv) (generic of NAPRELAN)</i>	Non Preferred	PA
<i>naproxen sodium tab er 24hr 500 mg (base equiv) (generic of NAPRELAN)</i>	Non Preferred	PA
<i>naproxen sodium tab er 24hr 750 mg (base equiv) (generic of NAPRELAN)</i>	Non Preferred	PA
<i>naproxen susp 125 mg/5ml (generic of NAPROSYN)</i>	Preferred	QL (100 mL every 1 day)
<i>naproxen tab 250 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>naproxen tab 375 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>naproxen tab 500 mg (generic of NAPROSYN)</i>	Preferred	QL (3 tabs every 1 day)
<i>naproxen tab ec 375 mg (generic of EC-NAPROSYN)</i>	Preferred	QL (3 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>naproxen tab ec 500 mg</i> (generic of EC-NAPROSYN)	Preferred	QL (3 tabs every 1 day)
<i>naproxen-esomeprazole magnesium tab dr 375-20 mg</i> (generic of VIMOVO)	Non Preferred	PA
<i>naproxen-esomeprazole magnesium tab dr 500-20 mg</i> (generic of VIMOVO)	Non Preferred	PA
<i>oxaprozin tab 600 mg</i> (generic of DAYPRO)	Non Preferred	PA, QL (3 tabs every 1 day)
<i>piroxicam cap 10 mg</i> (generic of FELDENE)	Non Preferred	PA, QL (4 caps every 1 day)
<i>piroxicam cap 20 mg</i> (generic of FELDENE)	Non Preferred	PA, QL (2 caps every 1 day)
RELAFEN DS TAB 1000MG	Non Preferred	PA
<i>sulindac tab 150 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>sulindac tab 200 mg</i>	Preferred	QL (3 tabs every 1 day)
VIMOVO TAB 375-20MG	Non Preferred	PA
VIMOVO TAB 500-20MG	Non Preferred	PA
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
OTEZLA TAB 10/20/30	Non Preferred	SP, PA
OTEZLA TAB 30MG	Non Preferred	SP, PA
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>		
ARAVA TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
ARAVA TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>leflunomide tab 10 mg</i> (generic of ARAVA)	Preferred	QL (1 tab every 1 day)
<i>leflunomide tab 20 mg</i> (generic of ARAVA)	Preferred	QL (1 tab every 1 day)
<b>SELECTIVE COSTIMULATION MODULATORS</b>		
ORENCIA CLCK INJ 125MG/ML	Non Preferred	SP, PA
ORENCIA INJ 50/0.4ML	Non Preferred	SP, PA
ORENCIA INJ 87.5/0.7	Non Preferred	SP, PA
ORENCIA INJ 125MG/ML	Non Preferred	SP, PA
ORENCIA INJ 250MG	Non Preferred	SP, PA
<b>SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS</b>		
ENBREL INJ 25/0.5ML	Preferred	SP, PA
ENBREL INJ 25MG	Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ENBREL INJ 50MG/ML	Preferred	SP, PA
ENBREL MINI INJ 50MG/ML	Preferred	SP, PA
ENBREL SRCLK INJ 50MG/ML	Preferred	SP, PA

## **ANALGESICS - NONNARCOTIC**

### **ANALGESIC COMBINATIONS**

ALLZITAL TAB 25-325MG	Non Preferred	PA
<i>bac tab</i> (generic of ESGIC)	Preferred	QL (6 tabs every 1 day)
<i>bupap tab 50-300mg</i>	Preferred	
<i>butalbital-acetaminophen cap 50-300 mg</i>	Non Preferred	PA
<i>butalbital-acetaminophen tab 50-300 mg</i>	Preferred	
<i>butalbital-acetaminophen tab 50-325 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>butalbital-acetaminophen-caffeine cap 50-300-40 mg</i> (generic of FIORICET)	Preferred	
<i>butalbital-acetaminophen-caffeine cap 50-325-40 mg</i>	Preferred	QL (2 caps every 1 day)
<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg</i> (generic of ESGIC)	Preferred	QL (6 tabs every 1 day)
<i>butalbital-aspirin-caffeine cap 50-325-40 mg</i>	Preferred	
ESGIC TAB	Non Preferred	PA, QL (6 tabs every 1 day)
FIORICET CAP	Non Preferred	PA

### **ANALGESICS OTHER**

<i>acetaminophen cap 500 mg</i>	Preferred	QL (8 caps every 1 day), OTC
<i>acetaminophen chew tab 80 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
<i>acetaminophen chew tab 160 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
<i>acetaminophen disintegrating tab 160 mg</i>	Preferred	QL (25 tabs every 1 day), OTC
<i>acetaminophen liquid 160 mg/5ml</i>	Preferred	OTC
<i>acetaminophen liquid 167 mg/5ml</i>	Preferred	OTC
<i>acetaminophen soln 160 mg/5ml</i>	Preferred	OTC
<i>acetaminophen suppos 120 mg</i>	Preferred	QL (34 supp every 1 day), OTC
<i>acetaminophen suppos 650 mg</i>	Preferred	QL (6 supp every 1 day), OTC
<i>acetaminophen susp 160 mg/5ml</i>	Preferred	OTC
<i>acetaminophen tab 325 mg</i>	Preferred	QL (12 tabs every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>acetaminophen tab 500 mg</i>	Preferred	QL (8 tabs every 1 day), OTC
<i>acetaminophen tab er 650 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
FEVERALL INF SUP 80MG	Preferred	QL (50 supp every 1 day), OTC

### **SALICYLATES**

<i>aspirin chew tab 81 mg</i>	Preferred	OTC
<i>aspirin tab 325 mg</i>	Preferred	OTC
<i>aspirin tab delayed release 81 mg</i>	Preferred	OTC
<i>aspirin tab delayed release 325 mg</i>	Preferred	OTC
<i>diflunisal tab 500 mg</i>	Preferred	
<i>salsalate tab 500 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>salsalate tab 750 mg</i>	Preferred	QL (4 tabs every 1 day)

### **ANALGESICS - OPIOID - DRUGS TO TREAT PAIN**

#### **OPIOID AGONISTS**

ACTIQ LOZ 200MCG	Non Preferred	PA
ACTIQ LOZ 400MCG	Non Preferred	PA
ACTIQ LOZ 600MCG	Non Preferred	PA
ACTIQ LOZ 800MCG	Non Preferred	PA
ACTIQ LOZ 1200MCG	Non Preferred	PA
ACTIQ LOZ 1600MCG	Non Preferred	PA
CODEINE SULF TAB 15MG	Preferred	AGE (Min 18), Max 5 day supply initial fill
CODEINE SULF TAB 60MG	Preferred	QL (8 tabs every 1 day); AGE (Min 18), Max 5 day supply initial fill
<i>codeine sulfate tab 30 mg</i>	Preferred	QL (12 tabs every 1 day); AGE (Min 18), Max 5 day supply initial fill
CONZIP CAP 100MG	Non Preferred	PA; AGE (Min 18)
CONZIP CAP 200MG	Non Preferred	PA; AGE (Min 18)
CONZIP CAP 300MG	Non Preferred	PA; AGE (Min 18)
DILAUDID LIQ 1MG/ML	Non Preferred	PA
DILAUDID TAB 2MG	Non Preferred	PA, QL (12 tabs every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DILAUDID TAB 4MG	Non Preferred	PA, QL (12 tabs every 1 day)
DILAUDID TAB 8MG	Non Preferred	PA
<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	Non Preferred	PA
<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	Non Preferred	PA
<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	Non Preferred	PA
<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	Non Preferred	PA
<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 200 mcg</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 400 mcg</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 600 mcg</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 800 mcg</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	Non Preferred	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	Non Preferred	PA
<i>fentanyl td patch 72hr 12 mcg/hr</i>	Non Preferred	PA, QL (0.334 patches every 1 day)
<i>fentanyl td patch 72hr 25 mcg/hr</i>	Non Preferred	PA, QL (0.334 patches every 1 day)
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	Non Preferred	PA
<i>fentanyl td patch 72hr 50 mcg/hr</i>	Non Preferred	PA, QL (0.334 patches every 1 day)
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	Non Preferred	PA
<i>fentanyl td patch 72hr 75 mcg/hr</i>	Non Preferred	PA, QL (0.334 patches every 1 day)
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	Non Preferred	PA
<i>fentanyl td patch 72hr 100 mcg/hr</i>	Non Preferred	PA, QL (0.334 patches every 1 day)
FENTORA TAB 100MCG	Non Preferred	PA
FENTORA TAB 200MCG	Non Preferred	PA
FENTORA TAB 400MCG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FENTORA TAB 600MCG	Non Preferred	PA
FENTORA TAB 800MCG	Non Preferred	PA
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 20 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 100 mg</i>	Non Preferred	PA
<i>hydrocodone bitartrate tab er 24hr deter 120 mg</i>	Non Preferred	PA
HYDROMORPHON SUP 3MG	Preferred	Max 5 day supply initial fill
<i>hydromorphone hcl liqd 1 mg/ml (generic of DILAUDID)</i>	Preferred	Max 5 day supply initial fill
<i>hydromorphone hcl tab 2 mg (generic of DILAUDID)</i>	Preferred	QL (12 tabs every 1 day); Max 5 day supply initial fill
<i>hydromorphone hcl tab 4 mg (generic of DILAUDID)</i>	Preferred	QL (12 tabs every 1 day); Max 5 day supply initial fill
<i>hydromorphone hcl tab 8 mg (generic of DILAUDID)</i>	Preferred	Max 5 day supply initial fill
<i>hydromorphone hcl tab er 24hr 8 mg</i>	Non Preferred	PA
<i>hydromorphone hcl tab er 24hr 12 mg</i>	Non Preferred	PA
<i>hydromorphone hcl tab er 24hr 16 mg</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydromorphone hcl tab er 24hr 32 mg</i>	Non Preferred	PA
HYSINGLA ER TAB 20 MG	Non Preferred	PA
HYSINGLA ER TAB 30 MG	Non Preferred	PA
HYSINGLA ER TAB 40 MG	Non Preferred	PA
HYSINGLA ER TAB 60 MG	Non Preferred	PA
HYSINGLA ER TAB 80 MG	Non Preferred	PA
HYSINGLA ER TAB 100 MG	Non Preferred	PA
HYSINGLA ER TAB 120 MG	Non Preferred	PA
<i>levorphanol tartrate tab 2 mg</i>	Non Preferred	PA
<i>levorphanol tartrate tab 3 mg</i>	Non Preferred	PA
<i>meperidine hcl oral soln 50 mg/5ml</i>	Non Preferred	PA, QL (500 mL every 25 days)
<i>meperidine hcl tab 50 mg</i>	Non Preferred	PA, QL (10 tabs every 1 day)
<i>methadone hcl conc 10 mg/ml (generic of METHADOSE)</i>	Non Preferred	PA
<i>methadone hcl soln 5 mg/5ml</i>	Non Preferred	PA
<i>methadone hcl soln 10 mg/5ml</i>	Non Preferred	PA
<i>methadone hcl tab 5 mg</i>	Non Preferred	PA
<i>methadone hcl tab 10 mg</i>	Non Preferred	PA
<i>methadone hcl tab for oral susp 40 mg</i>	Non Preferred	PA
METHADOSE CON 10MG/ML	Non Preferred	PA
METHADOSE SF CON 10MG/ML	Non Preferred	PA
<i>methadose tab 40mg</i>	Non Preferred	PA
<i>morphine sulfate beads cap er 24hr 30 mg</i>	Non Preferred	PA
<i>morphine sulfate beads cap er 24hr 45 mg</i>	Non Preferred	PA
<i>morphine sulfate beads cap er 24hr 60 mg</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>morphine sulfate beads cap er 24hr 75 mg</i>	Non Preferred	PA
<i>morphine sulfate beads cap er 24hr 90 mg</i>	Non Preferred	PA
<i>morphine sulfate beads cap er 24hr 120 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 10 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 20 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 30 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 50 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 60 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 80 mg</i>	Non Preferred	PA
<i>morphine sulfate cap er 24hr 100 mg</i>	Non Preferred	PA
<i>morphine sulfate oral soln 10 mg/5ml</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate oral soln 20 mg/5ml</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate suppos 5 mg</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate suppos 10 mg</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate suppos 20 mg</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate suppos 30 mg</i>	Preferred	Max 5 day supply initial fill
<i>morphine sulfate tab 15 mg</i>	Preferred	QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>morphine sulfate tab 30 mg</i>	Preferred	QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>morphine sulfate tab er 15 mg (generic of MS CONTIN)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>morphine sulfate tab er 30 mg (generic of MS CONTIN)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 5 day supply initial fill

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>morphine sulfate tab er 60 mg</i> (generic of MS CONTIN)	Preferred	PA, QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>morphine sulfate tab er 100 mg</i> (generic of MS CONTIN)	Preferred	PA, QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>morphine sulfate tab er 200 mg</i> (generic of MS CONTIN)	Preferred	PA, QL (3 tabs every 1 day); Max 5 day supply initial fill
MS CONTIN TAB 15MG ER	Non Preferred	PA, QL (3 tabs every 1 day)
MS CONTIN TAB 30MG ER	Non Preferred	PA, QL (3 tabs every 1 day)
MS CONTIN TAB 60MG ER	Non Preferred	PA, QL (3 tabs every 1 day)
MS CONTIN TAB 100MG ER	Non Preferred	PA, QL (3 tabs every 1 day)
MS CONTIN TAB 200MG ER	Non Preferred	PA, QL (3 tabs every 1 day)
NUCYNTA ER TAB 50MG	Non Preferred	PA
NUCYNTA ER TAB 100MG	Non Preferred	PA
NUCYNTA ER TAB 150MG	Non Preferred	PA
NUCYNTA ER TAB 200MG	Non Preferred	PA
NUCYNTA ER TAB 250MG	Non Preferred	PA
NUCYNTA TAB 50MG	Non Preferred	PA
NUCYNTA TAB 75MG	Non Preferred	PA
NUCYNTA TAB 100MG	Non Preferred	PA
<i>oxycodone hcl cap 5 mg</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl soln 5 mg/5ml</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl tab 5 mg</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl tab 10 mg</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl tab 15 mg</i> (generic of ROXICODONE)	Preferred	Max 5 day supply initial fill

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxycodone hcl tab 20 mg</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl tab 30 mg (generic of ROXICODONE)</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	Non Preferred	PA
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	Non Preferred	PA
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	Non Preferred	PA
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	Non Preferred	PA
OXYCONTIN TAB 10MG ER	Non Preferred	PA
OXYCONTIN TAB 15MG ER	Non Preferred	PA
OXYCONTIN TAB 20MG ER	Non Preferred	PA
OXYCONTIN TAB 30MG ER	Non Preferred	PA
OXYCONTIN TAB 40MG ER	Non Preferred	PA
OXYCONTIN TAB 60MG ER	Non Preferred	PA
OXYCONTIN TAB 80MG ER	Non Preferred	PA
<i>oxymorphone hcl tab 5 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab 10 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 5 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 7.5 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 10 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 15 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 20 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 30 mg</i>	Non Preferred	PA
<i>oxymorphone hcl tab er 12hr 40 mg</i>	Non Preferred	PA
ROXICODONE TAB 15MG	Non Preferred	PA
ROXICODONE TAB 30MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ROXYBOND TAB 5MG	Non Preferred	PA
ROXYBOND TAB 15MG	Non Preferred	PA
ROXYBOND TAB 30MG	Non Preferred	PA
<i>tramadol hcl cap er 24hr biphasic release 100 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl cap er 24hr biphasic release 200 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl cap er 24hr biphasic release 300 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl oral soln 5 mg/ml</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab 50 mg</i>	Preferred	QL (8 tabs every 1 day); AGE (Min 18), Max 5 day supply initial fill
<i>tramadol hcl tab 100 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab er 24hr 100 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab er 24hr 200 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab er 24hr 300 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	Non Preferred	PA; AGE (Min 18)
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	Non Preferred	PA; AGE (Min 18)
TRAMADOL SOL 5MG/ML	Non Preferred	PA; AGE (Min 18)
XTAMPZA ER CAP 9MG	Non Preferred	PA
XTAMPZA ER CAP 13.5MG	Non Preferred	PA
XTAMPZA ER CAP 18MG	Non Preferred	PA
XTAMPZA ER CAP 27MG	Non Preferred	PA
XTAMPZA ER CAP 36MG	Non Preferred	PA
<b>OPIOID COMBINATIONS</b>		
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	Preferred	PA, QL (3750 mL every 25 days); AGE (Max 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>acetaminophen w/ codeine tab 300-15 mg</i>	Preferred	QL (6 tabs every 1 day); AGE (Min 18), Max 5 day supply initial fill
<i>acetaminophen w/ codeine tab 300-30 mg</i>	Preferred	QL (6 tabs every 1 day); AGE (Min 18), Max 5 day supply initial fill
<i>acetaminophen w/ codeine tab 300-60 mg</i>	Preferred	QL (6 tabs every 1 day); AGE (Min 18), Max 5 day supply initial fill
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	Non Preferred	PA
APADAZ TAB 4.08-325	Non Preferred	PA
APADAZ TAB 6.12-325	Non Preferred	PA
APADAZ TAB 8.16-325	Non Preferred	PA
<i>ascomp/cod cap 30mg</i>	Preferred	AGE (Min 18), Max 5 day supply initial fill
BENZHY/ACETA TAB 4.08-325	Non Preferred	PA
BENZHY/ACETA TAB 6.12-325	Non Preferred	PA
BENZHY/ACETA TAB 8.16-325	Non Preferred	PA
<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg (generic of FIORICET/CODEINE)</i>	Non Preferred	PA; AGE (Min 18)
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	Non Preferred	PA, QL (8 caps every 1 day); AGE (Min 18)
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	Preferred	AGE (Min 18), Max 5 day supply initial fill
<i>endocet tab 5-325mg (generic of PERCOCET)</i>	Preferred	QL (8 tabs every 1 day); Max 5 day supply initial fill
<i>endocet tab 7.5-325 (generic of PERCOCET)</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
<i>endocet tab 10-325mg (generic of PERCOCET)</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
FIORICET CAP CODEINE	Non Preferred	PA; AGE (Min 18)
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	Preferred	QL (3750 mL every 25 days); Max 5 day supply initial fill
<i>hydrocodone-acetaminophen tab 5-300 mg (generic of XODOL)</i>	Preferred	Max 5 day supply initial fill



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
<i>hydrocodone-acetaminophen tab 7.5-300 mg</i>	Preferred	Max 5 day supply initial fill
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
<i>hydrocodone-acetaminophen tab 10-300 mg</i>	Preferred	Max 5 day supply initial fill
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
<i>hydrocodone-ibuprofen tab 5-200 mg</i>	Preferred	Max 5 day supply initial fill
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	Preferred	Max 5 day supply initial fill
<i>hydrocodone-ibuprofen tab 10-200 mg</i>	Preferred	Max 5 day supply initial fill
NALOCET TAB 2.5-300	Non Preferred	PA
<i>oxycodone w/ acetaminophen soln 5-325 mg/5ml</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone w/ acetaminophen tab 2.5-325 mg (generic of PERCOCET)</i>	Preferred	Max 5 day supply initial fill
<i>oxycodone w/ acetaminophen tab 5-325 mg (generic of PERCOCET)</i>	Preferred	QL (8 tabs every 1 day); Max 5 day supply initial fill
<i>oxycodone w/ acetaminophen tab 7.5-325 mg (generic of PERCOCET)</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
<i>oxycodone w/ acetaminophen tab 10-325 mg (generic of PERCOCET)</i>	Preferred	QL (6 tabs every 1 day); Max 5 day supply initial fill
PERCOCET TAB 2.5-325	Non Preferred	PA
PERCOCET TAB 5-325MG	Non Preferred	PA, QL (8 tabs every 1 day); Max 5 day supply initial fill
PERCOCET TAB 7.5-325	Non Preferred	PA, QL (6 tabs every 1 day)
PERCOCET TAB 10-325MG	Non Preferred	PA, QL (6 tabs every 1 day)
PROLATE SOL 10/300MG	Non Preferred	PA
PROLATE TAB 5-300MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PROLATE TAB 7.5-300	Non Preferred	PA
PROLATE TAB 10-300MG	Non Preferred	PA
SEGLENTIS TAB 56-44MG	Non Preferred	PA; AGE (Min 18)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	Non Preferred	PA; AGE (Min 18)

### **OPIOID PARTIAL AGONISTS**

BELBUCA MIS 75MCG	Non Preferred	PA
BELBUCA MIS 150MCG	Non Preferred	PA
BELBUCA MIS 300MCG	Non Preferred	PA
BELBUCA MIS 450MCG	Non Preferred	PA
BELBUCA MIS 600MCG	Non Preferred	PA
BELBUCA MIS 750MCG	Non Preferred	PA
BELBUCA MIS 900MCG	Non Preferred	PA
<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	Preferred	QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	Preferred	QL (3 tabs every 1 day); Max 5 day supply initial fill
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (generic of SUBOXONE)</i>	Preferred	QL (3 films every 1 day)
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) (generic of SUBOXONE)</i>	Preferred	QL (3 films every 1 day)
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (generic of SUBOXONE)</i>	Preferred	QL (3 films every 1 day)
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) (generic of SUBOXONE)</i>	Preferred	QL (3 films every 1 day)
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	Preferred	QL (3 tabs every 1 day)
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	Preferred	QL (3 tabs every 1 day)
<i>buprenorphine td patch weekly 5 mcg/hr (generic of BUTRANS)</i>	Non Preferred	PA
<i>buprenorphine td patch weekly 7.5 mcg/hr (generic of BUTRANS)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>buprenorphine td patch weekly 10 mcg/hr (generic of BUTRANS)</i>	Non Preferred	PA
<i>buprenorphine td patch weekly 15 mcg/hr (generic of BUTRANS)</i>	Non Preferred	PA
<i>buprenorphine td patch weekly 20 mcg/hr (generic of BUTRANS)</i>	Non Preferred	PA
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	Non Preferred	PA
BUTRANS DIS 5MCG/HR	Non Preferred	PA
BUTRANS DIS 7.5/HR	Non Preferred	PA
BUTRANS DIS 10MCG/HR	Non Preferred	PA
BUTRANS DIS 15MCG/HR	Non Preferred	PA
BUTRANS DIS 20MCG/HR	Non Preferred	PA
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	Non Preferred	PA
SUBLOCADE INJ 100/0.5	Preferred	SP
SUBLOCADE INJ 300/1.5	Preferred	SP
SUBOXONE MIS 2-0.5MG	Preferred	QL (3 films every 1 day)
SUBOXONE MIS 4-1MG	Preferred	QL (3 films every 1 day)
SUBOXONE MIS 8-2MG	Preferred	QL (3 films every 1 day)
SUBOXONE MIS 12-3MG	Preferred	QL (3 films every 1 day)
ZUBSOLV SUB 0.7-0.18	Preferred	QL (3 tabs every 1 day)
ZUBSOLV SUB 1.4-0.36	Preferred	QL (3 tabs every 1 day)
ZUBSOLV SUB 2.9-0.71	Preferred	QL (3 tabs every 1 day)
ZUBSOLV SUB 5.7-1.4	Preferred	QL (3 tabs every 1 day)
ZUBSOLV SUB 8.6-2.1	Preferred	QL (3 tabs every 1 day)
ZUBSOLV SUB 11.4-2.9	Preferred	QL (3 tabs every 1 day)

## **ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES**

### **ANDROGENS**

<i>depo-testost inj 100mg/ml</i>	Preferred	
<i>depo-testost inj 200mg/ml</i>	Preferred	
<i>testosterone cypionate im inj in oil 100 mg/ml</i>	Preferred	
<i>testosterone cypionate im inj in oil 200 mg/ml</i>	Preferred	
<i>testosterone enanthate im inj in oil 200 mg/ml</i>	Preferred	

## **ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS**

### **INTRARECTAL STEROIDS**

<i>budesonide rectal foam 2 mg/act (generic of UCERIS)</i>	Non Preferred	PA
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CORTENEMA ENE 100MG	Non Preferred	PA, QL (60 mL every 1 day)
CORTIFOAM AER 90MG	Non Preferred	PA
<i>hydrocortisone enema 100 mg/60ml (generic of CORTENEMA)</i>	Preferred	QL (60 mL every 1 day)
UCERIS AER 2MG/ACT	Non Preferred	PA

### **RECTAL COMBINATIONS**

<i>ana-lex kit</i>	Non Preferred	PA
LIDO-HYDRO GEL 2.8-0.55	Non Preferred	PA
<i>lidocaine-hydrocortisone acetate perianal cream 3-0.5%</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone acetate rectal cream kit 2-2%</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone acetate rectal cream kit 3-0.5%</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone acetate rectal cream kit 3-1%</i>	Non Preferred	PA
<i>lidocaine-hydrocortisone acetate rectal gel kit 3-2.5%</i>	Non Preferred	PA
<i>lidocort cre 3-0.5%</i>	Non Preferred	PA
<i>pramox-pe-glycerin-petrolatum rectal cream 1-0.25-14.4-15%</i>	Preferred	OTC
PROCTOFOAM AER HC 1%	Non Preferred	PA

### **RECTAL LOCAL ANESTHETICS**

<i>qc dibucaine oin 1%</i>	Preferred	OTC
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### **RECTAL STEROIDS**

ANUSOL-HC CRE 2.5%	Non Preferred	PA
<i>hydrocortisone perianal cream 1% (generic of PROCTOCORT)</i>	Preferred	
<i>hydrocortisone perianal cream 2.5% (generic of ANUSOL-HC)</i>	Preferred	
<i>procto-med cre hc 2.5% (generic of ANUSOL-HC)</i>	Preferred	
<i>proctosol hc cre 2.5% (generic of ANUSOL-HC)</i>	Preferred	
<i>proctozone cre -hc 2.5% (generic of ANUSOL-HC)</i>	Preferred	

### **VASODILATING AGENTS**

RECTIV OIN 0.4%	Non Preferred	PA
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Drug Name	Drug Tier	Requirements/Limits
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**ANTACIDS - DRUGS FOR ULCERS AND STOMACH ACID**

**ANTACID COMBINATIONS**

<i>alum &amp; mag hydroxide-simethicone chew tab 200-200-25 mg</i>	Preferred	OTC
<i>alum &amp; mag hydroxide-simethicone susp 200-200-20 mg/5ml</i>	Preferred	OTC
<i>alum &amp; mag hydroxide-simethicone susp 400-400-40 mg/5ml</i>	Preferred	OTC
<i>aluminum hydroxide-magnesium carbonate chew tab 160-105 mg</i>	Preferred	OTC
<i>aluminum hydroxide-magnesium carbonate susp 95-358 mg/15ml</i>	Preferred	OTC

**ANTACIDS - BICARBONATE**

<i>sodium bicarbonate tab 325 mg</i>	Preferred	OTC
<i>sodium bicarbonate tab 650 mg</i>	Preferred	OTC

**ANTACIDS - CALCIUM SALTS**

CALCIUM CARB TAB 648MG	Preferred	OTC
<i>calcium carbonate (antacid) chew tab 500 mg</i>	Preferred	OTC
<i>calcium carbonate (antacid) chew tab 750 mg</i>	Preferred	OTC
<i>calcium carbonate (antacid) chew tab 1000 mg</i>	Preferred	OTC
<i>calcium carbonate (antacid) susp 1250 mg/5ml</i>	Preferred	OTC

**ANTACIDS - MAGNESIUM SALTS**

<i>magnesium oxide tab 400 mg</i>	Preferred	OTC
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**ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES**

**ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES**

<i>albendazole tab 200 mg</i>	Non Preferred	PA
BENZNIDAZOLE TAB 12.5MG	Non Preferred	PA
BENZNIDAZOLE TAB 100MG	Non Preferred	PA
BILTRICIDE TAB 600MG	Non Preferred	PA
EMVERM CHW 100MG	Non Preferred	PA
<i>ivermectin tab 3 mg (generic of STROMEKTOL)</i>	Non Preferred	PA, QL (10 tabs every 1 day)
<i>praziquantel tab 600 mg (generic of BILTRICIDE)</i>	Preferred	
STROMEKTOL TAB 3MG	Non Preferred	PA, QL (10 tabs every 1 day)

**Drug Name Drug Tier Requirements/Limits**  
**ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS**  
**ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS**

AEMCOLO TAB 194MG	Non Preferred	PA
FLAGYL CAP 375MG	Non Preferred	PA
<i>metronidazole cap 375 mg (generic of FLAGYL)</i>	Non Preferred	PA
<i>metronidazole tab 250 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>metronidazole tab 500 mg</i>	Preferred	QL (4 tabs every 1 day)
NEBUPENT INH 300MG	Preferred	
<i>pentamidine isethionate for nebulization soln 300 mg (generic of NEBUPENT)</i>	Preferred	
<i>tinidazole tab 250 mg</i>	Non Preferred	PA
<i>tinidazole tab 500 mg</i>	Non Preferred	PA
<i>trimethoprim tab 100 mg</i>	Preferred	QL (6 tabs every 1 day)
XIFAXAN TAB 200MG	Non Preferred	PA
XIFAXAN TAB 550MG	Non Preferred	PA

**ANTI-INFECTIVE MISC. - COMBINATIONS**

BACTRIM DS TAB 800-160	Non Preferred	PA, QL (4 tabs every 1 day)
BACTRIM TAB 400-80MG	Non Preferred	PA, QL (4 tabs every 1 day)
<i>hyophen tab</i>	Non Preferred	PA
<i>me/naphos/mb tab hyo 1</i>	Non Preferred	PA
<i>phosphasal tab</i>	Non Preferred	PA
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>sulfamethoxazole-trimethoprim tab 400-80 mg (generic of BACTRIM)</i>	Preferred	QL (4 tabs every 1 day)
<i>sulfamethoxazole-trimethoprim tab 800-160 mg (generic of BACTRIM DS)</i>	Preferred	QL (4 tabs every 1 day)
<i>sulfatrim pd sus 200-40/5</i>	Preferred	QL (40 mL every 1 day)
<i>uro-mp cap 118mg</i>	Non Preferred	PA
UROGESIC- TAB BLUE	Non Preferred	PA
<i>ustell cap</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIPROTOZOAL AGENTS</b>		
<i>atovaquone susp 750 mg/5ml (generic of MEPRON)</i>	Preferred	
LAMPIT TAB 30MG	Non Preferred	PA
LAMPIT TAB 120MG	Non Preferred	PA
MEPRON SUS	Non Preferred	PA
<i>nitazoxanide tab 500 mg (generic of ALINIA)</i>	Non Preferred	PA
<b>CARBAPENEMS</b>		
<i>ertapenem sodium for inj 1 gm (base equivalent) (generic of INVANZ)</i>	Preferred	
<i>meropenem iv for soln 1 gm</i>	Preferred	
<i>meropenem iv for soln 500 mg</i>	Preferred	
<b>GLYCOPEPTIDES</b>		
FIRVANQ SOL 25MG/ML	Non Preferred	PA, QL (40 mL every 1 day)
FIRVANQ SOL 50MG/ML	Non Preferred	PA, QL (40 mL every 1 day)
VANCOCIN CAP 125MG	Non Preferred	PA
VANCOCIN CAP 250MG	Non Preferred	PA
<i>vancomycin hcl cap 125 mg (base equivalent) (generic of VANCOCIN)</i>	Preferred	
<i>vancomycin hcl cap 250 mg (base equivalent) (generic of VANCOCIN)</i>	Preferred	
<i>vancomycin hcl for iv soln 1 gm (base equivalent)</i>	Preferred	
<i>vancomycin hcl for iv soln 1.5 gm (base equivalent)</i>	Preferred	
<i>vancomycin hcl for iv soln 5 gm (base equivalent)</i>	Preferred	
<i>vancomycin hcl for iv soln 10 gm (base equivalent)</i>	Preferred	
<i>vancomycin hcl for iv soln 500 mg (base equivalent)</i>	Preferred	
<i>vancomycin hcl for iv soln 750 mg (base equivalent)</i>	Preferred	
<i>vancomycin hcl for oral soln 25 mg/ml (base equivalent) (generic of FIRVANQ)</i>	Preferred	QL (40 mL every 1 day)
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent) (generic of FIRVANQ)</i>	Preferred	QL (40 mL every 1 day)
VANCOMYCIN INJ 750MG	Preferred	
VANCOMYCIN SOL 1.5GM	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VANCOMYCIN SOL 1.25GM	Preferred	
VANCOMYCIN SOL 250/5ML	Preferred	QL (40 mL every 1 day)
<b>LEPROSTATICS</b>		
<i>dapsone tab 25 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>dapsone tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<b>LINCOSAMIDES</b>		
CLEOCIN CAP 75MG	Non Preferred	PA
CLEOCIN CAP 150MG	Non Preferred	PA, QL (8 caps every 1 day)
CLEOCIN CAP 300MG	Non Preferred	PA, QL (6 caps every 1 day)
CLEOCIN PED SOL 75MG/5ML	Non Preferred	PA
<i>clindamycin hcl cap 75 mg (generic of CLEOCIN)</i>	Preferred	
<i>clindamycin hcl cap 150 mg (generic of CLEOCIN)</i>	Preferred	QL (8 caps every 1 day)
<i>clindamycin hcl cap 300 mg (generic of CLEOCIN)</i>	Preferred	QL (6 caps every 1 day)
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv) (generic of CLEOCIN PEDIATRIC GRANULE)</i>	Preferred	
<b>MONOBACTAMS</b>		
CAYSTON INH 75MG	Non Preferred	SP, PA
<b>OXAZOLIDINONES</b>		
<i>linezolid for susp 100 mg/5ml (generic of ZYVOX)</i>	Non Preferred	PA
<i>linezolid tab 600 mg (generic of ZYVOX)</i>	Non Preferred	PA
SIVEXTRO TAB 200MG	Non Preferred	PA
ZYVOX SUS 100MG/5M	Non Preferred	PA
ZYVOX TAB 600MG	Non Preferred	PA
<b>PLEUROMUTILINS</b>		
XENLETA TAB 600MG	Non Preferred	PA
<b>URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS</b>		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent) (generic of MONUROL)</i>	Preferred	
HIPREX TAB 1GM	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MACROBID CAP 100MG	Non Preferred	PA, QL (2 caps every 1 day)
MACRODANTIN CAP 25MG	Non Preferred	PA
MACRODANTIN CAP 50MG	Non Preferred	PA, QL (2 caps every 1 day)
MACRODANTIN CAP 100MG	Non Preferred	PA, QL (4 caps every 1 day)
<i>methenamine hippurate tab 1 gm</i> (generic of HIPREX)	Preferred	
<i>methenamine mandelate tab 0.5 gm</i>	Preferred	
<i>methenamine mandelate tab 1 gm</i>	Preferred	
MONUROL PAK GRANULES	Preferred	
<i>nitrofurantoin macrocrystalline cap 25 mg</i> (generic of MACRODANTIN)	Preferred	
<i>nitrofurantoin macrocrystalline cap 50 mg</i> (generic of MACRODANTIN)	Preferred	QL (2 caps every 1 day)
<i>nitrofurantoin macrocrystalline cap 100 mg</i> (generic of MACRODANTIN)	Preferred	QL (4 caps every 1 day)
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i> (generic of MACROBID)	Preferred	QL (2 caps every 1 day)
<i>nitrofurantoin susp 25 mg/5ml</i>	Preferred	QL (40 mL every 1 day)

## **ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS**

### **ANTIANGINALS-OTHER**

ASPRUZYO SPR GRA 500MG	Non Preferred	PA
ASPRUZYO SPR GRA 1000MG	Non Preferred	PA
<i>ranolazine tab er 12hr 500 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>ranolazine tab er 12hr 1000 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)

### **NITRATES**

GONITRO POW 400MCG	Non Preferred	PA
ISORDIL TAB 5MG	Non Preferred	PA, QL (4 tabs every 1 day)
ISORDIL TAB 40MG	Non Preferred	PA
<i>isosorbide dinitrate tab 5 mg</i> (generic of ISORDIL TITRADOSE)	Preferred	QL (4 tabs every 1 day)
<i>isosorbide dinitrate tab 10 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>isosorbide dinitrate tab 20 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>isosorbide dinitrate tab 30 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>isosorbide dinitrate tab 40 mg</i> (generic of ISORDIL TITRADOSE)	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>isosorbide mononitrate tab 10 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>isosorbide mononitrate tab 20 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	Preferred	QL (2 tabs every 1 day)
NITRO-BID OIN 2%	Preferred	
NITRO-DUR DIS 0.1MG/HR	Non Preferred	PA, QL (1 ea every 1 day)
NITRO-DUR DIS 0.2MG/HR	Non Preferred	PA, QL (1 patch every 1 day)
NITRO-DUR DIS 0.3MG/HR	Non Preferred	PA
NITRO-DUR DIS 0.4MG/HR	Non Preferred	PA, QL (1 patch every 1 day)
NITRO-DUR DIS 0.6MG/HR	Non Preferred	PA, QL (1 tab every 1 day)
NITRO-DUR DIS 0.8MG/HR	Non Preferred	PA
<i>nitroglycerin sl tab 0.3 mg (generic of NITROSTAT)</i>	Preferred	QL (10 tabs every 1 day)
<i>nitroglycerin sl tab 0.4 mg (generic of NITROSTAT)</i>	Preferred	QL (10 tabs every 1 day)
<i>nitroglycerin sl tab 0.6 mg (generic of NITROSTAT)</i>	Preferred	QL (10 tabs every 1 day)
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	Preferred	QL (1 patch every 1 day)
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	Preferred	QL (1 patch every 1 day)
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	Preferred	QL (1 patch every 1 day)
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	Preferred	QL (1 patch every 1 day)
<i>nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray) (generic of NITROLINGUAL PUMPSPRAY)</i>	Non Preferred	PA
NITROLINGUAL SPR PUMSPRA	Non Preferred	PA
NITROSTAT SUB 0.3MG	Non Preferred	PA, QL (10 tabs every 1 day)
NITROSTAT SUB 0.4MG	Non Preferred	PA, QL (10 tabs every 1 day)
NITROSTAT SUB 0.6MG	Non Preferred	PA, QL (10 tabs every 1 day)

## **ANTI-ANXIETY AGENTS - DRUGS TO TREAT ANXIETY**

### **ANTI-ANXIETY AGENTS - MISC.**

<i>bupirone hcl tab 5 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>bupirone hcl tab 7.5 mg</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bupirone hcl tab 10 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>bupirone hcl tab 15 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>bupirone hcl tab 30 mg</i>	Preferred	
<i>hydroxyzine hcl syrup 10 mg/5ml</i>	Preferred	QL (60 mL every 1 day)
<i>hydroxyzine hcl tab 10 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>hydroxyzine hcl tab 25 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>hydroxyzine hcl tab 50 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>hydroxyzine pamoate cap 25 mg (generic of VISTARIL)</i>	Preferred	QL (8 caps every 1 day)
<i>hydroxyzine pamoate cap 50 mg (generic of VISTARIL)</i>	Preferred	QL (8 caps every 1 day)
<i>hydroxyzine pamoate cap 100 mg</i>	Preferred	QL (4 caps every 1 day)
<i>meprobamate tab 200 mg</i>	Non Preferred	PA
<i>meprobamate tab 400 mg</i>	Non Preferred	PA
VISTARIL CAP 25MG	Non Preferred	PA, QL (8 caps every 1 day)
VISTARIL CAP 50MG	Non Preferred	PA, QL (8 caps every 1 day)

### **BENZODIAZEPINES**

ALPRAZOLAM CON 1 MG/ML	Preferred	PA; Max 14 day supply initial fill
<i>alprazolam orally disintegrating tab 0.5 mg</i>	Non Preferred	PA
<i>alprazolam orally disintegrating tab 0.25 mg</i>	Non Preferred	PA
<i>alprazolam orally disintegrating tab 1 mg</i>	Non Preferred	PA
<i>alprazolam orally disintegrating tab 2 mg</i>	Non Preferred	PA
<i>alprazolam tab 0.5 mg (generic of XANAX)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>alprazolam tab 0.5mg xr (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab 0.25 mg (generic of XANAX)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>alprazolam tab 1 mg (generic of XANAX)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>alprazolam tab 1mg xr (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab 2 mg (generic of XANAX)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>alprazolam tab 2mg xr (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab 3mg xr (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab er 24hr 0.5 mg (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab er 24hr 1 mg (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab er 24hr 2 mg (generic of XANAX XR)</i>	Non Preferred	PA
<i>alprazolam tab er 24hr 3 mg (generic of XANAX XR)</i>	Non Preferred	PA
ATIVAN TAB 0.5MG	Non Preferred	PA, QL (3 tabs every 1 day)
ATIVAN TAB 1MG	Non Preferred	PA, QL (3 tabs every 1 day)
ATIVAN TAB 2MG	Non Preferred	PA, QL (3 tabs every 1 day)
<i>chlordiazepoxide hcl cap 5 mg</i>	Preferred	PA, QL (3 caps every 1 day); Max 14 day supply initial fill
<i>chlordiazepoxide hcl cap 10 mg</i>	Preferred	PA, QL (3 caps every 1 day); Max 14 day supply initial fill
<i>chlordiazepoxide hcl cap 25 mg</i>	Preferred	PA, QL (3 caps every 1 day); Max 14 day supply initial fill
<i>clorazepate dipotassium tab 3.75 mg</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>clorazepate dipotassium tab 7.5 mg</i>	Preferred	PA, QL (4 tabs every 1 day); Max 14 day supply initial fill
<i>clorazepate dipotassium tab 15 mg</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>diazepam conc 5 mg/ml</i>	Preferred	PA, QL (3 mL every 1 day); Max 14 day supply initial fill
<i>diazepam oral soln 1 mg/ml</i>	Preferred	PA, QL (4 mL every 1 day); Max 14 day supply initial fill
<i>diazepam tab 2 mg (generic of VALIUM)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>diazepam tab 5 mg (generic of VALIUM)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diazepam tab 10 mg (generic of VALIUM)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>lorazepam conc 2 mg/ml</i>	Preferred	PA, QL (3 mL every 1 day); Max 14 day supply initial fill
<i>lorazepam tab 0.5 mg (generic of ATIVAN)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>lorazepam tab 1 mg (generic of ATIVAN)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
<i>lorazepam tab 2 mg (generic of ATIVAN)</i>	Preferred	PA, QL (3 tabs every 1 day); Max 14 day supply initial fill
LOREEV XR CAP 1.5MG	Non Preferred	PA
LOREEV XR CAP 1MG	Non Preferred	PA
LOREEV XR CAP 2MG	Non Preferred	PA
LOREEV XR CAP 3MG	Non Preferred	PA
<i>oxazepam cap 10 mg</i>	Preferred	PA, QL (3 caps every 1 day); Max 14 day supply initial fill
<i>oxazepam cap 15 mg</i>	Preferred	PA, QL (3 caps every 1 day); Max 14 day supply initial fill
<i>oxazepam cap 30 mg</i>	Preferred	PA, QL (4 caps every 1 day); Max 14 day supply initial fill
XANAX TAB 0.5MG	Non Preferred	PA, QL (3 tabs every 1 day)
XANAX TAB 0.25MG	Non Preferred	PA, QL (3 tabs every 1 day)
XANAX TAB 1MG	Non Preferred	PA, QL (3 tabs every 1 day)
XANAX TAB 2MG	Non Preferred	PA, QL (3 tabs every 1 day)
XANAX XR TAB 0.5MG	Non Preferred	PA
XANAX XR TAB 1MG	Non Preferred	PA
XANAX XR TAB 2MG	Non Preferred	PA
XANAX XR TAB 3MG	Non Preferred	PA

Drug Name	Drug Tier	Requirements/Limits
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**ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS**

**ANTIARRHYTHMICS TYPE I-A**

<i>disopyramide phosphate cap 100 mg</i> (generic of NORPACE)	Preferred	QL (8 caps every 1 day)
<i>disopyramide phosphate cap 150 mg</i> (generic of NORPACE)	Preferred	QL (5 caps every 1 day)
NORPACE CAP 100MG	Non Preferred	PA, QL (8 caps every 1 day)
NORPACE CAP 100MG CR	Preferred	
NORPACE CAP 150MG	Non Preferred	PA, QL (5 caps every 1 day)
NORPACE CAP 150MG CR	Preferred	
<i>quinidine gluconate tab er 324 mg</i>	Preferred	
<i>quinidine gluconate tab er 324 mg</i>	Preferred	
<i>quinidine sulfate tab 200 mg</i>	Preferred	
<i>quinidine sulfate tab 300 mg</i>	Preferred	QL (8 tabs every 1 day)

**ANTIARRHYTHMICS TYPE I-B**

<i>mexiletine hcl cap 150 mg</i>	Preferred	QL (6 caps every 1 day)
<i>mexiletine hcl cap 200 mg</i>	Preferred	QL (6 caps every 1 day)
<i>mexiletine hcl cap 250 mg</i>	Preferred	QL (6 caps every 1 day)

**ANTIARRHYTHMICS TYPE I-C**

<i>flecainide acetate tab 50 mg</i>	Preferred	QL (7 tabs every 1 day)
<i>flecainide acetate tab 100 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>flecainide acetate tab 150 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>propafenone hcl cap er 12hr 225 mg</i> (generic of RYTHMOL SR)	Non Preferred	PA
<i>propafenone hcl cap er 12hr 325 mg</i> (generic of RYTHMOL SR)	Non Preferred	PA
<i>propafenone hcl cap er 12hr 425 mg</i> (generic of RYTHMOL SR)	Non Preferred	PA
<i>propafenone hcl tab 150 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>propafenone hcl tab 225 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>propafenone hcl tab 300 mg</i>	Preferred	QL (3 tabs every 1 day)
RYTHMOL SR CAP 225MG	Non Preferred	PA
RYTHMOL SR CAP 325MG	Non Preferred	PA
RYTHMOL SR CAP 425MG	Non Preferred	PA

**ANTIARRHYTHMICS TYPE III**

<i>amiodarone hcl tab 100 mg</i>	Preferred	
<i>amiodarone hcl tab 200 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>amiodarone hcl tab 400 mg</i>	Preferred	
<i>dofetilide cap 125 mcg (0.125 mg)</i> (generic of TIKOSYN)	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dofetilide cap 250 mcg (0.25 mg)</i> (generic of TIKOSYN)	Preferred	
<i>dofetilide cap 500 mcg (0.5 mg)</i> (generic of TIKOSYN)	Preferred	
MULTAQ TAB 400MG	Non Preferred	PA
<i>pacerone tab 100mg</i>	Preferred	
<i>pacerone tab 200mg</i>	Preferred	QL (4 tabs every 1 day)
<i>pacerone tab 400mg</i>	Preferred	
TIKOSYN CAP 125MCG	Non Preferred	PA
TIKOSYN CAP 250MCG	Non Preferred	PA
TIKOSYN CAP 500MCG	Non Preferred	PA

## **ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

### **ANTI-INFLAMMATORY AGENTS**

<i>cromolyn sodium soln nebu 20 mg/2ml</i>	Preferred	QL (26 each every 1 day)
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### **ANTI-ASTHMATIC - MONOCLONAL ANTIBODIES**

CINQAIR INJ	Non Preferred	SP, PA
FASENRA INJ 30MG/ML	Preferred	SP, PA
FASENRA PEN INJ 30MG/ML	Preferred	SP, PA
NUCALA INJ 40MG/0.4	Preferred	SP, PA
NUCALA INJ 100MG	Preferred	SP, PA
NUCALA INJ 100MG/ML	Preferred	SP, PA
TEZSPIRE INJ 210MG	Non Preferred	SP, PA
TEZSPIRE SOL 210MG	Non Preferred	SP, PA
XOLAIR INJ 75/0.5	Preferred	SP, PA
XOLAIR INJ 150MG/ML	Preferred	SP, PA
XOLAIR SOL 150MG	Preferred	SP, PA

### **BRONCHODILATORS - ANTICHOLINERGICS**

ATROVENT HFA AER 17MCG	Preferred	QL (1 inhaler every 25 days)
INCRUSE ELPT INH 62.5MCG	Preferred	QL (1 blister every 1 day)
<i>ipratropium bromide inhal soln 0.02%</i>	Preferred	QL (10 mL every 1 day)
LONHALA MAGN SOL 25MCG	Non Preferred	PA
SPIRIVA AER 1.25MCG	Preferred	AGE (Min 6, Max 17)
SPIRIVA CAP HANDIHLR	Preferred	
SPIRIVA SPR 2.5MCG	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TUDORZA PRES AER 400/ACT	Non Preferred	PA
YUPELRI SOL	Non Preferred	PA

### **LEUKOTRIENE MODULATORS**

ACCOLATE TAB 10MG	Non Preferred	PA
ACCOLATE TAB 20MG	Non Preferred	PA
<i>montelukast sodium chew tab 4 mg (base equiv) (generic of SINGULAIR)</i>	Preferred	QL (1 tab every 1 day)
<i>montelukast sodium chew tab 5 mg (base equiv) (generic of SINGULAIR)</i>	Preferred	QL (1 tab every 1 day)
<i>montelukast sodium oral granules packet 4 mg (base equiv) (generic of SINGULAIR)</i>	Preferred	
<i>montelukast sodium tab 10 mg (base equiv) (generic of SINGULAIR)</i>	Preferred	QL (1 tab every 1 day)
SINGULAIR CHW 4MG	Non Preferred	PA, QL (1 tab every 1 day)
SINGULAIR CHW 5MG	Non Preferred	PA, QL (1 tab every 1 day)
SINGULAIR GRA 4MG	Non Preferred	PA
SINGULAIR TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>zafirlukast tab 10 mg (generic of ACCOLATE)</i>	Preferred	
<i>zafirlukast tab 20 mg (generic of ACCOLATE)</i>	Preferred	
<i>zileuton tab er 12hr 600 mg</i>	Non Preferred	PA
ZYFLO TAB 600MG	Non Preferred	PA

### **SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS**

DALIRESP TAB 250MCG	Non Preferred	PA
DALIRESP TAB 500MCG	Non Preferred	PA
<i>roflumilast tab 250 mcg (generic of DALIRESP)</i>	Non Preferred	PA
<i>roflumilast tab 500 mcg (generic of DALIRESP)</i>	Non Preferred	PA

### **STEROID INHALANTS**

ALVESCO AER 80MCG	Non Preferred	PA
ALVESCO AER 160MCG	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ARMONAIR DIG AER 55MCG	Non Preferred	PA
ARMONAIR DIG AER 113MCG	Non Preferred	PA
ARMONAIR DIG AER 232MCG	Non Preferred	PA
ARNUITY ELPT INH 50MCG	Non Preferred	PA, QL (0.033 inhalers every 1 day)
ARNUITY ELPT INH 100MCG	Non Preferred	PA, QL (1 blister every 1 day)
ARNUITY ELPT INH 200MCG	Non Preferred	PA, QL (1 blister every 1 day)
ASMANEX 14 AER 220MCG	Preferred	
ASMANEX 30 AER 110MCG	Preferred	
ASMANEX 30 AER 220MCG	Preferred	
ASMANEX 60 AER 220MCG	Preferred	
ASMANEX 120 AER 220MCG	Preferred	
ASMANEX HFA AER 50MCG	Non Preferred	PA
ASMANEX HFA AER 100 MCG	Non Preferred	PA
ASMANEX HFA AER 200 MCG	Non Preferred	PA
<i>budesonide inhalation susp 0.5 mg/2ml (generic of PULMICORT)</i>	Preferred	QL (4 mL every 1 day); AGE (Max 7)
<i>budesonide inhalation susp 0.25 mg/2ml (generic of PULMICORT)</i>	Preferred	QL (4 mL every 1 day); AGE (Max 7)
<i>budesonide inhalation susp 1 mg/2ml (generic of PULMICORT)</i>	Preferred	AGE (Max 7)
FLOVENT DISK AER 50MCG	Preferred	
FLOVENT DISK AER 100MCG	Preferred	
FLOVENT DISK AER 250MCG	Preferred	
FLOVENT HFA AER 44MCG	Preferred	QL (0.033 inhalers every 1 day)
FLOVENT HFA AER 110MCG	Preferred	QL (0.033 inhalers every 1 day)
FLOVENT HFA AER 220MCG	Preferred	
<i>fluticasone propionate hfa inhal aer 110 mcg/act (125/valve)</i>	Non Preferred	PA, QL (0.033 inhalers every 1 day)
<i>fluticasone propionate hfa inhal aer 220 mcg/act (250/valve)</i>	Non Preferred	PA
<i>fluticasone propionate hfa inhal aero 44 mcg/act (50/valve)</i>	Non Preferred	PA, QL (0.033 inhalers every 1 day)
PULMICORT INH 90MCG	Non Preferred	PA
PULMICORT INH 180MCG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PULMICORT SUS 0.5MG/2	Non Preferred	PA, QL (4 mL every 1 day); AGE (Max 7)
PULMICORT SUS 0.25MG/2	Non Preferred	PA, QL (4 mL every 1 day); AGE (Max 7)
PULMICORT SUS 1MG/2ML	Non Preferred	PA; AGE (Max 7)
QVAR REDIHA AER 80MCG	Non Preferred	PA, QL (0.354 gm every 1 day)
QVAR REDIHAL AER 40MCG	Non Preferred	PA, QL (0.354 gm every 1 day)

### **SYMPATHOMIMETICS**

ADVAIR DISKU AER 100/50	Preferred	QL (2 inhalations every 1 day)
ADVAIR DISKU AER 250/50	Preferred	QL (2 inhalations every 1 day)
ADVAIR DISKU AER 500/50	Preferred	QL (2 inhalations every 1 day)
ADVAIR HFA AER 45/21	Preferred	
ADVAIR HFA AER 115/21	Preferred	
ADVAIR HFA AER 230/21	Preferred	
AIRDUO DGHLR INH 55-14	Preferred	
AIRDUO DGHLR INH 113-14	Preferred	
AIRDUO DGHLR INH 232-14	Preferred	
AIRDUO RESPI INH 55-14	Preferred	QL (0.04 inhalers every 1 day)
AIRDUO RESPI INH 113-14	Preferred	QL (0.04 inhalers every 1 day)
AIRDUO RESPI INH 232-14	Preferred	QL (0.04 inhalers every 1 day)
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	Preferred	QL (1 inhaler every 25 days)
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv) (generic of PROVENTIL HFA)</i>	Preferred	QL (1 inhaler every 25 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	Preferred	QL (6 each every 1 day)
<i>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</i>	Preferred	QL (12 each every 1 day)
<i>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</i>	Preferred	QL (12 each every 1 day)
<i>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</i>	Preferred	QL (9 each every 1 day)
<i>albuterol sulfate syrup 2 mg/5ml</i>	Non Preferred	PA, QL (150 mL every 1 day)
<i>albuterol sulfate tab 2 mg</i>	Non Preferred	PA
<i>albuterol sulfate tab 4 mg</i>	Non Preferred	PA, QL (8 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ANORO ELLIPT AER 62.5-25	Preferred	QL (2 blisters every 1 day)
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv) (generic of BROVANA)</i>	Non Preferred	PA
BEVESPI AER 9-4.8MCG	Non Preferred	PA
BREO ELLIPTA INH 100-25	Non Preferred	PA
BREO ELLIPTA INH 200-25	Non Preferred	PA
BREZTRI AERO AER SPHERE	Non Preferred	PA
BREZTRI AERO AER SPHERE	Non Preferred	PA
BROVANA NEB 15MCG	Non Preferred	PA
<i>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act (generic of SYMBICORT)</i>	Non Preferred	PA, QL (0.033 inhalers every 1 day)
<i>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act (generic of SYMBICORT)</i>	Non Preferred	PA, QL (0.033 inhalers every 1 day)
COMBIVENT AER 20-100	Non Preferred	PA
DUAKLIR AER 400/12	Non Preferred	PA
DULERA AER 50-5MCG	Preferred	
DULERA AER 100-5MCG	Preferred	
DULERA AER 200-5MCG	Preferred	
<i>fluticasone furoate-vilanterol aero powd ba 100-25 mcg/act</i>	Non Preferred	PA
<i>fluticasone furoate-vilanterol aero powd ba 200-25 mcg/act</i>	Non Preferred	PA
<i>fluticasone-salmeterol aer powder ba 55-14 mcg/act</i>	Non Preferred	PA, QL (0.04 inhalers every 1 day)
<i>fluticasone-salmeterol aer powder ba 100-50 mcg/act (generic of ADVAIR DISKUS)</i>	Non Preferred	PA, QL (2 inhalations every 1 day)
<i>fluticasone-salmeterol aer powder ba 113-14 mcg/act</i>	Non Preferred	PA, QL (0.04 inhalers every 1 day)
<i>fluticasone-salmeterol aer powder ba 232-14 mcg/act</i>	Non Preferred	PA, QL (0.04 inhalers every 1 day)
<i>fluticasone-salmeterol aer powder ba 250-50 mcg/act (generic of ADVAIR DISKUS)</i>	Non Preferred	PA, QL (2 inhalations every 1 day)
<i>fluticasone-salmeterol aer powder ba 500-50 mcg/act (generic of ADVAIR DISKUS)</i>	Non Preferred	PA, QL (2 inhalations every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluticasone-salmeterol inhal aerosol 45-21 mcg/act</i>	Non Preferred	PA
<i>fluticasone-salmeterol inhal aerosol 115-21 mcg/act</i>	Non Preferred	PA
<i>fluticasone-salmeterol inhal aerosol 230-21 mcg/act</i>	Non Preferred	PA
<i>formoterol fumarate soln nebu 20 mcg/2ml (generic of PERFOROMIST)</i>	Non Preferred	PA
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	Preferred	QL (360 mL every 25 days)
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	Preferred	
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	Preferred	
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	Preferred	
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	Preferred	
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	Preferred	
PERFOROMIST NEB 20MCG	Non Preferred	PA
PROAIR DIGIH AER	Non Preferred	PA
PROAIR RESPI AER	Non Preferred	PA
PROVENTIL AER HFA	Preferred	QL (1 inhaler every 25 days)
SEREVENT DIS AER 50MCG	Preferred	
STIOLTO AER 2.5-2.5	Non Preferred	PA
STRIVERDI AER 2.5MCG	Non Preferred	PA, QL (0.5 inhalers every 1 day)
SYMBICORT AER 80-4.5	Preferred	QL (0.033 inhalers every 1 day)
SYMBICORT AER 80-4.5	Preferred	QL (0.049 inhalers every 1 day)
SYMBICORT AER 160-4.5	Preferred	QL (0.033 inhalers every 1 day)
SYMBICORT AER 160-4.5	Preferred	QL (0.057 inhalers every 1 day)
<i>terbutaline sulfate tab 2.5 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>terbutaline sulfate tab 5 mg</i>	Preferred	QL (6 tabs every 1 day)
TRELEGY AER 100MCG	Non Preferred	PA
TRELEGY AER 200MCG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VENTOLIN HFA AER	Preferred	QL (1 inhaler every 25 days)
<i>wixela inhub aer 100/50</i> (generic of ADVAIR DISKUS)	Non Preferred	PA, QL (2 inhalations every 1 day)
<i>wixela inhub aer 250/50</i> (generic of ADVAIR DISKUS)	Non Preferred	PA, QL (2 inhalations every 1 day)
<i>wixela inhub aer 500/50</i> (generic of ADVAIR DISKUS)	Non Preferred	PA, QL (2 inhalations every 1 day)
XOPENEX HFA AER	Preferred	

### **XANTHINES**

THEO-24 CAP 100MG CR	Preferred	
THEO-24 CAP 200MG CR	Preferred	
THEO-24 CAP 300MG CR	Preferred	
THEO-24 CAP 400MG ER	Preferred	
<i>theophylline elixir 80 mg/15ml</i>	Preferred	
<i>theophylline soln 80 mg/15ml</i>	Preferred	
<i>theophylline tab er 12hr 300 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>theophylline tab er 12hr 450 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>theophylline tab er 24hr 400 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>theophylline tab er 24hr 600 mg</i>	Preferred	QL (3 tabs every 1 day)

### **ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS**

#### **COUMARIN ANTICOAGULANTS**

<i>warfarin sodium tab 1 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 2 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 2.5 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 3 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 4 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 5 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 6 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 7.5 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>warfarin sodium tab 10 mg</i>	Preferred	QL (10 tabs every 1 day)

#### **DIRECT FACTOR XA INHIBITORS**

ELIQUIS ST P TAB 5MG	Preferred	PA
ELIQUIS TAB 2.5MG	Preferred	PA
ELIQUIS TAB 5MG	Preferred	PA
SAVAYSA TAB 15MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SAVAYSA TAB 30MG	Non Preferred	PA
SAVAYSA TAB 60MG	Non Preferred	PA
XARELTO STAR TAB 15/20MG	Preferred	PA
XARELTO SUS 1MG/ML	Non Preferred	PA
XARELTO TAB 2.5MG	Preferred	PA
XARELTO TAB 10MG	Preferred	PA, QL (1 tab every 1 day)
XARELTO TAB 15MG	Preferred	PA, QL (2 tabs every 1 day)
XARELTO TAB 20MG	Preferred	PA, QL (1 tab every 1 day)

### **HEPARINS AND HEPARINOID-LIKE AGENTS**

ARIXTRA INJ 2.5/0.5	Non Preferred	PA
ARIXTRA INJ 5/0.4ML	Non Preferred	PA
ARIXTRA INJ 7.5/0.6	Non Preferred	PA
ARIXTRA INJ 10/0.8ML	Non Preferred	PA
<i>enoxaparin sodium inj 300 mg/3ml (generic of LOVENOX)</i>	Preferred	
<i>enoxaparin sodium inj soln pref syr 30 mg/0.3ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>enoxaparin sodium inj soln pref syr 40 mg/0.4ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>enoxaparin sodium inj soln pref syr 60 mg/0.6ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>enoxaparin sodium inj soln pref syr 80 mg/0.8ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>enoxaparin sodium inj soln pref syr 100 mg/ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>enoxaparin sodium inj soln pref syr 120 mg/0.8ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>enoxaparin sodium inj soln pref syr 150 mg/ml (generic of LOVENOX)</i>	Preferred	QL (2 syringes every 1 day)
<i>fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml (generic of ARIXTRA)</i>	Preferred	
<i>fondaparinux sodium subcutaneous inj 5 mg/0.4ml (generic of ARIXTRA)</i>	Preferred	
<i>fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml (generic of ARIXTRA)</i>	Preferred	
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml (generic of ARIXTRA)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FRAGMIN INJ 2500/0.2	Preferred	
FRAGMIN INJ 2500/ML	Preferred	
FRAGMIN INJ 5000/0.2	Preferred	
FRAGMIN INJ 7500/0.3	Preferred	
FRAGMIN INJ 10000/ML	Preferred	
FRAGMIN INJ 12500UNT	Preferred	
FRAGMIN INJ 15000UNT	Preferred	
FRAGMIN INJ 18000UNT	Preferred	
FRAGMIN INJ 95000UNT	Preferred	
HEPARIN SOD INJ 5000/0.5	Preferred	
HEPARIN SOD INJ 5000/ML	Preferred	
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	Preferred	
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	Preferred	
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	Preferred	
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	Preferred	
<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>	Preferred	
LOVENOX INJ 30/0.3ML	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 40/0.4ML	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 60/0.6ML	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 80/0.8ML	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 100MG/ML	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 120/0.8	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 150MG/ML	Non Preferred	PA, QL (2 syringes every 1 day)
LOVENOX INJ 300/3ML	Non Preferred	PA
<b>THROMBIN INHIBITORS</b>		
<i>dabigatran etexilate mesylate cap 75 mg (etexilate base eq)</i>	Non Preferred	PA
<i>dabigatran etexilate mesylate cap 150 mg (etexilate base eq) (generic of PRADAXA)</i>	Non Preferred	PA
PRADAXA CAP 75MG	Non Preferred	PA
PRADAXA CAP 110MG	Non Preferred	PA
PRADAXA CAP 150MG	Non Preferred	PA
PRADAXA PAK 20MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PRADAXA PAK 30MG	Non Preferred	PA
PRADAXA PAK 40MG	Non Preferred	PA
PRADAXA PAK 50MG	Non Preferred	PA
PRADAXA PAK 110MG	Non Preferred	PA
PRADAXA PAK 150MG	Non Preferred	PA

## **ANTICONVULSANTS - DRUGS TO TREAT SEIZURES**

### **AMPA GLUTAMATE RECEPTOR ANTAGONISTS**

FYCOMPA SUS 0.5MG/ML	Non Preferred	PA
FYCOMPA TAB 2MG	Non Preferred	PA
FYCOMPA TAB 4MG	Non Preferred	PA
FYCOMPA TAB 6MG	Non Preferred	PA
FYCOMPA TAB 8MG	Non Preferred	PA
FYCOMPA TAB 10MG	Non Preferred	PA
FYCOMPA TAB 12MG	Non Preferred	PA

### **ANTICONVULSANTS - BENZODIAZEPINES**

<i>clobazam suspension 2.5 mg/ml (generic of ONFI)</i>	Non Preferred	PA
<i>clobazam tab 10 mg (generic of ONFI)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>clobazam tab 20 mg (generic of ONFI)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>clonazepam orally disintegrating tab 0.5 mg</i>	Non Preferred	PA
<i>clonazepam orally disintegrating tab 0.25 mg</i>	Non Preferred	PA
<i>clonazepam orally disintegrating tab 0.125 mg</i>	Non Preferred	PA
<i>clonazepam orally disintegrating tab 1 mg</i>	Non Preferred	PA
<i>clonazepam orally disintegrating tab 2 mg</i>	Non Preferred	PA
<i>clonazepam tab 0.5 mg (generic of KLONOPIN)</i>	Preferred	QL (10 tabs every 1 day)
<i>clonazepam tab 1 mg (generic of KLONOPIN)</i>	Preferred	QL (10 tabs every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clonazepam tab 2 mg (generic of KLONOPIN)</i>	Preferred	QL (10 tabs every 1 day)
DIASTAT ACDL GEL 5-10MG	Preferred	QL (0.2 ea every 1 day)
DIASTAT ACDL GEL 12.5-20	Preferred	QL (0.2 ea every 1 day)
DIASTAT PED GEL 2.5M GEL	Preferred	QL (0.2 ea every 1 day)
<i>diazepam rectal gel delivery system 2.5 mg</i>	Preferred	QL (0.2 ea every 1 day)
<i>diazepam rectal gel delivery system 10 mg</i>	Preferred	QL (0.2 ea every 1 day)
<i>diazepam rectal gel delivery system 20 mg</i>	Preferred	QL (0.2 ea every 1 day)
KLONOPIN TAB 0.5MG	Non Preferred	PA, QL (10 tabs every 1 day)
KLONOPIN TAB 1MG	Non Preferred	PA, QL (10 tabs every 1 day)
KLONOPIN TAB 2MG	Non Preferred	PA, QL (10 tabs every 1 day)
NAYZILAM SPR 5MG	Non Preferred	PA
ONFI SUS 2.5MG/ML	Non Preferred	PA
ONFI TAB 10MG	Non Preferred	PA, QL (2 tabs every 1 day)
ONFI TAB 20MG	Non Preferred	PA, QL (2 tabs every 1 day)
SYMPAZAN MIS 5MG	Non Preferred	PA
SYMPAZAN MIS 10MG	Non Preferred	PA
SYMPAZAN MIS 20MG	Non Preferred	PA
VALTOCO SPR 5MG	Non Preferred	PA, QL (10 sprays every 25 days)
VALTOCO SPR 10MG	Non Preferred	PA, QL (10 sprays every 26 days)
VALTOCO SPR 15MG	Non Preferred	PA, QL (10 ea every 27 days)
VALTOCO SPR 20MG	Non Preferred	PA, QL (10 ea every 28 days)
<b>ANTICONVULSANTS - MISC.</b>		
APTIOM TAB 200MG	Non Preferred	PA
APTIOM TAB 400MG	Non Preferred	PA
APTIOM TAB 600MG	Non Preferred	PA
APTIOM TAB 800MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BANZEL SUS 40MG/ML	Non Preferred	PA, QL (80 mL every 1 day)
BANZEL TAB 200MG	Non Preferred	PA, QL (16 tabs every 1 day)
BANZEL TAB 400MG	Non Preferred	PA, QL (8 tabs every 1 day)
BRIVIACT SOL 10MG/ML	Non Preferred	PA
BRIVIACT TAB 10MG	Non Preferred	PA
BRIVIACT TAB 25MG	Non Preferred	PA
BRIVIACT TAB 50MG	Non Preferred	PA
BRIVIACT TAB 75MG	Non Preferred	PA
BRIVIACT TAB 100MG	Non Preferred	PA
<i>carbamazepine cap er 12hr 100 mg (generic of CARBATROL)</i>	Non Preferred	PA, QL (8 caps every 1 day)
<i>carbamazepine cap er 12hr 200 mg (generic of CARBATROL)</i>	Non Preferred	PA, QL (8 caps every 1 day)
<i>carbamazepine cap er 12hr 300 mg (generic of CARBATROL)</i>	Non Preferred	PA, QL (8 caps every 1 day)
<i>carbamazepine chew tab 100 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>carbamazepine susp 100 mg/5ml (generic of TEGRETOL)</i>	Preferred	QL (60 mL every 1 day)
<i>carbamazepine tab 200 mg (generic of TEGRETOL)</i>	Preferred	QL (8 tabs every 1 day)
<i>carbamazepine tab er 12hr 100 mg (generic of TEGRETOL-XR)</i>	Preferred	QL (8 tabs every 1 day)
<i>carbamazepine tab er 12hr 200 mg (generic of TEGRETOL-XR)</i>	Preferred	QL (8 tabs every 1 day)
<i>carbamazepine tab er 12hr 400 mg (generic of TEGRETOL-XR)</i>	Preferred	QL (8 tabs every 1 day)
CARBATROL CAP 100MG	Non Preferred	PA, QL (8 caps every 1 day)
CARBATROL CAP 200MG	Non Preferred	PA, QL (8 caps every 1 day)
CARBATROL CAP 300MG	Non Preferred	PA, QL (8 caps every 1 day)
DIACOMIT CAP 250MG	Non Preferred	SP, PA
DIACOMIT CAP 500MG	Non Preferred	SP, PA
DIACOMIT PAK 250MG	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DIACOMIT PAK 500MG	Non Preferred	SP, PA
ELEPSIA XR TAB 1000MG	Non Preferred	PA
ELEPSIA XR TAB 1500MG	Non Preferred	PA
EPIDIOLEX SOL 100MG/ML	Non Preferred	SP, PA
<i>epitol tab 200mg</i> (generic of TEGRETOL)	Preferred	QL (8 tabs every 1 day)
EPRONTIA SOL 25MG/ML	Non Preferred	PA
FINTEPLA SOL 2.2MG/ML	Non Preferred	PA
<i>gabapentin cap 100 mg</i> (generic of NEURONTIN)	Preferred	QL (10 caps every 1 day)
<i>gabapentin cap 300 mg</i> (generic of NEURONTIN)	Preferred	QL (10 caps every 1 day)
<i>gabapentin cap 400 mg</i> (generic of NEURONTIN)	Preferred	QL (9 caps every 1 day)
<i>gabapentin oral soln 250 mg/5ml</i> (generic of NEURONTIN)	Preferred	
<i>gabapentin tab 600 mg</i> (generic of NEURONTIN)	Preferred	QL (6 tabs every 1 day)
<i>gabapentin tab 800 mg</i> (generic of NEURONTIN)	Preferred	QL (4 tabs every 1 day)
KEPPRA SOL 100MG/ML	Non Preferred	PA, QL (30 mL every 1 day)
KEPPRA TAB 250MG	Non Preferred	PA, QL (6 tabs every 1 day)
KEPPRA TAB 500MG	Non Preferred	PA, QL (6 tabs every 1 day)
KEPPRA TAB 750MG	Non Preferred	PA, QL (4 tabs every 1 day)
KEPPRA TAB 1000MG	Non Preferred	PA, QL (3 tabs every 1 day)
KEPPRA XR TAB 500MG	Non Preferred	PA, QL (6 tabs every 1 day)
KEPPRA XR TAB 750MG	Non Preferred	PA, QL (4 tabs every 1 day)
<i>lacosamide oral solution 10 mg/ml</i> (generic of VIMPAT)	Non Preferred	PA, QL (40 mL every 1 day)
<i>lacosamide tab 50 mg</i> (generic of VIMPAT)	Non Preferred	PA, QL (2 tabs every 1 day)
<i>lacosamide tab 100 mg</i> (generic of VIMPAT)	Non Preferred	PA, QL (2 tabs every 1 day)
<i>lacosamide tab 150 mg</i> (generic of VIMPAT)	Non Preferred	PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lacosamide tab 200 mg</i> (generic of VIMPAT)	Non Preferred	PA, QL (2 tabs every 1 day)
LAMICTAL CHW 5MG	Non Preferred	PA, QL (8 tabs every 1 day)
LAMICTAL CHW 25MG	Non Preferred	PA, QL (8 tabs every 1 day)
LAMICTAL KIT START 35	Non Preferred	PA
LAMICTAL KIT START 49	Non Preferred	PA
LAMICTAL KIT START 98	Non Preferred	PA
LAMICTAL ODT KIT	Non Preferred	PA
LAMICTAL ODT KIT	Non Preferred	PA
LAMICTAL ODT TAB 25MG	Non Preferred	PA
LAMICTAL ODT TAB 50MG	Non Preferred	PA
LAMICTAL ODT TAB 100MG	Non Preferred	PA
LAMICTAL ODT TAB 200MG	Non Preferred	PA
LAMICTAL TAB 25MG	Non Preferred	PA, QL (10 tabs every 1 day)
LAMICTAL TAB 100MG	Non Preferred	PA, QL (8 tabs every 1 day)
LAMICTAL TAB 150MG	Non Preferred	PA, QL (4 tabs every 1 day)
LAMICTAL TAB 200MG	Non Preferred	PA, QL (4 tabs every 1 day)
LAMICTAL XR KIT	Non Preferred	PA
LAMICTAL XR TAB 25MG	Non Preferred	PA
LAMICTAL XR TAB 50MG	Non Preferred	PA
LAMICTAL XR TAB 100MG	Non Preferred	PA
LAMICTAL XR TAB 200MG	Non Preferred	PA
LAMICTAL XR TAB 250MG	Non Preferred	PA
LAMICTAL XR TAB 300MG	Non Preferred	PA
<i>lamotrigine orally disintegrating tab 25 mg</i> (generic of LAMICTAL ODT)	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lamotrigine orally disintegrating tab 50 mg (generic of LAMICTAL ODT)</i>	Non Preferred	PA
<i>lamotrigine orally disintegrating tab 100 mg (generic of LAMICTAL ODT)</i>	Non Preferred	PA
<i>lamotrigine orally disintegrating tab 200 mg (generic of LAMICTAL ODT)</i>	Non Preferred	PA
<i>lamotrigine tab 25 mg (generic of LAMICTAL)</i>	Preferred	QL (10 tabs every 1 day)
<i>lamotrigine tab 25 mg (42) &amp; 100 mg (7) starter kit (generic of LAMICTAL STARTER/NOT TAKI)</i>	Non Preferred	PA
<i>lamotrigine tab 35 x 25 mg starter kit (generic of LAMICTAL STARTER/TAKING V)</i>	Non Preferred	PA
<i>lamotrigine tab 84 x 25 mg &amp; 14 x 100 mg starter kit (generic of LAMICTAL STARTER/TAKING C)</i>	Non Preferred	PA
<i>lamotrigine tab 100 mg (generic of LAMICTAL)</i>	Preferred	QL (8 tabs every 1 day)
<i>lamotrigine tab 150 mg (generic of LAMICTAL)</i>	Preferred	QL (4 tabs every 1 day)
<i>lamotrigine tab 200 mg (generic of LAMICTAL)</i>	Preferred	QL (4 tabs every 1 day)
<i>lamotrigine tab chewable dispersible 5 mg (generic of LAMICTAL CHEWABLE DISPERS)</i>	Preferred	QL (8 tabs every 1 day)
<i>lamotrigine tab chewable dispersible 25 mg (generic of LAMICTAL CHEWABLE DISPERS)</i>	Preferred	QL (8 tabs every 1 day)
<i>lamotrigine tab disint 21 x 25 mg &amp; 7 x 50 mg titration kit</i>	Non Preferred	PA
<i>lamotrigine tab disint 25 (14) &amp; 50 mg (14) &amp; 100 mg (7) kit (generic of LAMICTAL ODT)</i>	Non Preferred	PA
<i>lamotrigine tab disint 42 x 50mg &amp; 14 x 100mg titration kit</i>	Non Preferred	PA
<i>lamotrigine tab er 24hr 25 mg (generic of LAMICTAL XR)</i>	Non Preferred	PA
<i>lamotrigine tab er 24hr 50 mg (generic of LAMICTAL XR)</i>	Non Preferred	PA
<i>lamotrigine tab er 24hr 100 mg (generic of LAMICTAL XR)</i>	Non Preferred	PA
<i>lamotrigine tab er 24hr 200 mg (generic of LAMICTAL XR)</i>	Non Preferred	PA
<i>lamotrigine tab er 24hr 250 mg (generic of LAMICTAL XR)</i>	Non Preferred	PA
<i>lamotrigine tab er 24hr 300 mg (generic of LAMICTAL XR)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levetiracetam oral soln 100 mg/ml (generic of KEPPRA)</i>	Preferred	QL (30 mL every 1 day)
<i>levetiracetam tab 250 mg (generic of KEPPRA)</i>	Preferred	QL (6 tabs every 1 day)
<i>levetiracetam tab 500 mg (generic of KEPPRA)</i>	Preferred	QL (6 tabs every 1 day)
<i>levetiracetam tab 750 mg (generic of KEPPRA)</i>	Preferred	QL (4 tabs every 1 day)
<i>levetiracetam tab 1000 mg (generic of KEPPRA)</i>	Preferred	QL (3 tabs every 1 day)
<i>levetiracetam tab er 24hr 500 mg (generic of KEPPRA XR)</i>	Preferred	QL (6 tabs every 1 day)
<i>levetiracetam tab er 24hr 750 mg (generic of KEPPRA XR)</i>	Preferred	QL (4 tabs every 1 day)
LYRICA CAP 25MG	Non Preferred	PA, QL (3 caps every 1 day)
LYRICA CAP 50MG	Non Preferred	PA, QL (6 caps every 1 day)
LYRICA CAP 75MG	Non Preferred	PA
LYRICA CAP 100MG	Non Preferred	PA, QL (3 caps every 1 day)
LYRICA CAP 150MG	Non Preferred	PA, QL (4 caps every 1 day)
LYRICA CAP 200MG	Non Preferred	PA, QL (3 caps every 1 day)
LYRICA CAP 225MG	Non Preferred	PA, QL (2 caps every 1 day)
LYRICA CAP 300MG	Non Preferred	PA, QL (2 caps every 1 day)
LYRICA SOL 20MG/ML	Non Preferred	PA
MYSOLINE TAB 50MG	Non Preferred	PA, QL (4 tabs every 1 day)
MYSOLINE TAB 250MG	Non Preferred	PA, QL (4 tabs every 1 day)
NEURONTIN CAP 100MG	Non Preferred	PA, QL (10 caps every 1 day)
NEURONTIN CAP 300MG	Non Preferred	PA, QL (10 caps every 1 day)
NEURONTIN CAP 400MG	Non Preferred	PA, QL (9 caps every 1 day)
NEURONTIN SOL 250/5ML	Non Preferred	PA
NEURONTIN TAB 600MG	Non Preferred	PA, QL (6 tabs every 1 day)
NEURONTIN TAB 800MG	Non Preferred	PA, QL (4 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml) (generic of TRILEPTAL)</i>	Preferred	QL (16.667 mL every 1 day)
<i>oxcarbazepine tab 150 mg (generic of TRILEPTAL)</i>	Preferred	QL (16 tabs every 1 day)
<i>oxcarbazepine tab 300 mg (generic of TRILEPTAL)</i>	Preferred	QL (8 tabs every 1 day)
<i>oxcarbazepine tab 600 mg (generic of TRILEPTAL)</i>	Preferred	QL (4 tabs every 1 day)
OXTELLAR XR TAB 150MG	Non Preferred	PA
OXTELLAR XR TAB 300MG	Non Preferred	PA
OXTELLAR XR TAB 600MG	Non Preferred	PA
<i>pregabalin cap 25 mg (generic of LYRICA)</i>	Preferred	QL (3 caps every 1 day)
<i>pregabalin cap 50 mg (generic of LYRICA)</i>	Preferred	QL (6 caps every 1 day)
<i>pregabalin cap 75 mg (generic of LYRICA)</i>	Preferred	
<i>pregabalin cap 100 mg (generic of LYRICA)</i>	Preferred	QL (3 caps every 1 day)
<i>pregabalin cap 150 mg (generic of LYRICA)</i>	Preferred	QL (4 caps every 1 day)
<i>pregabalin cap 200 mg (generic of LYRICA)</i>	Preferred	QL (3 caps every 1 day)
<i>pregabalin cap 225 mg (generic of LYRICA)</i>	Preferred	QL (2 caps every 1 day)
<i>pregabalin cap 300 mg (generic of LYRICA)</i>	Preferred	QL (2 caps every 1 day)
<i>pregabalin soln 20 mg/ml (generic of LYRICA)</i>	Preferred	
<i>primidone tab 50 mg (generic of MYSOLINE)</i>	Preferred	QL (4 tabs every 1 day)
<i>primidone tab 125 mg</i>	Preferred	
<i>primidone tab 250 mg (generic of MYSOLINE)</i>	Preferred	QL (4 tabs every 1 day)
QUDEXY XR CAP 25/24HR	Non Preferred	PA
QUDEXY XR CAP 50/24HR	Non Preferred	PA
QUDEXY XR CAP 100/24HR	Non Preferred	PA
QUDEXY XR CAP 150/24HR	Non Preferred	PA
QUDEXY XR CAP 200/24HR	Non Preferred	PA
<i>roweepra tab 500mg (generic of KEPPRA)</i>	Preferred	QL (6 tabs every 1 day)
<i>rufinamide susp 40 mg/ml (generic of BANZEL)</i>	Non Preferred	PA, QL (80 mL every 1 day)
<i>rufinamide tab 200 mg (generic of BANZEL)</i>	Non Preferred	PA, QL (16 tabs every 1 day)
<i>rufinamide tab 400 mg (generic of BANZEL)</i>	Non Preferred	PA, QL (8 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SPRITAM TAB 250MG	Non Preferred	PA
SPRITAM TAB 500MG	Non Preferred	PA
SPRITAM TAB 750MG	Non Preferred	PA
SPRITAM TAB 1000MG	Non Preferred	PA
<i>subvenite kit start 35</i> (generic of LAMICTAL STARTER/TAKING V)	Non Preferred	PA
<i>subvenite kit start 49</i> (generic of LAMICTAL STARTER/NOT TAKI)	Non Preferred	PA
<i>subvenite kit start 98</i> (generic of LAMICTAL STARTER/TAKING C)	Non Preferred	PA
<i>subvenite tab 25mg</i> (generic of LAMICTAL)	Preferred	QL (10 tabs every 1 day)
<i>subvenite tab 100mg</i> (generic of LAMICTAL)	Preferred	QL (8 tabs every 1 day)
<i>subvenite tab 150mg</i> (generic of LAMICTAL)	Preferred	QL (4 tabs every 1 day)
<i>subvenite tab 200mg</i> (generic of LAMICTAL)	Preferred	QL (4 tabs every 1 day)
TEGRETOL SUS 100/5ML	Non Preferred	PA, QL (60 mL every 1 day)
TEGRETOL TAB 200MG	Non Preferred	PA, QL (8 tabs every 1 day)
TEGRETOL-XR TAB 100MG	Non Preferred	PA, QL (8 tabs every 1 day)
TEGRETOL-XR TAB 200MG	Non Preferred	PA, QL (8 tabs every 1 day)
TEGRETOL-XR TAB 400MG	Non Preferred	PA, QL (8 tabs every 1 day)
TOPAMAX SPR CAP 15MG	Non Preferred	PA, QL (8 caps every 1 day)
TOPAMAX SPR CAP 25MG	Non Preferred	PA, QL (8 caps every 1 day)
TOPAMAX TAB 25MG	Non Preferred	PA, QL (4 tabs every 1 day)
TOPAMAX TAB 50MG	Non Preferred	PA, QL (2 tabs every 1 day)
TOPAMAX TAB 100MG	Non Preferred	PA, QL (2 tabs every 1 day)
TOPAMAX TAB 200MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>topiramate cap er 24hr 25 mg</i> (generic of TROKENDI XR)	Non Preferred	PA
<i>topiramate cap er 24hr 50 mg</i> (generic of TROKENDI XR)	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>topiramate cap er 24hr 100 mg (generic of TROKENDI XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr 200 mg (generic of TROKENDI XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr sprinkle 25 mg (generic of QUDEXY XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr sprinkle 50 mg (generic of QUDEXY XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr sprinkle 100 mg (generic of QUDEXY XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr sprinkle 150 mg (generic of QUDEXY XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr sprinkle 200 mg (generic of QUDEXY XR)</i>	Non Preferred	PA
<i>topiramate cap er 24hr sprinkle 200 mg (generic of QUDEXY XR)</i>	Non Preferred	PA
<i>topiramate sprinkle cap 15 mg (generic of TOPAMAX SPRINKLE)</i>	Preferred	QL (8 caps every 1 day)
<i>topiramate sprinkle cap 25 mg (generic of TOPAMAX SPRINKLE)</i>	Preferred	QL (8 caps every 1 day)
<i>topiramate tab 25 mg (generic of TOPAMAX)</i>	Preferred	QL (4 tabs every 1 day)
<i>topiramate tab 50 mg (generic of TOPAMAX)</i>	Preferred	QL (2 tabs every 1 day)
<i>topiramate tab 100 mg (generic of TOPAMAX)</i>	Preferred	QL (2 tabs every 1 day)
<i>topiramate tab 200 mg (generic of TOPAMAX)</i>	Preferred	QL (2 tabs every 1 day)
TRILEPTAL SUS 300MG/5M	Non Preferred	PA, QL (16.667 mL every 1 day)
TRILEPTAL TAB 150MG	Non Preferred	PA, QL (16 each every 1 day)
TRILEPTAL TAB 300MG	Non Preferred	PA, QL (8 each every 1 day)
TRILEPTAL TAB 600MG	Non Preferred	PA, QL (4 each every 1 day)
TROKENDI XR CAP 25MG	Non Preferred	PA
TROKENDI XR CAP 50MG	Non Preferred	PA
TROKENDI XR CAP 100MG	Non Preferred	PA
TROKENDI XR CAP 200MG	Non Preferred	PA
VIMPAT SOL 10MG/ML	Non Preferred	PA, QL (40 mL every 1 day)
VIMPAT TAB 50MG	Non Preferred	PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VIMPAT TAB 100MG	Non Preferred	PA, QL (2 tabs every 1 day)
VIMPAT TAB 150MG	Non Preferred	PA, QL (2 tabs every 1 day)
VIMPAT TAB 200MG	Non Preferred	PA, QL (2 tabs every 1 day)
ZONISADE SUS 100MG/5	Non Preferred	PA
<i>zonisamide cap 25 mg</i> (generic of ZONEGRAN)	Preferred	QL (2 caps every 1 day)
<i>zonisamide cap 50 mg</i>	Preferred	QL (2 caps every 1 day)
<i>zonisamide cap 100 mg</i> (generic of ZONEGRAN)	Preferred	QL (6 caps every 1 day)
ZTALMY SUS 50MG/ML	Non Preferred	SP, PA

### **CARBAMATES**

<i>felbamate susp 600 mg/5ml</i> (generic of FELBATOL)	Non Preferred	PA
<i>felbamate tab 400 mg</i> (generic of FELBATOL)	Non Preferred	PA
<i>felbamate tab 600 mg</i> (generic of FELBATOL)	Non Preferred	PA
FELBATOL SUS 600/5ML	Non Preferred	PA
FELBATOL TAB 400MG	Non Preferred	PA
FELBATOL TAB 600MG	Non Preferred	PA
XCOPRI PAK 12.5-25	Preferred	
XCOPRI PAK 50-100MG	Preferred	
XCOPRI PAK 100-150	Preferred	
XCOPRI PAK 150-200	Preferred	
XCOPRI TAB 50MG	Preferred	
XCOPRI TAB 100MG	Preferred	
XCOPRI TAB 150MG	Preferred	
XCOPRI TAB 200MG	Preferred	

### **GABA MODULATORS**

GABITRIL TAB 2MG	Non Preferred	PA, QL (28 tabs every 1 day)
GABITRIL TAB 4MG	Non Preferred	PA, QL (14 tabs every 1 day)
GABITRIL TAB 12MG	Non Preferred	PA
GABITRIL TAB 16MG	Non Preferred	PA
SABRIL POW 500MG	Non Preferred	PA, QL (6 packets every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SABRIL TAB 500MG	Non Preferred	PA, QL (6 tabs every 1 day)
<i>tiagabine hcl tab 2 mg</i>	Non Preferred	PA, QL (28 tabs every 1 day)
<i>tiagabine hcl tab 4 mg</i>	Non Preferred	PA, QL (14 tabs every 1 day)
<i>tiagabine hcl tab 12 mg</i>	Non Preferred	PA
<i>tiagabine hcl tab 16 mg</i>	Non Preferred	PA
<i>vigabatrin powd pack 500 mg (generic of SABRIL)</i>	Non Preferred	PA, QL (6 packets every 1 day)
<i>vigabatrin tab 500 mg (generic of SABRIL)</i>	Non Preferred	PA, QL (6 tabs every 1 day)
<i>vigadrone pow 500mg (generic of SABRIL)</i>	Non Preferred	PA, QL (6 packets every 1 day)

### **HYDANTOINS**

DILANTIN CAP 30MG	Non Preferred	PA, QL (6 caps every 1 day)
DILANTIN CAP 100MG	Non Preferred	PA, QL (6 caps every 1 day)
DILANTIN CHW 50MG	Non Preferred	PA, QL (5 tabs every 1 day)
DILANTIN-125 SUS 125/5ML	Non Preferred	PA, QL (20 mL every 1 day)
PHENYTEK CAP 200MG	Non Preferred	PA, QL (6 caps every 1 day)
PHENYTEK CAP 300MG	Non Preferred	PA, QL (6 caps every 1 day)
<i>phenytoin chew tab 50 mg (generic of DILANTIN INFATABS)</i>	Preferred	QL (5 tabs every 1 day)
<i>phenytoin sodium extended cap 100 mg (generic of DILANTIN)</i>	Preferred	QL (6 caps every 1 day)
<i>phenytoin sodium extended cap 200 mg (generic of PHENYTEK)</i>	Preferred	QL (6 caps every 1 day)
<i>phenytoin sodium extended cap 300 mg (generic of PHENYTEK)</i>	Preferred	QL (6 caps every 1 day)
<i>phenytoin susp 125 mg/5ml (generic of DILANTIN-125)</i>	Preferred	QL (20 mL every 1 day)

### **SUCCINIMIDES**

CELONTIN CAP 300MG	Non Preferred	PA
<i>ethosuximide cap 250 mg (generic of ZARONTIN)</i>	Preferred	QL (6 caps every 1 day)
<i>ethosuximide soln 250 mg/5ml (generic of ZARONTIN)</i>	Preferred	QL (30 mL every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZARONTIN CAP 250MG	Non Preferred	PA, QL (6 caps every 1 day)
ZARONTIN SOL 250/5ML	Non Preferred	PA, QL (30 mL every 1 day)

### **VALPROIC ACID**

DEPAKOTE ER TAB 250MG	Non Preferred	PA, QL (10 tabs every 1 day)
DEPAKOTE ER TAB 500MG	Non Preferred	PA, QL (10 tabs every 1 day)
DEPAKOTE SPR CAP 125MG	Non Preferred	PA, QL (10 caps every 1 day)
DEPAKOTE TAB 125MG DR	Non Preferred	PA, QL (15 tabs every 1 day)
DEPAKOTE TAB 250MG DR	Non Preferred	PA, QL (10 tabs every 1 day)
DEPAKOTE TAB 500MG DR	Non Preferred	PA, QL (10 tabs every 1 day)
<i>divalproex sodium cap delayed release sprinkle 125 mg (generic of DEPAKOTE SPRINKLES)</i>	Preferred	QL (10 caps every 1 day)
<i>divalproex sodium tab delayed release 125 mg (generic of DEPAKOTE)</i>	Preferred	QL (15 tabs every 1 day)
<i>divalproex sodium tab delayed release 250 mg (generic of DEPAKOTE)</i>	Preferred	QL (10 tabs every 1 day)
<i>divalproex sodium tab delayed release 500 mg (generic of DEPAKOTE)</i>	Preferred	QL (10 tabs every 1 day)
<i>divalproex sodium tab er 24 hr 250 mg (generic of DEPAKOTE ER)</i>	Preferred	QL (10 tabs every 1 day)
<i>divalproex sodium tab er 24 hr 500 mg (generic of DEPAKOTE ER)</i>	Preferred	QL (10 tabs every 1 day)
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	Preferred	QL (100 mL every 1 day)
<i>valproic acid cap 250 mg</i>	Preferred	QL (20 caps every 1 day)

### **ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION**

#### **ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)**

<i>mirtazapine orally disintegrating tab 15 mg (generic of REMERON SOLTAB)</i>	Preferred	
<i>mirtazapine orally disintegrating tab 30 mg (generic of REMERON SOLTAB)</i>	Preferred	
<i>mirtazapine orally disintegrating tab 45 mg (generic of REMERON SOLTAB)</i>	Preferred	
<i>mirtazapine tab 7.5 mg</i>	Preferred	
<i>mirtazapine tab 15 mg (generic of REMERON)</i>	Preferred	QL (1 tab every 1 day)
<i>mirtazapine tab 30 mg (generic of REMERON)</i>	Preferred	QL (4 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mirtazapine tab 45 mg</i>	Preferred	QL (1 tab every 1 day)
REMERON SLTB TAB 15MG	Non Preferred	PA
REMERON SLTB TAB 30MG	Non Preferred	PA
REMERON SLTB TAB 45MG	Non Preferred	PA
REMERON TAB 15MG	Non Preferred	PA, QL (1 tab every 1 day)
REMERON TAB 30MG	Non Preferred	PA, QL (4 tabs every 1 day)

### **ANTIDEPRESSANT COMBINATIONS**

AUVELITY TAB 45-105MG	Non Preferred	PA
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### **ANTIDEPRESSANTS - MISC.**

APLENZIN TAB 174MG	Non Preferred	PA
APLENZIN TAB 348MG	Non Preferred	PA
APLENZIN TAB 522MG	Non Preferred	PA
<i>bupropion hcl tab 75 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>bupropion hcl tab 100 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>bupropion hcl tab er 12hr 100 mg (generic of WELLBUTRIN SR)</i>	Preferred	QL (2 tabs every 1 day)
<i>bupropion hcl tab er 12hr 150 mg (generic of WELLBUTRIN SR)</i>	Preferred	QL (3 tabs every 1 day)
<i>bupropion hcl tab er 12hr 200 mg (generic of WELLBUTRIN SR)</i>	Preferred	QL (2 tabs every 1 day)
<i>bupropion hcl tab er 24hr 150 mg (generic of WELLBUTRIN XL)</i>	Preferred	QL (1 tab every 1 day)
<i>bupropion hcl tab er 24hr 300 mg (generic of WELLBUTRIN XL)</i>	Preferred	QL (1 tab every 1 day)
<i>bupropion hcl tab er 24hr 450 mg</i>	Preferred	
FORFIVO XL TAB 450MG	Non Preferred	PA
WELLBUTRIN TAB 100MG SR	Non Preferred	PA, QL (2 tabs every 1 day)
WELLBUTRIN TAB 150MG SR	Non Preferred	PA, QL (3 tabs every 1 day)
WELLBUTRIN TAB 200MG SR	Non Preferred	PA, QL (2 tabs every 1 day)
WELLBUTRIN TAB XL 150MG	Non Preferred	PA, QL (1 tab every 1 day)
WELLBUTRIN TAB XL 300MG	Non Preferred	PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MONOAMINE OXIDASE INHIBITORS (MAOIS)</b>		
EMSAM DIS 6MG/24HR	Non Preferred	PA
EMSAM DIS 9MG/24HR	Non Preferred	PA
EMSAM DIS 12MG/24H	Non Preferred	PA
MARPLAN TAB 10MG	Non Preferred	PA
NARDIL TAB 15MG	Non Preferred	PA, QL (6 tabs every 1 day)
<i>phenelzine sulfate tab 15 mg (generic of NARDIL)</i>	Preferred	QL (6 tabs every 1 day)
<i>tranylcypromine sulfate tab 10 mg (generic of PARNATE)</i>	Preferred	QL (8 tabs every 1 day)
<b>N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS</b>		
SPRAVATO SOL 56MG DOS	Non Preferred	SP, PA
SPRAVATO SOL 84MG DOS	Non Preferred	SP, PA
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>		
CELEXA TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
CELEXA TAB 20MG	Non Preferred	PA, QL (2 tabs every 1 day)
CELEXA TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)
CITALOPRAM CAP 30MG	Non Preferred	PA
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	Preferred	QL (20 mL every 1 day)
<i>citalopram hydrobromide tab 10 mg (base equiv) (generic of CELEXA)</i>	Preferred	QL (1 tab every 1 day)
<i>citalopram hydrobromide tab 20 mg (base equiv) (generic of CELEXA)</i>	Preferred	QL (2 tabs every 1 day)
<i>citalopram hydrobromide tab 40 mg (base equiv) (generic of CELEXA)</i>	Preferred	QL (2 tabs every 1 day)
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	Preferred	
<i>escitalopram oxalate tab 5 mg (base equiv) (generic of LEXAPRO)</i>	Preferred	QL (1 tab every 1 day)
<i>escitalopram oxalate tab 10 mg (base equiv) (generic of LEXAPRO)</i>	Preferred	QL (1 tab every 1 day)
<i>escitalopram oxalate tab 20 mg (base equiv) (generic of LEXAPRO)</i>	Preferred	QL (1 tab every 1 day)
<i>fluoxetine hcl cap 10 mg (generic of PROZAC)</i>	Preferred	QL (3 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluoxetine hcl cap 20 mg (generic of PROZAC)</i>	Preferred	QL (4 caps every 1 day)
<i>fluoxetine hcl cap 40 mg (generic of PROZAC)</i>	Preferred	
<i>fluoxetine hcl cap delayed release 90 mg</i>	Non Preferred	PA
<i>fluoxetine hcl solution 20 mg/5ml</i>	Preferred	
<i>fluoxetine hcl tab 10 mg</i>	Preferred	
<i>fluoxetine hcl tab 20 mg</i>	Preferred	
<i>fluoxetine hcl tab 60 mg (generic of FLUOXETINE HYDROCHLORIDE)</i>	Preferred	
FLUOXETINE TAB 60MG	Preferred	
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	Non Preferred	PA
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	Non Preferred	PA
<i>fluvoxamine maleate tab 25 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>fluvoxamine maleate tab 50 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>fluvoxamine maleate tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
LEXAPRO TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
LEXAPRO TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
LEXAPRO TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>paroxetine hcl oral susp 10 mg/5ml (base equiv) (generic of PAXIL)</i>	Preferred	
<i>paroxetine hcl tab 10 mg (generic of PAXIL)</i>	Preferred	QL (2 tabs every 1 day)
<i>paroxetine hcl tab 20 mg (generic of PAXIL)</i>	Preferred	QL (2 tabs every 1 day)
<i>paroxetine hcl tab 30 mg (generic of PAXIL)</i>	Preferred	QL (2 tabs every 1 day)
<i>paroxetine hcl tab 40 mg (generic of PAXIL)</i>	Preferred	QL (2 tabs every 1 day)
<i>paroxetine hcl tab er 24hr 12.5 mg (generic of PAXIL CR)</i>	Non Preferred	PA
<i>paroxetine hcl tab er 24hr 25 mg (generic of PAXIL CR)</i>	Non Preferred	PA
<i>paroxetine hcl tab er 24hr 37.5 mg (generic of PAXIL CR)</i>	Non Preferred	PA
PAXIL CR TAB 12.5MG	Non Preferred	PA
PAXIL CR TAB 25MG	Non Preferred	PA
PAXIL CR TAB 37.5MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PAXIL SUS 10MG/5ML	Non Preferred	PA
PAXIL TAB 10MG	Non Preferred	PA, QL (2 tabs every 1 day)
PAXIL TAB 20MG	Non Preferred	PA, QL (2 tabs every 1 day)
PAXIL TAB 30MG	Non Preferred	PA, QL (2 tabs every 1 day)
PAXIL TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)
PEXEVA TAB 10MG	Non Preferred	PA
PEXEVA TAB 20MG	Non Preferred	PA
PEXEVA TAB 30MG	Non Preferred	PA
PROZAC CAP 10MG	Non Preferred	PA, QL (3 caps every 1 day)
PROZAC CAP 20MG	Non Preferred	PA, QL (4 caps every 1 day)
PROZAC CAP 40MG	Non Preferred	PA
SERTRALINE CAP 150MG	Non Preferred	PA
SERTRALINE CAP 200MG	Non Preferred	PA
<i>sertraline hcl oral concentrate for solution 20 mg/ml (generic of ZOLOFT)</i>	Preferred	
<i>sertraline hcl tab 25 mg (generic of ZOLOFT)</i>	Preferred	QL (1 tab every 1 day)
<i>sertraline hcl tab 50 mg (generic of ZOLOFT)</i>	Preferred	QL (2 tabs every 1 day)
<i>sertraline hcl tab 100 mg (generic of ZOLOFT)</i>	Preferred	QL (2 tabs every 1 day)
ZOLOFT CON 20MG/ML	Non Preferred	PA
ZOLOFT TAB 25MG	Non Preferred	PA, QL (1 tab every 1 day)
ZOLOFT TAB 50MG	Non Preferred	PA, QL (2 tabs every 1 day)
ZOLOFT TAB 100MG	Non Preferred	PA, QL (2 tabs every 1 day)
<b>SEROTONIN MODULATORS</b>		
<i>nefazodone hcl tab 50 mg</i>	Non Preferred	PA
<i>nefazodone hcl tab 100 mg</i>	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nefazodone hcl tab 150 mg</i>	Non Preferred	PA
<i>nefazodone hcl tab 200 mg</i>	Non Preferred	PA
<i>nefazodone hcl tab 250 mg</i>	Non Preferred	PA
<i>trazodone hcl tab 50 mg</i>	Preferred	
<i>trazodone hcl tab 100 mg</i>	Preferred	
<i>trazodone hcl tab 150 mg</i>	Preferred	
<i>trazodone hcl tab 300 mg</i>	Preferred	
TRINTELLIX TAB 5MG	Non Preferred	PA
TRINTELLIX TAB 10MG	Non Preferred	PA
TRINTELLIX TAB 20MG	Non Preferred	PA
VIIBRYD KIT STARTER	Non Preferred	PA
VIIBRYD TAB 10MG	Non Preferred	PA
VIIBRYD TAB 20MG	Non Preferred	PA
VIIBRYD TAB 40MG	Non Preferred	PA
<i>vilazodone hcl tab 10 mg (generic of VIIBRYD)</i>	Non Preferred	PA
<i>vilazodone hcl tab 20 mg (generic of VIIBRYD)</i>	Non Preferred	PA
<i>vilazodone hcl tab 40 mg (generic of VIIBRYD)</i>	Non Preferred	PA
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)</b>		
CYMBALTA CAP 20MG	Non Preferred	PA, QL (2 caps every 1 day)
CYMBALTA CAP 30MG	Non Preferred	PA, QL (2 caps every 1 day)
CYMBALTA CAP 60MG	Non Preferred	PA, QL (2 caps every 1 day)
DESVENLAFAX TAB 50MG ER	Non Preferred	PA
DESVENLAFAX TAB 100MG ER	Non Preferred	PA
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv) (generic of PRISTIQ)</i>	Non Preferred	PA
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv) (generic of PRISTIQ)</i>	Non Preferred	PA
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv) (generic of PRISTIQ)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DRIZALMA CAP 20MG DR	Non Preferred	PA
DRIZALMA CAP 30MG DR	Non Preferred	PA
DRIZALMA CAP 40MG DR	Non Preferred	PA
DRIZALMA CAP 60MG DR	Non Preferred	PA
<i>duloxetine hcl enteric coated pellets cap 20 mg (base eq) (generic of CYMBALTA)</i>	Preferred	QL (2 caps every 1 day)
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq) (generic of CYMBALTA)</i>	Preferred	QL (2 caps every 1 day)
<i>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</i>	Preferred	
<i>duloxetine hcl enteric coated pellets cap 60 mg (base eq) (generic of CYMBALTA)</i>	Preferred	QL (2 caps every 1 day)
EFFEXOR XR CAP 37.5MG	Non Preferred	PA, QL (1 cap every 1 day)
EFFEXOR XR CAP 75MG	Non Preferred	PA, QL (3 caps every 1 day)
EFFEXOR XR CAP 150MG	Non Preferred	PA, QL (1 cap every 1 day)
FETZIMA CAP 20MG	Non Preferred	PA
FETZIMA CAP 40MG	Non Preferred	PA
FETZIMA CAP 80MG	Non Preferred	PA
FETZIMA CAP 120MG	Non Preferred	PA
FETZIMA CAP TITRATIO	Non Preferred	PA
PRISTIQ TAB 25MG	Non Preferred	PA
PRISTIQ TAB 50MG	Non Preferred	PA
PRISTIQ TAB 100MG	Non Preferred	PA
<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent) (generic of EFFEXOR XR)</i>	Preferred	QL (1 cap every 1 day)
<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent) (generic of EFFEXOR XR)</i>	Preferred	QL (3 caps every 1 day)
<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent) (generic of EFFEXOR XR)</i>	Preferred	QL (1 cap every 1 day)
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	Preferred	QL (3 tabs every 1 day)
<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	Preferred	QL (3 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	Preferred	QL (3 tabs every 1 day)
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	Preferred	QL (3 tabs every 1 day)
<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	Preferred	QL (3 tabs every 1 day)
<i>venlafaxine hcl tab er 24hr 37.5 mg (base equivalent)</i>	Non Preferred	PA
<i>venlafaxine hcl tab er 24hr 75 mg (base equivalent)</i>	Non Preferred	PA
<i>venlafaxine hcl tab er 24hr 150 mg (base equivalent)</i>	Non Preferred	PA
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	Non Preferred	PA
VENLAFAXINE TAB 112.5MG	Preferred	

### **TRICYCLIC AGENTS**

<i>amitriptyline hcl tab 10 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>amitriptyline hcl tab 25 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>amitriptyline hcl tab 50 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>amitriptyline hcl tab 75 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>amitriptyline hcl tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>amitriptyline hcl tab 150 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>amoxapine tab 25 mg</i>	Non Preferred	PA
<i>amoxapine tab 50 mg</i>	Non Preferred	PA
<i>amoxapine tab 100 mg</i>	Non Preferred	PA
<i>amoxapine tab 150 mg</i>	Non Preferred	PA
ANAFRANIL CAP 25MG	Non Preferred	PA, QL (6 caps every 1 day)
ANAFRANIL CAP 50MG	Non Preferred	PA, QL (4 caps every 1 day)
ANAFRANIL CAP 75MG	Non Preferred	PA, QL (4 caps every 1 day)
<i>clomipramine hcl cap 25 mg (generic of ANAFRANIL)</i>	Preferred	QL (6 caps every 1 day)
<i>clomipramine hcl cap 50 mg (generic of ANAFRANIL)</i>	Preferred	QL (4 caps every 1 day)
<i>clomipramine hcl cap 75 mg (generic of ANAFRANIL)</i>	Preferred	QL (4 caps every 1 day)
<i>desipramine hcl tab 10 mg (generic of NORPRAMIN)</i>	Preferred	QL (6 tabs every 1 day)
<i>desipramine hcl tab 25 mg (generic of NORPRAMIN)</i>	Preferred	QL (4 tabs every 1 day)
<i>desipramine hcl tab 50 mg</i>	Preferred	QL (6 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>desipramine hcl tab 75 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>desipramine hcl tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>desipramine hcl tab 150 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>doxepin hcl cap 10 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxepin hcl cap 25 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxepin hcl cap 50 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxepin hcl cap 75 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxepin hcl cap 100 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxepin hcl cap 150 mg</i>	Preferred	QL (2 caps every 1 day)
<i>doxepin hcl conc 10 mg/ml</i>	Preferred	QL (30 mL every 1 day)
<i>imipramine hcl tab 10 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>imipramine hcl tab 25 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>imipramine hcl tab 50 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>imipramine pamoate cap 75 mg</i>	Non Preferred	PA
<i>imipramine pamoate cap 100 mg</i>	Non Preferred	PA
<i>imipramine pamoate cap 125 mg</i>	Non Preferred	PA
<i>imipramine pamoate cap 150 mg</i>	Non Preferred	PA
NORPRAMIN TAB 10MG	Non Preferred	PA, QL (6 tabs every 1 day)
NORPRAMIN TAB 25MG	Non Preferred	PA, QL (4 tabs every 1 day)
<i>nortriptyline hcl cap 10 mg (generic of PAMELOR)</i>	Preferred	QL (6 caps every 1 day)
<i>nortriptyline hcl cap 25 mg (generic of PAMELOR)</i>	Preferred	QL (6 caps every 1 day)
<i>nortriptyline hcl cap 50 mg (generic of PAMELOR)</i>	Preferred	QL (4 caps every 1 day)
<i>nortriptyline hcl cap 75 mg (generic of PAMELOR)</i>	Preferred	QL (2 caps every 1 day)
<i>nortriptyline hcl soln 10 mg/5ml</i>	Preferred	
PAMELOR CAP 10MG	Non Preferred	PA, QL (6 caps every 1 day)
PAMELOR CAP 25MG	Non Preferred	PA, QL (6 caps every 1 day)
PAMELOR CAP 50MG	Non Preferred	PA, QL (4 caps every 1 day)
PAMELOR CAP 75MG	Non Preferred	PA, QL (2 caps every 1 day)
<i>protriptyline hcl tab 5 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>protriptyline hcl tab 10 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>trimipramine maleate cap 25 mg</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>trimipramine maleate cap 50 mg</i>	Non Preferred	PA
<i>trimipramine maleate cap 100 mg</i>	Non Preferred	PA

## **ANTIDIABETICS - DRUGS TO TREAT DIABETES**

### **ALPHA-GLUCOSIDASE INHIBITORS**

<i>acarbose tab 25 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>acarbose tab 50 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>acarbose tab 100 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>miglitol tab 25 mg</i>	Preferred	
<i>miglitol tab 50 mg</i>	Preferred	
<i>miglitol tab 100 mg</i>	Preferred	

### **ANTIDIABETIC - AMYLIN ANALOGS**

SYMLINPEN 60 INJ 1000MCG	Non Preferred	PA
SYMLNPEN 120 INJ 1000MCG	Non Preferred	PA

### **ANTIDIABETIC COMBINATIONS**

ACTOPLUS MET TAB 15-850MG	Non Preferred	PA
<i>alogliptin-metformin hcl tab 12.5-500 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>alogliptin-metformin hcl tab 12.5-1000 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>alogliptin-pioglitazone tab 12.5-30 mg</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>alogliptin-pioglitazone tab 25-15 mg</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>alogliptin-pioglitazone tab 25-30 mg</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>alogliptin-pioglitazone tab 25-45 mg</i>	Non Preferred	PA, QL (1 tab every 1 day)
DUETACT TAB 30-2MG	Non Preferred	PA
DUETACT TAB 30-4MG	Non Preferred	PA
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	Preferred	
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	Preferred	
<i>glipizide-metformin hcl tab 5-500 mg</i>	Preferred	
<i>glyburide-metformin tab 1.25-250 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>glyburide-metformin tab 2.5-500 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>glyburide-metformin tab 5-500 mg</i>	Preferred	QL (4 tabs every 1 day)
GLYXAMBI TAB 10-5 MG	Non Preferred	PA
GLYXAMBI TAB 25-5 MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INVOKAMET TAB 50-500MG	Non Preferred	PA
INVOKAMET TAB 50-1000	Non Preferred	PA
INVOKAMET TAB 150-500	Non Preferred	PA
INVOKAMET TAB 150-1000	Non Preferred	PA
INVOKAMET XR TAB 50-500MG	Non Preferred	PA
INVOKAMET XR TAB 50-1000	Non Preferred	PA
INVOKAMET XR TAB 150-500	Non Preferred	PA
INVOKAMET XR TAB 150-1000	Non Preferred	PA
JANUMET TAB 50-500MG	Non Preferred	PA
JANUMET TAB 50-1000	Non Preferred	PA
JANUMET XR TAB 50-500MG	Non Preferred	PA
JANUMET XR TAB 50-1000	Non Preferred	PA
JANUMET XR TAB 100-1000	Non Preferred	PA
JENTADUETO TAB 2.5-500	Non Preferred	PA
JENTADUETO TAB 2.5-850	Non Preferred	PA
JENTADUETO TAB 2.5-1000	Non Preferred	PA
JENTADUETO TAB XR	Non Preferred	PA
KAZANO 12.5- TAB 500MG	Non Preferred	PA, QL (2 tabs every 1 day)
KAZANO 12.5- TAB 1000MG	Non Preferred	PA, QL (2 tabs every 1 day)
KOMBIGLYZ XR TAB 2.5-1000	Non Preferred	PA
KOMBIGLYZ XR TAB 5-500MG	Non Preferred	PA
KOMBIGLYZ XR TAB 5-1000MG	Non Preferred	PA
OSENI TAB 12.5-30	Non Preferred	PA, QL (1 tab every 1 day)
OSENI TAB 25-15MG	Non Preferred	PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
OSENI TAB 25-30MG	Non Preferred	PA, QL (1 tab every 1 day)
OSENI TAB 25-45MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>pioglitazone hcl-glimepiride tab 30-2 mg (generic of DUETACT)</i>	Non Preferred	PA
<i>pioglitazone hcl-glimepiride tab 30-4 mg (generic of DUETACT)</i>	Non Preferred	PA
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	Non Preferred	PA
<i>pioglitazone hcl-metformin hcl tab 15-850 mg (generic of ACTOPLUS MET)</i>	Non Preferred	PA
QTERN TAB 5-5MG	Non Preferred	PA
QTERN TAB 10-5MG	Non Preferred	PA
SEGLUROMET TAB 2.5-500	Non Preferred	PA, QL (2 tabs every 1 day)
SEGLUROMET TAB 2.5-1000	Non Preferred	PA, QL (2 tabs every 1 day)
SEGLUROMET TAB 7.5-500	Non Preferred	PA, QL (2 tabs every 1 day)
SEGLUROMET TAB 7.5-1000	Non Preferred	PA, QL (2 tabs every 1 day)
SOLIQUA INJ 100/33	Non Preferred	PA
STEGLUJAN TAB 5-100MG	Non Preferred	PA
STEGLUJAN TAB 15-100MG	Non Preferred	PA
SYNJARDY TAB	Non Preferred	PA
SYNJARDY TAB 5-500MG	Non Preferred	PA
SYNJARDY TAB 5-1000MG	Non Preferred	PA
SYNJARDY TAB 12.5-500	Non Preferred	PA
SYNJARDY XR TAB	Non Preferred	PA
SYNJARDY XR TAB 5-1000MG	Non Preferred	PA
SYNJARDY XR TAB 10-1000	Non Preferred	PA
SYNJARDY XR TAB 25-1000	Non Preferred	PA
TRIJARDY XR TAB	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XIGDUO XR TAB 2.5-1000	Non Preferred	PA
XIGDUO XR TAB 5-500MG	Non Preferred	PA
XIGDUO XR TAB 5-1000MG	Non Preferred	PA
XIGDUO XR TAB 10-500MG	Non Preferred	PA
XIGDUO XR TAB 10-1000	Non Preferred	PA
XULTOPHY INJ 100/3.6	Non Preferred	PA

### **BIGUANIDES**

GLUMETZA TAB 500MG	Non Preferred	PA
GLUMETZA TAB 1000MG	Non Preferred	PA
<i>metformin hcl oral soln 500 mg/5ml</i> (generic of RIOMET)	Non Preferred	PA
<i>metformin hcl tab 500 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>metformin hcl tab 850 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>metformin hcl tab 1000 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>metformin hcl tab er 24hr 500 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>metformin hcl tab er 24hr 750 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>metformin hcl tab er 24hr modified release</i> <i>500 mg</i> (generic of GLUMETZA)	Non Preferred	PA
<i>metformin hcl tab er 24hr modified release</i> <i>1000 mg</i> (generic of GLUMETZA)	Non Preferred	PA
<i>metformin hcl tab er 24hr osmotic 500 mg</i>	Non Preferred	PA
<i>metformin hcl tab er 24hr osmotic 1000</i> <i>mg</i>	Non Preferred	PA
RIOMET SOL 500/5ML	Non Preferred	PA

### **DIABETIC OTHER**

BAQSIMI ONE POW 3MG/DOSE	Preferred	QL (2 ea every 25 days)
BAQSIMI TWO POW 3MG/DOSE	Preferred	QL (2 ea every 25 days)
<i>diazoxide susp 50 mg/ml</i> (generic of PROGLYCEM)	Preferred	
GLUCAGEN INJ HYPOKIT	Non Preferred	PA, QL (2 syringes every 25 days)
<i>glucagon (rdna) for inj kit 1 mg</i> (generic of GLUCAGON EMERGENCY KIT)	Non Preferred	PA, QL (2 kits every 25 days)
GLUCAGON EMR SOL 1MG	Non Preferred	PA
GLUCAGON KIT 1MG	Non Preferred	PA, QL (2 kits every 25 days)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GLUCOSE CHEW TABS	Preferred	OTC
GVOKE HYPO 1 INJ 1MG/.2ML	Preferred	
GVOKE HYPO 1 INJ .5/.1ML	Preferred	
GVOKE HYPO 2 INJ 1MG/.2ML	Preferred	
GVOKE HYPO 2 INJ .5/.1ML	Preferred	
GVOKE KIT SOL 1MG/0.2M	Preferred	
GVOKE PFS INJ	Preferred	
KORLYM TAB 300MG	Non Preferred	SP, PA
PROGLYCEM SUS 50MG/ML	Preferred	
ZEGALOGUE INJ 0.6/0.6	Preferred	

### **DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS**

<i>alogliptin benzoate tab 6.25 mg (base equiv)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>alogliptin benzoate tab 12.5 mg (base equiv)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>alogliptin benzoate tab 25 mg (base equiv)</i>	Non Preferred	PA, QL (1 tab every 1 day)
JANUVIA TAB 25MG	Preferred	
JANUVIA TAB 50MG	Preferred	
JANUVIA TAB 100MG	Preferred	
NESINA TAB 6.25MG	Non Preferred	PA, QL (1 tab every 1 day)
NESINA TAB 12.5MG	Non Preferred	PA, QL (1 tab every 1 day)
NESINA TAB 25MG	Non Preferred	PA, QL (1 tab every 1 day)
ONGLYZA TAB 2.5MG	Non Preferred	PA
ONGLYZA TAB 5MG	Non Preferred	PA
TRADJENTA TAB 5MG	Preferred	

### **DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC**

CYCLOSET TAB 0.8MG	Non Preferred	PA
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### **INCRETIN MIMETIC AGENTS**

BYDUREON BC INJ 2/0.85ML	Non Preferred	PA
BYETTA INJ 5MCG	Non Preferred	PA
BYETTA INJ 10MCG	Non Preferred	PA
MOUNJARO INJ 2.5/0.5	Non Preferred	PA
MOUNJARO INJ 5MG/0.5	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MOUNJARO INJ 7.5/0.5	Non Preferred	PA
MOUNJARO INJ 10MG/0.5	Non Preferred	PA
MOUNJARO INJ 12.5/0.5	Non Preferred	PA
MOUNJARO INJ 15MG/0.5	Non Preferred	PA
OZEMPIC INJ 2MG/3ML	Non Preferred	PA
OZEMPIC INJ 4MG/3ML	Non Preferred	PA
OZEMPIC INJ 8MG/3ML	Non Preferred	PA
RYBELSUS TAB 3MG	Preferred	PA
RYBELSUS TAB 7MG	Preferred	PA
RYBELSUS TAB 14MG	Preferred	PA
TRULICITY INJ 0.75/0.5	Preferred	QL (0.144 pens every 1 day)
TRULICITY INJ 1.5/0.5	Preferred	QL (0.144 pens every 1 day)
TRULICITY INJ 3/0.5	Preferred	QL (0.144 pens every 1 day)
TRULICITY INJ 4.5/0.5	Preferred	QL (0.144 pens every 1 day)
VICTOZA INJ 18MG/3ML	Preferred	
<b>INSULIN</b>		
ADMELOG INJ 100U/ML	Non Preferred	PA
ADMELOG SOLO INJ 100U/ML	Non Preferred	PA
AFREZZA POW 4-8 UNIT	Non Preferred	PA
AFREZZA POW 4-8-12	Non Preferred	PA
AFREZZA POW 4UNIT	Non Preferred	PA
AFREZZA POW 8 UNIT	Non Preferred	PA
AFREZZA POW 8-12UNIT	Non Preferred	PA
AFREZZA POW 12 UNIT	Non Preferred	PA
APIDRA INJ SOLOSTAR	Non Preferred	PA
APIDRA INJ U-100	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BASAGLAR INJ 100UNIT	Non Preferred	PA, QL (0.447 pens every 1 day)
BASAGLAR INJ TEMPO PN	Non Preferred	PA
FIASP FLEX INJ TOUCH	Non Preferred	PA
FIASP INJ 100/ML	Non Preferred	PA
FIASP PENFIL INJ U-100	Non Preferred	PA
HUMALOG INJ 100/ML	Preferred	
HUMALOG JR INJ 100/ML	Preferred	
HUMALOG KWIK INJ 100/ML	Preferred	
HUMALOG KWIK INJ 200/ML	Preferred	
HUMALOG MIX INJ 50/50	Preferred	QL (1.34 mL every 1 day)
HUMALOG MIX INJ 50/50KWP	Preferred	QL (0.447 pens every 1 day)
HUMALOG MIX INJ 75/25KWP	Preferred	QL (0.447 pens every 1 day)
HUMALOG MIX SUS 75/25	Preferred	QL (1.34 mL every 1 day)
HUMALOG TMPO INJ 100/ML	Non Preferred	PA
HUMULIN INJ 70/30	Preferred	QL (1.34 mL every 1 day), OTC
HUMULIN INJ 70/30KWP	Preferred	QL (0.447 pens every 1 day), OTC
HUMULIN N INJ U-100	Preferred	QL (1.34 mL every 1 day), OTC
HUMULIN N INJ U-100KWP	Preferred	OTC
HUMULIN R INJ U-100	Preferred	QL (0.447 vials every 1 day), OTC
HUMULIN R INJ U-500	Preferred	
HUMULIN R INJ U-500	Preferred	QL (0.05 vials every 1 day)
INS ASP PROT INJ FLEXPEN	Non Preferred	PA, QL (0.447 pens every 1 day)
INS DEGL FLX INJ 100UNIT	Non Preferred	PA
INS DEGL FLX INJ 200UNIT	Non Preferred	PA
INSULIN ASPA INJ 70/30	Non Preferred	PA, QL (1.34 mL every 1 day)
INSULIN ASPA INJ 100/ML	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSULIN ASPA INJ FLEXPEN	Non Preferred	PA
INSULIN ASPA INJ PENFILL	Non Preferred	PA
INSULIN DEGL INJ 100UNIT	Non Preferred	PA
INSULIN GLAR INJ 100U/ML	Non Preferred	PA
INSULIN GLAR INJ 100U/ML	Non Preferred	PA, QL (0.447 pens every 1 day)
INSULIN GLAR SOL 100U/ML	Non Preferred	PA
INSULIN LISP INJ 100/ML	Preferred	
INSULIN LISP INJ JUNIOR	Preferred	
INSULIN LISP INJ PROTAMIN	Preferred	QL (0.447 pens every 1 day)
LANTUS INJ 100/ML	Preferred	
LANTUS SOLOS INJ 100/ML	Preferred	QL (0.447 pens every 1 day)
LEVEMIR INJ	Preferred	
LEVEMIR INJ FLEXPEN	Preferred	
LYUMJEV INJ 100UT/ML	Non Preferred	PA
LYUMJEV KWPN INJ 100UT/ML	Non Preferred	PA
LYUMJEV KWPN INJ 200UT/ML	Non Preferred	PA
LYUMJEV TMPO INJ 100UT/ML	Non Preferred	PA
NOVOLIN70/30 INJ RELION	Non Preferred	PA, QL (1.34 mL every 1 day), OTC
NOVOLIN INJ 70/30	Non Preferred	PA, QL (1.34 mL every 1 day), OTC
NOVOLIN INJ 70/30 FP	Non Preferred	PA, QL (0.447 pens every 1 day), OTC
NOVOLIN N INJ 100 UNIT	Non Preferred	PA, QL (0.447 pens every 1 day), OTC
NOVOLIN N INJ RELION	Non Preferred	PA, QL (1.34 mL every 1 day), OTC
NOVOLIN N INJ U-100	Non Preferred	PA, QL (1.34 mL every 1 day), OTC
NOVOLIN R INJ 100 UNIT	Non Preferred	PA, OTC
NOVOLIN R INJ RELION	Non Preferred	PA, QL (0.134 vials every 1 day), OTC
NOVOLIN R INJ U-100	Non Preferred	PA, QL (0.134 vials every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NOVOLOG INJ 100/ML	Non Preferred	PA
NOVOLOG INJ FLEX REL	Non Preferred	PA
NOVOLOG INJ FLEXPEN	Non Preferred	PA
NOVOLOG INJ PENFILL	Non Preferred	PA
NOVOLOG INJ RELION	Non Preferred	PA
NOVOLOG MIX INJ 70/30	Non Preferred	PA, QL (1.34 mL every 1 day)
NOVOLOG MIX INJ FLEX REL	Non Preferred	PA, QL (0.447 pens every 1 day)
NOVOLOG MIX INJ FLEXPEN	Non Preferred	PA, QL (0.447 pens every 1 day)
NOVOLOG RELI INJ 70/30	Non Preferred	PA, QL (1.34 mL every 1 day)
REZVOGLAR INJ 100UT/ML	Non Preferred	PA
SEMGLEE PEN 100U/ML	Non Preferred	PA
SEMGLEE SOL 100U/ML	Non Preferred	PA
TOUJEO MAX INJ 300IU/ML	Non Preferred	PA
TOUJEO SOLO INJ 300IU/ML	Non Preferred	PA
TRESIBA FLEX INJ 100UNIT	Non Preferred	PA
TRESIBA FLEX INJ 200UNIT	Non Preferred	PA
TRESIBA INJ 100UNIT	Non Preferred	PA

### **INSULIN SENSITIZING AGENTS**

ACTOS TAB 15MG	Non Preferred	PA, QL (1 tab every 1 day)
ACTOS TAB 30MG	Non Preferred	PA, QL (1 tab every 1 day)
ACTOS TAB 45MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>pioglitazone hcl tab 15 mg (base equiv)</i> (generic of ACTOS)	Preferred	QL (1 tab every 1 day)
<i>pioglitazone hcl tab 30 mg (base equiv)</i> (generic of ACTOS)	Preferred	QL (1 tab every 1 day)
<i>pioglitazone hcl tab 45 mg (base equiv)</i> (generic of ACTOS)	Preferred	QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MEGLITINIDE ANALOGUES</b>		
<i>nateglinide tab 60 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>nateglinide tab 120 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>repaglinide tab 0.5 mg</i>	Non Preferred	PA, QL (6 tabs every 1 day)
<i>repaglinide tab 1 mg</i>	Non Preferred	PA, QL (6 tabs every 1 day)
<i>repaglinide tab 2 mg</i>	Non Preferred	PA, QL (6 tabs every 1 day)
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS</b>		
FARXIGA TAB 5MG	Preferred	
FARXIGA TAB 10MG	Preferred	
INVOKANA TAB 100MG	Preferred	
INVOKANA TAB 300MG	Preferred	
JARDIANCE TAB 10MG	Preferred	
JARDIANCE TAB 25MG	Preferred	
STEGLATRO TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
STEGLATRO TAB 15MG	Non Preferred	PA, QL (1 tab every 1 day)
<b>SULFONYLUREAS</b>		
AMARYL TAB 1MG	Non Preferred	PA, QL (3 tabs every 1 day)
AMARYL TAB 2MG	Non Preferred	PA, QL (4 tabs every 1 day)
AMARYL TAB 4MG	Non Preferred	PA, QL (3 tabs every 1 day)
<i>glimepiride tab 1 mg (generic of AMARYL)</i>	Preferred	QL (3 tabs every 1 day)
<i>glimepiride tab 2 mg (generic of AMARYL)</i>	Preferred	QL (4 tabs every 1 day)
<i>glimepiride tab 4 mg (generic of AMARYL)</i>	Preferred	QL (3 tabs every 1 day)
<i>glipizide tab 5 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>glipizide tab 10 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>glipizide tab er 24hr 2.5 mg (generic of GLUCOTROL XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>glipizide tab er 24hr 5 mg (generic of GLUCOTROL XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>glipizide tab er 24hr 10 mg (generic of GLUCOTROL XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>glipizide xl tab 2.5mg (generic of GLUCOTROL XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>glipizide xl tab 5mg (generic of GLUCOTROL XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>glipizide xl tab 10mg (generic of GLUCOTROL XL)</i>	Preferred	QL (2 tabs every 1 day)
GLUCOTROL XL TAB 2.5MG	Non Preferred	PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GLUCOTROL XL TAB 5MG	Non Preferred	PA, QL (2 tabs every 1 day)
GLUCOTROL XL TAB 10MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>glyburide micronized tab 1.5 mg</i> (generic of GLYNASE)	Preferred	QL (4 tabs every 1 day)
<i>glyburide micronized tab 3 mg</i> (generic of GLYNASE)	Preferred	QL (4 tabs every 1 day)
<i>glyburide micronized tab 6 mg</i> (generic of GLYNASE)	Preferred	QL (4 tabs every 1 day)
<i>glyburide tab 1.25 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>glyburide tab 2.5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>glyburide tab 5 mg</i>	Preferred	QL (4 tabs every 1 day)
GLYNASE TAB 1.5MG	Non Preferred	PA, QL (4 tabs every 1 day)
GLYNASE TAB 3MG	Non Preferred	PA, QL (4 tabs every 1 day)
GLYNASE TAB 6MG	Non Preferred	PA, QL (4 tabs every 1 day)

## **ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA**

### **ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.**

<i>bismuth subsalicylate chew tab 262 mg</i>	Preferred	OTC
<i>bismuth subsalicylate susp 262 mg/15ml</i>	Preferred	OTC
<i>bismuth subsalicylate susp 525 mg/15ml</i>	Preferred	OTC
<i>bismuth subsalicylate tab 262 mg</i>	Preferred	OTC

### **ANTIPERISTALTIC AGENTS**

<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i> (generic of LOMOTIL)	Preferred	QL (8 tabs every 1 day)
<i>loperamide hcl cap 2 mg</i>	Preferred	QL (8 caps every 1 day)
<i>loperamide hcl cap 2 mg</i>	Preferred	QL (8 caps every 1 day), OTC
<i>loperamide hcl tab 2 mg</i>	Preferred	QL (8 tabs every 1 day), OTC
<i>loperamide sus 1mg/7.5</i>	Preferred	OTC

## **ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING**

### **ANTIDOTES - CHELATING AGENTS**

CHEMET CAP 100MG	Preferred	
<i>deferasirox granules packet 90 mg</i> (generic of JADENU SPRINKLE)	Non Preferred	PA
<i>deferasirox granules packet 180 mg</i> (generic of JADENU SPRINKLE)	Non Preferred	PA
<i>deferasirox granules packet 360 mg</i> (generic of JADENU SPRINKLE)	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>deferasirox tab 90 mg (generic of JADENU)</i>	Non Preferred	PA
<i>deferasirox tab 180 mg (generic of JADENU)</i>	Non Preferred	PA
<i>deferasirox tab 360 mg (generic of JADENU)</i>	Non Preferred	PA
<i>deferasirox tab for oral susp 125 mg (generic of EXJADE)</i>	Non Preferred	PA
<i>deferasirox tab for oral susp 250 mg (generic of EXJADE)</i>	Non Preferred	PA
<i>deferasirox tab for oral susp 500 mg (generic of EXJADE)</i>	Non Preferred	PA
<i>deferiprone tab 500 mg (generic of FERRIPROX)</i>	Non Preferred	PA
<i>deferiprone tab 1000 mg (generic of FERRIPROX)</i>	Non Preferred	PA
EXJADE TAB 125MG	Non Preferred	PA
EXJADE TAB 250MG	Non Preferred	PA
EXJADE TAB 500MG	Non Preferred	PA
FERPRX 2-DAY TAB 1000MG	Non Preferred	PA
FERRIPROX SOL 100MG/ML	Non Preferred	PA
FERRIPROX TAB 500MG	Non Preferred	PA
FERRIPROX TAB 1000MG	Non Preferred	PA
JADENU SPRKL GRA 90MG	Non Preferred	PA
JADENU SPRKL GRA 180MG	Non Preferred	PA
JADENU SPRKL GRA 360MG	Non Preferred	PA
JADENU TAB 90MG	Non Preferred	PA
JADENU TAB 180MG	Non Preferred	PA
JADENU TAB 360MG	Non Preferred	PA
<b>OPIOID ANTAGONISTS</b>		
KLOXXADO SPR 8MG	Preferred	
NALMEFENE INJ 1MG/ML	Preferred	
<i>naloxone hcl inj 0.4 mg/ml</i>	Preferred	
<i>naloxone hcl inj 4 mg/10ml</i>	Preferred	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>naloxone hcl inj 4 mg/10ml</i>	Preferred	
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	Preferred	
<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	Preferred	
<i>naloxone hcl soln prefilled syringe 2 mg/2ml</i>	Preferred	
<i>naltrexone hcl tab 50 mg</i>	Preferred	QL (2 tabs every 1 day)
NARCAN SPR 4MG	Preferred	
VIVITROL INJ 380MG	Preferred	
ZIMHI SOL	Preferred	

## **ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING**

### **5-HT3 RECEPTOR ANTAGONISTS**

ANZEMET TAB 50MG	Non Preferred	PA
<i>granisetron hcl tab 1 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	Preferred	
<i>ondansetron hcl tab 4 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>ondansetron hcl tab 8 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>ondansetron orally disintegrating tab 4 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>ondansetron orally disintegrating tab 8 mg</i>	Preferred	QL (3 tabs every 1 day)
SANCUSO DIS 3.1MG	Non Preferred	PA

### **ANTIEMETICS - ANTICHOLINERGIC**

ANTIVERT CHW 25MG	Non Preferred	PA
ANTIVERT TAB 50MG	Non Preferred	PA
<i>dimenhydrinate tab 50 mg</i>	Preferred	OTC
<i>meclizine hcl chew tab 25 mg</i>	Preferred	OTC
<i>meclizine hcl tab 12.5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>meclizine hcl tab 25 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>scopolamine td patch 72hr 1 mg/3days</i> (generic of TRANSDERM-SCOP)	Preferred	
TRANSDERM-SC DIS 1MG/3DAY	Preferred	
<i>trimethobenzamide hcl cap 300 mg</i>	Non Preferred	PA

### **ANTIEMETICS - MISCELLANEOUS**

AKYNZEO CAP 300-0.5	Non Preferred	PA
BONJESTA TAB 20-20MG	Non Preferred	PA
DICLEGIS TAB 10-10MG	Non Preferred	PA
<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i> (generic of DICLEGIS)	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dronabinol cap 2.5 mg</i> (generic of MARINOL)	Non Preferred	PA
<i>dronabinol cap 5 mg</i>	Non Preferred	PA
<i>dronabinol cap 10 mg</i>	Non Preferred	PA
MARINOL CAP 2.5MG	Non Preferred	PA

### ***SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS***

<i>aprepitant capsule 40 mg</i>	Preferred	
<i>aprepitant capsule 80 mg</i> (generic of EMEND)	Preferred	
<i>aprepitant capsule 125 mg</i>	Preferred	
<i>aprepitant capsule therapy pack 80 &amp; 125 mg</i>	Preferred	
EMEND CAP 80MG	Non Preferred	PA
EMEND SUS 125MG	Non Preferred	PA
EMEND TRIPAC PAK 80 & 125	Non Preferred	PA

### **ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS**

#### ***ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS***

BREXAFEMME TAB 150MG	Non Preferred	PA
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#### ***ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS***

ANCOBON CAP 250MG	Non Preferred	PA
ANCOBON CAP 500MG	Non Preferred	PA
<i>flucytosine cap 250 mg</i> (generic of ANCOBON)	Non Preferred	PA
<i>flucytosine cap 500 mg</i> (generic of ANCOBON)	Non Preferred	PA
<i>griseofulvin microsize susp 125 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>griseofulvin microsize tab 500 mg</i>	Preferred	
<i>griseofulvin ultramicrosize tab 125 mg</i>	Preferred	
<i>griseofulvin ultramicrosize tab 250 mg</i>	Preferred	
<i>nystatin tab 500000 unit</i>	Preferred	QL (8 tabs every 1 day)
<i>terbinafine hcl tab 250 mg</i>	Preferred	QL (1 tab every 1 day)

#### ***IMIDAZOLE-RELATED ANTIFUNGALS***

CRESEMBA CAP 186 MG	Non Preferred	PA
DIFLUCAN SUS 10MG/ML	Non Preferred	PA, QL (3 mL every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DIFLUCAN SUS 40MG/ML	Non Preferred	PA, QL (5 mL every 1 day)
DIFLUCAN TAB 100MG	Non Preferred	PA
DIFLUCAN TAB 150MG	Non Preferred	PA
DIFLUCAN TAB 200MG	Non Preferred	PA
<i>fluconazole for susp 10 mg/ml (generic of DIFLUCAN)</i>	Preferred	QL (3 mL every 1 day)
<i>fluconazole for susp 40 mg/ml (generic of DIFLUCAN)</i>	Preferred	QL (5 mL every 1 day)
<i>fluconazole tab 50 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>fluconazole tab 100 mg (generic of DIFLUCAN)</i>	Preferred	
<i>fluconazole tab 150 mg (generic of DIFLUCAN)</i>	Preferred	
<i>fluconazole tab 200 mg (generic of DIFLUCAN)</i>	Preferred	
<i>itraconazole cap 100 mg (generic of SPORANOX)</i>	Preferred	
<i>itraconazole oral soln 10 mg/ml (generic of SPORANOX)</i>	Non Preferred	PA
<i>itraconazole oral soln 10 mg/ml (generic of SPORANOX)</i>	Non Preferred	PA
<i>ketoconazole tab 200 mg</i>	Preferred	QL (2 tabs every 1 day)
NOXAFIL PAK 300MG	Non Preferred	PA
NOXAFIL SUS 40MG/ML	Non Preferred	PA
NOXAFIL TAB 100MG	Non Preferred	PA
<i>posaconazole susp 40 mg/ml (generic of NOXAFIL)</i>	Non Preferred	PA
<i>posaconazole tab delayed release 100 mg (generic of NOXAFIL)</i>	Non Preferred	PA
SPORANOX CAP 100MG	Non Preferred	PA
SPORANOX SOL 10MG/ML	Non Preferred	PA
TOLSURA CAP 65MG	Non Preferred	PA
VFEND SUS 40MG/ML	Non Preferred	PA
VFEND TAB 50MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VFEND TAB 200MG	Non Preferred	PA
VIVJOA CAP 150MG	Non Preferred	PA
<i>voriconazole for susp 40 mg/ml (generic of VFEND)</i>	Non Preferred	PA
<i>voriconazole tab 50 mg (generic of VFEND)</i>	Non Preferred	PA
<i>voriconazole tab 200 mg (generic of VFEND)</i>	Non Preferred	PA

## **ANTIHIISTAMINES - DRUGS TO TREAT ALLERGIES**

### **ANTIHIISTAMINES - ALKYLAMINES**

<i>chlorpheniramine maleate syrup 2 mg/5ml</i>	Preferred	OTC
<i>chlorpheniramine tab 4 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
<i>chlorpheniramine tab er 12 mg</i>	Preferred	QL (2 tabs every 1 day), OTC

### **ANTIHIISTAMINES - ETHANOLAMINES**

<i>carbinoxamine maleate soln 4 mg/5ml</i>	Preferred	
<i>carbinoxamine maleate tab 4 mg</i>	Preferred	
<i>clemastine fumarate tab 1.34 mg</i>	Preferred	QL (2 tabs every 1 day), OTC
<i>clemastine fumarate tab 2.68 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>diphenhydramine hcl cap 25 mg</i>	Preferred	QL (6 caps every 1 day), OTC; AGE (Max 64)
<i>diphenhydramine hcl cap 50 mg</i>	Preferred	QL (6 caps every 1 day), OTC; AGE (Max 64)
<i>diphenhydramine hcl chew tab 12.5 mg</i>	Preferred	QL (6 ea every 1 day), OTC; AGE (Max 12)
<i>diphenhydramine hcl elixir 12.5 mg/5ml</i>	Preferred	QL (80 mL every 1 day); AGE (Max 12)
<i>diphenhydramine hcl inj 50 mg/ml</i>	Preferred	AGE (Max 64)
<i>diphenhydramine hcl liquid 12.5 mg/5ml</i>	Preferred	QL (60 mL every 1 day), OTC; AGE (Max 12)
<i>diphenhydramine hcl tab 25 mg</i>	Preferred	QL (6 tabs every 1 day), OTC; AGE (Max 64)

### **ANTIHIISTAMINES - NON-SEDATING**

<i>allerclear tab 10mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>allergy chld sol 5mg/5ml</i>	Preferred	QL (10 mL every 1 day), OTC; AGE (Max 12)
<i>allergy relf sol 5mg/5ml</i>	Preferred	QL (10 mL every 1 day), OTC; AGE (Max 12)
<i>allergy relf tab 5mg</i>	Preferred	QL (1 tab every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>allergy relf tab 10mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>	Preferred	QL (10 mL every 1 day); AGE (Max 12)
<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>	Preferred	QL (10 mL every 1 day), OTC; AGE (Max 12)
<i>cetirizine hcl tab 5 mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>cetirizine hcl tab 10 mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>loratadine rapidly-disintegrating tab 10 mg</i>	Preferred	QL (1 tab every 1 day), OTC; AGE (Max 12)
<i>loratadine sol 5mg/5ml</i>	Preferred	QL (10 mL every 1 day), OTC; AGE (Max 12)
<i>loratadine tab 10 mg</i>	Preferred	QL (1 each every 1 day), OTC
<i>qc allergy tab 10mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>qc loratadin tab 10mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>sm all day tab allr rel</i>	Preferred	QL (1 tab every 1 day), OTC
<i>sm allergy sol 5mg/5ml</i>	Preferred	QL (10 mL every 1 day), OTC; AGE (Max 12)
<i>sm loratadin tab 10mg</i>	Preferred	QL (1 tab every 1 day), OTC

### **ANTI-HISTAMINES - PHENOTHIAZINES**

<i>promethazine hcl inj 25 mg/ml (generic of PHENERGAN)</i>	Preferred	QL (100 vials every 1 day); AGE (Min 2, Max 64)
<i>promethazine hcl inj 50 mg/ml (generic of PHENERGAN)</i>	Preferred	QL (50 ampules every 1 day); AGE (Min 2, Max 64)
<i>promethazine hcl suppos 12.5 mg</i>	Preferred	QL (8 supp every 1 day); AGE (Min 2, Max 64)
<i>promethazine hcl suppos 25 mg</i>	Preferred	QL (8 supp every 1 day); AGE (Min 2, Max 64)
<i>promethazine hcl syrup 6.25 mg/5ml</i>	Preferred	QL (100 mL every 1 day); AGE (Min 2, Max 64)
<i>promethazine hcl tab 12.5 mg</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 2, Max 64)
<i>promethazine hcl tab 25 mg</i>	Preferred	QL (6 tabs every 1 day); AGE (Min 2, Max 64)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>promethazine hcl tab 50 mg</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 2, Max 64)
<b>ANTIHIISTAMINES - PIPERIDINES</b>		
<i>cyproheptadine hcl syrup 2 mg/5ml</i>	Preferred	QL (20 mL every 1 day); AGE (Max 64)
<i>cyproheptadine hcl tab 4 mg</i>	Preferred	QL (6 tabs every 1 day); AGE (Max 64)
<b>ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<b>ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS</b>		
NEXLETOL TAB 180MG	Non Preferred	PA
<b>ANTIHYPERLIPIDEMICS - COMBINATIONS</b>		
<i>ezetimibe-simvastatin tab 10-10 mg</i> (generic of VYTORIN)	Non Preferred	PA
<i>ezetimibe-simvastatin tab 10-20 mg</i> (generic of VYTORIN)	Non Preferred	PA
<i>ezetimibe-simvastatin tab 10-40 mg</i> (generic of VYTORIN)	Non Preferred	PA
<i>ezetimibe-simvastatin tab 10-80 mg</i> (generic of VYTORIN)	Non Preferred	PA
NEXLIZET TAB 180/10MG	Non Preferred	PA
VYTORIN TAB 10-10MG	Non Preferred	PA
VYTORIN TAB 10-20MG	Non Preferred	PA
VYTORIN TAB 10-40MG	Non Preferred	PA
VYTORIN TAB 10-80MG	Non Preferred	PA
<b>ANTIHYPERLIPIDEMICS - MISC.</b>		
<i>icosapent ethyl cap 0.5 gm</i> (generic of VASCEPA)	Non Preferred	PA
<i>icosapent ethyl cap 1 gm</i> (generic of VASCEPA)	Non Preferred	PA
LOVAZA CAP 1GM	Non Preferred	PA
<i>omega-3-acid ethyl esters cap 1 gm</i> (generic of LOVAZA)	Non Preferred	PA
VASCEPA CAP 0.5GM	Non Preferred	PA
VASCEPA CAP 1GM	Non Preferred	PA
<b>BILE ACID SEQUESTRANTS</b>		
<i>cholestyramine light powder 4 gm/dose</i> (generic of QUESTRAN LIGHT)	Preferred	QL (8 gm every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cholestyramine light powder packets 4 gm</i>	Preferred	
<i>cholestyramine powder 4 gm/dose (generic of QUESTRAN)</i>	Preferred	QL (48 gm every 1 day)
<i>cholestyramine powder packets 4 gm (generic of QUESTRAN)</i>	Preferred	
<i>colesevelam hcl packet for susp 3.75 gm (generic of WELCHOL)</i>	Non Preferred	PA
<i>colesevelam hcl tab 625 mg (generic of WELCHOL)</i>	Non Preferred	PA
COLESTID FLA GRA 5/7.5GM	Non Preferred	PA
COLESTID FLA GRA 5GM	Non Preferred	PA
COLESTID GRA 5GM	Non Preferred	PA
COLESTID POW 5GM	Non Preferred	PA
COLESTID TAB 1GM	Non Preferred	PA, QL (16 tabs every 1 day)
<i>colestipol hcl granule packets 5 gm (generic of COLESTID)</i>	Non Preferred	PA
<i>colestipol hcl granules 5 gm (generic of COLESTID)</i>	Non Preferred	PA
<i>colestipol hcl tab 1 gm (generic of COLESTID)</i>	Non Preferred	PA, QL (16 tabs every 1 day)
<i>prevalite pow 4gm (generic of QUESTRAN LIGHT)</i>	Preferred	QL (8 gm every 1 day)
<i>prevalite pow 4gm pk</i>	Preferred	
QUESTRAN POW 4GM	Non Preferred	PA
QUESTRAN POW 4GM	Non Preferred	PA, QL (48 gm every 1 day)
QUESTRAN POW 4GM LITE	Non Preferred	PA, QL (8 gm every 1 day)
WELCHOL PAK 3.75GM	Non Preferred	PA
WELCHOL TAB 625MG	Non Preferred	PA
<b>FIBRIC ACID DERIVATIVES</b>		
ANTARA CAP 90MG	Non Preferred	PA
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv) (generic of TRILIPIX)</i>	Preferred	
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv) (generic of TRILIPIX)</i>	Preferred	
<i>fenofibrate cap 50 mg</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fenofibrate cap 150 mg</i>	Preferred	
<i>fenofibrate micronized cap 43 mg</i>	Preferred	
<i>fenofibrate micronized cap 67 mg</i>	Preferred	
<i>fenofibrate micronized cap 90 mg</i>	Preferred	
<i>fenofibrate micronized cap 130 mg</i>	Preferred	
<i>fenofibrate micronized cap 134 mg</i>	Preferred	
<i>fenofibrate micronized cap 200 mg</i>	Preferred	
<i>fenofibrate tab 40 mg (generic of FENOGLIDE)</i>	Preferred	
<i>fenofibrate tab 48 mg (generic of TRICOR)</i>	Preferred	QL (1 tab every 1 day)
<i>fenofibrate tab 54 mg</i>	Preferred	QL (1 tab every 1 day)
<i>fenofibrate tab 120 mg (generic of FENOGLIDE)</i>	Preferred	
<i>fenofibrate tab 145 mg (generic of TRICOR)</i>	Preferred	QL (1 tab every 1 day)
<i>fenofibrate tab 160 mg</i>	Preferred	QL (1 tab every 1 day)
<i>fenofibric acid tab 35 mg</i>	Non Preferred	PA
<i>fenofibric acid tab 105 mg</i>	Non Preferred	PA
FENOGLIDE TAB 40MG	Non Preferred	PA
FENOGLIDE TAB 120MG	Non Preferred	PA
<i>gemfibrozil tab 600 mg (generic of LOPID)</i>	Preferred	QL (4 tabs every 1 day)
LIPOFEN CAP 50MG	Non Preferred	PA
LIPOFEN CAP 150MG	Non Preferred	PA
LOPID TAB 600MG	Non Preferred	PA, QL (4 tabs every 1 day)
TRICOR TAB 48MG	Non Preferred	PA, QL (1 tab every 1 day)
TRICOR TAB 145MG	Non Preferred	PA, QL (1 tab every 1 day)
TRILIPIX CAP 45MG	Non Preferred	PA
TRILIPIX CAP 135MG	Non Preferred	PA
<b>HMG COA REDUCTASE INHIBITORS</b>		
ALTOPREV TAB 20MG ER	Non Preferred	PA
ALTOPREV TAB 40MG ER	Non Preferred	PA
ALTOPREV TAB 60MG ER	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ATORVALIQ SUS 20MG/5ML	Non Preferred	PA
<i>atorvastatin calcium tab 10 mg (base equivalent) (generic of LIPITOR)</i>	Preferred	QL (1 tab every 1 day)
<i>atorvastatin calcium tab 20 mg (base equivalent) (generic of LIPITOR)</i>	Preferred	QL (1 tab every 1 day)
<i>atorvastatin calcium tab 40 mg (base equivalent) (generic of LIPITOR)</i>	Preferred	QL (1 tab every 1 day)
<i>atorvastatin calcium tab 80 mg (base equivalent) (generic of LIPITOR)</i>	Preferred	QL (1 tab every 1 day)
CRESTOR TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
CRESTOR TAB 40MG	Non Preferred	PA, QL (1 tab every 1 day)
EZALLOR SPR CAP 5MG	Non Preferred	PA
EZALLOR SPR CAP 10MG	Non Preferred	PA
EZALLOR SPR CAP 20MG	Non Preferred	PA
EZALLOR SPR CAP 40MG	Non Preferred	PA
<i>fluvastatin sodium cap 20 mg (base equivalent)</i>	Non Preferred	PA
<i>fluvastatin sodium cap 40 mg (base equivalent)</i>	Non Preferred	PA
<i>fluvastatin sodium tab er 24 hr 80 mg (base equivalent) (generic of LESCOL XL)</i>	Non Preferred	PA
LESCOL XL TAB 80MG	Non Preferred	PA
LIPITOR TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
LIPITOR TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
LIPITOR TAB 40MG	Non Preferred	PA, QL (1 tab every 1 day)
LIPITOR TAB 80MG	Non Preferred	PA, QL (1 tab every 1 day)
LIVALO TAB 1MG	Non Preferred	PA
LIVALO TAB 2MG	Non Preferred	PA
LIVALO TAB 4MG	Non Preferred	PA
<i>lovastatin tab 10 mg</i>	Preferred	QL (1 tab every 1 day)
<i>lovastatin tab 20 mg</i>	Preferred	QL (1 tab every 1 day)
<i>lovastatin tab 40 mg</i>	Preferred	QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pravastatin sodium tab 10 mg</i>	Preferred	QL (1 tab every 1 day)
<i>pravastatin sodium tab 20 mg</i>	Preferred	QL (1 tab every 1 day)
<i>pravastatin sodium tab 40 mg</i>	Preferred	QL (1 tab every 1 day)
<i>pravastatin sodium tab 80 mg</i>	Preferred	QL (1 tab every 1 day)
<i>rosuvastatin calcium tab 5 mg (generic of CRESTOR)</i>	Preferred	QL (1 tab every 1 day)
<i>rosuvastatin calcium tab 10 mg (generic of CRESTOR)</i>	Preferred	QL (1 tab every 1 day)
<i>rosuvastatin calcium tab 20 mg (generic of CRESTOR)</i>	Preferred	QL (1 tab every 1 day)
<i>rosuvastatin calcium tab 40 mg (generic of CRESTOR)</i>	Preferred	QL (1 tab every 1 day)
<i>simvastatin tab 5 mg</i>	Preferred	QL (1 tab every 1 day)
<i>simvastatin tab 10 mg (generic of ZOCOR)</i>	Preferred	QL (1 tab every 1 day)
<i>simvastatin tab 20 mg (generic of ZOCOR)</i>	Preferred	QL (1 tab every 1 day)
<i>simvastatin tab 40 mg (generic of ZOCOR)</i>	Preferred	QL (1 tab every 1 day)
<i>simvastatin tab 80 mg</i>	Preferred	
ZOCOR TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
ZOCOR TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
ZOCOR TAB 40MG	Non Preferred	PA, QL (1 tab every 1 day)
ZYPITAMAG TAB 2MG	Non Preferred	PA
ZYPITAMAG TAB 4MG	Non Preferred	PA
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>		
<i>ezetimibe tab 10 mg (generic of ZETIA)</i>	Preferred	QL (1 tab every 1 day)
ZETIA TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
<b>MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS</b>		
JUXTAPID CAP 5MG	Non Preferred	SP, PA
JUXTAPID CAP 10MG	Non Preferred	SP, PA
JUXTAPID CAP 20MG	Non Preferred	SP, PA
JUXTAPID CAP 30MG	Non Preferred	SP, PA
<b>NICOTINIC ACID DERIVATIVES</b>		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	Non Preferred	PA
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	Non Preferred	PA

### ***PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS***

LEQVIO SOL	Non Preferred	PA
PRALUENT INJ 75MG/ML	Non Preferred	PA
PRALUENT INJ 150MG/ML	Non Preferred	PA
REPATHA INJ 140MG/ML	Non Preferred	PA
REPATHA PUSH INJ 420/3.5	Non Preferred	PA
REPATHA SURE INJ 140MG/ML	Non Preferred	PA

### **ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE**

#### ***ACE INHIBITORS***

ACCUPRIL TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
ACCUPRIL TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
ACCUPRIL TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
ACCUPRIL TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)
ALTACE CAP 1.25MG	Non Preferred	PA, QL (1 cap every 1 day)
ALTACE CAP 2.5MG	Non Preferred	PA, QL (1 cap every 1 day)
ALTACE CAP 5MG	Non Preferred	PA, QL (1 cap every 1 day)
ALTACE CAP 10MG	Non Preferred	PA, QL (1 cap every 1 day)
<i>benazepril hcl tab 5 mg</i>	Preferred	QL (1.5 tabs every 1 day)
<i>benazepril hcl tab 10 mg (generic of LOTENSIN)</i>	Preferred	QL (1.5 tabs every 1 day)
<i>benazepril hcl tab 20 mg (generic of LOTENSIN)</i>	Preferred	QL (1.5 tabs every 1 day)
<i>benazepril hcl tab 40 mg (generic of LOTENSIN)</i>	Preferred	QL (2 tabs every 1 day)
<i>captopril tab 12.5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>captopril tab 25 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>captopril tab 50 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>captopril tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>enalapril maleate oral soln 1 mg/ml (generic of EPANED)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>enalapril maleate tab 2.5 mg</i> (generic of VASOTEC)	Preferred	QL (1 tab every 1 day)
<i>enalapril maleate tab 5 mg</i> (generic of VASOTEC)	Preferred	QL (1 tab every 1 day)
<i>enalapril maleate tab 10 mg</i> (generic of VASOTEC)	Preferred	QL (1 tab every 1 day)
<i>enalapril maleate tab 20 mg</i> (generic of VASOTEC)	Preferred	QL (2 tabs every 1 day)
EPANED SOL 1MG/ML	Non Preferred	PA
<i>fosinopril sodium tab 10 mg</i>	Preferred	QL (1 tab every 1 day)
<i>fosinopril sodium tab 20 mg</i>	Preferred	QL (1 tab every 1 day)
<i>fosinopril sodium tab 40 mg</i>	Preferred	QL (1 tab every 1 day)
<i>lisinopril tab 2.5 mg</i> (generic of ZESTRIL)	Preferred	QL (1 tab every 1 day)
<i>lisinopril tab 5 mg</i> (generic of ZESTRIL)	Preferred	QL (1 tab every 1 day)
<i>lisinopril tab 10 mg</i> (generic of ZESTRIL)	Preferred	QL (1 tab every 1 day)
<i>lisinopril tab 20 mg</i> (generic of ZESTRIL)	Preferred	QL (1 tab every 1 day)
<i>lisinopril tab 30 mg</i> (generic of ZESTRIL)	Preferred	QL (2 tabs every 1 day)
<i>lisinopril tab 40 mg</i> (generic of ZESTRIL)	Preferred	QL (2 tabs every 1 day)
LOTENSIN TAB 10MG	Non Preferred	PA, QL (1.5 tabs every 1 day)
LOTENSIN TAB 20MG	Non Preferred	PA, QL (1.5 tabs every 1 day)
LOTENSIN TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>moexipril hcl tab 7.5 mg</i>	Preferred	
<i>moexipril hcl tab 15 mg</i>	Preferred	
<i>perindopril erbumine tab 2 mg</i>	Non Preferred	PA
<i>perindopril erbumine tab 4 mg</i>	Non Preferred	PA
<i>perindopril erbumine tab 8 mg</i>	Non Preferred	PA
QBRELIS SOL 1MG/ML	Non Preferred	PA
<i>quinapril hcl tab 5 mg</i> (generic of ACCUPRIL)	Preferred	QL (1 tab every 1 day)
<i>quinapril hcl tab 10 mg</i> (generic of ACCUPRIL)	Preferred	QL (1 tab every 1 day)
<i>quinapril hcl tab 20 mg</i> (generic of ACCUPRIL)	Preferred	QL (1 tab every 1 day)
<i>quinapril hcl tab 40 mg</i> (generic of ACCUPRIL)	Preferred	QL (2 tabs every 1 day)
<i>ramipril cap 1.25 mg</i> (generic of ALTACE)	Preferred	QL (1 cap every 1 day)
<i>ramipril cap 2.5 mg</i> (generic of ALTACE)	Preferred	QL (1 cap every 1 day)
<i>ramipril cap 5 mg</i> (generic of ALTACE)	Preferred	QL (1 cap every 1 day)
<i>ramipril cap 10 mg</i> (generic of ALTACE)	Preferred	QL (1 cap every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>trandolapril tab 1 mg</i>	Preferred	QL (1 tab every 1 day)
<i>trandolapril tab 2 mg</i>	Preferred	QL (1 tab every 1 day)
<i>trandolapril tab 4 mg</i>	Preferred	QL (1 tab every 1 day)
VASOTEC TAB 2.5MG	Non Preferred	PA, QL (1 tab every 1 day)
VASOTEC TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
VASOTEC TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
VASOTEC TAB 20MG	Non Preferred	PA, QL (2 tabs every 1 day)
ZESTRIL TAB 2.5MG	Non Preferred	PA, QL (1 tab every 1 day)
ZESTRIL TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
ZESTRIL TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
ZESTRIL TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
ZESTRIL TAB 30MG	Non Preferred	PA, QL (2 tabs every 1 day)
ZESTRIL TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)

#### **AGENTS FOR PHEOCHROMOCYTOMA**

DEMSER CAP 250MG	Preferred	
<i>metyrosine cap 250 mg (generic of DEMSER)</i>	Preferred	
<i>phenoxybenzamine hcl cap 10 mg (generic of DIBENZYLIN)</i>	Non Preferred	PA

#### **ANGIOTENSIN II RECEPTOR ANTAGONISTS**

ATACAND TAB 4MG	Non Preferred	PA
ATACAND TAB 8MG	Non Preferred	PA
ATACAND TAB 16MG	Non Preferred	PA
ATACAND TAB 32MG	Non Preferred	PA
AVAPRO TAB 75MG	Non Preferred	PA, QL (1 tab every 1 day)
AVAPRO TAB 150MG	Non Preferred	PA, QL (1 tab every 1 day)
AVAPRO TAB 300MG	Non Preferred	PA, QL (1 tab every 1 day)
BENICAR TAB 5MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BENICAR TAB 20MG	Non Preferred	PA
BENICAR TAB 40MG	Non Preferred	PA
<i>candesartan cilexetil tab 4 mg (generic of ATACAND)</i>	Non Preferred	PA
<i>candesartan cilexetil tab 8 mg (generic of ATACAND)</i>	Non Preferred	PA
<i>candesartan cilexetil tab 16 mg (generic of ATACAND)</i>	Non Preferred	PA
<i>candesartan cilexetil tab 32 mg (generic of ATACAND)</i>	Non Preferred	PA
COZAAR TAB 25MG	Non Preferred	PA, QL (1 tab every 1 day)
COZAAR TAB 50MG	Non Preferred	PA, QL (1 tab every 1 day)
COZAAR TAB 100MG	Non Preferred	PA, QL (1 tab every 1 day)
DIOVAN TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)
DIOVAN TAB 80MG	Non Preferred	PA, QL (2 tabs every 1 day)
DIOVAN TAB 160MG	Non Preferred	PA, QL (2 tabs every 1 day)
DIOVAN TAB 320MG	Non Preferred	PA, QL (2 tabs every 1 day)
EDARBI TAB 40MG	Non Preferred	PA
EDARBI TAB 80MG	Non Preferred	PA
<i>irbesartan tab 75 mg (generic of AVAPRO)</i>	Preferred	QL (1 tab every 1 day)
<i>irbesartan tab 150 mg (generic of AVAPRO)</i>	Preferred	QL (1 tab every 1 day)
<i>irbesartan tab 300 mg (generic of AVAPRO)</i>	Preferred	QL (1 tab every 1 day)
<i>losartan potassium tab 25 mg (generic of COZAAR)</i>	Preferred	QL (1 tab every 1 day)
<i>losartan potassium tab 50 mg (generic of COZAAR)</i>	Preferred	QL (1 tab every 1 day)
<i>losartan potassium tab 100 mg (generic of COZAAR)</i>	Preferred	QL (1 tab every 1 day)
MICARDIS TAB 20MG	Non Preferred	PA
MICARDIS TAB 40MG	Non Preferred	PA
MICARDIS TAB 80MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>olmesartan medoxomil tab 5 mg (generic of BENICAR)</i>	Non Preferred	PA
<i>olmesartan medoxomil tab 20 mg (generic of BENICAR)</i>	Non Preferred	PA
<i>olmesartan medoxomil tab 40 mg (generic of BENICAR)</i>	Non Preferred	PA
<i>telmisartan tab 20 mg (generic of MICARDIS)</i>	Non Preferred	PA
<i>telmisartan tab 40 mg (generic of MICARDIS)</i>	Non Preferred	PA
<i>telmisartan tab 80 mg (generic of MICARDIS)</i>	Non Preferred	PA
<i>valsartan tab 40 mg (generic of DIOVAN)</i>	Preferred	QL (2 tabs every 1 day)
<i>valsartan tab 80 mg (generic of DIOVAN)</i>	Preferred	QL (2 tabs every 1 day)
<i>valsartan tab 160 mg (generic of DIOVAN)</i>	Preferred	QL (2 tabs every 1 day)
<i>valsartan tab 320 mg (generic of DIOVAN)</i>	Preferred	QL (2 tabs every 1 day)

### **ANTIADRENERGIC ANTIHYPERTENSIVES**

CARDURA TAB 1MG	Non Preferred	PA, QL (1 tab every 1 day)
CARDURA TAB 2MG	Non Preferred	PA, QL (1 tab every 1 day)
CARDURA TAB 4MG	Non Preferred	PA, QL (1 tab every 1 day)
CARDURA TAB 8MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>clonidine hcl tab 0.1 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>clonidine hcl tab 0.2 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>clonidine hcl tab 0.3 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>clonidine hcl tab er 24hr 0.17 mg (base equivalent)</i>	Non Preferred	PA
<i>clonidine td patch weekly 0.1 mg/24hr (generic of CATAPRES-TTS-1)</i>	Preferred	
<i>clonidine td patch weekly 0.2 mg/24hr (generic of CATAPRES-TTS-2)</i>	Preferred	
<i>clonidine td patch weekly 0.3 mg/24hr (generic of CATAPRES-TTS-3)</i>	Preferred	
<i>doxazosin mesylate tab 1 mg (generic of CARDURA)</i>	Preferred	QL (1 tab every 1 day)
<i>doxazosin mesylate tab 2 mg (generic of CARDURA)</i>	Preferred	QL (1 tab every 1 day)
<i>doxazosin mesylate tab 4 mg (generic of CARDURA)</i>	Preferred	QL (1 tab every 1 day)
<i>doxazosin mesylate tab 8 mg (generic of CARDURA)</i>	Preferred	QL (2 tabs every 1 day)
<i>guanfacine hcl tab 1 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>guanfacine hcl tab 2 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>methyldopa tab 250 mg</i>	Preferred	QL (4 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methyldopa tab 500 mg</i>	Preferred	QL (6 tabs every 1 day)
MINIPRESS CAP 1MG	Non Preferred	PA, QL (6 caps every 1 day)
MINIPRESS CAP 2MG	Non Preferred	PA, QL (6 caps every 1 day)
MINIPRESS CAP 5MG	Non Preferred	PA, QL (6 caps every 1 day)
<i>prazosin hcl cap 1 mg (generic of MINIPRESS)</i>	Preferred	QL (6 caps every 1 day)
<i>prazosin hcl cap 2 mg (generic of MINIPRESS)</i>	Preferred	QL (6 caps every 1 day)
<i>prazosin hcl cap 5 mg (generic of MINIPRESS)</i>	Preferred	QL (6 caps every 1 day)
<i>terazosin hcl cap 1 mg (base equivalent)</i>	Preferred	QL (1 cap every 1 day)
<i>terazosin hcl cap 2 mg (base equivalent)</i>	Preferred	QL (2 caps every 1 day)
<i>terazosin hcl cap 5 mg (base equivalent)</i>	Preferred	QL (1 cap every 1 day)
<i>terazosin hcl cap 10 mg (base equivalent)</i>	Preferred	QL (2 caps every 1 day)

### **ANTIHYPERTENSIVE COMBINATIONS**

ACCURETIC TAB 10-12.5	Non Preferred	PA, QL (1 tab every 1 day)
ACCURETIC TAB 20-12.5	Non Preferred	PA, QL (1 tab every 1 day)
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	Preferred	
<i>amlodipine besylate-benazepril hcl cap 5-10 mg (generic of LOTREL)</i>	Preferred	QL (1 cap every 1 day)
<i>amlodipine besylate-benazepril hcl cap 5-20 mg (generic of LOTREL)</i>	Preferred	QL (1 cap every 1 day)
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	Preferred	QL (1 cap every 1 day)
<i>amlodipine besylate-benazepril hcl cap 10-20 mg (generic of LOTREL)</i>	Preferred	QL (1 cap every 1 day)
<i>amlodipine besylate-benazepril hcl cap 10-40 mg (generic of LOTREL)</i>	Preferred	QL (1 cap every 1 day)
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg (generic of AZOR)</i>	Non Preferred	PA
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg (generic of AZOR)</i>	Non Preferred	PA
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg (generic of AZOR)</i>	Non Preferred	PA
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg (generic of AZOR)</i>	Non Preferred	PA
<i>amlodipine besylate-valsartan tab 5-160 mg (generic of EXFORGE)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>amlodipine besylate-valsartan tab 5-320 mg (generic of EXFORGE)</i>	Non Preferred	PA, QL (1 tab every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amlodipine besylate-valsartan tab 10-160 mg (generic of EXFORGE)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>amlodipine besylate-valsartan tab 10-320 mg (generic of EXFORGE)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg (generic of EXFORGE HCT)</i>	Non Preferred	PA
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg (generic of EXFORGE HCT)</i>	Non Preferred	PA
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg (generic of EXFORGE HCT)</i>	Non Preferred	PA
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg (generic of EXFORGE HCT)</i>	Non Preferred	PA
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg (generic of EXFORGE HCT)</i>	Non Preferred	PA
ATACAND HCT TAB 16-12.5	Non Preferred	PA
ATACAND HCT TAB 32-12.5	Non Preferred	PA
ATACAND HCT TAB 32-25MG	Non Preferred	PA
<i>atenolol &amp; chlorthalidone tab 50-25 mg (generic of TENORETIC 50)</i>	Preferred	QL (2 tabs every 1 day)
<i>atenolol &amp; chlorthalidone tab 100-25 mg (generic of TENORETIC 100)</i>	Preferred	QL (1 tab every 1 day)
AVALIDE TAB 150-12.5	Non Preferred	PA, QL (1 tab every 1 day)
AVALIDE TAB 300-12.5	Non Preferred	PA, QL (1 tab every 1 day)
AZOR TAB 5-20MG	Non Preferred	PA
AZOR TAB 5-40MG	Non Preferred	PA
AZOR TAB 10-20MG	Non Preferred	PA
AZOR TAB 10-40MG	Non Preferred	PA
<i>benazepril &amp; hydrochlorothiazide tab 5-6.25 mg</i>	Preferred	QL (1 tab every 1 day)
<i>benazepril &amp; hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT)</i>	Preferred	QL (1 tab every 1 day)
<i>benazepril &amp; hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT)</i>	Preferred	QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>benazepril &amp; hydrochlorothiazide tab 20-25 mg (generic of LOTENSIN HCT)</i>	Preferred	QL (1 tab every 1 day)
BENICAR HCT TAB 20-12.5	Non Preferred	PA
BENICAR HCT TAB 40-12.5	Non Preferred	PA
BENICAR HCT TAB 40-25MG	Non Preferred	PA
<i>bisoprolol &amp; hydrochlorothiazide tab 2.5-6.25 mg (generic of ZIAC)</i>	Preferred	QL (3 tabs every 1 day)
<i>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg (generic of ZIAC)</i>	Preferred	QL (3 tabs every 1 day)
<i>bisoprolol &amp; hydrochlorothiazide tab 10-6.25 mg (generic of ZIAC)</i>	Preferred	QL (4 tabs every 1 day)
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg (generic of ATACAND HCT)</i>	Non Preferred	PA
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg (generic of ATACAND HCT)</i>	Non Preferred	PA
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg (generic of ATACAND HCT)</i>	Non Preferred	PA
<i>captopril &amp; hydrochlorothiazide tab 25-15 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>captopril &amp; hydrochlorothiazide tab 25-25 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>captopril &amp; hydrochlorothiazide tab 50-15 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>captopril &amp; hydrochlorothiazide tab 50-25 mg</i>	Preferred	QL (2 tabs every 1 day)
DIOVAN HCT TAB 80/12.5	Non Preferred	PA, QL (1 tab every 1 day)
DIOVAN HCT TAB 160-12.5	Non Preferred	PA, QL (1 tab every 1 day)
DIOVAN HCT TAB 160-25MG	Non Preferred	PA, QL (1 tab every 1 day)
DIOVAN HCT TAB 320-12.5	Non Preferred	PA, QL (1 tab every 1 day)
DIOVAN HCT TAB 320-25MG	Non Preferred	PA, QL (1 tab every 1 day)
EDARBYCLOR TAB 40-12.5	Non Preferred	PA
EDARBYCLOR TAB 40-25MG	Non Preferred	PA
<i>enalapril maleate &amp; hydrochlorothiazide tab 5-12.5 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>enalapril maleate &amp; hydrochlorothiazide tab 10-25 mg (generic of VASERETIC)</i>	Preferred	QL (2 tabs every 1 day)
EXFORGE TAB 5-160MG	Non Preferred	PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EXFORGE TAB 5-320MG	Non Preferred	PA, QL (1 tab every 1 day)
EXFORGE TAB 10-160MG	Non Preferred	PA, QL (1 tab every 1 day)
EXFORGE TAB 10-320MG	Non Preferred	PA, QL (1 tab every 1 day)
EXFORGEH/5- TAB 160-12.5	Non Preferred	PA
EXFORGEH/5- TAB 160-25	Non Preferred	PA
EXFORGEH/10- TAB 160-12.5	Non Preferred	PA
EXFORGEH/10- TAB 160-25	Non Preferred	PA
EXFORGEH/10- TAB 320-25	Non Preferred	PA
<i>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</i>	Preferred	QL (1 tab every 1 day)
<i>fosinopril sodium &amp; hydrochlorothiazide tab 20-12.5 mg</i>	Preferred	QL (1 tab every 1 day)
HYZAAR TAB 50-12.5	Non Preferred	PA, QL (1 tab every 1 day)
HYZAAR TAB 100-12.5	Non Preferred	PA, QL (1 tab every 1 day)
HYZAAR TAB 100-25	Non Preferred	PA, QL (1 tab every 1 day)
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg (generic of AVALIDE)</i>	Preferred	QL (1 tab every 1 day)
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg (generic of AVALIDE)</i>	Preferred	QL (1 tab every 1 day)
<i>lisinopril &amp; hydrochlorothiazide tab 10-12.5 mg (generic of ZESTORETIC)</i>	Preferred	QL (2 tabs every 1 day)
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5 mg (generic of ZESTORETIC)</i>	Preferred	QL (2 tabs every 1 day)
<i>lisinopril &amp; hydrochlorothiazide tab 20-25 mg (generic of ZESTORETIC)</i>	Preferred	QL (2 tabs every 1 day)
<i>losartan potassium &amp; hydrochlorothiazide tab 50-12.5 mg (generic of HYZAAR)</i>	Preferred	QL (1 tab every 1 day)
<i>losartan potassium &amp; hydrochlorothiazide tab 100-12.5 mg (generic of HYZAAR)</i>	Preferred	QL (1 tab every 1 day)
<i>losartan potassium &amp; hydrochlorothiazide tab 100-25 mg (generic of HYZAAR)</i>	Preferred	QL (1 tab every 1 day)
LOTENSIN HCT TAB 10-12.5	Non Preferred	PA, QL (1 tab every 1 day)
LOTENSIN HCT TAB 20-12.5	Non Preferred	PA, QL (1 tab every 1 day)
LOTENSIN HCT TAB 20-25MG	Non Preferred	PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LOTREL CAP 5-10MG	Non Preferred	PA, QL (1 cap every 1 day)
LOTREL CAP 5-20MG	Non Preferred	PA, QL (1 cap every 1 day)
LOTREL CAP 10-20MG	Non Preferred	PA, QL (1 cap every 1 day)
LOTREL CAP 10-40MG	Non Preferred	PA, QL (1 cap every 1 day)
<i>metoprolol &amp; hydrochlorothiazide tab 50-25 mg</i>	Preferred	
<i>metoprolol &amp; hydrochlorothiazide tab 100-25 mg</i>	Preferred	
<i>metoprolol &amp; hydrochlorothiazide tab 100-50 mg</i>	Preferred	
MICARDIS HCT TAB 40/12.5	Non Preferred	PA
MICARDIS HCT TAB 80-25MG	Non Preferred	PA
MICARDIS HCT TAB 80/12.5	Non Preferred	PA
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg (generic of BENICAR HCT)</i>	Non Preferred	PA
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg (generic of BENICAR HCT)</i>	Non Preferred	PA
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg (generic of BENICAR HCT)</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg (generic of TRIBENZOR)</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg (generic of TRIBENZOR)</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg (generic of TRIBENZOR)</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg (generic of TRIBENZOR)</i>	Non Preferred	PA
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg (generic of TRIBENZOR)</i>	Non Preferred	PA
TEKTURNA HCT TAB 300-12.5	Non Preferred	PA
TEKTURNA HCT TAB 300-25MG	Non Preferred	PA
<i>telmisartan-amlodipine tab 40-5 mg</i>	Non Preferred	PA
<i>telmisartan-amlodipine tab 40-10 mg</i>	Non Preferred	PA
<i>telmisartan-amlodipine tab 80-5 mg</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>telmisartan-amlodipine tab 80-10 mg</i>	Non Preferred	PA
<i>telmisartan-hydrochlorothiazide tab 40-12.5 mg (generic of MICARDIS HCT)</i>	Non Preferred	PA
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg (generic of MICARDIS HCT)</i>	Non Preferred	PA
<i>telmisartan-hydrochlorothiazide tab 80-25 mg (generic of MICARDIS HCT)</i>	Non Preferred	PA
TENORETIC TAB 50	Non Preferred	PA, QL (2 tabs every 1 day)
TENORETIC TAB 100	Non Preferred	PA, QL (1 tab every 1 day)
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	Preferred	
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	Preferred	
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	Preferred	
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	Preferred	
TRIBENZOR20- TAB 5-12.5MG	Non Preferred	PA
TRIBENZOR40- TAB 5-12.5MG	Non Preferred	PA
TRIBENZOR40- TAB 5-25MG	Non Preferred	PA
TRIBENZOR40- TAB 10-12.5	Non Preferred	PA
TRIBENZOR40- TAB 10-25MG	Non Preferred	PA
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg (generic of DIOVAN HCT)</i>	Preferred	QL (1 tab every 1 day)
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg (generic of DIOVAN HCT)</i>	Preferred	QL (1 tab every 1 day)
<i>valsartan-hydrochlorothiazide tab 160-25 mg (generic of DIOVAN HCT)</i>	Preferred	QL (1 tab every 1 day)
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg (generic of DIOVAN HCT)</i>	Preferred	QL (1 tab every 1 day)
<i>valsartan-hydrochlorothiazide tab 320-25 mg (generic of DIOVAN HCT)</i>	Preferred	QL (1 tab every 1 day)
VASERETIC TAB 10-25MG	Non Preferred	PA, QL (2 tabs every 1 day)
ZESTORETIC TAB 10-12.5	Non Preferred	PA, QL (2 tabs every 1 day)
ZESTORETIC TAB 20-12.5	Non Preferred	PA, QL (2 tabs every 1 day)
ZESTORETIC TAB 20-25MG	Non Preferred	PA, QL (2 tabs every 1 day)
ZIAC TAB 2.5/6.25	Non Preferred	PA, QL (3 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZIAC TAB 5-6.25MG	Non Preferred	PA, QL (3 tabs every 1 day)
ZIAC TAB 10/6.25	Non Preferred	PA, QL (4 tabs every 1 day)

### **ANTIHYPERTENSIVES - MISC.**

VECAMYL TAB 2.5MG	Non Preferred	PA
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### **DIRECT RENIN INHIBITORS**

<i>aliskiren fumarate tab 150 mg (base equivalent)</i> (generic of TEKTURNIA)	Non Preferred	PA
<i>aliskiren fumarate tab 300 mg (base equivalent)</i> (generic of TEKTURNIA)	Non Preferred	PA
TEKTURNIA TAB 150MG	Non Preferred	PA
TEKTURNIA TAB 300MG	Non Preferred	PA

### **SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)**

<i>eplerenone tab 25 mg</i> (generic of INSPRA)	Non Preferred	PA
<i>eplerenone tab 50 mg</i> (generic of INSPRA)	Non Preferred	PA
INSPRA TAB 25MG	Non Preferred	PA
INSPRA TAB 50MG	Non Preferred	PA

### **VASODILATORS**

<i>hydralazine hcl tab 10 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>hydralazine hcl tab 25 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>hydralazine hcl tab 50 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>hydralazine hcl tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>minoxidil tab 2.5 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>minoxidil tab 10 mg</i>	Preferred	QL (5 tabs every 1 day)

### **ANTIMALARIALS - DRUGS TO TREAT MALARIA**

#### **ANTIMALARIAL COMBINATIONS**

<i>atovaquone-proguanil hcl tab 62.5-25 mg</i> (generic of MALARONE)	Preferred	
<i>atovaquone-proguanil hcl tab 250-100 mg</i> (generic of MALARONE)	Preferred	
COARTEM TAB 20-120MG	Non Preferred	PA
MALARONE TAB 62.5-25	Non Preferred	PA
MALARONE TAB 250-100	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIMALARIALS - DRUGS TO TREAT MALARIA</b>		
<i>chloroquine phosphate tab 250 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>chloroquine phosphate tab 500 mg</i>	Preferred	QL (1 tab every 1 day)
DARAPRIM TAB 25MG	Non Preferred	PA
<i>hydroxychloroquine sulfate tab 100 mg</i>	Preferred	
<i>hydroxychloroquine sulfate tab 200 mg (generic of PLAQUENIL)</i>	Preferred	QL (4 tabs every 1 day)
<i>hydroxychloroquine sulfate tab 300 mg</i>	Preferred	
<i>hydroxychloroquine sulfate tab 400 mg</i>	Preferred	
KRINTAFEL TAB 150MG	Non Preferred	PA
<i>mefloquine hcl tab 250 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>primaquine phosphate tab 26.3 mg (15 mg base) (generic of PRIMAQUINE PHOSPHATE)</i>	Preferred	
PRIMAQUINE TAB 26.3MG	Preferred	
<i>pyrimethamine tab 25 mg (generic of DARAPRIM)</i>	Non Preferred	PA
QUALAQUIN CAP 324MG	Non Preferred	PA
<i>quinine sulfate cap 324 mg (generic of QUALAQUIN)</i>	Non Preferred	PA

**ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS**

**ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS**

FIRDAPSE TAB 10MG	Non Preferred	SP, PA
MESTINON SOL 60MG/5ML	Non Preferred	PA
MESTINON TAB 60MG	Non Preferred	PA, QL (6 tabs every 1 day)
MESTINON TAB TIMESPAN	Non Preferred	PA
<i>pyridostigmine bromide oral soln 60 mg/5ml (generic of MESTINON)</i>	Preferred	
<i>pyridostigmine bromide tab 30 mg</i>	Preferred	
<i>pyridostigmine bromide tab 60 mg (generic of MESTINON)</i>	Preferred	QL (6 tabs every 1 day)
<i>pyridostigmine bromide tab er 180 mg (generic of MESTINON TIMESPAN)</i>	Preferred	

**ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS**

**ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS**

<i>cycloserine cap 250 mg</i>	Preferred	
<i>ethambutol hcl tab 100 mg</i>	Preferred	QL (5 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ethambutol hcl tab 400 mg</i> (generic of MYAMBUTOL)	Preferred	QL (5 tabs every 1 day)
<i>isoniazid syrup 50 mg/5ml</i>	Preferred	QL (30 mL every 1 day)
<i>isoniazid tab 100 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>isoniazid tab 300 mg</i>	Preferred	QL (3 tabs every 1 day)
MYAMBUTOL TAB 400MG	Non Preferred	PA, QL (5 tabs every 1 day)
MYCOBUTIN CAP 150MG	Non Preferred	PA
PRETOMANID TAB 200MG	Non Preferred	PA
PRIFTIN TAB 150MG	Preferred	QL (1.143 tabs every 1 day)
<i>pyrazinamide tab 500 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>rifabutin cap 150 mg</i> (generic of MYCOBUTIN)	Preferred	
<i>rifampin cap 150 mg</i>	Preferred	QL (8 caps every 1 day)
<i>rifampin cap 300 mg</i>	Preferred	QL (4 caps every 1 day)
SIRTURO TAB 20MG	Non Preferred	PA
SIRTURO TAB 100MG	Non Preferred	PA
TRECTOR TAB 250MG	Preferred	

## **ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER**

### **ALKYLATING AGENTS**

CYCLOPHOSPH TAB 25MG	Preferred	
CYCLOPHOSPH TAB 50MG	Preferred	
<i>cyclophosphamide cap 25 mg</i>	Preferred	SP, QL (16 caps every 1 day)
<i>cyclophosphamide cap 50 mg</i>	Preferred	SP, QL (16 caps every 1 day)
LEUKERAN TAB 2MG	Preferred	QL (8 tabs every 1 day)
<i>melphalan tab 2 mg</i>	Preferred	
MYLERAN TAB 2MG	Preferred	
<i>temozolomide cap 5 mg</i>	Preferred	SP
<i>temozolomide cap 20 mg</i>	Preferred	SP
<i>temozolomide cap 100 mg</i>	Preferred	SP
<i>temozolomide cap 140 mg</i>	Preferred	SP
<i>temozolomide cap 180 mg</i>	Preferred	SP
<i>temozolomide cap 250 mg</i>	Preferred	SP

### **ANTIMETABOLITES**

<i>capecitabine tab 150 mg</i> (generic of XELODA)	Non Preferred	SP, PA
<i>capecitabine tab 500 mg</i> (generic of XELODA)	Non Preferred	SP, PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mercaptopurine tab 50 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	Preferred	QL (0.2 vials every 1 day)
<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	Preferred	QL (0.04 vials every 1 day)
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	Preferred	QL (0.2 vials every 1 day)
<i>methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)</i>	Preferred	QL (0.04 vials every 1 day)
<i>methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)</i>	Preferred	QL (0.01 vials every 1 day)
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	Preferred	QL (24 tabs every 1 day)
ONUREG TAB 200MG	Non Preferred	SP, PA
ONUREG TAB 300MG	Non Preferred	SP, PA
PURIXAN SUS 20MG/ML	Non Preferred	PA
TABLOID TAB 40MG	Preferred	
TREXALL TAB 5MG	Preferred	
TREXALL TAB 7.5MG	Preferred	
TREXALL TAB 10MG	Preferred	
TREXALL TAB 15MG	Preferred	
XATMEP SOL 2.5MG/ML	Non Preferred	PA
XELODA TAB 150MG	Non Preferred	SP, PA
XELODA TAB 500MG	Non Preferred	SP, PA

### **ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS**

INLYTA TAB 1MG	Non Preferred	SP, PA, QL (6 tabs every 1 day)
INLYTA TAB 5MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
LENVIMA CAP 4MG	Non Preferred	SP, PA, QL (1 ea every 1 day)
LENVIMA CAP 8 MG	Non Preferred	SP, PA, QL (2 ea every 1 day)
LENVIMA CAP 10 MG	Non Preferred	SP, PA, QL (1 ea every 1 day)
LENVIMA CAP 12MG	Non Preferred	SP, PA, QL (3 ea every 1 day)
LENVIMA CAP 14 MG	Non Preferred	SP, PA, QL (2 ea every 1 day)
LENVIMA CAP 18 MG	Non Preferred	SP, PA, QL (3 ea every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LENVIMA CAP 20 MG	Non Preferred	SP, PA, QL (2 ea every 1 day)
LENVIMA CAP 24 MG	Non Preferred	SP, PA, QL (3 ea every 1 day)

### **ANTINEOPLASTIC - ANTI-HER2 AGENTS**

TUKYSA TAB 50MG	Non Preferred	SP, PA
TUKYSA TAB 150MG	Non Preferred	SP, PA

### **ANTINEOPLASTIC - BCL-2 INHIBITORS**

VENCLEXTA TAB 10MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
VENCLEXTA TAB 50MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
VENCLEXTA TAB 100MG	Non Preferred	SP, PA, QL (6 tabs every 1 day)
VENCLEXTA TAB START PK	Non Preferred	SP, PA, QL (1.5 tabs every 1 day)

### **ANTINEOPLASTIC - EGFR INHIBITORS**

<i>erlotinib hcl tab 25 mg (base equivalent)</i> (generic of TARCEVA)	Preferred	SP, QL (3 tabs every 1 day)
<i>erlotinib hcl tab 100 mg (base equivalent)</i> (generic of TARCEVA)	Preferred	SP, QL (1 tab every 1 day)
<i>erlotinib hcl tab 150 mg (base equivalent)</i> (generic of TARCEVA)	Preferred	SP, QL (1 tab every 1 day)
EXKIVITY CAP 40MG	Non Preferred	SP, PA
GILOTRIF TAB 20MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
GILOTRIF TAB 30MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
GILOTRIF TAB 40MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IRESSA TAB 250MG	Preferred	SP, QL (1 tab every 1 day)
TAGRISSE TAB 40MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
TAGRISSE TAB 80MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
TARCEVA TAB 25MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
TARCEVA TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
TARCEVA TAB 150MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
VIZIMPRO TAB 15MG	Non Preferred	SP, PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VIZIMPRO TAB 30MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
VIZIMPRO TAB 45MG	Non Preferred	SP, PA, QL (1 tab every 1 day)

### **ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS**

DAURISMO TAB 25MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
DAURISMO TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
ERIVEDGE CAP 150MG	Preferred	SP, QL (1 cap every 1 day)
ODOMZO CAP 200MG	Non Preferred	SP, PA, QL (1 cap every 1 day)

### **ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS**

<i>abiraterone acetate tab 250 mg</i> (generic of ZYTIGA)	Preferred	SP, QL (4 tabs every 1 day)
<i>abiraterone acetate tab 500 mg</i> (generic of ZYTIGA)	Preferred	SP
<i>anastrozole tab 1 mg</i> (generic of ARIMIDEX)	Preferred	QL (1 tab every 1 day); AGE (Min 40)
ARIMIDEX TAB 1MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 40)
AROMASIN TAB 25MG	Non Preferred	PA; AGE (Min 40)
<i>bicalutamide tab 50 mg</i> (generic of CASODEX)	Preferred	QL (3 tabs every 1 day)
CASODEX TAB 50MG	Non Preferred	PA, QL (3 tabs every 1 day)
EMCYT CAP 140MG	Preferred	
ERLEADA TAB 60MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
ERLEADA TAB 240MG	Non Preferred	SP, PA
<i>exemestane tab 25 mg</i> (generic of AROMASIN)	Preferred	AGE (Min 40)
FARESTON TAB 60MG	Non Preferred	PA
FEMARA TAB 2.5MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 40)
<i>letrozole tab 2.5 mg</i> (generic of FEMARA)	Preferred	QL (1 tab every 1 day); AGE (Min 40)
LYSODREN TAB 500MG	Preferred	SP
<i>megestrol acetate susp 40 mg/ml</i>	Preferred	QL (40 mL every 1 day)
<i>megestrol acetate tab 20 mg</i>	Preferred	QL (40 tabs every 1 day)
<i>megestrol acetate tab 40 mg</i>	Preferred	QL (20 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nilutamide tab 150 mg (generic of NILANDRON)</i>	Preferred	
NUBEQA TAB 300MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
ORGOVYX TAB 120MG	Non Preferred	SP, PA
ORSERDU TAB 86MG	Non Preferred	SP, PA
ORSERDU TAB 345MG	Non Preferred	SP, PA
SOLTAMOX SOL 10MG/5ML	Preferred	
<i>tamoxifen citrate tab 10 mg (base equivalent)</i>	Preferred	QL (2 tabs every 1 day)
<i>tamoxifen citrate tab 20 mg (base equivalent)</i>	Preferred	QL (2 tabs every 1 day)
<i>toremifene citrate tab 60 mg (base equivalent) (generic of FARESTON)</i>	Preferred	
XTANDI CAP 40MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
XTANDI TAB 40MG	Non Preferred	SP, PA
XTANDI TAB 80MG	Non Preferred	SP, PA
YONSA TAB 125MG	Non Preferred	PA, QL (4 tabs every 1 day)
ZYTIGA TAB 250MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
ZYTIGA TAB 500MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
<b>ANTINEOPLASTIC - IMMUNOMODULATORS</b>		
POMALYST CAP 1MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
POMALYST CAP 2MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
POMALYST CAP 3MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
POMALYST CAP 4MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
<b>ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS</b>		
AYVAKIT TAB 25MG	Non Preferred	SP, PA
AYVAKIT TAB 50MG	Non Preferred	SP, PA
AYVAKIT TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
AYVAKIT TAB 200MG	Non Preferred	SP, PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AYVAKIT TAB 300MG	Non Preferred	SP, PA, QL (1 tab every 1 day)

### **ANTINEOPLASTIC - XPO1 INHIBITORS**

XPOVIO PAK 40MG	Non Preferred	PA
XPOVIO PAK 50MG	Non Preferred	PA
XPOVIO PAK 60MG	Non Preferred	PA
XPOVIO TWICE WEEKLY PAK 60MG	Non Preferred	SP, PA
XPOVIO TWICE WEEKLY PAK 80MG	Non Preferred	SP, PA, QL (32 tabs every 24 days)

### **ANTINEOPLASTIC COMBINATIONS**

INQOVI TAB 35-100MG	Non Preferred	SP, PA
KISQALI 200 PAK FEMARA	Non Preferred	SP, PA, QL (49 tabs every 24 days)
KISQALI 400 PAK FEMARA	Non Preferred	SP, PA, QL (70 tabs every 24 days)
KISQALI 600 PAK FEMARA	Non Preferred	SP, PA, QL (91 tabs every 24 days)
LONSURF TAB 15-6.14	Non Preferred	SP, PA, QL (100 tabs every 24 days)
LONSURF TAB 20-8.19	Non Preferred	SP, PA, QL (100 tabs every 24 days)

### **ANTINEOPLASTIC ENZYME INHIBITORS**

AFINITOR DIS TAB 2MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
AFINITOR DIS TAB 3MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
AFINITOR DIS TAB 5MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
AFINITOR TAB 2.5MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
AFINITOR TAB 5MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
AFINITOR TAB 7.5MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
AFINITOR TAB 10MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
ALECENSA CAP 150MG	Non Preferred	SP, PA, QL (8 caps every 1 day)
ALUNBRIG PAK	Non Preferred	SP, PA, QL (1 tab every 1 day)
ALUNBRIG TAB 30MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ALUNBRIG TAB 90MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
ALUNBRIG TAB 180MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
BALVERSA TAB 3MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
BALVERSA TAB 4MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
BALVERSA TAB 5MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
BOSULIF TAB 100MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
BOSULIF TAB 400MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
BOSULIF TAB 500MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
BRAFTOVI CAP 75MG	Non Preferred	PA, QL (6 caps every 1 day)
BRUKINSA CAP 80MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
CABOMETYX TAB 20MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
CABOMETYX TAB 40MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
CABOMETYX TAB 60MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
CALQUENCE TAB 100MG	Non Preferred	PA
CAPRELSA TAB 100MG	Preferred	SP, QL (2 tabs every 1 day)
CAPRELSA TAB 300MG	Preferred	SP, QL (1 tab every 1 day)
COMETRIQ KIT 60MG	Non Preferred	SP, PA, QL (0.036 kits every 1 day)
COMETRIQ KIT 100MG	Non Preferred	SP, PA, QL (0.036 kits every 1 day)
COMETRIQ KIT 140MG	Non Preferred	SP, PA, QL (0.036 kits every 1 day)
COPIKTRA CAP 15MG	Non Preferred	SP, PA, QL (2 caps every 1 day)
COPIKTRA CAP 25MG	Non Preferred	SP, PA, QL (2 caps every 1 day)
COTELLIC TAB 20MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
<i>everolimus tab 2.5 mg (generic of AFINITOR)</i>	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>everolimus tab 5 mg (generic of AFINITOR)</i>	Non Preferred	SP, PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>everolimus tab 7.5 mg (generic of AFINITOR)</i>	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>everolimus tab 10 mg (generic of AFINITOR)</i>	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>everolimus tab for oral susp 2 mg (generic of AFINITOR DISPERZ)</i>	Non Preferred	SP, PA, QL (2 tabs every 1 day)
<i>everolimus tab for oral susp 3 mg (generic of AFINITOR DISPERZ)</i>	Non Preferred	SP, PA, QL (3 tabs every 1 day)
<i>everolimus tab for oral susp 5 mg (generic of AFINITOR DISPERZ)</i>	Non Preferred	SP, PA, QL (2 tabs every 1 day)
FOTIVDA CAP 0.89MG	Non Preferred	SP, PA
FOTIVDA CAP 1.34MG	Non Preferred	SP, PA
GAVRETO CAP 100MG	Non Preferred	PA
GLEEVEC TAB 100MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
GLEEVEC TAB 400MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
IBRANCE CAP 75MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
IBRANCE CAP 100MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
IBRANCE CAP 125MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
IBRANCE TAB 75MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IBRANCE TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IBRANCE TAB 125MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
ICLUSIG TAB 10MG	Non Preferred	PA
ICLUSIG TAB 15MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
ICLUSIG TAB 30MG	Non Preferred	PA
ICLUSIG TAB 45MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IDHIFA TAB 50MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IDHIFA TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>imatinib mesylate tab 100 mg (base equivalent) (generic of GLEEVEC)</i>	Non Preferred	SP, PA, QL (3 tabs every 1 day)
<i>imatinib mesylate tab 400 mg (base equivalent) (generic of GLEEVEC)</i>	Non Preferred	SP, PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
IMBRUVICA CAP 70MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
IMBRUVICA CAP 140MG	Non Preferred	SP, PA, QL (3 caps every 1 day)
IMBRUVICA SUS 70MG/ML	Non Preferred	PA
IMBRUVICA TAB 140MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IMBRUVICA TAB 280MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IMBRUVICA TAB 420MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
IMBRUVICA TAB 560MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
INREBIC CAP 100MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
JAKAFI TAB 5MG	Preferred	SP, QL (2 tabs every 1 day)
JAKAFI TAB 10MG	Preferred	SP, QL (2 tabs every 1 day)
JAKAFI TAB 15MG	Preferred	SP, QL (2 tabs every 1 day)
JAKAFI TAB 20MG	Preferred	SP, QL (2 tabs every 1 day)
JAKAFI TAB 25MG	Preferred	SP, QL (2 tabs every 1 day)
JAYPIRCA TAB 50MG	Non Preferred	SP, PA
JAYPIRCA TAB 100MG	Non Preferred	SP, PA
KISQALI TAB 200DOSE	Non Preferred	SP, PA, QL (1 tab every 1 day)
KISQALI TAB 400DOSE	Non Preferred	SP, PA, QL (2 tabs every 1 day)
KISQALI TAB 600DOSE	Non Preferred	SP, PA, QL (3 tabs every 1 day)
KOSELUGO CAP 10MG	Non Preferred	SP, PA
KOSELUGO CAP 25MG	Non Preferred	SP, PA
KRAZATI TAB 200MG	Non Preferred	SP, PA
<i>lapatinib ditosylate tab 250 mg (base equiv) (generic of TYKERB)</i>	Non Preferred	SP, PA, QL (6 tabs every 1 day)
LORBRENA TAB 25MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
LORBRENA TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LUMAKRAS TAB 120MG	Non Preferred	SP, PA
LUMAKRAS TAB 320MG	Non Preferred	SP, PA
LYNPARZA TAB 100MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
LYNPARZA TAB 150MG	Non Preferred	SP, PA, QL (4 tabs every 1 day)
LYTGOBI TAB 4MG	Non Preferred	SP, PA
MEKINIST TAB 0.5MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
MEKINIST TAB 2MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
MEKTOVI TAB 15MG	Non Preferred	PA, QL (6 tabs every 1 day)
NERLYNX TAB 40MG	Non Preferred	SP, PA, QL (6 tabs every 1 day)
NEXAVAR TAB 200MG	Preferred	SP, QL (4 tabs every 1 day)
NINLARO CAP 2.3MG	Non Preferred	SP, PA, QL (3 caps every 17 days)
NINLARO CAP 3MG	Non Preferred	SP, PA, QL (3 caps every 17 days)
NINLARO CAP 4MG	Non Preferred	SP, PA, QL (3 caps every 17 days)
PEMAZYRE TAB 4.5MG	Non Preferred	SP, PA
PEMAZYRE TAB 9MG	Non Preferred	SP, PA
PEMAZYRE TAB 13.5MG	Non Preferred	SP, PA
PIQRAY 200MG TAB DOSE	Non Preferred	SP, PA, QL (1 tab every 1 day)
PIQRAY 250MG TAB DOSE	Non Preferred	SP, PA, QL (2 tabs every 1 day)
PIQRAY 300MG TAB DOSE	Non Preferred	SP, PA, QL (2 tabs every 1 day)
QINLOCK TAB 50MG	Non Preferred	SP, PA
RETEVMO CAP 40MG	Non Preferred	SP, PA
RETEVMO CAP 80MG	Non Preferred	SP, PA
REZLIDHIA CAP 150MG	Non Preferred	SP, PA
ROZLYTREK CAP 100MG	Non Preferred	SP, PA, QL (1 cap every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ROZLYTREK CAP 200MG	Non Preferred	SP, PA, QL (3 caps every 1 day)
RYDAPT CAP 25MG	Non Preferred	SP, PA, QL (8 caps every 1 day)
SCSEMBLIX TAB 20MG	Non Preferred	SP, PA
SCSEMBLIX TAB 40MG	Non Preferred	SP, PA
<i>sorafenib tosylate tab 200 mg (base equivalent) (generic of NEXAVAR)</i>	Preferred	SP, QL (4 tabs every 1 day)
SPRYCEL TAB 20MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
SPRYCEL TAB 50MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
SPRYCEL TAB 70MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
SPRYCEL TAB 80MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
SPRYCEL TAB 100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
SPRYCEL TAB 140MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
STIVARGA TAB 40MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
<i>sunitinib malate cap 12.5 mg (base equivalent) (generic of SUTENT)</i>	Preferred	SP, QL (4 caps every 1 day)
<i>sunitinib malate cap 25 mg (base equivalent) (generic of SUTENT)</i>	Preferred	SP, QL (2 caps every 1 day)
<i>sunitinib malate cap 37.5 mg (base equivalent) (generic of SUTENT)</i>	Preferred	SP, QL (1 cap every 1 day)
<i>sunitinib malate cap 50 mg (base equivalent) (generic of SUTENT)</i>	Preferred	SP, QL (1 cap every 1 day)
SUTENT CAP 12.5MG	Preferred	SP, QL (4 caps every 1 day)
SUTENT CAP 25MG	Preferred	SP, QL (2 caps every 1 day)
SUTENT CAP 37.5MG	Preferred	SP, QL (1 cap every 1 day)
SUTENT CAP 50MG	Preferred	SP, QL (1 cap every 1 day)
TABRECTA TAB 150MG	Non Preferred	SP, PA
TABRECTA TAB 200MG	Non Preferred	SP, PA
TAFINLAR CAP 50MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
TAFINLAR CAP 75MG	Non Preferred	SP, PA, QL (4 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TALZENNA CAP 0.5MG	Non Preferred	SP, PA
TALZENNA CAP 0.25MG	Non Preferred	SP, PA, QL (3 caps every 1 day)
TALZENNA CAP 0.75MG	Non Preferred	SP, PA
TALZENNA CAP 1MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
TASIGNA CAP 50MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
TASIGNA CAP 150MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
TASIGNA CAP 200MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
TAZVERIK TAB 200MG	Non Preferred	SP, PA, QL (8 tabs every 1 day)
TEPMETKO TAB 225MG	Non Preferred	PA
TIBSOVO TAB 250MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
TURALIO CAP 125MG	Non Preferred	PA
TYKERB TAB 250MG	Non Preferred	SP, PA, QL (6 tabs every 1 day)
VERZENIO TAB 50MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
VERZENIO TAB 100MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
VERZENIO TAB 150MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
VERZENIO TAB 200MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
VITRAKVI CAP 25MG	Non Preferred	SP, PA, QL (6 caps every 1 day)
VITRAKVI CAP 100MG	Non Preferred	SP, PA, QL (2 caps every 1 day)
VITRAKVI SOL 20MG/ML	Non Preferred	SP, PA, QL (10 mL every 1 day)
VONJO CAP 100MG	Non Preferred	SP, PA
VOTRIENT TAB 200MG	Preferred	SP, QL (4 tabs every 1 day)
XALKORI CAP 200MG	Non Preferred	SP, PA, QL (2 caps every 1 day)
XALKORI CAP 250MG	Non Preferred	SP, PA, QL (2 caps every 1 day)
XOSPATA TAB 40MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZEJULA CAP 100MG	Non Preferred	SP, PA, QL (3 caps every 1 day)
ZELBORAF TAB 240MG	Non Preferred	SP, PA, QL (8 tabs every 1 day)
ZOLINZA CAP 100MG	Non Preferred	SP, PA, QL (4 caps every 1 day)
ZYDELIG TAB 100MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
ZYDELIG TAB 150MG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
ZYKADIA TAB 150MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)

### **ANTINEOPLASTICS MISC.**

<i>bexarotene cap 75 mg</i> (generic of TARGRETIN)	Preferred	SP
HYDREA CAP 500MG	Non Preferred	PA
<i>hydroxyurea cap 500 mg</i> (generic of HYDREA)	Preferred	
MATULANE CAP 50MG	Preferred	SP
TARGRETIN CAP 75MG	Non Preferred	SP, PA
<i>tretinoin cap 10 mg</i>	Preferred	

### **CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS**

<i>leucovorin calcium tab 5 mg</i>	Preferred	
<i>leucovorin calcium tab 10 mg</i>	Preferred	
<i>leucovorin calcium tab 15 mg</i>	Preferred	
<i>leucovorin calcium tab 25 mg</i>	Preferred	
MESNEX TAB 400MG	Preferred	

### **MITOTIC INHIBITORS**

<i>etoposide cap 50 mg</i>	Preferred	
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### **TOPOISOMERASE I INHIBITORS**

HYCAMTIN CAP 0.25MG	Preferred	SP
HYCAMTIN CAP 1MG	Preferred	SP

## **ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE**

### **ANTIPARKINSON ADJUNCTIVE THERAPY**

<i>carbidopa tab 25 mg</i> (generic of LODOSYN)	Preferred	
LODOSYN TAB 25MG	Non Preferred	PA
NOURIANZ TAB 20MG	Non Preferred	PA
NOURIANZ TAB 40MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIPARKINSON ANTICHOLINERGICS</b>		
<i>benztropine mesylate tab 0.5 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>benztropine mesylate tab 1 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>benztropine mesylate tab 2 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i>	Preferred	
<i>trihexyphenidyl hcl tab 2 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>trihexyphenidyl hcl tab 5 mg</i>	Preferred	QL (3 tabs every 1 day)
<b>ANTIPARKINSON COMT INHIBITORS</b>		
COMTAN TAB 200MG	Non Preferred	PA, QL (8 tabs every 1 day)
<i>entacapone tab 200 mg (generic of COMTAN)</i>	Preferred	QL (8 tabs every 1 day)
ONGENTYS CAP 25MG	Non Preferred	PA
ONGENTYS CAP 50MG	Non Preferred	PA
TASMAR TAB 100MG	Non Preferred	PA
<i>tolcapone tab 100 mg (generic of TASMAR)</i>	Non Preferred	PA
<b>ANTIPARKINSON DOPAMINERGICS</b>		
<i>amantadine hcl cap 100 mg</i>	Preferred	QL (4 caps every 1 day)
<i>amantadine hcl soln 50 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>amantadine hcl tab 100 mg</i>	Preferred	
APOKYN INJ 10MG/ML	Non Preferred	SP, PA
<i>apomorphine hcl soln cartridge 30 mg/3ml</i>	Non Preferred	SP, PA
<i>bromocriptine mesylate cap 5 mg (base equivalent) (generic of PARLODEL)</i>	Preferred	QL (6 caps every 1 day)
<i>bromocriptine mesylate tab 2.5 mg (base equivalent) (generic of PARLODEL)</i>	Preferred	QL (6 tabs every 1 day)
<i>carbidopa &amp; levodopa orally disintegrating tab 10-100 mg</i>	Non Preferred	PA
<i>carbidopa &amp; levodopa orally disintegrating tab 25-100 mg</i>	Non Preferred	PA
<i>carbidopa &amp; levodopa orally disintegrating tab 25-250 mg</i>	Non Preferred	PA
<i>carbidopa &amp; levodopa tab 10-100 mg (generic of SINEMET)</i>	Preferred	QL (8 tabs every 1 day)
<i>carbidopa &amp; levodopa tab 25-100 mg (generic of SINEMET)</i>	Preferred	QL (12 tabs every 1 day)
<i>carbidopa &amp; levodopa tab 25-250 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>carbidopa &amp; levodopa tab er 25-100 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>carbidopa &amp; levodopa tab er 50-200 mg</i>	Preferred	QL (8 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg (generic of STALEVO 50)</i>	Non Preferred	PA, QL (8 tabs every 1 day)
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg (generic of STALEVO 75)</i>	Non Preferred	PA, QL (8 tabs every 1 day)
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg (generic of STALEVO 100)</i>	Non Preferred	PA, QL (8 tabs every 1 day)
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg (generic of STALEVO 125)</i>	Non Preferred	PA, QL (8 tabs every 1 day)
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg (generic of STALEVO 150)</i>	Non Preferred	PA, QL (8 tabs every 1 day)
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg (generic of STALEVO 200)</i>	Non Preferred	PA, QL (6 tabs every 1 day)
DHIVY TAB 25-100MG	Non Preferred	PA, QL (12 tabs every 1 day)
GOCOVRI CAP 68.5MG	Non Preferred	SP, PA
GOCOVRI CAP 137MG	Non Preferred	SP, PA
INBRIJA CAP 42MG	Non Preferred	SP, PA
KYNMOBI MIS 10MG	Non Preferred	SP, PA
KYNMOBI MIS 15MG	Non Preferred	SP, PA
KYNMOBI MIS 20MG	Non Preferred	SP, PA
KYNMOBI MIS 25MG	Non Preferred	SP, PA
KYNMOBI MIS 30MG	Non Preferred	SP, PA
MIRAPEX ER TAB 0.75MG	Non Preferred	PA
MIRAPEX ER TAB 0.375MG	Non Preferred	PA
MIRAPEX ER TAB 1.5MG	Non Preferred	PA
MIRAPEX ER TAB 2.25MG	Non Preferred	PA
MIRAPEX ER TAB 3.75MG	Non Preferred	PA
MIRAPEX ER TAB 3MG	Non Preferred	PA
MIRAPEX ER TAB 4.5MG	Non Preferred	PA
NEUPRO DIS 1MG/24HR	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NEUPRO DIS 2MG/24HR	Non Preferred	PA
NEUPRO DIS 3MG/24HR	Non Preferred	PA
NEUPRO DIS 4MG/24HR	Non Preferred	PA
NEUPRO DIS 6MG/24HR	Non Preferred	PA
NEUPRO DIS 8MG/24HR	Non Preferred	PA
OSMOLEX ER TAB 129MG	Non Preferred	PA
OSMOLEX ER TAB 193MG	Non Preferred	PA
PARLODEL CAP 5MG	Non Preferred	PA, QL (6 caps every 1 day)
PARLODEL TAB 2.5MG	Non Preferred	PA, QL (6 tabs every 1 day)
<i>pramipexole dihydrochloride tab 0.5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>pramipexole dihydrochloride tab 0.25 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>pramipexole dihydrochloride tab 0.75 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>pramipexole dihydrochloride tab 0.125 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>pramipexole dihydrochloride tab 1 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>pramipexole dihydrochloride tab 1.5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>pramipexole dihydrochloride tab er 24hr 0.75 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>pramipexole dihydrochloride tab er 24hr 0.375 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>pramipexole dihydrochloride tab er 24hr 1.5 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>pramipexole dihydrochloride tab er 24hr 2.25 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>pramipexole dihydrochloride tab er 24hr 3 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>pramipexole dihydrochloride tab er 24hr 3.75 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>pramipexole dihydrochloride tab er 24hr 4.5 mg (generic of MIRAPEX ER)</i>	Non Preferred	PA
<i>ropinirole hydrochloride tab 0.5 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>ropinirole hydrochloride tab 0.25 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>ropinirole hydrochloride tab 1 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>ropinirole hydrochloride tab 2 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>ropinirole hydrochloride tab 3 mg</i>	Preferred	QL (12 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ropinirole hydrochloride tab 4 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>ropinirole hydrochloride tab 5 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	Non Preferred	PA
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	Non Preferred	PA
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	Non Preferred	PA
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	Non Preferred	PA
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	Non Preferred	PA
RYTARY CAP 95MG	Non Preferred	PA
RYTARY CAP 145MG	Non Preferred	PA
RYTARY CAP 195MG	Non Preferred	PA
RYTARY CAP 245MG	Non Preferred	PA
SINEMET TAB 10-100MG	Non Preferred	PA, QL (8 tabs every 1 day)
SINEMET TAB 25-100MG	Non Preferred	PA, QL (12 tabs every 1 day)
STALEVO 50 TAB	Non Preferred	PA, QL (8 tabs every 1 day)
STALEVO 75 TAB	Non Preferred	PA, QL (8 tabs every 1 day)
STALEVO 100 TAB	Non Preferred	PA, QL (8 tabs every 1 day)
STALEVO 125 TAB	Non Preferred	PA, QL (8 tabs every 1 day)
STALEVO 150 TAB	Non Preferred	PA, QL (8 tabs every 1 day)
STALEVO 200 TAB	Non Preferred	PA, QL (6 tabs every 1 day)
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>		
AZILECT TAB 0.5MG	Non Preferred	PA
AZILECT TAB 1MG	Non Preferred	PA
<i>rasagiline mesylate tab 0.5 mg (base equiv) (generic of AZILECT)</i>	Non Preferred	PA
<i>rasagiline mesylate tab 1 mg (base equiv) (generic of AZILECT)</i>	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>selegiline hcl cap 5 mg</i>	Preferred	QL (2 caps every 1 day)
<i>selegiline hcl tab 5 mg</i>	Preferred	QL (2 tabs every 1 day)
XADAGO TAB 50MG	Non Preferred	PA
XADAGO TAB 100MG	Non Preferred	PA
ZELAPAR TAB 1.25MG	Non Preferred	PA

## **ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES**

### **ANTIMANIC AGENTS**

<i>lithium carbonate cap 150 mg</i>	Preferred	QL (12 caps every 1 day)
<i>lithium carbonate cap 300 mg</i>	Preferred	QL (6 caps every 1 day)
<i>lithium carbonate cap 600 mg</i>	Preferred	QL (3 caps every 1 day)
<i>lithium carbonate tab 300 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>lithium carbonate tab er 300 mg</i> (generic of LITHOBID)	Preferred	QL (6 tabs every 1 day)
<i>lithium carbonate tab er 450 mg</i>	Preferred	QL (4 tabs every 1 day)
LITHOBID TAB 300MG CR	Non Preferred	PA, QL (6 tabs every 1 day)

### **ANTIPSYCHOTICS - MISC.**

CAPLYTA CAP 10.5MG	Non Preferred	PA; AGE (Min 8)
CAPLYTA CAP 21MG	Non Preferred	PA; AGE (Min 8)
CAPLYTA CAP 42MG	Non Preferred	PA; AGE (Min 8)
EQUETRO CAP 100MG	Non Preferred	PA; AGE (Min 8)
EQUETRO CAP 200MG	Non Preferred	PA; AGE (Min 8)
EQUETRO CAP 300MG	Non Preferred	PA; AGE (Min 8)
GEODON CAP 20MG	Non Preferred	PA, QL (2 caps every 1 day); AGE (Min 8)
GEODON CAP 40MG	Non Preferred	PA, QL (2 caps every 1 day); AGE (Min 8)
GEODON CAP 60MG	Non Preferred	PA, QL (2 caps every 1 day); AGE (Min 8)
GEODON CAP 80MG	Non Preferred	PA, QL (2 caps every 1 day); AGE (Min 8)
GEODON INJ 20MG	Non Preferred	PA; AGE (Min 18)
LATUDA TAB 20MG	Non Preferred	PA; AGE (Min 8)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LATUDA TAB 40MG	Non Preferred	PA; AGE (Min 8)
LATUDA TAB 60MG	Non Preferred	PA; AGE (Min 8)
LATUDA TAB 80MG	Non Preferred	PA; AGE (Min 8)
LATUDA TAB 120MG	Non Preferred	PA; AGE (Min 8)
<i>lurasidone hcl tab 20 mg (generic of LATUDA)</i>	Preferred	AGE (Min 8)
<i>lurasidone hcl tab 40 mg (generic of LATUDA)</i>	Preferred	AGE (Min 8)
<i>lurasidone hcl tab 60 mg (generic of LATUDA)</i>	Preferred	AGE (Min 8)
<i>lurasidone hcl tab 80 mg (generic of LATUDA)</i>	Preferred	AGE (Min 8)
<i>lurasidone hcl tab 120 mg (generic of LATUDA)</i>	Preferred	AGE (Min 8)
NUPLAZID CAP 34MG	Non Preferred	SP, PA; AGE (Min 8)
NUPLAZID TAB 10MG	Non Preferred	SP, PA; AGE (Min 8)
VRAYLAR CAP 1.5-3MG	Non Preferred	PA; AGE (Min 8)
VRAYLAR CAP 1.5MG	Non Preferred	PA; AGE (Min 8)
VRAYLAR CAP 3MG	Non Preferred	PA; AGE (Min 8)
VRAYLAR CAP 4.5MG	Non Preferred	PA; AGE (Min 8)
VRAYLAR CAP 6MG	Non Preferred	PA; AGE (Min 8)
<i>ziprasidone hcl cap 20 mg (generic of GEODON)</i>	Preferred	QL (2 caps every 1 day); AGE (Min 8)
<i>ziprasidone hcl cap 40 mg (generic of GEODON)</i>	Preferred	QL (2 caps every 1 day); AGE (Min 8)
<i>ziprasidone hcl cap 60 mg (generic of GEODON)</i>	Preferred	QL (2 caps every 1 day); AGE (Min 8)
<i>ziprasidone hcl cap 80 mg (generic of GEODON)</i>	Preferred	QL (2 caps every 1 day); AGE (Min 8)
<i>ziprasidone mesylate for inj 20 mg (base equivalent) (generic of GEODON)</i>	Non Preferred	PA; AGE (Min 18)
<b>BENZISOXAZOLES</b>		
FANAPT PAK	Non Preferred	PA; AGE (Min 8)
FANAPT TAB 1MG	Non Preferred	PA; AGE (Min 8)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FANAPT TAB 2MG	Non Preferred	PA; AGE (Min 8)
FANAPT TAB 4MG	Non Preferred	PA; AGE (Min 8)
FANAPT TAB 6MG	Non Preferred	PA; AGE (Min 8)
FANAPT TAB 8MG	Non Preferred	PA; AGE (Min 8)
FANAPT TAB 10MG	Non Preferred	PA; AGE (Min 8)
FANAPT TAB 12MG	Non Preferred	PA; AGE (Min 8)
INVEGA HAFYE INJ 1092MG	Preferred	PA; AGE (Min 18)
INVEGA HAFYE INJ 1560MG	Preferred	PA; AGE (Min 18)
INVEGA SUST INJ 39/0.25	Preferred	PA; AGE (Min 18)
INVEGA SUST INJ 78/0.5ML	Preferred	PA; AGE (Min 18)
INVEGA SUST INJ 117/0.75	Preferred	PA; AGE (Min 18)
INVEGA SUST INJ 156MG/ML	Preferred	PA; AGE (Min 18)
INVEGA SUST INJ 234/1.5	Preferred	PA; AGE (Min 18)
INVEGA TAB 1.5MG	Non Preferred	PA; AGE (Min 8)
INVEGA TAB 3MG	Non Preferred	PA; AGE (Min 8)
INVEGA TAB 6MG	Non Preferred	PA; AGE (Min 8)
INVEGA TAB 9MG	Non Preferred	PA; AGE (Min 8)
INVEGA TRINZ INJ 273MG	Preferred	PA; AGE (Min 18)
INVEGA TRINZ INJ 410MG	Preferred	PA; AGE (Min 18)
INVEGA TRINZ INJ 546MG	Preferred	PA; AGE (Min 18)
INVEGA TRINZ INJ 819MG	Preferred	PA; AGE (Min 18)
<i>paliperidone tab er 24hr 1.5 mg (generic of INVEGA)</i>	Non Preferred	PA; AGE (Min 8)
<i>paliperidone tab er 24hr 3 mg (generic of INVEGA)</i>	Non Preferred	PA; AGE (Min 8)
<i>paliperidone tab er 24hr 6 mg (generic of INVEGA)</i>	Non Preferred	PA; AGE (Min 8)
<i>paliperidone tab er 24hr 9 mg (generic of INVEGA)</i>	Non Preferred	PA; AGE (Min 8)
PERSERIS INJ 90MG	Non Preferred	PA; AGE (Min 18)
PERSERIS INJ 120MG	Non Preferred	PA; AGE (Min 18)
RISPERDAL INJ 12.5MG	Non Preferred	PA; AGE (Min 18)
RISPERDAL INJ 25MG	Non Preferred	PA; AGE (Min 18)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RISPERDAL INJ 37.5MG	Non Preferred	PA; AGE (Min 18)
RISPERDAL INJ 50MG	Non Preferred	PA; AGE (Min 18)
RISPERDAL SOL 1MG/ML	Non Preferred	PA, QL (16 mL every 1 day); AGE (Min 8)
RISPERDAL TAB 0.5MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
RISPERDAL TAB 1MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
RISPERDAL TAB 2MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
RISPERDAL TAB 3MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
RISPERDAL TAB 4MG	Non Preferred	PA, QL (4 tabs every 1 day); AGE (Min 8)
<i>risperidone orally disintegrating tab 0.5 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone orally disintegrating tab 0.25 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone orally disintegrating tab 1 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone orally disintegrating tab 2 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone orally disintegrating tab 3 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone orally disintegrating tab 4 mg</i>	Non Preferred	PA, QL (4 tabs every 1 day); AGE (Min 8)
<i>risperidone soln 1 mg/ml (generic of RISPERDAL)</i>	Preferred	QL (16 mL every 1 day); AGE (Min 8)
<i>risperidone tab 0.5 mg (generic of RISPERDAL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone tab 0.25 mg</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone tab 1 mg (generic of RISPERDAL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone tab 2 mg (generic of RISPERDAL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone tab 3 mg (generic of RISPERDAL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>risperidone tab 4 mg (generic of RISPERDAL)</i>	Preferred	QL (4 tabs every 1 day); AGE (Min 8)
<b>BUTYROPHENONES</b>		
<i>haloperidol decanoate im soln 50 mg/ml (generic of HALDOL DECANOATE 50)</i>	Preferred	AGE (Min 6)
<i>haloperidol decanoate im soln 100 mg/ml (generic of HALDOL DECANOATE 100)</i>	Preferred	AGE (Min 6)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>haloperidol lactate oral conc 2 mg/ml</i>	Preferred	
<i>haloperidol tab 0.5 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>haloperidol tab 1 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>haloperidol tab 2 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>haloperidol tab 5 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>haloperidol tab 10 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>haloperidol tab 20 mg</i>	Preferred	QL (5 tabs every 1 day)

### **DIBENZAPINES**

<i>asenapine maleate sl tab 2.5 mg (base equiv) (generic of SAPHRIS)</i>	Non Preferred	PA; AGE (Min 8)
<i>asenapine maleate sl tab 5 mg (base equiv) (generic of SAPHRIS)</i>	Non Preferred	PA; AGE (Min 8)
<i>asenapine maleate sl tab 10 mg (base equiv) (generic of SAPHRIS)</i>	Non Preferred	PA; AGE (Min 8)
<i>clozapine orally disintegrating tab 12.5 mg</i>	Non Preferred	PA; AGE (Min 8)
<i>clozapine orally disintegrating tab 25 mg</i>	Non Preferred	PA; AGE (Min 8)
<i>clozapine orally disintegrating tab 100 mg</i>	Non Preferred	PA; AGE (Min 8)
<i>clozapine orally disintegrating tab 150 mg</i>	Non Preferred	PA; AGE (Min 8)
<i>clozapine orally disintegrating tab 200 mg</i>	Non Preferred	PA; AGE (Min 8)
<i>clozapine tab 25 mg (generic of CLOZARIL)</i>	Preferred	AGE (Min 8)
<i>clozapine tab 50 mg (generic of CLOZARIL)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>clozapine tab 100 mg (generic of CLOZARIL)</i>	Preferred	AGE (Min 8)
<i>clozapine tab 200 mg (generic of CLOZARIL)</i>	Preferred	AGE (Min 8)
CLOZARIL TAB 25MG	Non Preferred	PA; AGE (Min 8)
CLOZARIL TAB 50MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
CLOZARIL TAB 100MG	Non Preferred	PA; AGE (Min 8)
CLOZARIL TAB 200MG	Non Preferred	PA; AGE (Min 8)
<i>loxapine succinate cap 5 mg</i>	Preferred	QL (15 caps every 1 day); AGE (Min 8)
<i>loxapine succinate cap 10 mg</i>	Preferred	QL (15 caps every 1 day); AGE (Min 8)
<i>loxapine succinate cap 25 mg</i>	Preferred	QL (6 caps every 1 day); AGE (Min 8)
<i>loxapine succinate cap 50 mg</i>	Preferred	QL (15 caps every 1 day); AGE (Min 8)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>olanzapine for im inj 10 mg</i> (generic of ZYPREXA)	Non Preferred	PA; AGE (Min 18)
<i>olanzapine orally disintegrating tab 5 mg</i> (generic of ZYPREXA ZYDIS)	Preferred	AGE (Min 8)
<i>olanzapine orally disintegrating tab 10 mg</i> (generic of ZYPREXA ZYDIS)	Preferred	AGE (Min 8)
<i>olanzapine orally disintegrating tab 15 mg</i> (generic of ZYPREXA ZYDIS)	Preferred	AGE (Min 8)
<i>olanzapine orally disintegrating tab 20 mg</i> (generic of ZYPREXA ZYDIS)	Preferred	AGE (Min 8)
<i>olanzapine tab 2.5 mg</i> (generic of ZYPREXA)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>olanzapine tab 5 mg</i> (generic of ZYPREXA)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>olanzapine tab 7.5 mg</i> (generic of ZYPREXA)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>olanzapine tab 10 mg</i> (generic of ZYPREXA)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>olanzapine tab 15 mg</i> (generic of ZYPREXA)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>olanzapine tab 20 mg</i> (generic of ZYPREXA)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab 25 mg</i> (generic of SEROQUEL)	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab 50 mg</i> (generic of SEROQUEL)	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab 100 mg</i> (generic of SEROQUEL)	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab 150 mg</i>	Preferred	AGE (Min 4)
<i>quetiapine fumarate tab 200 mg</i> (generic of SEROQUEL)	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab 300 mg</i> (generic of SEROQUEL)	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab 400 mg</i> (generic of SEROQUEL)	Preferred	QL (2 tabs every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab er 24hr 50 mg</i> (generic of SEROQUEL XR)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab er 24hr 150 mg</i> (generic of SEROQUEL XR)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab er 24hr 200 mg</i> (generic of SEROQUEL XR)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab er 24hr 300 mg</i> (generic of SEROQUEL XR)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>quetiapine fumarate tab er 24hr 400 mg</i> (generic of SEROQUEL XR)	Preferred	QL (1 tab every 1 day); AGE (Min 8)
SAPHRIS SUB 2.5MG	Non Preferred	PA; AGE (Min 8)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SAPHRIS SUB 5MG	Non Preferred	PA; AGE (Min 8)
SAPHRIS SUB 10MG	Non Preferred	PA; AGE (Min 8)
SECUADO DIS 3.8MG	Non Preferred	PA; AGE (Min 18)
SECUADO DIS 5.7MG	Non Preferred	PA; AGE (Min 18)
SECUADO DIS 7.6MG	Non Preferred	PA; AGE (Min 18)
SEROQUEL TAB 25MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
SEROQUEL TAB 50MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
SEROQUEL TAB 100MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
SEROQUEL TAB 200MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
SEROQUEL TAB 300MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
SEROQUEL TAB 400MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 8)
SEROQUEL XR TAB 50MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
SEROQUEL XR TAB 150MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
SEROQUEL XR TAB 200MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
SEROQUEL XR TAB 300MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
SEROQUEL XR TAB 400MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
VERSACLOZ SUS 50MG/ML	Non Preferred	PA; AGE (Min 8)
ZYPREXA INJ 10MG	Non Preferred	PA; AGE (Min 18)
ZYPREXA RELP INJ 210MG	Non Preferred	PA; AGE (Min 18)
ZYPREXA RELP INJ 300MG	Non Preferred	PA; AGE (Min 18)
ZYPREXA RELP INJ 405MG	Non Preferred	PA; AGE (Min 18)
ZYPREXA TAB 2.5MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ZYPREXA TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ZYPREXA TAB 7.5MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZYPREXA TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ZYPREXA TAB 15MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ZYPREXA TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ZYPREXA ZYDI TAB 5MG	Non Preferred	PA; AGE (Min 8)
ZYPREXA ZYDI TAB 10MG	Non Preferred	PA; AGE (Min 8)
ZYPREXA ZYDI TAB 15MG	Non Preferred	PA; AGE (Min 8)
ZYPREXA ZYDI TAB 20MG	Non Preferred	PA; AGE (Min 8)

### **DIHYDROINDOLONES**

<i>molindone hcl tab 5 mg</i>	Non Preferred	PA
<i>molindone hcl tab 10 mg</i>	Non Preferred	PA
<i>molindone hcl tab 25 mg</i>	Non Preferred	PA

### **PHENOTHIAZINES**

<i>chlorpromazine hcl conc 30 mg/ml</i>	Preferred	
<i>chlorpromazine hcl conc 100 mg/ml</i>	Preferred	
<i>chlorpromazine hcl tab 10 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>chlorpromazine hcl tab 25 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>chlorpromazine hcl tab 50 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>chlorpromazine hcl tab 100 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>chlorpromazine hcl tab 200 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>compro sup 25mg</i>	Preferred	QL (12 supp every 1 day)
<i>fluphenazine decanoate inj 25 mg/ml</i>	Preferred	
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	Preferred	
<i>fluphenazine hcl oral conc 5 mg/ml</i>	Preferred	
<i>fluphenazine hcl tab 1 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>fluphenazine hcl tab 2.5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>fluphenazine hcl tab 5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>fluphenazine hcl tab 10 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>perphenazine tab 2 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>perphenazine tab 4 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>perphenazine tab 8 mg</i>	Preferred	QL (3 tabs every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>perphenazine tab 16 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	Preferred	QL (10 tabs every 1 day)
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	Preferred	QL (8 tabs every 1 day)
<i>prochlorperazine suppos 25 mg</i>	Preferred	QL (12 supp every 1 day)
<i>thioridazine hcl tab 10 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>thioridazine hcl tab 25 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>thioridazine hcl tab 50 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>thioridazine hcl tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	Preferred	QL (6 tabs every 1 day)
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	Preferred	QL (6 tabs every 1 day)
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	Preferred	QL (6 tabs every 1 day)
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	Preferred	QL (4 tabs every 1 day)

### **QUINOLINONE DERIVATIVES**

ABILIFY MAIN INJ 300MG	Preferred	PA; AGE (Min 18)
ABILIFY MAIN INJ 400MG	Preferred	PA; AGE (Min 18)
ABILIFY MYCI TAB 2MG MANT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 2MG STRT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 5MG MANT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 5MG STRT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 10MG MNT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 10MG STR	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 15MG MNT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 15MG STR	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 20MG MNT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 20MG STR	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 30MG MNT	Non Preferred	PA; AGE (Min 8)
ABILIFY MYCI TAB 30MG STR	Non Preferred	PA; AGE (Min 8)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ABILIFY TAB 2MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ABILIFY TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ABILIFY TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ABILIFY TAB 15MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ABILIFY TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
ABILIFY TAB 30MG	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole oral solution 1 mg/ml</i>	Non Preferred	PA; AGE (Min 8)
<i>aripiprazole orally disintegrating tab 10 mg</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole orally disintegrating tab 15 mg</i>	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole tab 2 mg (generic of ABILIFY)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole tab 5 mg (generic of ABILIFY)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole tab 10 mg (generic of ABILIFY)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole tab 15 mg (generic of ABILIFY)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole tab 20 mg (generic of ABILIFY)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 8)
<i>aripiprazole tab 30 mg (generic of ABILIFY)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 8)
ARISTADA INJ 441MG/1.	Preferred	PA; AGE (Min 18)
ARISTADA INJ 662MG/2	Preferred	PA; AGE (Min 18)
ARISTADA INJ 882MG/3	Preferred	PA; AGE (Min 18)
ARISTADA INJ 1064MG	Preferred	PA; AGE (Min 18)
ARISTADA INJ INITIO	Preferred	PA; AGE (Min 18)
REXULTI TAB 0.5MG	Non Preferred	PA; AGE (Min 8)
REXULTI TAB 0.25MG	Non Preferred	PA; AGE (Min 8)
REXULTI TAB 1MG	Non Preferred	PA; AGE (Min 8)
REXULTI TAB 2MG	Non Preferred	PA; AGE (Min 8)
REXULTI TAB 3MG	Non Preferred	PA; AGE (Min 8)
REXULTI TAB 4MG	Non Preferred	PA; AGE (Min 8)

Drug Name	Drug Tier	Requirements/Limits
<b>THIOXANTHENES</b>		
<i>thiothixene cap 1 mg</i>	Preferred	QL (6 caps every 1 day)
<i>thiothixene cap 2 mg</i>	Preferred	QL (6 caps every 1 day)
<i>thiothixene cap 5 mg</i>	Preferred	QL (6 caps every 1 day)
<i>thiothixene cap 10 mg</i>	Preferred	QL (6 caps every 1 day)

## ANTISEPTICS & DISINFECTANTS - PRODUCTS TO DISINFECT

### CHLORINE ANTISEPTICS

<i>betasept liq 4%</i>	Preferred	OTC
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## ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS

### ANTIRETROVIRALS

<i>abacavir sulfate soln 20 mg/ml (base equiv) (generic of ZIAGEN)</i>	Preferred	QL (30 mL every 1 day)
<i>abacavir sulfate tab 300 mg (base equiv) (generic of ZIAGEN)</i>	Preferred	QL (2 tabs every 1 day)
<i>abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)</i>	Preferred	QL (1 tab every 1 day)
APRETUDE SUS 600MG ER	Preferred	
APRETUDE SUS 600MG ER	Non Preferred	PA
APTIVUS CAP 250MG	Preferred	
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	Preferred	QL (2 caps every 1 day)
<i>atazanavir sulfate cap 200 mg (base equiv) (generic of REYATAZ)</i>	Preferred	QL (2 caps every 1 day)
<i>atazanavir sulfate cap 300 mg (base equiv) (generic of REYATAZ)</i>	Preferred	QL (1 cap every 1 day)
BIKTARVY TAB 30-120-15 MG	Preferred	
BIKTARVY TAB 50-200-25 MG	Preferred	QL (1 tab every 1 day)
CABENUVA SUS 400-600	Preferred	PA
CABENUVA SUS 600-900	Preferred	PA
CIMDUO TAB 300-300	Non Preferred	PA, QL (1 tab every 1 day)
COMBIVIR TAB 150-300	Non Preferred	PA, QL (2 tabs every 1 day)
COMPLERA TAB	Preferred	QL (1 tab every 1 day)
DELSTRIGO TAB	Preferred	
DESCOVY TAB 120-15MG	Preferred	
DESCOVY TAB 200/25MG	Preferred	QL (1 tab every 1 day)
DOVATO TAB 50-300MG	Preferred	QL (1 tab every 1 day)
EDURANT TAB 25MG	Preferred	QL (1 tab every 1 day)
<i>efavirenz cap 50 mg</i>	Preferred	QL (12 caps every 1 day)
<i>efavirenz cap 200 mg</i>	Preferred	QL (3 caps every 1 day)
<i>efavirenz tab 600 mg (generic of SUSTIVA)</i>	Preferred	QL (1 tab every 1 day)
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg (generic of ATRIPLA)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg (generic of SYMFI LO)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg (generic of SYMFI)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>emtricitabine caps 200 mg (generic of EMTRIVA)</i>	Preferred	QL (1 cap every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg (generic of TRUVADA)</i>	Preferred	QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg (generic of TRUVADA)</i>	Preferred	QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg (generic of TRUVADA)</i>	Preferred	QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg (generic of TRUVADA)</i>	Preferred	QL (1 tab every 1 day)
EMTRIVA CAP 200MG	Preferred	QL (1 cap every 1 day)
EMTRIVA SOL 10MG/ML	Preferred	QL (20 mL every 1 day)
EPIVIR SOL 10MG/ML	Non Preferred	PA, QL (30 mL every 1 day)
EPIVIR TAB 150MG	Non Preferred	PA, QL (2 tabs every 1 day)
EPIVIR TAB 300MG	Non Preferred	PA, QL (1 tab every 1 day)
EPZICOM TAB 600-300	Non Preferred	PA, QL (1 tab every 1 day)
<i>etravirine tab 100 mg (generic of INTELENCE)</i>	Preferred	QL (4 tabs every 1 day)
<i>etravirine tab 200 mg (generic of INTELENCE)</i>	Preferred	QL (2 tabs every 1 day)
EVOTAZ TAB 300-150	Non Preferred	PA, QL (1 tab every 1 day)
<i>fosamprenavir calcium tab 700 mg (base equiv) (generic of LEXIVA)</i>	Preferred	QL (4 tabs every 1 day)
FUZEON INJ 90MG	Non Preferred	PA
GENVOYA TAB	Preferred	QL (1 tab every 1 day)
INTELENCE TAB 25MG	Preferred	
INTELENCE TAB 100MG	Preferred	QL (4 tabs every 1 day)
INTELENCE TAB 200MG	Preferred	QL (2 tabs every 1 day)
ISENTRESS CHW 25MG	Preferred	
ISENTRESS CHW 100MG	Preferred	QL (12 tabs every 1 day)
ISENTRESS HD TAB 600MG	Preferred	QL (2 tabs every 1 day)
ISENTRESS POW 100MG	Preferred	
ISENTRESS TAB 400MG	Preferred	QL (2 tabs every 1 day)
JULUCA TAB 50-25MG	Non Preferred	PA, QL (1 tab every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KALETRA SOL	Non Preferred	PA, QL (16 mL every 1 day)
KALETRA TAB 100-25MG	Preferred	QL (8 tabs every 1 day)
KALETRA TAB 200-50MG	Preferred	QL (4 tabs every 1 day)
<i>lamivudine oral soln 10 mg/ml (generic of EPIVIR)</i>	Preferred	QL (30 mL every 1 day)
<i>lamivudine tab 150 mg (generic of EPIVIR)</i>	Preferred	QL (2 tabs every 1 day)
<i>lamivudine tab 300 mg (generic of EPIVIR)</i>	Preferred	QL (1 tab every 1 day)
<i>lamivudine-zidovudine tab 150-300 mg (generic of COMBIVIR)</i>	Preferred	QL (2 tabs every 1 day)
LEXIVA SUS 50MG/ML	Preferred	
LEXIVA TAB 700MG	Preferred	QL (4 tabs every 1 day)
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml) (generic of KALETRA)</i>	Preferred	QL (16 mL every 1 day)
<i>lopinavir-ritonavir tab 100-25 mg (generic of KALETRA)</i>	Preferred	QL (8 tabs every 1 day)
<i>lopinavir-ritonavir tab 200-50 mg (generic of KALETRA)</i>	Preferred	QL (4 tabs every 1 day)
<i>maraviroc tab 150 mg (generic of SELZENTRY)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>maraviroc tab 300 mg (generic of SELZENTRY)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>nevirapine susp 50 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>nevirapine tab 200 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>nevirapine tab er 24hr 100 mg</i>	Preferred	
<i>nevirapine tab er 24hr 400 mg</i>	Preferred	QL (1 tab every 1 day)
NORVIR POW 100MG	Preferred	
ODEFSEY TAB	Preferred	QL (1 tab every 1 day)
PIFELTRO TAB 100MG	Non Preferred	PA
PREZCOBIX TAB 800-150	Non Preferred	PA, QL (1 tab every 1 day)
PREZISTA SUS 100MG/ML	Preferred	QL (8 mL every 1 day)
PREZISTA TAB 75MG	Preferred	
PREZISTA TAB 150MG	Preferred	
PREZISTA TAB 600MG	Preferred	QL (2 tabs every 1 day)
PREZISTA TAB 800MG	Preferred	QL (1 tab every 1 day)
RETROVIR CAP 100MG	Non Preferred	PA, QL (6 caps every 1 day)
RETROVIR SYP 50MG/5ML	Non Preferred	PA, QL (60 mL every 1 day)
REYATAZ CAP 200MG	Preferred	QL (2 caps every 1 day)
REYATAZ CAP 300MG	Preferred	QL (1 cap every 1 day)
REYATAZ POW 50MG	Preferred	
<i>ritonavir tab 100 mg (generic of NORVIR)</i>	Preferred	QL (12 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RUKOBIA TAB 600MG ER	Non Preferred	PA
SELZENTRY SOL 20MG/ML	Non Preferred	PA
SELZENTRY TAB 25MG	Non Preferred	PA
SELZENTRY TAB 75MG	Non Preferred	PA
SELZENTRY TAB 150MG	Non Preferred	PA, QL (2 tabs every 1 day)
SELZENTRY TAB 300MG	Non Preferred	PA, QL (2 tabs every 1 day)
STRIBILD TAB	Non Preferred	PA, QL (1 tab every 1 day)
SUNLENCA INJ	Preferred	PA
SUNLENCA TAB 300MG	Preferred	PA
SYMFI LO TAB	Preferred	QL (1 tab every 1 day)
SYMFI TAB	Preferred	QL (1 tab every 1 day)
SYMTUZA TAB	Preferred	
<i>tenofovir disoproxil fumarate tab 300 mg</i> (generic of VIREAD)	Preferred	QL (1 tab every 1 day)
TIVICAY PD TAB 5MG	Preferred	
TIVICAY TAB 10MG	Preferred	
TIVICAY TAB 25MG	Preferred	
TIVICAY TAB 50MG	Preferred	QL (2 tabs every 1 day)
TRIUMEQ PD TAB	Preferred	
TRIUMEQ TAB	Preferred	QL (1 tab every 1 day)
TRIZIVIR TAB	Non Preferred	PA, QL (2 tabs every 1 day)
TROGARZO INJ 150MG/ML	Preferred	PA
TRUVADA TAB 100-150	Preferred	QL (1 tab every 1 day)
TRUVADA TAB 133-200	Preferred	QL (1 tab every 1 day)
TRUVADA TAB 167-250	Preferred	QL (1 tab every 1 day)
TRUVADA TAB 200-300	Preferred	QL (1 tab every 1 day)
TYBOST TAB 150MG	Non Preferred	PA
VIRACEPT TAB 250MG	Preferred	QL (10 tabs every 1 day)
VIRACEPT TAB 625MG	Preferred	QL (4 tabs every 1 day)
VIREAD POW 40MG/GM	Preferred	QL (7.5 gm every 1 day)
VIREAD TAB 150MG	Preferred	QL (1 tab every 1 day)
VIREAD TAB 200MG	Preferred	QL (1 tab every 1 day)
VIREAD TAB 250MG	Preferred	QL (1 tab every 1 day)
VIREAD TAB 300MG	Preferred	QL (1 tab every 1 day)
ZIAGEN SOL 20MG/ML	Preferred	QL (30 mL every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZIAGEN TAB 300MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>zidovudine cap 100 mg</i> (generic of RETROVIR)	Preferred	QL (6 caps every 1 day)
<i>zidovudine syrup 10 mg/ml</i> (generic of RETROVIR)	Preferred	QL (60 mL every 1 day)
<i>zidovudine tab 300 mg</i>	Preferred	QL (2 tabs every 1 day)

### **ANTIVIRAL COMBINATIONS**

PAXLOVID TAB 150-100	Preferred	AGE (Min 12)
PAXLOVID TAB 300-100	Preferred	AGE (Min 12)

### **CMV AGENTS**

LIVTENCITY TAB 200MG	Preferred	SP, PA
PREVYMIS TAB 240MG	Non Preferred	PA
PREVYMIS TAB 480MG	Non Preferred	PA
VALCYTE SOL 50MG/ML	Non Preferred	PA
VALCYTE TAB 450MG	Non Preferred	PA
<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i> (generic of VALCYTE)	Non Preferred	PA
<i>valganciclovir hcl tab 450 mg (base equivalent)</i> (generic of VALCYTE)	Preferred	

### **HEPATITIS AGENTS**

<i>adefovir dipivoxil tab 10 mg</i>	Non Preferred	PA, QL (1 tab every 1 day)
BARACLUDE SOL	Non Preferred	PA, QL (30 mL every 1 day)
BARACLUDE TAB 0.5MG	Non Preferred	PA, QL (1 tab every 1 day)
BARACLUDE TAB 1MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>entecavir tab 0.5 mg</i> (generic of BARACLUDE)	Preferred	QL (1 tab every 1 day)
<i>entecavir tab 1 mg</i> (generic of BARACLUDE)	Preferred	QL (1 tab every 1 day)
EPCLUSA PAK 150-37.5	Non Preferred	SP, PA
EPCLUSA PAK 200-50MG	Non Preferred	SP, PA
EPCLUSA TAB 200-50MG	Non Preferred	SP, PA
EPCLUSA TAB 400-100	Non Preferred	SP, PA, QL (1 tab every 1 day)
HARVONI PAK	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HARVONI PAK 45-200MG	Non Preferred	SP, PA
HARVONI TAB 45-200MG	Non Preferred	SP, PA
HARVONI TAB 90-400MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>lamivudine tab 100 mg (hbv)</i>	Non Preferred	PA, QL (3 tabs every 1 day)
LEDIP-SOFOSB TAB 90-400MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
MAVYRET PAK 50-20MG	Preferred	SP
MAVYRET TAB 100-40MG	Preferred	SP
<i>ribavirin cap 200 mg</i>	Preferred	SP
<i>ribavirin tab 200 mg</i>	Preferred	SP
SOFOS/VELPAT TAB 400-100	Preferred	SP, QL (1 tab every 1 day)
SOVALDI PAK 150MG	Non Preferred	SP, PA
SOVALDI PAK 200MG	Non Preferred	SP, PA
SOVALDI TAB 200MG	Non Preferred	SP, PA
SOVALDI TAB 400MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
VEMLIDY TAB 25MG	Non Preferred	PA
VOSEVI TAB	Non Preferred	SP, PA, QL (1 tab every 1 day)
ZEPATIER TAB 50-100MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
<b>HERPES AGENTS</b>		
<i>acyclovir cap 200 mg</i>	Preferred	QL (5 caps every 1 day)
<i>acyclovir susp 200 mg/5ml</i>	Preferred	QL (25 mL every 1 day)
<i>acyclovir tab 400 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>acyclovir tab 800 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>famciclovir tab 125 mg</i>	Non Preferred	PA, QL (3 tabs every 1 day)
<i>famciclovir tab 250 mg</i>	Non Preferred	PA, QL (3 tabs every 1 day)
<i>famciclovir tab 500 mg</i>	Non Preferred	PA, QL (3 tabs every 1 day)
SITAVIG TAB 50MG	Non Preferred	PA
<i>valacyclovir hcl tab 1 gm (generic of VALTREX)</i>	Preferred	QL (8 tabs every 1 day)
<i>valacyclovir hcl tab 500 mg (generic of VALTREX)</i>	Preferred	QL (8 tabs every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VALTREX TAB 1GM	Non Preferred	PA, QL (8 tabs every 1 day)
VALTREX TAB 500MG	Non Preferred	PA, QL (8 tabs every 1 day)

### **INFLUENZA AGENTS**

<i>oseltamivir phosphate cap 30 mg (base equiv) (generic of TAMIFLU)</i>	Preferred	
<i>oseltamivir phosphate cap 45 mg (base equiv) (generic of TAMIFLU)</i>	Preferred	
<i>oseltamivir phosphate cap 75 mg (base equiv) (generic of TAMIFLU)</i>	Preferred	
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv) (generic of TAMIFLU)</i>	Preferred	
RELENZA MIS DISKHALE	Preferred	
<i>rimantadine hydrochloride tab 100 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
TAMIFLU CAP 30MG	Non Preferred	PA
TAMIFLU CAP 45MG	Non Preferred	PA
TAMIFLU CAP 75MG	Non Preferred	PA
TAMIFLU SUS 6MG/ML	Non Preferred	PA
XOFLUZA TAB 40MG	Non Preferred	PA
XOFLUZA TAB 80MG	Non Preferred	PA

### **MISC. ANTIVIRALS**

LAGEVRIO CAP 200MG	Preferred	AGE (Min 18)
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### **RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS**

<i>ribavirin for inhal soln 6 gm (generic of VIRAZOLE)</i>	Preferred	
VIRAZOLE INH 6GM	Non Preferred	PA

## **BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS**

### **ALPHA-BETA BLOCKERS**

<i>carvedilol phosphate cap er 24hr 10 mg (generic of COREG CR)</i>	Non Preferred	PA
<i>carvedilol phosphate cap er 24hr 20 mg (generic of COREG CR)</i>	Non Preferred	PA
<i>carvedilol phosphate cap er 24hr 40 mg (generic of COREG CR)</i>	Non Preferred	PA
<i>carvedilol phosphate cap er 24hr 80 mg (generic of COREG CR)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>carvedilol tab 3.125 mg</i> (generic of COREG)	Preferred	QL (2 tabs every 1 day)
<i>carvedilol tab 6.25 mg</i> (generic of COREG)	Preferred	QL (2 tabs every 1 day)
<i>carvedilol tab 12.5 mg</i> (generic of COREG)	Preferred	QL (2 tabs every 1 day)
<i>carvedilol tab 25 mg</i> (generic of COREG)	Preferred	QL (2 tabs every 1 day)
COREG CR CAP 10MG	Non Preferred	PA
COREG CR CAP 20MG	Non Preferred	PA
COREG CR CAP 40MG	Non Preferred	PA
COREG CR CAP 80MG	Non Preferred	PA
COREG TAB 3.125MG	Non Preferred	PA, QL (2 tabs every 1 day)
COREG TAB 6.25MG	Non Preferred	PA, QL (2 tabs every 1 day)
COREG TAB 12.5MG	Non Preferred	PA, QL (2 tabs every 1 day)
COREG TAB 25MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>labetalol hcl tab 100 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>labetalol hcl tab 200 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>labetalol hcl tab 300 mg</i>	Preferred	QL (6 tabs every 1 day)
<b>BETA BLOCKERS CARDIO-SELECTIVE</b>		
<i>acebutolol hcl cap 200 mg</i>	Preferred	QL (16 caps every 1 day)
<i>acebutolol hcl cap 400 mg</i>	Preferred	QL (16 caps every 1 day)
<i>atenolol tab 25 mg</i> (generic of TENORMIN)	Preferred	QL (2 tabs every 1 day)
<i>atenolol tab 50 mg</i> (generic of TENORMIN)	Preferred	QL (2 tabs every 1 day)
<i>atenolol tab 100 mg</i> (generic of TENORMIN)	Preferred	QL (2 tabs every 1 day)
<i>betaxolol hcl tab 10 mg</i>	Preferred	
<i>betaxolol hcl tab 20 mg</i>	Preferred	
<i>bisoprolol fumarate tab 5 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>bisoprolol fumarate tab 10 mg</i>	Preferred	QL (2 tabs every 1 day)
BYSTOLIC TAB 2.5MG	Non Preferred	PA
BYSTOLIC TAB 5MG	Non Preferred	PA
BYSTOLIC TAB 10MG	Non Preferred	PA
BYSTOLIC TAB 20MG	Non Preferred	PA
KAPSPARGO CAP 25MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KAPSPARGO CAP 50MG	Non Preferred	PA
KAPSPARGO CAP 100MG	Non Preferred	PA
KAPSPARGO CAP 200MG	Non Preferred	PA
LOPRESSOR TAB 50MG	Non Preferred	PA, QL (3 tabs every 1 day)
LOPRESSOR TAB 100MG	Non Preferred	PA, QL (3 tabs every 1 day)
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv) (generic of TOPROL XL)</i>	Preferred	QL (3 tabs every 1 day)
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv) (generic of TOPROL XL)</i>	Preferred	QL (4 tabs every 1 day)
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv) (generic of TOPROL XL)</i>	Preferred	QL (3 tabs every 1 day)
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv) (generic of TOPROL XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>metoprolol tartrate tab 25 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>metoprolol tartrate tab 37.5 mg</i>	Preferred	
<i>metoprolol tartrate tab 50 mg (generic of LOPRESSOR)</i>	Preferred	QL (3 tabs every 1 day)
<i>metoprolol tartrate tab 75 mg</i>	Preferred	
<i>metoprolol tartrate tab 100 mg (generic of LOPRESSOR)</i>	Preferred	QL (3 tabs every 1 day)
<i>nebivolol hcl tab 2.5 mg (base equivalent) (generic of BYSTOLIC)</i>	Non Preferred	PA
<i>nebivolol hcl tab 5 mg (base equivalent) (generic of BYSTOLIC)</i>	Non Preferred	PA
<i>nebivolol hcl tab 10 mg (base equivalent) (generic of BYSTOLIC)</i>	Non Preferred	PA
<i>nebivolol hcl tab 20 mg (base equivalent) (generic of BYSTOLIC)</i>	Non Preferred	PA
TENORMIN TAB 25MG	Non Preferred	PA, QL (2 tabs every 1 day)
TENORMIN TAB 50MG	Non Preferred	PA, QL (2 tabs every 1 day)
TENORMIN TAB 100MG	Non Preferred	PA, QL (2 tabs every 1 day)
TOPROL XL TAB 25MG	Non Preferred	PA, QL (3 tabs every 1 day)
TOPROL XL TAB 50MG	Non Preferred	PA, QL (4 tabs every 1 day)
TOPROL XL TAB 100MG	Non Preferred	PA, QL (3 tabs every 1 day)
TOPROL XL TAB 200MG	Non Preferred	PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>BETA BLOCKERS NON-SELECTIVE</b>		
BETAPACE AF TAB 80MG	Non Preferred	PA, QL (2 tabs every 1 day)
BETAPACE AF TAB 120MG	Non Preferred	PA, QL (2 tabs every 1 day)
BETAPACE AF TAB 160MG	Non Preferred	PA, QL (2 tabs every 1 day)
BETAPACE TAB 80MG	Non Preferred	PA, QL (2 tabs every 1 day)
BETAPACE TAB 120MG	Non Preferred	PA, QL (2 tabs every 1 day)
BETAPACE TAB 160MG	Non Preferred	PA, QL (2 tabs every 1 day)
CORGARD TAB 20MG	Non Preferred	PA, QL (3 tabs every 1 day)
CORGARD TAB 40MG	Non Preferred	PA, QL (3 tabs every 1 day)
HEMANGEOL SOL 4.28/ML	Preferred	PA; AGE (Max 1)
INDERAL LA CAP 60MG	Non Preferred	PA, QL (3 caps every 1 day)
INDERAL LA CAP 80MG	Non Preferred	PA, QL (4 caps every 1 day)
INDERAL LA CAP 120MG	Non Preferred	PA, QL (3 caps every 1 day)
INDERAL LA CAP 160MG	Non Preferred	PA, QL (2 caps every 1 day)
INDERAL XL CAP 80MG	Non Preferred	PA
INDERAL XL CAP 120MG	Non Preferred	PA
INNOPRAN XL CAP 80MG	Non Preferred	PA
INNOPRAN XL CAP 120MG	Non Preferred	PA
<i>nadolol tab 20 mg (generic of CORGARD)</i>	Preferred	QL (3 tabs every 1 day)
<i>nadolol tab 40 mg (generic of CORGARD)</i>	Preferred	QL (3 tabs every 1 day)
<i>nadolol tab 80 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>pindolol tab 5 mg</i>	Preferred	
<i>pindolol tab 10 mg</i>	Preferred	
<i>propranolol hcl cap er 24hr 60 mg (generic of INDERAL LA)</i>	Preferred	QL (3 caps every 1 day)
<i>propranolol hcl cap er 24hr 80 mg (generic of INDERAL LA)</i>	Preferred	QL (4 caps every 1 day)
<i>propranolol hcl cap er 24hr 120 mg (generic of INDERAL LA)</i>	Preferred	QL (3 caps every 1 day)
<i>propranolol hcl cap er 24hr 160 mg (generic of INDERAL LA)</i>	Preferred	QL (2 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>propranolol hcl oral soln 20 mg/5ml</i>	Preferred	QL (20 mL every 1 day)
<i>propranolol hcl oral soln 40 mg/5ml</i>	Preferred	
<i>propranolol hcl tab 10 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>propranolol hcl tab 20 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>propranolol hcl tab 40 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>propranolol hcl tab 60 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>propranolol hcl tab 80 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>sorine tab 80mg (generic of BETAPACE)</i>	Preferred	QL (2 tabs every 1 day)
<i>sorine tab 120mg (generic of BETAPACE)</i>	Preferred	QL (2 tabs every 1 day)
<i>sorine tab 160mg (generic of BETAPACE)</i>	Preferred	QL (2 tabs every 1 day)
<i>sorine tab 240mg</i>	Preferred	QL (2 tabs every 1 day)
<i>sotalol hcl (afib/af) tab 80 mg (generic of BETAPACE AF)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>sotalol hcl (afib/af) tab 120 mg (generic of BETAPACE AF)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>sotalol hcl (afib/af) tab 160 mg (generic of BETAPACE AF)</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>sotalol hcl tab 80 mg (generic of BETAPACE)</i>	Preferred	QL (2 tabs every 1 day)
<i>sotalol hcl tab 120 mg (generic of BETAPACE)</i>	Preferred	QL (2 tabs every 1 day)
<i>sotalol hcl tab 160 mg (generic of BETAPACE)</i>	Preferred	QL (2 tabs every 1 day)
<i>sotalol hcl tab 240 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>SOTYLIZE SOL 5MG/ML</i>	Non Preferred	PA
<i>timolol maleate tab 5 mg</i>	Preferred	
<i>timolol maleate tab 10 mg</i>	Preferred	
<i>timolol maleate tab 20 mg</i>	Preferred	

**CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS**

**CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS**

<i>amlodipine besylate tab 2.5 mg (base equivalent) (generic of NORVASC)</i>	Preferred	QL (1 tab every 1 day)
<i>amlodipine besylate tab 5 mg (base equivalent) (generic of NORVASC)</i>	Preferred	QL (1 tab every 1 day)
<i>amlodipine besylate tab 10 mg (base equivalent) (generic of NORVASC)</i>	Preferred	QL (1 tab every 1 day)
<i>CALAN SR TAB 120MG</i>	Non Preferred	PA, QL (3 tabs every 1 day)
<i>CALAN SR TAB 180MG</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>CALAN SR TAB 240MG</i>	Non Preferred	PA, QL (3 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CARDIZEM CD CAP 120MG/24	Non Preferred	PA, QL (1 cap every 1 day)
CARDIZEM CD CAP 180MG/24	Non Preferred	PA, QL (2 caps every 1 day)
CARDIZEM CD CAP 240MG/24	Non Preferred	PA, QL (1 cap every 1 day)
CARDIZEM CD CAP 300MG/24	Non Preferred	PA, QL (1 cap every 1 day)
CARDIZEM CD CAP 360MG/24	Non Preferred	PA
CARDIZEM LA TAB 120MG	Non Preferred	PA
CARDIZEM LA TAB 180MG	Non Preferred	PA
CARDIZEM LA TAB 240MG	Non Preferred	PA
CARDIZEM LA TAB 300MG/24	Non Preferred	PA
CARDIZEM LA TAB 360MG	Non Preferred	PA
CARDIZEM LA TAB 420MG/24	Non Preferred	PA
CARDIZEM TAB 30MG	Non Preferred	PA, QL (2 tabs every 1 day)
CARDIZEM TAB 60MG	Non Preferred	PA, QL (4 tabs every 1 day)
CARDIZEM TAB 120MG	Non Preferred	PA, QL (4 tabs every 1 day)
<i>cartia xt cap 120/24hr</i> (generic of CARDIZEM CD)	Preferred	QL (1 cap every 1 day)
<i>cartia xt cap 180/24hr</i> (generic of CARDIZEM CD)	Preferred	QL (2 caps every 1 day)
<i>cartia xt cap 240/24hr</i> (generic of CARDIZEM CD)	Preferred	QL (1 cap every 1 day)
<i>cartia xt cap 300/24hr</i> (generic of CARDIZEM CD)	Preferred	QL (1 cap every 1 day)
<i>dilt-xr cap 120mg</i>	Preferred	
<i>dilt-xr cap 180mg</i>	Preferred	QL (60 caps every 25 days)
<i>dilt-xr cap 240mg</i>	Preferred	
<i>diltiazem hcl cap er 12hr 60 mg</i>	Preferred	
<i>diltiazem hcl cap er 12hr 90 mg</i>	Preferred	
<i>diltiazem hcl cap er 12hr 120 mg</i>	Preferred	
<i>diltiazem hcl cap er 24hr 120 mg</i>	Preferred	
<i>diltiazem hcl cap er 24hr 180 mg</i>	Preferred	
<i>diltiazem hcl cap er 24hr 240 mg</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diltiazem hcl coated beads cap er 24hr 120 mg (generic of CARDIZEM CD)</i>	Preferred	QL (1 cap every 1 day)
<i>diltiazem hcl coated beads cap er 24hr 180 mg (generic of CARDIZEM CD)</i>	Preferred	QL (2 caps every 1 day)
<i>diltiazem hcl coated beads cap er 24hr 240 mg (generic of CARDIZEM CD)</i>	Preferred	QL (1 cap every 1 day)
<i>diltiazem hcl coated beads cap er 24hr 300 mg (generic of CARDIZEM CD)</i>	Preferred	QL (1 cap every 1 day)
<i>diltiazem hcl coated beads cap er 24hr 360 mg (generic of CARDIZEM CD)</i>	Preferred	
<i>diltiazem hcl extended release beads cap er 24hr 120 mg (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>diltiazem hcl extended release beads cap er 24hr 180 mg (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>diltiazem hcl extended release beads cap er 24hr 240 mg (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>diltiazem hcl extended release beads cap er 24hr 300 mg (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>diltiazem hcl extended release beads cap er 24hr 360 mg (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>diltiazem hcl extended release beads cap er 24hr 420 mg (generic of TIAZAC)</i>	Preferred	QL (1 cap every 1 day)
<i>diltiazem hcl tab 30 mg (generic of CARDIZEM)</i>	Preferred	QL (2 tabs every 1 day)
<i>diltiazem hcl tab 60 mg (generic of CARDIZEM)</i>	Preferred	QL (4 tabs every 1 day)
<i>diltiazem hcl tab 90 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>diltiazem hcl tab 120 mg (generic of CARDIZEM)</i>	Preferred	QL (4 tabs every 1 day)
<i>diltiazem hcl tab er 24hr 120 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 180 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 240 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 240 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 300 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 300 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 360 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 360 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>diltiazem hcl tab er 24hr 420 mg (generic of CARDIZEM LA)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diltiazem hcl tab er 24hr 420 mg (generic of CARDIZEM LA)</i>	Preferred	
<i>felodipine tab er 24hr 2.5 mg</i>	Preferred	QL (1 tab every 1 day)
<i>felodipine tab er 24hr 5 mg</i>	Preferred	QL (1 tab every 1 day)
<i>felodipine tab er 24hr 10 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>isradipine cap 2.5 mg</i>	Non Preferred	PA
<i>isradipine cap 5 mg</i>	Non Preferred	PA
KATERZIA SUS 1MG/ML	Non Preferred	PA
<i>levamlodipine maleate tab 2.5 mg</i>	Non Preferred	PA
<i>levamlodipine maleate tab 5 mg</i>	Non Preferred	PA
<i>matzim la tab 180mg/24 (generic of CARDIZEM LA)</i>	Preferred	
<i>matzim la tab 240mg/24 (generic of CARDIZEM LA)</i>	Preferred	
<i>matzim la tab 300mg/24 (generic of CARDIZEM LA)</i>	Preferred	
<i>matzim la tab 360mg/24 (generic of CARDIZEM LA)</i>	Preferred	
<i>matzim la tab 420mg/24 (generic of CARDIZEM LA)</i>	Preferred	
<i>nicardipine hcl cap 20 mg</i>	Non Preferred	PA
<i>nicardipine hcl cap 30 mg</i>	Non Preferred	PA
<i>nifedipine cap 10 mg</i>	Preferred	QL (4 caps every 1 day)
<i>nifedipine cap 20 mg</i>	Preferred	QL (4 caps every 1 day)
<i>nifedipine tab er 24hr 30 mg</i>	Preferred	QL (1 tab every 1 day)
<i>nifedipine tab er 24hr 60 mg</i>	Preferred	QL (1 tab every 1 day)
<i>nifedipine tab er 24hr 90 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>nifedipine tab er 24hr osmotic release 30 mg (generic of PROCARDIA XL)</i>	Preferred	QL (1 tab every 1 day)
<i>nifedipine tab er 24hr osmotic release 60 mg (generic of PROCARDIA XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>nifedipine tab er 24hr osmotic release 90 mg (generic of PROCARDIA XL)</i>	Preferred	QL (2 tabs every 1 day)
<i>nimodipine cap 30 mg</i>	Preferred	
<i>nisoldipine tab er 24hr 8.5 mg (generic of SULAR)</i>	Non Preferred	PA
<i>nisoldipine tab er 24hr 17 mg (generic of SULAR)</i>	Non Preferred	PA
<i>nisoldipine tab er 24hr 20 mg</i>	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nisoldipine tab er 24hr 25.5 mg</i>	Non Preferred	PA
<i>nisoldipine tab er 24hr 30 mg</i>	Non Preferred	PA
<i>nisoldipine tab er 24hr 34 mg (generic of SULAR)</i>	Non Preferred	PA
<i>nisoldipine tab er 24hr 40 mg</i>	Non Preferred	PA
NORLIQVA SOL 1MG/ML	Non Preferred	PA
NORVASC TAB 2.5MG	Non Preferred	PA, QL (1 tab every 1 day)
NORVASC TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
NORVASC TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
NYMALIZE SOL	Non Preferred	PA
PROCARDIA XL TAB 30MG CR	Non Preferred	PA, QL (1 tab every 1 day)
PROCARDIA XL TAB 60MG CR	Non Preferred	PA, QL (2 tabs every 1 day)
PROCARDIA XL TAB 90MG CR	Non Preferred	PA, QL (2 tabs every 1 day)
SULAR TAB 8.5MG	Non Preferred	PA
SULAR TAB 17MG	Non Preferred	PA
SULAR TAB 34MG	Non Preferred	PA
<i>taztia xt cap 120mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>taztia xt cap 180mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>taztia xt cap 240mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>taztia xt cap 300mg er (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>taztia xt cap 360mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>tiadylt cap 120mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>tiadylt cap 180mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>tiadylt cap 240mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>tiadylt cap 300mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>tiadylt cap 360mg/24 (generic of TIAZAC)</i>	Preferred	QL (2 caps every 1 day)
<i>tiadylt cap 420mg/24 (generic of TIAZAC)</i>	Preferred	QL (1 cap every 1 day)
TIAZAC CAP 120MG/24	Non Preferred	PA, QL (2 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TIAZAC CAP 180MG/24	Non Preferred	PA, QL (2 caps every 1 day)
TIAZAC CAP 240MG/24	Non Preferred	PA, QL (2 caps every 1 day)
TIAZAC CAP 300MG/24	Non Preferred	PA, QL (2 caps every 1 day)
TIAZAC CAP 360MG/24	Non Preferred	PA, QL (2 caps every 1 day)
TIAZAC CAP 420MG/24	Non Preferred	PA, QL (1 cap every 1 day)
VERAPAMIL CAP 100MG ER	Preferred	
<i>verapamil hcl cap er 24hr 100 mg</i>	Preferred	
<i>verapamil hcl cap er 24hr 120 mg</i> (generic of VERELAN)	Preferred	
<i>verapamil hcl cap er 24hr 180 mg</i> (generic of VERELAN)	Preferred	
<i>verapamil hcl cap er 24hr 200 mg</i>	Preferred	
<i>verapamil hcl cap er 24hr 240 mg</i> (generic of VERELAN)	Preferred	
<i>verapamil hcl cap er 24hr 300 mg</i>	Preferred	
<i>verapamil hcl cap er 24hr 360 mg</i>	Preferred	QL (1 cap every 1 day)
<i>verapamil hcl tab 40 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>verapamil hcl tab 80 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>verapamil hcl tab 120 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>verapamil hcl tab er 120 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>verapamil hcl tab er 180 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>verapamil hcl tab er 240 mg</i>	Preferred	QL (3 tabs every 1 day)
VERELAN CAP 120MG SR	Non Preferred	PA
VERELAN CAP 180MG SR	Non Preferred	PA
VERELAN CAP 240MG SR	Non Preferred	PA
VERELAN CAP 360MG SR	Non Preferred	PA, QL (1 cap every 1 day)
VERELAN PM CAP 100MG ER	Non Preferred	PA
VERELAN PM CAP 200MG ER	Non Preferred	PA
VERELAN PM CAP 300MG ER	Non Preferred	PA

## **CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS**

### **CARDIAC GLYCOSIDES**

<i>digoxin oral soln 0.05 mg/ml</i>	Preferred	
<i>digoxin tab 62.5 mcg (0.0625 mg)</i> (generic of LANOXIN)	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>digoxin tab 125 mcg (0.125 mg)</i> (generic of DIGOXIN TAB 125 MCG (0.125 MG))	Preferred	QL (1 tab every 1 day)
<i>digoxin tab 250 mcg (0.25 mg)</i> (generic of DIGOXIN TAB 250 MCG (0.25 MG))	Preferred	QL (1 tab every 1 day)

## **CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS**

### **CARDIAC MYOSIN INHIBITORS**

CAMZYOS CAP 2.5MG	Non Preferred	PA
CAMZYOS CAP 5MG	Non Preferred	PA
CAMZYOS CAP 10MG	Non Preferred	PA
CAMZYOS CAP 15MG	Non Preferred	PA

### **CARDIOVASCULAR AGENTS MISC. - COMBINATIONS**

<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i> (generic of CADUET)	Non Preferred	PA
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i> (generic of CADUET)	Non Preferred	PA
BIDIL TAB	Preferred	
CADUET TAB 5-10MG	Non Preferred	PA
CADUET TAB 5-20MG	Non Preferred	PA
CADUET TAB 5-40MG	Non Preferred	PA
CADUET TAB 5-80MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CADUET TAB 10-10MG	Non Preferred	PA
CADUET TAB 10-20MG	Non Preferred	PA
CADUET TAB 10-40MG	Non Preferred	PA
CADUET TAB 10-80MG	Non Preferred	PA
ENTRESTO TAB 24-26MG	Preferred	
ENTRESTO TAB 49-51MG	Preferred	
ENTRESTO TAB 97-103MG	Preferred	
<i>isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg (generic of BIDIL)</i>	Preferred	
<b>IMPOTENCE AGENTS</b>		
CIALIS TAB 5MG	Non Preferred	PA
<i>tadalafil tab 5 mg (generic of CIALIS)</i>	Non Preferred	PA
<b>PROSTAGLANDIN VASODILATORS</b>		
<i>epoprostenol sodium for inj 0.5 mg (generic of VELETRI)</i>	Preferred	SP, PA
<i>epoprostenol sodium for inj 1.5 mg (generic of VELETRI)</i>	Preferred	SP, PA
FLOLAN INJ 0.5MG	Preferred	SP, PA
FLOLAN INJ 1.5MG	Preferred	SP, PA
ORENITRAM TAB 0.25MG	Non Preferred	SP, PA
ORENITRAM TAB 0.125MG	Non Preferred	SP, PA
ORENITRAM TAB 1MG	Non Preferred	SP, PA
ORENITRAM TAB 2.5MG	Non Preferred	SP, PA
ORENITRAM TAB 5MG	Non Preferred	SP, PA
ORENITRAM TAB MONTH 1	Non Preferred	SP, PA
ORENITRAM TAB MONTH 2	Non Preferred	SP, PA
ORENITRAM TAB MONTH 3	Non Preferred	SP, PA
REMODULIN INJ 1MG/ML	Non Preferred	SP, PA
REMODULIN INJ 2.5MG/ML	Non Preferred	SP, PA
REMODULIN INJ 5MG/ML	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
REMODULIN INJ 10MG/ML	Non Preferred	SP, PA
<i>treprostinil inj soln 20 mg/20ml (1 mg/ml)</i>	Non Preferred	SP, PA
<i>treprostinil inj soln 50 mg/20ml (2.5 mg/ml)</i>	Non Preferred	SP, PA
<i>treprostinil inj soln 100 mg/20ml (5 mg/ml)</i>	Non Preferred	SP, PA
<i>treprostinil inj soln 200 mg/20ml (10 mg/ml)</i>	Non Preferred	SP, PA
TYVASO DPI POW 16-32-48	Non Preferred	SP, PA
TYVASO DPI POW 16-32MCG	Non Preferred	SP, PA
TYVASO DPI POW 16MCG	Non Preferred	SP, PA
TYVASO DPI POW 32-48MCG	Non Preferred	SP, PA
TYVASO DPI POW 32MCG	Non Preferred	SP, PA
TYVASO DPI POW 48MCG	Non Preferred	SP, PA
TYVASO DPI POW 64MCG	Non Preferred	SP, PA
TYVASO REFIL SOL 0.6MG/ML	Non Preferred	SP, PA
TYVASO SOL 0.6MG/ML	Non Preferred	SP, PA
TYVASO START SOL 0.6MG/ML	Non Preferred	SP, PA
VELETRI INJ 0.5MG	Non Preferred	SP, PA
VELETRI INJ 1.5MG	Non Preferred	SP, PA
VENTAVIS SOL 10MCG/ML	Non Preferred	SP, PA
VENTAVIS SOL 20MCG/ML	Non Preferred	SP, PA

### **PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS**

<i>ambrisentan tab 5 mg (generic of LETAIRIS)</i>	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>ambrisentan tab 10 mg (generic of LETAIRIS)</i>	Non Preferred	SP, PA, QL (1 tab every 1 day)
<i>bosentan tab 62.5 mg (generic of TRACLEER)</i>	Non Preferred	SP, PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>bosentan tab 125 mg</i> (generic of TRACLEER)	Non Preferred	SP, PA, QL (2 tabs every 1 day)
LETAIRIS TAB 5MG	Preferred	SP, PA, QL (1 tab every 1 day)
LETAIRIS TAB 10MG	Preferred	SP, PA, QL (1 tab every 1 day)
OPSUMIT TAB 10MG	Non Preferred	SP, PA, QL (1 tab every 1 day)
TRACLEER TAB 32MG	Preferred	SP, PA
TRACLEER TAB 62.5MG	Preferred	SP, PA, QL (2 tabs every 1 day)
TRACLEER TAB 125MG	Preferred	SP, PA, QL (2 tabs every 1 day)

### **PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS**

ADCIRCA TAB 20MG	Preferred	SP, PA
<i>alyq tab 20mg</i> (generic of ADCIRCA)	Preferred	SP, PA
REVATIO INJ	Non Preferred	SP, PA
REVATIO SUS 10MG/ML	Preferred	SP, PA
REVATIO TAB 20MG	Non Preferred	SP, PA, QL (3 tabs every 1 day)
<i>sildenafil citrate for suspension 10 mg/ml</i> (generic of REVATIO)	Non Preferred	SP, PA
<i>sildenafil citrate iv soln 10 mg/12.5ml</i> (base equivalent) (generic of REVATIO)	Non Preferred	SP, PA
<i>sildenafil citrate tab 20 mg</i> (generic of REVATIO)	Preferred	SP, PA, QL (3 tabs every 1 day)
<i>tadalafil tab 20 mg (pah)</i> (generic of ADCIRCA)	Preferred	SP, PA
TADLIQ SUS 20MG/5ML	Non Preferred	SP, PA

### **PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST**

UPTRAVI INJ 1800MCG	Non Preferred	SP, PA
UPTRAVI PACK TAB 200/800	Non Preferred	SP, PA
UPTRAVI TAB 200MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 400MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 600MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 800MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1000MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
UPTRAVI TAB 1200MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1400MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1600MCG	Non Preferred	SP, PA, QL (2 tabs every 1 day)

***PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR***

ADEMPAS TAB 0.5MG	Non Preferred	SP, PA
ADEMPAS TAB 1.5MG	Non Preferred	SP, PA
ADEMPAS TAB 1MG	Non Preferred	SP, PA
ADEMPAS TAB 2.5MG	Non Preferred	SP, PA
ADEMPAS TAB 2MG	Non Preferred	SP, PA

***SINUS NODE INHIBITORS***

CORLANOR SOL 5MG/5ML	Non Preferred	PA
CORLANOR TAB 5MG	Non Preferred	PA
CORLANOR TAB 7.5MG	Non Preferred	PA

***TRANSTHYRETIN STABILIZERS***

VYNDAMAX CAP 61MG	Non Preferred	SP, PA
VYNDAQEL CAP 20MG	Non Preferred	SP, PA

***VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)***

VERQUVO TAB 2.5MG	Preferred	PA
VERQUVO TAB 2.5MG	Non Preferred	PA
VERQUVO TAB 5MG	Preferred	PA
VERQUVO TAB 5MG	Non Preferred	PA
VERQUVO TAB 10MG	Preferred	PA
VERQUVO TAB 10MG	Non Preferred	PA

***CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS***

***CEPHALOSPORINS - 1ST GENERATION***

<i>cefadroxil cap 500 mg</i>	Preferred	
<i>cefadroxil for susp 250 mg/5ml</i>	Preferred	
<i>cefadroxil for susp 500 mg/5ml</i>	Preferred	
<i>cefadroxil tab 1 gm</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cefazolin sodium for inj 1 gm</i>	Preferred	
<i>cefazolin sodium for inj 10 gm</i>	Preferred	
<i>cephalexin cap 250 mg</i>	Preferred	QL (6 caps every 1 day)
<i>cephalexin cap 500 mg</i>	Preferred	QL (6 caps every 1 day)
<i>cephalexin cap 750 mg</i>	Preferred	
<i>cephalexin for susp 125 mg/5ml</i>	Preferred	
<i>cephalexin for susp 250 mg/5ml</i>	Preferred	
<i>cephalexin tab 250 mg</i>	Preferred	
<i>cephalexin tab 500 mg</i>	Preferred	

### **CEPHALOSPORINS - 2ND GENERATION**

<i>cefaclor cap 250 mg</i>	Preferred	
<i>cefaclor cap 500 mg</i>	Preferred	
CEFACLOR ER TAB 500MG	Non	PA
	Preferred	
<i>cefaclor for susp 125 mg/5ml</i>	Preferred	
<i>cefaclor for susp 375 mg/5ml</i>	Preferred	
<i>cefprozil for susp 125 mg/5ml</i>	Preferred	
<i>cefprozil for susp 250 mg/5ml</i>	Preferred	
<i>cefprozil tab 250 mg</i>	Non	PA
	Preferred	
<i>cefprozil tab 500 mg</i>	Non	PA
	Preferred	
<i>cefuroxime axetil tab 250 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>cefuroxime axetil tab 500 mg</i>	Preferred	QL (2 tabs every 1 day)

### **CEPHALOSPORINS - 3RD GENERATION**

<i>cefdinir cap 300 mg</i>	Preferred	QL (2 caps every 1 day)
<i>cefdinir for susp 125 mg/5ml</i>	Preferred	
<i>cefdinir for susp 250 mg/5ml</i>	Preferred	
<i>cefixime cap 400 mg (generic of SUPRAX)</i>	Preferred	
<i>cefixime for susp 100 mg/5ml</i>	Non	PA
	Preferred	
<i>cefixime for susp 200 mg/5ml (generic of SUPRAX)</i>	Non	PA
	Preferred	
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	Non	PA
	Preferred	
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	Non	PA
	Preferred	
<i>cefpodoxime proxetil tab 100 mg</i>	Non	PA
	Preferred	
<i>cefpodoxime proxetil tab 200 mg</i>	Non	PA
	Preferred	
<i>ceftazidime for iv soln 2 gm</i>	Preferred	
<i>ceftriaxone sodium for inj 1 gm</i>	Preferred	
<i>ceftriaxone sodium for inj 2 gm</i>	Preferred	
<i>ceftriaxone sodium for inj 10 gm</i>	Preferred	
<i>ceftriaxone sodium for inj 250 mg</i>	Preferred	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ceftriaxone sodium for inj 500 mg</i>	Preferred	
<i>ceftriaxone sodium for iv soln 1 gm</i>	Preferred	
<i>ceftriaxone sodium for iv soln 2 gm</i>	Preferred	
SUPRAX CHW 100MG	Non Preferred	PA
SUPRAX CHW 200MG	Non Preferred	PA
SUPRAX SUS 200/5ML	Non Preferred	PA
<i>tazicef inj 2gm</i>	Preferred	

### **CEPHALOSPORINS - 4TH GENERATION**

<i>cefepime hcl for inj 1 gm</i>	Preferred	
<i>cefepime hcl for iv soln 2 gm</i>	Preferred	

### **CHEMICALS - PRODUCTS FOR DRUG COMPOUNDING**

#### **LIQUIDS**

BENZYL BENZO LIQ	Preferred	AGE (Min 16, Max 60)
BENZYL BENZO LIQ	Preferred	OTC; AGE (Min 16, Max 60)
SESAME OIL	Preferred	
SESAME OIL	Preferred	OTC

### **CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL**

#### **COMBINATION CONTRACEPTIVES - ORAL**

<i>afirmelle tab 0.1-0.02</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>altavera tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>alyacen tab 1/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>alyacen tab 7/7/7</i>	Preferred	AGE (Min 10, Max 55)
<i>amethia tab</i> (generic of SEASONIQUE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>amethyst tab 90-20mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>apri tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>aranelle tab</i>	Preferred	AGE (Min 10, Max 55)
<i>ashlyna tab</i> (generic of SEASONIQUE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>aubra eq tab 0.1-0.02</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>aurovela 24 tab fe 1/20</i>	Preferred	AGE (Min 10, Max 55)
<i>aurovela fe tab 1.5/30</i>	Preferred	AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>aurovela fe tab 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>aurovela tab 1.5/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>aurovela tab 1/20</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>aviane tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>ayuna tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>azurette tab</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
BALCOLTRA TAB 0.1-20	Preferred	AGE (Min 10, Max 55)
<i>balziva tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
BEYAZ TAB	Preferred	AGE (Min 10, Max 55)
<i>blisovi 24 tab fe 1/20</i>	Preferred	AGE (Min 10, Max 55)
<i>blisovi fe tab 1.5/30</i>	Preferred	AGE (Min 10, Max 55)
<i>blisovi fe tab 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>briellyn tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>camrese lo tab</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>camrese tab</i> (generic of SEASONIQUE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>charlotte 24 chw fe 1/20</i> (generic of MINASTRIN 24 FE)	Preferred	AGE (Min 10, Max 55)
<i>chateal eq tab 0.15/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>cryselle-28 tab 28 tabs</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>cyred eq tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>cyred tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dasetta tab 1/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>dasetta tab 7/7/7</i>	Preferred	AGE (Min 10, Max 55)
<i>daysee tab</i> (generic of SEASONIQUE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>desogest-eth estrad &amp; eth estrad tab 0.15-0.02/0.01 mg(21/5)</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>dolishale tab 90-20mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</i> (generic of BEYAZ)	Preferred	AGE (Min 10, Max 55)
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i> (generic of SAFYRAL)	Preferred	AGE (Min 10, Max 55)
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i> (generic of YAZ)	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i> (generic of YASMIN 28)	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>elinest tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>enpresse-28 tab</i>	Preferred	AGE (Min 10, Max 55)
<i>enskyce tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>estarylla tab 0.25-35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-35 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-50 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>falmina tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>fayosim tab</i> (generic of QUARTETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>finzala chw fe 1/20</i> (generic of MINASTRIN 24 FE)	Preferred	AGE (Min 10, Max 55)
<i>gemmily cap 1/20</i> (generic of TAYTULLA)	Preferred	AGE (Min 10, Max 55)
<i>hailey 24 tab fe</i>	Preferred	AGE (Min 10, Max 55)
<i>hailey fe tab 1.5/30</i>	Preferred	AGE (Min 10, Max 55)
<i>hailey fe tab 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hailey tab 1.5/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>iclevia tab</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>introvale tab</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>isibloom tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>jaimiess tab</i> (generic of SEASONIQUE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>jasmiel tab 3-0.02mg</i> (generic of YAZ)	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>jolessa tab</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>juleber tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>junel 1.5/30 tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>junel 1/20 tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>junel fe 24 tab 1/20</i>	Preferred	AGE (Min 10, Max 55)
<i>junel fe tab 1.5/30</i>	Preferred	AGE (Min 10, Max 55)
<i>junel fe tab 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>kaitlib fe chw</i> (generic of GENERESS FE)	Preferred	AGE (Min 10, Max 55)
<i>kalliga tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>kariva tab 28 day</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>kelnor 1/50 tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>kelnor tab 1/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>kurvelo tab 0.15/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>larin 24 tab fe 1/20</i>	Preferred	AGE (Min 10, Max 55)
<i>larin fe tab 1.5/30</i>	Preferred	AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>larin fe tab 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>larin tab 1.5/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>larin tab 1/20</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>layolis fe chw (generic of GENERESS FE)</i>	Preferred	AGE (Min 10, Max 55)
<i>leena tab</i>	Preferred	AGE (Min 10, Max 55)
<i>lessina tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>levonest tab</i>	Preferred	AGE (Min 10, Max 55)
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &amp; eth est 0.01 mg (generic of QUARTETTE)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>levonorg-eth est tab 0.1-0.02mg(84) &amp; eth est tab 0.01mg(7)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>levonorg-eth est tab 0.15-0.03mg(84) &amp; eth est tab 0.01mg(7) (generic of SEASONIQUE)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>levonorgestrel &amp; ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-20 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>levonorgestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>levora-28 tab 0.15/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<b>LO LOESTRIN TAB 1-10-10</b>	Preferred	AGE (Min 10, Max 55)
<i>lo-zumandimi tab 3-0.02mg (generic of YAZ)</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>loestrin 21 tab 1.5/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>loestrin fe tab 1.5/30</i>	Preferred	AGE (Min 10, Max 55)
<i>loestrin fe tab 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>loestrin tab 1/20-21</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>lojaimiess tab</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>loryna tab 3-0.02mg (generic of YAZ)</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
LOSEASONIQUE TAB	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>low-ogestrel tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>lutera tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>marlissa tab 0.15/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>merzee cap 1/20 (generic of TAYTULLA)</i>	Preferred	AGE (Min 10, Max 55)
<i>micrgstin 24 tab fe 1/20</i>	Preferred	AGE (Min 10, Max 55)
<i>microgestin tab 1.5/30</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>microgestin tab 1/20</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>microgestin tab fe1.5/30</i>	Preferred	AGE (Min 10, Max 55)
<i>microgestin tab fe 1/20</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>mili tab 0.25/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
MINASTRIN 24 CHW FE	Preferred	AGE (Min 10, Max 55)
MIRCETTE TAB 28 DAY	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>mono-lynyah tab 0.25-35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
NATAZIA TAB	Preferred	AGE (Min 10, Max 55)
<i>necon tab 0.5/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
NEXTSTELLIS TAB 3-14.2MG	Preferred	AGE (Min 10, Max 55)
<i>nikki tab 3-0.02mg (generic of YAZ)</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>norethindrone &amp; ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>norethindrone &amp; ethinyl estradiol-fe chew tab 0.8 mg-25 mcg (generic of GENERESS FE)</i>	Preferred	AGE (Min 10, Max 55)
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>norethindrone ace &amp; ethinyl estradiol tab 1 mg-20 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>norethindrone ace &amp; ethinyl estradiol tab 1.5 mg-30 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>norethindrone ace &amp; ethinyl estradiol-fe tab 1 mg-20 mcg</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>norethindrone ace &amp; ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24) (generic of MINASTRIN 24 FE)</i>	Preferred	AGE (Min 10, Max 55)
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24) (generic of TAYTULLA)</i>	Preferred	AGE (Min 10, Max 55)
<i>norgestimate &amp; ethinyl estradiol tab 0.25 mg-35 mcg</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	Preferred	AGE (Min 10, Max 55)
<i>nortrel tab 0.5/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>nortrel tab 1/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>nortrel tab 7/7/7</i>	Preferred	AGE (Min 10, Max 55)
<i>nylia tab 1/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>nylia tab 7/7/7</i>	Preferred	AGE (Min 10, Max 55)
<i>nymyo tab 0.25-35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>ocella tab 3-0.03mg (generic of YASMIN 28)</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>philith tab 0.4-35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pimtreea tab</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>pirmella tab 1/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>pirmella tab 7/7/7</i>	Preferred	AGE (Min 10, Max 55)
<i>portia-28 tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
QUARTETTE TAB	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>reclipsen tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>rivelsa tab</i> (generic of QUARTETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
SAFYRAL TAB	Preferred	AGE (Min 10, Max 55)
SEASONIQUE TAB	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>setlakin tab</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>simliya tab 28 day</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>simpesse tab</i> (generic of SEASONIQUE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>sprintec 28 tab 28 day</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>sronyx tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>syeda tab 3-0.03mg</i> (generic of YASMIN 28)	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>tarina 24 fe tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tarina fe tab 1/20 eq</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>taysofy cap 1/20</i> (generic of TAYTULLA)	Preferred	AGE (Min 10, Max 55)
TAYTULLA CAP 1MG/20MC	Preferred	AGE (Min 10, Max 55)
<i>tilia fe tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-estaryll tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-legest tab fe</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-linyah tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-lo tab estaryll</i> (generic of ORTHO TRI-CYCLEN LO)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>tri-lo- tab marzia</i> (generic of ORTHO TRI-CYCLEN LO)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tri-lo- tab sprintec</i> (generic of ORTHO TRI-CYCLEN LO)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>tri-lo-mili tab</i> (generic of ORTHO TRI-CYCLEN LO)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>tri-mili tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-nymyo tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-sprintec tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-vylibra tab</i>	Preferred	AGE (Min 10, Max 55)
<i>tri-vylibra tab lo</i> (generic of ORTHO TRI-CYCLEN LO)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>trivora-28 tab</i>	Preferred	AGE (Min 10, Max 55)
TYBLUME CHW 0.1-0.02	Preferred	QL (1.34 ea every 1 day); AGE (Min 10, Max 55)
<i>tydemy tab</i> (generic of SAFYRAL)	Preferred	AGE (Min 10, Max 55)
<i>velivet pak</i>	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>vestura tab 3-0.02mg</i> (generic of YAZ)	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>vienva tab 0.1-20</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>viorele tab</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>volnea tab</i> (generic of MIRCETTE)	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
<i>vyfemla tab 0.4-35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>vylibra tab 0.25-35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>wera tab 0.5/35</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>wymzya fe chw 0.4mg-35</i>	Preferred	AGE (Min 10, Max 55)
YASMIN 28 TAB 3-0.03MG	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
YAZ TAB 3-0.02MG	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)
<i>zovia 1/35 tab</i>	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>zumandimine tab 3-0.03mg</i> (generic of YASMIN 28)	Preferred	QL (1.34 tabs every 1 day); AGE (Min 10, Max 55)

### **COMBINATION CONTRACEPTIVES - TRANSDERMAL**

TWIRLA DIS 120-30	Preferred	AGE (Min 10, Max 55)
<i>xulane dis 150-35</i>	Preferred	QL (0.143 patches every 1 day); AGE (Min 10, Max 55)
<i>zafemy dis 150/35</i>	Preferred	QL (0.143 patches every 1 day); AGE (Min 10, Max 55)

### **COMBINATION CONTRACEPTIVES - VAGINAL**

ANNOVERA MIS	Preferred	AGE (Min 10, Max 55)
<i>eluryng mis</i> (generic of NUVARING)	Preferred	QL (0.05 rings every 1 day); AGE (Min 10, Max 55)
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i> (generic of NUVARING)	Preferred	QL (0.05 rings every 1 day); AGE (Min 10, Max 55)
<i>haloette mis</i> (generic of NUVARING)	Preferred	QL (0.05 rings every 1 day); AGE (Min 10, Max 55)
NUVARING MIS	Preferred	QL (0.05 rings every 1 day); AGE (Min 10, Max 55)

### **COPPER CONTRACEPTIVES - IUD**

PARAGARD IUD T380A	Preferred	
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### **EMERGENCY CONTRACEPTIVES**

ELLA TAB 30MG	Preferred	QL (4 tabs every 28 days); AGE (Min 10, Max 55)
<i>levonorgestrel tab 1.5 mg</i>	Preferred	QL (4 tabs every 28 days), OTC

### **PROGESTIN CONTRACEPTIVES - IMPLANTS**

NEXPLANON IMP 68MG	Preferred	
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### **PROGESTIN CONTRACEPTIVES - INJECTABLE**

DEPO-PROVERA INJ 150MG/ML	Preferred	QL (0.012 injections every 1 day); AGE (Min 10, Max 55)
DEPO-PROVERA INJ 150MG/ML	Preferred	QL (1 injection every 71 days); AGE (Min 10, Max 55)
DEPO-SQ PROV INJ 104	Preferred	AGE (Min 10, Max 55)
<i>medroxyprogesterone acetate im susp 150 mg/ml</i> (generic of DEPO-PROVERA CONTRACEPTIV)	Preferred	QL (1 injection every 71 days); AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>medroxyprogesterone acetate im susp prefilled syr 150 mg/ml (generic of DEPO-PROVERA CONTRACEPTIV)</i>	Preferred	QL (0.012 injections every 1 day); AGE (Min 10, Max 55)

### **PROGESTIN CONTRACEPTIVES - IUD**

KYLEENA IUD 19.5MG	Preferred	
LILETTA IUD 52MG	Preferred	
MIRENA IUD SYSTEM	Preferred	
SKYLA IUD 13.5MG	Preferred	

### **PROGESTIN CONTRACEPTIVES - ORAL**

<i>camila tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>deblitane tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>errin tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>heather tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>incassia tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>jencycla tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>lyleq tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>lyza tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>nora-be tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
<i>norethindrone tab 0.35 mg</i>	Preferred	AGE (Min 10, Max 55)
<i>sharobel tab 0.35mg</i>	Preferred	AGE (Min 10, Max 55)
SLYND TAB 4MG	Preferred	AGE (Min 10, Max 55)

## **CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE**

### **GLUCOCORTICOSTEROIDS**

ALKINDI SPRI CAP 0.5MG	Non Preferred	SP, PA
ALKINDI SPRI CAP 1MG	Non Preferred	SP, PA
ALKINDI SPRI CAP 2MG	Non Preferred	SP, PA
ALKINDI SPRI CAP 5MG	Non Preferred	SP, PA
<i>budesonide delayed release particles cap 3 mg</i>	Non Preferred	PA
<i>budesonide tab er 24hr 9 mg (generic of UCERIS)</i>	Non Preferred	PA
CORTEF TAB 5MG	Non Preferred	PA, QL (24 tabs every 1 day)
CORTEF TAB 10MG	Non Preferred	PA, QL (12 tabs every 1 day)
CORTEF TAB 20MG	Non Preferred	PA, QL (6 tabs every 1 day)
CORTISONE TAB 25MG	Non Preferred	PA
DEXAMETHASON CON 1MG/ML	Preferred	
<i>dexamethasone elixir 0.5 mg/5ml</i>	Preferred	QL (60 mL every 1 day)
<i>dexamethasone soln 0.5 mg/5ml</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dexamethasone tab 0.5 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>dexamethasone tab 0.75 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dexamethasone tab 1 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dexamethasone tab 1.5 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dexamethasone tab 2 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dexamethasone tab 4 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dexamethasone tab 6 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	Preferred	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	Preferred	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	Preferred	
EMFLAZA SUS 22.75/ML	Non Preferred	SP, PA
EMFLAZA TAB 6MG	Non Preferred	SP, PA
EMFLAZA TAB 18MG	Non Preferred	SP, PA
EMFLAZA TAB 30MG	Non Preferred	SP, PA
EMFLAZA TAB 36MG	Non Preferred	SP, PA
HEMADY TAB 20MG	Non Preferred	PA
<i>hydrocortisone tab 5 mg (generic of CORTEF)</i>	Preferred	QL (24 tabs every 1 day)
<i>hydrocortisone tab 10 mg (generic of CORTEF)</i>	Preferred	QL (12 tabs every 1 day)
<i>hydrocortisone tab 20 mg</i>	Preferred	QL (6 tabs every 1 day)
MEDROL TAB 2MG	Non Preferred	PA
MEDROL TAB 4MG	Non Preferred	PA, QL (12 tabs every 1 day)
MEDROL TAB 8MG	Non Preferred	PA, QL (6 tabs every 1 day)
MEDROL TAB 16MG	Non Preferred	PA, QL (4 tabs every 1 day)
<i>methylprednisolone tab 4 mg (generic of MEDROL)</i>	Preferred	QL (12 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylprednisolone tab 8 mg</i> (generic of MEDROL)	Preferred	QL (6 tabs every 1 day)
<i>methylprednisolone tab 16 mg</i> (generic of MEDROL)	Preferred	QL (4 tabs every 1 day)
<i>methylprednisolone tab 32 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>methylprednisolone tab therapy pack 4 mg (21)</i> (generic of MEDROL DOSEPAK)	Preferred	QL (12 tabs every 1 day)
<i>millipred tab 5mg</i>	Preferred	
ORTIKOS CAP 6MG ER	Non Preferred	PA
ORTIKOS CAP 9MG ER	Non Preferred	PA
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	Non Preferred	PA
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	Non Preferred	PA
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	Non Preferred	PA
<i>prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)</i> (generic of PEDIAPRED)	Preferred	
<i>prednisolone sod phosphate oral soln 10 mg/5ml (base equiv)</i>	Preferred	
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	Preferred	
<i>prednisolone sod phosphate oral soln 20 mg/5ml (base equiv)</i>	Preferred	
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	Preferred	
<i>prednisolone soln 15 mg/5ml</i>	Preferred	
<i>prednisolone tab 5 mg</i>	Preferred	
PREDNISONO CON 5MG/ML	Preferred	
<i>prednisone oral soln 5 mg/5ml</i>	Preferred	QL (60 mL every 1 day)
<i>prednisone tab 1 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>prednisone tab 2.5 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>prednisone tab 5 mg</i>	Preferred	QL (16 tabs every 1 day)
<i>prednisone tab 10 mg</i>	Preferred	QL (9 tabs every 1 day)
<i>prednisone tab 20 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>prednisone tab 50 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>prednisone tab therapy pack 5 mg (21)</i>	Preferred	
<i>prednisone tab therapy pack 5 mg (48)</i>	Preferred	
<i>prednisone tab therapy pack 10 mg (21)</i>	Preferred	
<i>prednisone tab therapy pack 10 mg (48)</i>	Preferred	
RAYOS TAB 1MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RAYOS TAB 2MG	Non Preferred	PA
RAYOS TAB 5MG	Non Preferred	PA
<i>taperdex pak 6 day</i>	Non Preferred	PA
<i>taperdex pak 7-day</i>	Non Preferred	PA
<i>taperdex pak 12-day</i>	Non Preferred	PA
TARPEYO CAP 4MG	Non Preferred	PA
UCERIS TAB 9MG	Non Preferred	PA

### **MINERALOCORTICIDS**

<i>fludrocortisone acetate tab 0.1 mg</i>	Preferred	QL (5 tabs every 1 day)
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## **COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS**

### **ANTITUSSIVES**

<i>benzonatate cap 100 mg</i>	Preferred	QL (6 caps every 1 day)
<i>benzonatate cap 200 mg</i>	Preferred	QL (5 caps every 1 day)
<i>cough relief liq 15mg/5ml</i>	Preferred	OTC

### **COUGH/COLD/ALLERGY COMBINATIONS**

<i>aller/conges tab 10-240mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>allergy rel/ tab deconges</i>	Preferred	QL (1 tab every 1 day), OTC
<i>allergy relf tab d-24</i>	Preferred	QL (1 tab every 1 day), OTC
<i>allergy relf tab deconges</i>	Preferred	QL (1 tab every 1 day), OTC
<i>brompheniramine &amp; pseudoephedrine elixir 1-15 mg/5ml</i>	Preferred	QL (480 mL every 25 days), OTC
<i>cetirizine-pseudoephedrine tab er 12hr 5-120 mg</i>	Preferred	QL (2 tabs every 1 day), OTC; AGE (Min 4)
<i>chest conges tab 20-400mg</i>	Preferred	OTC
<i>chest conges tab relf dm</i>	Preferred	OTC
<i>dextromethorphan-guaifenesin liquid 10-100 mg/5ml</i>	Preferred	QL (240 mL every 25 days), OTC
<i>dextromethorphan-guaifenesin syrup 10-100 mg/5ml</i>	Preferred	QL (180 mL every 25 days), OTC
<i>dextromethorphan-guaifenesin tab 20-400 mg</i>	Preferred	OTC
<i>dextromethorphan-guaifenesin tab er 12hr 30-600 mg</i>	Preferred	QL (2 tabs every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dextromethorphan-guaifenesin tab er 12hr 60-1200 mg</i>	Preferred	OTC
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	Preferred	QL (60 mL every 1 day), OTC; AGE (Min 2)
<i>hm mucus dm tab 60-1200</i>	Preferred	OTC
<i>lorata-dine tab d 24hr</i>	Preferred	QL (1 tab every 1 day), OTC
<i>loratadine &amp; pseudoephedrine tab er 12hr 5-120 mg</i>	Preferred	QL (2 tabs every 1 day), OTC
<i>loratadine-d tab 10-240mg</i>	Preferred	QL (20 tabs every 5 days), OTC
<i>mucus dm max tab 60-1200</i>	Preferred	OTC
<i>mucus dm tab 60-1200</i>	Preferred	OTC
<i>mucus rel dm liq</i>	Preferred	OTC
<i>mucus rel dm liq 5-100/5</i>	Preferred	OTC
<i>mucus rel dm liq 20-400mg</i>	Preferred	OTC
<i>mucus relief liq 5-100mg</i>	Preferred	OTC
<i>mucus relief tab 60-1200</i>	Preferred	OTC
<i>mucus relief tab dm</i>	Preferred	OTC
<i>mucus rlf dm liq 20-400mg</i>	Preferred	OTC
<i>mucus-dm max tab 60-1200</i>	Preferred	OTC
<i>mucus/cough liq 5-100mg</i>	Preferred	OTC
<i>prometh vc syp 6.25-5/5</i>	Preferred	QL (60 mL every 1 day); AGE (Max 64)
<i>prometh vc/ syp codeine</i>	Preferred	QL (60 mL every 1 day); AGE (Min 2, Max 64)
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	Preferred	QL (240 mL every 25 days); AGE (Min 2, Max 64)
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	Preferred	QL (180 mL every 25 days); AGE (Min 4, Max 64)
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	Preferred	QL (60 mL every 1 day)
<i>pseudoephedrine-guaifenesin tab er 12hr 60-600 mg</i>	Preferred	QL (4 tabs every 1 day), OTC; AGE (Min 4)
<i>qc medifin tab dm</i>	Preferred	OTC
<i>sm tussin dm liq 5-100/5</i>	Preferred	OTC
<i>tab tussin tab dm</i>	Preferred	OTC
<i>tussin dm liq 5-100mg</i>	Preferred	OTC
<i>tussin dm liq 20-400mg</i>	Preferred	OTC
<i>tussin dm mx liq</i>	Preferred	OTC
<b>EXPECTORANTS</b>		
<i>guaifenesin liquid 100 mg/5ml</i>	Preferred	OTC; AGE (Min 4)
<i>guaifenesin tab 200 mg</i>	Preferred	OTC; AGE (Min 4)
<i>guaifenesin tab 400 mg</i>	Preferred	OTC; AGE (Min 4)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>guaifenesin tab er 12hr 600 mg</i>	Preferred	QL (2 tabs every 1 day), OTC

### **MISC. RESPIRATORY INHALANTS**

<i>nebusal neb 3%</i>	Preferred	
<i>pulmosal neb 7%</i>	Preferred	
<i>sodium chloride soln nebu 0.9%</i>	Preferred	
<i>sodium chloride soln nebu 3%</i>	Preferred	
<i>sodium chloride soln nebu 7%</i>	Preferred	

### **MUCOLYTICS**

<i>acetylcysteine inhal soln 20%</i>	Preferred	QL (4 vials every 1 day)
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## **DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS**

### **ACNE PRODUCTS**

ABSORICA CAP 10MG	Non Preferred	PA; AGE (Min 12)
ABSORICA CAP 20MG	Non Preferred	PA; AGE (Min 12)
ABSORICA CAP 25MG	Non Preferred	PA; AGE (Min 12)
ABSORICA CAP 30MG	Non Preferred	PA; AGE (Min 12)
ABSORICA CAP 35MG	Non Preferred	PA; AGE (Min 12)
ABSORICA CAP 40MG	Non Preferred	PA; AGE (Min 12)
ABSORICA LD CAP 8MG	Non Preferred	PA; AGE (Min 10, Max 20)
ABSORICA LD CAP 16MG	Non Preferred	PA; AGE (Min 10, Max 20)
ABSORICA LD CAP 24MG	Non Preferred	PA; AGE (Min 10, Max 20)
ABSORICA LD CAP 32MG	Non Preferred	PA; AGE (Min 10, Max 20)
ACANYA GEL 1.2-2.5%	Non Preferred	PA; AGE (Min 10, Max 20)
<i>acutane cap 10mg</i>	Non Preferred	PA; AGE (Min 12)
<i>acutane cap 20mg</i>	Non Preferred	PA; AGE (Min 12)
<i>acutane cap 30mg</i>	Non Preferred	PA; AGE (Min 12)
<i>acutane cap 40mg</i>	Non Preferred	PA; AGE (Min 12)
ACZONE GEL 7.5%	Non Preferred	PA; AGE (Min 10, Max 20)
ADAPAL/BEN P PAD 0.1-2.5%	Non Preferred	PA; AGE (Min 10, Max 20)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>adapalene cream 0.1%</i> (generic of DIFFERIN)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>adapalene gel 0.1%</i>	Preferred	QL (1.5 gm every 1 day), OTC; AGE (Min 10)
<i>adapalene gel 0.3%</i> (generic of DIFFERIN)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i> (generic of EPIDUO)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i> (generic of EPIDUO FORTE)	Non Preferred	PA; AGE (Min 10, Max 20)
ALTRENO LOT 0.05%	Non Preferred	PA; AGE (Min 10, Max 20)
<i>amneesteem cap 10mg</i>	Non Preferred	PA; AGE (Min 12)
<i>amneesteem cap 20mg</i>	Non Preferred	PA; AGE (Min 12)
<i>amneesteem cap 40mg</i>	Non Preferred	PA; AGE (Min 12)
AMZEEQ AER 4%	Non Preferred	PA; AGE (Min 10, Max 20)
ARAZLO LOT 0.045%	Non Preferred	PA; AGE (Min 10, Max 20)
ATRALIN GEL 0.05%	Non Preferred	PA, QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>avar cleanse liq 10-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>avita cre 0.025%</i> (generic of RETIN-A)	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>avita gel 0.025%</i>	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
BENZAMYCIN GEL 5-3%	Non Preferred	PA, QL (1.6 gm every 1 day); AGE (Min 10)
<i>benzoyl peroxide-erythromycin gel 5-3%</i> (generic of BENZAMYCIN)	Preferred	QL (1.6 gm every 1 day); AGE (Min 10)
<i>bp 10-1 emu</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>bp cleansing emu 10-4%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>claravis cap 10mg</i>	Non Preferred	PA; AGE (Min 12)
<i>claravis cap 20mg</i>	Non Preferred	PA; AGE (Min 12)
<i>claravis cap 30mg</i>	Non Preferred	PA; AGE (Min 12)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>claravis cap 40mg</i>	Non Preferred	PA; AGE (Min 12)
CLEOCIN-T LOT 1%	Non Preferred	PA, QL (10 mL every 1 day); AGE (Min 10)
<i>clindacin aer 1%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
CLINDACIN KIT ETZ 1%	Non Preferred	PA; AGE (Min 10, Max 20)
CLINDACIN KIT PAC 1%	Non Preferred	PA; AGE (Min 10, Max 20)
<i>clindacin mis etz 1%</i>	Preferred	QL (2 swabs every 1 day); AGE (Min 10)
<i>clindacin-p pad 1%</i>	Preferred	QL (2 pads every 1 day); AGE (Min 10)
CLINDAGEL GEL 1%	Non Preferred	PA, QL (2 mL every 1 day); AGE (Min 10)
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>clindamycin phosphate foam 1%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>clindamycin phosphate gel 1%</i>	Preferred	QL (2 mL every 1 day); AGE (Min 10)
<i>clindamycin phosphate lotion 1%</i> (generic of CLEOCIN-T)	Preferred	QL (10 mL every 1 day); AGE (Min 10)
<i>clindamycin phosphate soln 1%</i>	Preferred	QL (2 mL every 1 day); AGE (Min 10)
<i>clindamycin phosphate swab 1%</i>	Preferred	QL (2 swabs every 1 day); AGE (Min 10)
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i> (generic of ACANYA)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i> (generic of VELTIN)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>dapsone gel 5%</i> (generic of ACZONE)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>dapsone gel 7.5%</i> (generic of ACZONE)	Non Preferred	PA; AGE (Min 10, Max 20)
<i>ery pad 2%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
ERYGEL GEL 2%	Non Preferred	PA, QL (1 gm every 1 day); AGE (Min 10)
<i>erythromycin gel 2%</i> (generic of ERYGEL)	Preferred	QL (1 gm every 1 day); AGE (Min 10)
<i>erythromycin soln 2%</i>	Preferred	QL (15 mL every 1 day); AGE (Min 10)
FABIOR AER 0.1%	Non Preferred	PA; AGE (Min 10, Max 20)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>isotretinoin cap 10 mg</i> (generic of ABSORICA)	Non Preferred	PA; AGE (Min 12)
<i>isotretinoin cap 20 mg</i> (generic of ABSORICA)	Non Preferred	PA; AGE (Min 12)
<i>isotretinoin cap 25 mg</i> (generic of ABSORICA)	Non Preferred	PA; AGE (Min 12)
<i>isotretinoin cap 30 mg</i> (generic of ABSORICA)	Non Preferred	PA; AGE (Min 12)
<i>isotretinoin cap 35 mg</i> (generic of ABSORICA)	Non Preferred	PA; AGE (Min 12)
<i>isotretinoin cap 40 mg</i> (generic of ABSORICA)	Non Preferred	PA; AGE (Min 12)
KLARON LOT 10%	Non Preferred	PA, QL (118 mL every 25 days); AGE (Min 10, Max 20)
<i>neuac gel 1.2-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
ONEXTON GEL 1.2-3.75	Non Preferred	PA; AGE (Min 10, Max 20)
RETIN-A CRE 0.1%	Non Preferred	PA, QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
RETIN-A CRE 0.05%	Non Preferred	PA, QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
RETIN-A CRE 0.025%	Non Preferred	PA, QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
RETIN-A GEL 0.01%	Non Preferred	PA, QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
RETIN-A GEL 0.025%	Non Preferred	PA, QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
RETIN-A MICR GEL 0.1%	Non Preferred	PA; AGE (Min 10, Max 20)
RETIN-A MICR GEL 0.1%PUMP	Non Preferred	PA; AGE (Min 10, Max 20)
RETIN-A MICR GEL 0.04%	Non Preferred	PA; AGE (Min 10, Max 20)
RETIN-A MICR GEL 0.04%PMP	Non Preferred	PA; AGE (Min 10, Max 20)
RETIN-A MICR GEL 0.06%	Non Preferred	PA; AGE (Min 10, Max 20)
RETIN-A MICR GEL 0.08%	Non Preferred	PA; AGE (Min 10, Max 20)
SOD SUL/SULF EMU 10-5%	Non Preferred	PA; AGE (Min 10, Max 20)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sss 10-5 aer 10-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sss cre 10%-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium lotion 10% (acne)</i> (generic of KLARON)	Non Preferred	PA, QL (118 mL every 25 days); AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cleanser 9-4%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cleanser 9-4.5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cleanser 9.8-4.8%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cleanser 10-2%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cleanser 10-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cream 10-2%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur cream 10-5%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>sulfacetamide sodium w/ sulfur susp 8-4%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
SUMADAN KIT	Non Preferred	PA; AGE (Min 10, Max 20)
SUMADAN WASH LIQ 9-4.5%	Non Preferred	PA; AGE (Min 10, Max 20)
SUMADAN XLT KIT 9-4.5%	Non Preferred	PA; AGE (Min 10, Max 20)
SUMAXIN CP KIT	Non Preferred	PA; AGE (Min 10, Max 20)
SUMAXIN PAD 10-4%	Non Preferred	PA; AGE (Min 10, Max 20)
TAZAROTENE AER 0.1%	Non Preferred	PA; AGE (Min 10, Max 20)
<i>tretinoin cream 0.1% (generic of RETIN-A)</i>	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>tretinoin cream 0.05% (generic of RETIN-A)</i>	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>tretinoin cream 0.025% (generic of RETIN-A)</i>	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tretinoin gel 0.01%</i> (generic of RETIN-A)	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>tretinoin gel 0.05%</i> (generic of ATRALIN)	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>tretinoin gel 0.025%</i> (generic of RETIN-A)	Preferred	QL (1.5 gm every 1 day); AGE (Min 10, Max 35)
<i>tretinoin microsphere gel 0.1%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
<i>tretinoin microsphere gel 0.04%</i>	Non Preferred	PA; AGE (Min 10, Max 20)
WINLEVI CRE 1%	Non Preferred	PA; AGE (Min 10, Max 20)
<i>zenatane cap 10mg</i>	Non Preferred	PA; AGE (Min 12)
<i>zenatane cap 20mg</i>	Non Preferred	PA; AGE (Min 12)
<i>zenatane cap 30mg</i>	Non Preferred	PA; AGE (Min 12)
<i>zenatane cap 40mg</i>	Non Preferred	PA; AGE (Min 12)
ZIANA GEL	Non Preferred	PA; AGE (Min 10, Max 20)
ZMA CLEAR SUS 9-4.5%	Non Preferred	PA; AGE (Min 10, Max 20)

### **AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS**

VEREGEN OIN 15%	Non Preferred	PA
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### **ANTI-INFLAMMATORY AGENTS - TOPICAL**

<i>arthr pain gel 1%</i>	Preferred	QL (100 gm every 25 days), OTC
DERMACINRX PAK LEXITRAL	Non Preferred	PA
<i>diclofenac epolamine patch 1.3%</i>	Non Preferred	PA
<i>diclofenac sodium gel 1% (1.16% diethylamine equiv)</i>	Preferred	QL (100 gm every 25 days), OTC
<i>diclofenac sodium gel 1% (1.16% diethylamine equiv)</i>	Non Preferred	PA
<i>diclofenac sodium soln 1.5%</i>	Non Preferred	PA
<i>diclofenac sodium soln 2%</i> (generic of PENNSAID)	Non Preferred	PA
DICLOTREX II PAK	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DICLOTREX PAK	Non Preferred	PA
FLECTOR DIS 1.3%	Non Preferred	PA
<i>goodsense gel art pain</i>	Preferred	QL (100 gm every 25 days), OTC
LICART DIS 1.3%	Non Preferred	PA
PENNSAID SOL 2%	Non Preferred	PA
<i>qc diclofena gel 1%</i>	Preferred	QL (100 gm every 25 days), OTC
VENNGEL ONE KIT 1%	Non Preferred	PA
XRYLIX II PAK	Non Preferred	PA

### **ANTIBIOTICS - TOPICAL**

<i>bacitracin oint 500 unit/gm</i>	Preferred	OTC
<i>bacitracin zinc oint 500 unit/gm</i>	Preferred	OTC
<i>bacitracin-polymyxin b oint</i>	Preferred	OTC
<i>gentamicin sulfate cream 0.1%</i>	Preferred	QL (1 gm every 1 day)
<i>gentamicin sulfate oint 0.1%</i>	Preferred	QL (1 gm every 1 day)
<i>mupirocin calcium cream 2%</i>	Non Preferred	PA; AGE (Max 20)
<i>mupirocin oint 2%</i>	Preferred	
NEO-SYNALAR CRE	Non Preferred	PA
NEO-SYNALAR KIT	Non Preferred	PA
<i>neomycin-bacitracin-polymyxin oint</i>	Preferred	OTC
<i>neomycin-bacitracin-polymyxin-pramoxine oint 1%</i>	Preferred	OTC
XEPI CRE 1%	Non Preferred	PA

### **ANTIFUNGALS - TOPICAL**

<i>ciclodan sol 8%</i>	Non Preferred	PA, QL (6.6 mL every 25 days)
<i>ciclopirox gel 0.77%</i>	Non Preferred	PA
<i>ciclopirox kit 8%</i>	Non Preferred	PA
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	Non Preferred	PA, QL (180 gm every 30 days)
<i>ciclopirox olamine susp 0.77% (base equiv) (generic of LOPROX)</i>	Non Preferred	PA, QL (60 mL every 25 days)
<i>ciclopirox shampoo 1% (generic of LOPROX SHAMPOO)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ciclopirox solution 8%</i>	Non Preferred	PA, QL (6.6 mL every 25 days)
<i>clotrimazole cream 1%</i>	Preferred	QL (60 gm every 30 days)
<i>clotrimazole soln 1%</i>	Non Preferred	PA, QL (60 mL every 30 days)
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	Non Preferred	PA
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	Non Preferred	PA
<i>econazole nitrate cream 1%</i>	Preferred	
ERTACZO CRE 2%	Non Preferred	PA
EXELDERM CRE 1%	Non Preferred	PA
EXELDERM SOL 1%	Non Preferred	PA
JUBLIA SOL 10%	Non Preferred	PA
KERYDIN SOL 5%	Non Preferred	PA
<i>ketconazole cream 2%</i>	Preferred	QL (2 gm every 1 day)
<i>ketconazole foam 2%</i>	Non Preferred	PA
<i>ketconazole shampoo 2%</i>	Preferred	QL (4 mL every 1 day)
<i>ketodan aer 2%</i>	Non Preferred	PA
KETODAN KIT 2%	Non Preferred	PA
LOPROX KIT 0.77%	Non Preferred	PA
LOPROX SHA 1%	Non Preferred	PA
LOPROX SUS 0.77%	Non Preferred	PA, QL (60 mL every 25 days)
<i>luliconazole cream 1%</i>	Non Preferred	PA
LUZU CRE 1%	Non Preferred	PA
MENTAX CRE 1%	Non Preferred	PA
<i>miconazole nitrate aerosol pow 2%</i>	Preferred	QL (133 gm every 30 days), OTC
<i>miconazole nitrate cream 2%</i>	Preferred	OTC
<i>miconazole nitrate powder 2%</i>	Preferred	QL (90 gm every 30 days), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%</i>	Non Preferred	PA
<i>naftifine hcl cream 1%</i>	Non Preferred	PA
<i>naftifine hcl cream 2%</i>	Non Preferred	PA
<i>naftifine hcl gel 2% (generic of NAFTIN)</i>	Non Preferred	PA
NAFTIN GEL 1%	Non Preferred	PA
NAFTIN GEL 2%	Non Preferred	PA
<i>nystatin cream 100000 unit/gm</i>	Preferred	
<i>nystatin oint 100000 unit/gm</i>	Preferred	
<i>nystatin oint 100000 unit/gm</i>	Preferred	
<i>nystatin topical powder 100000 unit/gm</i>	Preferred	QL (30 gm every 25 days)
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	Non Preferred	PA
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	Non Preferred	PA
<i>oxiconazole nitrate cream 1% (generic of OXISTAT)</i>	Non Preferred	PA
OXISTAT LOT 1%	Non Preferred	PA
<i>sulconazole nitrate cream 1%</i>	Non Preferred	PA
<i>sulconazole nitrate solution 1%</i>	Non Preferred	PA
<i>tavorole soln 5% (generic of KERYDIN)</i>	Non Preferred	PA
<i>terbinafine hcl cream 1%</i>	Preferred	OTC
<i>tolnaftate aerosol pow 1%</i>	Preferred	QL (133 gm every 30 days), OTC
<i>tolnaftate cream 1%</i>	Preferred	QL (60 gm every 30 days), OTC
<i>tolnaftate powder 1%</i>	Preferred	QL (67.5 gm every 30 days), OTC
VUSION OIN	Non Preferred	PA
<b>ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL</b>		
AMELUZ GEL 10%	Non Preferred	PA
<i>bexarotene gel 1% (generic of TARGRETIN)</i>	Non Preferred	SP, PA
CARAC CRE 0.5%	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	Non Preferred	PA
EFUDEX CRE 5%	Non Preferred	PA
<i>fluorouracil cream 0.5%</i>	Non Preferred	PA
<i>fluorouracil cream 5% (generic of EFUDEX)</i>	Non Preferred	PA
<i>fluorouracil soln 2%</i>	Non Preferred	PA
<i>fluorouracil soln 5%</i>	Non Preferred	PA
LEVULAN KERA SOL 20%	Preferred	
TARGRETIN GEL 1%	Preferred	SP
VALCHLOR GEL 0.016%	Non Preferred	PA

### **ANTIPRURITICS - TOPICAL**

<i>doxepin hcl cream 5% (generic of PRUDOXIN)</i>	Non Preferred	PA
PRUDOXIN CRE 5%	Non Preferred	PA
ZONALON CRE 5%	Non Preferred	PA

### **ANTIPSORIATICS**

<i>acitretin cap 10 mg</i>	Non Preferred	PA
<i>acitretin cap 17.5 mg</i>	Non Preferred	PA
<i>acitretin cap 25 mg</i>	Non Preferred	PA
<i>calcipotriene cream 0.005%</i>	Preferred	
<i>calcipotriene foam 0.005%</i>	Non Preferred	PA
<i>calcipotriene oint 0.005%</i>	Preferred	
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	Preferred	
<i>calcitriol oint 3 mcg/gm</i>	Non Preferred	PA
COSENTYX INJ 75MG/0.5	Preferred	SP, PA
COSENTYX INJ 150MG/ML	Preferred	SP, PA
COSENTYX INJ 300DOSE	Preferred	SP, PA
COSENTYX PEN INJ 150MG/ML	Preferred	SP, PA
COSENTYX PEN INJ 300DOSE	Preferred	SP, PA
DOVONEX CRE 0.005%	Non Preferred	PA
ILUMYA SOL 100MG/ML	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methoxsalen rapid cap 10 mg</i>	Non Preferred	PA
SILIQ INJ 210/1.5	Non Preferred	SP, PA
SKYRIZI INJ 150MG/ML	Non Preferred	SP, PA
SKYRIZI PEN INJ 150MG/ML	Non Preferred	SP, PA
SORILUX AER 0.005%	Non Preferred	PA
SOTYKTU TAB 6MG	Non Preferred	SP, PA
STELARA INJ 45MG/0.5	Non Preferred	SP, PA
STELARA INJ 90MG/ML	Non Preferred	SP, PA
TALTZ INJ 80MG/ML	Non Preferred	SP, PA
<i>tazarotene cream 0.1% (generic of TAZORAC)</i>	Non Preferred	PA
<i>tazarotene gel 0.1% (generic of TAZORAC)</i>	Non Preferred	PA
<i>tazarotene gel 0.05% (generic of TAZORAC)</i>	Non Preferred	PA
TREMFYA INJ 100MG/ML	Non Preferred	SP, PA
VTAMA CRE 1%	Non Preferred	PA
ZORYVE CRE 0.3%	Non Preferred	PA
<b>ANTISEBORRHEIC PRODUCTS</b>		
<i>selenium sulfide lotion 1%</i>	Preferred	OTC
<i>selenium sulfide lotion 2.5%</i>	Preferred	
<i>selenium sulfide shampoo 2.3%</i>	Non Preferred	PA
<i>selenium sulfide shampoo 2.25%</i>	Non Preferred	PA
<i>sulfacetamide sodium cleansing gel 10%</i>	Non Preferred	PA
<i>sulfacetamide sodium liquid 10%</i>	Non Preferred	PA
<b>ANTIVIRALS - TOPICAL</b>		
<i>acyclovir cream 5% (generic of ZOVIRAX)</i>	Non Preferred	PA
<i>acyclovir oint 5% (generic of ZOVIRAX)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DENAVIR CRE 1%	Non Preferred	PA
<i>penciclovir cream 1% (generic of DENAVIR)</i>	Non Preferred	PA
XERESE CRE 5-1%	Non Preferred	PA
ZOVIRAX CRE 5%	Non Preferred	PA
ZOVIRAX OIN 5%	Non Preferred	PA

### **BURN PRODUCTS**

<i>mafenide acetate packet for topical soln 5% (50 gm) (generic of SULFAMYLON)</i>	Preferred	
SILVADENE CRE 1%	Non Preferred	PA
<i>silver sulfadiazine cream 1% (generic of SILVADENE)</i>	Preferred	
<i>ssd cre 1% (generic of SILVADENE)</i>	Preferred	
SULFAMYLON CRE 85MG/GM	Preferred	

### **CAUTERIZING AGENTS**

SILVER NITRA SOL 0.5%	Non Preferred	PA
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### **CORTICOSTEROIDS - TOPICAL**

<i>alclometasone dipropionate cream 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>alclometasone dipropionate oint 0.05%</i>	Preferred	QL (2 gm every 1 day)
APEXICON E CRE 0.05%	Non Preferred	PA
<i>betamethasone dipropionate augmented cream 0.05%</i>	Non Preferred	PA, QL (2 gm every 1 day)
<i>betamethasone dipropionate augmented gel 0.05%</i>	Non Preferred	PA, QL (2 gm every 1 day)
<i>betamethasone dipropionate augmented lotion 0.05%</i>	Non Preferred	PA, QL (60 mL every 25 days)
<i>betamethasone dipropionate augmented oint 0.05% (generic of DIPROLENE)</i>	Non Preferred	PA, QL (2 gm every 1 day)
<i>betamethasone dipropionate cream 0.05%</i>	Non Preferred	PA, QL (2 gm every 1 day)
<i>betamethasone dipropionate lotion 0.05%</i>	Non Preferred	PA, QL (60 mL every 25 days)
<i>betamethasone dipropionate oint 0.05%</i>	Non Preferred	PA, QL (2 gm every 1 day)
<i>betamethasone valerate aerosol foam 0.12% (generic of LUXIQ)</i>	Non Preferred	PA
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	Preferred	QL (2 gm every 1 day)
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	Preferred	QL (60 mL every 25 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	Preferred	QL (2 gm every 1 day)
BRYHALI LOT 0.01%	Non Preferred	PA
<i>calcipotriene-betamethasone dipropionate oint 0.005-0.064% (generic of TACLONEX)</i>	Non Preferred	PA
<i>calcipotriene-betamethasone dipropionate susp 0.005-0.064% (generic of TACLONEX)</i>	Non Preferred	PA
<i>clobetasol propionate cream 0.05%</i>	Preferred	
<i>clobetasol propionate emollient base cream 0.05%</i>	Preferred	
<i>clobetasol propionate emulsion foam 0.05% (generic of OLUX-E)</i>	Non Preferred	PA
<i>clobetasol propionate foam 0.05%</i>	Non Preferred	PA
<i>clobetasol propionate gel 0.05%</i>	Preferred	
<i>clobetasol propionate lotion 0.05% (generic of CLOBEX)</i>	Non Preferred	PA
<i>clobetasol propionate oint 0.05%</i>	Preferred	
<i>clobetasol propionate shampoo 0.05% (generic of CLOBEX)</i>	Non Preferred	PA
<i>clobetasol propionate soln 0.05%</i>	Preferred	QL (50 mL every 25 days)
<i>clobetasol propionate spray 0.05% (generic of CLOBEX)</i>	Non Preferred	PA
<i>clocortolone pivalate cream 0.1% (generic of CLODERM)</i>	Non Preferred	PA
CLODAN KIT 0.05%	Non Preferred	PA
<i>clodan sha 0.05% (generic of CLOBEX)</i>	Non Preferred	PA
CLODERM CRE 0.1%	Non Preferred	PA
DERMA-SMOOTH OIL /FS BODY	Non Preferred	PA, QL (4 mL every 1 day)
DERMA-SMOOTH OIL /FS SCLP	Non Preferred	PA, QL (4 mL every 1 day)
<i>desonide cream 0.05% (generic of DESOWEN)</i>	Preferred	QL (2 gm every 1 day)
<i>desonide lotion 0.05%</i>	Non Preferred	PA
<i>desonide oint 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>desoximetasone cream 0.05% (generic of TOPICORT)</i>	Non Preferred	PA
<i>desoximetasone cream 0.25% (generic of TOPICORT)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>desoximetasone gel 0.05%</i> (generic of TOPICORT)	Non Preferred	PA
<i>desoximetasone oint 0.05%</i> (generic of TOPICORT)	Non Preferred	PA
<i>desoximetasone oint 0.25%</i> (generic of TOPICORT)	Non Preferred	PA
<i>desoximetasone spray 0.25%</i> (generic of TOPICORT)	Non Preferred	PA
<i>diflorasone diacetate cream 0.05%</i>	Preferred	QL (60 gm every 25 days)
<i>diflorasone diacetate oint 0.05%</i>	Preferred	QL (60 gm every 25 days)
DIPROLENE OIN 0.05%	Non Preferred	PA, QL (2 gm every 1 day)
DUOBRII LOT	Non Preferred	PA
ENSTILAR AER	Non Preferred	PA
EPIFOAM AER 1%	Non Preferred	PA
<i>fluocinolone acetonide cream 0.01%</i>	Preferred	
<i>fluocinolone acetonide cream 0.025%</i> (generic of SYNALAR)	Preferred	QL (2 gm every 1 day)
<i>fluocinolone acetonide oil 0.01% (body oil)</i> (generic of DERMA-SMOOTHIE/FS BODY)	Preferred	QL (4 mL every 1 day)
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i> (generic of DERMA-SMOOTHIE/FS SCALP)	Preferred	QL (4 mL every 1 day)
<i>fluocinolone acetonide oint 0.025%</i> (generic of SYNALAR)	Preferred	QL (2 gm every 1 day)
<i>fluocinolone acetonide soln 0.01%</i> (generic of SYNALAR)	Preferred	
<i>fluocinonide cream 0.1%</i> (generic of VANOS)	Preferred	
<i>fluocinonide cream 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>fluocinonide emulsified base cream 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>fluocinonide gel 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>fluocinonide oint 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>fluocinonide soln 0.05%</i>	Preferred	QL (60 mL every 25 days)
FLUOPAR KIT	Non Preferred	PA
<i>flurandrenolide cream 0.05%</i>	Non Preferred	PA
<i>flurandrenolide lotion 0.05%</i>	Non Preferred	PA
<i>fluticasone propionate cream 0.05%</i>	Preferred	QL (2 gm every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluticasone propionate lotion 0.05%</i>	Non Preferred	PA
<i>fluticasone propionate oint 0.005%</i>	Preferred	QL (2 gm every 1 day)
<i>halcinonide cream 0.1%</i> (generic of HALOG)	Non Preferred	PA
HALOBETASOL AER 0.05%	Non Preferred	PA
<i>halobetasol propionate cream 0.05%</i>	Preferred	QL (2 gm every 1 day)
<i>halobetasol propionate oint 0.05%</i>	Preferred	QL (2 gm every 1 day)
HALOG CRE 0.1%	Non Preferred	PA
HALOG OIN 0.1%	Non Preferred	PA
HALOG SOL 0.1%	Non Preferred	PA
<i>hydrocortisone butyrate cream 0.1%</i>	Non Preferred	PA
<i>hydrocortisone butyrate hydrophilic lipo base cream 0.1%</i> (generic of LOCOID LIPOCREAM)	Non Preferred	PA
<i>hydrocortisone butyrate lotion 0.1%</i> (generic of LOCOID)	Non Preferred	PA
<i>hydrocortisone butyrate oint 0.1%</i>	Non Preferred	PA
<i>hydrocortisone butyrate soln 0.1%</i>	Non Preferred	PA
<i>hydrocortisone cream 0.5%</i>	Preferred	OTC
<i>hydrocortisone cream 1%</i>	Preferred	OTC
<i>hydrocortisone cream 1%- rx</i>	Preferred	
<i>hydrocortisone cream 2.5%</i>	Preferred	
<i>hydrocortisone lotion 1%</i>	Preferred	OTC
<i>hydrocortisone lotion 2.5%</i>	Preferred	QL (60 mL every 25 days)
<i>hydrocortisone oint 0.5%</i>	Preferred	OTC
<i>hydrocortisone oint 1%- rx</i>	Preferred	
<i>hydrocortisone oint 2.5%</i>	Preferred	
<i>hydrocortisone valerate cream 0.2%</i>	Preferred	
<i>hydrocortisone valerate oint 0.2%</i>	Preferred	
IMPEKLO LOT 0.05%	Non Preferred	PA
KENALOG AER SPRAY	Non Preferred	PA
LEXETTE AER 0.05%	Non Preferred	PA
LOCOID LIPO CRE 0.1%	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LOCOID LOT 0.1%	Non Preferred	PA
LUXIQ AER 0.12%	Non Preferred	PA
<i>mometasone furoate cream 0.1%</i>	Preferred	QL (2 gm every 1 day)
<i>mometasone furoate oint 0.1%</i>	Preferred	QL (2 gm every 1 day)
<i>mometasone furoate solution 0.1% (lotion)</i>	Preferred	QL (60 mL every 25 days)
OLUX-E AER 0.05%	Non Preferred	PA
PANDEL CRE 0.1%	Non Preferred	PA
RADIAURA CRE 3-0.5%	Non Preferred	PA
SYNALAR CRE 0.025%	Non Preferred	PA, QL (2 gm every 1 day)
SYNALAR KIT 0.025%	Non Preferred	PA
SYNALAR OIN 0.025%	Non Preferred	PA, QL (2 gm every 1 day)
SYNALAR SOL 0.01%	Non Preferred	PA
SYNALAR TS KIT 0.01%	Non Preferred	PA
TACLONEX OIN	Non Preferred	PA
TACLONEX SUS	Non Preferred	PA
TEXACORT SOL 2.5%	Non Preferred	PA
TOPICORT CRE 0.05%	Non Preferred	PA
TOPICORT CRE 0.25%	Non Preferred	PA
TOPICORT GEL 0.05%	Non Preferred	PA
TOPICORT OIN 0.05%	Non Preferred	PA
TOPICORT OIN 0.25%	Non Preferred	PA
TOPICORT SPR 0.25%	Non Preferred	PA
<i>tovet aer 0.05% (generic of OLUX-E)</i>	Non Preferred	PA
TOVET KIT KIT 0.05%	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>triamcinolone acetonide aerosol soln 0.147 mg/gm (generic of KENALOG)</i>	Non Preferred	PA
<i>triamcinolone acetonide cream 0.1%</i>	Preferred	
<i>triamcinolone acetonide cream 0.5%</i>	Preferred	
<i>triamcinolone acetonide cream 0.025%</i>	Preferred	
<i>triamcinolone acetonide lotion 0.1%</i>	Preferred	
<i>triamcinolone acetonide lotion 0.025%</i>	Preferred	
<i>triamcinolone acetonide oint 0.1%</i>	Preferred	
<i>triamcinolone acetonide oint 0.5%</i>	Preferred	
<i>triamcinolone acetonide oint 0.05%</i>	Non Preferred	PA
<i>triamcinolone acetonide oint 0.025%</i>	Preferred	
TRIASIL PAK	Non Preferred	PA
ULTRAVATE LOT 0.05%	Non Preferred	PA
VANOS CRE 0.1%	Non Preferred	PA

### **ECZEMA AGENTS**

ADBRY INJ 150MG/ML	Non Preferred	SP, PA
CIBINQO TAB 50MG	Non Preferred	PA
CIBINQO TAB 100MG	Non Preferred	PA
CIBINQO TAB 200MG	Non Preferred	PA
DUPIXENT INJ 100/0.67	Preferred	SP, PA
DUPIXENT INJ 100/0.67	Non Preferred	SP, PA
DUPIXENT INJ 200/1.14	Preferred	SP, PA
DUPIXENT INJ 200MG	Preferred	SP, PA
DUPIXENT INJ 200MG	Non Preferred	SP, PA
DUPIXENT INJ 300/2ML	Preferred	SP, PA
DUPIXENT INJ 300/2ML	Non Preferred	SP, PA
DUPIXENT SYRINGE 300/2ML	Preferred	SP, PA
OPZELURA CRE 1.5%	Non Preferred	PA

### **EMOLLIENT/KERATOLYTIC AGENTS**

UREA CRE 39.5%	Non Preferred	PA
<i>urea cre 41%</i>	Preferred	
<i>urea cream 39%</i>	Preferred	
<i>urea cream 40%</i>	Preferred	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>urea hydrati aer 35%</i>	Non Preferred	PA
<i>urea lotion 40%</i>	Preferred	

### **EMOLLIENTS**

<i>lactic acid (ammonium lactate) cream 12%</i>	Non Preferred	PA
<i>lactic acid (ammonium lactate) lotion 12%</i>	Preferred	QL (225 gm every 25 days)

### **IMMUNOMODULATING AGENTS - TOPICAL**

<i>imiquimod cream 3.75% (generic of ZYCLARA)</i>	Non Preferred	PA; AGE (Min 10)
<i>imiquimod cream 5%</i>	Preferred	QL (1 packet every 1 day); AGE (Min 10)
ZYCLARA CRE 3.75%	Non Preferred	PA; AGE (Min 10)
ZYCLARA PUMP CRE 2.5%	Non Preferred	PA; AGE (Min 10)
ZYCLARA PUMP CRE 3.75%	Non Preferred	PA; AGE (Min 10)

### **IMMUNOSUPPRESSIVE AGENTS - TOPICAL**

ELIDEL CRE 1%	Preferred	PA, QL (2 gm every 1 day)
HYFTOR GEL 0.2%	Non Preferred	PA
<i>pimecrolimus cream 1% (generic of ELIDEL)</i>	Preferred	PA, QL (2 gm every 1 day)
PROTOPIC OIN 0.1%	Preferred	PA
PROTOPIC OIN 0.03%	Preferred	PA
<i>tacrolimus oint 0.1%</i>	Preferred	PA
<i>tacrolimus oint 0.03%</i>	Preferred	PA

### **KERATOLYTIC/ANTIMITOTIC AGENTS**

BENSAL HP OIN	Non Preferred	PA
CONDYLOX GEL 0.5%	Preferred	
PODOCON-25 SOL	Non Preferred	PA
<i>podofilox soln 0.5%</i>	Preferred	QL (7 mL every 180 days)
<i>salicylic ac liq 27.5%</i>	Preferred	
SALICYLIC AC OIN 3%	Preferred	
<i>salicylic acid foam 6%</i>	Non Preferred	PA
<i>salicylic acid gel 6%</i>	Preferred	
UREA/SALICY CRE 39.5-2%	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>LOCAL ANESTHETICS - TOPICAL</b>		
<i>arth pain cre 0.075%</i>	Preferred	OTC
<i>capsaicin cream 0.1%</i>	Preferred	OTC
<i>capsaicin cream 0.025%</i>	Preferred	OTC
<i>dermacinrx cre penetral</i>	Preferred	OTC
<i>glydo gel 2%</i>	Preferred	
<i>lidocaine cream 4%</i>	Preferred	OTC
LIDOCAINE HC CRE 4.12%	Non Preferred	PA
<i>lidocaine hcl cream 3%</i>	Preferred	
<i>lidocaine hcl soln 4%</i>	Preferred	
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	Preferred	
<i>lidocaine oint 5%</i>	Preferred	
<i>lidocaine patch 4%</i>	Preferred	OTC
<i>lidocaine patch 5% (generic of LIDODERM)</i>	Preferred	QL (3 packets every 1 day)
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	Non Preferred	PA
<i>lidocaine-prilocaine cream kit 2.5-2.5%</i>	Non Preferred	PA
LIDODERM DIS 5%	Non Preferred	PA, QL (3 packets every 1 day)
LIDOGEL GEL 2.8%	Non Preferred	PA
LIDOREX GEL 2.8%	Non Preferred	PA
LIDOTRAL CRE 3.88%	Non Preferred	PA
LIDOTRAN CRE 3.88%	Non Preferred	PA
LYDEXA CRE 4.12%	Non Preferred	PA
PLIAGLIS CRE 7-7%	Non Preferred	PA
QUTENZA KIT 8% 1-PCH	Non Preferred	SP, PA
QUTENZA KIT 8% 2-PCH	Non Preferred	SP, PA
QUTENZA KIT 8% 4-PCH	Non Preferred	SP, PA
ZTLIDO PAD 1.8%	Non Preferred	PA
<b>MISC. DERMATOLOGICAL PRODUCTS</b>		
ALADERM PLUS EMU	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HYLATOPIC CRE PLUS	Non Preferred	PA
NUVAIL SOL 16%	Non Preferred	PA
TETRIX CRE	Non Preferred	PA
<b>MISC. TOPICAL</b>		
HYCLODEX SOL 0.012%	Non Preferred	PA
<i>minerin cre</i>	Preferred	OTC
QBREXZA PAD 2.4%	Non Preferred	PA
XERAC-AC SOL 6.25%	Non Preferred	PA
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL</b>		
EUCRISA OIN 2%	Preferred	PA
<b>ROSACEA AGENTS</b>		
<i>azelaic acid gel 15%</i> (generic of FINACEA)	Non Preferred	PA
<i>brimonidine tartrate gel 0.33%</i> (base equivalent) (generic of MIRVASO)	Non Preferred	PA
<i>doxycycline (rosacea) cap delayed release 40 mg</i>	Non Preferred	PA
FINACEA AER 15%	Non Preferred	PA
FINACEA GEL 15%	Non Preferred	PA
<i>ivermectin cream 1%</i> (generic of SOOLANTRA)	Non Preferred	PA
<i>metronidazole cream 0.75%</i> (generic of METROCREAM)	Preferred	
<i>metronidazole gel 0.75%</i>	Preferred	
<i>metronidazole gel 1%</i> (generic of METROGEL)	Preferred	
<i>metronidazole lotion 0.75%</i> (generic of METROLOTION)	Preferred	
NORITATE CRE 1%	Non Preferred	PA
RHOFADE CRE 1%	Non Preferred	PA
ZILXI AER 1.5%	Non Preferred	PA
<b>SCABICIDES &amp; PEDICULICIDES</b>		
<i>crotan lot 10%</i>	Non Preferred	PA
<i>goodsense liq lice rin</i>	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lice treatmt liq 1%</i>	Preferred	OTC
<i>lice trtmnt liq 1%</i>	Preferred	OTC
<i>lindane shampoo 1%</i>	Non Preferred	PA
<i>malathion lotion 0.5%</i>	Non Preferred	PA
NATROBA SUS 0.9%	Preferred	QL (8 mL every 1 day)
OVIDE LOT 0.5%	Non Preferred	PA
<i>permethrin aerosol 0.5%</i>	Preferred	OTC
<i>permethrin cream 5%</i>	Preferred	
<i>permethrin lotion 1%</i>	Preferred	OTC
<i>pyrethrins-piperonyl butoxide liq 0.33-4%</i>	Preferred	OTC
<i>pyrethrins-piperonyl butoxide shampoo 0.33-4%</i>	Preferred	OTC
<i>spinosad susp 0.9%</i>	Non Preferred	PA, QL (8 mL every 1 day)

## **DIAGNOSTIC PRODUCTS - PRODUCTS FOR DIAGNOSIS**

### **DIAGNOSTIC TESTS**

ACCU-CHEK TES AVIVA PL	Non Preferred	PA, QL (4 strips every 1 day), OTC
ACCU-CHEK TES GUIDE	Non Preferred	PA, QL (4 strips every 1 day), OTC
ACCU-CHEK TES SMART	Non Preferred	PA, QL (4 strips every 1 day), OTC
ACCUTREND TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
ACETONE (URINE) TEST STRIP	Preferred	OTC
ADVANCE TES INTUITIO	Non Preferred	PA, QL (4 strips every 1 day), OTC
ADVANCE TES MICRO-DW	Non Preferred	PA, QL (4 strips every 1 day), OTC
ADVOCATE TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
ADVOCATE TES REDI-COD	Non Preferred	PA, QL (4 strips every 1 day), OTC
ADVOCATE TES REDICODE	Non Preferred	PA, QL (4 strips every 1 day), OTC
AGAMATRIX TES AMP	Non Preferred	PA, QL (4 strips every 1 day), OTC
AGAMATRIX TES JAZZ	Non Preferred	PA, QL (4 strips every 1 day), OTC
AGAMATRIX TES KEYNOTE	Non Preferred	PA, QL (4 strips every 1 day), OTC
AGAMATRIX TES PRESTO	Non Preferred	PA, QL (4 strips every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ASSURE 3 TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
ASSURE 4 TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
ASSURE II TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
ASSURE II TES CHECK	Non Preferred	PA, QL (4 strips every 1 day), OTC
ASSURE PRISM TES MULTI	Non Preferred	PA, QL (4 strips every 1 day), OTC
ASSURE PRO TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
ASSURE TES PLATINUM	Non Preferred	PA, QL (4 strips every 1 day), OTC
AUTOCODE TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
BLOOD GLUCOS TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
BLOOD GLUCOS TES 333	Non Preferred	PA, QL (4 strips every 1 day), OTC
BLOOD GLUCOS TES LE1	Non Preferred	PA, QL (4 strips every 1 day), OTC
BLOOD GLUCOS TES PREMIUM	Non Preferred	PA, QL (4 strips every 1 day), OTC
BLOOD GLUCOS TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
BLULINK TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
CARESENS N TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
CARETOUCH MIS TST STRP	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVER CHEK TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVER CHEK TES AUTO CD	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVER CHEK TES TALK	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVER CHEK TES VOICE	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVER CHOIC TES MICRO	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVR CHOICE TES AUTO-CD	Non Preferred	PA, QL (4 strips every 1 day), OTC
CLEVR CHOICE TES NOCODE	Non Preferred	PA, QL (4 strips every 1 day), OTC
CONFIRM/MICR TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CONTOUR TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
CONTOUR TES NEXT	Non Preferred	PA, QL (4 strips every 1 day), OTC
COOL BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
CVS ADVANCED TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
CVS GLUCOSE TES TEST STR	Non Preferred	PA, QL (4 strips every 1 day), OTC
D-CARE BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day)
DIATHRIVE MIS TEST STR	Non Preferred	PA, QL (4 strips every 1 day), OTC
DIATHRIVE+ MIS TEST STR	Non Preferred	PA, QL (4 strips every 1 day), OTC
DIATRUE PLUS TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
DUO-CARE TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY PLUS II TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY STEP TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TALK TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TALK TES PLUS II	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TOUCH TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TOUCH TES HEALTHPR	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TOUCH TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TRAK II TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASY TRAK TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASYGLUCO TES	Non Preferred	PA, QL (4 test strips every 1 day), OTC
EASYMAX 15 TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASYMAX TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASYPRO PLUS TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EASYPRO TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ELEMENT TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
ELEMNT COMPA TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
EMBRACE EVO TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EMBRACE PRO TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
EMBRACE TALK TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
EMBRACE TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
EVOLUTION TES AUTOCODE	Non Preferred	PA, QL (4 strips every 1 day), OTC
FIFTY50 GLUC TES 2.0	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA 6 MIS CONNECT	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA ADVANCE TES PRO	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA D15G TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA D20 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA D40/G31 TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA G20 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA G30/V10 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA GD20 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA GD50 TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA GTEL TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA TN'G TES TN'G VOI	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA V10 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA V12 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA V20 TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORA V30A TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FORACARE TES GD40	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORACARE TES PREM V10	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORACARE TES TST N GO	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORTISCARE TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
FORTISCARE TES G1 BLOOD	Non Preferred	PA, QL (4 strips every 1 day), OTC
FREESTYLE TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
FREESTYLE TES INSULINX	Non Preferred	PA, QL (4 strips every 1 day), OTC
FREESTYLE TES LITE	Non Preferred	PA, QL (4 strips every 1 day), OTC
FREESTYLE TES PREC NEO	Non Preferred	PA, QL (4 strips every 1 day), OTC
GE100 BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
GENULTIMATE TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
GHT TEST TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCO PERFEC TES 3	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCARD 01 TES PLUS	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCARD 01 TES SENSOR	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCARD TES EXPRESSI	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCARD TES SHINE	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCARD TES VITAL	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCARD TES X-SENSOR	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOCOM TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCONAVII TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
GLUCOSE TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
GNP TRU METR TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
GNP TRUETRAC TES SMRT SYS	Non Preferred	PA, QL (4 strips every 1 day), OTC



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GOJJI BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
GOJJI STRIPS MIS W/LANCET	Non Preferred	PA, QL (4 strips every 1 day), OTC
HW EMBRACE TES PRO	Non Preferred	PA, QL (4 strips every 1 day), OTC
HW EMBRACE TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
IGLUCOSE TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
IN TOUCH TES BLOOD	Non Preferred	PA, QL (4 strips every 1 day), OTC
INFINITY TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
INFINITY TES VOICE	Non Preferred	PA, QL (4 strips every 1 day), OTC
KROGER BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
LIBERTY NEXT TES GEN	Non Preferred	PA, QL (4 strips every 1 day), OTC
LIBERTY TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
MEIJER BLOOD TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
MEIJER TES TRUETEST	Non Preferred	PA, QL (4 strips every 1 day), OTC
MEIJER TES TRUETRAC	Non Preferred	PA, QL (4 strips every 1 day), OTC
MICRODOT TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
MICRODOT TES XTRA	Non Preferred	PA, QL (4 strips every 1 day), OTC
MYGLUCOHEALT TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
NEUTEK 2TEK TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
NO CODING TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
NOVA MAX TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
ON CALL TES EXPRESS	Non Preferred	PA, QL (4 strips every 1 day), OTC
ONE DROP TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
ONETOUCH TES ULTRA	Preferred	QL (4 strips every 1 day), OTC
ONETOUCH TES VERIO	Preferred	QL (4 strips every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ONETOUCH TES VERIO	Non Preferred	PA, QL (4 strips every 1 day), OTC
OPTIUMES TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
PIP BLOOD TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
POCKETCHEM TES EZ	Non Preferred	PA, QL (4 strips every 1 day), OTC
PRECISION TES XTRA	Non Preferred	PA, QL (4 strips every 1 day), OTC
PREMIUM BLOO MIS GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
PRO VOICE TES V8/V9	Non Preferred	PA, QL (4 strips every 1 day), OTC
PRODIGY NO TES CODING	Non Preferred	PA, QL (4 strips every 1 day), OTC
PTS PANELS TES EGLU	Non Preferred	PA, QL (4 strips every 1 day), OTC
QUICKTEK TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
QUINTET AC TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
QUINTET TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
REFUAH PLUS TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
RELION PREMI TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
RELION PRIME TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
RELION PRIME TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
RELION TES ULTIMA	Non Preferred	PA, QL (4 strips every 1 day), OTC
RELION TRUE TES METRIX	Non Preferred	PA, QL (4 strips every 1 day), OTC
RIGHTEST TES GS100	Non Preferred	PA, QL (4 strips every 1 day), OTC
RIGHTEST TES GS300	Non Preferred	PA, QL (4 strips every 1 day), OTC
RIGHTEST TES GS550	Non Preferred	PA, QL (4 strips every 1 day), OTC
RIGHTEST TES GT333	Non Preferred	PA, QL (4 strips every 1 day), OTC
SMART SENSE TES TEST	Non Preferred	PA, QL (4 strips every 1 day), OTC
SMARTEST TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SOLUS V2 TES AUDIBLE	Non Preferred	PA, QL (4 strips every 1 day), OTC
SUPREME TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRU METRIX TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRUE FOCUS MIS BLOOD	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRUE METRIX TES GLUCOSE	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRUETEST TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRUETRACK TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRUETRACK TES BLD GLUC	Non Preferred	PA, QL (4 strips every 1 day), OTC
TRUETRACK TES STRIPS	Non Preferred	PA, QL (4 strips every 1 day), OTC
UNISTRIP1 TES GENERIC	Non Preferred	PA, QL (4 strips every 1 day), OTC
VERASENS TES	Non Preferred	PA, QL (4 strips every 1 day), OTC
VIVAGUARD TES INO	Non Preferred	PA, QL (4 strips every 1 day), OTC

## **DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS**

### ***DIGESTIVE ENZYMES***

CREON CAP 3000UNIT	Preferred	QL (6 caps every 1 day)
CREON CAP 6000UNIT	Preferred	QL (6 caps every 1 day)
CREON CAP 12000UNT	Preferred	QL (6 caps every 1 day)
CREON CAP 24000UNT	Preferred	QL (6 caps every 1 day)
CREON CAP 36000UNT	Preferred	QL (6 caps every 1 day)
PERTZYE CAP 4000UNIT	Non Preferred	PA
PERTZYE CAP 8000UNIT	Non Preferred	PA
PERTZYE CAP 16000U	Non Preferred	PA
PERTZYE CAP 24000U	Non Preferred	PA
VIOKACE TAB 10440	Non Preferred	PA
VIOKACE TAB 20880	Non Preferred	PA
ZENPEP CAP 3000UNIT	Preferred	QL (6 caps every 1 day)
ZENPEP CAP 5000UNIT	Preferred	QL (6 caps every 1 day)
ZENPEP CAP 10000UNT	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZENPEP CAP 15000UNT	Preferred	QL (6 caps every 1 day)
ZENPEP CAP 20000UNT	Preferred	QL (6 caps every 1 day)
ZENPEP CAP 25000UNT	Preferred	QL (6 caps every 1 day)
ZENPEP CAP 40000UNT	Preferred	QL (6 caps every 1 day)

## **DIURETICS - DRUGS TO TREAT HEART CONDITIONS**

### **CARBONIC ANHYDRASE INHIBITORS**

<i>acetazolamide cap er 12hr 500 mg</i>	Preferred	QL (4 caps every 1 day)
<i>acetazolamide tab 125 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>acetazolamide tab 250 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>dichlorphenamide tab 50 mg (generic of KEVEYIS)</i>	Non Preferred	SP, PA
KEVEYIS TAB 50MG	Non Preferred	SP, PA
<i>methazolamide tab 25 mg</i>	Preferred	
<i>methazolamide tab 50 mg</i>	Preferred	

### **DIURETIC COMBINATIONS**

ALDACTAZIDE TAB 25/25	Non Preferred	PA, QL (4 tabs every 1 day)
<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i>	Preferred	QL (2 tabs every 1 day)
MAXZIDE TAB 75-50	Non Preferred	PA, QL (4 tabs every 1 day)
MAXZIDE-25 TAB	Non Preferred	PA, QL (4 tabs every 1 day)
<i>spironolactone &amp; hydrochlorothiazide tab 25-25 mg (generic of ALDACTAZIDE)</i>	Preferred	QL (4 each every 1 day)
<i>triamterene &amp; hydrochlorothiazide cap 37.5-25 mg</i>	Preferred	QL (2 caps every 1 day)
<i>triamterene &amp; hydrochlorothiazide tab 37.5-25 mg (generic of MAXZIDE-25)</i>	Preferred	QL (4 tabs every 1 day)
<i>triamterene &amp; hydrochlorothiazide tab 75-50 mg (generic of MAXZIDE)</i>	Preferred	QL (4 tabs every 1 day)

### **LOOP DIURETICS**

<i>bumetanide tab 0.5 mg (generic of BUMEX)</i>	Preferred	QL (2 tabs every 1 day)
<i>bumetanide tab 1 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>bumetanide tab 2 mg</i>	Preferred	QL (5 tabs every 1 day)
BUMEX TAB 0.5MG	Non Preferred	PA, QL (2 tabs every 1 day)
EDECRIN TAB 25MG	Non Preferred	PA
<i>ethacrynic acid tab 25 mg (generic of EDECRIN)</i>	Preferred	
<i>furosemide oral soln 8 mg/ml</i>	Preferred	
<i>furosemide oral soln 10 mg/ml</i>	Preferred	
<i>furosemide tab 20 mg (generic of LASIX)</i>	Preferred	QL (6 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>furosemide tab 40 mg (generic of LASIX)</i>	Preferred	QL (6 tabs every 1 day)
<i>furosemide tab 80 mg (generic of LASIX)</i>	Preferred	QL (6 tabs every 1 day)
LASIX TAB 20MG	Non Preferred	PA, QL (6 tabs every 1 day)
LASIX TAB 40MG	Non Preferred	PA, QL (6 tabs every 1 day)
LASIX TAB 80MG	Non Preferred	PA, QL (6 tabs every 1 day)
<i>torsemide tab 5 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>torsemide tab 10 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>torsemide tab 20 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>torsemide tab 100 mg</i>	Preferred	QL (2 tabs every 1 day)

### **POTASSIUM SPARING DIURETICS**

ALDACTONE TAB 25MG	Non Preferred	PA, QL (8 tabs every 1 day)
ALDACTONE TAB 50MG	Non Preferred	PA, QL (4 tabs every 1 day)
ALDACTONE TAB 100MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>amiloride hcl tab 5 mg</i>	Preferred	QL (4 tabs every 1 day)
CAROSPIR SUS 25MG/5ML	Non Preferred	PA
<i>spironolactone tab 25 mg (generic of ALDACTONE)</i>	Preferred	QL (8 tabs every 1 day)
<i>spironolactone tab 50 mg (generic of ALDACTONE)</i>	Preferred	QL (4 tabs every 1 day)
<i>spironolactone tab 100 mg (generic of ALDACTONE)</i>	Preferred	QL (2 tabs every 1 day)
<i>triamterene cap 50 mg (generic of DYRENIUM)</i>	Preferred	
<i>triamterene cap 100 mg (generic of DYRENIUM)</i>	Preferred	

### **THIAZIDES AND THIAZIDE-LIKE DIURETICS**

<i>chlorthalidone tab 25 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>chlorthalidone tab 50 mg</i>	Preferred	QL (4 tabs every 1 day)
DIURIL SUS 250/5ML	Preferred	
<i>hydrochlorothiazide cap 12.5 mg</i>	Preferred	QL (2 caps every 1 day)
<i>hydrochlorothiazide tab 12.5 mg</i>	Preferred	
<i>hydrochlorothiazide tab 25 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>hydrochlorothiazide tab 50 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>indapamide tab 1.25 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>indapamide tab 2.5 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>metolazone tab 2.5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>metolazone tab 5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>metolazone tab 10 mg</i>	Preferred	QL (2 tabs every 1 day)

Drug Name	Drug Tier	Requirements/Limits
THALITONE TAB 15MG	Non Preferred	PA

## ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES

### ADRENAL STEROID INHIBITORS

ISTURISA TAB 1MG	Non Preferred	SP, PA
ISTURISA TAB 5MG	Non Preferred	SP, PA
ISTURISA TAB 10MG	Non Preferred	SP, PA
RECORLEV TAB 150MG	Non Preferred	PA

### BONE DENSITY REGULATORS

ACTONEL TAB 35MG	Non Preferred	PA
ACTONEL TAB 150MG	Non Preferred	PA
<i>alendronate sodium oral soln 70 mg/75ml</i>	Preferred	
<i>alendronate sodium tab 10 mg</i>	Preferred	QL (1 tab every 1 day)
<i>alendronate sodium tab 35 mg</i>	Preferred	QL (0.143 tabs every 1 day)
<i>alendronate sodium tab 70 mg (generic of FOSAMAX)</i>	Preferred	QL (0.143 tabs every 1 day)
AELVIA TAB	Non Preferred	PA
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	Preferred	QL (1 mL every 1 day)
FOSAMAX + D TAB 70-2800	Non Preferred	PA
FOSAMAX + D TAB 70-5600	Non Preferred	PA
FOSAMAX TAB 70MG	Non Preferred	PA, QL (0.143 tabs every 1 day)
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	Non Preferred	PA, QL (0.036 each every 1 day)
<i>risedronate sodium tab 5 mg</i>	Non Preferred	PA
<i>risedronate sodium tab 30 mg</i>	Non Preferred	PA
<i>risedronate sodium tab 35 mg (generic of ACTONEL)</i>	Non Preferred	PA
<i>risedronate sodium tab 150 mg (generic of ACTONEL)</i>	Non Preferred	PA
<i>risedronate sodium tab delayed release 35 mg (generic of AELVIA)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b><i>GNRH/LHRH ANTAGONISTS</i></b>		
ORLISSA TAB 150MG	Preferred	PA
ORLISSA TAB 200MG	Preferred	PA
<b><i>GROWTH HORMONE RELEASING HORMONES (GHRH)</i></b>		
EGRIFTA SV INJ 2MG	Non Preferred	SP, PA
<b><i>GROWTH HORMONES</i></b>		
GENOTROPIN INJ 0.2MG	Preferred	SP, PA
GENOTROPIN INJ 0.4MG	Preferred	SP, PA
GENOTROPIN INJ 0.6MG	Preferred	SP, PA
GENOTROPIN INJ 0.8MG	Preferred	SP, PA
GENOTROPIN INJ 1.2MG	Preferred	SP, PA
GENOTROPIN INJ 1.4MG	Preferred	SP, PA
GENOTROPIN INJ 1.6MG	Preferred	SP, PA
GENOTROPIN INJ 1.8MG	Preferred	SP, PA
GENOTROPIN INJ 1MG	Preferred	SP, PA
GENOTROPIN INJ 2MG	Preferred	SP, PA
GENOTROPIN INJ 5MG	Preferred	SP, PA
GENOTROPIN INJ 12MG	Preferred	SP, PA
HUMATROPE INJ 6MG	Non Preferred	SP, PA
HUMATROPE INJ 12MG	Non Preferred	SP, PA
HUMATROPE INJ 24MG	Non Preferred	SP, PA
NORDITROPIN INJ 5/1.5ML	Non Preferred	SP, PA
NORDITROPIN INJ 10/1.5ML	Non Preferred	SP, PA
NORDITROPIN INJ 15/1.5ML	Non Preferred	SP, PA
NORDITROPIN INJ 30/3ML	Non Preferred	SP, PA
NUTROPIN AQ INJ 10MG/2ML	Non Preferred	SP, PA
NUTROPIN AQ INJ 20MG/2ML	Non Preferred	SP, PA
NUTROPIN AQ INJ NUSPIN 5	Non Preferred	SP, PA
OMNITROPE INJ 5.8MG	Non Preferred	SP, PA
OMNITROPE INJ 5/1.5ML	Non Preferred	SP, PA
OMNITROPE INJ 10/1.5ML	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SAIZEN INJ 5MG	Non Preferred	SP, PA
SAIZEN INJ 8.8MG	Non Preferred	SP, PA
SAIZENPREP INJ 8.8MG	Non Preferred	SP, PA
SEROSTIM INJ 4MG	Non Preferred	SP, PA
SEROSTIM INJ 5MG	Non Preferred	SP, PA
SEROSTIM INJ 6MG	Non Preferred	SP, PA
SKYTROFA INJ 3.6MG	Non Preferred	SP, PA
SKYTROFA INJ 3MG	Non Preferred	SP, PA
SKYTROFA INJ 4.3MG	Non Preferred	SP, PA
SKYTROFA INJ 5.2MG	Non Preferred	SP, PA
SKYTROFA INJ 6.3MG	Non Preferred	SP, PA
SKYTROFA INJ 7.6MG	Non Preferred	SP, PA
SKYTROFA INJ 9.1MG	Non Preferred	SP, PA
SKYTROFA INJ 11MG	Non Preferred	SP, PA
SKYTROFA INJ 13.3MG	Non Preferred	SP, PA
ZOMACTON INJ 5MG	Non Preferred	SP, PA
ZOMACTON INJ 10MG	Non Preferred	SP, PA
ZORBTIVE INJ 8.8MG	Non Preferred	SP, PA
<b>HORMONE RECEPTOR MODULATORS</b>		
EVISTA TAB 60MG	Non Preferred	PA, QL (1 tab every 1 day)
OSPHENA TAB 60MG	Non Preferred	PA
<i>raloxifene hcl tab 60 mg (generic of EVISTA)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>		
INCRELEX INJ 40MG/4ML	Non Preferred	SP, PA



Drug Name	Drug Tier	Requirements/Limits
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
SYNAREL SOL 2MG/ML	Non Preferred	SP, PA

**METABOLIC MODIFIERS**

<i>betaine powder for oral solution</i> (generic of CYSTADANE)	Non Preferred	SP, PA
BUPHENYL POW	Non Preferred	SP, PA
BUPHENYL TAB 500MG	Non Preferred	SP, PA
<i>calcitriol cap 0.5 mcg</i> (generic of ROCALTROL)	Preferred	QL (4 caps every 1 day)
<i>calcitriol cap 0.25 mcg</i> (generic of ROCALTROL)	Preferred	QL (4 caps every 1 day)
<i>calcitriol oral soln 1 mcg/ml</i> (generic of ROCALTROL)	Preferred	
CARBAGLU TAB 200MG	Non Preferred	SP, PA
<i>carglumic acid soluble tab 200 mg</i> (generic of CARBAGLU)	Preferred	SP, PA
<i>carglumic acid soluble tab 200 mg</i> (generic of CARBAGLU)	Non Preferred	SP, PA
CARNITOR SF SOL 1GM/10ML	Non Preferred	PA, QL (60 mL every 1 day)
CARNITOR SOL 1GM/10ML	Non Preferred	PA, QL (60 mL every 1 day)
CARNITOR TAB 330MG	Non Preferred	PA, QL (18 tabs every 1 day)
<i>cinacalcet hcl tab 30 mg (base equiv)</i> (generic of SENSIPAR)	Non Preferred	PA
<i>cinacalcet hcl tab 60 mg (base equiv)</i> (generic of SENSIPAR)	Non Preferred	PA
<i>cinacalcet hcl tab 90 mg (base equiv)</i> (generic of SENSIPAR)	Non Preferred	PA
CYSTADANE POW	Non Preferred	SP, PA
<i>doxercalciferol cap 0.5 mcg</i>	Preferred	
<i>doxercalciferol cap 1 mcg</i>	Preferred	
<i>doxercalciferol cap 2.5 mcg</i>	Preferred	
GALAFOLD CAP 123MG	Non Preferred	SP, PA
<i>javygtor pak 100mg</i> (generic of KUVAN)	Non Preferred	SP, PA
<i>javygtor pow 500mg</i> (generic of KUVAN)	Non Preferred	SP, PA
<i>javygtor tab 100mg</i> (generic of KUVAN)	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KUVAN POW 100MG	Non Preferred	SP, PA
KUVAN POW 500MG	Non Preferred	SP, PA
KUVAN TAB 100MG	Non Preferred	SP, PA
<i>levocarnitine oral soln 1 gm/10ml (10%)</i> (generic of CARNITOR)	Non Preferred	PA, QL (60 mL every 1 day)
<i>levocarnitine tab 330 mg</i> (generic of CARNITOR)	Non Preferred	PA, QL (18 tabs every 1 day)
<i>nitisinone cap 2 mg</i> (generic of ORFADIN)	Preferred	SP
<i>nitisinone cap 5 mg</i> (generic of ORFADIN)	Preferred	SP
<i>nitisinone cap 10 mg</i> (generic of ORFADIN)	Preferred	SP
NITYR TAB 2MG	Non Preferred	SP, PA
NITYR TAB 5MG	Non Preferred	SP, PA
NITYR TAB 10MG	Non Preferred	SP, PA
ORFADIN CAP 2MG	Preferred	SP
ORFADIN CAP 5MG	Preferred	SP
ORFADIN CAP 10MG	Preferred	SP
ORFADIN CAP 20MG	Preferred	SP
ORFADIN SUS 4MG/ML	Non Preferred	SP, PA
<i>paricalcitol cap 1 mcg</i> (generic of ZEMPLAR)	Non Preferred	PA
<i>paricalcitol cap 2 mcg</i> (generic of ZEMPLAR)	Non Preferred	PA
<i>paricalcitol cap 4 mcg</i>	Non Preferred	PA
PHEBURANE MIS 483/GM	Non Preferred	SP, PA
RAVICTI LIQ 1.1GM/ML	Non Preferred	SP, PA
RAYALDEE CAP 30MCG	Non Preferred	PA
ROCALTROL CAP 0.5MCG	Non Preferred	PA, QL (4 caps every 1 day)
ROCALTROL CAP 0.25MCG	Non Preferred	PA, QL (4 caps every 1 day)
ROCALTROL SOL 1MCG/ML	Non Preferred	PA
<i>sapropterin dihydrochloride powder packet 100 mg</i> (generic of KUVAN)	Non Preferred	SP, PA
<i>sapropterin dihydrochloride powder packet 500 mg</i> (generic of KUVAN)	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sapropterin dihydrochloride tab 100 mg</i> (generic of KUVAN)	Non Preferred	SP, PA
SENSIPAR TAB 30MG	Non Preferred	PA
SENSIPAR TAB 60MG	Non Preferred	PA
SENSIPAR TAB 90MG	Non Preferred	PA
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i> (generic of BUPHENYL)	Non Preferred	SP, PA
<i>sodium phenylbutyrate tab 500 mg</i> (generic of BUPHENYL)	Non Preferred	SP, PA
ZEMPLAR CAP 1MCG	Non Preferred	PA
ZEMPLAR CAP 2MCG	Non Preferred	PA

### **MINERALOCORTICOID RECEPTOR ANTAGONISTS**

KERENDIA TAB 10MG	Preferred	PA
KERENDIA TAB 20MG	Preferred	PA

### **POSTERIOR PITUITARY HORMONES**

DDAVP TAB 0.1MG	Non Preferred	PA, QL (4 tabs every 1 day)
DDAVP TAB 0.2MG	Non Preferred	PA, QL (5 tabs every 1 day)
<i>desmopressin acetate nasal spray soln 0.01%</i>	Preferred	
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	Preferred	
<i>desmopressin acetate tab 0.1 mg</i> (generic of DDAVP)	Preferred	QL (4 tabs every 1 day)
<i>desmopressin acetate tab 0.2 mg</i> (generic of DDAVP)	Preferred	QL (5 tabs every 1 day)
NOCDURNA SUB 27.7MCG	Non Preferred	PA
NOCDURNA SUB 55.3MCG	Non Preferred	PA

### **PROGESTERONE RECEPTOR ANTAGONISTS**

MIFEPREX TAB 200MG	Non Preferred	PA
<i>mifepristone tab 200 mg</i> (generic of MIFEPREX)	Non Preferred	PA

### **PROLACTIN INHIBITORS**

<i>cabergoline tab 0.5 mg</i>	Preferred	
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### **SOMATOSTATIC AGENTS**

LANREOTIDE INJ 120/.5ML	Non Preferred	SP, PA
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MYCAPSSA CAP 20MG	Non Preferred	SP, PA
<i>octreotide acetate inj 50 mcg/ml (0.05 mg/ml) (generic of SANDOSTATIN)</i>	Non Preferred	SP, PA
<i>octreotide acetate inj 100 mcg/ml (0.1 mg/ml) (generic of SANDOSTATIN)</i>	Non Preferred	SP, PA
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	Non Preferred	SP, PA
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	Non Preferred	SP, PA
<i>octreotide acetate inj 500 mcg/ml (0.5 mg/ml) (generic of SANDOSTATIN)</i>	Non Preferred	SP, PA
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	Non Preferred	SP, PA
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	Non Preferred	SP, PA
<i>octreotide acetate subcutaneous soln pref syr 50 mcg/ml</i>	Non Preferred	SP, PA
<i>octreotide acetate subcutaneous soln pref syr 100 mcg/ml</i>	Non Preferred	SP, PA
<i>octreotide acetate subcutaneous soln pref syr 500 mcg/ml</i>	Non Preferred	SP, PA
SANDOSTATIN INJ 50MCG/ML	Non Preferred	SP, PA
SANDOSTATIN INJ 100MCG	Non Preferred	SP, PA
SANDOSTATIN INJ 500MCG	Non Preferred	SP, PA
SANDOSTATIN KIT LAR 10MG	Non Preferred	SP, PA
SANDOSTATIN KIT LAR 20MG	Non Preferred	SP, PA
SANDOSTATIN KIT LAR 30MG	Non Preferred	SP, PA
SIGNIFOR INJ 0.3MG/ML	Non Preferred	SP, PA
SIGNIFOR INJ 0.6MG/ML	Non Preferred	SP, PA
SIGNIFOR INJ 0.9MG/ML	Non Preferred	SP, PA
SIGNIFOR LAR INJ 10MG	Non Preferred	SP, PA
SIGNIFOR LAR INJ 20MG	Non Preferred	SP, PA
SIGNIFOR LAR INJ 30MG	Non Preferred	SP, PA
SIGNIFOR LAR INJ 40MG	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SIGNIFOR LAR INJ 60MG	Non Preferred	SP, PA
SOMATULINE INJ 60/0.2ML	Non Preferred	SP, PA
SOMATULINE INJ 90/0.3ML	Non Preferred	SP, PA
SOMATULINE INJ 120/.5ML	Non Preferred	SP, PA

### **VASOPRESSIN RECEPTOR ANTAGONISTS**

JYNARQUE PAK 15MG	Non Preferred	SP, PA
JYNARQUE PAK 30-15MG	Non Preferred	SP, PA
JYNARQUE PAK 45-15MG	Non Preferred	SP, PA
JYNARQUE PAK 60-30MG	Non Preferred	SP, PA
JYNARQUE PAK 90-30MG	Non Preferred	SP, PA
JYNARQUE TAB 15MG	Non Preferred	SP, PA
JYNARQUE TAB 30MG	Non Preferred	SP, PA
SAMSCA TAB 15MG	Non Preferred	SP, PA
SAMSCA TAB 30MG	Non Preferred	SP, PA
<i>tolvaptan tab 15 mg (generic of SAMSCA)</i>	Non Preferred	SP, PA
<i>tolvaptan tab 30 mg (generic of SAMSCA)</i>	Non Preferred	SP, PA

### **ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES**

#### **ESTROGEN COMBINATIONS**

ACTIVELLA TAB 1-0.5MG	Non Preferred	PA
<i>amabelz tab 0.5-0.1</i>	Preferred	
<i>amabelz tab 1-0.5mg</i>	Preferred	
ANGELIQ TAB 0.5-1MG	Non Preferred	PA
ANGELIQ TAB 0.25-0.5	Non Preferred	PA
BIJUVA CAP 1-100MG	Non Preferred	PA
CLIMARA PRO DIS WEEKLY	Non Preferred	PA
COMBIPATCH DIS	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DUAVEE TAB 0.45-20	Non Preferred	PA
<i>est estrogen tab mtest hs</i>	Preferred	
<i>estradiol &amp; norethindrone acetate tab 0.5-0.1 mg</i>	Preferred	
<i>estradiol &amp; norethindrone acetate tab 1-0.5 mg (generic of ACTIVELLA)</i>	Preferred	
<i>estrog/mtest tab 1.25-2.5</i>	Preferred	
<i>fyavolv tab 0.5-2.5</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>fyavolv tab 1-5</i>	Non Preferred	PA
<i>jinteli tab 1mg-5mcg</i>	Non Preferred	PA
<i>mimvey tab 1-0.5mg (generic of ACTIVELLA)</i>	Preferred	
MYFEMBREE TAB	Preferred	PA
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	Non Preferred	PA
ORIAHNN CAP	Preferred	PA
PREFEST TAB	Non Preferred	PA
PREMPHASE TAB	Preferred	
PREMPRO TAB	Preferred	
PREMPRO TAB 0.3-1.5	Preferred	
PREMPRO TAB 0.45-1.5	Preferred	
PREMPRO TAB 0.625-5	Preferred	
<b>ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES</b>		
CLIMARA DIS 0.1MG	Non Preferred	PA
CLIMARA DIS 0.05MG	Non Preferred	PA
CLIMARA DIS 0.06MG	Non Preferred	PA
CLIMARA DIS 0.025MG	Non Preferred	PA
CLIMARA DIS 0.075MG	Non Preferred	PA
CLIMARA DIS 0.0375MG	Non Preferred	PA
DELESTROGEN INJ 10MG/ML	Non Preferred	PA
DELESTROGEN INJ 20MG/ML	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DELESTROGEN INJ 40MG/ML	Non Preferred	PA
DEPO-ESTRADI INJ 5MG/ML	Non Preferred	PA
DIVIGEL GEL 0.5MG	Non Preferred	PA
DIVIGEL GEL 0.25MG	Non Preferred	PA
DIVIGEL GEL 0.75MG	Non Preferred	PA
DIVIGEL GEL 1.25MG	Non Preferred	PA
DIVIGEL GEL 1MG/GM	Non Preferred	PA
<i>dotti dis 0.1mg</i> (generic of VIVELLE-DOT)	Preferred	
<i>dotti dis 0.05mg</i> (generic of VIVELLE-DOT)	Preferred	
<i>dotti dis 0.025mg</i> (generic of VIVELLE-DOT)	Preferred	
<i>dotti dis 0.075mg</i> (generic of VIVELLE-DOT)	Preferred	
<i>dotti dis 0.0375mg</i> (generic of VIVELLE-DOT)	Preferred	
ELESTRIN GEL 0.06%	Non Preferred	PA
ESTRACE TAB 0.5MG	Non Preferred	PA
ESTRACE TAB 1MG	Non Preferred	PA
ESTRACE TAB 2MG	Non Preferred	PA
<i>estradiol tab 0.5 mg</i> (generic of ESTRACE)	Preferred	
<i>estradiol tab 1 mg</i> (generic of ESTRACE)	Preferred	
<i>estradiol tab 2 mg</i> (generic of ESTRACE)	Preferred	
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i> (generic of DIVIGEL)	Non Preferred	PA
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i> (generic of DIVIGEL)	Non Preferred	PA
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i> (generic of DIVIGEL)	Non Preferred	PA
<i>estradiol td gel 1 mg/gm (0.1%)</i> (generic of DIVIGEL)	Non Preferred	PA
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i> (generic of DIVIGEL)	Non Preferred	PA
<i>estradiol td patch twice weekly 0.1 mg/24hr</i> (generic of MINIVELLE)	Preferred	
<i>estradiol td patch twice weekly 0.05 mg/24hr</i> (generic of MINIVELLE)	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>estradiol td patch twice weekly 0.025 mg/24hr (generic of MINIVELLE)</i>	Preferred	
<i>estradiol td patch twice weekly 0.075 mg/24hr (generic of MINIVELLE)</i>	Preferred	
<i>estradiol td patch twice weekly 0.0375 mg/24hr (generic of MINIVELLE)</i>	Preferred	
<i>estradiol td patch weekly 0.1 mg/24hr (generic of CLIMARA)</i>	Preferred	
<i>estradiol td patch weekly 0.05 mg/24hr (generic of CLIMARA)</i>	Preferred	
<i>estradiol td patch weekly 0.06 mg/24hr (generic of CLIMARA)</i>	Preferred	
<i>estradiol td patch weekly 0.025 mg/24hr (generic of CLIMARA)</i>	Preferred	
<i>estradiol td patch weekly 0.075 mg/24hr (generic of CLIMARA)</i>	Preferred	
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr) (generic of CLIMARA)</i>	Preferred	
<i>estradiol valerate im in oil 10 mg/ml (generic of DELESTROGEN)</i>	Non Preferred	PA
<i>estradiol valerate im in oil 20 mg/ml (generic of DELESTROGEN)</i>	Non Preferred	PA
<i>estradiol valerate im in oil 40 mg/ml (generic of DELESTROGEN)</i>	Non Preferred	PA
EVAMIST SPR 1.53MG	Non Preferred	PA
<i>lyllana dis 0.1mg (generic of MINIVELLE)</i>	Preferred	
<i>lyllana dis 0.05mg (generic of MINIVELLE)</i>	Preferred	
<i>lyllana dis 0.025mg (generic of MINIVELLE)</i>	Preferred	
<i>lyllana dis 0.075mg (generic of MINIVELLE)</i>	Preferred	
<i>lyllana dis 0.0375mg (generic of MINIVELLE)</i>	Preferred	
MENEST TAB 0.3MG	Preferred	
MENEST TAB 0.625MG	Preferred	
MENEST TAB 1.25MG	Preferred	
MENEST TAB 2.5MG	Preferred	
MENOSTAR DIS 14MCG	Non Preferred	PA
MINIVELLE DIS 0.1MG	Non Preferred	PA
MINIVELLE DIS 0.05MG	Non Preferred	PA
MINIVELLE DIS 0.025MG	Non Preferred	PA
MINIVELLE DIS 0.075MG	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MINIVELLE DIS 0.0375MG	Non Preferred	PA
PREMARIN TAB 0.3MG	Preferred	
PREMARIN TAB 0.9MG	Preferred	
PREMARIN TAB 0.45MG	Preferred	
PREMARIN TAB 0.625MG	Preferred	
PREMARIN TAB 1.25MG	Preferred	
VIVELLE-DOT DIS 0.1MG	Non Preferred	PA
VIVELLE-DOT DIS 0.05MG	Non Preferred	PA
VIVELLE-DOT DIS 0.025MG	Non Preferred	PA
VIVELLE-DOT DIS 0.075MG	Non Preferred	PA
VIVELLE-DOT DIS 0.0375MG	Non Preferred	PA

## **FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS**

### **FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS**

BAXDELA TAB 450MG	Non Preferred	PA; AGE (Min 16)
CIPRO (5%) SUS 250MG/5	Non Preferred	PA; AGE (Min 16)
CIPRO (10%) SUS 500MG/5	Non Preferred	PA; AGE (Min 16)
CIPRO TAB 250MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 16)
CIPRO TAB 500MG	Non Preferred	PA, QL (2 tabs every 1 day); AGE (Min 16)
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	Preferred	AGE (Min 16)
<i>ciprofloxacin hcl tab 250 mg (base equiv) (generic of CIPRO)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 16)
<i>ciprofloxacin hcl tab 500 mg (base equiv) (generic of CIPRO)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 16)
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	Preferred	QL (2 tabs every 1 day); AGE (Min 16)
<i>levofloxacin oral soln 25 mg/ml</i>	Preferred	AGE (Min 16)
<i>levofloxacin tab 250 mg (generic of LEVAQUIN)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 16)
<i>levofloxacin tab 500 mg</i>	Preferred	QL (1 tab every 1 day); AGE (Min 16)
<i>levofloxacin tab 750 mg (generic of LEVAQUIN)</i>	Preferred	QL (1 tab every 1 day); AGE (Min 16)
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	Preferred	AGE (Min 16)
<i>ofloxacin tab 300 mg</i>	Non Preferred	PA; AGE (Min 16)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ofloxacin tab 400 mg</i>	Non Preferred	PA; AGE (Min 16)

**GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS**

**5-HT4 RECEPTOR AGONISTS**

MOTEGRITY TAB 1MG	Non Preferred	PA
MOTEGRITY TAB 2MG	Non Preferred	PA

**AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)**

TRULANCE TAB 3MG	Non Preferred	PA
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**ANTIFLATULENTS**

<i>simethicone cap 125 mg</i>	Preferred	OTC
<i>simethicone cap 180 mg</i>	Preferred	OTC
<i>simethicone chew tab 80 mg</i>	Preferred	OTC
<i>simethicone chew tab 125 mg</i>	Preferred	OTC
<i>simethicone susp 40 mg/0.6ml</i>	Preferred	OTC

**BILE ACID SYNTHESIS DISORDER AGENTS**

CHOLBAM CAP 50MG	Non Preferred	SP, PA
CHOLBAM CAP 250MG	Non Preferred	SP, PA

**FARNESOID X RECEPTOR (FXR) AGONISTS**

OCALIVA TAB 5MG	Non Preferred	SP, PA
OCALIVA TAB 10MG	Non Preferred	SP, PA

**GALLSTONE SOLUBILIZING AGENTS**

CHENODAL TAB 250MG	Non Preferred	SP, PA
RELTONE CAP 200MG	Non Preferred	PA
RELTONE CAP 400MG	Non Preferred	PA
URSO 250 TAB 250MG	Non Preferred	PA, QL (4 tabs every 1 day)
URSO FORTE TAB 500MG	Non Preferred	PA, QL (2 tabs every 1 day)
<i>ursodiol cap 300 mg</i>	Preferred	QL (3 caps every 1 day)
<i>ursodiol tab 250 mg (generic of URSO 250)</i>	Non Preferred	PA, QL (4 tabs every 1 day)
<i>ursodiol tab 500 mg (generic of URSO FORTE)</i>	Non Preferred	PA, QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>		
<i>cromolyn sodium oral conc 100 mg/5ml</i> (generic of GASTROCROM)	Preferred	
GASTROCROM CON 100/5ML	Non Preferred	PA
<b>GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS</b>		
AMITIZA CAP 8MCG	Non Preferred	PA
AMITIZA CAP 24MCG	Non Preferred	PA
<i>lubiprostone cap 8 mcg</i> (generic of AMITIZA)	Non Preferred	PA
<i>lubiprostone cap 24 mcg</i> (generic of AMITIZA)	Non Preferred	PA
<b>GASTROINTESTINAL STIMULANTS</b>		
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	Non Preferred	PA
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	Preferred	
<i>metoclopramide hcl tab 5 mg (base equivalent) (generic of REGLAN)</i>	Preferred	QL (6 each every 1 day)
<i>metoclopramide hcl tab 10 mg (base equivalent) (generic of REGLAN)</i>	Preferred	QL (6 tabs every 1 day)
REGLAN TAB 5MG	Non Preferred	PA, QL (6 tabs every 1 day)
REGLAN TAB 10MG	Non Preferred	PA, QL (6 tabs every 1 day)
<b>INFLAMMATORY BOWEL AGENTS</b>		
APRISO CAP 0.375GM	Non Preferred	PA, QL (4 caps every 1 day)
ASACOL HD TAB 800MG	Non Preferred	PA
AVSOLA INJ 100MG	Non Preferred	SP, PA
AZULFIDINE TAB 500MG	Non Preferred	PA, QL (10 tabs every 1 day)
AZULFIDINE TAB 500MG EN	Non Preferred	PA, QL (8 tabs every 1 day)
<i>balsalazide disodium cap 750 mg</i> (generic of COLAZAL)	Preferred	
CANASA SUP 1000MG	Non Preferred	PA
CIMZIA KIT 200MG	Non Preferred	SP, PA
CIMZIA PREFL KIT 200MG/ML	Preferred	SP, PA
CIMZIA START KIT 200MG/ML	Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
COLAZAL CAP 750MG	Non Preferred	PA
DELZICOL CAP 400MG	Non Preferred	PA
DIPENTUM CAP 250MG	Non Preferred	PA
ENTYVIO INJ 300MG	Non Preferred	SP, PA
INFLECTRA INJ 100MG	Non Preferred	SP, PA
INFLIXIMAB INJ 100MG	Non Preferred	SP, PA
LIALDA TAB 1.2GM	Non Preferred	PA
<i>mesalamine cap dr 400 mg (generic of DELZICOL)</i>	Non Preferred	PA
<i>mesalamine cap er 24hr 0.375 gm (generic of APRISO)</i>	Non Preferred	PA, QL (4 caps every 1 day)
<i>mesalamine cap er 500 mg (generic of PENTASA)</i>	Preferred	
<i>mesalamine enema 4 gm</i>	Preferred	
<i>mesalamine rectal enema 4 gm &amp; cleanser wipe kit (generic of ROWASA)</i>	Non Preferred	PA
<i>mesalamine suppos 1000 mg (generic of CANASA)</i>	Preferred	
<i>mesalamine tab delayed release 1.2 gm (generic of LIALDA)</i>	Non Preferred	PA
<i>mesalamine tab delayed release 800 mg</i>	Non Preferred	PA
PENTASA CAP 250MG CR	Preferred	
PENTASA CAP 500MG CR	Preferred	
REMICADE INJ 100MG	Non Preferred	SP, PA
RENFLEXIS INJ 100MG	Non Preferred	SP, PA
ROWASA KIT 4GM	Non Preferred	PA
SFROWASA ENE 4GM	Preferred	
SKYRIZI INJ 180/1.2	Non Preferred	SP, PA
SKYRIZI INJ 360/2.4	Non Preferred	SP, PA
SKYRIZI SOL 60MG/ML	Non Preferred	SP, PA
STELARA INJ 5MG/ML	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sulfasalazine tab 500 mg</i> (generic of AZULFIDINE)	Preferred	QL (10 tabs every 1 day)
<i>sulfasalazine tab delayed release 500 mg</i> (generic of AZULFIDINE EN-TABS)	Preferred	QL (8 tabs every 1 day)

### **INTESTINAL ACIDIFIERS**

<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	Preferred	QL (180 mL every 1 day)
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### **IRRITABLE BOWEL SYNDROME (IBS) AGENTS**

<i>alose tron hcl tab 0.5 mg</i> (base equiv) (generic of LOTRONEX)	Non Preferred	PA
<i>alose tron hcl tab 1 mg</i> (base equiv) (generic of LOTRONEX)	Non Preferred	PA
IBSRELA TAB 50MG	Non Preferred	PA
LINZESS CAP 72MCG	Non Preferred	PA
LINZESS CAP 145MCG	Non Preferred	PA
LINZESS CAP 290MCG	Non Preferred	PA
LOTRO NEX TAB 0.5MG	Non Preferred	PA
LOTRO NEX TAB 1MG	Non Preferred	PA
VIBERZI TAB 75MG	Non Preferred	PA
VIBERZI TAB 100MG	Non Preferred	PA

### **PERIPHERAL OPIOID RECEPTOR ANTAGONISTS**

<i>alvimopan cap 12 mg</i> (generic of ENTEREG)	Non Preferred	PA
ENTEREG CAP 12MG	Non Preferred	PA
MOVANTIK TAB 12.5MG	Non Preferred	PA
MOVANTIK TAB 25MG	Non Preferred	PA
RELISTOR INJ 8/0.4ML	Non Preferred	PA
RELISTOR INJ 12/0.6ML	Non Preferred	PA
RELISTOR TAB 150MG	Non Preferred	PA
SYMPROIC TAB 0.2MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PHOSPHATE BINDER AGENTS</b>		
AURYXIA TAB 210MG	Non Preferred	PA
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	Preferred	
<i>calcium acetate (phosphate binder) tab 667 mg</i>	Preferred	
FOSRENOL CHW 500MG	Non Preferred	PA
FOSRENOL CHW 750MG	Non Preferred	PA
FOSRENOL CHW 1000MG	Non Preferred	PA
FOSRENOL POW 750MG	Preferred	
FOSRENOL POW 1000MG	Preferred	
<i>lanthanum carbonate chew tab 500 mg (elemental) (generic of FOSRENOL)</i>	Preferred	
<i>lanthanum carbonate chew tab 750 mg (elemental) (generic of FOSRENOL)</i>	Preferred	
<i>lanthanum carbonate chew tab 1000 mg (elemental) (generic of FOSRENOL)</i>	Preferred	
PHOSLYRA SOL	Non Preferred	PA
RENAGEL TAB 800MG	Non Preferred	PA
RENVELA POW 0.8GM	Non Preferred	PA
RENVELA POW 2.4GM	Non Preferred	PA
RENVELA TAB 800MG	Non Preferred	PA
<i>sevelamer carbonate packet 0.8 gm (generic of RENVELA)</i>	Non Preferred	PA
<i>sevelamer carbonate packet 2.4 gm (generic of RENVELA)</i>	Non Preferred	PA
<i>sevelamer carbonate tab 800 mg (generic of RENVELA)</i>	Preferred	
<i>sevelamer hcl tab 400 mg</i>	Preferred	
<i>sevelamer hcl tab 800 mg (generic of RENAGEL)</i>	Preferred	
VELPHORO CHW 500MG	Non Preferred	PA
<b>SHORT BOWEL SYNDROME (SBS) AGENTS</b>		
GATTEX KIT 5MG	Non Preferred	SP, PA

**Drug Name Drug Tier Requirements/Limits**  
**GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT**  
**GENITAL AND URINARY TRACT CONDITIONS**

**ACIDIFIERS**

K-PHOS TAB NO 2	Non Preferred	PA
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**ALKALINIZERS**

<i>cytra k gra crystals</i>	Non Preferred	PA
ORACIT SOL	Preferred	
<i>pot &amp; sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	Non Preferred	PA
<i>pot &amp; sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	Non Preferred	PA
<i>potassium citrate &amp; citric acid soln 1100-334 mg/5ml</i>	Non Preferred	PA
<i>potassium citrate tab er 5 meq (540 mg) (generic of UROCIT-K 5)</i>	Non Preferred	PA, QL (3 tabs every 1 day)
<i>potassium citrate tab er 10 meq (1080 mg) (generic of UROCIT-K 10)</i>	Non Preferred	PA, QL (3 tabs every 1 day)
<i>potassium citrate tab er 15 meq (1620 mg) (generic of UROCIT-K 15)</i>	Non Preferred	PA, QL (4 tabs every 1 day)
<i>sodium citrate &amp; citric acid soln 500-334 mg/5ml</i>	Preferred	
UROCIT-K 5 TAB	Non Preferred	PA, QL (3 tabs every 1 day)
UROCIT-K 10 TAB	Non Preferred	PA, QL (3 tabs every 1 day)
UROCIT-K 15 TAB	Non Preferred	PA, QL (4 tabs every 1 day)

**CYSTINOSIS AGENTS**

CYSTAGON CAP 50MG	Preferred	SP
CYSTAGON CAP 150MG	Preferred	SP
PROCYSBI CAP 25MG	Non Preferred	SP, PA
PROCYSBI CAP 75MG	Non Preferred	SP, PA
PROCYSBI GRA 75MG	Non Preferred	SP, PA
PROCYSBI GRA 300MG	Non Preferred	SP, PA

**INTERSTITIAL CYSTITIS AGENTS**

ELMIRON CAP 100MG	Non Preferred	PA
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**PROSTATIC HYPERTROPHY AGENTS**

<i>alfuzosin hcl tab er 24hr 10 mg (generic of UROXATRAL)</i>	Preferred	QL (1 tab every 1 day)
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AVODART CAP 0.5MG	Non Preferred	PA
CARDURA XL TAB 4MG	Non Preferred	PA
CARDURA XL TAB 8MG	Non Preferred	PA
<i>dutasteride cap 0.5 mg</i> (generic of AVODART)	Non Preferred	PA
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i> (generic of JALYN)	Non Preferred	PA
ENTADFI CAP 5-5MG	Non Preferred	PA
<i>finasteride tab 5 mg</i> (generic of PROSCAR)	Preferred	QL (1 tab every 1 day)
FLOMAX CAP 0.4MG	Non Preferred	PA, QL (2 caps every 1 day)
JALYN CAP	Non Preferred	PA
PROSCAR TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
RAPAFLO CAP 4MG	Non Preferred	PA
RAPAFLO CAP 8MG	Non Preferred	PA
<i>silodosin cap 4 mg</i> (generic of RAPAFLO)	Non Preferred	PA
<i>silodosin cap 8 mg</i> (generic of RAPAFLO)	Non Preferred	PA
<i>tamsulosin hcl cap 0.4 mg</i> (generic of FLOMAX)	Preferred	QL (2 caps every 1 day)
<b>URINARY ANALGESICS</b>		
<i>phenazopyridine hcl tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>phenazopyridine hcl tab 200 mg</i>	Preferred	QL (3 tabs every 1 day)
PYRIDIDIUM TAB 100MG	Non Preferred	PA, QL (3 tabs every 1 day)
PYRIDIDIUM TAB 200MG	Non Preferred	PA, QL (3 tabs every 1 day)
<b>URINARY STONE AGENTS</b>		
LITHOSTAT TAB 250MG	Non Preferred	PA
THIOLA EC TAB 100MG	Non Preferred	PA
THIOLA EC TAB 300MG	Non Preferred	PA
THIOLA TAB 100MG	Non Preferred	PA
<i>tiopronin tab 100 mg</i> (generic of THIOLA)	Non Preferred	PA



Drug Name	Drug Tier	Requirements/Limits
<b>GOUT AGENTS - DRUGS TO TREAT GOUT</b>		
<b>GOUT AGENT COMBINATIONS</b>		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	Preferred	QL (3 tabs every 1 day)

**GOUT AGENTS - DRUGS TO TREAT GOUT**

<i>allopurinol tab 100 mg (generic of ZYLOPRIM)</i>	Preferred	QL (6 tabs every 1 day)
ALLOPURINOL TAB 200MG	Preferred	
<i>allopurinol tab 300 mg (generic of ZYLOPRIM)</i>	Preferred	QL (4 tabs every 1 day)
<i>colchicine cap 0.6 mg</i>	Non Preferred	PA
<i>colchicine tab 0.6 mg (generic of COLCRYS)</i>	Non Preferred	PA
COLCRYS TAB 0.6MG	Non Preferred	PA
<i>febuxostat tab 40 mg (generic of ULORIC)</i>	Non Preferred	PA
<i>febuxostat tab 80 mg (generic of ULORIC)</i>	Non Preferred	PA
MITIGARE CAP 0.6MG	Non Preferred	PA
ULORIC TAB 40MG	Non Preferred	PA
ULORIC TAB 80MG	Non Preferred	PA

**URICOSURICS**

<i>probenecid tab 500 mg</i>	Preferred	QL (3 tabs every 1 day)
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**HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS**

**ANTIHEMOPHILIC PRODUCTS**

ADVATE INJ 250UNIT	Preferred	SP, PA
ADVATE INJ 500UNIT	Preferred	SP, PA
ADVATE INJ 1000UNIT	Preferred	SP, PA
ADVATE INJ 1500UNIT	Preferred	SP, PA
ADVATE INJ 2000UNIT	Preferred	SP, PA
ADVATE INJ 3000UNIT	Preferred	SP, PA
ADVATE INJ 4000UNIT	Preferred	SP, PA
ADYNOVATE INJ 250UNIT	Preferred	SP, PA
ADYNOVATE INJ 500UNIT	Preferred	SP, PA
ADYNOVATE INJ 750UNIT	Preferred	SP, PA
ADYNOVATE INJ 1000UNIT	Preferred	SP, PA
ADYNOVATE INJ 1500UNIT	Preferred	SP, PA
ADYNOVATE INJ 2000UNIT	Preferred	SP, PA
ADYNOVATE INJ 3000UNIT	Preferred	SP, PA
AFSTYLA KIT 250UNIT	Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AFSTYLA KIT 500UNIT	Preferred	SP, PA
AFSTYLA KIT 1000UNIT	Preferred	SP, PA
AFSTYLA KIT 1500UNIT	Preferred	SP, PA
AFSTYLA KIT 2000UNIT	Preferred	SP, PA
AFSTYLA KIT 2500UNIT	Preferred	SP, PA
AFSTYLA KIT 3000UNIT	Preferred	SP, PA
ALPHANATE INJ 250 UNIT	Preferred	SP, PA
ALPHANATE INJ 500 UNIT	Preferred	SP, PA
ALPHANATE INJ 1000UNIT	Preferred	SP, PA
ALPHANATE INJ 1500UNIT	Preferred	SP, PA
ALPHANATE INJ 2000UNIT	Preferred	SP, PA
ALPHANINE SD INJ 500UNIT	Preferred	SP, PA
ALPHANINE SD INJ 1000UNIT	Preferred	SP, PA
ALPHANINE SD INJ 1500UNIT	Preferred	SP, PA
ALPROLIX INJ 250UNIT	Preferred	SP, PA
ALPROLIX INJ 500UNIT	Preferred	SP, PA
ALPROLIX INJ 1000UNIT	Preferred	SP, PA
ALPROLIX INJ 2000UNIT	Preferred	SP, PA
ALPROLIX INJ 3000UNIT	Preferred	SP, PA
ALPROLIX INJ 4000UNIT	Preferred	SP, PA
BENEFIX INJ 250UNIT	Preferred	SP, PA
BENEFIX INJ 500UNIT	Preferred	SP, PA
BENEFIX INJ 1000UNIT	Preferred	SP, PA
BENEFIX INJ 2000UNIT	Preferred	SP, PA
BENEFIX INJ 3000UNIT	Preferred	SP, PA
COAGADEX INJ 250UNIT	Preferred	SP, PA
COAGADEX INJ 500UNIT	Preferred	SP, PA
CORIFACT KIT	Preferred	SP, PA
ELOCTATE INJ 250UNIT	Preferred	SP, PA
ELOCTATE INJ 500UNIT	Preferred	SP, PA
ELOCTATE INJ 750UNIT	Preferred	SP, PA
ELOCTATE INJ 1000UNIT	Preferred	SP, PA
ELOCTATE INJ 1500UNIT	Preferred	SP, PA
ELOCTATE INJ 2000UNIT	Preferred	SP, PA
ELOCTATE INJ 3000UNIT	Preferred	SP, PA
ELOCTATE INJ 4000UNIT	Preferred	SP, PA
ELOCTATE INJ 5000UNIT	Preferred	SP, PA
ELOCTATE INJ 6000UNIT	Preferred	SP, PA
ESPEROCT INJ 500UNIT	Preferred	SP, PA
ESPEROCT INJ 1000UNIT	Preferred	SP, PA
ESPEROCT INJ 1500UNIT	Preferred	SP, PA
ESPEROCT INJ 2000UNIT	Preferred	SP, PA
ESPEROCT INJ 3000UNIT	Preferred	SP, PA
FEIBA INJ	Preferred	SP, PA
HEMLIBRA INJ 30MG/ML	Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HEMLIBRA INJ 60/0.4	Preferred	SP, PA
HEMLIBRA INJ 105/0.7	Preferred	SP, PA
HEMLIBRA INJ 150/ML	Preferred	SP, PA
HEMOFIL M INJ 250UNIT	Preferred	SP, PA
HEMOFIL M INJ 500UNIT	Preferred	SP, PA
HEMOFIL M INJ 1000UNIT	Preferred	SP, PA
HEMOFIL M INJ 1700UNIT	Preferred	SP, PA
HUMATE-P SOL 250-600	Preferred	SP, PA
HUMATE-P SOL 500-1200	Preferred	SP, PA
HUMATE-P SOL 2400UNIT	Preferred	SP, PA
IDELVION SOL 250UNIT	Preferred	SP, PA
IDELVION SOL 500UNIT	Preferred	SP, PA
IDELVION SOL 1000UNIT	Preferred	SP, PA
IDELVION SOL 2000UNIT	Preferred	SP, PA
IDELVION SOL 3500UNIT	Preferred	SP, PA
IXINITY INJ 250UNIT	Preferred	SP, PA
IXINITY INJ 500UNIT	Preferred	SP, PA
IXINITY INJ 1000UNIT	Preferred	SP, PA
IXINITY INJ 1500UNIT	Preferred	SP, PA
IXINITY INJ 2000UNIT	Preferred	SP, PA
IXINITY INJ 3000UNIT	Preferred	SP, PA
JIVI INJ 500 UNIT	Preferred	SP, PA
JIVI INJ 1000UNIT	Preferred	SP, PA
JIVI INJ 2000UNIT	Preferred	SP, PA
JIVI INJ 3000UNIT	Preferred	SP, PA
KOATE INJ 250UNIT	Preferred	SP, PA
KOATE INJ 500 UNIT	Preferred	SP, PA
KOATE INJ 1000UNIT	Preferred	SP, PA
KOATE-DVI INJ 1000UNIT	Preferred	SP, PA
KOGENATE FS INJ 250UNIT	Preferred	SP, PA
KOGENATE FS INJ 500UNIT	Preferred	SP, PA
KOGENATE FS INJ 1000UNIT	Preferred	SP, PA
KOGENATE FS INJ 2000UNIT	Preferred	SP, PA
KOGENATE FS INJ 3000UNIT	Preferred	SP, PA
KOVALTRY INJ 250UNIT	Preferred	SP, PA
KOVALTRY INJ 500UNIT	Preferred	SP, PA
KOVALTRY INJ 1000UNIT	Preferred	SP, PA
KOVALTRY INJ 2000UNIT	Preferred	SP, PA
KOVALTRY INJ 3000UNIT	Preferred	SP, PA
NOVOEIGHT INJ 250UNIT	Preferred	SP, PA
NOVOEIGHT INJ 500UNIT	Preferred	SP, PA
NOVOEIGHT INJ 1000UNIT	Preferred	SP, PA
NOVOEIGHT INJ 1500UNIT	Preferred	SP, PA
NOVOEIGHT INJ 2000UNIT	Preferred	SP, PA
NOVOEIGHT INJ 3000UNIT	Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NOVOSEVEN RT INJ 1MG	Preferred	SP, PA
NOVOSEVEN RT INJ 2MG	Preferred	SP, PA
NOVOSEVEN RT INJ 5MG	Preferred	SP, PA
NOVOSEVEN RT INJ 8MG	Preferred	SP, PA
NUWIQ INJ 250UNIT	Preferred	SP, PA
NUWIQ INJ 500UNIT	Preferred	SP, PA
NUWIQ INJ 1000UNIT	Preferred	SP, PA
NUWIQ INJ 1500UNIT	Preferred	SP, PA
NUWIQ INJ 2000UNIT	Preferred	SP, PA
NUWIQ INJ 2500UNIT	Preferred	SP, PA
NUWIQ INJ 3000UNIT	Preferred	SP, PA
NUWIQ INJ 4000UNIT	Preferred	SP, PA
NUWIQ KIT 250UNIT	Preferred	SP, PA
NUWIQ KIT 500UNIT	Preferred	SP, PA
NUWIQ KIT 1000UNIT	Preferred	SP, PA
NUWIQ KIT 1500UNIT	Preferred	SP, PA
NUWIQ KIT 2000UNIT	Preferred	SP, PA
NUWIQ KIT 2500UNIT	Preferred	SP, PA
NUWIQ KIT 3000UNIT	Preferred	SP, PA
NUWIQ KIT 4000UNIT	Preferred	SP, PA
OBIZUR INJ 500 UNIT	Preferred	SP, PA
PROFILNINE INJ 500UNIT	Preferred	SP, PA
PROFILNINE INJ 1000UNIT	Preferred	SP, PA
PROFILNINE INJ 1500UNIT	Preferred	SP, PA
REBINYN INJ 3000UNIT	Preferred	SP, PA
REBINYN SOL 500UNIT	Preferred	SP, PA
REBINYN SOL 1000UNIT	Preferred	SP, PA
REBINYN SOL 2000UNIT	Preferred	SP, PA
RECOMBINATE INJ	Preferred	SP, PA
RECOMBINATE INJ 220-400	Preferred	SP, PA
RECOMBINATE INJ 401-800	Preferred	SP, PA
RECOMBINATE INJ 801-1240	Preferred	SP, PA
RIXUBIS INJ 250 UNIT	Preferred	SP, PA
RIXUBIS INJ 500UNIT	Preferred	SP, PA
RIXUBIS INJ 1000UNIT	Preferred	SP, PA
RIXUBIS INJ 2000UNIT	Preferred	SP, PA
RIXUBIS INJ 3000UNIT	Preferred	SP, PA
SEVENFACT INJ 1MG	Preferred	SP, PA
SEVENFACT INJ 5MG	Preferred	SP, PA
TRETTEN INJ	Preferred	SP, PA
VONVENDI INJ 650UNIT	Preferred	SP, PA
VONVENDI INJ 1300UNIT	Preferred	SP, PA
WILATE INJ	Preferred	SP, PA
XYNTHA INJ 250UNIT	Preferred	SP, PA
XYNTHA INJ 500UNIT	Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XYNTHA INJ 1000UNIT	Preferred	SP, PA
XYNTHA INJ 2000UNIT	Preferred	SP, PA
XYNTHA SOLOF INJ 500UNIT	Preferred	SP, PA
XYNTHA SOLOF INJ 1000UNIT	Preferred	SP, PA
XYNTHA SOLOF INJ 2000UNIT	Preferred	SP, PA
XYNTHA SOLOF INJ 3000UNIT	Preferred	SP, PA
XYNTHA SOLOF KIT 250UNIT	Preferred	SP, PA
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
FIRAZYR INJ 30MG/3ML	Non Preferred	PA
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml (generic of FIRAZYR)</i>	Non Preferred	PA
<i>sajazir inj 30mg/3ml (generic of FIRAZYR)</i>	Non Preferred	PA
<b>COMPLEMENT INHIBITORS</b>		
BERINERT INJ 500UNIT	Preferred	SP, PA
CINRYZE SOL 500 UNIT	Non Preferred	SP, PA
EMPAVELI INJ 1080MG	Non Preferred	PA
ENJAYMO SOL	Non Preferred	PA
HAEGARDA INJ 2000UNIT	Non Preferred	SP, PA
HAEGARDA INJ 3000UNIT	Non Preferred	SP, PA
RUCONEST INJ 2100UNIT	Non Preferred	SP, PA
SOLIRIS INJ 10MG/ML	Non Preferred	PA
TAVNEOS CAP 10MG	Non Preferred	PA
ULTOMIRIS INJ 100MG/ML	Non Preferred	PA
<b>HEMATAOLOGIC - TYROSINE KINASE INHIBITORS</b>		
TAVALISSE TAB 100MG	Non Preferred	SP, PA
TAVALISSE TAB 150MG	Non Preferred	SP, PA
<b>HEMATORHEOLOGIC AGENTS</b>		
<i>pentoxifylline tab er 400 mg</i>	Preferred	QL (4 ea every 1 day)
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR INJ 10MG/ML	Non Preferred	SP, PA
ORLADEYO CAP 110MG	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ORLADEYO CAP 150MG	Non Preferred	SP, PA
TAKHZYRO INJ 150MG/ML	Non Preferred	SP, PA
TAKHZYRO INJ 300/2ML	Non Preferred	SP, PA

### **PLATELET AGGREGATION INHIBITORS**

AGRYLIN CAP 0.5MG	Non Preferred	PA
<i>anagrelide hcl cap 0.5 mg (generic of AGRYLIN)</i>	Preferred	
<i>anagrelide hcl cap 1 mg</i>	Preferred	
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	Preferred	
BRILINTA TAB 60MG	Preferred	
BRILINTA TAB 90MG	Preferred	
<i>cilostazol tab 50 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>cilostazol tab 100 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
<i>clopidogrel bisulfate tab 75 mg (base equiv) (generic of PLAVIX)</i>	Preferred	QL (1 tab every 1 day)
<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	Preferred	
<i>dipyridamole tab 25 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>dipyridamole tab 50 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>dipyridamole tab 75 mg</i>	Preferred	QL (4 tabs every 1 day)
EFFIENT TAB 5MG	Non Preferred	PA
EFFIENT TAB 10MG	Non Preferred	PA
PLAVIX TAB 75MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>prasugrel hcl tab 5 mg (base equiv) (generic of EFFIENT)</i>	Non Preferred	PA
<i>prasugrel hcl tab 10 mg (base equiv) (generic of EFFIENT)</i>	Non Preferred	PA

### **HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS**

#### **COBALAMINS**

<i>cyanocobalamin tab 100 mcg</i>	Preferred	OTC
<i>cyanocobalamin tab 500 mcg</i>	Preferred	OTC
<i>cyanocobalamin tab 1000 mcg</i>	Preferred	OTC

#### **FOLIC ACID/FOLATES**

<i>folic acid tab 1 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>folic acid tab 400 mcg</i>	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
ARANESP INJ 10MCG	Non Preferred	PA
ARANESP INJ 25MCG	Non Preferred	PA
ARANESP INJ 40MCG	Non Preferred	PA
ARANESP INJ 60MCG	Non Preferred	PA
ARANESP INJ 100MCG	Non Preferred	PA
ARANESP INJ 150MCG	Non Preferred	PA
ARANESP INJ 200MCG	Non Preferred	PA
ARANESP INJ 300MCG	Non Preferred	PA
ARANESP INJ 500MCG	Non Preferred	PA
DOPTELET TAB 20MG	Non Preferred	SP, PA
EPOGEN INJ 2000/ML	Preferred	PA
EPOGEN INJ 3000/ML	Preferred	PA
EPOGEN INJ 4000/ML	Preferred	PA
EPOGEN INJ 10000/ML	Preferred	PA
EPOGEN INJ 20000/ML	Preferred	PA
FULPHILA INJ 6/0.6ML	Non Preferred	PA, QL (0.072 syringes every 1 day)
FYLNETRA INJ 6MG/0.6	Non Preferred	PA
GRANIX INJ 300/0.5	Non Preferred	PA
GRANIX INJ 300/1ML	Non Preferred	PA
GRANIX INJ 480/0.8	Non Preferred	PA
GRANIX INJ 480/1.6	Non Preferred	PA
LEUKINE INJ 250MCG	Preferred	
MIRCERA INJ 30MCG	Non Preferred	PA
MIRCERA INJ 50MCG	Non Preferred	PA
MIRCERA INJ 75MCG	Non Preferred	PA
MIRCERA INJ 100MCG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MIRCERA INJ 120MCG	Non Preferred	PA
MIRCERA INJ 150MCG	Non Preferred	PA
MIRCERA INJ 200MCG	Non Preferred	PA
MULPLETA TAB 3MG	Non Preferred	SP, PA
NEULASTA INJ 6MG/0.6M	Non Preferred	PA, QL (0.072 syringes every 1 day)
NEULASTA KIT 6MG/0.6M	Non Preferred	PA, QL (0.6 mL every 11 days)
NEUPOGEN INJ 300/0.5	Preferred	
NEUPOGEN INJ 300MCG	Preferred	
NEUPOGEN INJ 480/0.8	Preferred	
NEUPOGEN INJ 480MCG	Preferred	
NIVESTYM INJ 300/0.5	Non Preferred	PA
NIVESTYM INJ 300MCG	Non Preferred	PA
NIVESTYM INJ 480/0.8	Non Preferred	PA
NIVESTYM INJ 480MCG	Non Preferred	PA
NPLATE INJ 125MCG	Non Preferred	SP, PA
NPLATE INJ 250MCG	Non Preferred	SP, PA
NPLATE INJ 500MCG	Non Preferred	SP, PA
NYVEPRIA INJ 6/0.6ML	Non Preferred	PA
PROCRIT INJ 2000/ML	Preferred	PA
PROCRIT INJ 3000/ML	Preferred	PA
PROCRIT INJ 4000/ML	Preferred	PA
PROCRIT INJ 10000/ML	Preferred	PA
PROCRIT INJ 20000/ML	Preferred	PA
PROCRIT INJ 40000/ML	Preferred	PA
PROMACTA PAK 25MG	Non Preferred	SP, PA
PROMACTA POW 12.5MG	Non Preferred	SP, PA
PROMACTA TAB 12.5MG	Non Preferred	SP, PA
PROMACTA TAB 25MG	Non Preferred	SP, PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PROMACTA TAB 50MG	Non Preferred	SP, PA
PROMACTA TAB 75MG	Non Preferred	SP, PA
REBLOZYL INJ 25MG	Non Preferred	SP, PA
REBLOZYL INJ 75MG	Non Preferred	SP, PA
RELEUKO INJ 300MCG	Non Preferred	PA
RELEUKO INJ 480MCG	Non Preferred	PA
RETACRIT INJ 2000UNIT	Non Preferred	PA
RETACRIT INJ 3000UNIT	Non Preferred	PA
RETACRIT INJ 4000UNIT	Non Preferred	PA
RETACRIT INJ 10000UNT	Non Preferred	PA
RETACRIT INJ 20000UNI	Non Preferred	PA
RETACRIT INJ 40000UNT	Non Preferred	PA
ROLVEDON INJ 13.2MG	Non Preferred	PA
STIMUFEND INJ 6/0.6ML	Non Preferred	PA
UDENYCA INJ 6MG/.6ML	Non Preferred	PA, QL (0.072 syringes every 1 day)
ZARXIO INJ 300/0.5	Non Preferred	PA
ZARXIO INJ 480/0.8	Non Preferred	PA
ZIEXTENZO INJ 6/0.6ML	Non Preferred	PA, QL (0.072 syringes every 1 day)
<b>IRON</b>		
<i>ferrex 150 cap 150mg</i>	Preferred	OTC
<i>ferrocite tab 324mg</i>	Preferred	OTC
<i>ferrous fumarate tab 324 mg (106 mg elemental fe)</i>	Preferred	OTC
FERROUS GLUC TAB 324MG	Preferred	OTC
<i>ferrous gluconate tab 240 mg (27 mg elemental fe)</i>	Preferred	OTC
FERROUS SULF TAB 324MG EC	Preferred	OTC
<i>ferrous sulfate dried tab 200 mg (65 mg elemental fe)</i>	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ferrous sulfate dried tab er 160 mg (50 mg fe equivalent)</i>	Preferred	OTC
<i>ferrous sulfate elixir 220 mg/5ml (44 mg/5ml elemental fe)</i>	Preferred	OTC
<i>ferrous sulfate soln 75 mg/ml (15 mg/ml elemental fe)</i>	Preferred	OTC
<i>ferrous sulfate tab 325 mg (65 mg elemental fe)</i>	Preferred	OTC
<i>ferrous sulfate tab ec 325 mg (65 mg fe equivalent)</i>	Preferred	OTC
<i>ferrous sulfate tab er 142 mg (45 mg fe equivalent)</i>	Preferred	OTC
<i>nu-iron 150 cap 150mg</i>	Preferred	OTC
<i>poly-iron cap 150mg</i>	Preferred	OTC
<i>polysaccharide iron complex cap 150 mg (iron equivalent)</i>	Preferred	OTC

## **HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS**

### **ANTIHISTAMINE HYPNOTICS**

<i>diphenhydramine hcl (sleep) tab 25 mg</i>	Preferred	QL (1 tab every 1 day), OTC
<i>doxylamine succinate (sleep) tab 25 mg</i>	Preferred	QL (1 tab every 1 day), OTC

### **BARBITURATE HYPNOTICS**

<i>phenobarbital elixir 20 mg/5ml</i>	Preferred	QL (50 mL every 1 day)
<i>phenobarbital tab 15 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>phenobarbital tab 16.2 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>phenobarbital tab 30 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>phenobarbital tab 32.4 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>phenobarbital tab 60 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>phenobarbital tab 64.8 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>phenobarbital tab 97.2 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>phenobarbital tab 100 mg</i>	Preferred	QL (2 tabs every 1 day)

### **HYPNOTICS - TRICYCLIC AGENTS**

<i>doxepin hcl (sleep) tab 3 mg (base equiv) (generic of SILENOR)</i>	Non Preferred	PA
<i>doxepin hcl (sleep) tab 6 mg (base equiv) (generic of SILENOR)</i>	Non Preferred	PA
SILENOR TAB 3MG	Non Preferred	PA
SILENOR TAB 6MG	Non Preferred	PA

### **NON-BARBITURATE HYPNOTICS**

AMBIEN CR TAB 6.25MG	Non Preferred	PA
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AMBIEN CR TAB 12.5MG	Non Preferred	PA
AMBIEN TAB 5MG	Non Preferred	PA, QL (2 tabs every 1 day)
AMBIEN TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
DORAL TAB 15MG	Non Preferred	PA
EDLUAR SUB 5MG	Non Preferred	PA
EDLUAR SUB 10MG	Non Preferred	PA
<i>estazolam tab 1 mg</i>	Preferred	QL (1 tab every 1 day)
<i>estazolam tab 2 mg</i>	Preferred	QL (1 tab every 1 day)
<i>eszopiclone tab 1 mg (generic of LUNESTA)</i>	Non Preferred	PA
<i>eszopiclone tab 2 mg (generic of LUNESTA)</i>	Non Preferred	PA
<i>eszopiclone tab 3 mg (generic of LUNESTA)</i>	Non Preferred	PA
HALCION TAB 0.25MG	Non Preferred	PA, QL (2 tabs every 1 day)
LUNESTA TAB 1MG	Non Preferred	PA
LUNESTA TAB 2MG	Non Preferred	PA
LUNESTA TAB 3MG	Non Preferred	PA
<i>midazolam hcl syrup 2 mg/ml (base equivalent)</i>	Non Preferred	PA
<i>midazolam hcl syrup 2 mg/ml (base equivalent)</i>	Non Preferred	PA
<i>quazepam tab 15 mg</i>	Preferred	
RESTORIL CAP 7.5MG	Non Preferred	PA
RESTORIL CAP 15MG	Non Preferred	PA, QL (1 cap every 1 day)
RESTORIL CAP 22.5MG	Non Preferred	PA
RESTORIL CAP 30MG	Non Preferred	PA, QL (1 cap every 1 day)
<i>temazepam cap 7.5 mg (generic of RESTORIL)</i>	Preferred	
<i>temazepam cap 15 mg (generic of RESTORIL)</i>	Preferred	QL (1 cap every 1 day)
<i>temazepam cap 22.5 mg (generic of RESTORIL)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>temazepam cap 30 mg</i> (generic of RESTORIL)	Preferred	QL (1 cap every 1 day)
<i>triazolam tab 0.25 mg</i> (generic of HALCION)	Preferred	QL (2 tabs every 1 day)
<i>triazolam tab 0.125 mg</i>	Preferred	QL (1 tab every 1 day)
<i>zaleplon cap 5 mg</i>	Non Preferred	PA
<i>zaleplon cap 10 mg</i>	Non Preferred	PA
<i>zolpidem tartrate sl tab 1.75 mg</i>	Non Preferred	PA
<i>zolpidem tartrate sl tab 3.5 mg</i>	Non Preferred	PA
<i>zolpidem tartrate tab 5 mg</i> (generic of AMBIEN)	Preferred	QL (2 tabs every 1 day)
<i>zolpidem tartrate tab 10 mg</i> (generic of AMBIEN)	Preferred	QL (1 tab every 1 day)
<i>zolpidem tartrate tab er 6.25 mg</i> (generic of AMBIEN CR)	Non Preferred	PA
<i>zolpidem tartrate tab er 12.5 mg</i> (generic of AMBIEN CR)	Non Preferred	PA
<b>OREXIN RECEPTOR ANTAGONISTS</b>		
BELSOMRA TAB 5MG	Non Preferred	PA
BELSOMRA TAB 10MG	Non Preferred	PA
BELSOMRA TAB 15MG	Non Preferred	PA
BELSOMRA TAB 20MG	Non Preferred	PA
DAYVIGO TAB 5MG	Non Preferred	PA
DAYVIGO TAB 10MG	Non Preferred	PA
QUVIVIQ TAB 25MG	Non Preferred	PA
QUVIVIQ TAB 50MG	Non Preferred	PA
<b>SELECTIVE MELATONIN RECEPTOR AGONISTS</b>		
HETLIOZ CAP 20MG	Non Preferred	SP, PA
HETLIOZ LQ SUS 4MG/ML	Non Preferred	PA
<i>ramelteon tab 8 mg</i> (generic of ROZEREM)	Non Preferred	PA
ROZEREM TAB 8MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tasimelteon capsule 20 mg (generic of HETLIOZ)</i>	Non Preferred	SP, PA

## **LAXATIVES - DRUGS TO TREAT CONSTIPATION**

### **BULK LAXATIVES**

<i>calcium polycarbophil tab 625 mg</i>	Preferred	OTC
KONSYL DAILY POW 100%	Preferred	OTC
KONSYL ORIG POW 100%	Preferred	OTC
<i>methylcellulose tab 500 mg</i>	Preferred	OTC
<i>psyllium cap 0.52 gm</i>	Preferred	OTC
<i>psyllium powder 28.3%</i>	Preferred	OTC
<i>psyllium powder 48.57%</i>	Preferred	OTC
<i>psyllium powder 58.6%</i>	Preferred	OTC
<i>qc natural pow vegetabl</i>	Preferred	OTC
<i>wheat dextrin oral powder</i>	Preferred	OTC

### **LAXATIVE COMBINATIONS**

<i>gavilyte-c sol</i>	Preferred	QL (4000 mL every 1 day)
<i>gavilyte-g sol (generic of GOLYTELY)</i>	Preferred	QL (4000 mL every 1 day)
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm (generic of GOLYTELY)</i>	Preferred	QL (4000 mL every 1 day)
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	Preferred	QL (4000 mL every 1 day)
<i>sennosides-docusate sodium tab 8.6-50 mg</i>	Preferred	QL (6 tabs every 1 day), OTC

### **LAXATIVES - MISCELLANEOUS**

<i>constulose sol 10gm/15</i>	Preferred	QL (180 mL every 1 day)
<i>glycerin suppos 1.2 gm</i>	Preferred	OTC
<i>glycerin suppos 2 gm</i>	Preferred	OTC
<i>glycerin suppos 2.1 gm</i>	Preferred	OTC
<i>glycerin suppos 80.7%</i>	Preferred	OTC
<i>lactulose solution 10 gm/15ml</i>	Preferred	QL (180 mL every 1 day)
<i>polyethylene glycol 3350 oral powder</i>	Preferred	QL (34 gm every 1 day), OTC

### **LUBRICANT LAXATIVES**

<i>mineral oil</i>	Preferred	OTC
<i>mineral oil enema</i>	Preferred	OTC

### **SALINE LAXATIVES**

<i>magnesium citrate soln</i>	Preferred	OTC
<i>magnesium hydroxide susp 400 mg/5ml</i>	Preferred	OTC
<i>sodium phosphates - enema</i>	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>STIMULANT LAXATIVES</b>		
<i>bisacodyl suppos 10 mg</i>	Preferred	QL (1 supp every 1 day), OTC
<i>bisacodyl tab delayed release 5 mg</i>	Preferred	QL (3 tabs every 1 day), OTC
<i>sennosides chew tab 15 mg</i>	Preferred	OTC
<i>sennosides syrup 8.8 mg/5ml</i>	Preferred	OTC
<i>sennosides tab 8.6 mg</i>	Preferred	QL (2 tabs every 1 day), OTC
<i>sennosides tab 25 mg</i>	Preferred	OTC
<b>SURFACTANT LAXATIVES</b>		
<i>docusate calcium cap 240 mg</i>	Preferred	QL (2 caps every 1 day), OTC
<i>docusate sodium cap 100 mg</i>	Preferred	QL (6 caps every 1 day), OTC
<i>docusate sodium cap 250 mg</i>	Preferred	QL (6 caps every 1 day), OTC
<i>docusate sodium liquid 150 mg/15ml</i>	Preferred	QL (30 mL every 1 day), OTC
<i>docusate sodium tab 100 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
<i>docusol plus ene 20-283</i>	Preferred	OTC
<i>enemeez plus ene 20-283</i>	Preferred	OTC
PEDIA-LAX LIQ 50MG	Preferred	QL (30 mL every 1 day), OTC

## **MACROLIDES - DRUGS TO TREAT INFECTIONS**

### **AZITHROMYCIN**

<i>azithromycin for susp 100 mg/5ml (generic of ZITHROMAX)</i>	Preferred	QL (20 mL every 1 day)
<i>azithromycin for susp 200 mg/5ml (generic of ZITHROMAX)</i>	Preferred	QL (30 mL every 1 day)
<i>azithromycin powd pack for susp 1 gm</i>	Preferred	QL (1 packet every 1 day)
<i>azithromycin tab 250 mg (generic of ZITHROMAX)</i>	Preferred	
<i>azithromycin tab 500 mg (generic of ZITHROMAX)</i>	Preferred	
<i>azithromycin tab 600 mg</i>	Preferred	QL (1 tab every 1 day)
ZITHROMAX POW 1GM PAK	Preferred	QL (1 packet every 1 day)
ZITHROMAX SUS 100/5ML	Non Preferred	PA, QL (20 mL every 1 day)
ZITHROMAX SUS 200/5ML	Non Preferred	PA, QL (30 mL every 1 day)
ZITHROMAX TAB 250MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZITHROMAX TAB 500MG	Non Preferred	PA
ZITHROMAX TAB TRI-PAK	Non Preferred	PA
ZITHROMAX TAB Z-PAK	Non Preferred	PA

### **CLARITHROMYCIN**

<i>clarithromycin for susp 125 mg/5ml</i>	Preferred	
<i>clarithromycin for susp 250 mg/5ml</i>	Preferred	
<i>clarithromycin tab 250 mg</i>	Preferred	
<i>clarithromycin tab 500 mg</i>	Preferred	
<i>clarithromycin tab er 24hr 500 mg (generic of BIAXIN XL)</i>	Preferred	

### **ERYTHROMYCINS**

<i>e.e.s. 400 tab 400mg</i>	Preferred	
E.E.S. GRAN SUS 200/5ML	Preferred	
<i>ery-tab tab 250mg ec</i>	Preferred	
<i>ery-tab tab 333mg ec</i>	Preferred	
<i>ery-tab tab 500mg ec</i>	Preferred	
ERYPED SUS 200/5ML	Preferred	
ERYPED SUS 400/5ML	Preferred	
<i>erythrocin tab 250mg</i>	Preferred	
<i>erythromycin ethylsuccinate for susp 200 mg/5ml (generic of E.E.S. GRANULES)</i>	Preferred	
<i>erythromycin ethylsuccinate for susp 400 mg/5ml (generic of ERYPED 400)</i>	Preferred	
<i>erythromycin ethylsuccinate tab 400 mg</i>	Preferred	
<i>erythromycin tab 250 mg</i>	Preferred	
<i>erythromycin tab 500 mg</i>	Preferred	
<i>erythromycin tab delayed release 250 mg</i>	Preferred	
<i>erythromycin tab delayed release 333 mg</i>	Preferred	
<i>erythromycin tab delayed release 500 mg</i>	Preferred	
<i>erythromycin w/ delayed release particles cap 250 mg</i>	Preferred	

### **FIDAXOMICIN**

DIFICID SUS	Non Preferred	PA
DIFICID TAB 200MG	Non Preferred	PA

## **MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING**

### **CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL**

CONDOMS - FEMALE	Preferred	OTC
CONDOMS - MALE	Preferred	OTC; QL (max quantity 12 per fill)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CONDOMS LATEX LUBRICATED	Preferred	OTC; QL (max quantity 12 per fill)
CONDOMS LATEX NON-LUBRICATED	Preferred	OTC; QL (max quantity 12 per fill)
FEMCAP MIS 30MM	Preferred	

### **DIABETIC SUPPLIES**

ACCU-CHECK KIT GUIDE ME	Non Preferred	PA, QL (1 kit every year), OTC
ACCU-CHEK KIT AVIVA PL	Non Preferred	PA, QL (1 kit every year), OTC
ACCU-CHEK KIT GUIDE	Non Preferred	PA, QL (1 kit every year), OTC
ACTI-LANCE MIS 28G	Preferred	OTC
ACTI-LANCE MIS LITE 28G	Preferred	OTC
ACTI-LANCE MIS SPEC 17G	Preferred	OTC
ACTI-LANCE MIS UNIV 23G	Preferred	OTC
ADVANCE KIT INTUITIO	Non Preferred	PA, QL (1 kit every year), OTC
ADVANCE MIS INTUITIO	Non Preferred	PA, OTC
ADVANCE MIS MICRO-DW	Non Preferred	PA, OTC
ADVOCATE KIT	Non Preferred	PA, QL (1 kit every year), OTC
ADVOCATE KIT REDICODE	Non Preferred	PA, QL (1 kit every year), OTC
ADVOCATE MIS	Non Preferred	PA, OTC
ADVOCATE MIS LANC 30G	Preferred	OTC
ADVOCATE MIS REDICODE	Non Preferred	PA, OTC
ADVOCATE RED MIS	Non Preferred	PA, OTC
ADVOCATE+ MIS REDI-COD	Non Preferred	PA, OTC
AGAMA JAZZ KIT WRLSS 2	Non Preferred	PA, QL (1 kit every year), OTC
AGAMATRIX KIT PRESTO	Non Preferred	PA, QL (1 kit every year), OTC
AGAMATRIX MIS 33G	Preferred	OTC
AGAMATRIX MIS AMP	Non Preferred	PA, OTC
AGAMATRIX MIS PRESTO	Non Preferred	PA, OTC
AIMSCO TWIST MIS 32G	Preferred	OTC
AIMSCO TWIST MIS 33G	Preferred	OTC



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ASSURE 3 KIT METER	Non Preferred	PA, OTC
ASSURE 4 MIS	Non Preferred	PA, OTC
ASSURE LANCE MIS 21G	Preferred	OTC
ASSURE LANCE MIS 28G	Preferred	OTC
ASSURE LANCE MIS LOW FLOW	Preferred	OTC
ASSURE LANCE MIS MICRO	Preferred	OTC
ASSURE LANCE MIS SAFE 25G	Preferred	OTC
ASSURE LANCE MIS SAFE 30G	Preferred	OTC
ASSURE MIS PLATINUM	Non Preferred	PA, OTC
ASSURE PLUS MIS HIGH 18G	Preferred	OTC
ASSURE PLUS MIS LOW 25G	Preferred	OTC
ASSURE PLUS MIS MCRO 28G	Preferred	OTC
ASSURE PLUS MIS NORM 21G	Preferred	OTC
ASSURE PLUS MIS PEDIATRI	Preferred	OTC
ASSURE PRISM MIS MULTI	Non Preferred	PA, OTC
ASSURE PRO MIS METER	Non Preferred	PA, OTC
AURORA LANCE MIS 30G	Preferred	OTC
AURORA LANCE MIS THIN 23G	Preferred	OTC
AUTOCODE SYS KIT GLUCOSE	Non Preferred	PA, QL (1 kit every year), OTC
BD LANCET UF MIS 30G	Preferred	OTC
BD LANCET UF MIS 33G	Preferred	OTC
BD LATITUDE KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
BD LOGIC KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
BIGFOOT UNIT KIT PROGRAM	Non Preferred	PA
BIOTEL CARE KIT	Non Preferred	PA, QL (1 kit every year), OTC
BIOTEL CARE KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
BLOOD GLUC KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
BLOOD GLUC MIS METER	Non Preferred	PA, OTC
BLOOD GLUCOS KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
BLOOD GLUCOS MIS 333	Non Preferred	PA, OTC
BLULINK MIS GLUCOSE	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CAREONE LANC MIS 30G	Preferred	OTC
CAREONE LANC MIS THIN 23G	Preferred	OTC
CARESENS 30G MIS LANCETS	Preferred	OTC
CARESENS N MIS SYSTEM	Non Preferred	PA, OTC
CARESENS N MIS VOICE	Non Preferred	PA, OTC
CARETOUCH KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
CARETOUCH MIS TWIST 28	Preferred	OTC
CARETOUCH MIS TWIST 30	Preferred	OTC
CLEANLET 28G MIS LANCETS	Preferred	OTC
CLEVER CHEK KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
CLEVER CHEK MIS AUTO-CD	Non Preferred	PA, OTC
CLEVER CHEK MIS VOICE	Non Preferred	PA, OTC
CLEVER CHOIC KIT MICRO	Non Preferred	PA, QL (1 kit every year), OTC
CLEVR CHOICE MIS AUTO-CD	Non Preferred	PA, OTC
CLEVR CHOICE MIS MINI	Non Preferred	PA, OTC
CLEVR CHOICE MIS TALK	Non Preferred	PA, OTC
COAGUCHEK MIS LANCETS	Preferred	OTC
COMFORT ASSU MIS LANC 28G	Preferred	OTC
COMFORT ASSU MIS LANC 33G	Preferred	OTC
COMFORT MIS LANCETS	Preferred	OTC
COMFORT TCH MIS LANC 28G	Preferred	OTC
COMFORT TCH MIS LANC 30G	Preferred	OTC
COMFORT TCH MIS LANC 31G	Preferred	OTC
COMFORTOUCH MIS LANCET	Preferred	OTC
CONTOUR KIT NEXT	Non Preferred	PA, QL (1 kit every year), OTC
CONTOUR KIT NEXT EZ	Non Preferred	PA, QL (1 kit every year), OTC
CONTOUR KIT NEXT LNK	Non Preferred	PA, QL (1 kit every year), OTC
CONTOUR MIS MONITOR	Non Preferred	PA, OTC
CONTOUR NEXT KIT GEN	Non Preferred	PA, QL (1 kit every year), OTC
CONTOUR NEXT KIT ONE	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CONTOUR NEXT MIS ONE	Non Preferred	PA, OTC
CONTOUR NXT KIT LINK 2.4	Non Preferred	PA, QL (1 kit every year), OTC
COOL MIS MONITOR	Non Preferred	PA, OTC
COOL MONITOR KIT	Non Preferred	PA, QL (1 kit every year), OTC
CVS GLUCOSE KIT METER	Non Preferred	PA, QL (1 kit every year), OTC
CVS LANCETS MIS 21G	Preferred	OTC
CVS LANCETS MIS 30G	Preferred	OTC
CVS LANCETS MIS 33G	Preferred	OTC
CVS LANCETS MIS ORIGINAL	Preferred	OTC
CVS LANCETS MIS THIN 26G	Preferred	OTC
CVS LANCETS MIS THIN 30G	Preferred	OTC
CVS LANCETS MIS THIN 33G	Preferred	OTC
D-CARE GLUCO KIT TEST STR	Non Preferred	PA, QL (1 kit every year)
DEXCOM G6 RECEIVER	Preferred	PA
DEXCOM G6 SENSOR	Preferred	PA
DEXCOM G6 TRANSMITTER	Preferred	PA
DEXCOM G7 MIS RECEIVER	Preferred	PA
DEXCOM G7 MIS SENSOR	Preferred	PA
DIABETES KIT ADD-ON	Non Preferred	PA, OTC
DIABETES KIT SOLUTION	Non Preferred	PA, OTC
DIATHRIVE MIS LANCETS	Preferred	OTC
DIATHRIVE MIS METER	Non Preferred	PA, OTC
DIATHRIVE MIS UT 30G	Preferred	OTC
DIATHRIVE+ KIT SYSTEM	Non Preferred	PA, OTC
DIATRUE PLUS MIS MONITOR	Non Preferred	PA, OTC
DROPLET LANC MIS 30G	Preferred	OTC
DROPLET PERS MIS LANC 30G	Preferred	OTC
E-Z JECT MIS 21G	Preferred	OTC
E-Z JECT MIS 21G COLR	Preferred	OTC
E-Z JECT MIS 30G	Preferred	OTC
E-Z JECT MIS 32G COLR	Preferred	OTC
E-Z JECT MIS LANC 21G	Preferred	OTC
E-Z JECT MIS THIN 26G	Preferred	OTC
E-ZJECT LANC MIS 33G	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EASY PLUS II MIS SYSTEM	Non Preferred	PA, OTC
EASY STEP MIS MONITOR	Non Preferred	PA, OTC
EASY TALK MIS SYSTEM	Non Preferred	PA, OTC
EASY TOUCH KIT METER	Non Preferred	PA, QL (1 kit every year), OTC
EASY TOUCH KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
EASY TOUCH MIS LANC/21G	Preferred	OTC
EASY TOUCH MIS LANC/23G	Preferred	OTC
EASY TOUCH MIS LANC/26G	Preferred	OTC
EASY TOUCH MIS LANC/28G	Preferred	OTC
EASY TOUCH MIS LANC/30G	Preferred	OTC
EASY TOUCH MIS LANC/32G	Preferred	OTC
EASY TOUCH MIS LANC/33G	Preferred	OTC
EASY TOUCH MIS METER	Non Preferred	PA, OTC
EASY TOUNCH MIS GLUCOSE	Non Preferred	PA, OTC
EASY TRAK II MIS SYSTEM	Non Preferred	PA, OTC
EASY TRAK MIS SYSTEM	Non Preferred	PA, OTC
EASYGLUCO KIT	Non Preferred	PA, OTC
EASYGLUCO KIT STARTER	Non Preferred	PA, OTC
EASYMAX NG KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
EASYMAX NG MIS SYSTEM	Non Preferred	PA, OTC
EASYMAX V MIS SYSTEM	Non Preferred	PA, OTC
EASYPRO KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
EASYPRO PLUS KIT	Non Preferred	PA, QL (1 kit every year), OTC
ELEMENT AUTO KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
ELEMENT GLUC MIS SYSTEM	Non Preferred	PA, OTC
ELEMENT PLUS MIS METER	Non Preferred	PA, OTC
EMBRACE EVO KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EMBRACE EVO MIS MONITOR	Non Preferred	PA, OTC
EMBRACE LANC MIS 21G	Preferred	OTC
EMBRACE LANC MIS 28G	Preferred	OTC
EMBRACE MIS	Non Preferred	PA, OTC
EMBRACE PRO MIS	Non Preferred	PA, OTC
EMBRACE TALK KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
EMBRACE TALK MIS MONITOR	Non Preferred	PA, OTC
ENLITE GLUCO MIS SENSOR	Non Preferred	PA
EQL LANCETS MIS 21G COLR	Preferred	OTC
EQL LANCETS MIS 33G COLR	Preferred	OTC
EQL LANCETS MIS THIN 26G	Preferred	OTC
EQL LANCETS MIS THIN 30G	Preferred	OTC
EVERSENSE E3 MIS SENSOR	Non Preferred	PA
EVERSENSE E3 MIS TRANSMTR	Non Preferred	PA
EVERSENSE MIS SENSOR	Non Preferred	PA
EVERSENSE MIS TRANSMTR	Non Preferred	PA
EVOLUTION MIS AUTOCODE	Non Preferred	PA, OTC
EZ-LETS 21G MIS LANCETS	Preferred	OTC
EZ-LETS 26G MIS LANCETS	Preferred	OTC
EZ-LETS 28G MIS LANCETS	Preferred	OTC
EZ-LETS 30G MIS LANCETS	Preferred	OTC
FASTCLIX MIS LANCETS	Preferred	OTC
FIFTY50 GLUC KIT METR 2.0	Non Preferred	PA, QL (1 kit every year), OTC
FIFTY50 SAFE MIS LANCETS	Preferred	OTC
FINE 30 MIS	Preferred	OTC
FORA G20 KIT	Non Preferred	PA, QL (1 kit every year), OTC
FORA G30A MIS	Non Preferred	PA, OTC
FORA GD20 MIS	Non Preferred	PA, OTC
FORA GD50 MIS MONITOR	Non Preferred	PA, OTC
FORA GTEL MIS MONITOR	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FORA LANCETS MIS 30G	Preferred	OTC
FORA MIS LANCETS	Preferred	OTC
FORA TEST N' MIS GO	Non Preferred	PA, OTC
FORA TN'G KIT VOICE	Non Preferred	PA, QL (1 kit every year), OTC
FORA V10 MIS	Non Preferred	PA, OTC
FORA V12 MIS	Non Preferred	PA, OTC
FORA V12 MIS NO CODE	Non Preferred	PA, OTC
FORA V20 MIS	Non Preferred	PA, OTC
FORA V30A KIT	Non Preferred	PA, QL (1 kit every year), OTC
FORA V30A MIS	Non Preferred	PA, OTC
FORACARE MIS GD40	Non Preferred	PA, OTC
FORACARE MIS TST N GO	Non Preferred	PA, OTC
FORTISCARE MIS T1	Non Preferred	PA, OTC
FREESTY LIBR KIT 2 SENSOR	Preferred	PA
FREESTY LIBR KIT 3 SENSOR	Preferred	PA
FREESTY LIBR MIS 2 READER	Preferred	PA
FREESTYLE KIT FREEDOM	Non Preferred	PA, QL (1 kit every year), OTC
FREESTYLE KIT LITE	Non Preferred	PA, QL (1 kit every year), OTC
FREESTYLE LIBRE READER	Preferred	PA
FREESTYLE LIBRE READER	Non Preferred	PA
FREESTYLE LIBRE SENSOR	Preferred	PA
FREESTYLE MIS LANCETS	Preferred	OTC
FREESTYLE MIS LITE	Non Preferred	PA, OTC
GE100 BLOOD MIS GLUCOSE	Non Preferred	PA, OTC
GE100 GLUCOS KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
GENTEEL MIS LANCETS	Preferred	OTC
GENTLE-LET MIS 26G	Preferred	OTC
GENTLE-LET MIS 28G	Preferred	OTC
GENTLE-LET MIS LANCETS	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GLUCO PERFEC MIS 3 METER	Non Preferred	PA, OTC
GLUCO PERFEC MIS 3/VOICE	Non Preferred	PA, OTC
GLUCOCARD 01 KIT MINI	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD 01 KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD 01 MIS METER	Non Preferred	PA, OTC
GLUCOCARD KIT EXPRESSI	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD KIT SHINE	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD KIT SHNE CON	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD KIT SHNE EXP	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD KIT VITAL	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD KIT X-METER	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCARD MIS SHINE	Non Preferred	PA, OTC
GLUCOCARD MIS SHINE XL	Non Preferred	PA, OTC
GLUCOCOM KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
GLUCOCOM MIS 28G	Preferred	OTC
GLUCOCOM MIS 30G	Preferred	OTC
GLUCOCOM MIS 33G	Preferred	OTC
GLUCOCOM MIS MONITOR	Non Preferred	PA, OTC
GLUCONAVII KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
GNP LANCETS MIS 21G	Preferred	OTC
GNP LANCETS MIS 28G	Preferred	OTC
GNP LANCETS MIS 30G	Preferred	OTC
GNP LANCETS MIS 33G	Preferred	OTC
GNP LANCETS MIS THIN 26G	Preferred	OTC
GOJJI LANCET MIS 30G	Preferred	OTC
GOODSENSE MIS LANC 26G	Preferred	OTC
GOODSENSE MIS LANC 30G	Preferred	OTC
GOODSENSE MIS LANC 33G	Preferred	OTC
GUARDIAN 4 MIS SENSOR	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GUARDIAN 4 MIS TRANSMIT	Non Preferred	PA
GUARDIAN CON MIS TRANSMIT	Non Preferred	PA
GUARDIAN MIS LINK 3	Non Preferred	PA
GUARDIAN MIS SENSOR 3	Non Preferred	PA
GUARDIAN RT MIS CHARGER	Non Preferred	PA
GUARDIAN RT MIS REPL PED	Non Preferred	PA
GUARDIAN RT MIS TST PLUG	Non Preferred	PA
HAEMOLANCE MIS HIGH FLO	Preferred	OTC
HAEMOLANCE MIS LOW FLOW	Preferred	OTC
HAEMOLANCE MIS PLUS	Preferred	OTC
HAEMOLANCE MIS PLUS LOW	Preferred	OTC
HAEMOLANCE MIS PLUS MAX	Preferred	OTC
HAEMOLANCE MIS PLUS PED	Preferred	OTC
HAEMOLANCE MIS RETRACT	Preferred	OTC
HLTHY ACCNTS MIS LANC 30G	Preferred	OTC
HM EMBRACE KIT TALK	Non Preferred	PA, QL (1 kit every year), OTC
HW EMBRACE MIS PRO	Non Preferred	PA, OTC
HW EMBRACE MIS TALK	Non Preferred	PA, OTC
IGLUCOSE KIT	Non Preferred	PA, QL (1 kit every year), OTC
IN TOUCH MIS	Non Preferred	PA, OTC
INCONTROL MIS LANC 28G	Preferred	OTC
INCONTROL MIS LANC 30G	Preferred	OTC
INCONTROL MIS LANC 33G	Preferred	OTC
INFINITY KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
INFINITY KIT VOICE	Non Preferred	PA, QL (1 kit every year), OTC
KINNEY MIS LANCETS	Preferred	OTC
KINNEY THIN MIS LANCETS	Preferred	OTC
KROGER BGM KIT	Non Preferred	PA, QL (1 kit every year), OTC
KROGER BGM KIT PREMIUM	Non Preferred	PA, QL (1 kit every year), OTC
KROGER LANCE MIS	Preferred	OTC
KROGER LANCE MIS 26G	Preferred	OTC



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KROGER LANCE MIS THIN	Preferred	OTC
KROGER LANCE MIS THIN 30G	Preferred	OTC
LANCET MICRO MIS THIN 33G	Preferred	OTC
LANCET STAND MIS 21G	Preferred	OTC
LANCET SUPER MIS THIN 30G	Preferred	OTC
LANCET ULTRA MIS 28G	Preferred	OTC
LANCET ULTRA MIS THIN 30G	Preferred	OTC
LANCETS KIT	Preferred	OTC
LANCETS MICR MIS THIN 33G	Preferred	OTC
LANCETS MIS	Preferred	OTC
LANCETS MIS 21G	Preferred	OTC
LANCETS MIS 21G COLR	Preferred	OTC
LANCETS MIS 26G	Preferred	OTC
LANCETS MIS 28G	Preferred	OTC
LANCETS MIS 30G	Preferred	OTC
LANCETS MIS 33G	Preferred	OTC
LANCETS MIS ORIGINAL	Preferred	OTC
LANCETS MIS THIN	Preferred	OTC
LANCETS MIS THIN 26G	Preferred	OTC
LANCETS MIS THIN 30G	Preferred	OTC
LANCETS SUPR MIS THIN 28G	Preferred	OTC
LANCETS THIN MIS	Preferred	OTC
LANCETS THIN MIS 26G	Preferred	OTC
LANCETS ULTR MIS THIN	Preferred	OTC
LANCETS ULTR MIS THIN 31G	Preferred	OTC
LB LANCET MIS 28G	Preferred	OTC
LIBERTY NEXT MIS MONITOR	Non Preferred	PA, OTC
LITE TOUCH MIS LANCETS	Preferred	OTC
LITETOUCH MIS LANCETS	Preferred	OTC
LONGS LANCET MIS STANDARD	Preferred	OTC
LONGS LANCET MIS THIN	Preferred	OTC
LONGS LANCET MIS ULTRA TH	Preferred	OTC
MEDICHOICE MIS LANCET	Preferred	OTC
MEDLANCE MIS 30G PLUS	Preferred	OTC
MEDLANCE MIS EXTR 21G	Preferred	OTC
MEDLANCE MIS LITE 25G	Preferred	OTC
MEDLANCE MIS PLUS	Preferred	OTC
MEDLANCE MIS PLUS 30G	Preferred	OTC
MEDLANCE MIS UNV 21G	Preferred	OTC
MEDLANCE PLS MIS 0.8MM	Preferred	OTC
MEDLANCE PLS MIS EXTR 21G	Preferred	OTC
MEDLANCE PLS MIS LITE 25G	Preferred	OTC
MEDLANCE PLS MIS UNIV 21G	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MEIJER BGM KIT ESSENTIA	Non Preferred	PA, QL (1 kit every year), OTC
MEIJER BGM KIT PREMIUM	Non Preferred	PA, QL (1 kit every year), OTC
MEIJER GLUCO KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
MEIJER LANCE MIS COLOR	Preferred	OTC
MEIJER LANCE MIS UNIV 21G	Preferred	OTC
MEIJER LANCE MIS UNIV 30G	Preferred	OTC
MEIJER LANCE MIS UNIVERSA	Preferred	OTC
MEIJER MIS LANCETS	Preferred	OTC
MICRO THIN MIS LANC 33G	Preferred	OTC
MICRODOT KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
MICROLET MIS LANCETS	Preferred	OTC
MINILINK RT MIS TRANSMIT	Non Preferred	PA
MINIMED 630G MIS TRANSMIT	Non Preferred	PA
MM TWIST MIS LANCETS	Preferred	OTC
MOBILE LANCE MIS 30G	Preferred	OTC
MONOLET MIS LANCETS	Preferred	OTC
MONOLET OPD MIS LANCETS	Preferred	OTC
MPD SFTY LAN MIS 21G	Preferred	OTC
MPD SFTY LAN MIS 23G	Preferred	OTC
MPD SFTY LAN MIS 28G	Preferred	OTC
MPD SFTY LAN MIS 30G	Preferred	OTC
MYGLUCOHEALT KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
MYGLUCOHEALT MIS LANC 30G	Preferred	OTC
NOVA MAX KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
NOVA MAX MIS SYSTEM	Non Preferred	PA, OTC
NOVA SURE MIS LANCETS	Preferred	OTC
OMNIPOD 5 G6 KIT INTRO	Preferred	PA
OMNIPOD 5 G6 MIS PODS	Preferred	PA
OMNIPOD DASH KIT INTRO	Preferred	PA
OMNIPOD DASH KIT PDM	Preferred	PA
OMNIPOD DASH MIS PODS	Preferred	PA
OMNIPOD MIS CLASSIC	Preferred	PA
ON CALL EXPR KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
ONE TOUCH KIT VERIO FL	Preferred	QL (1 kit every year), OTC
ONETOUCH DEL MIS PLUS 30G	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ONETOUCH DEL MIS PLUS 33G	Preferred	OTC
ONETOUCH KIT ULTRA 2	Preferred	QL (1 kit every year), OTC
ONETOUCH KIT VERIO RE	Preferred	QL (1 kit every year), OTC
ONETOUCH US MIS 2 30G	Preferred	OTC
OVAL TAPE MIS	Non Preferred	PA, OTC
PARADIGM REA MIS TRANSMIT	Non Preferred	PA
PC LANCETS MIS 30G	Preferred	OTC
PERFECT 28G MIS LANCETS	Preferred	OTC
PERFECT 30G MIS LANCETS	Preferred	OTC
PHARM CHOICE MIS MINI	Non Preferred	PA, OTC
PHARMACY COU MIS LANCETS	Preferred	OTC
PIP BLOOD MIS MONITOR	Non Preferred	PA, OTC
PIP LANCETS MIS 28G	Preferred	OTC
PIP LANCETS MIS 30G	Preferred	OTC
POCKETCHEM KIT EZ	Non Preferred	PA, QL (1 kit every year), OTC
POGO AUTOMAT MIS MONITOR	Non Preferred	PA, OTC
PREC NEO SYS KIT FREESTYL	Non Preferred	PA, QL (1 kit every year), OTC
PRECISION KIT XTRA	Non Preferred	PA, QL (1 kit every year), OTC
PREM V10 BLE MIS GLUC SYS	Non Preferred	PA, OTC
PREMIUM V10 MIS METER	Non Preferred	PA, OTC
PRO COMFORT MIS LANC 30G	Preferred	OTC
PRO VOICE V8 MIS SYSTEM	Non Preferred	PA, OTC
PRO VOICE V9 MIS SYSTEM	Non Preferred	PA, OTC
PRODIGY AUTO KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
PRODIGY AUTO MIS SYSTEM	Non Preferred	PA, OTC
PRODIGY KIT NO CODIN	Non Preferred	PA, QL (1 kit every year), OTC
PRODIGY MIS 26G	Preferred	OTC
PRODIGY MIS 28G	Preferred	OTC
PRODIGY PCKT KIT METER	Non Preferred	PA, QL (1 kit every year), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PRODIGY VOIC KIT METER	Non Preferred	PA, QL (1 kit every year), OTC
PSS SAFE LAN MIS	Preferred	OTC
PSS SEL LANC MIS	Preferred	OTC
PURE COMFORT MIS 30G LAN	Preferred	OTC
PX LANCETS MIS 28G	Preferred	OTC
PX LANCETS MIS 33G	Preferred	OTC
PX LANCETS MIS ULT THIN	Preferred	OTC
QC LANCETS MIS 28G	Preferred	OTC
QC LANCETS MIS 30G	Preferred	OTC
QUICKTEK KIT	Non Preferred	PA, OTC
QUICKTEK KIT	Non Preferred	PA, QL (1 kit every year), OTC
QUINTET AC MIS SYSTEM	Non Preferred	PA, OTC
QUINTET MIS SYSTEM	Non Preferred	PA, OTC
RA E-ZJECT MIS 28G	Preferred	OTC
RA E-ZJECT MIS THIN 26G	Preferred	OTC
RA E-ZJECT MIS THIN 28G	Preferred	OTC
RA E-ZJECT MIS ULT THIN	Preferred	OTC
READYLANCE MIS 21G	Preferred	OTC
READYLANCE MIS 23G	Preferred	OTC
READYLANCE MIS 26G	Preferred	OTC
READYLANCE MIS 28G	Preferred	OTC
READYLANCE MIS 30G	Preferred	OTC
REALITY MIS LANCETS	Preferred	OTC
REALITY TRIG MIS LANCETS	Preferred	OTC
REFUAH PLUS KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
RELION ALL- MIS IN-ONE	Non Preferred	PA, OTC
RELION KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
RELION LANCE MIS THIN 26G	Preferred	OTC
RELION LANCE MIS THIN 30G	Preferred	OTC
RELION MICRO KIT	Non Preferred	PA, QL (1 kit every year), OTC
RELION MICRO MIS THIN 33G	Preferred	OTC
RELION PREMI KIT COMP SYS	Non Preferred	PA, QL (1 kit every year), OTC
RELION PREMI MIS MONITOR	Non Preferred	PA, OTC
RELION PRIME MIS MONITOR	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RELION TRUE KIT MET AIR	Non Preferred	PA, QL (1 kit every year), OTC
RELION ULTIM KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
RELION ULTRA MIS THIN 30G	Preferred	OTC
RELION ULTRA MIS THIN PLS	Preferred	OTC
RIGHTEST MIS GL300	Preferred	OTC
RIGHTEST SYS KIT GM100	Non Preferred	PA, QL (1 kit every year), OTC
RIGHTEST SYS KIT GM300	Non Preferred	PA, QL (1 kit every year), OTC
RIGHTEST SYS KIT GM550	Non Preferred	PA, QL (1 kit every year), OTC
RIGHTEST SYS MIS GT333	Non Preferred	PA, OTC
SAFE-T-LANCE MIS 21G	Preferred	OTC
SAFE-T-LANCE MIS 25G	Preferred	OTC
SAFE-T-PRO MIS LANCETS	Preferred	OTC
SAFE-T-PRO MIS PLUS	Preferred	OTC
SAFETY 21G MIS LANCETS	Preferred	OTC
SAFETY 23G MIS LANCETS	Preferred	OTC
SAFETY 28G MIS LANCETS	Preferred	OTC
SAFETY 30G MIS LANCETS	Preferred	OTC
SAPS HEALTH MIS TWIST	Preferred	OTC
SB LANCETS MIS THIN	Preferred	OTC
SB LANCETS MIS ULTR THN	Preferred	OTC
SM LANCETS MIS 33G	Preferred	OTC
SMART SENSE KIT GLUC SYS	Non Preferred	PA, QL (1 kit every year), OTC
SMART SENSE MIS LANC 21G	Preferred	OTC
SMART SENSE MIS LANC 26G	Preferred	OTC
SMART SENSE MIS LANC 30G	Preferred	OTC
SMART SENSE MIS LANC 33G	Preferred	OTC
SMARTEST KIT EJECT	Non Preferred	PA, QL (1 kit every year), OTC
SMARTEST KIT PERSONA	Non Preferred	PA, QL (1 kit every year), OTC
SMARTEST KIT PRONTO	Non Preferred	PA, QL (1 kit every year), OTC
SMARTEST KIT PROTEGE	Non Preferred	PA, QL (1 kit every year), OTC
SMARTEST MIS EJECT	Non Preferred	PA, OTC
SMARTEST MIS PROTEGE	Non Preferred	PA, OTC
SOFTCLIX MIS LANCETS	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SOLUS V2 KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
SOLUS V2 MIS AUDIBLE	Non Preferred	PA, OTC
SOLUS V2 MIS LANC 30G	Preferred	OTC
STERILANCE MIS TL 28G	Preferred	OTC
STERILANCE MIS TL 30G	Preferred	OTC
STERILANCE MIS TL 32G	Preferred	OTC
SUPER THIN MIS LANC 28G	Preferred	OTC
SUPER THIN MIS LANCETS	Preferred	OTC
SURE COMFORT MIS LANCETS	Preferred	OTC
SUREFLEX MIS LANCETS	Preferred	OTC
SURELITE MIS LANCETS	Preferred	OTC
TECHLITE AST MIS LANCETS	Preferred	OTC
TECHLITE MIS LANC 30G	Preferred	OTC
TECHLITE MIS LANCETS	Preferred	OTC
TEMPO REFILL KIT	Non Preferred	PA, OTC
TEMPO WELCOM KIT	Non Preferred	PA, QL (1 kit every year)
TGT LANCET MIS 26G	Preferred	OTC
TGT LANCET MIS 30G	Preferred	OTC
TGT LANCET MIS 33G	Preferred	OTC
THIN LANCETS MIS 26G	Preferred	OTC
THIN LANCETS MIS 30G	Preferred	OTC
THINLETS GP MIS 26G	Preferred	OTC
TOPCARE MIS LANC 33G	Preferred	OTC
TRU METRIX KIT METER	Non Preferred	PA, QL (1 kit every year), OTC
TRU MTRX AIR KIT GLUCOSE	Non Preferred	PA, QL (1 kit every year), OTC
TRUE2GO KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
TRUE COMFORT MIS LANC 30G	Preferred	OTC
TRUE FOCUS MIS METER	Non Preferred	PA, OTC
TRUE METRIX KIT AIR	Non Preferred	PA, QL (1 kit every year), OTC
TRUE METRIX KIT METER	Non Preferred	PA, QL (1 kit every year), OTC
TRUE METRIX MIS	Non Preferred	PA, OTC
TRUE METRIX MIS AIR	Non Preferred	PA, OTC
TRUERESULT KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TRUERESULT KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
TRUETRACK KIT MONITOR	Non Preferred	PA, QL (1 kit every year), OTC
TRUETRACK KIT SYSTEM	Non Preferred	PA, QL (1 kit every year), OTC
TRUETRACK MIS BLD GLC	Non Preferred	PA, OTC
TRUPLUS LANC MIS 26G	Preferred	OTC
TRUPLUS LANC MIS 28G	Preferred	OTC
TRUPLUS LANC MIS 30G	Preferred	OTC
TRUPLUS LANC MIS 33G	Preferred	OTC
TWIST LANCET MIS 30G	Preferred	OTC
TWIST LANCET MIS 30G MULT	Preferred	OTC
ULTILET MIS 26G	Preferred	OTC
ULTILET MIS 28G	Preferred	OTC
ULTILET MIS 33G	Preferred	OTC
ULTILET MIS LANCETS	Preferred	OTC
ULTRA THIN MIS 33G	Preferred	OTC
ULTRA THIN MIS LAN 31G	Preferred	OTC
ULTRA THIN MIS LANC 28G	Preferred	OTC
ULTRA THIN MIS LANC 30G	Preferred	OTC
ULTRA THIN MIS LANCETS	Preferred	OTC
UNILET CMFR MIS TCH 28G	Preferred	OTC
UNILET CMFR MIS TCH 30G	Preferred	OTC
UNILET EX II MIS 28G	Preferred	OTC
UNILET EXCEL MIS 23G	Preferred	OTC
UNILET G.P MIS SUPR 23G	Preferred	OTC
UNILET G.P. MIS 21G	Preferred	OTC
UNILET GP 28 MIS ULT THIN	Preferred	OTC
UNILET LANCE MIS 21G	Preferred	OTC
UNILET LANCE MIS 28G	Preferred	OTC
UNILET LANCE MIS 33G	Preferred	OTC
UNILET LANCT MIS 28G	Preferred	OTC
UNILET LANCT MIS 30G	Preferred	OTC
UNILET LANCT MIS 33G	Preferred	OTC
UNILET MICRO MIS 33G	Preferred	OTC
UNILET MIS 21G	Preferred	OTC
UNILET SUPER MIS 23G	Preferred	OTC
UNILET SUPER MIS G.P. 23G	Preferred	OTC
UNIVERSAL 1 MIS 33G	Preferred	OTC
UNIVERSAL 1 MIS LANC 26G	Preferred	OTC
UNIVERSAL 1 MIS LANC 30G	Preferred	OTC
V10/V12/D10/ KIT D20/FORA	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
V-GO 20 KIT	Non Preferred	PA
V-GO 30 KIT	Non Preferred	PA
V-GO 40 KIT	Non Preferred	PA
VERASENS KIT	Non Preferred	PA, QL (1 kit every year), OTC
VERASENS MIS METER	Non Preferred	PA, OTC
VERIFINE MIS UNIV 28G	Preferred	OTC
VERIFINE MIS UNIV 30G	Preferred	OTC
VERIFINE MIS UNIV 33G	Preferred	OTC
VIVAGUARD MIS 28G	Preferred	OTC
VIVAGUARD MIS 30G	Preferred	OTC
VIVAGUARD MIS INO	Non Preferred	PA, OTC
VIVAGUARD MIS INO SMRT	Non Preferred	PA, OTC
WAVESENSE KIT AMP	Non Preferred	PA, QL (1 kit every year), OTC
ZEVRX TWIST MIS LANC 30G	Preferred	OTC
<b>MISC. DEVICES</b>		
ALCOHOL SWABS	Preferred	QL (8 pads every 1 day), OTC
ESSENTRA MIS 9X9"	Preferred	QL (8 sheets every 1 day)
<b>PARENTERAL THERAPY SUPPLIES</b>		
ABOUTTIME MIS 30GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
ABOUTTIME MIS 31GX3/16	Non Preferred	PA, OTC
ABOUTTIME MIS 31GX5/16	Non Preferred	PA, OTC
ABOUTTIME MIS 32GX5/32	Non Preferred	PA, OTC
AQINJECT PEN MIS 31GX3/16	Non Preferred	PA
AQINJECT PEN MIS 32GX5/32	Non Preferred	PA
ASSURE ID MIS 0.5/31G	Non Preferred	PA, OTC
ASSURE ID MIS 1ML/31G	Non Preferred	PA, OTC
ASSURE ID MIS 30GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AUM MINI PEN MIS 32GX4MM	Non Preferred	PA, OTC
AUM MINI PEN MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
AUM MINI PEN MIS 32GX6MM	Non Preferred	PA, OTC
AUM MINI PEN MIS 32GX8MM	Non Preferred	PA, OTC
AUM MINI PEN MIS 33GX4MM	Non Preferred	PA, OTC
AUM MINI PEN MIS 33GX5MM	Non Preferred	PA, OTC
AUM MINI PEN MIS 33GX6MM	Non Preferred	PA, OTC
AUM READYGRD MIS 32GX4MM	Non Preferred	PA, OTC
AUM SAFETY MIS 31GX4MM	Non Preferred	PA, OTC
AUM SAFETY MIS 31GX5MM	Non Preferred	PA, OTC
AUTOSHIELD MIS 29X3/16"	Non Preferred	PA, QL (8 needles every 1 day), OTC
AUTOSHIELD MIS 29X5/16"	Non Preferred	PA, QL (8 needles every 1 day), OTC
AUTOSHIELD MIS 30GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
BD PEN NEEDL MIS 29GX12.7	Non Preferred	PA, OTC
BD PEN NEEDL MIS 31GX5MM	Non Preferred	PA, OTC
BD PEN NEEDL MIS 31GX8MM	Non Preferred	PA, OTC
BD PEN NEEDL MIS 32GX4MM	Non Preferred	PA
BD PEN NEEDL MIS 32GX4MM	Non Preferred	PA, OTC
BD PEN NEEDL MIS 32GX6MM	Non Preferred	PA, OTC
CAREFINE MIS 31GX8MM	Non Preferred	PA, OTC
CAREFINE MIS 32GX4MM	Non Preferred	PA, OTC
CAREFINE MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
CAREFINE MIS 32GX6MM	Non Preferred	PA, OTC
CARETOUCH MIS 31GX5MM	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CARETOUCH MIS 31GX6MM	Non Preferred	PA, OTC
CARETOUCH MIS 31GX8MM	Non Preferred	PA, OTC
CARETOUCH MIS 32GX4MM	Non Preferred	PA, OTC
CARETOUCH MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
CLICKFINE MIS 31GX1/4"	Non Preferred	PA, OTC
CLICKFINE MIS 31GX3/16	Non Preferred	PA, OTC
CLICKFINE MIS 31GX5/16	Non Preferred	PA, OTC
CLICKFINE MIS 31GX8MM	Non Preferred	PA, OTC
CLICKFINE MIS 32GX5/32	Non Preferred	PA, OTC
COMFORT EZ MIS 29GX12MM	Non Preferred	PA, OTC
COMFORT EZ MIS 31GX5/16	Non Preferred	PA, OTC
COMFORT EZ MIS 31GX5MM	Non Preferred	PA, OTC
COMFORT EZ MIS 31GX6MM	Non Preferred	PA, OTC
COMFORT EZ MIS 31GX8MM	Non Preferred	PA, OTC
COMFORT EZ MIS 32GX4MM	Non Preferred	PA, OTC
COMFORT EZ MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
COMFORT EZ MIS 32GX6MM	Non Preferred	PA, OTC
COMFORT EZ MIS 32GX8MM	Non Preferred	PA, OTC
COMFORT EZ MIS 33GX4MM	Non Preferred	PA, OTC
COMFORT EZ MIS 33GX5MM	Non Preferred	PA, OTC
COMFORT EZ MIS 33GX6MM	Non Preferred	PA, OTC
COMFORT EZ MIS 33GX8MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 31GX4MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 31GX5MM	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
COMFORT TOUC MIS 31GX6MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 31GX8MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 32GX4MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
COMFORT TOUC MIS 32GX6MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 32GX8MM	Non Preferred	PA, OTC
COMFORT TOUC MIS 33GX1/4"	Non Preferred	PA, OTC
COMFORT TOUC MIS 33GX3/16	Non Preferred	PA, OTC
COMFORT TOUC MIS 33GX5/32	Non Preferred	PA, OTC
DIATHRIVE MIS 31GX5MM	Non Preferred	PA, OTC
DIATHRIVE MIS 31GX6MM	Non Preferred	PA, OTC
DIATHRIVE MIS 31GX8MM	Non Preferred	PA, OTC
DIATHRIVE MIS 32GX4MM	Non Preferred	PA, OTC
DROPLET MICR MIS 34GX9/64	Non Preferred	PA, OTC
DROPSAFE MIS 31GX5MM	Non Preferred	PA, OTC
EASY COMFORT MIS 31GX1/4"	Non Preferred	PA, OTC
EASY COMFORT MIS 31GX3/16	Non Preferred	PA, OTC
EASY COMFORT MIS 31GX5/16	Non Preferred	PA, OTC
EASY COMFORT MIS 32GX5/32	Non Preferred	PA, OTC
EASY TOUCH MIS 29GX1/2"	Non Preferred	PA, OTC
EASY TOUCH MIS 29GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
EASY TOUCH MIS 29GX8MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
EASY TOUCH MIS 30G	Non Preferred	PA, OTC
EASY TOUCH MIS 31GX1/4"	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EASY TOUCH MIS 31GX3/16	Non Preferred	PA, OTC
EASY TOUCH MIS 31GX5/16	Non Preferred	PA, OTC
EASY TOUCH MIS 32GX1/4"	Non Preferred	PA, OTC
EASY TOUCH MIS 32GX3/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
EASY TOUCH MIS 32GX5/32	Non Preferred	PA, OTC
EASY TOUCH MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
EASY TOUCH MIS 32GX6MM	Non Preferred	PA, OTC
FIFTY50 MIS 31GX3/16	Non Preferred	PA, OTC
FIFTY50 MIS 31GX5/16	Non Preferred	PA, OTC
FIFTY50 MIS 31GX5MM	Non Preferred	PA, OTC
FIFTY50 PEN MIS 31GX8MM	Non Preferred	PA, OTC
FIFTY50 PEN MIS 32GX4MM	Non Preferred	PA, OTC
FIFTY50 PEN MIS 32GX6MM	Non Preferred	PA, OTC
GNP ULTICARE MIS 31GX5/16	Non Preferred	PA, OTC
GNP ULTICARE MIS 31GX5MM	Non Preferred	PA, OTC
GNP ULTICARE MIS 32GX1/4"	Non Preferred	PA, OTC
GNP ULTICARE MIS 32GX5/32	Non Preferred	PA, OTC
HM INSULIN S MIS 0.3/31G	Non Preferred	PA, OTC
HM INSULIN S MIS 1ML/30G	Non Preferred	PA, OTC
HM ULTICARE MIS 31GX8MM	Non Preferred	PA, OTC
IN CONTROL MIS 31GX3/16	Non Preferred	PA, OTC
IN CONTROL MIS 31GX5MM	Non Preferred	PA, OTC
IN CONTROL MIS 31GX6MM	Non Preferred	PA, OTC
IN CONTROL MIS 31GX8MM	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INCONTROL MIS 29GX12MM	Non Preferred	PA, OTC
INCONTROL MIS 31GX6MM	Non Preferred	PA, OTC
INCONTROL MIS 31GX8MM	Non Preferred	PA, OTC
INCONTROL MIS 32GX4MM	Non Preferred	PA, OTC
INS SY 0.3ML MIS 30GX1/2"	Non Preferred	PA, OTC
INS SY 0.3ML MIS 31GX5/16	Non Preferred	PA, OTC
INS SY 0.5ML MIS 30GX1/2"	Non Preferred	PA, OTC
INS SY 0.5ML MIS 30GX5/16	Non Preferred	PA, OTC
INS SY 1/2ML MIS 30GX1/2"	Non Preferred	PA, OTC
INS SYR 1ML MIS 30GX1/2"	Non Preferred	PA, OTC
INS SYR 1ML MIS 30GX5/16	Non Preferred	PA, OTC
INS SYR 1ML MIS 31GX5/16	Non Preferred	PA, OTC
INS SYR .3ML MIS 30GX1/2"	Non Preferred	PA, OTC
INSULIN SRYG MIS 1ML/32G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.3/29G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.3/29G	Non Preferred	PA
INSULIN SYRG MIS 0.3/29G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.3/30G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.3/30G	Non Preferred	PA
INSULIN SYRG MIS 0.3/30G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.3/31G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.3/31G	Non Preferred	PA
INSULIN SYRG MIS 0.3/31G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.3ML/30	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.3ML/31	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSULIN SYRG MIS 0.5/27G	Non Preferred	PA, QL (8 syringes every 1 day), OTC
INSULIN SYRG MIS 0.5/28G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.5/28G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.5/29G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.5/29G	Non Preferred	PA
INSULIN SYRG MIS 0.5/29G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.5/30G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.5/30G	Non Preferred	PA
INSULIN SYRG MIS 0.5/30G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.5/31G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 0.5/31G	Non Preferred	PA
INSULIN SYRG MIS 0.5/31G	Non Preferred	PA, OTC
INSULIN SYRG MIS 0.5/32G	Non Preferred	PA, OTC
INSULIN SYRG MIS 1/2ML/30	Non Preferred	PA, OTC
INSULIN SYRG MIS 1/2ML/31	Non Preferred	PA, OTC
INSULIN SYRG MIS 1ML/25G	Non Preferred	PA, QL (8 syringes every 1 day), OTC
INSULIN SYRG MIS 1ML/26G	Non Preferred	PA, QL (8 syringes every 1 day), OTC
INSULIN SYRG MIS 1ML/27G	Non Preferred	PA
INSULIN SYRG MIS 1ML/27G	Non Preferred	PA, OTC
INSULIN SYRG MIS 1ML/27G	Non Preferred	PA, QL (8 syringes every 1 day), OTC
INSULIN SYRG MIS 1ML/28G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 1ML/28G	Non Preferred	PA
INSULIN SYRG MIS 1ML/28G	Non Preferred	PA, OTC
INSULIN SYRG MIS 1ML/29G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 1ML/29G	Non Preferred	PA
INSULIN SYRG MIS 1ML/29G	Non Preferred	PA, OTC
INSULIN SYRG MIS 1ML/30G	Preferred	OTC; TRUEPLUS

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSULIN SYRG MIS 1ML/30G	Non Preferred	PA
INSULIN SYRG MIS 1ML/30G	Non Preferred	PA, OTC
INSULIN SYRG MIS 1ML/31G	Preferred	OTC; TRUEPLUS
INSULIN SYRG MIS 1ML/31G	Non Preferred	PA; TRUEPLUS
INSULIN SYRG MIS 1ML/31G	Non Preferred	PA, OTC
INSULIN SYRG MIS 2/27.5G	Non Preferred	PA, OTC
INSULIN SYRG MIS 27GX1/2"	Non Preferred	PA
INSULIN SYRG MIS 27GX1/2"	Non Preferred	PA, QL (8 syringes every 1 day)
INSULIN SYRG MIS 27GX1/2"	Non Preferred	PA, OTC
INSULIN SYRG MIS 27GX1/2"	Non Preferred	PA, QL (8 syringes every 1 day), OTC
INSULIN SYRG MIS 28GX1/2"	Non Preferred	PA
INSULIN SYRG MIS 28GX1/2"	Non Preferred	PA, OTC
INSULIN SYRG MIS 29GX1/2"	Non Preferred	PA
INSULIN SYRG MIS 29GX1/2"	Non Preferred	PA, OTC
INSULIN SYRG MIS 30GX1/2"	Non Preferred	PA
INSULIN SYRG MIS 30GX1/2"	Non Preferred	PA, OTC
INSULIN SYRG MIS 30GX5/16	Non Preferred	PA
INSULIN SYRG MIS 30GX5/16	Non Preferred	PA, OTC
INSULIN SYRG MIS 31GX5/16	Non Preferred	PA; TRUEPLUS
INSULIN SYRG MIS 31GX5/16	Non Preferred	PA, OTC
INSULIN SYRI MIS 0.3/31G	Non Preferred	PA, OTC
INSULIN SYRINGE (DISP) U-100 1 ML	Non Preferred	PA, QL (5 syringes every 1 day), OTC
INSULIN SYRINGE (DISP) U-100 1 ML - RX	Non Preferred	PA, QL (5 syringes every 1 day)
INSUPEN MIS 29GX12MM	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSUPEN MIS 31GX5MM	Non Preferred	PA, OTC
INSUPEN MIS 31GX8MM	Non Preferred	PA, OTC
INSUPEN MIS 32GX4MM	Non Preferred	PA, OTC
INSUPEN MIS 33GX4MM	Non Preferred	PA, OTC
INSUPEN SENS MIS 32GX6MM	Non Preferred	PA, OTC
INSUPEN SENS MIS 32GX8MM	Non Preferred	PA, OTC
INSUPEN ULTR MIS 30GX8MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
INSUPEN ULTR MIS 31GX6MM	Non Preferred	PA, OTC
INSUPEN ULTR MIS 31GX8MM	Non Preferred	PA, OTC
LITETOUCH MIS 29GX12.7	Non Preferred	PA, OTC
LITETOUCH MIS 31GX8MM	Non Preferred	PA, OTC
10ML LL SYRN MIS 22GX1"	Preferred	OTC
5ML LL SYRNG MIS 21GX1"	Preferred	OTC
3ML LL SYRNG MIS 25GX5/8"	Preferred	
3ML LL SYRNG MIS 25GX5/8"	Preferred	OTC
3ML LUER LOC MIS 25GX5/8"	Preferred	OTC
LUER-LOK SYR MIS 1ML/20G	Preferred	QL (100 boxes every 75 days), OTC
MAXICOMFORT MIS 27GX1/2	Non Preferred	PA, QL (8 syringes every 1 day), OTC
MAXICOMFORT MIS 27GX1/2"	Non Preferred	PA, OTC
MAXICOMFORT MIS 31GX1/4"	Non Preferred	PA, OTC
MM PENTIPS MIS 29GX12MM	Non Preferred	PA
MM PENTIPS MIS 31GX5MM	Non Preferred	PA
MM PENTIPS MIS 31GX8MM	Non Preferred	PA
MM PENTIPS MIS 32GX4MM	Non Preferred	PA
NEEDLE (DISP) 18 X 1-1/2"	Preferred	OTC
NEEDLE (DISP) 18 X 1-1/2"- RX	Preferred	
NOVOFINE AUT MIS 30GX8MM	Non Preferred	PA, QL (8 needles every 1 day), OTC



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NOVOFINE MIS 32GX6MM	Non Preferred	PA, OTC
NOVOFINE PLS MIS 32GX4MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 29GX1/2"	Non Preferred	PA, OTC
PEN NEEDLE MIS 29GX3/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLE MIS 29GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLE MIS 31GX3/16	Non Preferred	PA, OTC
PEN NEEDLE MIS 31GX4MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 31GX5/16	Non Preferred	PA, OTC
PEN NEEDLE MIS 31GX5MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 31GX6MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 31GX8MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 32GX1/4"	Non Preferred	PA, OTC
PEN NEEDLE MIS 32GX4MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 32GX5/32	Non Preferred	PA, OTC
PEN NEEDLE MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLE MIS 32GX6MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 33GX4MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 33GX5/32	Non Preferred	PA, OTC
PEN NEEDLE MIS 33GX5MM	Non Preferred	PA, OTC
PEN NEEDLE MIS 33GX6MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 29GX1/2"	Non Preferred	PA, OTC
PEN NEEDLES MIS 29GX12.7	Preferred	OTC; TRUEPLUS
PEN NEEDLES MIS 29GX12.7	Non Preferred	PA, OTC
PEN NEEDLES MIS 29GX12MM	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PEN NEEDLES MIS 29GX12MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 30GX3/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLES MIS 30GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLES MIS 30GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLES MIS 30GX8MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLES MIS 31GX1/4"	Non Preferred	PA, OTC
PEN NEEDLES MIS 31GX3/16	Non Preferred	PA, OTC
PEN NEEDLES MIS 31GX5/16	Preferred	OTC
PEN NEEDLES MIS 31GX5/16	Non Preferred	PA, OTC
PEN NEEDLES MIS 31GX5MM	Preferred	OTC; TRUEPLUS
PEN NEEDLES MIS 31GX5MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 31GX6MM	Preferred	OTC; TRUEPLUS
PEN NEEDLES MIS 31GX6MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 31GX8MM	Preferred	OTC; TRUEPLUS
PEN NEEDLES MIS 31GX8MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 32GX1/4	Non Preferred	PA, OTC
PEN NEEDLES MIS 32GX1/4"	Non Preferred	PA, OTC
PEN NEEDLES MIS 32GX3/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLES MIS 32GX4MM	Preferred	OTC; TRUEPLUS
PEN NEEDLES MIS 32GX4MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 32GX5/16	Non Preferred	PA, OTC
PEN NEEDLES MIS 32GX5/32	Non Preferred	PA, OTC
PEN NEEDLES MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
PEN NEEDLES MIS 32GX6MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 33GX4MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 33GX5/32	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PEN NEEDLES MIS 33GX5MM	Non Preferred	PA, OTC
PEN NEEDLES MIS 33GX6MM	Non Preferred	PA, OTC
PENTIPS MIS 29GX12MM	Non Preferred	PA
PENTIPS MIS 29GX12MM	Non Preferred	PA, OTC
PENTIPS MIS 31GX5MM	Non Preferred	PA
PENTIPS MIS 31GX5MM	Non Preferred	PA, OTC
PENTIPS MIS 31GX6MM	Non Preferred	PA, OTC
PENTIPS MIS 31GX8MM	Non Preferred	PA
PENTIPS MIS 31GX8MM	Non Preferred	PA, OTC
PENTIPS MIS 32GX4MM	Non Preferred	PA
PENTIPS MIS 32GX4MM	Non Preferred	PA, OTC
PENTIPS MIS 32GX6MM	Non Preferred	PA, OTC
PIP PEN NEED MIS 32GX4MM	Non Preferred	PA, OTC
PREVENT DROP MIS 31GX1/4"	Non Preferred	PA, OTC
PREVENT DROP MIS 31GX5/16	Non Preferred	PA, OTC
PREVENT SAFE MIS 31GX1/4"	Non Preferred	PA, OTC
PREVENT SAFE MIS 31GX5/16	Non Preferred	PA, OTC
PRO COMFORT MIS 0.5/30G	Non Preferred	PA, OTC
PRO COMFORT MIS 0.5/31G	Non Preferred	PA, OTC
PRO COMFORT MIS 1ML/30G	Non Preferred	PA, OTC
PRO COMFORT MIS 1ML/31G	Non Preferred	PA, OTC
PRO COMFORT MIS 31GX8MM	Non Preferred	PA
PRO COMFORT MIS 32GX4MM	Non Preferred	PA
PRO COMFORT MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PRO COMFORT MIS 32GX6MM	Non Preferred	PA, OTC
PURE COMFORT MIS 32GX4MM	Non Preferred	PA, OTC
PURE COMFORT MIS 32GX5MM	Non Preferred	PA, QL (8 needles every 1 day), OTC
PURE COMFORT MIS 32GX6MM	Non Preferred	PA, OTC
PURE COMFORT MIS 32GX8MM	Non Preferred	PA, OTC
RA PEN NEEDL MIS 31GX3/16	Non Preferred	PA, OTC
RAYA SURE MIS 29GX12MM	Non Preferred	PA, OTC
RAYA SURE MIS 31GX4MM	Non Preferred	PA, OTC
RAYA SURE MIS 31GX5MM	Non Preferred	PA, OTC
RAYA SURE MIS 31GX6MM	Non Preferred	PA, OTC
RAYA SURE MIS 31GX8MM	Non Preferred	PA, OTC
RELION PEN MIS 29GX12MM	Non Preferred	PA, OTC
RELION PEN MIS 31GX1/4"	Non Preferred	PA, OTC
RELION PEN MIS 31GX5/16	Non Preferred	PA, OTC
RELION PEN MIS 31GX6MM	Non Preferred	PA, OTC
RELION PEN MIS 31GX8MM	Non Preferred	PA, OTC
RELION PEN MIS 32GX4MM	Non Preferred	PA, OTC
RELION PEN MIS 32GX5/32	Non Preferred	PA, OTC
SECURESAFE MIS 0.5/29G	Non Preferred	PA, OTC
SECURESAFE MIS 29GX1/2"	Non Preferred	PA, OTC
SECURESAFE MIS 30GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
SHARP CONTAI MIS	Preferred	
SHARPS CONT MIS 14QT	Preferred	
SHARPS CONTAINER - MISC	Preferred	OTC
SURE COMFORT MIS 0.5/31G	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SURE COMFORT MIS 29GX1/2"	Non Preferred	PA, OTC
SURE COMFORT MIS 30GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
SURE COMFORT MIS 31GX1/4	Non Preferred	PA
SURE COMFORT MIS 31GX3/16	Non Preferred	PA, OTC
SURE COMFORT MIS 31GX5/16	Non Preferred	PA, OTC
SURE COMFORT MIS 31GX6MM	Non Preferred	PA
SURE COMFORT MIS 32GX5/32	Non Preferred	PA
SURE COMFORT MIS 32GX5/32	Non Preferred	PA, OTC
SURE COMFORT MIS 32GX6MM	Non Preferred	PA, OTC
SYRG/NDL 3ML MIS 25GX5/8"	Preferred	OTC
SYRG/NEEDLE MIS 29GX12.5	Non Preferred	PA
SYRG/NEEDLE MIS 31GX6MM	Non Preferred	PA
SYRG/NEEDLE MIS 31GX8MM	Non Preferred	PA
SYRG/NEEDLE MIS 31GX8MM	Non Preferred	PA; TRUEPLUS
SYRINGE (DISPOSABLE) 3 ML	Preferred	OTC
SYRINGE (DISPOSABLE) 3 ML - RX	Preferred	
SYRINGE MIS 0.5/30G	Non Preferred	PA, OTC
5ML SYRINGE MIS 21GX1"	Preferred	OTC
10ML SYRINGE MIS 22GX1"	Preferred	OTC
3ML SYRINGE MIS 25GX5/8"	Preferred	
3ML SYRINGE MIS 25GX5/8"	Preferred	OTC
1ML SYRINGE MIS 29G	Non Preferred	PA, OTC
1ML SYRINGE MIS 30G	Non Preferred	PA, OTC
SYRINGE/NEEDLE (DISP) 3 ML 22 X 1"	Preferred	OTC
SYRINGE/NEEDLE (DISP) 3 ML 22 X 1" - RX	Preferred	
SYRINGE/NEEDLE (DISP) 3 ML 25 X 1"	Preferred	OTC
SYRINGE/NEEDLE (DISP) 3 ML 25 X 1" - RX	Preferred	
5ML SYRINGES MIS 21GX1"	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
1ST TIER UNI MIS 29GX12MM	Non Preferred	PA, OTC
1ST TIER UNI MIS 31GX5MM	Non Preferred	PA, OTC
1ST TIER UNI MIS 31GX6MM	Non Preferred	PA, OTC
1ST TIER UNI MIS 31GX8MM	Non Preferred	PA, OTC
1ST TIER UNI MIS 32GX4MM	Non Preferred	PA, OTC
TIER UNI PLS MIS 31GX8MM	Non Preferred	PA, OTC
ULTICARE MIC MIS 32GX4MM	Non Preferred	PA, OTC
ULTICARE MIS 30GX3/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
ULTICARE MIS 30GX5/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
ULTICARE PEN MIS 31GX5MM	Non Preferred	PA, OTC
ULTICARE PEN MIS 31GX6MM	Non Preferred	PA, OTC
ULTICARE PEN MIS 31GX8MM	Non Preferred	PA, OTC
ULTIGUARD MIS 31GX5MM	Non Preferred	PA, OTC
ULTIGUARD MIS 31GX6MM	Non Preferred	PA, OTC
ULTIGUARD MIS 31GX8MM	Non Preferred	PA, OTC
ULTIGUARD MIS 32GX4MM	Non Preferred	PA, OTC
ULTIGUARD MIS 32GX6MM	Non Preferred	PA, OTC
ULTILET PEN MIS 29GX12.7	Non Preferred	PA, OTC
ULTILET PEN MIS 31GX5MM	Non Preferred	PA, OTC
ULTILET PEN MIS 31GX8MM	Non Preferred	PA, OTC
ULTILET PEN MIS 32GX4MM	Non Preferred	PA, OTC
ULTRA FLO MIS 31GX5MM	Non Preferred	PA, OTC
ULTRA FLO MIS 31GX8MM	Non Preferred	PA, OTC
ULTRA FLO MIS PEN NEED	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
UNIFINE PNTD MIS 32GX4MM	Non Preferred	PA, OTC
UNIFINE PLUS MIS 31GX1/4"	Non Preferred	PA, OTC
UNIFINE PLUS MIS 31GX3/16	Non Preferred	PA, OTC
UNIFINE PLUS MIS 31GX5/16	Non Preferred	PA, OTC
UNIFINE PLUS MIS 32GX5/32	Non Preferred	PA, OTC
UNIFINE PLUS MIS 33GX5/32	Non Preferred	PA, OTC
UNIFINE PNTD MIS 29GX1/2"	Non Preferred	PA, OTC
UNIFINE PNTD MIS 29GX12MM	Non Preferred	PA, OTC
UNIFINE PNTD MIS 30GX3/16	Non Preferred	PA, QL (8 needles every 1 day), OTC
UNIFINE PNTD MIS 31GX3/16	Non Preferred	PA, OTC
UNIFINE PNTD MIS 31GX5/16	Non Preferred	PA, OTC
UNIFINE PNTD MIS 31GX5MM	Non Preferred	PA, OTC
UNIFINE PNTD MIS 31GX6MM	Non Preferred	PA, OTC
UNIFINE PNTD MIS 31GX8MM	Non Preferred	PA, OTC
UNIFINE PNTD MIS 32GX4MM	Non Preferred	PA, OTC
UNIFINE PNTD MIS 32GX5/32	Non Preferred	PA, OTC
UNIFINE PNTD MIS 32GX6MM	Non Preferred	PA, OTC
UNIFINE PNTD MIS 33GX4MM	Non Preferred	PA, OTC
UNIFINE SAFE MIS 32GX4MM	Non Preferred	PA, OTC
UNIFINE ULTR MIS 31GX5MM	Non Preferred	PA, OTC
UNIFINE ULTR MIS 31GX6MM	Non Preferred	PA, OTC
UNIFINE ULTR MIS 31GX8MM	Non Preferred	PA, OTC
UNIFINE ULTR MIS 32GX4MM	Non Preferred	PA, OTC
VERIFINE PEN MIS 29GX12MM	Non Preferred	PA, OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VERIFINE PEN MIS 31GX5MM	Non Preferred	PA, OTC
VERIFINE PEN MIS 31GX8MM	Non Preferred	PA, OTC
VERIFINE PEN MIS 32GX4MM	Non Preferred	PA, OTC
VERIFINE PEN MIS 32GX6MM	Non Preferred	PA, OTC
ZEV RX MIS 31GX5MM	Non Preferred	PA, OTC
ZEV RX MIS 31GX6MM	Non Preferred	PA, OTC
ZEV RX MIS 31GX8MM	Non Preferred	PA, OTC
ZEV RX MIS 32GX4MM	Non Preferred	PA, OTC

### **RESPIRATORY THERAPY SUPPLIES**

ADULT MASK MIS	Preferred	
AEROBIKA MIS	Preferred	
EASY FLOW MIS BLCK/BLU	Preferred	OTC
EASY FLOW MIS BLCK/ORG	Preferred	OTC
EASY FLOW MIS BLCK/RED	Preferred	OTC
EASY FLOW MIS BLCK/WHT	Preferred	OTC
EASY FLOW MIS BLCK/YEL	Preferred	OTC
EASY FLOW MIS WHT/BLUE	Preferred	OTC
EASY FLOW MIS WHT/GREE	Preferred	OTC
EASY FLOW MIS WHT/PINK	Preferred	OTC
EASY FLOW MIS WHT/WHT	Preferred	OTC
EASY FLOW MIS WHT/YELL	Preferred	OTC
FLEXICHAMBER MIS MASK LRG	Preferred	QL (1 box every year)
FLEXICHAMBER MIS MASK SM	Preferred	QL (1 box every year)
IN-CHK FLOW MIS METER	Preferred	
MASK VORTEX/ MIS FROG	Preferred	QL (1 each every year), OTC
MASK VORTEX/ MIS LADY BUG	Preferred	QL (1 each every year), OTC
NEBULIZER MIS CUP/TUBI	Preferred	OTC
PANDA MASK MIS LARGE	Preferred	QL (1 pack every year), OTC
PANDA MASK MIS MEDIUM	Preferred	QL (1 pack every year), OTC
PANDA MASK MIS PEDIATRI	Preferred	QL (1 pack every year), OTC
PANDA MASK MIS SMALL	Preferred	QL (1 pack every year), OTC
PARI MANUAL MIS INTERRUP	Preferred	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PARI TREK S KIT COMBO	Preferred	
PARI VORTEX MIS ADL MASK	Preferred	QL (1 box every year), OTC
PEAK FLOW METER	Preferred	OTC
PFT FILTER MIS 1000	Preferred	
PFT FILTER MIS 2000	Preferred	
PFT FILTER MIS 3000	Preferred	
PFT FILTER MIS 4000	Preferred	
PFT FILTER MIS 5000	Preferred	
PFT FILTER MIS 6000	Preferred	
PFT FILTER MIS 7000	Preferred	
PURE COMFORT MIS 3-BALL	Preferred	OTC
QUAKE MIS	Preferred	
RESPIRATORY THERAPY SUPPLIES - MISC (MASK)	Preferred	QL (1 box every year), OTC
RESPIRATORY THERAPY SUPPLIES - MISC (MASK)- RX	Preferred	QL (1 box every year)
SPACER/AEROSOL-HOLDING CHAMBERS - DEVICE	Preferred	QL (1 spacer every year), OTC
SPACER/AEROSOL-HOLDING CHAMBERS - DEVICE- RX	Preferred	QL (1 spacer every year)
THRESHOLD MIS PEP	Preferred	

## **MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES**

### ***CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG***

AIMOVIG INJ 70MG/ML	Preferred	PA
AIMOVIG INJ 140MG/ML	Preferred	PA
AJOVY INJ 225/1.5	Preferred	PA
AJOVY INJ 225/1.5	Preferred	PA
EMGALITY INJ 100MG/ML	Preferred	PA
EMGALITY INJ 120MG/ML	Preferred	PA
NURTEC TAB 75MG ODT	Preferred	PA
QULIPTA TAB 10MG	Preferred	PA
QULIPTA TAB 30MG	Preferred	PA
QULIPTA TAB 60MG	Preferred	PA
UBRELVY TAB 50MG	Preferred	PA
UBRELVY TAB 100MG	Preferred	PA
VYEPTI INJ 100MG/ML	Non Preferred	SP, PA

### ***MIGRAINE COMBINATIONS***

<i>migergot sup 2/100</i>	Preferred	
SUMANSETRON PAK	Non Preferred	PA
<i>sumatriptan-naproxen sodium tab 85-500 mg (generic of TREXIMET)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TREXIMET TAB 85-500MG	Non Preferred	PA

### **MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES**

<i>dihydroergotamine mesylate nasal spray 4 mg/ml (generic of MIGRANAL)</i>	Non Preferred	PA
MIGRANAL SPR 4MG/ML	Non Preferred	PA
TRUDHESA AER 0.725MG	Non Preferred	PA

### **MIGRAINE PRODUCTS - NSAIDS**

<i>diclofenac potassium (migraine) packet 50 mg (generic of CAMBIA)</i>	Non Preferred	PA
ELYXYB SOL 120/4.8	Non Preferred	PA

### **SEROTONIN AGONISTS**

<i>almotriptan malate tab 6.25 mg</i>	Non Preferred	PA
<i>almotriptan malate tab 12.5 mg</i>	Non Preferred	PA
<i>eletriptan hydrobromide tab 20 mg (base equivalent) (generic of RELPAX)</i>	Non Preferred	PA
<i>eletriptan hydrobromide tab 40 mg (base equivalent) (generic of RELPAX)</i>	Non Preferred	PA
FROVA TAB 2.5MG	Non Preferred	PA
<i>frovatriptan succinate tab 2.5 mg (base equivalent) (generic of FROVA)</i>	Non Preferred	PA
IMITREX INJ 4MG/0.5	Non Preferred	PA
IMITREX INJ 6MG/0.5	Non Preferred	PA
IMITREX SPR 5MG/ACT	Non Preferred	PA, QL (0.2 inhalers every 1 day)
IMITREX SPR 20MG/ACT	Non Preferred	PA, QL (0.2 inhalers every 1 day)
IMITREX TAB 25MG	Non Preferred	PA, QL (9 tabs every 25 days)
IMITREX TAB 50MG	Non Preferred	PA, QL (9 tabs every 25 days)
IMITREX TAB 100MG	Non Preferred	PA, QL (9 tabs every 25 days)
MAXALT TAB 10MG	Non Preferred	PA, QL (12 tabs every 25 days)
MAXALT-MLT TAB 10MG	Non Preferred	PA, QL (12 tabs every 25 days)
<i>naratriptan hcl tab 1 mg (base equiv)</i>	Non Preferred	PA, QL (9 tabs every 25 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>naratriptan hcl tab 2.5 mg (base equiv)</i>	Non Preferred	PA, QL (9 tabs every 25 days)
ONZETRA XSAI MIS 11MG	Non Preferred	PA
RELPAK TAB 20MG	Non Preferred	PA
RELPAK TAB 40MG	Non Preferred	PA
REYVOW TAB 50MG	Non Preferred	PA
REYVOW TAB 100MG	Non Preferred	PA
<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i>	Preferred	QL (12 tabs every 25 days)
<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq) (generic of MAXALT-MLT)</i>	Preferred	QL (12 tabs every 25 days)
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	Preferred	QL (12 tabs every 25 days)
<i>rizatriptan benzoate tab 10 mg (base equivalent) (generic of MAXALT)</i>	Preferred	QL (12 tabs every 25 days)
<i>sumatriptan nasal spray 5 mg/act (generic of IMITREX)</i>	Preferred	QL (0.2 inhalers every 1 day)
<i>sumatriptan nasal spray 20 mg/act (generic of IMITREX)</i>	Preferred	QL (0.2 inhalers every 1 day)
<i>sumatriptan succinate inj 6 mg/0.5ml</i>	Preferred	QL (8 injections every 25 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml (generic of IMITREX STATDOSE SYSTEM)</i>	Preferred	
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml (generic of IMITREX STATDOSE SYSTEM)</i>	Preferred	
<i>sumatriptan succinate solution cartridge 4 mg/0.5ml (generic of IMITREX STATDOSE REFILL)</i>	Preferred	
<i>sumatriptan succinate solution cartridge 6 mg/0.5ml (generic of IMITREX STATDOSE REFILL)</i>	Preferred	
<i>sumatriptan succinate tab 25 mg (generic of IMITREX)</i>	Preferred	QL (9 tabs every 25 days)
<i>sumatriptan succinate tab 50 mg (generic of IMITREX)</i>	Preferred	QL (9 tabs every 25 days)
<i>sumatriptan succinate tab 100 mg (generic of IMITREX)</i>	Preferred	QL (9 tabs every 25 days)
TOSYMRA SOL 10MG	Non Preferred	PA
ZEMBRACE SYM INJ 3/0.5ML	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>zolmitriptan nasal spray 5 mg/spray unit (generic of ZOMIG)</i>	Non Preferred	PA
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	Non Preferred	PA
<i>zolmitriptan orally disintegrating tab 5 mg</i>	Non Preferred	PA
<i>zolmitriptan tab 2.5 mg (generic of ZOMIG)</i>	Non Preferred	PA
<i>zolmitriptan tab 5 mg (generic of ZOMIG)</i>	Non Preferred	PA
ZOMIG SPR 2.5MG	Non Preferred	PA
ZOMIG SPR 5MG	Non Preferred	PA
ZOMIG TAB 2.5MG	Non Preferred	PA
ZOMIG TAB 5MG	Non Preferred	PA

## **MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION**

### **CALCIUM**

<i>calcium carb-cholecalciferol tab 250 mg-3.125 mcg (125 unit)</i>	Preferred	OTC
<i>calcium carbonate tab 1500 mg (600 mg elemental ca)</i>	Preferred	OTC
<i>calcium carbonate-cholecalciferol chew tab 500 mg-600 unit</i>	Preferred	OTC
<i>calcium carbonate-cholecalciferol tab 500 mg-200 unit</i>	Preferred	OTC
<i>calcium carbonate-cholecalciferol tab 500 mg-400 unit</i>	Preferred	OTC
<i>calcium carbonate-cholecalciferol tab 600 mg-400 unit</i>	Preferred	OTC
<i>calcium citrate-vitamin d tab 200 mg-250 unit (elemental ca)</i>	Preferred	OTC
<i>calcium citrate-vitamin d tab 315 mg-200 unit (elemental ca)</i>	Preferred	OTC
<i>calcium citrate-vitamin d tab 315 mg-250 unit (elemental ca)</i>	Preferred	OTC
<i>calcium-magnesium-zinc tab 333-133-5 mg</i>	Preferred	OTC
<i>oyster shell calcium tab 500 mg</i>	Preferred	OTC
RISACAL-D TAB	Preferred	OTC

### **ELECTROLYTE MIXTURES**

<i>oral electrolyte solution</i>	Preferred	OTC
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### **FLUORIDE**

<i>sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)</i>	Preferred	QL (1 tab every 1 day)
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)</i>	Preferred	QL (1 tab every 1 day)
<i>sodium fluoride chew tab 1 mg f (from 2.2 mg naf)</i>	Preferred	QL (1 tab every 1 day)
<i>sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)</i>	Preferred	QL (1.67 mL every 1 day)

### **MAGNESIUM**

<i>magnesium oxide tab 400 mg (240 mg elemental mg)</i>	Preferred	OTC
<i>magnesium oxide tab 500 mg (mg supplement)</i>	Preferred	OTC
<i>magnesium tab 250 mg</i>	Preferred	OTC
<i>magnesium-ox tab 400mg</i>	Preferred	OTC

### **PHOSPHATE**

<i>pot phos monobasic w/sod phos di &amp; monobas tab 155-852-130mg</i>	Preferred	QL (4 tabs every 1 day)
<i>wes-phos 250 tab neutral</i>	Preferred	QL (4 tabs every 1 day), OTC

### **POTASSIUM**

<i>klor-con 8 tab 8meq er</i>	Preferred	QL (4 ea every 1 day)
<i>klor-con 10 tab 10meq er</i>	Preferred	QL (4 tabs every 1 day)
<i>klor-con m20 tab 20meq er</i>	Preferred	QL (5 tabs every 1 day)
<i>potassium bicarbonate effer tab 25 meq</i>	Preferred	QL (2 tabs every 1 day)
<i>potassium chloride cap er 8 meq</i>	Preferred	QL (4 caps every 1 day)
<i>potassium chloride cap er 10 meq</i>	Preferred	QL (4 ea every 1 day)
<i>potassium chloride microencapsulated crys er tab 10 meq</i>	Preferred	QL (4 tabs every 1 day)
<i>potassium chloride microencapsulated crys er tab 20 meq</i>	Preferred	QL (5 ea every 1 day)
<i>potassium chloride microencapsulated crys er tab 20 meq</i>	Preferred	QL (5 tabs every 1 day)
<i>potassium chloride oral soln 10% (20 meq/15ml)</i>	Preferred	
<i>potassium chloride oral soln 20% (40 meq/15ml)</i>	Preferred	
<i>potassium chloride tab er 8 meq (600 mg)</i>	Preferred	QL (4 tabs every 1 day)
<i>potassium chloride tab er 10 meq (generic of K-TAB)</i>	Preferred	QL (4 tabs every 1 day)
<i>potassium chloride tab er 20 meq (1500 mg) (generic of K-TAB)</i>	Preferred	QL (5 tabs every 1 day)

### **SODIUM**

<i>sodium chloride tab 1 gm</i>	Preferred	OTC
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## **MISCELLANEOUS THERAPEUTIC CLASSES**

### **CHELATING AGENTS**

CUPRIMINE CAP 250MG	Non Preferred	PA
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<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DEPEN TITRA TAB 250MG	Preferred	
<i>penicillamine cap 250 mg</i> (generic of CUPRIMINE)	Preferred	
<i>penicillamine tab 250 mg</i> (generic of DEPEN TITRATABS)	Preferred	
SYPRINE CAP 250MG	Non Preferred	PA
<i>trientine hcl cap 250 mg</i> (generic of SYPRINE)	Preferred	

### **IMMUNOMODULATORS**

JOENJA TAB 70MG	Non Preferred	PA
<i>lenalidomide cap 5 mg</i>	Non Preferred	SP, PA, QL (1 cap every 1 day)
<i>lenalidomide cap 10 mg</i>	Non Preferred	SP, PA, QL (1 cap every 1 day)
<i>lenalidomide cap 15 mg</i>	Non Preferred	SP, PA, QL (1 cap every 1 day)
<i>lenalidomide cap 20 mg</i>	Non Preferred	SP, PA, QL (1 cap every 1 day)
<i>lenalidomide cap 25 mg</i>	Non Preferred	SP, PA, QL (1 cap every 1 day)
<i>lenalidomide caps 2.5 mg</i>	Non Preferred	SP, PA, QL (1 cap every 1 day)
REVLIMID CAP 2.5MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
REVLIMID CAP 5MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
REVLIMID CAP 10MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
REVLIMID CAP 15MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
REVLIMID CAP 20MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
REVLIMID CAP 25MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
REZUROCK TAB 200MG	Non Preferred	SP, PA
THALOMID CAP 50MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
THALOMID CAP 100MG	Non Preferred	SP, PA, QL (1 cap every 1 day)
THALOMID CAP 150MG	Non Preferred	SP, PA, QL (2 caps every 1 day)
THALOMID CAP 200MG	Non Preferred	SP, PA, QL (2 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VYVGART INJ 400/20ML	Non Preferred	PA
<b>IMMUNOSUPPRESSIVE AGENTS</b>		
ASTAGRAF XL CAP 0.5MG	Non Preferred	PA
ASTAGRAF XL CAP 1MG	Non Preferred	PA
ASTAGRAF XL CAP 5MG	Non Preferred	PA
<i>azasan tab 75 mg</i>	Non Preferred	PA
<i>azasan tab 100mg</i>	Non Preferred	PA
<i>azathioprine tab 50 mg (generic of IMURAN)</i>	Preferred	QL (8 tabs every 1 day)
<i>azathioprine tab 75 mg</i>	Non Preferred	PA
<i>azathioprine tab 100 mg</i>	Non Preferred	PA
CELLCEPT CAP 250MG	Non Preferred	PA, QL (12 caps every 1 day)
CELLCEPT SUS 200MG/ML	Non Preferred	PA
CELLCEPT TAB 500MG	Non Preferred	PA, QL (8 tabs every 1 day)
<i>cyclosporine cap 25 mg (generic of SANDIMMUNE)</i>	Preferred	QL (16 caps every 1 day)
<i>cyclosporine cap 100 mg (generic of SANDIMMUNE)</i>	Preferred	QL (5 caps every 1 day)
<i>cyclosporine modified cap 25 mg (generic of NEORAL)</i>	Preferred	QL (15 caps every 1 day)
<i>cyclosporine modified cap 50 mg</i>	Preferred	QL (15 caps every 1 day)
<i>cyclosporine modified cap 100 mg (generic of NEORAL)</i>	Preferred	QL (10 caps every 1 day)
<i>cyclosporine modified oral soln 100 mg/ml (generic of NEORAL)</i>	Preferred	QL (10 mL every 1 day)
ENVARUSUS XR TAB 0.75MG	Non Preferred	PA
ENVARUSUS XR TAB 1MG	Non Preferred	PA
ENVARUSUS XR TAB 4MG	Non Preferred	PA
<i>everolimus tab 0.5 mg (generic of ZORTRESS)</i>	Non Preferred	PA
<i>everolimus tab 0.25 mg (generic of ZORTRESS)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>everolimus tab 0.75 mg</i> (generic of ZORTRESS)	Non Preferred	PA
<i>everolimus tab 1 mg</i> (generic of ZORTRESS)	Non Preferred	PA
<i>gengraf cap 25mg</i> (generic of NEORAL)	Preferred	QL (15 caps every 1 day)
<i>gengraf cap 100mg</i> (generic of NEORAL)	Preferred	QL (10 caps every 1 day)
<i>gengraf sol 100mg/ml</i> (generic of NEORAL)	Preferred	QL (10 mL every 1 day)
IMURAN TAB 50MG	Non Preferred	PA, QL (8 tabs every 1 day)
LUPKYNIS CAP 7.9MG	Non Preferred	PA
<i>mycophenolate mofetil cap 250 mg</i> (generic of CELLCEPT)	Preferred	QL (12 caps every 1 day)
<i>mycophenolate mofetil for oral susp 200 mg/ml</i> (generic of CELLCEPT)	Preferred	
<i>mycophenolate mofetil tab 500 mg</i> (generic of CELLCEPT)	Preferred	QL (8 tabs every 1 day)
<i>mycophenolate sodium tab dr 180 mg</i> (mycophenolic acid equiv) (generic of MYFORTIC)	Preferred	
<i>mycophenolate sodium tab dr 360 mg</i> (mycophenolic acid equiv) (generic of MYFORTIC)	Preferred	
MYFORTIC TAB 180MG	Non Preferred	PA
MYFORTIC TAB 360MG	Non Preferred	PA
NEORAL CAP 25MG	Non Preferred	PA, QL (15 caps every 1 day)
NEORAL CAP 100MG	Non Preferred	PA, QL (10 caps every 1 day)
NEORAL SOL 100MG/ML	Non Preferred	PA, QL (10 mL every 1 day)
PROGRAF CAP 0.5MG	Non Preferred	PA, QL (2 caps every 1 day)
PROGRAF CAP 1MG	Non Preferred	PA, QL (14 caps every 1 day)
PROGRAF CAP 5MG	Non Preferred	PA
PROGRAF GRA 0.2MG	Non Preferred	PA
PROGRAF GRA 1MG	Non Preferred	PA
RAPAMUNE SOL 1MG/ML	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RAPAMUNE TAB 0.5MG	Non Preferred	PA
RAPAMUNE TAB 1MG	Non Preferred	PA
RAPAMUNE TAB 2MG	Non Preferred	PA
SANDIMMUNE CAP 25MG	Non Preferred	PA, QL (16 caps every 1 day)
SANDIMMUNE CAP 100MG	Non Preferred	PA, QL (5 caps every 1 day)
SANDIMMUNE SOL 100MG/ML	Preferred	
<i>sirolimus oral soln 1 mg/ml</i> (generic of RAPAMUNE)	Preferred	
<i>sirolimus tab 0.5 mg</i> (generic of RAPAMUNE)	Preferred	
<i>sirolimus tab 1 mg</i> (generic of RAPAMUNE)	Preferred	
<i>sirolimus tab 2 mg</i> (generic of RAPAMUNE)	Preferred	
<i>tacrolimus cap 0.5 mg</i> (generic of PROGRAF)	Preferred	QL (2 caps every 1 day)
<i>tacrolimus cap 1 mg</i> (generic of PROGRAF)	Preferred	QL (14 caps every 1 day)
<i>tacrolimus cap 5 mg</i> (generic of PROGRAF)	Preferred	
ZORTRESS TAB 0.5MG	Non Preferred	PA
ZORTRESS TAB 0.25MG	Non Preferred	PA
ZORTRESS TAB 0.75MG	Non Preferred	PA
ZORTRESS TAB 1MG	Non Preferred	PA
<b>POTASSIUM REMOVING AGENTS</b>		
LOKELMA PAK 5GM	Non Preferred	PA
LOKELMA PAK 10GM	Non Preferred	PA
<i>sodium polystyrene sulfonate powder sps sus 15gm/60</i>	Preferred	
VELTASSA POW 8.4GM	Non Preferred	PA
VELTASSA POW 16.8GM	Non Preferred	PA
VELTASSA POW 25.2GM	Non Preferred	PA
<b>SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS</b>		
BENLYSTA INJ 200MG/ML	Non Preferred	SP, PA

Drug Name	Drug Tier	Requirements/Limits
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**MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT**

**ANESTHETICS TOPICAL ORAL**

<i>lidocaine hcl laryngotracheal soln 4%</i>	Preferred	
<i>lidocaine hcl viscous soln 2%</i>	Preferred	

**ANTI-INFECTIVES - THROAT**

<i>clotrimazole troche 10 mg</i>	Preferred	QL (5 ea every 1 day)
<i>nystatin susp 100000 unit/ml</i>	Preferred	QL (120 mL every 1 day)
ORAVIG TAB 50MG	Non Preferred	PA

**ANTISEPTICS - MOUTH/THROAT**

<i>chlorhexidine gluconate soln 0.12%</i> (generic of CHLORHEXIDINE GLUCONATE SOLN 0.12%)	Preferred	
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**DENTAL PRODUCTS**

<i>denta 5000 cre plus</i>	Non Preferred	PA
<i>denta 5000 cre plus 2pk</i>	Non Preferred	PA
<i>sf 5000 plus cre 1.1%</i>	Non Preferred	PA
<i>sf gel 1.1%</i>	Non Preferred	PA
<i>sod fluoride pst 1.1%</i>	Non Preferred	PA
<i>sodium fluor cre 5000 pls</i>	Non Preferred	PA
<i>sodium fluor cre 5000 ppm</i>	Non Preferred	PA
<i>sodium fluoride gel 1.1% (0.5% f)</i>	Non Preferred	PA

**STEROIDS - MOUTH/THROAT/DENTAL**

<i>oralone dent pst 0.1%</i>	Preferred	
<i>triamcinolone acetonide dental paste 0.1%</i>	Preferred	

**THROAT PRODUCTS - MISC.**

AQUORAL SPR	Non Preferred	PA
<i>cevimeline hcl cap 30 mg</i> (generic of EVOXAC)	Non Preferred	PA
EVOXAC CAP 30MG	Non Preferred	PA
GELX GEL	Non Preferred	PA
<i>pilocarpine hcl tab 5 mg</i> (generic of SALAGEN)	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pilocarpine hcl tab 7.5 mg (generic of SALAGEN)</i>	Preferred	

## **MULTIVITAMINS - DRUGS FOR NUTRITION**

### **B-COMPLEX W/ FOLIC ACID**

<i>b-complex w/ c &amp; folic acid tab 0.8 mg</i>	Preferred	OTC
<i>b-complex w/ c &amp; folic acid tab 1 mg</i>	Preferred	OTC

### **MULTIPLE VITAMINS W/ IRON**

<i>multiple vitamins w/ iron tab</i>	Preferred	QL (1 tab every 1 day), OTC
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### **MULTIPLE VITAMINS W/ MINERALS**

ADULT 50+ CAP OCUVITE	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
EYE MULTIVIT CAP	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
<i>multiple vitamins w/ minerals cap</i>	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
<i>multiple vitamins w/ minerals cap- rx</i>	Preferred	QL (1 cap every 1 day); AGE (Min 4)
<i>multiple vitamins w/ minerals tab</i>	Preferred	QL (1 tab every 1 day), OTC
<i>multiple vitamins w/ minerals tab- rx</i>	Preferred	QL (1 tab every 1 day)
OCUVITE CAP ADULT	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
<i>ocuvite eye chw health</i>	Preferred	QL (2 tabs every 1 day), OTC; AGE (Min 4)
OCUVITE LUTE CAP	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
ONE-DAILY CAP MULTI	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
PORENAL+D CAP OMEGA 3	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
PRESERVISION CAP AREDS	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
PRESERVISION CAP AREDS 2	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
PRESERVISION CAP LUTEIN	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
PRESERVISION CHW AREDS 2	Preferred	QL (2 tabs every 1 day), OTC; AGE (Min 4)
PRORENAL+D CAP OMEGA-3	Preferred	QL (1 cap every 1 day), OTC; AGE (Min 4)
SYSTANE ICAP CHW AREDS2	Preferred	QL (2 tabs every 1 day), OTC; AGE (Min 4)

### **MULTIVITAMINS - DRUGS FOR NUTRITION**

<i>multiple vitamin tab</i>	Preferred	OTC
THERA TAB	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PED MULTI VITAMINS W/FL &amp; FE</b>		
<i>multi-vit/fe dro /fl 0.25</i>	Preferred	QL (1.67 mL every 1 day), OTC
<i>pediatric multiple vitamins w/ fl-fe drops 0.25-10 mg/ml</i>	Preferred	QL (1.67 mL every 1 day)
POLY-VI-FLOR CHW W/IRON	Preferred	
POLY-VI-FLOR SUS /IRON	Preferred	
<b>PED MV W/ FLUORIDE</b>		
<i>multi vit/fl dro 0.5mg/ml</i>	Preferred	QL (1.67 mL every 1 day), OTC
<i>multivit/fl dro 0.25mg</i>	Preferred	QL (1.67 mL every 1 day), OTC
<i>pediatric multiple vitamins w/ fluoride chew tab 0.5 mg</i>	Preferred	QL (1 tab every 1 day)
<i>pediatric multiple vitamins w/ fluoride chew tab 0.25 mg</i>	Preferred	QL (1 tab every 1 day)
<i>pediatric multiple vitamins w/ fluoride chew tab 1 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>pediatric multiple vitamins w/ fluoride soln 0.5 mg/ml</i>	Preferred	QL (1.67 mL every 1 day)
<i>pediatric multiple vitamins w/ fluoride soln 0.25 mg/ml</i>	Preferred	QL (1.67 mL every 1 day)
<i>pediatric vitamins acd w/ fluoride soln 0.5 mg/ml</i>	Preferred	QL (1.67 mL every 1 day)
<i>pediatric vitamins acd w/ fluoride soln 0.25 mg/ml</i>	Preferred	QL (1.67 mL every 1 day)
POLY-VI-FLOR SUS 0.25/ML	Preferred	
<b>PED MV W/ IRON</b>		
<i>pediatric multiple vitamins w/ iron chew tab 15 mg</i>	Preferred	QL (1 tab every 1 day), OTC
<b>PEDIATRIC MULTIPLE VITAMINS</b>		
<i>child chew/ chw extra c</i>	Preferred	QL (1 tab every 1 day), OTC
<i>gnp little chw ones</i>	Preferred	QL (1 tab every 1 day), OTC
<i>qc childrens chw extra c</i>	Preferred	QL (1 tab every 1 day), OTC
<i>sm animal chw shapes</i>	Preferred	QL (1 tab every 1 day), OTC
<b>PRENATAL VITAMINS</b>		
C-NATE DHA CAP 28-1-200	Non Preferred	PA; AGE (Min 10, Max 55)
CITRANATAL CAP HARMONY	Non Preferred	PA; AGE (Min 10, Max 55)
CITRANATAL CAP MEDLEY	Non Preferred	PA; AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CITRANATAL MIS 90 DHA	Non Preferred	PA; AGE (Min 10, Max 55)
CITRANATAL MIS B-CALM	Non Preferred	PA; AGE (Min 10, Max 55)
CITRANATAL PAK ASSURE	Non Preferred	PA; AGE (Min 10, Max 55)
CITRANATAL PAK DHA	Non Preferred	PA; AGE (Min 10, Max 55)
CITRANATAL TAB BLOOM	Non Preferred	PA; AGE (Min 10, Max 55)
COMPLETE NAT PAK DHA	Non Preferred	PA; AGE (Min 10, Max 55)
COMPLETENATE CHW	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
DERMACINRX TAB PRETRATE	Non Preferred	PA; AGE (Min 10, Max 55)
<i>elite-ob tab</i>	Preferred	AGE (Min 10, Max 55)
ENBRACE HR CAP	Non Preferred	PA; AGE (Min 10, Max 55)
FOLIVANE-OB CAP	Non Preferred	PA; AGE (Min 10, Max 55)
M-NATAL PLUS TAB	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
MULTI-MAC TAB	Non Preferred	PA; AGE (Min 10, Max 55)
NATAL PNV TAB	Non Preferred	PA
NESTABS DHA PAK	Non Preferred	PA; AGE (Min 10, Max 55)
NESTABS ONE CAP	Non Preferred	PA; AGE (Min 10, Max 55)
NESTABS TAB	Non Preferred	PA; AGE (Min 10, Max 55)
NIVA-PLUS TAB	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
OB COMPLETE CAP ONE	Non Preferred	PA; AGE (Min 10, Max 55)
OB COMPLETE CAP PETITE	Non Preferred	PA; AGE (Min 10, Max 55)
OB COMPLETE TAB	Preferred	AGE (Min 10, Max 55)
OB COMPLETE TAB PREMIER	Non Preferred	PA; AGE (Min 10, Max 55)
OB COMPLETE/ CAP DHA	Non Preferred	PA; AGE (Min 10, Max 55)
<i>pnv-dha cap</i>	Non Preferred	PA; AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PNV-DHA CAP DOCUSATE	Non Preferred	PA; AGE (Min 10, Max 55)
PNV-OMEGA CAP	Non Preferred	PA; AGE (Min 10, Max 55)
<i>pnv-select tab</i>	Non Preferred	PA; AGE (Min 10, Max 55)
PREMESISRX TAB	Non Preferred	PA; AGE (Min 10, Max 55)
PRENAISSANCE CAP	Non Preferred	PA; AGE (Min 10, Max 55)
PRENAISSANCE CAP PLUS	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATAL TAB 27-1MG	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
PRENATAL TAB PLUS	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
PRENATAL VIT W/ FE FUMARATE-FA TAB 27-0.8 MG	Preferred	OTC
PRENATAL VIT W/ FE FUMARATE-FA TAB 28-0.8 MG	Preferred	OTC
PRENATE AM TAB 1MG	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE CAP ENHANCE	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE CAP ESSENT	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE CAP PIXIE	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE CAP RESTORE	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE CHW 0.6-0.4	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE MINI CAP	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATE TAB ELITE	Non Preferred	PA; AGE (Min 10, Max 55)
PRENATRIX TAB	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 10, Max 55)
PRENATRYL TAB	Non Preferred	PA, QL (1 tab every 1 day); AGE (Min 10, Max 55)
PRIMACARE CAP	Non Preferred	PA; AGE (Min 10, Max 55)
RELNATE DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SE-NATAL 19 CHW	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
SE-NATAL 19 TAB	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
SELECT-OB CHW	Non Preferred	PA; AGE (Min 10, Max 55)
SELECT-OB+ PAK DHA	Non Preferred	PA; AGE (Min 10, Max 55)
TARON-C DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)
THRIVITE RX TAB 29-1MG	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
TRICARE TAB PRENATAL	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
TRINATAL RX TAB 1	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
TRISTART DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)
VINATE DHA CAP 27-1.13	Non Preferred	PA; AGE (Min 10, Max 55)
VIRT-NATE CAP DHA	Non Preferred	PA; AGE (Min 10, Max 55)
VIRT-PN DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL CAP ULTRA	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL CHW GUMMIES	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL FE+ CAP	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL STRP MIS 1MG	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL-NANO TAB	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL-OB PAK +DHA	Non Preferred	PA; AGE (Min 10, Max 55)
VITAFOL-OB TAB 65-1MG	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
VITAFOL-ONE CAP	Non Preferred	PA; AGE (Min 10, Max 55)
WESCAP-C DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)
WESCAP-PN CAP DHA	Non Preferred	PA; AGE (Min 10, Max 55)
WESNATAL DHA PAK COMPLETE	Non Preferred	PA; AGE (Min 10, Max 55)
WESNATE DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)

**AGE** - Age Limit   **OTC** - Over the counter   **PA** - Prior Authorization   **QL** - Quantity Limits  
**SP** - Specialty   **ST** - Step Therapy

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
WESTAB PLUS TAB 27-1MG	Preferred	QL (1 tab every 1 day); AGE (Min 10, Max 55)
WESTGEL DHA CAP	Non Preferred	PA; AGE (Min 10, Max 55)

## **MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS**

### **CENTRAL MUSCLE RELAXANTS**

AMRIX CAP 15MG	Non Preferred	PA
AMRIX CAP 30MG	Non Preferred	PA
<i>baclofen oral soln 5 mg/5ml</i>	Non Preferred	PA
<i>baclofen tab 5 mg</i>	Preferred	
<i>baclofen tab 10 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>baclofen tab 20 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>carisoprodol tab 250 mg (generic of SOMA)</i>	Non Preferred	PA
<i>carisoprodol tab 350 mg (generic of SOMA)</i>	Non Preferred	PA
<i>chlorzoxazone tab 250 mg</i>	Preferred	
<i>chlorzoxazone tab 375 mg</i>	Preferred	
<i>chlorzoxazone tab 500 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>chlorzoxazone tab 750 mg</i>	Preferred	
<i>cyclobenzaprine hcl cap er 24hr 15 mg (generic of AMRIX)</i>	Non Preferred	PA
<i>cyclobenzaprine hcl cap er 24hr 30 mg (generic of AMRIX)</i>	Non Preferred	PA
<i>cyclobenzaprine hcl tab 5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>cyclobenzaprine hcl tab 7.5 mg</i>	Preferred	
<i>cyclobenzaprine hcl tab 10 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>fexmid tab 7.5mg</i>	Preferred	
FLEQSUVY SUS 25MG/5ML	Non Preferred	PA
<i>lorzone tab 375mg</i>	Preferred	
<i>lorzone tab 750mg</i>	Preferred	
LYVISPAH GRA 5MG	Non Preferred	PA
LYVISPAH GRA 10MG	Non Preferred	PA
LYVISPAH GRA 20MG	Non Preferred	PA
<i>metaxalone tab 400 mg</i>	Non Preferred	PA
<i>metaxalone tab 800 mg</i>	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methocarbamol tab 500 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>methocarbamol tab 750 mg</i>	Preferred	QL (10 tabs every 1 day)
<i>orphenadrine citrate tab er 12hr 100 mg</i>	Preferred	QL (2 tabs every 1 day)
SOMA TAB 250MG	Non Preferred	PA
SOMA TAB 350MG	Non Preferred	PA
<i>tizanidine hcl cap 2 mg (base equivalent) (generic of ZANAFLEX)</i>	Non Preferred	PA
<i>tizanidine hcl cap 4 mg (base equivalent) (generic of ZANAFLEX)</i>	Non Preferred	PA
<i>tizanidine hcl cap 6 mg (base equivalent) (generic of ZANAFLEX)</i>	Non Preferred	PA
<i>tizanidine hcl tab 2 mg (base equivalent) (generic of ZANAFLEX)</i>	Preferred	QL (3 tabs every 1 day)
<i>tizanidine hcl tab 4 mg (base equivalent) (generic of ZANAFLEX)</i>	Preferred	QL (9 tabs every 1 day)
ZANAFLEX CAP 2MG	Non Preferred	PA
ZANAFLEX CAP 4MG	Non Preferred	PA
ZANAFLEX CAP 6MG	Non Preferred	PA
ZANAFLEX TAB 4MG	Non Preferred	PA, QL (9 tabs every 1 day)

### ***DIRECT MUSCLE RELAXANTS***

DANTRIUM CAP 25MG	Non Preferred	PA
<i>dantrolene sodium cap 25 mg (generic of DANTRIUM)</i>	Preferred	
<i>dantrolene sodium cap 50 mg</i>	Preferred	
<i>dantrolene sodium cap 100 mg</i>	Preferred	

### ***MUSCLE RELAXANT COMBINATIONS***

<i>norgesic tab</i>	Preferred	
NORGESIC TAB FORTE	Non Preferred	PA
<i>orphenadrine w/ aspirin &amp; caffeine tab 25-385-30 mg</i>	Preferred	
<i>orphengesic tab forte</i>	Preferred	

### **NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE**

#### ***NASAL AGENT COMBINATIONS***

<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act (generic of DYMISTA)</i>	Non Preferred	PA
DYMISTA SPR 137-50	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RYALTRIS SPR 665-25	Non Preferred	PA
<b>NASAL AGENTS - MISC.</b>		
<i>saline nasal spray 0.65%</i>	Preferred	OTC
<b>NASAL ANTIALLERGY</b>		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	Preferred	QL (0.04 bottles every 1 day)
<i>azelastine hcl nasal spray 0.15% (205.5 mcg/spray)</i>	Preferred	
<i>cromolyn sodium nasal aerosol soln 5.2 mg/act (4%)</i>	Preferred	QL (52 mL every 25 days), OTC
<i>olopatadine hcl nasal soln 0.6% (generic of PATANASE)</i>	Preferred	
PATANASE SPR 0.6%	Non Preferred	PA
<b>NASAL ANTICHOLINERGICS</b>		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	Non Preferred	PA
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	Non Preferred	PA
<b>NASAL STEROIDS</b>		
BECONASE AQ SUS 0.042%	Non Preferred	PA
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	Preferred	
<i>fluticasone propionate nasal susp 50 mcg/act</i>	Preferred	QL (1 bottle every 25 days)
<i>mometasone furoate nasal susp 50 mcg/act</i>	Non Preferred	PA
OMNARIS SPR	Non Preferred	PA
PROPEL SDS IMP 370MCG	Non Preferred	PA
QNASL AER 80MCG	Non Preferred	PA
QNASL CHILD SPR 40MCG	Non Preferred	PA
SINUVA IMP 1350MCG	Non Preferred	PA
XHANCE MIS 93MCG	Non Preferred	PA
ZETONNA AER 37MCG	Non Preferred	PA
<b>SYMPATHOMIMETIC DECONGESTANTS</b>		
<i>oxymetazoline hcl nasal soln 0.05%</i>	Preferred	OTC
<i>phenylephrine hcl tab 10 mg</i>	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pseudoephedrine hcl tab 30 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
<i>pseudoephedrine hcl tab 60 mg</i>	Preferred	QL (6 tabs every 1 day), OTC
<i>pseudoephedrine hcl tab er 12hr 120 mg</i>	Preferred	QL (2 tabs every 1 day), OTC

## **NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES**

### **ALS AGENTS**

EXSERVAN MIS 50MG	Non Preferred	SP, PA
RADICAVA ORS SUS 105/5ML	Non Preferred	SP, PA
RADICAVA ORS SUS STARTER	Non Preferred	SP, PA
RELYVRIO PAK 3-1GM	Non Preferred	SP, PA
RILUTEK TAB 50MG	Non Preferred	PA
<i>riluzole tab 50 mg (generic of RILUTEK)</i>	Preferred	
TIGLUTIK SUS 50/10ML	Non Preferred	PA

### **RETT SYNDROME AGENTS**

DAYBUE SOL 200MG/ML	Non Preferred	PA
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## **NUTRIENTS - DRUGS FOR NUTRITION**

### **MISC. NUTRITIONAL SUBSTANCES**

<i>omega-3 fatty acids cap 500 mg</i>	Preferred	OTC
<i>omega-3 fatty acids cap 1000 mg</i>	Preferred	OTC
<i>omega-3 fatty acids cap 1200 mg</i>	Preferred	OTC

## **OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS**

### **ARTIFICIAL TEARS AND LUBRICANTS**

<i>artificial tear ophth solution</i>	Preferred	OTC
<i>carboxymethylcellulose sodium (pf) ophth soln 0.5%</i>	Preferred	OTC
<i>carboxymethylcellulose sodium ophth soln 0.5%</i>	Preferred	OTC
<i>dextran 70-hypromellose ophth soln 0.1-0.3%</i>	Preferred	OTC
<i>glycerin-hypromellose-peg 400 ophth soln 0.2-0.2-1%</i>	Preferred	OTC
LACRISERT MIS 5MG OP	Preferred	
<i>polyethylene glycol-propylene glycol ophth soln 0.4-0.3%</i>	Preferred	OTC
<i>polyethylene glycol-propylene glycol pf op soln 0.4-0.3%</i>	Preferred	OTC
<i>polyvinyl alcohol ophth soln 1.4%</i>	Preferred	OTC

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>polyvinyl alcohol-povidone ophth soln 5-6 mg/ml (0.5-0.6%)</i>	Preferred	OTC
<i>white petrolatum-mineral oil ophth ointment</i>	Preferred	OTC

### **BETA-BLOCKERS - OPHTHALMIC**

<i>betaxolol hcl ophth soln 0.5%</i>	Preferred	
BETIMOL SOL 0.5%	Non Preferred	PA
BETIMOL SOL 0.25%	Non Preferred	PA
BETOPTIC-S SUS 0.25% OP	Non Preferred	PA
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5% (generic of COMBIGAN)</i>	Non Preferred	PA
<i>carteolol hcl ophth soln 1%</i>	Preferred	QL (15 mL every 25 days)
COMBIGAN SOL 0.2/0.5%	Non Preferred	PA
COSOPT PF SOL 2%-0.5%	Non Preferred	PA
COSOPT SOL 22.3-6.8	Non Preferred	PA, QL (10 mL every 25 days)
<i>dorzolamide hcl-timolol maleate ophth sol 22.3-6.8 mg/ml pf (generic of COSOPT PF)</i>	Non Preferred	PA
<i>dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml (generic of COSOPT)</i>	Preferred	QL (10 mL every 25 days)
ISTALOL SOL 0.5% OP	Non Preferred	PA
<i>levobunolol hcl ophth soln 0.5%</i>	Preferred	QL (15 mL every 25 days)
<i>timolol maleate ophth gel forming soln 0.5% (generic of TIMOPTIC-XE)</i>	Preferred	
<i>timolol maleate ophth gel forming soln 0.25% (generic of TIMOPTIC-XE)</i>	Preferred	
<i>timolol maleate ophth soln 0.5% (generic of TIMOPTIC)</i>	Preferred	
<i>timolol maleate ophth soln 0.5% (once-daily) (generic of ISTALOL)</i>	Preferred	
<i>timolol maleate ophth soln 0.25% (generic of TIMOPTIC)</i>	Preferred	
<i>timolol maleate preservative free ophth soln 0.5% (generic of TIMOPTIC OCUDOSE)</i>	Non Preferred	PA
<i>timolol maleate preservative free ophth soln 0.25% (generic of TIMOPTIC OCUDOSE)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TIMOPTIC OCU SOL 0.5% OP	Non Preferred	PA
TIMOPTIC OCU SOL 0.25% OP	Non Preferred	PA
TIMOPTIC SOL 0.5% OP	Non Preferred	PA
TIMOPTIC SOL 0.25% OP	Non Preferred	PA
TIMOPTIC-XE SOL 0.5% OP	Non Preferred	PA
TIMOPTIC-XE SOL 0.25% OP	Non Preferred	PA

### **CYCLOPLEGIC MYDRIATICS**

ATROPINE SUL SOL 1% OP	Preferred	QL (15 mL every 25 days)
<i>atropine sulfate ophth oint 1%</i>	Preferred	
<i>atropine sulfate ophth soln 1%</i>	Preferred	QL (15 mL every 25 days)
CYCLOGYL SOL 0.5% OP	Non Preferred	PA
CYCLOGYL SOL 1% OP	Non Preferred	PA
CYCLOGYL SOL 2% OP	Non Preferred	PA
CYCLOMYDRIL SOL OP	Preferred	
<i>cyclopentolate hcl ophth soln 1% (generic of CYCLOGYL)</i>	Preferred	
ISOPTO ATROP SOL 1% OP	Non Preferred	PA, QL (15 mL every 25 days)
MYDRIACYL SOL 1% OP	Non Preferred	PA
<i>phenylephrine hcl ophth soln 2.5%</i>	Non Preferred	PA
<i>phenylephrine hcl ophth soln 10%</i>	Non Preferred	PA
<i>tropicamide ophth soln 0.5%</i>	Preferred	
<i>tropicamide ophth soln 1% (generic of MYDRIACYL)</i>	Preferred	

### **MIOTICS**

PHOSPHOLINE SOL 0.125%OP	Non Preferred	PA
<i>pilocarpine hcl ophth soln 1%</i>	Preferred	
<i>pilocarpine hcl ophth soln 2%</i>	Preferred	QL (60 mL every 25 days)
<i>pilocarpine hcl ophth soln 4%</i>	Preferred	
VUITY SOL 1.25% OP	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OPHTHALMIC ADRENERGIC AGENTS</b>		
ALPHAGAN P SOL 0.1%	Preferred	
ALPHAGAN P SOL 0.15%	Preferred	
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	Non Preferred	PA
<i>brimonidine tartrate ophth soln 0.2%</i>	Preferred	
<i>brimonidine tartrate ophth soln 0.15% (generic of ALPHAGAN P)</i>	Preferred	
IOPIDINE SOL 1% OP	Non Preferred	PA
SIMBRINZA SUS 1-0.2%	Non Preferred	PA
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
AZASITE SOL 1%	Non Preferred	PA
<i>bacitracin ophth oint 500 unit/gm</i>	Preferred	
<i>bacitracin-polymyxin b ophth oint</i>	Preferred	
BESIVANCE SUS 0.6%	Non Preferred	PA
BETADINE SOL 5% OP	Non Preferred	PA
CILOXAN OIN 0.3% OP	Preferred	
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	Preferred	
<i>erythromycin ophth oint 5 mg/gm</i>	Preferred	
<i>gatifloxacin ophth soln 0.5% (generic of ZYMAXID)</i>	Non Preferred	PA
<i>gentamicin sulfate ophth soln 0.3%</i>	Preferred	QL (10 mL every 30 days)
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	Non Preferred	PA
<i>moxifloxacin hcl ophth soln 0.5% (base equiv) (generic of VIGAMOX)</i>	Non Preferred	PA
<i>moxifloxacin hcl ophth soln 0.5% (base equiv) (generic of VIGAMOX)</i>	Non Preferred	PA
NATACYN SUS 5% OP	Non Preferred	PA
<i>neo-polycin oin op</i>	Preferred	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	Preferred	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	Preferred	
OCUFLOX DRO 0.3% OP	Non Preferred	PA
<i>ofloxacin ophth soln 0.3% (generic of OCUFLOX)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1% (generic of POLYTRIM)</i>	Preferred	
POLYTRIM SOL OP	Non Preferred	PA
<i>sulfacetamide sodium ophth oint 10%</i>	Preferred	
<i>sulfacetamide sodium ophth soln 10%</i>	Preferred	
<i>tobramycin ophth soln 0.3%</i>	Preferred	
TOBREX OIN 0.3% OP	Preferred	
<i>trifluridine ophth soln 1%</i>	Preferred	QL (7.5 mL every 25 days)
VIGAMOX DRO 0.5%	Non Preferred	PA
ZIRGAN GEL 0.15%	Preferred	
ZYMAXID SOL 0.5%	Non Preferred	PA
<b>OPHTHALMIC IMMUNOMODULATORS</b>		
CEQUA SOL 0.09%	Non Preferred	PA
<i>cyclosporine (ophth) emulsion 0.05% (generic of RESTASIS)</i>	Non Preferred	PA
RESTASIS EMU 0.05% OP	Non Preferred	PA
RESTASIS MUL EMU 0.05% OP	Non Preferred	PA
VERKAZIA EMU 0.1% OP	Non Preferred	PA
<b>OPHTHALMIC INTEGRIN ANTAGONISTS</b>		
XIIDRA DRO 5%	Non Preferred	PA
<b>OPHTHALMIC KINASE INHIBITORS</b>		
RHOPRESSA SOL 0.02%	Non Preferred	PA
ROCKLATAN DRO	Non Preferred	PA
<b>OPHTHALMIC LOCAL ANESTHETICS</b>		
AKTEN GEL 3.5%	Non Preferred	PA
ALCAINE SOL 0.5% OP	Non Preferred	PA
<i>proparacaine hcl ophth soln 0.5% (generic of ALCAINE)</i>	Non Preferred	PA
<i>tetracaine hcl ophth soln 0.5%</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OPHTHALMIC NERVE GROWTH FACTORS</b>		
OXERVATE SOL 20MCG/ML	Non Preferred	SP, PA
<b>OPHTHALMIC STEROIDS</b>		
ALREX SUS 0.2%	Preferred	
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	Preferred	
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	Preferred	
DEXTENZA MIS 0.4MG	Non Preferred	PA
<i>difluprednate ophth emulsion 0.05% (generic of DUREZOL)</i>	Non Preferred	PA
DUREZOL EMU 0.05%	Non Preferred	PA
EYSUVIS DRO 0.25%	Non Preferred	PA
FLAREX SUS 0.1% OP	Preferred	
<i>fluorometholone ophth susp 0.1%</i>	Preferred	QL (15 mL every 25 days)
FML FORTE SUS 0.25% OP	Preferred	
FML LIQUIFLM SUS 0.1% OP	Non Preferred	PA, QL (15 mL every 25 days)
INVELTYS SUS 1%	Non Preferred	PA
LOTEMAX GEL 0.5%	Non Preferred	PA
LOTEMAX OIN 0.5%	Non Preferred	PA
LOTEMAX SM GEL 0.38%	Non Preferred	PA
LOTEMAX SUS 0.5%	Non Preferred	PA
<i>loteprednol etabonate ophth gel 0.5% (generic of LOTEMAX)</i>	Non Preferred	PA
<i>loteprednol etabonate ophth susp 0.5% (generic of LOTEMAX)</i>	Preferred	
MAXIDEX SUS 0.1% OP	Preferred	
MAXITROL OIN 0.1% OP	Non Preferred	PA
MAXITROL SUS 0.1% OP	Non Preferred	PA
<i>neo-polycin oin hc 1%op</i>	Preferred	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1% (generic of MAXITROL)</i>	Preferred	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1% (generic of MAXITROL)</i>	Preferred	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>neomycin-polymyxin-hc ophth susp</i>	Preferred	
PRED FORTE SUS 1% OP	Non	PA
	Preferred	
PRED MILD SUS 0.12% OP	Preferred	
PRED SOD PHO SOL 1% OP	Preferred	
<i>prednisolone acetate ophth susp 1% (generic of PRED FORTE)</i>	Preferred	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	Non	PA
	Preferred	
TOBRADEX OIN 0.3-0.1%	Non	PA
	Preferred	
TOBRADEX ST SUS 0.3-0.05	Non	PA
	Preferred	
TOBRADEX SUS 0.3-0.1%	Non	PA
	Preferred	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1% (generic of TOBRADEX)</i>	Preferred	
ZYLET SUS 0.5-0.3%	Non	PA
	Preferred	
<b>OPHTHALMICS - MISC.</b>		
ACULAR LS SOL 0.4%	Non	PA
	Preferred	
ACULAR SOL 0.5% OP	Non	PA, QL (10 mL every 25 days)
	Preferred	
ACUVAIL SOL 0.45%	Non	PA
	Preferred	
ALOCRIAL SOL 2%	Non	PA
	Preferred	
ALOMIDE SOL 0.1% OP	Non	PA
	Preferred	
<i>azelastine hcl ophth soln 0.05%</i>	Preferred	QL (0.28 mL every 1 day)
AZOPT SUS 1% OP	Non	PA
	Preferred	
<i>bepotastine besilate ophth soln 1.5% (generic of BEPREVE)</i>	Non	PA
	Preferred	
BEPREVE DRO 1.5%	Non	PA
	Preferred	
<i>brinzolamide ophth susp 1% (generic of AZOPT)</i>	Non	PA
	Preferred	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	Non	PA
	Preferred	
BROMSITE DRO 0.075%	Non	PA
	Preferred	
<i>cromolyn sodium ophth soln 4%</i>	Preferred	
CYSTADROPS SOL 0.37%	Non	SP, PA
	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CYSTARAN SOL 0.44%	Non Preferred	SP, PA
<i>diclofenac sodium ophth soln 0.1%</i>	Preferred	
<i>dorzolamide hcl ophth soln 2%</i>	Preferred	
<i>epinastine hcl ophth soln 0.05%</i>	Non Preferred	PA
FLUORE/BENOX SOL 0.3-0.4%	Non Preferred	PA
<i>flurbiprofen sodium ophth soln 0.03%</i>	Preferred	
GLOSTRIPS MIS 1MG OP	Non Preferred	PA
ILEVRO DRO 0.3% OP	Non Preferred	PA
<i>ketorolac tromethamine ophth soln 0.4% (generic of ACULAR LS)</i>	Preferred	
<i>ketorolac tromethamine ophth soln 0.5% (generic of ACULAR)</i>	Preferred	QL (10 mL every 25 days)
<i>ketotifen fumarate ophth soln 0.025% (base equiv)</i>	Preferred	OTC
NEVANAC SUS 0.1% OP	Non Preferred	PA
<i>olopatadine hcl ophth soln 0.1% (base equivalent)</i>	Non Preferred	PA, QL (5 mL every 30 days)
<i>olopatadine hcl ophth soln 0.2% (base equivalent)</i>	Non Preferred	PA, QL (2.5 mL every 30 days)
PROLENSA SOL 0.07%	Non Preferred	PA
<i>sodium chloride hypertonic ophth oint 5%</i>	Preferred	OTC
<i>sodium chloride hypertonic ophth soln 5%</i>	Preferred	OTC
ZERVIAE DRO 0.24%	Non Preferred	PA

### **PROSTAGLANDINS - OPHTHALMIC**

<i>bimatoprost ophth soln 0.03%</i>	Non Preferred	PA
<i>latanoprost ophth soln 0.005% (generic of XALATAN)</i>	Preferred	QL (0.17 mL every 1 day)
LUMIGAN SOL 0.01%	Non Preferred	PA
<i>tafluprost preservative free (pf) ophth soln 0.0015% (generic of ZIOPTAN)</i>	Non Preferred	PA
TRAVATAN Z DRO 0.004%	Non Preferred	PA, QL (5 mL every 25 days)
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free) (generic of TRAVATAN Z)</i>	Non Preferred	PA, QL (5 mL every 25 days)
VYZULTA SOL 0.024%	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XALATAN SOL 0.005%	Non Preferred	PA, QL (0.17 mL every 1 day)
XELPROS EMU 0.005%	Non Preferred	PA
ZIOPTAN DRO 0.0015%	Non Preferred	PA

## **OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR**

### **OTIC AGENTS - MISCELLANEOUS**

<i>acetic acid otic soln 2%</i>	Preferred	QL (20 mL every 25 days)
<i>carbamide peroxide 6.5% otic soln</i>	Preferred	OTC

### **OTIC ANTI-INFECTIVES**

<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	Non Preferred	PA, QL (14 ea every 25 days)
<i>ofloxacin otic soln 0.3%</i>	Preferred	QL (5 mL every 25 days)

### **OTIC COMBINATIONS**

CIPRODEX SUS 0.3-0.1%	Preferred	QL (7.5 mL every 25 days)
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1% (generic of CIPRODEX)</i>	Preferred	QL (7.5 mL every 25 days)
<i>ciprofloxacin-fluocinolone acetone (pf) otic soln 0.3-0.025%</i>	Non Preferred	PA
CORTISPORIN SUS -TC OTIC	Non Preferred	PA
<i>neomycin-polymyxin-hc otic soln 1%</i>	Preferred	
<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	Preferred	

### **OTIC STEROIDS**

DERMOTIC OIL 0.01%	Non Preferred	PA
<i>flac oil 0.01% (generic of DERMOTIC)</i>	Non Preferred	PA
<i>fluocinolone acetonide (otic) oil 0.01% (generic of DERMOTIC)</i>	Non Preferred	PA
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	Non Preferred	PA

## **OXYTOCICS - DRUGS FOR PREGNANCY**

### **OXYTOCICS - DRUGS FOR PREGNANCY**

<i>methergine tab 0.2mg</i>	Preferred	QL (7 tabs every 1 day)
<i>methylergonovine maleate tab 0.2 mg</i>	Preferred	QL (7 tabs every 1 day)

## **PENICILLINS - DRUGS TO TREAT INFECTIONS**

### **AMINOPENICILLINS**

<i>amoxicillin (trihydrate) cap 250 mg</i>	Preferred	QL (8 caps every 1 day)
<i>amoxicillin (trihydrate) cap 500 mg</i>	Preferred	QL (8 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	Preferred	
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	Preferred	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	Preferred	
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	Preferred	
<i>amoxicillin (trihydrate) tab 500 mg</i>	Preferred	QL (5 tabs every 1 day)
<i>amoxicillin (trihydrate) tab 875 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>ampicillin cap 500 mg</i>	Preferred	QL (8 caps every 1 day)

### **NATURAL PENICILLINS**

<i>penicillin v potassium for soln 125 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>penicillin v potassium for soln 250 mg/5ml</i>	Preferred	QL (40 mL every 1 day)
<i>penicillin v potassium tab 250 mg</i>	Preferred	QL (8 tabs every 1 day)
<i>penicillin v potassium tab 500 mg</i>	Preferred	QL (8 tabs every 1 day)

### **PENICILLIN COMBINATIONS**

<i>amoxicillin &amp; k clavulanate chew tab 200-28.5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>amoxicillin &amp; k clavulanate chew tab 400-57 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>amoxicillin &amp; k clavulanate for susp 200-28.5 mg/5ml</i>	Preferred	
<i>amoxicillin &amp; k clavulanate for susp 250-62.5 mg/5ml</i>	Preferred	
<i>amoxicillin &amp; k clavulanate for susp 400-57 mg/5ml</i>	Preferred	
<i>amoxicillin &amp; k clavulanate for susp 600-42.9 mg/5ml (generic of AUGMENTIN ES-600)</i>	Preferred	
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>amoxicillin &amp; k clavulanate tab 500-125 mg (generic of AUGMENTIN)</i>	Preferred	QL (2 tabs every 1 day)
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-62.5 mg</i>	Non Preferred	PA
AUGMENTIN SUS 125/5ML	Preferred	
AUGMENTIN SUS ES-600	Non Preferred	PA

### **PENICILLINASE-RESISTANT PENICILLINS**

<i>dicloxacillin sodium cap 250 mg</i>	Preferred	QL (8 caps every 1 day)
<i>dicloxacillin sodium cap 500 mg</i>	Preferred	QL (6 caps every 1 day)

**Drug Name Drug Tier Requirements/Limits**  
**PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES**

**PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES**

AYGESTIN TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>medroxyprogesterone acetate tab 2.5 mg (generic of PROVERA)</i>	Preferred	QL (2 tabs every 1 day)
<i>medroxyprogesterone acetate tab 5 mg (generic of PROVERA)</i>	Preferred	QL (2 tabs every 1 day)
<i>medroxyprogesterone acetate tab 10 mg (generic of PROVERA)</i>	Preferred	QL (2 tabs every 1 day)
<i>megestrol acetate susp 625 mg/5ml</i>	Non Preferred	PA
<i>norethindrone acetate tab 5 mg (generic of AYGESTIN)</i>	Non Preferred	PA, QL (1 tab every 1 day)
<i>progesterone cap 100 mg (generic of PROMETRIUM)</i>	Preferred	QL (1 cap every 1 day)
<i>progesterone cap 200 mg (generic of PROMETRIUM)</i>	Preferred	QL (2 caps every 1 day)
<i>progesterone im in oil 50 mg/ml</i>	Preferred	
PROMETRIUM CAP 100MG	Non Preferred	PA, QL (1 cap every 1 day)
PROMETRIUM CAP 200MG	Non Preferred	PA, QL (2 caps every 1 day)
PROVERA TAB 2.5MG	Non Preferred	PA, QL (2 tabs every 1 day)
PROVERA TAB 5MG	Non Preferred	PA, QL (2 tabs every 1 day)
PROVERA TAB 10MG	Non Preferred	PA, QL (2 tabs every 1 day)

**PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS**

**AGENTS FOR CHEMICAL DEPENDENCY**

<i>acamprosate calcium tab delayed release 333 mg</i>	Preferred	
<i>disulfiram tab 250 mg</i>	Preferred	QL (1 tab every 1 day)
<i>disulfiram tab 500 mg</i>	Preferred	QL (1 tab every 1 day)
LUCEMYRA TAB 0.18MG	Preferred	

**ANTI-CATAPLECTIC AGENTS**

SOD OXYBATE SOL 500MG/ML	Non Preferred	SP, PA
XYREM SOL 500MG/ML	Non Preferred	SP, PA
XYWAV SOL 0.5GM/ML	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIDEMENTIA AGENTS</b>		
ADLARITY DIS 5MG/DAY	Non Preferred	PA
ADLARITY DIS 10MG/DAY	Non Preferred	PA
ADUHELM INJ 170MG	Non Preferred	PA
ADUHELM INJ 300MG	Non Preferred	PA
ARICEPT TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
ARICEPT TAB 10MG	Non Preferred	PA, QL (1 tab every 1 day)
ARICEPT TAB 23MG	Non Preferred	PA
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	Preferred	QL (1 tab every 1 day)
<i>donepezil hydrochloride tab 5 mg (generic of ARICEPT)</i>	Preferred	QL (1 tab every 1 day)
<i>donepezil hydrochloride tab 10 mg (generic of ARICEPT)</i>	Preferred	QL (1 tab every 1 day)
<i>donepezil hydrochloride tab 23 mg (generic of ARICEPT)</i>	Preferred	
EXELON DIS 4.6MG/24	Non Preferred	PA
EXELON DIS 9.5MG/24	Non Preferred	PA
EXELON DIS 13.3/24	Non Preferred	PA
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	Non Preferred	PA
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	Non Preferred	PA
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	Non Preferred	PA
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	Non Preferred	PA
<i>galantamine hydrobromide tab 4 mg</i>	Non Preferred	PA
<i>galantamine hydrobromide tab 8 mg</i>	Non Preferred	PA
<i>galantamine hydrobromide tab 12 mg</i>	Non Preferred	PA
LEQEMBI SOL 200/2ML	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LEQEMBI SOL 500/5ML	Non Preferred	PA
<i>memantine hcl cap er 24hr 7 mg (generic of NAMENDA XR)</i>	Non Preferred	PA
<i>memantine hcl cap er 24hr 14 mg (generic of NAMENDA XR)</i>	Non Preferred	PA
<i>memantine hcl cap er 24hr 21 mg (generic of NAMENDA XR)</i>	Non Preferred	PA
<i>memantine hcl cap er 24hr 28 mg (generic of NAMENDA XR)</i>	Non Preferred	PA
<i>memantine hcl oral solution 2 mg/ml</i>	Non Preferred	PA
<i>memantine hcl tab 5 mg (generic of NAMENDA)</i>	Preferred	
<i>memantine hcl tab 5 mg (generic of NAMENDA)</i>	Preferred	
<i>memantine hcl tab 10 mg (generic of NAMENDA)</i>	Preferred	
<i>memantine hcl tab 10 mg (generic of NAMENDA)</i>	Preferred	
<i>memantine hcl tab 28 x 5 mg &amp; 21 x 10 mg titration pack (generic of NAMENDA TITRATION PAK)</i>	Non Preferred	PA
NAMENDA TAB 5-10MG	Non Preferred	PA
NAMENDA TAB 5MG	Non Preferred	PA
NAMENDA TAB 10MG	Non Preferred	PA
NAMENDA XR CAP 7MG	Non Preferred	PA
NAMENDA XR CAP 14MG	Non Preferred	PA
NAMENDA XR CAP 21MG	Non Preferred	PA
NAMENDA XR CAP 28MG	Non Preferred	PA
NAMZARIC CAP	Non Preferred	PA
NAMZARIC CAP 7-10MG	Non Preferred	PA
NAMZARIC CAP 14-10MG	Non Preferred	PA
NAMZARIC CAP 21-10MG	Non Preferred	PA
NAMZARIC CAP 28-10MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RAZADYNE ER CAP 8MG	Non Preferred	PA
RAZADYNE ER CAP 24MG	Non Preferred	PA
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	Non Preferred	PA
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	Non Preferred	PA
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	Non Preferred	PA
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	Non Preferred	PA
<i>rivastigmine td patch 24hr 4.6 mg/24hr (generic of EXELON)</i>	Non Preferred	PA
<i>rivastigmine td patch 24hr 9.5 mg/24hr (generic of EXELON)</i>	Non Preferred	PA
<i>rivastigmine td patch 24hr 13.3 mg/24hr (generic of EXELON)</i>	Non Preferred	PA

### **COMBINATION PSYCHOTHERAPEUTICS**

<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	Preferred	
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	Preferred	
LYBALVI TAB 5-10MG	Non Preferred	PA
LYBALVI TAB 10-10MG	Non Preferred	PA
LYBALVI TAB 15-10MG	Non Preferred	PA
LYBALVI TAB 20-10MG	Non Preferred	PA
<i>olanzapine-fluoxetine hcl cap 3-25 mg (generic of SYMBYAX)</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl cap 6-25 mg (generic of SYMBYAX)</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	Non Preferred	PA
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	Non Preferred	PA
<i>perphenazine-amitriptyline tab 2-10 mg</i>	Preferred	
<i>perphenazine-amitriptyline tab 2-25 mg</i>	Preferred	
<i>perphenazine-amitriptyline tab 4-10 mg</i>	Preferred	
<i>perphenazine-amitriptyline tab 4-25 mg</i>	Preferred	
<i>perphenazine-amitriptyline tab 4-50 mg</i>	Preferred	QL (1 tab every 1 day)



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SYMBYAX CAP 3-25MG	Non Preferred	PA
SYMBYAX CAP 6-25MG	Non Preferred	PA

### **FIBROMYALGIA AGENTS**

SAVELLA MIS TITR PAK	Non Preferred	PA
SAVELLA TAB 12.5MG	Non Preferred	PA
SAVELLA TAB 25MG	Non Preferred	PA
SAVELLA TAB 50MG	Non Preferred	PA
SAVELLA TAB 100MG	Non Preferred	PA

### **MOVEMENT DISORDER DRUG THERAPY**

AUSTEDO TAB 6MG	Preferred	SP, PA
AUSTEDO TAB 9MG	Preferred	SP, PA
AUSTEDO TAB 12MG	Preferred	SP, PA
AUSTEDO XR TAB 6MG	Non Preferred	PA
AUSTEDO XR TAB 12MG	Non Preferred	PA
AUSTEDO XR TAB 24MG	Non Preferred	PA
INGREZZA CAP 40-80MG	Preferred	SP, PA
INGREZZA CAP 40MG	Preferred	SP, PA
INGREZZA CAP 60MG	Preferred	PA
INGREZZA CAP 80MG	Preferred	SP, PA
tetrabenazine tab 12.5 mg (generic of XENAZINE)	Non Preferred	SP, PA
tetrabenazine tab 25 mg (generic of XENAZINE)	Non Preferred	SP, PA
XENAZINE TAB 12.5MG	Non Preferred	SP, PA
XENAZINE TAB 25MG	Non Preferred	SP, PA

### **MULTIPLE SCLEROSIS AGENTS**

AMPYRA TAB 10MG	Non Preferred	SP, PA
AUBAGIO TAB 7MG	Non Preferred	SP, PA
AUBAGIO TAB 14MG	Non Preferred	SP, PA
AVONEX PEN KIT 30MCG	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AVONEX PREFL KIT 30MCG	Non Preferred	SP, PA
BAFIERTAM CAP 95MG	Non Preferred	SP, PA
BETASERON INJ 0.3MG	Preferred	SP
COPAXONE INJ 20MG/ML	Preferred	SP
COPAXONE INJ 40MG/ML	Preferred	SP
<i>dalfampridine tab er 12hr 10 mg (generic of AMPYRA)</i>	Non Preferred	SP, PA
<i>dimethyl fumarate capsule delayed release 120 mg (generic of TECFIDERA)</i>	Non Preferred	SP, PA, QL (2 caps every 1 day)
<i>dimethyl fumarate capsule delayed release 240 mg (generic of TECFIDERA)</i>	Non Preferred	SP, PA, QL (2 caps every 1 day)
<i>dimethyl fumarate capsule dr starter pack 120 mg &amp; 240 mg (generic of TECFIDERA STARTER PACK)</i>	Non Preferred	SP, PA
EXTAVIA INJ 0.3MG	Non Preferred	SP, PA
<i> fingolimod hcl cap 0.5 mg (base equiv) (generic of GILENYA)</i>	Non Preferred	SP, PA
GILENYA CAP 0.5MG	Preferred	SP, PA
GILENYA CAP 0.25MG	Non Preferred	SP, PA
<i>glatiramer acetate soln prefilled syringe 20 mg/ml (generic of COPAXONE)</i>	Non Preferred	SP, PA
<i>glatiramer acetate soln prefilled syringe 40 mg/ml (generic of COPAXONE)</i>	Non Preferred	SP, PA
<i>glatopa inj 20mg/ml (generic of COPAXONE)</i>	Non Preferred	SP, PA
<i>glatopa inj 40mg/ml (generic of COPAXONE)</i>	Non Preferred	SP, PA
KESIMPTA INJ 20/.4ML	Non Preferred	SP, PA
LEMTRADA INJ 12/1.2ML	Non Preferred	SP, PA
MAVENCLAD PAK 10MG(4)	Non Preferred	SP, PA
MAVENCLAD PAK 10MG(5)	Non Preferred	SP, PA
MAVENCLAD PAK 10MG(6)	Non Preferred	SP, PA
MAVENCLAD PAK 10MG(7)	Non Preferred	SP, PA
MAVENCLAD PAK 10MG(8)	Non Preferred	SP, PA
MAVENCLAD PAK 10MG(9)	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MAVENCLAD PAK 10MG(10)	Non Preferred	SP, PA
MAYZENT PAK STARTER	Non Preferred	PA
MAYZENT PAK STARTER	Non Preferred	SP, PA
MAYZENT TAB 0.25MG	Non Preferred	SP, PA
MAYZENT TAB 1MG	Non Preferred	PA
MAYZENT TAB 2MG	Non Preferred	SP, PA
OCREVUS INJ 300/10ML	Non Preferred	SP, PA
PLEGRIDY INJ	Non Preferred	SP, PA
PLEGRIDY INJ	Non Preferred	SP, PA
PLEGRIDY INJ PEN	Non Preferred	SP, PA
PLEGRIDY INJ STARTER	Non Preferred	SP, PA
PLEGRIDY PEN INJ STARTER	Non Preferred	SP, PA
PONVORY TAB 20MG	Non Preferred	SP, PA
PONVORY TAB STARTER	Non Preferred	SP, PA
REBIF INJ 22/0.5	Preferred	SP
REBIF INJ 44/0.5	Preferred	SP
REBIF REBIDO INJ 22/0.5	Preferred	SP
REBIF REBIDO INJ 44/0.5	Preferred	SP
REBIF REBIDO INJ TITRATN	Preferred	SP
REBIF TITRTN INJ PACK	Preferred	SP
TASCENSO ODT TAB 0.5MG	Non Preferred	SP, PA
TASCENSO ODT TAB 0.25MG	Non Preferred	SP, PA
TECFIDERA CAP 120MG	Preferred	SP, QL (2 caps every 1 day)
TECFIDERA CAP 240MG	Preferred	SP, QL (2 caps every 1 day)
TECFIDERA MIS STARTER	Preferred	SP
<i>teriflunomide tab 7 mg</i> (generic of AUBAGIO)	Non Preferred	SP, PA
<i>teriflunomide tab 14 mg</i> (generic of AUBAGIO)	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TYSABRI INJ 300/15ML	Non Preferred	SP, PA
VUMERITY CAP 231MG	Non Preferred	SP, PA
ZEPOSIA 7DAY CAP STR PACK	Non Preferred	SP, PA
ZEPOSIA CAP .92MG	Non Preferred	SP, PA
ZEPOSIA CAP STR KIT	Non Preferred	SP, PA

### **POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS**

GRALISE TAB 300MG	Non Preferred	PA
GRALISE TAB 450MG	Non Preferred	PA
GRALISE TAB 600MG	Non Preferred	PA
GRALISE TAB 750MG	Non Preferred	PA
GRALISE TAB 900MG	Non Preferred	PA
LYRICA CR TAB 82.5MG	Non Preferred	PA
LYRICA CR TAB 165MG	Non Preferred	PA
LYRICA CR TAB 330MG	Non Preferred	PA
<i>pregabalin tab er 24hr 82.5 mg (generic of LYRICA CR)</i>	Non Preferred	PA
<i>pregabalin tab er 24hr 165 mg (generic of LYRICA CR)</i>	Non Preferred	PA
<i>pregabalin tab er 24hr 330 mg (generic of LYRICA CR)</i>	Non Preferred	PA

### **PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS**

<i>fluoxetine hcl (pmdd) tab 10 mg</i>	Non Preferred	PA
<i>fluoxetine hcl (pmdd) tab 20 mg</i>	Non Preferred	PA

### **PSEUDOBULBAR AFFECT (PBA) AGENTS**

NUEDEXTA CAP 20-10MG	Non Preferred	PA
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### **PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS**

<i>ergoloid mesylates tab 1 mg</i>	Preferred	
<i>pimozide tab 1 mg</i>	Preferred	
<i>pimozide tab 2 mg</i>	Preferred	

Drug Name	Drug Tier	Requirements/Limits
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**RESTLESS LEG SYNDROME (RLS) AGENTS**

HORIZANT TAB 300MG ER	Non Preferred	PA
HORIZANT TAB 600MG ER	Non Preferred	PA

**SMOKING DETERRENTS**

<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>nicotine polacrilex gum 2 mg</i>	Preferred	QL (8 pieces every 1 day), OTC
<i>nicotine polacrilex gum 4 mg</i>	Preferred	QL (8 pieces every 1 day), OTC
<i>nicotine polacrilex lozenge 2 mg</i>	Preferred	QL (8 lozgs every 1 day), OTC
<i>nicotine polacrilex lozenge 4 mg</i>	Preferred	QL (8 lozgs every 1 day), OTC
NICOTINE SYS KIT TRANSDER	Preferred	OTC
<i>nicotine td patch 24hr 7 mg/24hr</i>	Preferred	QL (1 patch every 1 day), OTC
<i>nicotine td patch 24hr 14 mg/24hr</i>	Preferred	QL (1 patch every 1 day), OTC
<i>nicotine td patch 24hr 21 mg/24hr</i>	Preferred	QL (1 patch every 1 day), OTC
NICOTROL INH	Preferred	
NICOTROL NS SPR 10MG/ML	Preferred	
<i>varenicline tartrate tab 0.5 mg (base equiv)</i>	Preferred	QL (2 tabs every 1 day)
<i>varenicline tartrate tab 1 mg (base equiv)</i>	Preferred	QL (2 tabs every 1 day)
<i>varenicline tartrate tab 11 x 0.5 mg &amp; 42 x 1 mg start pack</i>	Preferred	QL (2 boxes every 1 day)

**TRANSTHYRETIN AMYLOIDOSIS AGENTS**

AMVUTTRA SOL 25/0.5ML	Non Preferred	SP, PA
TEGSEDI INJ 284/1.5	Non Preferred	SP, PA

**VASOMOTOR SYMPTOM AGENTS**

<i>paroxetine mesylate cap 7.5 mg (base equiv)</i>	Non Preferred	PA
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**RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS**

**CYSTIC FIBROSIS AGENTS**

BRONCHITOL CAP 40MG	Non Preferred	PA
BRONCHITOL CAP TOL TEST	Non Preferred	PA
KALYDECO PAK 25MG	Non Preferred	SP, PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KALYDECO PAK 50MG	Non Preferred	SP, PA
KALYDECO PAK 75MG	Non Preferred	SP, PA
KALYDECO TAB 150MG	Non Preferred	SP, PA
ORKAMBI GRA 75-94MG	Non Preferred	PA
ORKAMBI GRA 100-125	Non Preferred	SP, PA
ORKAMBI GRA 150-188	Non Preferred	SP, PA
ORKAMBI TAB 100-125	Non Preferred	SP, PA
ORKAMBI TAB 200-125	Non Preferred	SP, PA
PULMOZYME SOL 1MG/ML	Preferred	SP, QL (2.5 mL every 1 day)
SYMDEKO TAB 50-75MG	Non Preferred	SP, PA
SYMDEKO TAB 100-150	Non Preferred	SP, PA
TRIKAFTA TAB 50-25-37.5 MG & 75 MG	Non Preferred	SP, PA
TRIKAFTA TAB 100-50-75 MG & 150 MG	Non Preferred	SP, PA

### ***PULMONARY FIBROSIS AGENTS***

ESBRIET CAP 267MG	Non Preferred	SP, PA
ESBRIET TAB 267MG	Non Preferred	SP, PA
ESBRIET TAB 801MG	Non Preferred	SP, PA
OFEV CAP 100MG	Non Preferred	SP, PA
OFEV CAP 150MG	Non Preferred	SP, PA
<i>pirfenidone cap 267 mg (generic of ESBRIET)</i>	Non Preferred	SP, PA
<i>pirfenidone tab 267 mg (generic of ESBRIET)</i>	Non Preferred	SP, PA
<i>pirfenidone tab 534 mg</i>	Non Preferred	SP, PA
<i>pirfenidone tab 801 mg (generic of ESBRIET)</i>	Non Preferred	SP, PA

Drug Name	Drug Tier	Requirements/Limits
<b>SULFONAMIDES - DRUGS TO TREAT INFECTIONS</b>		
<b><i>SULFONAMIDES - DRUGS TO TREAT INFECTIONS</i></b>		
<i>sulfadiazine tab 500 mg</i>	Preferred	

**TETRACYCLINES - DRUGS TO TREAT INFECTIONS**  
***AMINOMETHYLCYCLINES***

NUZYRA TAB 150MG	Non Preferred	SP, PA
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***TETRACYCLINES - DRUGS TO TREAT INFECTIONS***

<i>demeclocycline hcl tab 150 mg</i>	Preferred	
<i>demeclocycline hcl tab 300 mg</i>	Preferred	
DORYX MPC TAB 60MG	Non Preferred	PA
DORYX MPC TAB 120MG	Non Preferred	PA
DORYX TAB 50MG	Non Preferred	PA
DORYX TAB 80MG	Non Preferred	PA
DORYX TAB 200MG	Non Preferred	PA
<i>doxycycline hyclate cap 50 mg</i>	Preferred	
<i>doxycycline hyclate cap 100 mg (generic of VIBRAMYCIN)</i>	Preferred	
<i>doxycycline hyclate tab 20 mg</i>	Preferred	
<i>doxycycline hyclate tab 50 mg</i>	Preferred	
<i>doxycycline hyclate tab 75 mg</i>	Preferred	
<i>doxycycline hyclate tab 100 mg</i>	Preferred	
<i>doxycycline hyclate tab 150 mg</i>	Preferred	
<i>doxycycline hyclate tab delayed release 50 mg (generic of DORYX)</i>	Non Preferred	PA
<i>doxycycline hyclate tab delayed release 75 mg</i>	Non Preferred	PA
<i>doxycycline hyclate tab delayed release 80 mg</i>	Non Preferred	PA
<i>doxycycline hyclate tab delayed release 100 mg</i>	Non Preferred	PA
<i>doxycycline hyclate tab delayed release 150 mg</i>	Non Preferred	PA
<i>doxycycline hyclate tab delayed release 200 mg (generic of DORYX)</i>	Non Preferred	PA
<i>doxycycline monohydrate cap 50 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxycycline monohydrate cap 75 mg</i>	Preferred	
<i>doxycycline monohydrate cap 100 mg</i>	Preferred	QL (3 caps every 1 day)
<i>doxycycline monohydrate cap 150 mg</i>	Preferred	
<i>doxycycline monohydrate for susp 25 mg/5ml (generic of VIBRAMYCIN)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>doxycycline monohydrate tab 50 mg</i>	Preferred	
<i>doxycycline monohydrate tab 75 mg</i>	Preferred	
<i>doxycycline monohydrate tab 100 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>doxycycline monohydrate tab 150 mg</i>	Preferred	
<i>minocycline hcl cap 50 mg</i>	Preferred	QL (2 caps every 1 day)
<i>minocycline hcl cap 75 mg</i>	Preferred	
<i>minocycline hcl cap 100 mg</i>	Preferred	QL (2 caps every 1 day)
<i>minocycline hcl cap er 24hr 45 mg (base equivalent)</i>	Non Preferred	PA
<i>minocycline hcl cap er 24hr 90 mg (base equivalent)</i>	Non Preferred	PA
<i>minocycline hcl cap er 24hr 135 mg (base equivalent)</i>	Non Preferred	PA
<i>minocycline hcl tab 50 mg</i>	Preferred	
<i>minocycline hcl tab 75 mg</i>	Preferred	
<i>minocycline hcl tab 100 mg</i>	Preferred	
<i>minocycline hcl tab er 24hr 45 mg</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 55 mg (generic of SOLODYN)</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 65 mg (generic of SOLODYN)</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 80 mg (generic of SOLODYN)</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 90 mg</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 105 mg (generic of SOLODYN)</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 115 mg (generic of SOLODYN)</i>	Non Preferred	PA
<i>minocycline hcl tab er 24hr 135 mg</i>	Non Preferred	PA
MINOLIRA TAB 105MG	Non Preferred	PA
MINOLIRA TAB 135MG	Non Preferred	PA
SOLODYN TAB 55MG	Non Preferred	PA
SOLODYN TAB 65MG	Non Preferred	PA
SOLODYN TAB 80MG	Non Preferred	PA
SOLODYN TAB 105MG	Non Preferred	PA
SOLODYN TAB 115MG	Non Preferred	PA
<i>targadox tab 50mg</i>	Preferred	



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tetracycline hcl cap 250 mg</i>	Preferred	
<i>tetracycline hcl cap 500 mg</i>	Preferred	
VIBRAMYCIN CAP 100MG	Non Preferred	PA
XIMINO CAP 45MG ER	Non Preferred	PA
XIMINO CAP 90MG ER	Non Preferred	PA
XIMINO CAP 135MG ER	Non Preferred	PA

## **THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS**

### **ANTITHYROID AGENTS**

<i>methimazole tab 5 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>methimazole tab 10 mg</i>	Preferred	QL (6 tabs every 1 day)
<i>propylthiouracil tab 50 mg</i>	Preferred	QL (20 tabs every 1 day)

### **THYROID HORMONES**

ADTHYZA TAB 16.25MG	Preferred	
ADTHYZA TAB 32.5MG	Preferred	
ADTHYZA TAB 65MG	Preferred	
ADTHYZA TAB 97.5MG	Preferred	
ADTHYZA TAB 130MG	Preferred	
ARMOUR THYRO TAB 15MG	Preferred	
ARMOUR THYRO TAB 30MG	Preferred	
ARMOUR THYRO TAB 60MG	Preferred	
ARMOUR THYRO TAB 90MG	Preferred	
ARMOUR THYRO TAB 120MG	Preferred	
ARMOUR THYRO TAB 180MG	Preferred	QL (1 tab every 1 day)
ARMOUR THYRO TAB 240MG	Preferred	QL (1 tab every 1 day)
ARMOUR THYRO TAB 300MG	Preferred	QL (1 tab every 1 day)
CYTOMEL TAB 5MCG	Non Preferred	PA
CYTOMEL TAB 25MCG	Non Preferred	PA
CYTOMEL TAB 50MCG	Non Preferred	PA
ERMEZA SOL 150/5ML	Non Preferred	PA
<i>levothyroxine sodium cap 13 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 25 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 50 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 75 mcg</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levothyroxine sodium cap 88 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 100 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 112 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 125 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 137 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 150 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 175 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium cap 200 mcg</i>	Non Preferred	PA
<i>levothyroxine sodium tab 25 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 25 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 50 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 50 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 75 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 75 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 88 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 88 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 100 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 100 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 112 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 112 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 125 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 125 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 137 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 137 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 150 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 150 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 175 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 175 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 200 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 200 MCG)	Preferred	QL (2 tabs every 1 day)
<i>levothyroxine sodium tab 300 mcg</i> (generic of LEVOTHYROXINE SODIUM TAB 300 MCG)	Preferred	QL (2 tabs every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>liothyronine sodium tab 5 mcg</i> (generic of CYTOMEL)	Preferred	
<i>liothyronine sodium tab 25 mcg</i> (generic of CYTOMEL)	Preferred	
<i>liothyronine sodium tab 50 mcg</i> (generic of CYTOMEL)	Preferred	
NP THYROID TAB 15MG	Preferred	
NP THYROID TAB 30MG	Preferred	
NP THYROID TAB 60MG	Preferred	
NP THYROID TAB 90MG	Preferred	
NP THYROID TAB 120MG	Preferred	
SYNTHROID TAB 25MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 50MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 75MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 88MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 100MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 112MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 125MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 137MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 150MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 175MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 200MCG	Non Preferred	PA, QL (2 tabs every 1 day)
SYNTHROID TAB 300MCG	Non Preferred	PA, QL (2 tabs every 1 day)
THYQUIDITY SOL 100MCG	Non Preferred	PA
TIROSINT CAP 13MCG	Non Preferred	PA
TIROSINT CAP 25MCG	Non Preferred	PA
TIROSINT CAP 37.5MCG	Non Preferred	PA
TIROSINT CAP 44MCG	Non Preferred	PA
TIROSINT CAP 50MCG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TIROSINT CAP 62.5MCG	Non Preferred	PA
TIROSINT CAP 75MCG	Non Preferred	PA
TIROSINT CAP 88MCG	Non Preferred	PA
TIROSINT CAP 100MCG	Non Preferred	PA
TIROSINT CAP 112MCG	Non Preferred	PA
TIROSINT CAP 125MCG	Non Preferred	PA
TIROSINT CAP 137MCG	Non Preferred	PA
TIROSINT CAP 150MCG	Non Preferred	PA
TIROSINT CAP 175MCG	Non Preferred	PA
TIROSINT CAP 200	Non Preferred	PA
TIROSINT-SOL SOL 13MCG/ML	Non Preferred	PA
TIROSINT-SOL SOL 25MCG/ML	Non Preferred	PA
TIROSINT-SOL SOL 37.5/ML	Non Preferred	PA
TIROSINT-SOL SOL 44MCG/ML	Non Preferred	PA
TIROSINT-SOL SOL 50MCG/ML	Non Preferred	PA
TIROSINT-SOL SOL 62.5/ML	Non Preferred	PA
TIROSINT-SOL SOL 75MCG/ML	Non Preferred	PA
TIROSINT-SOL SOL 88MCG/ML	Non Preferred	PA
TIROSINT-SOL SOL 100MCG	Non Preferred	PA
TIROSINT-SOL SOL 112MCG	Non Preferred	PA
TIROSINT-SOL SOL 125MCG	Non Preferred	PA
TIROSINT-SOL SOL 137MCG	Non Preferred	PA
TIROSINT-SOL SOL 150MCG	Non Preferred	PA
TIROSINT-SOL SOL 175MCG	Non Preferred	PA

Drug Name	Drug Tier	Requirements/Limits
TIROSINT-SOL SOL 200MCG	Non Preferred	PA

## TOXOIDS - DRUGS TO PREVENT INFECTIONS

### TOXOID COMBINATIONS

ADACEL INJ	Preferred	PA; AGE (Min 19)
BOOSTRIX INJ	Preferred	PA; AGE (Min 19)
TDVAX INJ 2-2 LF	Preferred	QL (max 1 fill per lifetime); AGE (Min 19)
TENIVAC INJ 5-2LF	Preferred	QL (max 1 fill per lifetime); AGE (Min 19)

## ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID

### ANTISPASMODICS

BELLA/OPIUM SUP 16.2-60	Preferred	
<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg (generic of LIBRAX)</i>	Non Preferred	PA
CUVPOSA SOL 1MG/5ML	Non Preferred	PA
DARTISLA ODT TAB 1.7MG	Non Preferred	PA
<i>dicyclomine hcl cap 10 mg</i>	Preferred	QL (4 caps every 1 day)
<i>dicyclomine hcl oral soln 10 mg/5ml</i>	Preferred	QL (80 mL every 1 day)
<i>dicyclomine hcl tab 20 mg</i>	Preferred	QL (8 tabs every 1 day)
GLYCATE TAB 1.5MG	Non Preferred	PA
<i>glycopyrrolate oral soln 1 mg/5ml (generic of CUVPOSA)</i>	Preferred	
<i>glycopyrrolate tab 1 mg (generic of ROBINUL)</i>	Preferred	
<i>glycopyrrolate tab 2 mg (generic of ROBINUL FORTE)</i>	Preferred	
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	Preferred	QL (60 mL every 1 day)
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>hyoscyamine sulfate soln 0.125 mg/ml</i>	Preferred	QL (60 mL every 1 day)
<i>hyoscyamine sulfate tab 0.125 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	Preferred	QL (12 tabs every 1 day)
<i>hyoscyamine sulfate tab er 12hr 0.375 mg</i>	Preferred	QL (4 tabs every 1 day)
LEVSIN TAB 0.125MG	Non Preferred	PA, QL (12 tabs every 1 day)
LEVSIN/SL SUB 0.125MG	Non Preferred	PA, QL (12 tabs every 1 day)
LIBRAX CAP 5-2.5MG	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methscopolamine bromide tab 2.5 mg</i>	Non Preferred	PA
<i>methscopolamine bromide tab 5 mg</i>	Non Preferred	PA
<i>oscimin tab 0.125mg</i>	Preferred	QL (12 tabs every 1 day)
ROBINUL FORT TAB 2MG	Non Preferred	PA
ROBINUL TAB 1MG	Non Preferred	PA

### **H-2 ANTAGONISTS**

<i>cimetidine tab 200 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>cimetidine tab 300 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>cimetidine tab 400 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>cimetidine tab 800 mg</i>	Preferred	QL (2 tabs every 1 day)
<i>famotidine for susp 40 mg/5ml</i>	Preferred	QL (5 mL every 1 day)
<i>famotidine tab 10 mg</i>	Preferred	OTC
<i>famotidine tab 20 mg (generic of PEPCID)</i>	Preferred	QL (2 tabs every 1 day)
<i>famotidine tab 40 mg (generic of PEPCID)</i>	Preferred	QL (2 tabs every 1 day)
<i>nizatidine cap 150 mg</i>	Preferred	QL (4 caps every 1 day)
<i>nizatidine cap 300 mg</i>	Preferred	
PEPCID TAB 20MG	Non Preferred	PA, QL (2 tabs every 1 day)
PEPCID TAB 40MG	Non Preferred	PA, QL (2 tabs every 1 day)

### **MISC. ANTI-ULCER**

CARAFATE SUS 1GM/10ML	Preferred	QL (40 mL every 1 day)
CARAFATE TAB 1GM	Non Preferred	PA, QL (4 tabs every 1 day)
<i>sucralfate susp 1 gm/10ml (generic of CARAFATE)</i>	Preferred	QL (40 mL every 1 day)
<i>sucralfate tab 1 gm (generic of CARAFATE)</i>	Preferred	QL (4 tabs every 1 day)

### **PROTON PUMP INHIBITORS**

ACIPHEX TAB 20MG	Non Preferred	PA
DEXILANT CAP 30MG DR	Non Preferred	PA
DEXILANT CAP 60MG DR	Non Preferred	PA
<i>dexlansoprazole cap delayed release 30 mg (generic of DEXILANT)</i>	Non Preferred	PA
<i>dexlansoprazole cap delayed release 60 mg (generic of DEXILANT)</i>	Non Preferred	PA
<i>esomeprazole magnesium cap delayed release 20 mg (base eq) (generic of NEXIUM)</i>	Non Preferred	PA, QL (2 caps every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>esomeprazole magnesium cap delayed release 40 mg (base eq) (generic of NEXIUM)</i>	Non Preferred	PA
<i>esomeprazole magnesium for delayed release susp packet 10 mg (generic of NEXIUM)</i>	Non Preferred	PA
<i>esomeprazole magnesium for delayed release susp packet 20 mg (generic of NEXIUM)</i>	Non Preferred	PA
<i>esomeprazole magnesium for delayed release susp packet 40 mg (generic of NEXIUM)</i>	Non Preferred	PA
<i>lansoprazole cap delayed release 15 mg</i>	Non Preferred	PA, QL (2 caps every 1 day)
<i>lansoprazole cap delayed release 30 mg (generic of PREVACID)</i>	Non Preferred	PA
<i>lansoprazole tab delayed release orally disintegrating 15 mg (generic of PREVACID SOLUTAB)</i>	Preferred	AGE (Max 10)
<i>lansoprazole tab delayed release orally disintegrating 30 mg (generic of PREVACID SOLUTAB)</i>	Preferred	AGE (Max 10)
NEXIUM CAP 20MG	Non Preferred	PA, QL (2 caps every 1 day)
NEXIUM CAP 40MG	Non Preferred	PA
NEXIUM GRA 2.5MG DR	Non Preferred	PA
NEXIUM GRA 5MG DR	Non Preferred	PA
NEXIUM GRA 10MG DR	Non Preferred	PA
NEXIUM GRA 20MG DR	Non Preferred	PA
NEXIUM GRA 40MG DR	Non Preferred	PA
<i>omeprazole cap delayed release 10 mg</i>	Preferred	QL (3 caps every 1 day)
<i>omeprazole cap delayed release 20 mg</i>	Preferred	QL (3 caps every 1 day)
<i>omeprazole cap delayed release 40 mg</i>	Preferred	QL (2 caps every 1 day)
<i>pantoprazole sodium ec tab 20 mg (base equiv) (generic of PROTONIX)</i>	Preferred	QL (1 tab every 1 day)
<i>pantoprazole sodium ec tab 40 mg (base equiv) (generic of PROTONIX)</i>	Preferred	QL (3 each every 1 day)
<i>pantoprazole sodium ec tab 40 mg (base equiv) (generic of PROTONIX)</i>	Preferred	QL (3 tabs every 1 day)
<i>pantoprazole sodium for delayed release susp packet 40 mg (generic of PROTONIX)</i>	Non Preferred	PA

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PREVACID CAP 30MG DR	Non Preferred	PA
PREVACID TAB 15MG STB	Non Preferred	PA; AGE (Max 10)
PREVACID TAB 30MG STB	Non Preferred	PA; AGE (Max 10)
PRILOSEC POW 2.5MG	Non Preferred	PA
PRILOSEC POW 10MG	Non Preferred	PA
PROTONIX PAK 40MG	Non Preferred	PA
PROTONIX TAB 20MG	Non Preferred	PA, QL (1 tab every 1 day)
PROTONIX TAB 40MG	Non Preferred	PA, QL (3 tabs every 1 day)
<i>rabeprazole sodium ec tab 20 mg (generic of ACIPHEX)</i>	Non Preferred	PA

#### **ULCER DRUGS - PROSTAGLANDINS**

CYTOTEC TAB 100MCG	Non Preferred	PA, QL (4 tabs every 1 day)
CYTOTEC TAB 200MCG	Non Preferred	PA, QL (4 tabs every 1 day)
<i>misoprostol tab 100 mcg (generic of CYTOTEC)</i>	Preferred	QL (4 tabs every 1 day)
<i>misoprostol tab 200 mcg (generic of CYTOTEC)</i>	Preferred	QL (4 tabs every 1 day)

#### **ULCER THERAPY COMBINATIONS**

<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap dr 500 &amp; 500 &amp; 30mg</i>	Non Preferred	PA
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg (generic of PYLERA)</i>	Non Preferred	PA
KONVOMEPEP SUS 2-84/ML	Non Preferred	PA
OMECLAMOX- MIS PAK	Non Preferred	PA
<i>omeprazole-sodium bicarbonate cap 20-1100 mg (generic of ZEGERID)</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate cap 40-1100 mg (generic of ZEGERID)</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate powd pack for susp 20-1680 mg (generic of ZEGERID)</i>	Non Preferred	PA
<i>omeprazole-sodium bicarbonate powd pack for susp 40-1680 mg (generic of ZEGERID)</i>	Non Preferred	PA
PYLERA CAP	Non Preferred	PA



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TALICIA CAP	Non Preferred	PA
ZEGERID CAP 20-1100	Non Preferred	PA
ZEGERID CAP 40-1100	Non Preferred	PA
ZEGERID POW 20-1680	Non Preferred	PA
ZEGERID POW 40-1680	Non Preferred	PA

## **URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE**

### **URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)**

<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	Non Preferred	PA
<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	Non Preferred	PA
DETROL LA CAP 2MG	Non Preferred	PA
DETROL LA CAP 4MG	Non Preferred	PA
DETROL TAB 1MG	Non Preferred	PA, QL (2 tabs every 1 day)
DETROL TAB 2MG	Non Preferred	PA, QL (2 tabs every 1 day)
DITROPAN XL TAB 5MG	Non Preferred	PA, QL (1 tab every 1 day)
<i>fesoterodine fumarate tab er 24hr 4 mg (generic of TOVIAZ)</i>	Non Preferred	PA
<i>fesoterodine fumarate tab er 24hr 8 mg (generic of TOVIAZ)</i>	Non Preferred	PA
GELNIQUE GEL 10%	Non Preferred	PA
<i>oxybutynin chloride syrup 5 mg/5ml</i>	Preferred	QL (20 mL every 1 day)
<i>oxybutynin chloride tab 2.5 mg</i>	Preferred	
<i>oxybutynin chloride tab 5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>oxybutynin chloride tab er 24hr 5 mg (generic of DITROPAN XL)</i>	Preferred	QL (1 tab every 1 day)
<i>oxybutynin chloride tab er 24hr 10 mg</i>	Preferred	QL (1 tab every 1 day)
<i>oxybutynin chloride tab er 24hr 15 mg</i>	Preferred	QL (1 tab every 1 day)
OXYBUTYNIN SOL 5MG/5ML	Preferred	
OXYTROL DIS 3.9MG/24	Non Preferred	PA
<i>solifenacin succinate tab 5 mg (generic of VESICARE)</i>	Preferred	

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>solifenacin succinate tab 10 mg</i> (generic of VESICARE)	Preferred	
<i>tolterodine tartrate cap er 24hr 2 mg</i> (generic of DETROL LA)	Non Preferred	PA
<i>tolterodine tartrate cap er 24hr 4 mg</i> (generic of DETROL LA)	Non Preferred	PA
<i>tolterodine tartrate tab 1 mg</i> (generic of DETROL)	Non Preferred	PA, QL (2 tabs every 1 day)
<i>tolterodine tartrate tab 2 mg</i> (generic of DETROL)	Non Preferred	PA, QL (2 tabs every 1 day)
TOVIAZ TAB 4MG	Non Preferred	PA
TOVIAZ TAB 8MG	Non Preferred	PA
<i>trospium chloride cap er 24hr 60 mg</i>	Non Preferred	PA
<i>trospium chloride tab 20 mg</i>	Non Preferred	PA, QL (2 tabs every 1 day)
VESICARE LS SUS 5MG/5ML	Non Preferred	PA
VESICARE TAB 5MG	Non Preferred	PA
VESICARE TAB 10MG	Non Preferred	PA
<b>URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS</b>		
GEMTESA TAB 75MG	Non Preferred	PA
MYRBETRIQ SUS 8MG/ML	Non Preferred	PA
MYRBETRIQ TAB 25MG	Non Preferred	PA
MYRBETRIQ TAB 50MG	Non Preferred	PA
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>		
<i>bethanechol chloride tab 5 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>bethanechol chloride tab 10 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>bethanechol chloride tab 25 mg</i>	Preferred	QL (4 tabs every 1 day)
<i>bethanechol chloride tab 50 mg</i>	Preferred	QL (4 tabs every 1 day)
<b>URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS</b>		
<i>flavoxate hcl tab 100 mg</i>	Non Preferred	PA, QL (4 tabs every 1 day)
<b>VACCINES - DRUGS TO PREVENT INFECTIONS</b>		
<b>BACTERIAL VACCINES</b>		
PNEUMOVAX 23 INJ 25/0.5	Preferred	QL (max 2 fills per lifetime); AGE (Min 19)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PREVNAR 13 INJ	Preferred	QL (max 1 fill per lifetime); AGE (Min 19)
PREVNAR 20 INJ	Preferred	AGE (Min 19)
VAXNEUVANCE INJ	Preferred	AGE (Min 19)

### **VIRAL VACCINES**

AFLURIA QUAD INJ 2021-22	Preferred	QL (max 1 fill per 180 days); AGE (Min 4)
ENGERIX-B INJ 10/0.5ML	Preferred	QL (max 3 fills per lifetime); AGE (Min 19)
ENGERIX-B INJ 20MCG/ML	Preferred	QL (max 3 fills per lifetime); AGE (Min 19)
FLUARIX QUAD INJ 2021-22	Preferred	QL (max 1 fill per 180 days); AGE (Min 4)
FLUBLOK QUAD INJ 2021-22	Preferred	QL (max 1 fill per 180 days); AGE (Min 4)
FLUCLVX QUAD INJ 2021-22	Preferred	QL (max 1 fill per 180 days); AGE (Min 4)
FLULAVAL QUA INJ 2021-22	Preferred	QL (max 1 fill per 180 days); AGE (Min 4)
FLUMIST QUAD SUS 2021-22	Preferred	QL (max 1 fill per year); AGE (Min 4, Max 49)
FLUZONE QUAD INJ 2021-22	Preferred	QL (max 1 fill per 180 days); AGE (Min 4)
HAVRIX INJ 720UNIT	Preferred	QL (max 2 fills per lifetime); AGE (Min 19)
HAVRIX INJ 1440UNIT	Preferred	QL (max 2 fills per lifetime); AGE (Min 19)
HEPLISAV-B INJ 20/0.5ML	Preferred	QL (max 3 fills per lifetime); AGE (Min 19)
JANSSEN VACC INJ COVID-19	Preferred	
MODERNA VAC INJ COVID-19	Preferred	
PFIZER VACC INJ COVID-19	Preferred	
RECOMBIVA HB INJ 5MCG/0.5	Preferred	QL (max 3 fills per lifetime); AGE (Min 19)
RECOMBIVA HB INJ 10MCG/ML	Preferred	QL (max 3 fills per lifetime); AGE (Min 19)
SHINGRIX INJ 50/0.5ML	Preferred	QL (max 2 fills per lifetime); AGE (Min 50)
TWINRIX INJ	Preferred	QL (max 3 fills per lifetime); AGE (Min 19)
VAQTA INJ 25/0.5ML	Preferred	QL (max 2 fills per lifetime); AGE (Min 19)
VAQTA INJ 50UNT/ML	Preferred	QL (max 2 fills per lifetime); AGE (Min 19)

Drug Name	Drug Tier	Requirements/Limits
<b>VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS</b>		
<b>MISCELLANEOUS VAGINAL PRODUCTS</b>		
INTRAROSA SUP 6.5MG	Non Preferred	PA
TRIMO-SAN GEL	Non Preferred	PA
<b>VAGINAL ANTI-INFECTIVES</b>		
CLEOCIN CRE 2% VAG	Non Preferred	PA
CLEOCIN SUP 100MG	Preferred	
<i>clindamycin phosphate vaginal cream 2% (generic of CLEOCIN)</i>	Preferred	
CLINDESSE CRE 2%	Non Preferred	PA
<i>clotrimazole vaginal cream 1%</i>	Preferred	OTC
<i>clotrimazole vaginal cream 2%</i>	Preferred	OTC
GYNAZOLE-1 CRE 2%	Non Preferred	PA
<i>metronidazole vaginal gel 0.75%</i>	Preferred	QL (70 gm every 5 days)
<i>miconazole 3 sup 200mg</i>	Preferred	
<i>miconazole nitrate vaginal app 200 mg &amp; 2% cream 9 gm kit</i>	Preferred	OTC
<i>miconazole nitrate vaginal cream 2%</i>	Preferred	OTC
<i>miconazole nitrate vaginal cream 4% (200 mg/5gm)</i>	Preferred	OTC
<i>miconazole nitrate vaginal supp 200 mg &amp; 2% cream 9 gm kit</i>	Preferred	OTC
<i>miconazole nitrate vaginal suppos 100 mg</i>	Preferred	OTC
NUVESSA GEL 1.3%	Non Preferred	PA
<i>qc clotrimaz cre 1%</i>	Preferred	OTC
<i>terconazole vaginal cream 0.4%</i>	Preferred	
<i>terconazole vaginal cream 0.8%</i>	Preferred	
<i>terconazole vaginal suppos 80 mg</i>	Preferred	QL (1 supp every 1 day)
<i>tioconazole vaginal oint 6.5%</i>	Preferred	OTC
VANDAZOLE GEL 0.75%	Non Preferred	PA, QL (70 gm every 5 days)
XACIATO GEL 2%	Non Preferred	PA
<b>VAGINAL CONTRACEPTIVE - PH MODULATORS</b>		
PHEXXI GEL	Preferred	
<b>VAGINAL ESTROGENS</b>		
ESTRACE VAG CRE 0.01%	Non Preferred	PA, QL (1.42 gm every 1 day)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>estradiol vaginal cream 0.1 mg/gm</i> (generic of ESTRACE)	Preferred	QL (1.42 gm every 1 day)
<i>estradiol vaginal tab 10 mcg</i> (generic of ESTRADIOL VAGINAL TAB 10 MCG)	Non Preferred	PA
ESTRING MIS 2MG	Non Preferred	PA
FEMRING MIS 0.1MG/24	Non Preferred	PA
FEMRING MIS 0.05/24H	Non Preferred	PA
IMVEXXY MAIN SUP 4MCG	Non Preferred	PA
IMVEXXY MAIN SUP 10MCG	Non Preferred	PA
IMVEXXY STRT SUP 4MCG	Non Preferred	PA
IMVEXXY STRT SUP 10MCG	Non Preferred	PA
PREMARIN VAG CRE 0.625MG	Preferred	
VAGIFEM TAB 10MCG	Non Preferred	PA

### **VAGINAL PROGESTINS**

CRINONE GEL 4% VAG	Non Preferred	PA
CRINONE GEL 8% VAG	Non Preferred	PA
ENDOMETRIN SUP 100MG	Preferred	

## **VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS**

### **ANAPHYLAXIS THERAPY AGENTS**

AUVI-Q INJ 0.1MG	Non Preferred	PA
AUVI-Q INJ 0.3MG	Non Preferred	PA, QL (2 pens every 25 days)
AUVI-Q INJ 0.15MG	Non Preferred	PA, QL (1 pen every 25 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	Preferred	QL (2 pens every 25 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i> (generic of EPIPEN 2-PAK)	Preferred	QL (2 pens every 25 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)</i> (generic of EPIPEN-JR 2-PAK)	Preferred	QL (2 pens every 25 days)
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	Preferred	QL (2 pens every 25 days)

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EPIPEN 2-PAK INJ 0.3MG	Non Preferred	PA, QL (2 pens every 25 days)
EPIPEN-JR INJ 0.15MG	Non Preferred	PA, QL (2 pens every 25 days)
SYMJEPI INJ 0.3MG	Non Preferred	PA
SYMJEPI INJ 0.15MG	Non Preferred	PA

### **NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS**

<i>droxidopa cap 100 mg</i> (generic of NORTHERA)	Non Preferred	SP, PA
<i>droxidopa cap 200 mg</i> (generic of NORTHERA)	Non Preferred	SP, PA
<i>droxidopa cap 300 mg</i> (generic of NORTHERA)	Non Preferred	SP, PA
NORTHERA CAP 100MG	Non Preferred	SP, PA
NORTHERA CAP 200MG	Non Preferred	SP, PA
NORTHERA CAP 300MG	Non Preferred	SP, PA

### **VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS**

<i>midodrine hcl tab 2.5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>midodrine hcl tab 5 mg</i>	Preferred	QL (3 tabs every 1 day)
<i>midodrine hcl tab 10 mg</i>	Preferred	QL (3 tabs every 1 day)

### **VITAMINS - DRUGS FOR NUTRITION**

#### **OIL SOLUBLE VITAMINS**

<i>cholecalciferol cap 2000 unit</i>	Preferred	OTC
<i>cholecalciferol cap 5000 unit</i>	Preferred	OTC
<i>cholecalciferol cap 50000 unit</i>	Preferred	OTC
<i>cholecalciferol oral liquid 400 unit/ml</i>	Preferred	OTC
<i>cholecalciferol tab 400 unit</i>	Preferred	OTC
<i>cholecalciferol tab 1000 unit</i>	Preferred	OTC
<i>ergocalciferol cap 1.25 mg (50000 unit)</i> (generic of DRISDOL)	Preferred	QL (6 caps every 1 day)

#### **WATER SOLUBLE VITAMINS**

<i>ascorbic acid tab 500 mg</i>	Preferred	OTC
<i>niacin cap er 250 mg</i>	Preferred	OTC
<i>niacin tab 500 mg</i>	Preferred	OTC
<i>pyridoxine hcl tab 25 mg</i>	Preferred	OTC
<i>pyridoxine hcl tab 100 mg</i>	Preferred	OTC
<i>thiamine hcl tab 100 mg</i>	Preferred	OTC
<i>thiamine mononitrate tab 100 mg</i>	Preferred	OTC

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VALCYTE TAB 450MG .....	159	( <i>base equivalent</i> ) .....	55
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( <i>base equiv</i> ) .....	159	<i>equivalent)</i> .....	55
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