2024

Prescription Drug Guide
Guía de Medicamentos Recetados

Formulary | Formulario

List of Covered Drugs | Lista de Medicamentos Cubiertos

Premier by Ultimate (HMO)

ULTIMATE HEALTH PLANS
Good health is where you live.

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN. This formulary was updated on 03/19/2024. For more recent information or other questions, please contact Ultimate Health Plans Member Services at 1-888-657-4170 (TTY users should call 711), Monday through Sunday from 8 am to 8 pm EST (during certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays) or visit www.ChooseUltimate.com.

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRE ESTE PLAN. Esta lista de medicamentos cubiertos se actualizó el 03/19/2024. Para obtener información más reciente o si tiene otras preguntas, comuníquese con Ultimate Health Plans Servicios para Miembros al 1-888-657-4170 y para usuarios TTY, 711, de lunes a domingo, de 8:00 a. m. a 8:00 p. m. hora del Este (en ciertos momentos del año podríamos usar tecnologías alternativas para responder sus llamadas los fines de semana y los feriados federales) o visite www.ChooseUltimate.com.

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

When this drug list (formulary) refers to "we," "us", or "our," it means Ultimate Health Plans. When it refers to "plan" or "our plan," it means Premier by Ultimate (HMO).

This document includes a list of the drugs (formulary) for our plan which is current as of 04/01/2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

What is the Ultimate Health Plans Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled "How do I request an exception to the Ultimate Health Plans Formulary?"

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

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

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

The enclosed formulary is current as of 04/01/2024. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages. In the event of midyear non-maintenance formulary changes, we update our printed formularies at the next printing, and we also publish a monthly summary of all drug list changes, which is available for download from our website or in printed format upon request.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiovascular Agents. If you know what your drug is used for, look for the category name in the list that begins below. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 71. The Index provides an alphabetical list of all the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug.

- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, our plan provides 30 per prescription for alprazolam ER 1 mg tablets. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plan will then cover Drug B.

- **Opioid Limits:** Our plan may need to perform a closer safety review of the prescription with the prescribing doctor if an opioid prescription exceeds a certain amount. You may be limited to a 7-day supply or less for acute pain when filling your opioid prescription. Additionally, if you are taking more than one opioid, additional limits called morphine milligram equivalent (MME) may apply. A review may be necessary to monitor safe dosing levels. If your doctor prescribes more than the amount, you or your doctor can ask our plan to cover the additional amount. Please call 1-800-311-7517 to initiate the safety review.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

What if my drug is not on the Formulary?

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

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

- You can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by our plan.

- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Ultimate Health Plans Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

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

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 98 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

We will cover a Transition Supply for enrollees who have a level of care change, which is defined as when enrollees:

- Enter a Long-Term-Care (LTC) facility from a hospital or other setting
- Leave a Long-Term-Care (LTC) facility and return to the community
- Are discharged from a hospital to a home
- End a skilled nursing facility (SNF) stay covered under Medicare Part A (where all pharmacy charges are covered), and must revert to coverage under their Part D plan Formulary
- Revert from hospice status to standard Medicare Part A and Part B benefits; or
- Are discharged from a psychiatric hospital with a medication regimen that is highly individualized

For more information

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

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

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov

Our Plan's Formulary

The formulary that begins on page 1 provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 71.

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

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

B/D: This drug may be eligible for payment under Medicare Part B or Part D. Drugs covered under Medicare Part B are subject to the cost-sharing amount outlined in your Evidence of Coverage and Summary of Benefits. Authorization rules may also apply. Please call 800-311-7517 (TTY 711) for more information on cost-sharing and authorization requirements. We are available 24 hours a day, 7 days a week.

E: Excluded Drug. This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

GC: Coverage in the Gap. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

MO: Mail Order Drug. This prescription is available through our mail order service, as well as through our retail network pharmacies. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. Our plan's mail-order service requires you to order a 90-day supply. Usually, a mail-order pharmacy order will get to you in no more than 14 days. However, if your order is delayed, immediately contact us so we can make arrangements for you to pick up your prescription at your local pharmacy. You may contact us 24 hours a day, 7 days a week at 1-800-311-7517 (TTY users dial 711).

PA: Prior Authorization. We require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

QL: Quantity Limit. For certain drugs, we limit the amount of the drug that we will cover.

ST: Step Therapy. In some cases, we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

The Formulary is Divided into 4 Tiers

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers with a corresponding cost-sharing amount depending on the plan as shown below. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Cost-Sharing Tier 1 (Generic)** includes generic drugs. This tier also offers drugs at the lowest cost.
- **Cost-Sharing Tier 2 (Preferred Brand)** includes preferred brand drugs and some generic drugs.
- **Cost-Sharing Tier 3 (Non-preferred Drug)** includes non-preferred brand drugs and some generic drugs.
- **Cost-Sharing Tier 4 (Specialty Tier)** includes high-cost drugs brand and generic drugs, which may require special handling and/or close monitoring. This is the highest-cost tier.

Cost-Sharing Tier	Copay or coinsurance for a 30-day supply at Retail Pharmacy	Copay or coinsurance for a 90-day supply at Retail Pharmacy (Up to a 100-day supply for some Tier 1 drugs)	Copay or coinsurance for a 90-day supply at Mail Order Pharmacy (Up to a 100-day supply for some Tier 1 drugs)	Copay or coinsurance for a 31-day long-term care supply
Premier by Ultimate (HMO) 001				
Tier 1	$0	$0	$0	$0
Tier 2	$15	$45	$30	$15
Tier 3	$60	$180	$120	$60
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Premier by Ultimate (HMO) 028, 046				
Tier 1	$0	$0	$0	$0
Tier 2	$30	$90	$60	$30
Tier 3	$60	$180	$120	$60
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Premier by Ultimate (HMO) 045				
Tier 1	$0	$0	$0	$0
Tier 2	$25	$75	$50	$25
Tier 3	$60	$180	$120	$60
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance
Premier by Ultimate (HMO) 047				
Tier 1	$0	$0	$0	$0
Tier 2	$35	$105	$70	$35
Tier 3	$85	$255	$170	$85
Tier 4	33% coinsurance	Not Covered	Not Covered	33% coinsurance

Please refer to your Evidence of Coverage for additional information on the applicable copays or coinsurance amounts in each formulary tier.

Nota para los miembros actuales: Esta lista de medicamentos cubiertos ha cambiado desde el año pasado. Revise este documento para asegurarse de que todavía tiene los medicamentos que usted recibe.

En esta lista de medicamentos (lista de medicamentos cubiertos), los términos "nosotros", "nos" o "nuestro" hacen referencia a Ultimate Health Plans. Cuando se menciona "plan" o "nuestro plan", se refiere Premier by Ultimate (HMO).

Este documento incluye la lista de medicamentos (cubiertos) correspondiente a nuestro plan, que está vigente a partir del 04/01/2024. Comuníquese con nosotros si desea obtener una lista de medicamentos cubiertos actualizada. Nuestra información de contacto y la fecha de la última actualización de la lista de medicamentos cubiertos aparece en la portada y en la contraportada.

Por lo general, se deben usar farmacias de la red para tener el beneficio de medicamentos recetados. Los beneficios, la lista de medicamentos cubiertos, la red de farmacias o los copagos/el coseguro podrían cambiar a partir del 1 de enero de 2024 y eventualmente durante el año.

¿Qué es la lista de medicamentos cubiertos de Ultimate Health Plans?

Un formulario es una lista de medicamentos cubiertos seleccionados por nuestro plan con el asesoramiento de un equipo de proveedores de atención médica, que representa las terapias recetadas que se cree que podrían ser necesarias en un programa de tratamiento de calidad. Por lo general, nuestro plan cubre los medicamentos mencionados en nuestra lista de medicamentos cubiertos, siempre que el medicamento sea médicamente necesario, se surta la receta en una farmacia de la red del plan y se cumplan otras reglas del plan. Para obtener más información de cómo surtir sus recetas, revise su Evidencia de Cobertura.

¿Puede cambiar la lista de medicamentos cubiertos (el formulario)?

La mayoría de los cambios en la cobertura de los medicamentos se hacen el 1 de enero, pero podemos agregar o quitar medicamentos de la Lista de medicamentos durante el año, pasarlos a diferentes niveles de costos compartidos o agregar nuevas restricciones. Debemos cumplir las reglas de Medicare para hacer estos cambios.

Cambios que le pueden afectar este año: En los casos de abajo, usted se verá afectado por los cambios de cobertura durante el año:

- **Nuevos medicamentos genéricos.** Podríamos quitar inmediatamente de nuestra lista de medicamentos algún medicamento de marca si lo reemplazamos por un nuevo medicamento genérico que se incluirá en el mismo nivel de costo compartido o en uno inferior y con las mismas o con menos restricciones. Además, al agregar el nuevo medicamento genérico, es posible que decidamos conservar el medicamento de marca en nuestra lista de medicamentos, pero que lo traslademos inmediatamente a otro nivel de costos compartidos o que agreguemos nuevas restricciones. Si actualmente toma ese medicamento de marca, es posible que no le avisemos antes de hacer el cambio, pero posteriormente le daremos información sobre los cambios específicos que hayamos hecho.
    - Si hacemos un cambio de este tipo, usted o el proveedor que receta pueden pedirnos que hagamos una excepción y que continuemos cubriendo el medicamento de marca. En el aviso que le enviemos, también incluiremos información de cómo pedir que se haga una excepción. Además, puede encontrar información en la sección de abajo llamada "¿Cómo pido que se haga una excepción a la lista de medicamentos cubiertos de Ultimate Health Plans ?"

- **Medicamentos que se quitan del mercado.** Si la Administración de Alimentos y Medicamentos considera que un medicamento que está incluido en nuestra lista de medicamentos cubiertos no es seguro o si el fabricante del medicamento lo saca del mercado, quitaremos inmediatamente ese medicamento de nuestra lista de medicamentos cubiertos y les avisaremos a los miembros que toman el medicamento.

- **Otros cambios.** Es posible que hagamos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podríamos agregar un medicamento genérico que no es nuevo para reemplazar un medicamento de marca que está incluido actualmente en la lista de medicamentos cubiertos o, podríamos agregar nuevas restricciones al medicamento de marca o pasarlo a otro nivel de costos compartidos o podríamos hacer ambas cosas. También podríamos hacer cambios según las nuevas directrices clínicas. Si quitamos medicamentos de nuestra lista de medicamentos cubiertos, agregamos el requisito de autorización previa, límites de cantidades o restricciones de terapia escalonada de un medicamento o pasamos el medicamento a un nivel superior de costos compartidos, tenemos la obligación de avisarles a los miembros afectados sobre el cambio, al menos 30 días antes de que entre en vigencia o cuando el miembro pida resurtir el medicamento, en ese momento el miembro recibirá un suministro del medicamento para 30 días.
    - Si hacemos estos otros cambios, usted o su proveedor que receta pueden pedirnos que hagamos una excepción y que continuemos cubriendo el medicamento de marca para usted. En el aviso que le enviemos, también incluiremos información de cómo pedir que se haga una excepción. Además, puede encontrar información en la sección de abajo llamada "¿Cómo pido que se haga una excepción a la lista de medicamentos cubiertos de Ultimate Health Plans?"

Cambios que no lo afectarán si está tomando el medicamento actualmente. Por lo general, si está tomando un medicamento que está en nuestra lista de medicamentos cubiertos de 2024 y estaba cubierto a principios del año, no interrumpiremos ni reduciremos la cobertura del medicamento durante la cobertura del año 2024, excepto como se describe arriba. Esto significa que durante el resto del año de cobertura estos medicamentos seguirán estando disponibles con los mismos costos compartidos y sin nuevas restricciones para los miembros que los toman. No recibirá ningún aviso directo este año sobre los cambios que no le afecten. Sin embargo, el 1 de enero del próximo año esos cambios lo afectarán y es importante que revise la Lista de medicamentos del nuevo año de beneficios para ver si hubo algún cambio en los medicamentos.

La lista de medicamentos cubiertos que se adjunta es la que está en vigencia a partir del 04/01/2024. Para obtener información actualizada sobre los medicamentos que cubre nuestro plan, comuníquese con nosotros. Nuestra información de contacto aparece en la portada y en la contraportada. En el caso de que a medio año haya algún cambio en la lista de medicamentos cubiertos que no sean de mantenimiento, actualizaremos nuestras lista de medicamentos cubiertos impresas en la siguiente impresión, y también publicaremos un resumen mensual de todos los cambios en la lista de medicamentos, que puede descargar en nuestro sitio web o puede obtener en formato impreso, si lo pide.

¿Cómo uso la lista de medicamentos cubiertos?

Puede buscar su medicamento de dos formas en la lista de medicamentos cubiertos:

Condición médica

La lista de medicamentos cubiertos comienza en la página 1. Los medicamentos de esta lista de medicamentos cubiertos están agrupados por categorías, según el tipo de condiciones médicas que tratan. Por ejemplo, los medicamentos que se usan para tratar condiciones médicas del corazón se mencionan en la categoría Agentes cardiovasculares. Si sabe para qué se usa su medicamento, busque el nombre de la categoría en la lista que comienza debajo. Después busque su medicamento en el nombre de su categoría.

Orden alfabético

Si no sabe con seguridad en qué categoría buscar, busque el nombre de su medicamento en el Índice que comienza en la página 71. El Índice da una lista de todos los medicamentos que se incluyen en este documento, en orden alfabético. El Índice menciona los medicamentos de marca y los medicamentos genéricos. Busque su medicamento en el índice. Al lado de su medicamento, verá el número de la página donde podrá encontrar información de la cobertura. Vaya a la página mencionada en el Índice y busque el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre tanto los medicamentos de marca como los medicamentos genéricos. Un medicamento genérico es aquel aprobado por la FDA porque tiene el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos son más asequibles que los medicamentos de marca.

¿Hay alguna restricción en mi cobertura?

Es posible que algunos medicamentos cubiertos tengan más requisitos o límites en la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** Nuestro plan exige que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener la aprobación de nuestro plan antes de surtir sus recetas. Si no obtiene una aprobación, es posible que nuestro plan no cubra el medicamento.

- **Límites de las cantidades:** Para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que cubre. Por ejemplo, nuestro plan da 30 tabletas de alprazolam ER 1 mg por cada receta. Esto podría ser además del suministro estándar de un mes o de tres meses.

- **Terapia escalonada:** En algunos casos, nuestro plan exige que primero pruebe ciertos medicamentos para tratar su condición médica antes de que cubramos otro medicamento para esa condición. Por ejemplo, si el medicamento A y el medicamento B sirven para tratar su condición médica, es posible que no cubramos el medicamento B a menos que antes haya probado el medicamento A. Si el medicamento A no le da resultado, entonces nuestro plan cubrirá el medicamento B.

- **Límites de opioides:** Es posible que nuestro plan deba realizar una revisión de seguridad más detallada de la receta con el médico que la recetó si una receta de opioides supera cierta cantidad. Es posible que esté limitado a un suministro de 7 días o menos para el dolor agudo al surtir su receta de opioides. Además, si está tomando más de un opioide, es posible que se apliquen límites adicionales llamados equivalentes en miligramos de morfina (EMM). Puede ser necesaria una revisión para controlar los niveles de dosificación seguros. Si su médico le receta una cantidad superior a la indicada, usted o su médico pueden pedirle a nuestro plan que cubra la cantidad adicional. Llame al 1-800-311-7517 para iniciar la revisión de seguridad.

Para saber si su medicamento tiene más requisitos o límites, consulte la lista de medicamentos cubiertos que comienza en la página 1. También puede visitar nuestro sitio web para obtener más información sobre las restricciones que se aplican a determinados medicamentos cubiertos. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia escalonada. También puede pedirnos que le enviemos una copia. Nuestra información de contacto y la fecha de la última actualización de la lista de medicamentos cubiertos aparece en la portada y en la cubierta de atrás.

Puede pedirnos que hagamos una excepción a estas restricciones o limites o puede pedirnos una lista de otros medicamentos similares que puedan tratar su condición médica. Para obtener más información sobre cómo pedir que se haga una excepción, consulte la sección “¿Cómo pido que se haga una excepción a la lista de medicamentos cubiertos de Ultimate Health Plans?” en la página xi.

¿Qué sucede si mi medicamento no está en la lista de medicamentos cubiertos?

Si su medicamento no está incluido en esta lista de medicamentos cubiertos (formulario), debe comunicarse primero con Servicios para los Miembros y preguntar si su medicamento está cubierto.

Si le informan que nuestro plan no cubre su medicamento, tiene dos opciones:

- Puede pedirle a Servicios para Miembros una lista de medicamentos similares que cubra nuestro plan. Cuando reciba la lista, mostrarla a su médico y pídale que le recete un medicamento similar que cubra nuestro plan.
- Puede pedirnos que hagamos una excepción y cubramos su medicamento. Para obtener información sobre cómo pedir que hagamos una excepción, vea abajo.

¿Cómo pido que se haga una excepción a la lista de medicamentos cubiertos de Ultimate Health Plans?

Puede pedirnos que hagamos una excepción a nuestras reglas de cobertura. Hay varios los tipos de excepciones que puede pedir que hagamos.

- Puede pedirnos que cubramos un medicamento, aunque no esté incluido en nuestra lista de medicamentos cubiertos. Si se aprueba, se cubrirá este medicamento con un nivel predeterminado de costo compartido y no nos podrá pedir que le entreguemos el medicamento a un nivel de costo compartido inferior.
- Puede pedirnos que cubramos un medicamento del Formulario a un nivel de costo compartido menor, a menos que el medicamento esté en el nivel de especialidad. Si se aprueba, bajará la cantidad que deberá pagar por su medicamento.
- Puede pedirnos que no apliquemos las restricciones ni los límites de cobertura a su medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad del medicamento que se cubrirá. Si su medicamento tiene límite de cantidad, puede pedirnos que no apliquemos el límite y que cubramos una cantidad mayor.

Por lo general, solo aprobaremos su petición de excepción, si los medicamentos alternativos que se incluyen en la lista de medicamentos cubiertos del plan, el medicamento con costos compartidos más asequibles o las otras restricciones de uso no son tan eficaces para tratar su condición, o podrían hacer que tenga efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión de cobertura inicial para una excepción de restricción de uso, nivel o formulario. **Cuando solicita una excepción de restricción de uso, nivel o formulario, debe enviar una declaración del proveedor que receta, o del médico que respalda la solicitud.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de haber recibido la declaración del proveedor que receta. Puede pedir que se haga una excepción expedita (rápida) si usted o su médico consideran que su salud podría verse gravemente perjudicada por tener que esperar hasta 72 horas para obtener una decisión. Si su petición es concedida, debemos darle nuestra decisión en un plazo máximo de 24 horas después de recibir la declaración de respaldo de su médico o del proveedor que receta.

¿Qué debo hacer antes de hablar con mi médico sobre cambiar mis medicamentos o pedir que se haga una excepción?

Como miembro nuevo o actual de nuestro plan, es posible que tome medicamentos que no están incluidos en nuestra lista de medicamentos cubiertos. O podría estar recibiendo un medicamento que está incluido en nuestra lista de medicamentos cubiertos, pero su posibilidad de obtenerlo es limitada. Por ejemplo, podría necesitar nuestra autorización previa antes de surtir su receta. Hable con su médico para decidir si debiera cambiar a un medicamento adecuado que esté cubierto o pedir que se haga una excepción a la lista de medicamentos cubiertos para que cubramos el medicamento que toma. Mientras habla con su médico para determinar qué opción es adecuada para usted, es posible que, en ciertos casos, cubramos su medicamento durante los primeros 90 días que usted es miembro de nuestro plan.

Cubriremos un suministro temporal de 30 días para cada uno de los medicamentos que no estén incluidos en nuestra lista de medicamentos cubiertos o si la capacidad para obtenerlos estuviera limitada. Si su receta es para menos días, podremos permitir que se resurta el medicamento hasta un suministro máximo hasta de 30 días. Después de su primer suministro de 30 días, no pagaremos esos medicamentos aunque haya sido miembro del plan menos de 90 días.

Si es residente de un centro de atención a largo plazo y necesita un medicamento que no está en nuestra lista de medicamentos cubiertos o si tiene capacidad limitada para obtener sus medicamentos, pero tiene más de 98 días de membresía en nuestro plan, cubriremos un suministro de emergencia del medicamento para 31 días, mientras pide que se haga una excepción a la lista de medicamentos cubiertos.

Cubriremos un suministro de transición para los inscritos que tengan un nivel de cambio de atención, que se define cuando los afiliados:

- Entran en un centro de atención a largo plazo (LTC) de un hospital u otro entorno
- Dejan un centro de atención a largo plazo (LTC) y regresan a la comunidad
- Reciben el alta hospitalaria para regresar a su casa
- Terminan la estancia en un centro de enfermería especializada (SNF) cubierto según Medicare Parte A (que cubre todos los cargos de farmacia) y deben regresar a la cobertura de la lista de medicamentos cubiertos del plan de la Parte D
- Regresan del estado de cuidados paliativos a los beneficios estándares de Medicare Parte A y Parte B, o
- Reciben el alta de un hospital psiquiátrico con un tratamiento de medicamentos sumamente personalizado

Para obtener más información

Para obtener información detallada sobre la cobertura de medicamentos recetados de su plan, revise su Evidencia de Cobertura y otro material del plan.

Comuníquese con nosotros si tiene alguna pregunta sobre nuestro plan. Nuestra información de contacto y la fecha de la última actualización de la lista de medicamentos cubiertos aparece en la portada y en la cubierta de atrás.

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O, visitar http://www.medicare.gov.

Lista de medicamentos cubiertos por nuestro plan

La lista de medicamentos cubiertos que comienza en la página 1 da información sobre la cobertura de los medicamentos que cubre nuestro plan. Si tiene dificultad para encontrar su medicamento en la lista, consulte el Índice que comienza en la página 71.

En la primera columna de la tabla aparece el nombre del medicamento. Los medicamentos de marca están en mayúscula (por ejemplo, JANUVIA) y los medicamentos genéricos están mencionados en minúscula e itálica (por ejemplo, *lisinopril*).

La información que se incluye en la columna Requisitos/Límites le permite saber si su plan tiene requisitos especiales para la cobertura de su medicamento.

B/D: Este medicamento puede ser eligible para pago bajo la Parte B o la Parte D de Medicare. Los medicamentos cubiertos por la Parte B de Medicare están sujetos al monto del costo compartido que se describe en su Evidencia de Cobertura y Resumen de Beneficios. También se pueden aplicar reglas de autorización. LLame al 800-311-7517 (TTY 711) para obtener más información sobre los costos compartidos y los requisitos de autorización. Estamos disponibles las 24 horas del día, los 7 días de la semana.

E: Medicamento excluido. Este medicamento recetado no suele estar cubierto por un plan de medicamentos recetados de Medicare. La cantidad que usted paga al surtir una receta de este medicamento no se tiene en cuenta para el total de sus gastos de medicamentos (es decir, la cantidad que paga no lo ayuda a calificar para una cobertura catastrófica). Además, si recibe más ayuda para pagar sus medicamentos recetados, no recibirá ningún otro tipo de ayuda para pagar este medicamento.

GC: Cobertura en el período sin cobertura. Damos más cobertura para este medicamento recetado durante el período sin cobertura. Para obtener más información sobre esta cobertura, consulte nuestra Evidencia de Cobertura.

MO: Medicamento pedido por correo. Este medicamento recetado está disponible a través de nuestro servicio de pedido por correo y a través de nuestras farmacias de la red. Por lo general, los medicamentos que se entregan por correo son aquellos que usted toma con frecuencia para tratar una condición médica crónica o de largo plazo. Cuando usa el servicio de pedido por correo del plan, es necesario pedir un suministro de 90 días. Generalmente, los pedidos que se hacen a través de este servicio llegarán en un plazo máximo de 14 días. No obstante, si el pedido se demora, comuníquese con nosotros de inmediato para que podamos hacer los arreglos pertinentes para que recoja el medicamento recetado en su farmacia local. Puede comunicarse con nosotros las 24 horas del día, los 7 días de la semana llamando al 1-800-311-7517 (si es usuario de TTY llame al 711).

PA: Autorización previa. Es necesario que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener una aprobación antes de surtir sus recetas. Si no obtiene una aprobación, es posible que no cubramos el medicamento.

QL: Límite de cantidad. Para ciertos medicamentos, limitamos la cantidad que se cubrirá del medicamento.

ST: Terapia escalonada. En algunos es necesario que primero pruebe ciertos medicamentos para tratar su condición médica antes de que cubramos otro medicamento para esa condición. Por ejemplo, si el medicamento A y el medicamento B sirven para tratar su condición médica, es posible que no cubramos el medicamento B a menos que antes haya probado el medicamento A. Si el medicamento A no le da resultado, entonces cubriremos el medicamento B.

La lista de medicamentos cubiertos se divide en 4 niveles

Cada medicamento incluido en la lista de medicamentos del plan está en uno de los 4 niveles de costos compartidos con una cantidad de costo compartido dependiendo del plan, como se muestra abajo. En general, cuanto más alto sea el nivel de costos compartidos, más alto será el costo que deberá pagar por el medicamento:

- **Nivel 1 de costo compartido (genérico)** incluye medicamentos genéricos. Este nivel también tiene medicamentos al menor costo.
- **Nivel 2 de costo compartido (marca preferida)** incluye medicamentos de marca preferida y algunos medicamentos genéricos.
- **Nivel 3 de costo compartido (medicamentos no preferidos)** incluye medicamentos de marca no preferidos y algunos medicamentos genéricos.
- **Nivel 4 de costo compartido (nivel de especialidad)** incluye medicamentos de marca y genéricos de alto costo, que pueden necesitar un manejo especial o una supervisión cercana. Este es el nivel de mayor costo.

Nivel de costos compartidos	Copago o coseguro para un suministro de 30 días en una farmacia	Copago o coseguro para un suministro de 90 días en una farmacia (Suministro de hasta 100 días para algunos medicamentos de nivel 1)	Copago o coseguro para un suministro de 90 días a través de la farmacia de pedido por correo (Suministro de hasta 100 días para algunos medicamentos de nivel 1)	Copago o coseguro para un suministro de 31 días para atención de largo plazo
Premier by Ultimate (HMO) 001				
Nivel 1	$0	$0	$0	$0
Nivel 2	$15	$45	$30	$15
Nivel 3	$60	$180	$120	$60
Nivel 4	Coseguro del 33%	Sin cobertura	Sin cobertura	Coseguro del 33%
Premier by Ultimate (HMO) 028, 046				
Nivel 1	$0	$0	$0	$0
Nivel 2	$30	$90	$60	$30
Nivel 3	$60	$180	$120	$60
Nivel 4	Coseguro del 33%	Sin cobertura	Sin cobertura	Coseguro del 33%
Premier by Ultimate (HMO) 045				
Nivel 1	$0	$0	$0	$0
Nivel 2	$25	$75	$50	$25
Nivel 3	$60	$180	$120	$60
Nivel 4	Coseguro del 33%	Sin cobertura	Sin cobertura	Coseguro del 33%
Premier by Ultimate (HMO) 047				
Nivel 1	$0	$0	$0	$0
Nivel 2	$35	$105	$70	$35
Nivel 3	$85	$255	$170	$85
Nivel 4	Coseguro del 33%	Sin cobertura	Sin cobertura	Coseguro del 33%

Para obtener más información de las cantidades de copagos o coseguros que se aplican en cada nivel de la lista de medicamentos cubiertos, consulte su Evidencia de Cobertura.

English / Inglés	Spanish / Español
Drug Name	Nombre del medicamento
Drug Tier	Nivel del medicamento
Requirements/Limits	Requisitos/Límites

Categories / Categorías	
English / Inglés	**Spanish / Español**
Antipsychotics	Antipsicóticos
Dermatological Agents	Agentes dermatológicos
Anti-Addiction/Substance Abuse Treatment Agents	Agentes para tratamientos antiadicción/contra la drogadicción
Antineoplastics	Antineoplásicos
Cardiovascular Agents	Agentes cardiovasculares
Antibacterials	Antibacterianos
Inflammatory Bowel Disease Agents	Agentes de la enfermedad inflamatoria intestinal
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)	Agentes hormonales, estimulación/sustitución/modificación (hormonas sexuales/modificadores)
Immunological Agents	Agentes inmunológicos
Antiparasitics	Antiparasitarios
Antiparkinson Agents	Agentes antiparkinsonianos
Blood Products and Modifiers	Productos y modificadores sanguíneos
Gastrointestinal Agents	Agentes gastrointestinales
Anticonvulsants	Anticonvulsivos
Antivirals	Antivírico
Antidementia Agents	Agentes antidemencia
Antidepressants	Antidepresivos
Blood Glucose Regulators	Reguladores de la glucemia
Antiemetics	Antieméticos
Antifungals	Antimicóticos
Antigout Agents	Agentes de antigout
Respiratory Tract/Pulmonary Agents	Agentes para vías respiratorias/pulmonares
Antimycobacterials	Antimicobacterianos
Genitourinary Agents	Agentes genitourinarios
Antispasticity Agents	Agentes antiespásticos
Hormonal Agents, Suppressant (Thyroid)	Agentes hormonales, inhibidor (tiroides)
Anxiolytics	Ansiolíticos
Central Nervous System Agents	Agentes del sistema nervioso central
Dental and Oral Agents	Agentes dentales y orales
Electrolytes/Minerals/Metals/Vitamins	Electrolitos/minerales/metales/vitaminas
Antimigraine Agents	Agentes antijaquecosos
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment	Trastorno genético, enzimático o proteico: Reemplazo, modificadores, tratamiento
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)	Agentes hormonales, estimulación/sustitución/modificación (suprarrenal)
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)	Agentes hormonales, estimulación/sustitución/modificación (hipófisis)
Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)	Agentes hormonales, estimulación/sustitución/modificación (prostaglandinas)
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)	Agentes hormonales, estimulación/sustitución/modificación (tiroides)
Hormonal Agents, Suppressant (Adrenal)	Agentes hormonales, inhibidor (suprarrenal)
Hormonal Agents, Suppressant (Pituitary)	Agentes hormonales, inhibidor (hipófisis)
Anesthetics	Anestésicos
Metabolic Bone Disease Agents	Agentes de las enfermedades óseas metabólicas
Miscellaneous Therapeutic Agents	Agentes Terapéuticos, Misceláneos
Bipolar Agents	Agentes para la bipolaridad
Analgesics	Analgésicos
Ophthalmic Agents	Agentes oftálmicos

Otic Agents	Agentes óticos
Antimyasthenic Agents	Agentes antimiasténicos
Skeletal Muscle Relaxants	Relajantes musculares esqueléticos
Sleep Disorder Agents	Agentes del trastorno del sueño

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
celecoxib capsule	1	QL(60 EA per 30 days); MO; GC
diclofenac potassium tablet 50mg	1	MO; GC
diclofenac sodium dr	1	MO; GC
diclofenac sodium er	1	MO; GC
diclofenac sodium/misoprostol	3	MO
diclofenac sodium gel 1%	1	QL(1000 GM per 30 days); MO; GC
diclofenac sodium external solution 1.5%	3	PA; MO
diflunisal tablet 500mg	1	MO; GC
etodolac er	1	MO; GC
etodolac capsule 300mg	1	MO; GC
etodolac capsule 200mg	2	MO
etodolac tablet	1	MO; GC
fenoprofen calcium capsule 400mg	3	MO
fenoprofen calcium tablet	3	MO
flurbiprofen tablet 100mg	1	MO; GC
ibu	1	MO; GC
ibuprofen suspension	1	MO; GC
ibuprofen tablet 400mg, 600mg, 800mg	1	MO; GC
indomethacin er	1	MO; GC
indomethacin capsule 25mg, 50mg	1	MO; GC
ketoprofen er capsule extended release 24 hour 200mg	3	MO
ketorolac tromethamine injection 30mg/ml, 60mg/2ml	3	MO
ketorolac tromethamine tablet 10mg	1	QL(20 EA per 30 days); MO; GC
mefenamic acid capsule	3	MO
meloxicam tablet	1	MO; GC
nabumetone tablet	1	MO; GC
naproxen sodium tablet 275mg, 550mg	1	MO; GC
naproxen tablet delayed release	1	MO; GC
naproxen suspension	3	MO
naproxen tablet 250mg, 375mg, 500mg	1	MO; GC
oxaprozin tablet	1	MO; GC
piroxicam capsule 10mg	1	MO; GC
piroxicam capsule 20mg	2	MO
sulindac tablet	1	MO; GC
tolmetin sodium capsule	1	MO; GC
tolmetin sodium tablet 600mg	1	MO; GC
Opioid Analgesics, Long-acting		
buprenorphine	3	QL(4 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
FENTANYL PATCH 72 HOUR 100MCG/HR, 12MCG/HR, 25MCG/HR, 50MCG/HR, 75MCG/HR	2	
fentanyl patch 72 hour 37.5mcg/hr, 62.5mcg/hr	3	
fentanyl patch 72 hour 87.5mcg/hr	4	
hydromorphone hcl er tablet extended release 24 hour 8mg	3	
methadone hcl solution, tablet	1	GC
methadone hydrochloride intensol	1	GC
methadone hydrochloride concentrate	1	GC
methadose sugar-free	1	GC
methadose concentrate 10mg/ml	1	GC
mitigo	1	B/D; GC
morphine sulfate er capsule extended release 24 hour	3	
morphine sulfate er tablet extended release 15mg, 30mg, 60mg	1	GC
morphine sulfate er tablet extended release 100mg, 200mg	2	
oxymorphone hydrochloride er tablet extended release 12 hour 10mg, 15mg, 20mg, 30mg, 5mg, 7.5mg	3	
oxymorphone hydrochlorideer	3	
tramadol hydrochloride er tablet extended release 24 hour 100mg	1	GC
tramadol hydrochloride er tablet extended release 24 hour 200mg, 300mg	3	
XTAMPZA ER	3	
Opioid Analgesics, Short-acting		
acetaminophen/codeine #2; #3; #4	1	GC
ascomp/codeine	2	
butalbital/acetaminophen/caffeine/codeine capsule 325mg; 50mg; 40mg; 30mg	1	GC
butalbital/acetaminophen/caffeine/codeine capsule 300mg; 50mg; 40mg; 30mg	2	
butalbital/aspirin/caffeine/codeine	2	
butorphanol tartrate solution	2	
CODEINE SULFATE TABLET 60MG	2	
codeine sulfate tablet 15mg, 30mg	1	GC
duramorph	1	GC
endocet tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	GC
fentanyl citrate oral transmucosal lozenge on a handle 200mcg	3	PA
fentanyl citrate oral transmucosal lozenge on a handle 1200mcg, 1600mcg, 400mcg, 600mcg, 800mcg	4	PA

Drug Name	Drug Tier	Requirements/Limits
hydrocodone bitartrate/acetaminophen solution 325mg/15ml; 7.5mg/15ml	1	GC
hydrocodone bitartrate/acetaminophen tablet 300mg; 5mg, 300mg; 7.5mg, 325mg; 10mg, 325mg; 5mg	1	GC
hydrocodone bitartrate/acetaminophen tablet 300mg; 10mg	2	
hydrocodone/acetaminophen tablet 325mg; 7.5mg	1	GC
hydrocodone/ibuprofen tablet 7.5mg; 200mg	1	GC
hydrocodone/ibuprofen tablet 10mg; 200mg, 5mg; 200mg	2	
hydromorphone hcl liquid, tablet	1	GC
hydromorphone hcl injection 2mg/ml	1	GC
hydromorphone hcl injection 10mg/ml	2	
hydromorphone hydrochloride injection 50mg/5ml	1	GC
morphine sulfate oral solution, tablet	1	GC
morphine sulfate injection 0.5mg/ml, 1mg/ml, 8mg/ml	1	GC
oxycodone and acetaminophen	4	
oxycodone hydrochloride capsule, solution, tablet	1	GC
oxycodone hydrochloride concentrate	3	
oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	GC
oxycodone/acetaminophen tablet 300mg; 10mg, 300mg; 5mg	4	
oxycodone/aspirin tablet 325mg; 4.835mg	1	GC
oxymorphone hydrochloride	2	
tramadol hydrochloride/acetaminophen	1	GC
tramadol hydrochloride tablet 50mg	1	GC
Anesthetics		
Local Anesthetics		
glydo	1	QL(30 ML per 30 days); PA; MO; GC
lidocaine hcl jelly	1	QL(30 ML per 30 days); PA; MO; GC
lidocaine hcl prefilled syringe	1	QL(30 ML per 30 days); PA; MO; GC
lidocaine hydrochloride solution	1	QL(250 ML per 30 days); PA; MO; GC
lidocaine/prilocaine cream	1	QL(30 GM per 30 days); PA; MO; GC
LIDOCAINE OINTMENT 5%	2	QL(150 GM per 30 days); PA; MO
LIDOCAINE PATCH 5%	2	PA; MO
Anti-Addiction/Substance Abuse Treatment Agents		
Alcohol Deterrents/Anti-craving		
acamprosate calcium dr	2	MO
disulfiram tablet	1	MO; GC
naltrexone hcl tablet	1	MO; GC
VIVITROL	4	
Opioid Dependence		

Drug Name	Drug Tier	Requirements/Limits
buprenorphine hcl/naloxone hcl tablet sublingual 2mg; 0.5mg	1	QL(360 EA per 30 days); GC
buprenorphine hcl/naloxone hcl tablet sublingual 8mg; 2mg	1	QL(90 EA per 30 days); GC
buprenorphine hcl tablet sublingual	1	GC
buprenorphine hydrochloride/naloxone hydrochloride film 12mg; 3mg, 4mg; 1mg	2	QL(60 EA per 30 days)
buprenorphine hydrochloride/naloxone hydrochloride film 2mg; 0.5mg, 8mg; 2mg	2	QL(90 EA per 30 days)
Opioid Reversal Agents		
naloxone hcl injection 2mg/2ml, 4mg/10ml	1	MO; GC
NALOXONE HYDROCHLORIDE LIQUID	2	MO
naloxone hydrochloride injection 0.4mg/ml, 2mg/2ml, 4mg/10ml	1	MO; GC
Smoking Cessation Agents		
bupropion hydrochloride er (sr) tablet extended release 12 hour 150mg	1	QL(60 EA per 30 days); MO; GC
NICOTROL INHALER	3	QL(2688 EA per 365 days); MO
NICOTROL NS	2	QL(360 ML per 365 days); MO
varenicline starting month box	1	QL(504 EA per 365 days); MO; GC
varenicline tartrate	1	QL(504 EA per 365 days); MO; GC
Antibacterials		
Aminoglycosides		
amikacin sulfate injection 1gm/4ml	1	MO; GC
amikacin sulfate injection 500mg/2ml	2	MO
gentamicin sulfate/0.9% sodium chloride injection 1.2mg/ml; 0.9%, 1.6mg/ml; 0.9%, 1mg/ml; 0.9%	1	MO; GC
gentamicin sulfate cream 0.1%	1	MO; GC
gentamicin sulfate injection 40mg/ml	1	MO; GC
gentamicin sulfate ointment 0.1%	1	MO; GC
isotonic gentamicin injection 0.8mg/ml; 0.9%	1	MO; GC
neomycin sulfate	1	MO; GC
paromomycin sulfate	2	MO
streptomycin sulfate injection 1gm	3	MO
tobramycin sulfate injection 1.2gm	1	MO; GC
tobramycin sulfate injection 10mg/ml, 80mg/2ml	2	MO
Antibacterials, Other		
aztreonam	3	MO
clindamycin hcl capsule 300mg	1	MO; GC
clindamycin hydrochloride capsule 150mg, 75mg	1	MO; GC
clindamycin palmitate hydrochloride	2	MO
clindamycin phosphate/dextrose	2	MO
clindamycin phosphate cream 2%	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
clindamycin phosphate injection 300mg/2ml, 600mg/4ml, 900mg/6ml	1	MO; GC
clindamycin phosphate swab 1%	1	MO; GC
colistimethate sodium	4	
daptomycin injection 500mg	4	
FOSFOMYCIN TROMETHAMINE	3	MO
IMPAVIDO	4	
linezolid tablet	2	QL(56 EA per 28 days); MO
linezolid suspension reconstituted	4	QL(1800 ML per 28 days)
linezolid injection 600mg/300ml	3	MO
methenamine hippurate	3	MO
metronidazole vaginal	2	MO
metronidazole injection 500mg/100ml	1	MO; GC
metronidazole tablet 250mg, 500mg	1	MO; GC
nitrofurantoin macrocrystals capsule 100mg, 50mg	1	MO; GC
nitrofurantoin macrocrystals capsule 25mg	2	MO
nitrofurantoin monohydrate/macrocrystals	1	MO; GC
polymyxin b sulfate injection	2	MO
tigecycline	3	MO
tinidazole tablet 500mg	1	MO; GC
tinidazole tablet 250mg	2	MO
trimethoprim tablet	1	MO; GC
vancomycin hcl injection 10gm	2	MO
vancomycin hydrochloride capsule 125mg	3	QL(120 EA per 30 days); MO
vancomycin hydrochloride capsule 250mg	3	QL(240 EA per 30 days); MO
vancomycin hydrochloride injection 250mg, 500mg, 750mg	1	MO; GC
vancomycin hydrochloride injection 1gm	2	MO
vandazole	2	MO
Beta-lactam, Cephalosporins		
AVYCAZ	4	
cefaclor er tablet extended release 12 hour 500mg	2	MO
cefaclor capsule	1	MO; GC
CEFACLOR SUSPENSION RECONSTITUTED 125MG/5ML, 250MG/5ML, 375MG/5ML	2	MO
cefadroxil	1	MO; GC
cefazolin sodium injection 10gm, 1gm	1	MO; GC
cefazolin sodium injection 500mg	2	MO
cefdinir	1	MO; GC
cefepime injection 1gm, 2gm	2	MO
CEFIXIME CAPSULE	2	MO
cefixime suspension reconstituted	3	MO

Drug Name	Drug Tier	Requirements/Limits
cefotaxime sodium injection 1gm, 2gm	1	MO; GC
cefotetan injection 2gm	1	MO; GC
cefoxitin sodium injection 10gm, 1gm, 2gm	1	MO; GC
cefpodoxime proxetil tablet	1	MO; GC
cefpodoxime proxetil suspension reconstituted	2	MO
cefprozil	1	MO; GC
ceftazidime injection 1gm	1	MO; GC
ceftazidime injection 2gm, 6gm	2	MO
ceftriaxone sodium injection 10gm, 1gm, 250mg, 2gm, 500mg	1	MO; GC
cefuroxime axetil tablet	1	MO; GC
cefuroxime sodium injection 1.5gm, 750mg	1	MO; GC
cephalexin capsule, suspension reconstituted	1	MO; GC
cephalexin tablet 250mg	1	MO; GC
cephalexin tablet 500mg	2	MO
SUPRAX SUSPENSION RECONSTITUTED 500MG/5ML	2	MO
tazicef injection 1gm	1	MO; GC
tazicef injection 2gm, 6gm	2	MO
TEFLARO	4	
Beta-lactam, Penicillins		
amoxicillin/clavulanate potassium	1	MO; GC
AMOXICILLIN/CLAVULANATE POTASSIUM ER	2	MO
amoxicillin capsule, suspension reconstituted, tablet	1	MO; GC
amoxicillin tablet chewable 125mg, 250mg	1	MO; GC
ampicillin sodium injection 10gm, 125mg, 1gm	1	MO; GC
ampicillin-sulbactam injection 10gm; 5gm, 1gm; 0.5gm	2	MO
ampicillin/sulbactam injection 2gm; 1gm	2	MO
ampicillin capsule 500mg	1	MO; GC
AUGMENTIN SUSPENSION RECONSTITUTED 125MG/5ML; 31.25MG/5ML	3	MO
BICILLIN C-R INJECTION 300000UNIT/ML; 300000UNIT/ML, 900000UNIT/2ML; 300000UNIT/2ML	3	MO
BICILLIN L-A INJECTION 1200000UNIT/2ML, 2400000UNIT/4ML, 600000UNIT/ML	3	MO
dicloxacillin sodium	1	MO; GC
nafcillin sodium injection 2gm	2	MO
nafcillin sodium injection 10gm, 1gm	3	MO
OXACILLIN SODIUM INJECTION 1.5GM/50ML; 1GM/50ML, 300MG/50ML; 2GM/50ML	3	MO
oxacillin sodium injection 10gm, 2gm	3	MO
penicillin g potassium injection 5000000unit	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
penicillin g potassium injection 20000000unit	2	MO
penicillin g sodium	4	
penicillin v potassium	1	MO; GC
pfizerpen injection 5000000unit	1	MO; GC
piperacillin sodium/tazobactam sodium injection 2gm; 0.25gm, 36gm; 4.5gm, 3gm; 0.375gm, 4gm; 0.5gm	2	MO
Carbapenems		
ERTAPENEM	2	MO
imipenem/cilastatin	3	MO
meropenem injection 500mg	2	MO
Macrolides		
azithromycin packet, tablet	1	MO; GC
azithromycin injection 500mg	1	MO; GC
azithromycin suspension reconstituted 200mg/5ml	1	MO; GC
azithromycin suspension reconstituted 100mg/5ml	2	MO
clarithromycin er	2	MO
clarithromycin suspension reconstituted, tablet	1	MO; GC
DIFICID	4	
ERYTHROCIN LACTOBIONATE INJECTION 500MG	3	MO
erythrocin stearate tablet 250mg	2	MO
erythromycin base tablet	2	MO
erythromycin dr	2	MO
erythromycin ethylsuccinate tablet	2	MO
ERYTHROMYCIN ETHYLSUCCINATE SUSPENSION RECONSTITUTED 400MG/5ML	2	MO
erythromycin ethylsuccinate suspension reconstituted 200mg/5ml	1	MO; GC
erythromycin lactobionate	1	MO; GC
erythromycin capsule delayed release particles 250mg	2	MO
Quinolones		
CIPRO SUSPENSION RECONSTITUTED	3	MO
ciprofloxacin hcl tablet 750mg	1	MO; GC
ciprofloxacin hcl tablet 100mg	2	MO
ciprofloxacin hydrochloride tablet 250mg, 500mg	1	MO; GC
ciprofloxacin i.v.-in d5w	1	MO; GC
ciprofloxacin suspension reconstituted 500mg/5ml, 5gm/100ml	3	MO
levofloxacin in d5w	1	MO; GC
levofloxacin injection 25mg/ml	3	MO
levofloxacin oral solution 25mg/ml	3	MO
levofloxacin tablet 250mg, 500mg, 750mg	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
moxifloxacin hydrochloride/sodium hydrochloride	3	MO
moxifloxacin hydrochloride tablet 400mg	1	MO; GC
ofloxacin tablet 300mg, 400mg	1	MO; GC
Sulfonamides		
sulfacetamide sodium lotion 10%	3	MO
sulfadiazine tablet	3	MO
sulfamethoxazole/trimethoprim ds	1	MO; GC
sulfamethoxazole/trimethoprim suspension, tablet	1	MO; GC
sulfatrim pediatric	1	MO; GC
Tetracyclines		
avidoxy	1	MO; GC
demeclocycline hcl tablet	2	MO
doxy 100	2	MO
doxycycline hyclate dr tablet delayed release 100mg, 150mg, 75mg	2	MO
doxycycline hyclate dr tablet delayed release 200mg, 50mg	3	MO
doxycycline hyclate capsule 100mg, 50mg	1	MO; GC
doxycycline hyclate injection 100mg	1	MO; GC
doxycycline hyclate tablet 100mg	1	MO; GC
doxycycline monohydrate capsule 100mg, 50mg, 75mg	1	MO; GC
doxycycline monohydrate tablet 100mg, 50mg, 75mg	1	MO; GC
doxycycline monohydrate tablet 150mg	2	MO
doxycycline suspension reconstituted	2	MO
MINOCIN INJECTION	4	
minocycline hcl capsule 75mg	1	MO; GC
minocycline hcl tablet	1	MO; GC
minocycline hydrochloride capsule 100mg, 50mg	1	MO; GC
mondoxyne nl capsule 100mg, 75mg	1	MO; GC
morgidox 1x100mg capsule	1	MO; GC
morgidox 2x100mg capsule	1	MO; GC
tetracycline hydrochloride capsule	3	MO
Anticonvulsants		
Anticonvulsants, Other		
BRIVIACT SOLUTION, TABLET	4	PA
EPIDIOLEX	4	PA
EPRONTIA	3	MO
felbamate tablet	3	MO
felbamate suspension	4	
FINTEPLA	4	PA
FYCOMPA SUSPENSION	4	
FYCOMPA TABLET 2MG	3	MO

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA TABLET 10MG, 12MG, 4MG, 6MG, 8MG	4	
LAMOTRIGINE ER	2	MO
lamotrigine odt	3	MO
lamotrigine starter kit/blue	3	MO
lamotrigine starter kit/green	3	MO
lamotrigine starter kit/orange	3	MO
lamotrigine titration	3	MO
lamotrigine tablet chewable, tablet	1	MO; GC
levetiracetam er tablet extended release 24 hour 500mg	1	MO; GC
levetiracetam er tablet extended release 24 hour 750mg	2	MO
levetiracetam solution, tablet	1	MO; GC
NAYZILAM	4	QL(10 EA per 30 days)
roweepra tablet 500mg	1	MO; GC
SPRITAM	3	MO
subvenite	1	MO; GC
subvenite starter kit/blue	3	MO
subvenite starter kit/green	3	MO
subvenite starter kit/orange	3	MO
topiramate er capsule er 24 hour sprinkle	3	MO
topiramate capsule sprinkle, tablet	1	MO; GC
XCOPRI TABLET	4	PA
XCOPRI TABLET THERAPY PACK 0	3	PA; MO
XCOPRI TABLET THERAPY PACK 0	4	PA
Calcium Channel Modifying Agents		
ethosuximide	1	MO; GC
methsuximide	3	MO
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
clobazam	3	MO
clonazepam odt tablet disintegrating 2mg	1	QL(300 EA per 30 days); MO; GC
clonazepam odt tablet disintegrating 0.125mg, 0.25mg, 0.5mg, 1mg	1	QL(90 EA per 30 days); MO; GC
clonazepam tablet 2mg	1	QL(300 EA per 30 days); MO; GC
clonazepam tablet 0.5mg, 1mg	1	QL(90 EA per 30 days); MO; GC
DIACOMIT	4	PA
diazepam rectal gel	3	MO
divalproex sodium dr	1	MO; GC
divalproex sodium er	1	MO; GC
divalproex sodium capsule delayed release sprinkle	1	MO; GC
gabapentin capsule 400mg	1	QL(270 EA per 30 days); MO; GC
gabapentin capsule 100mg, 300mg	1	QL(360 EA per 30 days); MO; GC
gabapentin solution	1	QL(2160 ML per 30 days); MO; GC

Drug Name	Drug Tier	Requirements/Limits
gabapentin tablet 800mg	1	QL(150 EA per 30 days); MO; GC
gabapentin tablet 600mg	1	QL(180 EA per 30 days); MO; GC
phenobarbital elixir 20mg/5ml	1	MO; GC
phenobarbital tablet 100mg, 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg	1	MO; GC
primidone tablet	1	MO; GC
SYMPAZAN FILM 5MG	3	MO
SYMPAZAN FILM 10MG, 20MG	4	
tiagabine hydrochloride	3	MO
VALTOCO 10 MG DOSE	4	QL(10 EA per 30 days)
VALTOCO 15 MG DOSE	4	QL(10 EA per 30 days)
VALTOCO 20 MG DOSE	4	QL(10 EA per 30 days)
VALTOCO 5 MG DOSE	4	QL(10 EA per 30 days)
vigabatrin	4	PA
vigadrone	4	PA
vigpoder	4	PA
Sodium Channel Agents		
APTIOM	4	
carbamazepine er capsule extended release 12 hour	1	MO; GC
carbamazepine er tablet extended release 12 hour 100mg	1	MO; GC
carbamazepine er tablet extended release 12 hour 200mg, 400mg	2	MO
carbamazepine tablet chewable, suspension, tablet	1	MO; GC
DILANTIN CAPSULE 30MG	3	MO
epitol	1	MO; GC
LACOSAMIDE SOLUTION	2	MO
lacosamide tablet	3	MO
oxcarbazepine tablet	1	MO; GC
oxcarbazepine suspension	3	MO
phenytek	1	MO; GC
phenytoin sodium extended	1	MO; GC
phenytoin tablet chewable, suspension	1	MO; GC
rufinamide suspension	4	
rufinamide tablet 200mg	3	MO
rufinamide tablet 400mg	4	
ZONISADE	3	ST; MO
zonisamide	1	MO; GC
Antidementia Agents		
Antidementia Agents, Other		
ERGOLOID MESYLATES TABLET	3	MO
NAMZARIC CAPSULE EXTENDED RELEASE 24 HOUR	3	QL(30 EA per 30 days); ST; MO

Drug Name	Drug Tier	Requirements/Limits
NAMZARIC CAPSULE ER 24 HOUR THERAPY PACK	3	QL(56 EA per 365 days); ST; MO
Cholinesterase Inhibitors		
donepezil hcl tablet disintegrating	1	MO; GC
donepezil hcl tablet 10mg	1	MO; GC
donepezil hcl tablet 23mg	2	MO
donepezil hydrochloride tablet 5mg	1	MO; GC
galantamine hydrobromide er	2	MO
galantamine hydrobromide solution	3	MO
galantamine hydrobromide tablet 4mg, 8mg	1	MO; GC
galantamine hydrobromide tablet 12mg	2	MO
rivastigmine tartrate	1	MO; GC
RIVASTIGMINE TRANSDERMAL SYSTEM	2	MO
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hcl titration pak	1	MO; GC
MEMANTINE HYDROCHLORIDE ER	2	QL(30 EA per 30 days); MO
memantine hydrochloride solution, tablet	1	MO; GC
NAMENDA XR TITRATION PACK	2	QL(56 EA per 365 days); MO
Antidepressants		
Antidepressants, Other		
AUVELITY	3	QL(60 EA per 30 days); ST; MO
bupropion hcl tablet 100mg	1	MO; GC
bupropion hydrochloride er (sr) tablet extended release 12 hour 150mg, 200mg	1	QL(60 EA per 30 days); MO; GC
bupropion hydrochloride er (sr) tablet extended release 12 hour 100mg	1	QL(90 EA per 30 days); MO; GC
BUPROPION HYDROCHLORIDE ER (XL) TABLET EXTENDED RELEASE 24 HOUR 450MG	2	QL(30 EA per 30 days); MO
bupropion hydrochloride er (xl) tablet extended release 24 hour 300mg	1	QL(30 EA per 30 days); MO; GC
bupropion hydrochloride er (xl) tablet extended release 24 hour 150mg	1	QL(90 EA per 30 days); MO; GC
bupropion hydrochloride tablet 75mg	1	MO; GC
chlordiazepoxide/amitriptyline	1	MO; GC
maprotiline hcl	1	MO; GC
mirtazapine odt	1	MO; GC
mirtazapine tablet	1	MO; GC
perphenazine/amitriptyline tablet 10mg; 2mg	1	MO; GC
perphenazine/amitriptyline tablet 10mg; 4mg, 25mg; 2mg, 25mg; 4mg, 50mg; 4mg	2	MO
ZURZUVAE CAPSULE 30MG	4	QL(14 EA per 14 days); PA
ZURZUVAE CAPSULE 20MG, 25MG	4	QL(28 EA per 14 days); PA

Drug Name	Drug Tier	Requirements/Limits
Monoamine Oxidase Inhibitors		
EMSAM	4	QL(30 EA per 30 days); ST
MARPLAN	3	MO
phenelzine sulfate	1	MO; GC
tranylcypromine sulfate	3	MO
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
citalopram hydrobromide solution, tablet	1	MO; GC
DESVENLAFAXINE ER TABLET EXTENDED RELEASE 24 HOUR 100MG	1	QL(120 EA per 30 days); ST; MO; GC
desvenlafaxine er tablet extended release 24 hour 100mg	1	QL(120 EA per 30 days); MO; GC
desvenlafaxine er tablet extended release 24 hour 25mg, 50mg	1	QL(30 EA per 30 days); MO; GC
desvenlafaxine er tablet extended release 24 hour 50mg	1	QL(30 EA per 30 days); ST; MO; GC
DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 20MG, 60MG	3	QL(60 EA per 30 days); MO
DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 30MG, 40MG	3	QL(90 EA per 30 days); MO
duloxetine hcl capsule delayed release particles 40mg	1	QL(90 EA per 30 days); MO; GC
duloxetine hydrochloride capsule delayed release particles 20mg, 60mg	1	QL(60 EA per 30 days); MO; GC
duloxetine hydrochloride capsule delayed release particles 30mg	1	QL(90 EA per 30 days); MO; GC
escitalopram oxalate solution, tablet	1	MO; GC
FETZIMA	3	QL(30 EA per 30 days); ST; MO
FETZIMA TITRATION PACK	3	QL(56 EA per 365 days); ST; MO
fluoxetine dr	3	MO
fluoxetine hydrochloride capsule, solution	1	MO; GC
fluvoxamine maleate	1	MO; GC
nefazodone hydrochloride	3	MO
paroxetine hcl er tablet extended release 24 hour 12.5mg, 25mg	1	MO; GC
paroxetine hcl er tablet extended release 24 hour 37.5mg	2	MO
paroxetine hcl tablet 30mg, 40mg	1	MO; GC
paroxetine hydrochloride suspension	2	MO
paroxetine hydrochloride tablet 10mg, 20mg	1	MO; GC
sertraline hcl concentrate	1	MO; GC
sertraline hcl tablet 50mg	1	MO; GC
sertraline hydrochloride tablet 100mg, 25mg	1	MO; GC
trazodone hydrochloride	1	MO; GC
TRINTELLIX	3	QL(30 EA per 30 days); MO

Drug Name	Drug Tier	Requirements/Limits
VENLAFAXINE BESYLATE ER	3	ST; MO
VENLAFAXINE HCL ER TABLET EXTENDED RELEASE 24 HOUR 37.5MG	2	MO
venlafaxine hydrochloride	1	MO; GC
VENLAFAXINE HYDROCHLORIDE ER TABLET EXTENDED RELEASE 24 HOUR	2	MO
venlafaxine hydrochloride er capsule extended release 24 hour	1	MO; GC
VIIBRYD STARTER PACK	3	QL(60 EA per 365 days); MO
vilazodone hydrochloride	2	QL(30 EA per 30 days); MO
Tricyclics		
amitriptyline hcl tablet 100mg, 150mg, 25mg, 75mg	1	MO; GC
amitriptyline hydrochloride tablet 100mg, 10mg, 25mg, 50mg	1	MO; GC
amoxapine	1	MO; GC
clomipramine hydrochloride	3	MO
desipramine hydrochloride tablet 10mg, 25mg	1	MO; GC
desipramine hydrochloride tablet 100mg, 150mg, 50mg, 75mg	2	MO
doxepin hcl capsule 75mg	1	MO; GC
doxepin hcl concentrate	1	MO; GC
doxepin hydrochloride capsule 100mg, 10mg, 150mg, 25mg, 50mg	1	MO; GC
imipramine hcl tablet 25mg, 50mg	1	MO; GC
imipramine hydrochloride tablet 10mg	1	MO; GC
imipramine pamoate	1	MO; GC
nortriptyline hcl capsule 25mg, 75mg	1	MO; GC
nortriptyline hcl solution	1	MO; GC
nortriptyline hydrochloride capsule 10mg, 50mg	1	MO; GC
protriptyline hcl	1	MO; GC
trimipramine maleate capsule	3	MO
Antiemetics		
Antiemetics, Other		
compro	1	MO; GC
meclizine hcl tablet	1	MO; GC
PROCHLORPERAZINE EDISYLATE INJECTION 10MG/2ML	2	MO
prochlorperazine maleate tablet	1	MO; GC
prochlorperazine suppository 25mg	1	MO; GC
promethazine hcl suppository 12.5mg, 25mg	1	MO; GC
promethazine hcl tablet 12.5mg	1	MO; GC
promethazine hydrochloride plain	1	MO; GC
promethazine hydrochloride tablet 25mg, 50mg	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
promethegan	1	MO; GC
scopolamine	2	MO
trimethobenzamide hydrochloride	1	B/D; MO; GC
Emetogenic Therapy Adjuncts		
AKYNZEO INJECTION 235MG/20ML; 0.25MG/20ML	3	MO
aprepitant capsule 40mg	2	QL(1 EA per 30 days); B/D; MO
aprepitant capsule 125mg	2	QL(2 EA per 30 days); B/D; MO
aprepitant capsule 0	2	QL(6 EA per 30 days); B/D; MO
aprepitant capsule 80mg	2	QL(8 EA per 30 days); B/D; MO
dronabinol	3	QL(60 EA per 30 days); PA; MO
EMEND SUSPENSION RECONSTITUTED	3	QL(6 EA per 30 days); B/D; MO
granisetron hydrochloride tablet	2	QL(30 EA per 30 days); B/D; MO
ondansetron hcl solution	1	QL(450 ML per 30 days); B/D; MO; GC
ondansetron hcl tablet 24mg	1	QL(14 EA per 28 days); B/D; MO; GC
ondansetron hydrochloride tablet	1	B/D; MO; GC
ONDANSETRON HYDROCHLORIDE INJECTION 4MG/2ML	2	MO
ondansetron odt	1	B/D; MO; GC
SANCUSO	4	QL(2 EA per 30 days)
Antifungals		
Antifungals		
ABELCET	3	B/D; MO
AMBISOME	4	B/D
amphotericin b liposome	4	B/D
amphotericin b injection	3	B/D; MO
caspofungin acetate injection 70mg	3	MO
caspofungin acetate injection 50mg	4	
clotrimazole cream, solution, troche	1	MO; GC
econazole nitrate cream	1	MO; GC
ERAXIS	4	
fluconazole in sodium chloride	1	MO; GC
fluconazole suspension reconstituted, tablet	1	MO; GC
flucytosine capsule	4	
griseofulvin microsize suspension	1	MO; GC
griseofulvin microsize tablet	3	MO
griseofulvin ultramicrosize tablet 125mg, 250mg	3	MO
itraconazole capsule	3	PA; MO
itraconazole solution	4	PA
ketoconazole shampoo, tablet	1	MO; GC
ketoconazole cream	1	QL(90 GM per 30 days); MO; GC
ketoconazole foam	3	MO

Drug Name	Drug Tier	Requirements/Limits
ketodan	3	MO
klayesta	1	QL(120 GM per 30 days); MO; GC
micafungin	4	
miconazole 3 suppository	1	MO; GC
naftifine hcl	3	MO
NAFTIFINE HYDROCHLORIDE GEL 1%	2	MO
NOXAFIL SUSPENSION	4	PA
nyamyc	1	QL(120 GM per 30 days); MO; GC
nystatin cream, ointment, suspension, tablet	1	MO; GC
nystatin powder	1	QL(120 GM per 30 days); MO; GC
nystop	1	QL(120 GM per 30 days); MO; GC
oxiconazole nitrate	1	QL(90 GM per 30 days); MO; GC
posaconazole dr	4	PA
posaconazole suspension	4	PA
terbinafine hcl tablet	1	QL(84 EA per 180 days); MO; GC
terconazole	1	MO; GC
voriconazole tablet	3	MO
voriconazole suspension reconstituted	4	
voriconazole injection	4	PA
Antigout Agents		
Antigout Agents		
allopurinol tablet 100mg, 300mg	1	MO; GC
COLCHICINE TABLET 0.6MG	2	MO
FEBUXOSTAT	2	MO
probenecid/colchicine	1	MO; GC
probenecid tablet	1	MO; GC
Antimigraine Agents		
Ergot Alkaloids		
dihydroergotamine mesylate solution	3	QL(8 ML per 30 days); PA; MO
ergotamine tartrate/caffeine	2	QL(24 EA per 28 days); MO
MIGERGOT	4	QL(20 EA per 28 days)
Prophylactic		
EMGALITY INJECTION 120MG/ML	3	QL(2 ML per 28 days); PA; MO
EMGALITY INJECTION 100MG/ML	3	QL(3 ML per 28 days); PA; MO
timolol maleate tablet 10mg, 20mg, 5mg	1	MO; GC
UBRELVY	4	QL(16 EA per 30 days); PA
Serotonin (5-HT) Receptor Agonist		
naratriptan hcl	1	QL(9 EA per 30 days); MO; GC
REYVOW TABLET 50MG	3	QL(4 EA per 30 days); PA; MO
REYVOW TABLET 100MG	3	QL(8 EA per 30 days); PA; MO
rizatriptan benzoate	1	QL(18 EA per 30 days); MO; GC

Drug Name	Drug Tier	Requirements/Limits
rizatriptan benzoate odt	1	QL(18 EA per 30 days); MO; GC
sumatriptan succinate refill	3	QL(5 ML per 30 days); MO
sumatriptan succinate tablet	1	QL(9 EA per 30 days); MO; GC
sumatriptan succinate injection	3	QL(5 ML per 30 days); MO
sumatriptan solution	3	QL(12 EA per 30 days); MO
zolmitriptan odt tablet disintegrating 2.5mg	2	QL(12 EA per 30 days); MO
zolmitriptan odt tablet disintegrating 5mg	2	QL(9 EA per 30 days); MO
zolmitriptan tablet	2	QL(12 EA per 30 days); MO
ZOLMITRIPTAN SOLUTION 2.5MG	3	MO
Antimyasthenic Agents		
Parasympathomimetics		
pyridostigmine bromide er	3	MO
pyridostigmine bromide solution	3	MO
pyridostigmine bromide tablet 60mg	1	MO; GC
Antimycobacterials		
Antimycobacterials, Other		
dapsone tablet 100mg	1	MO; GC
dapsone tablet 25mg	2	MO
rifabutin	1	MO; GC
Antituberculars		
CAPASTAT SULFATE	4	
cycloserine	4	
ethambutol hydrochloride	1	MO; GC
ISONIAZID INJECTION	2	MO
isoniazid tablet	1	MO; GC
isoniazid syrup	3	MO
PASER	3	MO
PRIFTIN	3	MO
pyrazinamide tablet	2	MO
rifampin capsule 300mg	1	MO; GC
rifampin capsule 150mg	2	MO
rifampin injection	3	MO
SIRTURO	4	
TRECATOR	3	MO
Antineoplastics		
Alkylating Agents		
CYCLOPHOSPHAMIDE CAPSULE, TABLET	2	B/D; MO
CYCLOPHOSPHAMIDE INJECTION 1GM/5ML	3	MO
CYCLOPHOSPHAMIDE INJECTION 500MG/2.5ML	4	
GLEOSTINE CAPSULE 100MG, 10MG, 40MG	3	MO
LEUKERAN	4	

Drug Name	Drug Tier	Requirements/Limits
MATULANE	4	
VALCHLOR	4	PA
ZEPZELCA	4	PA
Antiandrogens		
abiraterone acetate tablet 250mg	3	PA; MO
abiraterone acetate tablet 500mg	4	PA
bicalutamide	1	MO; GC
ERLEADA	4	PA
flutamide	1	MO; GC
nilutamide	4	
NUBEQA	4	PA
XTANDI	4	PA
Antiangiogenic Agents		
FOTIVDA	4	PA
lenalidomide	4	PA
POMALYST	4	PA
QINLOCK	4	PA
TABRECTA	4	QL(120 EA per 30 days); PA
THALOMID	4	PA
Antiestrogens/Modifiers		
EMCYT	4	
SOLTAMOX	4	
tamoxifen citrate tablet	1	MO; GC
toremifene citrate	4	
Antimetabolites		
hydroxyurea capsule	1	MO; GC
mercaptopurine tablet	1	MO; GC
nelarabine	4	
PURIXAN	4	
TABLOID	3	MO
Antineoplastics, Other		
AKEEGA	4	PA
ASPARLAS	4	
BESREMI	4	PA
GAVRETO	4	PA
IBRANCE TABLET 100MG, 125MG, 75MG	4	PA
IDHIFA	4	QL(30 EA per 30 days); PA
INREBIC	4	PA
IWILFIN	4	PA
KISQALI FEMARA 200 DOSE	4	PA
KISQALI FEMARA 400 DOSE	4	PA

Drug Name	Drug Tier	Requirements/Limits
KISQALI FEMARA 600 DOSE	4	PA
KRAZATI	4	PA
LONSURF	4	PA
LUMAKRAS	4	PA
LYTGOBI	4	PA
NINLARO	4	PA
OGSIVEO	4	PA
ONUREG	4	PA
ORSERDU	4	PA
PEMAZYRE	4	QL(30 EA per 30 days); PA
RETEVMO	4	PA
ROMIDEPSIN INJECTION 27.5MG/5.5ML	4	PA
SCEMBLIX TABLET 40MG	4	PA
SCEMBLIX TABLET 20MG	4	QL(60 EA per 30 days); PA
SYNRIBO	4	PA
TAZVERIK	4	PA
TICE BCG	3	MO
TRUSELTIQ	4	PA
TUKYSA	4	PA
VONJO	4	PA
XPOVIO	4	PA
XPOVIO 100 MG ONCE WEEKLY	4	PA
XPOVIO 40 MG ONCE WEEKLY	4	PA
XPOVIO 40 MG TWICE WEEKLY	4	PA
XPOVIO 60 MG ONCE WEEKLY	4	PA
XPOVIO 60 MG TWICE WEEKLY	4	PA
XPOVIO 80 MG ONCE WEEKLY	4	PA
XPOVIO 80 MG TWICE WEEKLY	4	PA
ZOLINZA	4	PA
Aromatase Inhibitors, 3rd Generation		
anastrozole tablet	1	MO; GC
exemestane	3	MO
letrozole	1	MO; GC
Molecular Target Inhibitors		
ALECENSA	4	PA
ALUNBRIG TABLET THERAPY PACK	4	QL(60 EA per 365 days); PA
ALUNBRIG TABLET 30MG	4	QL(120 EA per 30 days); PA
ALUNBRIG TABLET 180MG, 90MG	4	QL(30 EA per 30 days); PA
AYVAKIT	4	QL(30 EA per 30 days); PA
BALVERSA	4	PA
BOSULIF	4	PA

Drug Name	Drug Tier	Requirements/Limits
BRAFTOVI CAPSULE 75MG	4	PA
BRUKINSA	4	PA
CABOMETYX	4	PA
CALQUENCE	4	PA
CAPRELSA TABLET 300MG	4	PA
CAPRELSA TABLET 100MG	4	QL(60 EA per 30 days); PA
COMETRIQ	4	PA
COPIKTRA	4	PA
COTELLIC	4	PA
DAURISMO	4	PA
ERIVEDGE	4	PA
erlotinib hydrochloride tablet 100mg, 25mg	3	PA; MO
erlotinib hydrochloride tablet 150mg	4	PA
everolimus tablet soluble 2mg, 3mg, 5mg	4	PA
everolimus tablet 10mg, 2.5mg, 5mg, 7.5mg	4	QL(30 EA per 30 days); PA
EXKIVITY	4	
FARYDAK	4	
FRUZAQLA	4	PA
gefitinib	4	PA
GILOTRIF	4	QL(30 EA per 30 days); PA
IBRANCE CAPSULE 100MG, 125MG, 75MG	4	PA
ICLUSIG TABLET 30MG, 45MG	4	PA
ICLUSIG TABLET 10MG, 15MG	4	QL(30 EA per 30 days); PA
imatinib mesylate	2	PA; MO
IMBRUVICA	4	PA
INLYTA	4	PA
INQOVI	4	PA
JAKAFI TABLET 15MG, 20MG, 25MG, 5MG	4	PA
JAKAFI TABLET 10MG	4	QL(60 EA per 30 days); PA
JAYPIRCA TABLET 100MG	4	PA
JAYPIRCA TABLET 50MG	4	QL(30 EA per 30 days); PA
KISQALI	4	PA
KOSELUGO	4	PA
lapatinib ditosylate	4	PA
LENVIMA 10 MG DAILY DOSE	4	PA
LENVIMA 12MG DAILY DOSE	4	PA
LENVIMA 14 MG DAILY DOSE	4	PA
LENVIMA 18 MG DAILY DOSE	4	PA
LENVIMA 20 MG DAILY DOSE	4	PA
LENVIMA 24 MG DAILY DOSE	4	PA
LENVIMA 4 MG DAILY DOSE	4	PA

Drug Name	Drug Tier	Requirements/Limits
LENVIMA 8 MG DAILY DOSE	4	PA
LORBRENA	4	PA
LYNPARZA TABLET	4	PA
MEKINIST	4	PA
MEKTOVI	4	PA
NERLYNX	4	QL(180 EA per 30 days); PA
ODOMZO	4	PA
OJJAARA	4	PA
PAZOPANIB HYDROCHLORIDE	4	PA
PIQRAY 200MG DAILY DOSE	4	PA
PIQRAY 250MG DAILY DOSE	4	PA
PIQRAY 300MG DAILY DOSE	4	PA
REZLIDHIA	4	PA
ROZLYTREK CAPSULE	4	PA
RUBRACA	4	PA
RYDAPT	4	PA
sorafenib	4	PA
sorafenib tosylate	4	PA
SPRYCEL	4	PA
STIVARGA	4	PA
sunitinib malate	4	PA
TAFINLAR	4	PA
TAGRISSO TABLET 80MG	4	PA
TAGRISSO TABLET 40MG	4	QL(30 EA per 30 days); PA
TALZENNA	4	PA
TASIGNA	4	PA
TEPMETKO	4	PA
TIBSOVO	4	PA
TRUQAP	4	PA
TURALIO	4	PA
UKONIQ	4	
VANFLYTA	4	PA
VENCLEXTA STARTING PACK	4	PA
VENCLEXTA TABLET 10MG	2	PA; MO
VENCLEXTA TABLET 100MG, 50MG	4	PA
VERZENIO	4	PA
VITRAKVI	4	PA
VIZIMPRO	4	PA
VOTRIENT	4	PA
WELIREG	4	PA
XALKORI	4	PA

Drug Name	Drug Tier	Requirements/Limits
XOSPATA	4	PA
ZEJULA CAPSULE	4	PA
ZEJULA TABLET 200MG, 300MG	4	PA
ZEJULA TABLET 100MG	4	QL(30 EA per 30 days); PA
ZELBORAF	4	PA
ZYDELIG	4	PA
ZYKADIA TABLET	4	PA
Monoclonal Antibody/Antibody-Drug Conjugate		
AVASTIN	4	PA
DANYELZA	4	PA
JEMPERLI	4	PA
PADCEV INJECTION 20MG	4	PA
POLIVY	4	PA
RUXIENCE	4	PA
SARCLISA	4	PA
TRUXIMA	4	PA
Retinoids		
bexarotene	4	PA
PANRETIN	4	
tretinoin capsule 10mg	4	
Treatment Adjuncts		
ELITEK	4	
leucovorin calcium tablet 10mg, 5mg	1	MO; GC
leucovorin calcium tablet 15mg, 25mg	2	MO
MESNEX TABLET	4	
Antiparasitics		
Anthelmintics		
albendazole tablet	4	
ivermectin tablet 3mg	1	PA; MO; GC
PRAZIQUANTEL TABLET	2	MO
Antiprotozoals		
ALINIA SUSPENSION RECONSTITUTED	3	MO
atovaquone	3	MO
atovaquone/proguanil hcl	2	MO
BENZNIDAZOLE	2	MO
chloroquine phosphate tablet	1	MO; GC
COARTEM	3	MO
hydroxychloroquine sulfate tablet 200mg	1	MO; GC
hydroxychloroquine sulfate tablet 100mg	2	MO
mefloquine hcl	1	MO; GC
nitazoxanide	4	

Drug Name	Drug Tier	Requirements/Limits
pentamidine isethionate inhalation solution reconstituted	2	B/D; MO
pentamidine isethionate injection	3	MO
primaquine phosphate tablet	3	MO
pyrimethamine tablet	4	PA
quinine sulfate capsule 324mg	2	PA; MO
Antiparkinson Agents		
Anticholinergics		
benztropine mesylate tablet	1	MO; GC
trihexyphenidyl hcl solution	3	MO
trihexyphenidyl hydrochloride	1	MO; GC
Antiparkinson Agents, Other		
CARBIDOPA/LEVODOPA/ENTACAPONE TABLET 12.5MG; 200MG; 50MG, 18.75MG; 200MG; 75MG	3	MO
carbidopa/levodopa/entacapone tablet 25mg; 200mg; 100mg, 31.25mg; 200mg; 125mg, 37.5mg; 200mg; 150mg, 50mg; 200mg; 200mg	3	MO
entacapone	2	MO
tolcapone	4	QL(180 EA per 30 days)
Dopamine Agonists		
apomorphine hydrochloride injection	4	QL(90 ML per 30 days); PA
BROMOCRIPTINE MESYLATE TABLET	2	MO
bromocriptine mesylate capsule	3	MO
NEUPRO	3	MO
pramipexole dihydrochloride	1	MO; GC
pramipexole dihydrochloride er	3	MO
ropinirole er tablet extended release 24 hour 2mg	1	MO; GC
ropinirole er tablet extended release 24 hour 12mg, 4mg, 6mg, 8mg	2	MO
ropinirole hcl tablet 0.5mg, 1mg, 2mg, 4mg, 5mg	1	MO; GC
ropinirole hydrochloride tablet 0.25mg, 3mg	1	MO; GC
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	1	MO; GC
carbidopa/levodopa er	1	MO; GC
carbidopa/levodopa odt tablet disintegrating 10mg; 100mg	1	MO; GC
carbidopa/levodopa odt tablet disintegrating 25mg; 100mg, 25mg; 250mg	2	MO
carbidopa tablet	3	MO
RYTARY	3	ST; MO
Monoamine Oxidase B (MAO-B) Inhibitors		
rasagiline mesylate tablet	2	MO

Drug Name	Drug Tier	Requirements/Limits
selegiline hcl capsule, tablet	1	MO; GC
Antipsychotics		
1st Generation/Typical		
chlorpromazine hcl tablet	3	MO
chlorpromazine hydrochloride concentrate, tablet	3	MO
fluphenazine decanoate injection	1	MO; GC
fluphenazine hcl concentrate	1	MO; GC
fluphenazine hcl injection	2	MO
fluphenazine hcl tablet 1mg	1	MO; GC
fluphenazine hydrochloride elixir	1	MO; GC
fluphenazine hydrochloride tablet 10mg, 2.5mg, 5mg	1	MO; GC
haloperidol decanoate injection	1	MO; GC
haloperidol lactate	1	MO; GC
haloperidol concentrate, tablet	1	MO; GC
loxapine	1	MO; GC
molindone hydrochloride	3	MO
perphenazine tablet 2mg, 4mg, 8mg	1	MO; GC
perphenazine tablet 16mg	2	MO
pimozide	3	MO
thioridazine hcl tablet 100mg, 10mg, 25mg, 50mg	1	MO; GC
thiothixene capsule 10mg, 1mg, 2mg, 5mg	1	MO; GC
trifluoperazine hcl tablet 10mg, 2mg, 5mg	1	MO; GC
trifluoperazine hydrochloride tablet 1mg	1	MO; GC
2nd Generation/Atypical		
ABILIFY MAINTENA	4	
aripiprazole odt	4	QL(60 EA per 30 days)
aripiprazole solution	2	QL(750 ML per 30 days); MO
aripiprazole tablet 2mg, 5mg	1	QL(30 EA per 30 days); MO; GC
aripiprazole tablet 10mg, 15mg, 20mg, 30mg	3	QL(30 EA per 30 days); MO
ARISTADA	4	
ARISTADA INITIO	4	
asenapine maleate sl	1	QL(60 EA per 30 days); MO; GC
CAPLYTA	4	QL(30 EA per 30 days); PA
FANAPT	4	QL(60 EA per 30 days); ST
FANAPT TITRATION PACK	3	QL(8 EA per 180 days); ST; MO
INVEGA HAFYERA	4	ST
INVEGA SUSTENNA INJECTION 39MG/0.25ML	3	MO
INVEGA SUSTENNA INJECTION 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	4	
INVEGA TRINZA	4	
lurasidone hydrochloride tablet 120mg, 20mg, 40mg, 60mg	3	QL(30 EA per 30 days); MO

Drug Name	Drug Tier	Requirements/Limits
lurasidone hydrochloride tablet 80mg	3	QL(60 EA per 30 days); MO
LYBALVI	4	QL(30 EA per 30 days); ST
NUPLAZID CAPSULE	4	PA
NUPLAZID TABLET 10MG	4	PA
olanzapine odt	1	QL(30 EA per 30 days); MO; GC
olanzapine tablet	1	QL(30 EA per 30 days); MO; GC
olanzapine injection	2	MO
paliperidone er tablet extended release 24 hour 1.5mg, 3mg, 9mg	3	QL(30 EA per 30 days); MO
paliperidone er tablet extended release 24 hour 6mg	3	QL(60 EA per 30 days); MO
PERSERIS	4	
quetiapine fumarate er tablet extended release 24 hour 150mg, 50mg	1	QL(60 EA per 30 days); MO; GC
quetiapine fumarate er tablet extended release 24 hour 200mg	1	QL(90 EA per 30 days); MO; GC
quetiapine fumarate er tablet extended release 24 hour 300mg, 400mg	2	QL(60 EA per 30 days); MO
quetiapine fumarate tablet 300mg, 400mg	1	QL(60 EA per 30 days); MO; GC
quetiapine fumarate tablet 100mg, 150mg, 200mg, 25mg, 50mg	1	QL(90 EA per 30 days); MO; GC
REXULTI	4	QL(30 EA per 30 days)
RISPERDAL CONSTA INJECTION 12.5MG	3	MO
RISPERDAL CONSTA INJECTION 25MG, 37.5MG, 50MG	4	
risperidone er injection 12.5mg	3	MO
risperidone er injection 25mg, 37.5mg, 50mg	4	
risperidone odt	2	QL(60 EA per 30 days); MO
risperidone solution	1	QL(240 ML per 30 days); MO; GC
risperidone tablet	1	QL(60 EA per 30 days); MO; GC
SECUADO	4	QL(30 EA per 30 days); ST
VRAYLAR CAPSULE THERAPY PACK	3	QL(14 EA per 365 days); MO
VRAYLAR CAPSULE	4	QL(30 EA per 30 days); ST
ziprasidone hcl	1	QL(60 EA per 30 days); MO; GC
ZIPRASIDONE MESYLATE	2	QL(60 EA per 30 days); MO
ZYPREXA RELPREVV INJECTION 210MG	3	MO
Treatment-Resistant		
clozapine odt tablet disintegrating 150mg	3	QL(180 EA per 30 days); MO
clozapine odt tablet disintegrating 100mg, 25mg	3	QL(270 EA per 30 days); MO
clozapine odt tablet disintegrating 12.5mg	3	QL(90 EA per 30 days); MO
clozapine odt tablet disintegrating 200mg	4	QL(120 EA per 30 days)
clozapine tablet 50mg	1	QL(180 EA per 30 days); MO; GC
clozapine tablet 25mg	1	QL(270 EA per 30 days); MO; GC

Drug Name	Drug Tier	Requirements/Limits
clozapine tablet 200mg	2	QL(120 EA per 30 days); MO
clozapine tablet 100mg	2	QL(270 EA per 30 days); MO
VERSACLOZ	4	QL(540 ML per 30 days)
Antispasticity Agents		
Antispasticity Agents		
baclofen tablet	1	MO; GC
dantrolene sodium capsule	1	MO; GC
tizanidine hcl tablet 2mg	1	MO; GC
tizanidine hydrochloride tablet 4mg	1	MO; GC
Antivirals		
Anti-cytomegalovirus (CMV) Agents		
cidofovir	4	
ganciclovir injection 500mg/10ml, 500mg	1	B/D; MO; GC
LIVTENCITY	4	
PREVYMIS TABLET	4	
VALGANCICLOVIR	2	MO
valganciclovir hydrochloride	4	
Anti-hepatitis B (HBV) Agents		
adefovir dipivoxil	3	MO
BARACLUDE SOLUTION	3	QL(600 ML per 30 days); MO
entecavir	3	QL(30 EA per 30 days); MO
EPIVIR HBV SOLUTION	3	MO
lamivudine tablet 100mg	2	MO
Anti-hepatitis C (HCV) Agents		
ledipasvir/sofosbuvir	4	QL(168 EA per 365 days); PA
MAVYRET TABLET	4	QL(336 EA per 365 days); PA
MAVYRET PACKET	4	QL(560 EA per 365 days); PA
ribavirin capsule	1	MO; GC
ribavirin tablet 200mg	3	MO
sofosbuvir/velpatasvir	4	QL(84 EA per 365 days); PA
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
BIKTARVY	4	QL(30 EA per 30 days)
DOVATO	4	QL(30 EA per 30 days)
GENVOYA	4	QL(30 EA per 30 days)
ISENTRESS HD	4	
ISENTRESS PACKET, TABLET	4	
ISENTRESS TABLET CHEWABLE 25MG	2	MO
ISENTRESS TABLET CHEWABLE 100MG	4	
JULUCA	4	QL(30 EA per 30 days)
STRIBILD	4	QL(30 EA per 30 days)
TIVICAY PD	4	

Drug Name	Drug Tier	Requirements/Limits
TIVICAY TABLET 10MG	3	MO
TIVICAY TABLET 25MG, 50MG	4	
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
COMPLERA	4	QL(30 EA per 30 days)
DELSTRIGO	4	QL(30 EA per 30 days)
EDURANT	4	
efavirenz/emtricitabine/tenofovir disoproxil fumarate	3	QL(30 EA per 30 days); MO
efavirenz/lamivudine/tenofovir disoproxil fumarate	4	QL(30 EA per 30 days)
efavirenz capsule 50mg	2	MO
efavirenz capsule 200mg	3	MO
efavirenz tablet	3	MO
etravirine	4	
INTELENCE TABLET 25MG	3	MO
nevirapine er	3	MO
nevirapine tablet	1	MO; GC
nevirapine suspension	3	MO
PIFELTRO	4	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir	3	MO
abacavir sulfate/lamivudine	3	QL(30 EA per 30 days); MO
abacavir sulfate/lamivudine/zidovudine	4	QL(60 EA per 30 days)
CIMDUO	4	QL(30 EA per 30 days)
DESCOVY	4	QL(30 EA per 30 days)
emtricitabine	3	MO
emtricitabine/tenofovir disoproxil	4	QL(30 EA per 30 days)
emtricitabine/tenofovir disoproxil fumarate tablet 100mg; 150mg, 200mg; 300mg	3	QL(30 EA per 30 days); MO
emtricitabine/tenofovir disoproxil fumarate tablet 133mg; 200mg	4	QL(30 EA per 30 days)
EMTRIVA SOLUTION	3	MO
lamivudine/zidovudine	2	QL(60 EA per 30 days); MO
lamivudine solution 10mg/ml	1	MO; GC
lamivudine tablet 150mg, 300mg	2	MO
ODEFSEY	4	QL(30 EA per 30 days)
RETROVIR IV INFUSION	3	MO
TEMIXYS	4	QL(30 EA per 30 days)
tenofovir disoproxil fumarate	3	MO
TRIUMEQ	4	QL(30 EA per 30 days)
TRIUMEQ PD	4	QL(180 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
TRIZIVIR	4	QL(60 EA per 30 days)
VIREAD POWDER	4	
VIREAD TABLET 150MG, 200MG, 250MG	4	
zidovudine	1	MO; GC
Anti-HIV Agents, Other		
FUZEON	4	
maraviroc	4	
RUKOBIA	4	
SELZENTRY SOLUTION	4	
SELZENTRY TABLET 25MG	2	MO
SELZENTRY TABLET 75MG	4	
SUNLENCA TABLET THERAPY PACK	4	
TROGARZO	4	
TYBOST	2	MO
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS	4	
ATAZANAVIR	2	MO
ATAZANAVIR SULFATE CAPSULE 300MG	2	MO
CRIXIVAN CAPSULE 400MG	2	MO
darunavir	4	
EVOTAZ	4	QL(30 EA per 30 days)
fosamprenavir calcium	4	
INVIRASE TABLET	4	
LEXIVA SUSPENSION	3	MO
lopinavir/ritonavir	3	MO
NORVIR PACKET, SOLUTION	3	MO
PREZCOBIX	4	QL(30 EA per 30 days)
PREZISTA SUSPENSION	4	
PREZISTA TABLET 75MG	3	MO
PREZISTA TABLET 150MG	4	
REYATAZ PACKET	4	
ritonavir	3	MO
SYMTUZA	4	QL(30 EA per 30 days)
VIRACEPT	4	
Anti-influenza Agents		
amantadine hcl capsule, solution, tablet	1	MO; GC
oseltamivir phosphate capsule 75mg	1	QL(110 EA per 365 days); MO; GC
oseltamivir phosphate capsule 30mg	1	QL(168 EA per 365 days); MO; GC
oseltamivir phosphate capsule 45mg	1	QL(84 EA per 365 days); MO; GC
oseltamivir phosphate suspension reconstituted	2	QL(1080 ML per 365 days); MO
RELENZA DISKHALER	3	QL(240 EA per 365 days); MO

Drug Name	Drug Tier	Requirements/Limits
rimantadine hydrochloride	1	MO; GC
XOFLUZA TABLET THERAPY PACK 80MG	3	QL(2 EA per 365 days); MO
XOFLUZA TABLET THERAPY PACK 40MG	3	QL(4 EA per 365 days); MO
Antiherpetic Agents		
acyclovir sodium injection 50mg/ml	3	B/D; MO
acyclovir capsule 200mg	1	MO; GC
acyclovir suspension 200mg/5ml	3	MO
acyclovir tablet 400mg, 800mg	1	MO; GC
famciclovir tablet	1	MO; GC
valacyclovir hydrochloride	1	QL(120 EA per 30 days); MO; GC
Anxiolytics		
Anxiolytics, Other		
buspirone hcl tablet 15mg	1	MO; GC
buspirone hydrochloride tablet 10mg, 30mg, 5mg, 7.5mg	1	MO; GC
hydroxyzine pamoate capsule	1	MO; GC
Benzodiazepines		
alprazolam er tablet extended release 24 hour 2mg	1	QL(150 EA per 30 days); MO; GC
alprazolam er tablet extended release 24 hour 0.5mg, 1mg	1	QL(30 EA per 30 days); MO; GC
alprazolam er tablet extended release 24 hour 3mg	1	QL(90 EA per 30 days); MO; GC
alprazolam odt tablet disintegrating 0.25mg, 0.5mg, 1mg	1	QL(120 EA per 30 days); MO; GC
alprazolam odt tablet disintegrating 2mg	1	QL(150 EA per 30 days); MO; GC
alprazolam tablet 0.25mg, 0.5mg, 1mg	1	QL(120 EA per 30 days); MO; GC
alprazolam tablet 2mg	1	QL(150 EA per 30 days); MO; GC
chlordiazepoxide hcl capsule 5mg	1	QL(120 EA per 30 days); MO; GC
chlordiazepoxide hcl capsule 10mg	1	QL(900 EA per 30 days); MO; GC
chlordiazepoxide hydrochloride capsule 25mg	1	QL(360 EA per 30 days); MO; GC
clorazepate dipotassium tablet 15mg	1	QL(180 EA per 30 days); MO; GC
clorazepate dipotassium tablet 7.5mg	1	QL(360 EA per 30 days); MO; GC
clorazepate dipotassium tablet 3.75mg	1	QL(720 EA per 30 days); MO; GC
diazepam intensol	1	MO; GC
diazepam concentrate, oral solution	1	MO; GC
DIAZEPAM INJECTION 5MG/ML	2	MO
diazepam tablet 10mg	1	QL(120 EA per 30 days); MO; GC
diazepam tablet 5mg	1	QL(240 EA per 30 days); MO; GC
diazepam tablet 2mg	1	QL(300 EA per 30 days); MO; GC
lorazepam intensol	1	MO; GC
lorazepam tablet 2mg	1	QL(150 EA per 30 days); MO; GC
lorazepam tablet 0.5mg, 1mg	1	QL(90 EA per 30 days); MO; GC
oxazepam	1	QL(120 EA per 30 days); MO; GC
Bipolar Agents		
Mood Stabilizers		

Drug Name	Drug Tier	Requirements/Limits
lithium	2	
lithium carbonate er	1	MO; GC
lithium carbonate capsule, tablet	1	MO; GC
valproic acid capsule, solution	1	MO; GC
Blood Glucose Regulators		
Antidiabetic Agents		
acarbose tablet	1	MO; GC
CYCLOSET	3	MO
FARXIGA	2	MO
glimepiride	1	MO; GC
glipizide er	1	MO; GC
glipizide/metformin hydrochloride	1	MO; GC
glipizide tablet	1	MO; GC
glyburide micronized	1	MO; GC
glyburide/metformin hydrochloride	1	MO; GC
glyburide tablet 1.25mg, 2.5mg, 5mg	1	MO; GC
JANUMET	2	MO
JANUMET XR	2	MO
JANUVIA	2	QL(30 EA per 30 days); MO
JARDIANCE	2	MO
JENTADUETO	2	MO
JENTADUETO XR	2	MO
metformin hydrochloride er tablet extended release 24 hour 500mg, 750mg	1	MO; GC
metformin hydrochloride solution	3	MO
metformin hydrochloride tablet 1000mg, 500mg, 850mg	1	MO; GC
miglitol	3	MO
nateglinide	1	MO; GC
OZEMPIC INJECTION 2MG/1.5ML	2	QL(1.5 ML per 28 days); PA; MO
OZEMPIC INJECTION 2MG/1.5ML, 2MG/3ML, 4MG/3ML, 8MG/3ML	2	QL(3 ML per 28 days); PA; MO
pioglitazone hcl-glimepiride	1	MO; GC
pioglitazone hcl/metformin hcl	1	MO; GC
pioglitazone hcl tablet 45mg	1	MO; GC
pioglitazone hydrochloride tablet 15mg, 30mg	1	MO; GC
repaglinide	1	MO; GC
SYMLINPEN 120	4	PA
SYMLINPEN 60	4	PA
SYNJARDY	2	MO
SYNJARDY XR	2	MO
tolbutamide	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
TRADJENTA	2	QL(30 EA per 30 days); MO
TRULICITY	2	QL(2 ML per 28 days); PA; MO
VICTOZA	2	QL(9 ML per 30 days); PA; MO
XIGDUO XR	2	MO
Glycemic Agents		
BAQSIMI ONE PACK	2	MO
BAQSIMI TWO PACK	2	MO
diazoxide suspension	3	MO
GLUCAGON EMERGENCY KIT	2	MO
GLUCAGON EMERGENCY KIT FOR LOW BLOOD SUGAR INJECTION 1MG	2	MO
Insulins		
HUMALOG	2	MO
HUMALOG JUNIOR KWIKPEN	2	MO
HUMALOG KWIKPEN	2	MO
HUMALOG MIX 50/50	2	MO
HUMALOG MIX 50/50 KWIKPEN	2	MO
HUMALOG MIX 75/25	2	MO
HUMALOG MIX 75/25 KWIKPEN	2	MO
HUMULIN 70/30	2	MO
HUMULIN 70/30 KWIKPEN	2	MO
HUMULIN N	2	MO
HUMULIN N KWIKPEN	2	MO
HUMULIN R	2	MO
HUMULIN R U-500 (CONCENTRATED)	2	MO
HUMULIN R U-500 KWIKPEN	2	MO
INSULIN ASPART	2	MO
INSULIN ASPART FLEXPEN	2	MO
INSULIN ASPART PENFILL	2	MO
INSULIN ASPART PROTAMINE/INSULIN ASPART	2	MO
INSULIN ASPART PROTAMINE/INSULIN ASPART FLEXPEN	2	MO
INSULIN LISPRO	2	MO
INSULIN LISPRO JUNIOR KWIKPEN	2	MO
INSULIN LISPRO KWIKPEN	2	MO
INSULIN LISPRO PROTAMINE/INSULIN LISPRO KWIKPEN	2	MO
LANTUS	2	MO
LANTUS SOLOSTAR	2	MO
LEVEMIR	2	MO
LEVEMIR FLEXPEN	2	MO
NOVOLIN 70/30	2	MO
NOVOLIN 70/30 FLEXPEN	2	MO

Drug Name	Drug Tier	Requirements/Limits
novolin 70/30 flexpen relion	1	MO; GC
novolin 70/30 relion	1	MO; GC
NOVOLIN N	2	MO
NOVOLIN N FLEXPEN	2	MO
novolin n flexpen relion	1	MO; GC
novolin n relion	1	MO; GC
NOVOLIN R	2	MO
NOVOLIN R FLEXPEN	2	MO
novolin r flexpen relion	1	MO; GC
novolin r relion	1	MO; GC
NOVOLOG	2	MO
NOVOLOG FLEXPEN	2	MO
novolog flexpen relion	1	MO; GC
NOVOLOG MIX 70/30	2	MO
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	2	MO
novolog mix 70/30 prefilled flexpen relion	1	MO; GC
novolog mix 70/30 relion	1	MO; GC
NOVOLOG PENFILL	2	MO
novolog relion	1	MO; GC
TOUJEO MAX SOLOSTAR	2	MO
TOUJEO SOLOSTAR	2	MO
TRESIBA	2	MO
TRESIBA FLEXTOUCH	2	MO
Blood Products and Modifiers		
Anticoagulants		
dabigatran etexilate capsule 150mg, 75mg	1	QL(60 EA per 30 days); MO; GC
ELIQUIS STARTER PACK	2	QL(148 EA per 365 days); MO
ELIQUIS TABLET 2.5MG	2	QL(60 EA per 30 days); MO
ELIQUIS TABLET 5MG	2	QL(90 EA per 30 days); MO
ENOXAPARIN SODIUM INJECTION 100MG/ML, 120MG/0.8ML, 150MG/ML, 30MG/0.3ML, 40MG/0.4ML, 60MG/0.6ML, 80MG/0.8ML	2	MO
fondaparinux sodium injection 2.5mg/0.5ml	3	MO
fondaparinux sodium injection 10mg/0.8ml, 5mg/0.4ml, 7.5mg/0.6ml	4	
FRAGMIN INJECTION 2500UNIT/0.2ML	3	MO
FRAGMIN INJECTION 10000UNIT/ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNT/0.72ML, 5000UNIT/0.2ML, 7500UNIT/0.3ML, 95000UNIT/3.8ML	4	
heparin sodium injection 1000unit/ml, 5000unit/ml	1	MO; GC
heparin sodium injection 10000unit/ml, 20000unit/ml	2	MO

Drug Name	Drug Tier	Requirements/Limits
jantoven	1	MO; GC
warfarin sodium tablet	1	MO; GC
XARELTO STARTER PACK	2	QL(102 EA per 365 days); MO
XARELTO TABLET 10MG, 20MG	2	QL(30 EA per 30 days); MO
XARELTO TABLET 15MG, 2.5MG	2	QL(60 EA per 30 days); MO
Blood Products and Modifiers, Other		
ADAKVEO	4	PA
anagrelide hydrochloride	2	MO
ARANESP ALBUMIN FREE INJECTION 10MCG/0.4ML, 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML	3	PA; MO
ARANESP ALBUMIN FREE INJECTION 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML	4	PA
FULPHILA	4	PA
NEULASTA	4	PA
NIVESTYM INJECTION 300MCG/0.5ML, 480MCG/0.8ML	4	ST
OXBRYTA TABLET SOLUBLE	4	QL(240 EA per 30 days); PA
PROCRIT INJECTION 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA; MO
PROCRIT INJECTION 20000UNIT/ML, 40000UNIT/ML	4	PA
PROMACTA	4	PA
PYRUKYND TAPER PACK	4	QL(30 EA per 30 days); PA
PYRUKYND TABLET 50MG	4	QL(120 EA per 30 days); PA
PYRUKYND TABLET 20MG, 5MG	4	QL(60 EA per 30 days); PA
REBLOZYL	4	PA
RETACRIT INJECTION 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA; MO
RETACRIT INJECTION 40000UNIT/ML	4	PA
UDENYCA	4	PA
ZARXIO	4	
Hemostasis Agents		
tranexamic acid tablet	2	MO
Platelet Modifying Agents		
ASPIRIN/DIPYRIDAMOLE	2	MO
ASPIRIN/DIPYRIDAMOLE ER	2	MO
BRILINTA	2	MO
CABLIVI	4	QL(30 EA per 30 days); PA
cilostazol	1	MO; GC
clopidogrel	1	MO; GC
dipyridamole tablet 25mg	1	MO; GC
dipyridamole tablet 75mg	2	MO

Drug Name	Drug Tier	Requirements/Limits
dipyridamole tablet 50mg	3	MO
PRASUGREL	2	MO
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hcl patch weekly 0.1mg/24hr	1	MO; GC
clonidine hcl patch weekly 0.2mg/24hr, 0.3mg/24hr	2	MO
clonidine hydrochloride tablet	1	MO; GC
droxidopa	4	PA
guanfacine hydrochloride tablet 1mg, 2mg	3	MO
methyldopa tablet 250mg, 500mg	1	MO; GC
midodrine hcl tablet 2.5mg, 5mg	1	MO; GC
midodrine hcl tablet 10mg	2	MO
Alpha-adrenergic Blocking Agents		
doxazosin mesylate tablet	1	MO; GC
prazosin hydrochloride capsule	1	MO; GC
terazosin hcl capsule 10mg, 1mg, 5mg	1	MO; GC
terazosin hydrochloride capsule 2mg	1	MO; GC
Angiotensin II Receptor Antagonists		
candesartan cilexetil	1	MO; GC
irbesartan	1	MO; GC
losartan potassium tablet	1	MO; GC
olmesartan medoxomil tablet	1	MO; GC
telmisartan	1	MO; GC
valsartan tablet	1	MO; GC
Angiotensin-converting Enzyme (ACE) Inhibitors		
benazepril hcl tablet 10mg, 40mg, 5mg	1	MO; GC
benazepril hydrochloride tablet 20mg	1	MO; GC
captopril tablet	1	MO; GC
enalapril maleate tablet	1	MO; GC
fosinopril sodium	1	MO; GC
lisinopril tablet	1	MO; GC
moexipril hcl	1	MO; GC
perindopril erbumine	1	MO; GC
quinapril hydrochloride	1	MO; GC
ramipril	1	MO; GC
trandolapril	1	MO; GC
Antiarrhythmics		
amiodarone hydrochloride tablet	1	MO; GC
digitek tablet 0.125mg, 0.25mg	1	MO; GC
digox	1	MO; GC
DIGOXIN SOLUTION	2	MO

Drug Name	Drug Tier	Requirements/Limits
DIGOXIN TABLET 62.5MCG	2	MO
digoxin tablet 125mcg, 250mcg	1	MO; GC
disopyramide phosphate capsule	2	MO
DOFETILIDE	2	MO
flecainide acetate	1	MO; GC
MEXILETINE HCL	2	MO
MULTAQ	2	MO
pacerone tablet 100mg, 200mg, 400mg	1	MO; GC
propafenone hcl tablet 150mg, 225mg	1	MO; GC
propafenone hcl tablet 300mg	2	MO
propafenone hydrochloride er	3	MO
quinidine gluconate cr	3	MO
quinidine sulfate tablet	1	MO; GC
sorine	1	MO; GC
sotalol hcl	1	MO; GC
sotalol hcl (af) tablet 80mg	1	MO; GC
sotalol hcl af	1	MO; GC
sotalol hydrochloride (af)	1	MO; GC
Beta-adrenergic Blocking Agents		
acebutolol hydrochloride	1	MO; GC
atenolol tablet	1	MO; GC
betaxolol hcl tablet 10mg, 20mg	1	MO; GC
bisoprolol fumarate	1	MO; GC
carvedilol	1	MO; GC
labetalol hydrochloride tablet	1	MO; GC
metoprolol succinate er	1	MO; GC
metoprolol tartrate injection 5mg/5ml	1	MO; GC
metoprolol tartrate tablet 100mg, 25mg, 50mg, 75mg	1	MO; GC
nadolol tablet 20mg, 40mg, 80mg	1	MO; GC
nebivolol hydrochloride	2	MO
pindolol tablet	1	MO; GC
propranolol hcl er capsule extended release 24 hour 120mg, 160mg	1	MO; GC
propranolol hcl solution	1	MO; GC
propranolol hcl tablet 40mg	1	MO; GC
propranolol hydrochloride er capsule extended release 24 hour 60mg, 80mg	1	MO; GC
propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg	1	MO; GC
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate tablet	1	MO; GC
felodipine er	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
isradipine	3	MO
nicardipine hcl capsule	3	MO
nifedipine er	1	MO; GC
nimodipine capsule	3	MO
nisoldipine er	3	MO
Calcium Channel Blocking Agents, Nondihydropyridines		
cartia xt	1	MO; GC
dilt-xr	1	MO; GC
diltiazem hcl er capsule extended release 24 hour 120mg, 180mg, 240mg, 300mg, 420mg	1	MO; GC
diltiazem hcl er capsule extended release 12 hour	1	MO; GC
diltiazem hcl er tablet extended release 24 hour 240mg, 300mg, 360mg	1	MO; GC
diltiazem hcl er tablet extended release 24 hour 420mg	2	MO
diltiazem hcl tablet 30mg, 60mg, 90mg	1	MO; GC
diltiazem hydrochloride er capsule extended release 24 hour	1	MO; GC
diltiazem hydrochloride er tablet extended release 24 hour 120mg, 180mg, 240mg, 300mg, 360mg	1	MO; GC
diltiazem hydrochloride tablet 120mg	1	MO; GC
matzim la tablet extended release 24 hour 180mg, 240mg, 300mg, 360mg	1	MO; GC
matzim la tablet extended release 24 hour 420mg	2	MO
taztia xt	1	MO; GC
tiadylt er	1	MO; GC
verapamil hcl er capsule extended release 24 hour 100mg, 300mg	1	MO; GC
verapamil hcl er tablet extended release 120mg, 240mg	1	MO; GC
verapamil hcl sr capsule extended release 24 hour	1	MO; GC
verapamil hcl tablet 40mg, 80mg	1	MO; GC
verapamil hydrochloride er capsule extended release 24 hour 200mg	1	MO; GC
verapamil hydrochloride er tablet extended release 180mg	1	MO; GC
verapamil hydrochloride tablet 120mg	1	MO; GC
Cardiovascular Agents, Other		
acetazolamide tablet 250mg	1	MO; GC
aliskiren	3	MO
amiloride/hydrochlorothiazide	1	MO; GC
amlodipine besylate/atorvastatin calcium	1	MO; GC
amlodipine besylate/benazepril hydrochloride	1	MO; GC
amlodipine besylate/valsartan	1	MO; GC
amlodipine/olmesartan medoxomil	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
amlodipine/valsartan/hydrochlorothiazide	1	MO; GC
atenolol/chlorthalidone	1	MO; GC
benazepril hydrochloride/hydrochlorothiazide	1	MO; GC
bisoprolol fumarate/hydrochlorothiazide	1	MO; GC
candesartan cilexetil/hydrochlorothiazide tablet 16mg; 12.5mg	1	MO; GC
candesartan cilexetil/hydrochlorothiazide tablet 32mg; 12.5mg, 32mg; 25mg	2	MO
captopril/hydrochlorothiazide	1	MO; GC
CORLANOR SOLUTION	3	QL(450 ML per 30 days); PA; MO
CORLANOR TABLET	3	QL(60 EA per 30 days); PA; MO
enalapril maleate/hydrochlorothiazide	1	MO; GC
ENTRESTO	3	QL(60 EA per 30 days); MO
fosinopril sodium/hydrochlorothiazide	1	MO; GC
irbesartan/hydrochlorothiazide	1	MO; GC
isosorbide dinitrate/hydralazine hydrochloride	2	MO
KERENDIA	3	QL(30 EA per 30 days); PA; MO
lisinopril/hydrochlorothiazide	1	MO; GC
losartan potassium/hydrochlorothiazide	1	MO; GC
methyldopa/hydrochlorothiazide	1	MO; GC
metoprolol/hydrochlorothiazide	1	MO; GC
metyrosine	4	PA
olmesartan medoxomil/amlodipine/hydrochlorothiazide tablet 5mg; 12.5mg; 20mg	1	MO; GC
olmesartan medoxomil/amlodipine/hydrochlorothiazide tablet 10mg; 12.5mg; 40mg, 10mg; 25mg; 40mg, 5mg; 12.5mg; 40mg, 5mg; 25mg; 40mg	2	MO
olmesartan medoxomil/hydrochlorothiazide	1	MO; GC
pentoxifylline er	1	MO; GC
propranolol/hydrochlorothiazide	1	MO; GC
quinapril/hydrochlorothiazide	1	MO; GC
RANOLAZINE ER	2	MO
spironolactone/hydrochlorothiazide	1	MO; GC
telmisartan/amlodipine	2	MO
telmisartan/hydrochlorothiazide	1	MO; GC
trandolapril/verapamil hcl er	1	MO; GC
triamterene/hydrochlorothiazide capsule 25mg; 37.5mg	1	MO; GC
triamterene/hydrochlorothiazide tablet	1	MO; GC
valsartan/hydrochlorothiazide	1	MO; GC
VYNDAMAX	4	QL(30 EA per 30 days); PA
Diuretics, Loop		

Drug Name	Drug Tier	Requirements/Limits
bumetanide injection, tablet	1	MO; GC
ethacrynic acid tablet	3	MO
furosemide injection, oral solution, tablet	1	MO; GC
torsemide tablet	1	MO; GC
Diuretics, Potassium-sparing		
amiloride hcl tablet	1	MO; GC
eplerenone tablet 25mg	1	MO; GC
eplerenone tablet 50mg	2	MO
spironolactone tablet	1	MO; GC
triamterene capsule	1	MO; GC
Diuretics, Thiazide		
chlorthalidone tablet 25mg, 50mg	1	MO; GC
hydrochlorothiazide capsule, tablet	1	MO; GC
indapamide tablet	1	MO; GC
metolazone	1	MO; GC
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate micronized capsule 134mg, 200mg, 67mg	1	MO; GC
FENOFIBRATE CAPSULE 150MG	2	MO
fenofibrate capsule 130mg, 43mg, 50mg	1	MO; GC
fenofibrate tablet	1	MO; GC
fenofibric acid dr	1	MO; GC
gemfibrozil tablet	1	MO; GC
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium	1	MO; GC
fluvastatin	1	MO; GC
fluvastatin sodium er	1	MO; GC
lovastatin tablet	1	MO; GC
pravastatin sodium	1	MO; GC
rosuvastatin calcium	1	MO; GC
simvastatin tablet	1	MO; GC
Dyslipidemics, Other		
cholestyramine light powder	1	MO; GC
cholestyramine light packet	2	MO
cholestyramine powder	1	MO; GC
cholestyramine packet	2	MO
COLESEVELAM HYDROCHLORIDE	2	MO
colestipol hcl packet, tablet	1	MO; GC
ezetimibe	1	MO; GC
ezetimibe/simvastatin	2	MO
icosapent ethyl capsule 0.5gm	2	MO
JUXTAPID CAPSULE 10MG, 40MG, 5MG, 60MG	4	QL(30 EA per 30 days); PA

Drug Name	Drug Tier	Requirements/Limits
JUXTAPID CAPSULE 20MG, 30MG	4	QL(60 EA per 30 days); PA
niacin er tablet extended release 500mg	1	MO; GC
niacin er tablet extended release 1000mg, 750mg	2	MO
niacin tablet 500mg	1	MO; GC
niacor	2	MO
OMEGA-3-ACID ETHYL ESTERS	2	MO
PRALUENT	3	QL(2 ML per 28 days); PA; MO
prevalite powder	1	MO; GC
prevalite packet	2	MO
REPATHA	3	QL(3 ML per 28 days); PA; MO
REPATHA PUSHTRONEX SYSTEM	3	QL(7 ML per 28 days); PA; MO
REPATHA SURECLICK	3	QL(3 ML per 28 days); PA; MO
VASCEPA CAPSULE 0.5GM	3	MO
Vasodilators, Direct-acting Arterial/Venous		
isosorbide dinitrate tablet 10mg, 20mg, 30mg, 5mg	1	MO; GC
isosorbide mononitrate	1	MO; GC
isosorbide mononitrate er	1	MO; GC
minitran	1	MO; GC
nitro-bid	1	MO; GC
nitroglycerin transdermal	1	MO; GC
nitroglycerin solution 0.4mg/spray	3	MO
nitroglycerin tablet sublingual 0.3mg, 0.4mg, 0.6mg	1	MO; GC
VERQUVO	3	QL(30 EA per 30 days); PA; MO
Vasodilators, Direct-acting Arterial		
hydralazine hcl tablet 10mg	1	MO; GC
hydralazine hydrochloride tablet 100mg, 25mg, 50mg	1	MO; GC
minoxidil tablet	3	MO
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine/dextroamphetamine tablet	1	QL(90 EA per 30 days); MO; GC
amphetamine/dextroamphetamine capsule extended release 24 hour	2	QL(60 EA per 30 days); MO
dextroamphetamine sulfate er capsule extended release 24 hour 5mg	1	QL(60 EA per 30 days); MO; GC
dextroamphetamine sulfate er capsule extended release 24 hour 15mg	2	QL(120 EA per 30 days); MO
dextroamphetamine sulfate er capsule extended release 24 hour 10mg	2	QL(180 EA per 30 days); MO
dextroamphetamine sulfate tablet 10mg	1	QL(180 EA per 30 days); MO; GC
dextroamphetamine sulfate tablet 5mg	1	QL(90 EA per 30 days); MO; GC
dextroamphetamine sulfate tablet 30mg	3	QL(60 EA per 30 days); MO

Drug Name	Drug Tier	Requirements/Limits
dextroamphetamine sulfate tablet 15mg, 20mg	3	QL(90 EA per 30 days); MO
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
ATOMOXETINE HYDROCHLORIDE CAPSULE 25MG	2	QL(30 EA per 30 days); MO
ATOMOXETINE HYDROCHLORIDE CAPSULE 10MG	2	QL(60 EA per 30 days); MO
ATOMOXETINE CAPSULE 100MG, 18MG, 40MG, 60MG, 80MG	2	QL(30 EA per 30 days); MO
clonidine hydrochloride er	3	MO
dexmethylphenidate hcl er capsule extended release 24 hour 15mg, 30mg	3	QL(30 EA per 30 days); MO
dexmethylphenidate hcl tablet 10mg, 5mg	1	QL(60 EA per 30 days); MO; GC
dexmethylphenidate hydrochloride tablet 2.5mg	1	QL(60 EA per 30 days); MO; GC
guanfacine er tablet extended release 24 hour 2mg	3	MO
guanfacine hydrochloride tablet extended release 24 hour 1mg, 3mg, 4mg	3	MO
methylphenidate hydrochloride cd capsule extended release 10mg, 20mg, 30mg, 50mg, 60mg	3	QL(30 EA per 30 days); MO
methylphenidate hydrochloride er (la)	3	QL(30 EA per 30 days); MO
methylphenidate hydrochloride er capsule extended release 24 hour 10mg	3	QL(30 EA per 30 days); MO
methylphenidate hydrochloride er capsule extended release 40mg	3	QL(30 EA per 30 days); MO
methylphenidate hydrochloride er tablet extended release 24 hour 18mg, 27mg, 54mg	3	QL(30 EA per 30 days); MO
methylphenidate hydrochloride er tablet extended release 24 hour 36mg	3	QL(60 EA per 30 days); MO
methylphenidate hydrochloride er tablet extended release 10mg	3	QL(180 EA per 30 days); MO
methylphenidate hydrochloride er tablet extended release 18mg, 27mg, 54mg	3	QL(30 EA per 30 days); MO
methylphenidate hydrochloride er tablet extended release 36mg	3	QL(60 EA per 30 days); MO
methylphenidate hydrochloride er tablet extended release 20mg	3	QL(90 EA per 30 days); MO
methylphenidate hydrochloride tablet	1	QL(90 EA per 30 days); MO; GC
methylphenidate hydrochloride solution	3	MO
methylphenidate hydrochloride tablet chewable 10mg	2	QL(180 EA per 30 days); MO
methylphenidate hydrochloride tablet chewable 2.5mg, 5mg	2	QL(90 EA per 30 days); MO
Central Nervous System, Other		
AUSTEDO	4	QL(120 EA per 30 days); PA
butalbital/acetaminophen/caffeine capsule 325mg; 50mg; 40mg	2	MO

Drug Name	Drug Tier	Requirements/Limits
butalbital/acetaminophen/caffeine tablet 325mg; 50mg; 40mg	1	MO; GC
butalbital/acetaminophen tablet 325mg; 50mg	2	MO
butalbital/aspirin/caffeine capsule	1	MO; GC
NUEDEXTA	4	PA
riluzole	2	PA; MO
tencon tablet 325mg; 50mg	2	MO
tetrabenazine	3	PA; MO
ZTALMY	4	PA
Fibromyalgia Agents		
pregabalin capsule 300mg	1	QL(60 EA per 30 days); MO; GC
pregabalin capsule 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg	1	QL(90 EA per 30 days); MO; GC
pregabalin solution	1	QL(900 ML per 30 days); MO; GC
SAVELLA	2	QL(60 EA per 30 days); MO
SAVELLA TITRATION PACK	2	QL(110 EA per 365 days); MO
Multiple Sclerosis Agents		
AVONEX PEN	4	QL(4 EA per 28 days); PA
AVONEX INJECTION 30MCG/0.5ML	4	QL(4 EA per 28 days); PA
BETASERON	4	QL(15 EA per 30 days); PA
DALFAMPRIDINE ER	2	QL(60 EA per 30 days); PA; MO
dimethyl fumarate	3	QL(60 EA per 30 days); PA; MO
dimethyl fumarate starterpack	4	QL(120 EA per 365 days); PA
fingolimod	4	QL(30 EA per 30 days); PA
glatiramer acetate injection 40mg/ml	4	QL(12 ML per 28 days); PA
glatiramer acetate injection 20mg/ml	4	QL(30 ML per 30 days); PA
glatopa injection 40mg/ml	4	QL(12 ML per 28 days); PA
glatopa injection 20mg/ml	4	QL(30 ML per 30 days); PA
MAYZENT STARTER PACK TABLET THERAPY PACK 0.25MG	3	QL(14 EA per 365 days); PA; MO
MAYZENT STARTER PACK TABLET THERAPY PACK 0.25MG	4	QL(24 EA per 365 days); PA
MAYZENT TABLET 0.25MG	4	QL(120 EA per 30 days); PA
MAYZENT TABLET 1MG, 2MG	4	QL(30 EA per 30 days); PA
PLEGRIDY	4	QL(1 ML per 28 days); PA
PLEGRIDY STARTER PACK	4	QL(2 ML per 365 days); PA
REBIF	4	QL(6 ML per 28 days); PA
REBIF REBIDOSE	4	QL(6 ML per 28 days); PA
REBIF REBIDOSE TITRATION PACK	4	QL(8.4 ML per 365 days); PA
REBIF TITRATION PACK	4	QL(8.4 ML per 365 days); PA
teriflunomide	4	QL(30 EA per 30 days); PA
TYSABRI	4	PA
VUMERITY	4	QL(120 EA per 30 days); PA

Drug Name	Drug Tier	Requirements/Limits
ZEPOSIA	4	QL(30 EA per 30 days); PA
ZEPOSIA 7-DAY STARTER PACK	4	QL(14 EA per 365 days); PA
ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0	4	QL(56 EA per 365 days); PA
ZEPOSIA STARTER KIT CAPSULE THERAPY PACK 0	4	QL(74 EA per 365 days); PA
Dental and Oral Agents		
Dental and Oral Agents		
cevimeline hydrochloride	3	MO
chlorhexidine gluconate solution	1	MO; GC
doxycycline hyclate tablet 20mg	1	MO; GC
kourzeq	1	MO; GC
lidocaine hydrochloride viscous	1	MO; GC
lidocaine viscous	1	MO; GC
oralone dental paste	1	MO; GC
periogard	1	MO; GC
pilocarpine hydrochloride	2	MO
triamcinolone acetonide dental paste	1	MO; GC
Dermatological Agents		
Acne and Rosacea Agents		
accutane	3	MO
acitretin	3	MO
adapalene gel 0.1%	1	MO; GC
adapalene cream	2	MO
adapalene solution	4	
amnesteem	3	MO
avita cream	1	PA; MO; GC
AZELAIC ACID	2	MO
claravis	3	MO
clindamycin phosphate/benzoyl peroxide gel 5%; 1.2%	3	MO
clindamycin phosphate/tretinoin	3	MO
clindamycin/benzoyl peroxide	3	MO
erythromycin/benzoyl peroxide	2	MO
FINACEA FOAM	2	QL(50 GM per 30 days); MO
isotretinoin capsule	3	MO
metronidazole cream 0.75%	2	MO
metronidazole gel 0.75%	1	MO; GC
metronidazole gel 1%	2	MO
metronidazole lotion 0.75%	1	MO; GC
myorisan	3	MO
neuac	3	MO
rosadan	1	MO; GC
TAZAROTENE CREAM	2	MO

Drug Name	Drug Tier	Requirements/Limits
tazarotene gel	3	MO
tretinoin microsphere gel 0.04%, 0.1%	1	PA; MO; GC
tretinoin cream 0.025%, 0.05%, 0.1%	1	PA; MO; GC
tretinoin gel 0.01%, 0.025%	1	PA; MO; GC
tretinoin gel 0.05%	2	PA; MO
zenatane	3	MO
Dermatitis and Pruitus Agents		
ala-cort cream 2.5%	1	MO; GC
alclometasone dipropionate	1	MO; GC
amcinonide	3	MO
ammonium lactate cream, lotion	1	MO; GC
beser lotion	1	MO; GC
betamethasone dipropionate augmented	2	MO
betamethasone dipropionate cream, lotion	1	MO; GC
betamethasone dipropionate ointment	2	MO
betamethasone valerate cream, lotion, ointment	1	MO; GC
betamethasone valerate foam	3	QL(100 GM per 30 days); MO
clobetasol propionate e	2	MO
clobetasol propionate cream, ointment, solution	1	MO; GC
clobetasol propionate gel	2	MO
clobetasol propionate shampoo	3	MO
desonide cream, lotion	2	MO
desonide ointment	2	QL(120 GM per 30 days); MO
desoximetasone gel, ointment	3	MO
desoximetasone cream	3	QL(100 GM per 30 days); MO
diflorasone diacetate ointment	3	MO
doxepin hydrochloride cream 5%	3	QL(90 GM per 30 days); PA; MO
fluocinolone acetonide scalp	2	MO
fluocinolone acetonide cream 0.025%	1	MO; GC
fluocinolone acetonide cream 0.01%	2	MO
fluocinolone acetonide ointment 0.025%	1	MO; GC
fluocinolone acetonide solution 0.01%	2	MO
fluocinonide emulsified base	2	MO
fluocinonide cream 0.1%	3	QL(120 GM per 30 days); MO
fluocinonide ointment, solution	1	MO; GC
fluocinonide gel	2	MO
fluticasone propionate cream 0.05%	1	MO; GC
fluticasone propionate lotion 0.05%	1	MO; GC
fluticasone propionate ointment 0.005%	1	MO; GC
halobetasol propionate cream, ointment	2	MO
hydrocortisone butyrate cream, ointment, solution	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
hydrocortisone valerate ointment	2	MO
hydrocortisone valerate cream	2	QL(60 GM per 30 days); MO
hydrocortisone cream 2.5%	1	MO; GC
hydrocortisone lotion 2.5%	1	MO; GC
hydrocortisone ointment 2.5%	1	MO; GC
mometasone furoate cream 0.1%	1	MO; GC
mometasone furoate ointment 0.1%	1	MO; GC
mometasone furoate solution 0.1%	1	MO; GC
pimecrolimus	3	MO
prednicarbate ointment	1	MO; GC
selenium sulfide	1	MO; GC
tacrolimus ointment 0.03%, 0.1%	3	MO
triamcinolone acetonide cream 0.025%, 0.1%, 0.5%	1	MO; GC
triamcinolone acetonide lotion 0.025%, 0.1%	1	MO; GC
triamcinolone acetonide ointment 0.025%, 0.1%, 0.5%	1	MO; GC
triderm	1	MO; GC
Dermatological Agents, Other		
calcipotriene/betamethasone dipropionate ointment	3	QL(400 GM per 30 days); MO
calcipotriene solution	2	QL(60 ML per 30 days); MO
calcipotriene cream, ointment	3	QL(120 GM per 30 days); MO
calcitriol ointment 3mcg/gm	3	MO
clotrimazole/betamethasone dipropionate cream	1	MO; GC
clotrimazole/betamethasone dipropionate lotion	2	MO
diclofenac sodium gel 3%	3	QL(300 GM per 30 days); ST; MO
fluorouracil cream 5%	2	QL(40 GM per 30 days); MO
fluorouracil cream 0.5%	4	
fluorouracil solution	1	MO; GC
imiquimod pump	4	
imiquimod cream 5%	1	MO; GC
methoxsalen capsule	4	
nystatin/triamcinolone	1	MO; GC
OTEZLA TABLET 30MG	4	QL(60 EA per 30 days); PA
podofilox solution	1	MO; GC
REGRANEX	4	PA
SANTYL	2	MO
silver sulfadiazine	1	MO; GC
ssd	1	MO; GC
VEREGEN	4	
Pediculicides/Scabicides		
ivermectin cream 1%	3	QL(45 GM per 30 days); MO
ivermectin lotion 0.5%	3	MO

Drug Name	Drug Tier	Requirements/Limits
malathion	3	MO
permethrin cream	1	MO; GC
Topical Anti-infectives		
acyclovir cream 5%	3	QL(5 GM per 30 days); MO
acyclovir ointment 5%	3	MO
ciclodan solution	1	PA; MO; GC
ciclopirox nail lacquer	1	PA; MO; GC
ciclopirox olamine	1	MO; GC
ciclopirox gel, shampoo, suspension	1	MO; GC
clindacin	3	MO
clindamycin phosphate foam 1%	3	MO
clindamycin phosphate gel 1%	3	MO
clindamycin phosphate lotion 1%	2	QL(75 ML per 30 days); MO
clindamycin phosphate external solution 1%	1	QL(60 ML per 30 days); MO; GC
ery	1	MO; GC
erythromycin gel 2%	1	MO; GC
erythromycin solution 2%	1	MO; GC
MUPIROCIN CREAM	3	MO
mupirocin ointment	1	QL(110 GM per 30 days); MO; GC
penciclovir cream	3	MO
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
AMINOSYN-PF 7% INJECTION 32.5MEQ/L; 490MG/100ML; 861MG/100ML; 370MG/100ML; 576MG/100ML; 270MG/100ML; 220MG/100ML; 534MG/100ML; 831MG/100ML; 475MG/100ML; 125MG/100ML; 10.69GM/L; 300MG/100ML; 570MG/100ML; 70GM/L; 347MG/100ML; 50MG/100ML; 360MG/100ML; 125MG/100ML; 44MG/100ML; 452MG/100ML	3	B/D; MO
carglumic acid	4	
CLINIMIX 4.25%/DEXTROSE 10%	3	B/D; MO
CLINIMIX 4.25%/DEXTROSE 5%	3	B/D; MO
CLINIMIX 5%/DEXTROSE 15%	3	B/D; MO
CLINIMIX 5%/DEXTROSE 20%	3	B/D; MO
CLINIMIX E 2.75%/DEXTROSE 5%	3	B/D; MO
CLINIMIX E 4.25%/DEXTROSE 10%	3	B/D; MO
CLINIMIX E 4.25%/DEXTROSE 5%	3	B/D; MO
CLINIMIX E 5%/DEXTROSE 15%	3	B/D; MO
CLINIMIX E 5%/DEXTROSE 20%	3	B/D; MO
DEXTROSE 10%/NACL 0.45%	2	MO
dextrose 10%	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
DEXTROSE 10%/NACL 0.2%	2	MO
DEXTROSE 2.5%/NACL 0.45%	2	MO
dextrose 5%	1	MO; GC
dextrose 5%/nacl 0.2%	1	MO; GC
dextrose 5%/nacl 0.45%	1	MO; GC
dextrose 5%/nacl 0.9%	1	MO; GC
DEXTROSE/SODIUM CHLORIDE	2	MO
fluoride tablet chewable 0.25mg, 0.5mg, 1mg	1	MO; GC
fluoritab solution 0.125mg/drop	1	MO; GC
FREAMINE III INJECTION 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML	3	B/D; MO
ISOLYTE-P/DEXTROSE 5%	3	MO
ISOLYTE-S INJECTION 27MEQ/L; 98MEQ/L; 23MEQ/L; 3MEQ/L; 5MEQ/L; 140MEQ/L	3	MO
kcl 0.075%/d5w/nacl 0.45% injection 5%; 10meq/l; 0.45%	1	MO; GC
kcl 0.15%/d5w/nacl 0.2%	1	MO; GC
kcl 0.15%/d5w/nacl 0.45% injection 5%; 20meq/l; 0.45%	1	MO; GC
kcl 0.15%/d5w/nacl 0.9% injection 5%; 20meq/l; 0.9%	1	MO; GC
kcl 0.3%/d5w/nacl 0.45% injection 5%; 40meq/l; 0.45%	1	MO; GC
kcl 0.3%/d5w/nacl 0.9% injection 5%; 40meq/l; 0.9%	1	MO; GC
klor-con 10	1	MO; GC
klor-con 8	1	MO; GC
klor-con m10	1	MO; GC
klor-con m15	1	MO; GC
klor-con m20	1	MO; GC
magnesium sulfate injection 50%	1	MO; GC
MULTIPLE ELECTROLYTES INJECTION TYPE 1	3	MO
nafrinse	1	MO; GC
nafrinse drops	1	MO; GC
PLASMA-LYTE A	3	MO
PLASMA-LYTE-148	3	MO
PLENAMINE	3	B/D; MO
potassium chloride er	1	MO; GC
potassium chloride/dextrose/lactated ringers injection 3meq/l; 149meq/l; 5%; 28meq/l; 24meq/l; 130meq/l	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
potassium chloride/dextrose/sodium chloride injection 5%; 0.15%; 0.225%, 5%; 10meq/l; 0.45%, 5%; 20meq/l; 0.45%, 5%; 20meq/l; 0.9%, 5%; 30meq/l; 0.45%, 5%; 40meq/l; 0.45%, 5%; 40meq/l; 0.9%	1	MO; GC
potassium chloride/dextrose injection 5%; 20meq/l	1	MO; GC
potassium chloride/sodium chloride injection 20meq/l; 0.45%, 20meq/l; 0.9%, 40meq/l; 0.9%	1	MO; GC
potassium chloride oral solution	1	MO; GC
potassium chloride injection 10meq/100ml, 20meq/100ml, 2meq/ml, 40meq/100ml	1	MO; GC
potassium citrate er	2	MO
PREMASOL INJECTION 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML	3	B/D; MO
PROCALAMINE	3	B/D; MO
PROSOL	3	B/D; MO
sodium chloride 0.45% injection	1	MO; GC
sodium chloride injection 0.45%, 0.9%, 3%, 5%	1	MO; GC
sodium fluoride solution 0.5mg/ml	1	MO; GC
sodium fluoride tablet chewable 0.25mg, 0.5mg, 1mg	1	MO; GC
TPN ELECTROLYTES	2	MO
TRAVASOL INJECTION 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML	3	B/D; MO
TROPHAMINE INJECTION 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML	3	B/D; MO
Electrolyte/Mineral/Metal Modifiers		
clovique	4	PA
deferasirox packet	4	PA
deferasirox tablet soluble 125mg	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
deferasirox tablet soluble 250mg, 500mg	4	PA
deferasirox tablet 90mg	2	PA; MO
deferasirox tablet 180mg, 360mg	3	PA; MO
deferiprone	4	PA
FERRIPROX TWICE-A-DAY	4	PA
trientine hydrochloride capsule 250mg	4	PA
Phosphate Binders		
calcium acetate capsule	1	MO; GC
calcium acetate tablet 667mg	1	MO; GC
lanthanum carbonate	4	
SEVELAMER CARBONATE TABLET	2	MO
sevelamer carbonate packet	3	MO
sevelamer hydrochloride	3	MO
VELPHORO	4	
Potassium Binders		
LOKELMA	3	QL(90 EA per 30 days); MO
sodium polystyrene sulfonate powder	1	MO; GC
sps	1	MO; GC
VELTASSA	3	MO
Vitamins		
prenatal tablet 120mg; 0; 200mg; 10mcg; 2mg; 12mcg; 27mg; 1mg; 20mg; 10mg; 1200mcg; 3mg; 1.84mg; 10mg; 25mg	1	MO; GC
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose	1	MO; GC
enulose	1	MO; GC
generlac	1	MO; GC
lactulose solution	1	MO; GC
lactulose packet	4	
LINZESS	2	QL(30 EA per 30 days); MO
lubiprostone	1	QL(60 EA per 30 days); MO; GC
RELISTOR TABLET	4	QL(90 EA per 30 days); ST
RELISTOR INJECTION 8MG/0.4ML	4	QL(12 ML per 30 days); ST
RELISTOR INJECTION 12MG/0.6ML	4	QL(18 ML per 30 days); ST
Anti-Diarrheal Agents		
alosetron hydrochloride tablet 0.5mg	3	PA; MO
alosetron hydrochloride tablet 1mg	4	PA
diphenoxylate hydrochloride/atropine sulfate	1	MO; GC
diphenoxylate/atropine liquid	1	MO; GC
loperamide hcl capsule	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
XERMELO	4	QL(90 EA per 30 days); PA
Antispasmodics, Gastrointestinal		
dicyclomine hcl solution	1	MO; GC
dicyclomine hydrochloride capsule, tablet	1	MO; GC
glycopyrrolate solution	3	MO
glycopyrrolate tablet 1mg, 2mg	1	MO; GC
methscopolamine bromide tablet	3	MO
Gastrointestinal Agents, Other		
GATTEX	4	PA
gavilyte-c	1	MO; GC
gavilyte-g	1	MO; GC
gavilyte-n/flavor pack	1	MO; GC
lansoprazole/amoxicillin/clarithromycin therapy pack	2	MO
metoclopramide hcl solution	1	MO; GC
metoclopramide hcl tablet 5mg	1	MO; GC
metoclopramide hydrochloride injection	1	MO; GC
metoclopramide hydrochloride tablet 10mg	1	MO; GC
MYALEPT	4	PA
nitroglycerin ointment 0.4%	3	MO
OCALIVA	4	QL(30 EA per 30 days); PA
peg-3350/electrolytes	1	MO; GC
peg-3350/nacl/na bicarbonate/kcl	1	MO; GC
RECTIV	3	MO
URSODIOL TABLET	2	MO
XIFAXAN TABLET 200MG	3	PA; MO
XIFAXAN TABLET 550MG	4	PA
ZORBTIVE	4	PA
Histamine2 (H2) Receptor Antagonists		
cimetidine hcl solution	1	MO; GC
cimetidine hydrochloride solution 300mg/5ml	1	MO; GC
cimetidine tablet	1	MO; GC
famotidine suspension reconstituted	2	MO
famotidine tablet 20mg, 40mg	1	MO; GC
nizatidine capsule	1	MO; GC
nizatidine solution	3	MO
Protectants		
misoprostol	1	MO; GC
sucralfate suspension, tablet	1	MO; GC
Proton Pump Inhibitors		
ESOMEPRAZOLE MAGNESIUM PACKET	2	QL(60 EA per 30 days); MO
esomeprazole magnesium capsule delayed release	1	QL(60 EA per 30 days); MO; GC

Drug Name	Drug Tier	Requirements/Limits
lansoprazole capsule delayed release	1	QL(60 EA per 30 days); MO; GC
omeprazole dr capsule delayed release 10mg	1	QL(60 EA per 30 days); MO; GC
omeprazole capsule delayed release 20mg, 40mg	1	QL(60 EA per 30 days); MO; GC
pantoprazole sodium tablet delayed release	1	QL(60 EA per 30 days); MO; GC
rabeprazole sodium	1	QL(60 EA per 30 days); MO; GC
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
ARALAST NP INJECTION 1000MG	4	PA
betaine anhydrous	4	
CERDELGA	4	PA
CHOLBAM	4	PA
CREON CAPSULE DELAYED RELEASE PARTICLES 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	2	MO
cromolyn sodium concentrate 100mg/5ml	3	MO
CYSTAGON	3	MO
dichlorphenamide	4	QL(120 EA per 30 days); PA
ELAPRASE	4	PA
ENDARI	4	PA
EVRYSDI	4	QL(240 ML per 30 days); PA
GLASSIA	4	PA
KANUMA	4	PA
LUMIZYME	4	PA
miglustat	4	PA
NAGLAZYME	4	PA
nitisinone	4	
ORFADIN SUSPENSION	4	
PROLASTIN-C INJECTION 1000MG	4	PA
RAVICTI	4	PA
REVCOVI	4	PA
sapropterin dihydrochloride	4	PA
sodium phenylbutyrate powder, tablet	4	
STRENSIQ	4	PA
SUCRAID	4	PA
TEGSEDI	4	PA
VIMIZIM	4	PA
VYONDYS 53	4	PA
yargesa	4	PA

Drug Name	Drug Tier	Requirements/Limits
ZEMAIRA INJECTION 1000MG	4	PA
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 168000UNIT; 40000UNIT; 126000UNIT	2	MO
Genitourinary Agents		
Antispasmodics, Urinary		
darifenacin hydrobromide er	3	MO
fesoterodine fumarate er	2	MO
flavoxate hcl	1	MO; GC
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR	2	MO
oxybutynin chloride er	1	MO; GC
oxybutynin chloride solution	1	MO; GC
oxybutynin chloride tablet 5mg	1	MO; GC
SOLIFENACIN SUCCINATE	2	MO
tolterodine tartrate er	2	MO
tolterodine tartrate tablet 2mg	1	MO; GC
tolterodine tartrate tablet 1mg	2	MO
trospium chloride	1	MO; GC
trospium chloride er	2	MO
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er	1	MO; GC
dutasteride/tamsulosin hydrochloride	3	MO
dutasteride capsule	1	MO; GC
finasteride tablet	1	MO; GC
SILODOSIN	2	MO
tadalafil tablet 2.5mg, 5mg	3	QL(30 EA per 30 days); PA; MO
tamsulosin hydrochloride	1	MO; GC
Genitourinary Agents, Other		
bethanechol chloride tablet 10mg, 25mg, 5mg	1	MO; GC
bethanechol chloride tablet 50mg	2	MO
ELMIRON	4	
penicillamine tablet	4	
sildenafil citrate tablet 100mg, 25mg, 50mg	1	QL(12 EA per 30 days); MO; GC; E
tadalafil tablet 10mg, 20mg	1	QL(10 EA per 30 days); MO; GC; E
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
ACTHAR	4	PA
cortisone acetate tablet 25mg	1	MO; GC
CORTROPHIN	4	PA
dexamethasone intensol	1	MO; GC
dexamethasone elixir, solution	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
dexamethasone tablet 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	1	MO; GC
fludrocortisone acetate tablet	1	MO; GC
hydrocortisone tablet 10mg, 20mg, 5mg	1	MO; GC
methylprednisolone dose pack tablet therapy pack	1	MO; GC
methylprednisolone tablet	1	MO; GC
MILLIPRED TABLET	3	MO
prednisolone sodium phosphate oral solution 15mg/5ml, 25mg/5ml, 5mg/5ml	1	MO; GC
prednisolone sodium phosphate oral solution 10mg/5ml, 20mg/5ml	3	MO
prednisolone solution	1	MO; GC
prednisolone tablet	3	MO
prednisone intensol	3	MO
prednisone solution, tablet therapy pack	1	MO; GC
prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	MO; GC
TRIAMCINOLONE ACETONIDE INJECTION 10MG/ML	2	MO
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
desmopressin acetate tablet	1	MO; GC
DESMOPRESSIN ACETATE SOLUTION 1.5MG/ML	4	
desmopressin acetate solution 0.01%	2	MO
EGRIFTA INJECTION 1MG	4	QL(60 EA per 30 days); PA
GENOTROPIN	4	PA
GENOTROPIN MINIQUICK INJECTION 0.2MG	3	PA; MO
GENOTROPIN MINIQUICK INJECTION 0.4MG, 0.6MG, 0.8MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 1MG, 2MG	4	PA
INCRELEX	4	PA
LUPRON DEPOT-PED (6-MONTH)	4	QL(1 EA per 168 days); PA
STIMATE SOLUTION	4	
Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)		
Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)		
KORLYM	4	QL(120 EA per 30 days); PA
mifepristone tablet 200mg	3	MO
mifepristone tablet 300mg	4	QL(120 EA per 30 days); PA
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
Anabolic Steroids		
OXANDROLONE TABLET 2.5MG	2	QL(240 EA per 30 days); PA; MO

Drug Name	Drug Tier	Requirements/Limits
oxandrolone tablet 10mg	3	QL(60 EA per 30 days); PA; MO
Androgens		
ANDRODERM PATCH 24 HOUR 2MG/24HR, 4MG/24HR	2	PA; MO
danazol capsule	2	MO
methyltestosterone capsule	4	PA
testosterone cypionate injection 100mg/ml, 200mg/ml	1	MO; GC
testosterone enanthate injection	1	MO; GC
TESTOSTERONE PUMP GEL 1.62%	2	PA; MO
TESTOSTERONE GEL 20.25MG/1.25GM, 40.5MG/2.5GM	3	PA; MO
Estrogens		
afirmelle	1	MO; GC
altavera	1	MO; GC
alyacen 1/35	1	MO; GC
alyacen 7/7/7	1	MO; GC
amabelz	3	MO
amethia	1	QL(91 EA per 91 days); MO; GC
amethyst	1	MO; GC
apri	1	MO; GC
aranelle	1	MO; GC
ashlyna	1	QL(91 EA per 91 days); MO; GC
aubra eq	1	MO; GC
aurovela 1.5/30	1	MO; GC
aurovela 1/20	1	MO; GC
aurovela 24 fe	1	MO; GC
aurovela fe 1.5/30	1	MO; GC
aurovela fe 1/20	1	MO; GC
aviane	1	MO; GC
ayuna	1	MO; GC
azurette	1	MO; GC
balziva	1	MO; GC
blisovi 24 fe	2	MO
blisovi fe 1.5/30	1	MO; GC
blisovi fe 1/20	1	MO; GC
briellyn	2	MO
camrese	1	QL(91 EA per 91 days); MO; GC
caziant	1	MO; GC
chateal	1	MO; GC
chateal eq	1	MO; GC
CLIMARA PRO	3	MO
cryselle-28	1	MO; GC
cyclafem 1/35	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
cyclafem 7/7/7	1	MO; GC
cyred eq	1	MO; GC
dasetta 1/35	1	MO; GC
dasetta 7/7/7	1	MO; GC
daysee	1	QL(91 EA per 91 days); MO; GC
DEPO-ESTRADIOL INJECTION 5MG/ML	3	MO
desogestrel/ethinyl estradiol tablet 0; 0	1	MO; GC
desogestrel/ethinyl estradiol tablet 0.15mg; 30mcg	2	MO
dolishale	1	MO; GC
dotti patch twice weekly 0.025mg/24hr, 0.0375mg/24hr, 0.05mg/24hr, 0.075mg/24hr	1	MO; GC
dotti patch twice weekly 0.1mg/24hr	2	MO
drospirenone/ethinyl estradiol	1	MO; GC
elinest	1	MO; GC
eluryng	2	MO
emoquette	1	MO; GC
enilloring	1	MO; GC
enpresse-28	1	MO; GC
enskyce	1	MO; GC
estarylla	1	MO; GC
estradiol valerate injection 10mg/ml, 20mg/ml	1	MO; GC
estradiol valerate injection 40mg/ml	2	MO
estradiol/norethindrone acetate	1	MO; GC
ESTRADIOL CREAM	2	MO
estradiol patch twice weekly, patch weekly, oral tablet	1	MO; GC
estradiol gel, vaginal tablet	3	MO
ethynodiol diacetate/ethinyl estradiol	1	MO; GC
etonogestrel/ethinyl estradiol	1	MO; GC
falmina	1	MO; GC
fayosim	2	QL(91 EA per 91 days); MO
femynor	1	MO; GC
finzala	1	MO; GC
fyavolv tablet 5mcg; 1mg	2	MO
fyavolv tablet 2.5mcg; 0.5mg	3	MO
hailey 1.5/30	1	MO; GC
hailey 24 fe	2	MO
haloette	1	MO; GC
iclevia	2	QL(91 EA per 91 days); MO
introvale	1	QL(91 EA per 91 days); MO; GC
isibloom	1	MO; GC
jaimiess	1	QL(91 EA per 91 days); MO; GC

Drug Name	Drug Tier	Requirements/Limits
jasmiel	1	MO; GC
jinteli	2	MO
juleber	1	MO; GC
junel 1.5/30	1	MO; GC
junel 1/20	1	MO; GC
junel fe 1.5/30	1	MO; GC
junel fe 1/20	1	MO; GC
junel fe 24	1	MO; GC
kalliga	1	MO; GC
kariva	1	MO; GC
kelnor 1/35	1	MO; GC
kelnor 1/50	1	MO; GC
kurvelo	1	MO; GC
larin 1.5/30	1	MO; GC
larin 1/20	1	MO; GC
larin 24 fe	1	MO; GC
larin fe 1.5/30	1	MO; GC
larin fe 1/20	1	MO; GC
larissia	1	MO; GC
leena	1	MO; GC
lessina	1	MO; GC
levonest	1	MO; GC
levonorgestrel and ethinyl estradiol tablet 0; 0	1	QL(91 EA per 91 days); MO; GC
LEVONORGESTREL/ETHINYL ESTRADIOL TABLET 0; 0	2	QL(91 EA per 91 days); MO
levonorgestrel/ethinyl estradiol tablet 0.03mg; 0.15mg, 0; 0, 20mcg; 0.1mg	1	MO; GC
levonorgestrel/ethinyl estradiol tablet 0.03mg; 0.15mg	1	QL(91 EA per 91 days); MO; GC
levonorgestrel/ethinyl estradiol tablet 0; 0	2	QL(91 EA per 91 days); MO
levora 0.15/30-28	1	MO; GC
lillow	1	MO; GC
LO LOESTRIN FE	3	MO
lo-zumandimine	1	MO; GC
loryna	1	MO; GC
low-ogestrel	1	MO; GC
lutera	1	MO; GC
lyllana	1	MO; GC
marlissa	1	MO; GC
MENEST	3	MO
merzee	1	MO; GC
mibelas 24 fe	1	MO; GC
microgestin 1.5/30	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
microgestin 1/20	1	MO; GC
microgestin 24 fe	1	MO; GC
microgestin fe 1.5/30	1	MO; GC
microgestin fe 1/20	1	MO; GC
mili	1	MO; GC
mimvey	2	MO
mono-linyah	1	MO; GC
necon 0.5/35-28	1	MO; GC
nikki	1	MO; GC
norelgestromin/ethinyl estradiol	3	MO
norethindrone acetate/ethinyl estradiol/ferrous fumarate capsule, tablet	1	MO; GC
norethindrone acetate/ethinyl estradiol tablet 20mcg; 1mg, 30mcg; 1.5mg, 5mcg; 1mg	1	MO; GC
norethindrone acetate/ethinyl estradiol tablet 2.5mcg; 0.5mg	3	MO
norgestimate/ethinyl estradiol	1	MO; GC
nortrel 0.5/35 (28)	1	MO; GC
nortrel 1/35	1	MO; GC
nortrel 7/7/7	1	MO; GC
nylia 1/35	1	MO; GC
nylia 7/7/7	1	MO; GC
nymyo	1	MO; GC
orsythia	1	MO; GC
philith	1	MO; GC
pimtrea	1	MO; GC
pirmella 1/35	1	MO; GC
pirmella 7/7/7	1	MO; GC
portia-28	1	MO; GC
PREMARIN CREAM	2	MO
PREMARIN TABLET 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	2	MO
PREMPRO	2	MO
previfem	1	MO; GC
reclipsen	1	MO; GC
RIVELSA	2	QL(91 EA per 91 days); MO
setlakin	1	QL(91 EA per 91 days); MO; GC
simliya	1	MO; GC
simpesse	1	QL(91 EA per 91 days); MO; GC
sprintec 28	1	MO; GC
sronyx	1	MO; GC
syeda	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
tarina 24 fe	2	MO
tarina fe 1/20 eq	1	MO; GC
taysofy	1	MO; GC
tilia fe	1	MO; GC
tri-estarylla	1	MO; GC
tri-legest fe	2	MO
tri-lo-estarylla	1	MO; GC
tri-lo-sprintec	1	MO; GC
tri-mili	1	MO; GC
tri-nymyo	1	MO; GC
tri-previfem	1	MO; GC
tri-sprintec	1	MO; GC
tri-vylibra	1	MO; GC
tri-vylibra lo	1	MO; GC
trivora-28	1	MO; GC
turqoz	1	MO; GC
tyblume	1	MO; GC
velivet	1	MO; GC
vestura	2	MO
vienva	1	MO; GC
viorele	1	MO; GC
volnea	1	MO; GC
vyfemla	2	MO
vylibra	1	MO; GC
wera	1	MO; GC
xulane	3	MO
yuvafem	3	MO
zafemy	3	MO
zarah	1	MO; GC
zovia 1/35	1	MO; GC
zovia 1/35e	1	MO; GC
zumandimine	1	MO; GC
Progestins		
camila	1	MO; GC
deblitane	1	MO; GC
DEPO-SUBQ PROVERA 104	3	QL(0.65 ML per 90 days); MO
errin	1	MO; GC
heather	1	MO; GC
hydroxyprogesterone caproate injection 250mg/ml	4	PA
incassia	1	MO; GC
jencycla	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
lyleq	1	MO; GC
lyza	1	MO; GC
medroxyprogesterone acetate tablet	1	MO; GC
medroxyprogesterone acetate injection	1	QL(1 ML per 90 days); MO; GC
megestrol acetate tablet	1	MO; GC
megestrol acetate suspension 40mg/ml	1	MO; GC
megestrol acetate suspension 625mg/5ml	3	MO
norethindrone acetate tablet	1	MO; GC
norethindrone tablet	1	MO; GC
norlyda	1	MO; GC
progesterone capsule	1	MO; GC
sharobel	1	MO; GC
tulana	1	MO; GC
Selective Estrogen Receptor Modifying Agents		
DUAVEE	3	MO
raloxifene hydrochloride	1	MO; GC
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
levo-t	1	MO; GC
LEVOTHYROXINE SODIUM CAPSULE	3	MO
levothyroxine sodium tablet	1	MO; GC
liothyronine sodium tablet	1	MO; GC
SYNTHROID TABLET	2	MO
unithroid	1	MO; GC
Hormonal Agents, Suppressant (Adrenal)		
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	4	
RECORLEV	4	QL(240 EA per 30 days); PA
Hormonal Agents, Suppressant (Pituitary)		
Hormonal Agents, Suppressant (Pituitary)		
CABERGOLINE	2	MO
FIRMAGON INJECTION 80MG	3	QL(1 EA per 28 days); PA; MO
FIRMAGON INJECTION 120MG/VIAL	4	QL(4 EA per 365 days); PA
LANREOTIDE ACETATE	4	PA
LEUPROLIDE ACETATE INJECTION 22.5MG	3	QL(1 EA per 84 days); PA; MO
leuprolide acetate injection 1mg/0.2ml	4	PA
LUPRON DEPOT (1-MONTH) INJECTION 3.75MG	4	QL(1 EA per 28 days); PA
LUPRON DEPOT (3-MONTH)	4	QL(1 EA per 84 days); PA
LUPRON DEPOT (4-MONTH)	4	QL(1 EA per 112 days); PA
LUPRON DEPOT (6-MONTH)	4	QL(1 EA per 168 days); PA
LUPRON DEPOT-PED (1-MONTH) INJECTION 7.5MG	4	QL(1 EA per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
LUPRON DEPOT-PED (3-MONTH) INJECTION 11.25MG	4	QL(1 EA per 84 days); PA
octreotide acetate injection 100mcg/ml, 200mcg/ml, 50mcg/ml	3	PA; MO
octreotide acetate injection 1000mcg/ml, 500mcg/ml	4	PA
ORGOVYX	4	PA
SIGNIFOR	4	QL(60 ML per 30 days); PA
SOMATULINE DEPOT	4	PA
SOMAVERT	4	PA
SYNAREL	4	
TRIPTODUR	4	QL(1 EA per 168 days); PA
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole tablet 10mg, 5mg	1	MO; GC
propylthiouracil tablet	1	MO; GC
Immunological Agents		
Angioedema Agents		
CINRYZE	4	PA
icatibant acetate	4	PA
RUCONEST	4	PA
sajazir	4	PA
Immunoglobulins		
BIVIGAM INJECTION 10%, 5GM/50ML	4	PA
FLEBOGAMMA DIF INJECTION 10GM/100ML, 10GM/200ML, 20GM/200ML, 5GM/50ML	4	PA
GAMASTAN	3	PA; MO
GAMMAKED INJECTION 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML	4	PA
GAMMAPLEX INJECTION 10GM/100ML, 20GM/200ML, 5GM/50ML	4	PA
GAMUNEX-C INJECTION 10GM/100ML, 1GM/10ML, 20GM/200ML, 5GM/50ML	4	PA
HYPERHEP B	4	B/D
NABI-HB INJECTION 312UNIT/ML	4	B/D
OCTAGAM INJECTION 10GM/100ML, 10GM/200ML, 1GM/20ML, 20GM/200ML, 2GM/20ML, 5GM/50ML	4	PA
PRIVIGEN	4	PA
SYNAGIS INJECTION 100MG/ML, 50MG/0.5ML	4	
VARIZIG INJECTION 125UNIT/1.2ML	4	PA
Immunological Agents, Other		
ARCALYST	4	PA
BENLYSTA	4	PA

Drug Name	Drug Tier	Requirements/Limits
COSENTYX SENSOREADY PEN	4	QL(10 ML per 28 days); PA
COSENTYX UNOREADY	4	QL(10 ML per 28 days); PA
COSENTYX INJECTION 150MG/ML, 75MG/0.5ML	4	QL(10 ML per 28 days); PA
DUPIXENT INJECTION 100MG/0.67ML	4	QL(1.34 ML per 28 days); PA
DUPIXENT INJECTION 200MG/1.14ML	4	QL(4.56 ML per 28 days); PA
DUPIXENT INJECTION 300MG/2ML	4	QL(8 ML per 28 days); PA
ENJAYMO	4	PA
KINERET	4	PA
OTEZLA TABLET THERAPY PACK 0	4	QL(110 EA per 365 days); PA
RIDAURA	4	
RINVOQ	4	QL(30 EA per 30 days); PA
SKYRIZI PEN	4	QL(1 ML per 28 days); PA
SKYRIZI INJECTION 75MG/0.83ML	4	PA
SKYRIZI INJECTION 150MG/ML	4	QL(1 ML per 28 days); PA
SKYRIZI INJECTION 180MG/1.2ML	4	QL(1.2 ML per 56 days); PA
SKYRIZI INJECTION 360MG/2.4ML	4	QL(2.4 ML per 56 days); PA
SOLIRIS	4	PA
STELARA INJECTION 45MG/0.5ML, 90MG/ML	4	QL(3 ML per 84 days); PA
XELJANZ XR	4	QL(30 EA per 30 days); PA
XELJANZ SOLUTION	4	QL(300 ML per 30 days); PA
XELJANZ TABLET	4	QL(60 EA per 30 days); PA
XOLAIR INJECTION 150MG/ML, 150MG, 75MG/0.5ML	4	PA
Immunostimulants		
ACTIMMUNE	4	PA
INTRON A	4	PA
PEGASYS INJECTION 180MCG/ML	4	PA
Immunosuppressants		
ASTAGRAF XL	3	B/D; MO
azathioprine tablet 50mg	1	B/D; MO; GC
azathioprine tablet 100mg, 75mg	2	B/D; MO
cyclosporine modified capsule	1	B/D; MO; GC
cyclosporine modified solution	2	B/D; MO
cyclosporine capsule	2	B/D; MO
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	4	QL(6 EA per 28 days); PA
CYLTEZO STARTER PACKAGE FOR PSORIASIS	4	QL(6 EA per 28 days); PA
CYLTEZO INJECTION 10MG/0.2ML, 20MG/0.4ML	4	QL(2 EA per 28 days); PA
CYLTEZO INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
ENBREL MINI	4	QL(8 ML per 28 days); PA
ENBREL SURECLICK	4	QL(8 ML per 28 days); PA
ENBREL INJECTION 25MG	4	PA
ENBREL INJECTION 25MG/0.5ML	4	QL(4 ML per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
ENBREL INJECTION 50MG/ML	4	QL(8 ML per 28 days); PA
ENVARSUS XR TABLET EXTENDED RELEASE 24 HOUR 0.75MG, 1MG	3	B/D; MO
ENVARSUS XR TABLET EXTENDED RELEASE 24 HOUR 4MG	4	B/D
everolimus tablet 0.25mg, 0.5mg, 0.75mg, 1mg	4	B/D
gengraf capsule 100mg, 25mg	1	B/D; MO; GC
gengraf solution	2	B/D; MO
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 0	4	QL(4 EA per 365 days); PA
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 80MG/0.8ML	4	QL(6 EA per 365 days); PA
HUMIRA PEN-CD/UC/HS STARTER INJECTION 80MG/0.8ML	4	QL(4 EA per 28 days); PA
HUMIRA PEN-CD/UC/HS STARTER INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
HUMIRA PEN-PEDIATRIC UC STARTER PACK	4	QL(4 EA per 28 days); PA
HUMIRA PEN-PS/UV STARTER INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
HUMIRA PEN-PS/UV STARTER INJECTION 0	4	QL(6 EA per 365 days); PA
HUMIRA PEN INJECTION 40MG/0.4ML, 80MG/0.8ML	4	QL(4 EA per 28 days); PA
HUMIRA PEN INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
HUMIRA INJECTION 10MG/0.1ML, 20MG/0.2ML, 40MG/0.8ML	4	QL(2 EA per 28 days); PA
HUMIRA INJECTION 40MG/0.4ML	4	QL(4 EA per 28 days); PA
leflunomide tablet 20mg	1	MO; GC
leflunomide tablet 10mg	2	MO
methotrexate sodium tablet	1	MO; GC
methotrexate sodium injection 1gm/40ml, 50mg/2ml	1	MO; GC
methotrexate injection 50mg/2ml	1	MO; GC
mycophenolate mofetil capsule	1	B/D; MO; GC
mycophenolate mofetil tablet	2	B/D; MO
mycophenolate mofetil suspension reconstituted	4	B/D
mycophenolic acid dr	3	B/D; MO
PEGASYS INJECTION 180MCG/0.5ML	4	PA
PROGRAF PACKET	3	B/D; MO
REZUROCK	4	QL(60 EA per 30 days); PA
SANDIMMUNE SOLUTION	3	B/D; MO
sirolimus solution, tablet	3	B/D; MO
tacrolimus capsule 0.5mg	1	B/D; MO; GC
tacrolimus capsule 1mg, 5mg	2	B/D; MO
TREXALL	3	MO
XATMEP	3	MO
YUFLYMA 1-PEN KIT	4	QL(6 EA per 28 days); PA
YUFLYMA 2-PEN KIT	4	QL(6 EA per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
YUFLYMA 2-SYRINGE KIT	4	QL(6 EA per 28 days); PA
Vaccines		
ABRYSVO	2	MO
ACTHIB INJECTION 0	2	MO
ADACEL	2	MO
AREXVY	2	MO
BCG VACCINE INJECTION 50MG	3	MO
BEXSERO	2	MO
BOOSTRIX	2	MO
DAPTACEL INJECTION 15LF/0.5ML; 23MCG/0.5ML; 5LF/0.5ML	2	MO
DIPHTHERIA/TETANUS TOXOIDS ADSORBED PEDIATRIC	2	MO
ENGERIX-B	2	B/D; MO
GARDASIL 9	2	MO
HAVRIX INJECTION 1440ELU/ML, 720ELU/0.5ML	2	MO
HEPLISAV-B	2	B/D; MO
HIBERIX	2	MO
IMOVAX RABIES (H.D.C.V.)	3	B/D; MO
INFANRIX	2	MO
IPOL INACTIVATED IPV	2	MO
IXIARO	2	MO
JYNNEOS	2	MO
KINRIX INJECTION 25LFU/0.5ML; 58MCG/0.5ML; 0; 10LFU/0.5ML	2	MO
M-M-R II	2	MO
MENACTRA	2	MO
MENQUADFI	2	MO
MENVEO	2	MO
PEDIARIX INJECTION 25LFU/0.5ML; 10MCG/0.5ML; 58MCG/0.5ML; 0; 10LFU/0.5ML	3	MO
PEDVAX HIB INJECTION 7.5MCG/0.5ML	2	MO
PENBRAYA	2	MO
PENTACEL	2	MO
PREHEVBRIO	2	B/D; MO
PRIORIX	2	MO
PROQUAD	2	MO
QUADRACEL	2	MO
RABAVERT	3	B/D; MO
RECOMBIVAX HB	2	B/D; MO
ROTARIX	2	MO
ROTATEQ SOLUTION	2	MO
SHINGRIX	2	MO

Drug Name	Drug Tier	Requirements/Limits
TDVAX	2	MO
TENIVAC	2	MO
TETANUS/DIPHTHERIA TOXOIDS-ADSORBED ADULT	2	MO
TICOVAC	3	MO
TRUMENBA	2	MO
TWINRIX	2	MO
TYPHIM VI	2	MO
VAQTA	2	MO
VARIVAX	2	MO
YF-VAX	2	MO
Inflammatory Bowel Disease Agents		
Aminosalicylates		
balsalazide disodium	2	MO
MESALAMINE DR CAPSULE DELAYED RELEASE	2	MO
MESALAMINE DR TABLET DELAYED RELEASE 1.2GM	2	MO
MESALAMINE ER	2	MO
mesalamine enema, suppository	3	MO
PENTASA CAPSULE EXTENDED RELEASE 250MG	3	MO
sulfasalazine tablet, tablet delayed release	1	MO; GC
Glucocorticoids		
budesonide er	4	
budesonide capsule delayed release particles 3mg	3	MO
CORTIFOAM FOAM	3	MO
hydrocortisone cream 1%, 2.5%	1	MO; GC
hydrocortisone enema 100mg/60ml	1	MO; GC
procto-med hc	1	MO; GC
procto-pak	1	MO; GC
proctosol hc	1	MO; GC
proctozone-hc	1	MO; GC
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate sodium solution	1	MO; GC
alendronate sodium tablet 10mg, 35mg, 5mg	1	MO; GC
alendronate sodium tablet 70mg	1	QL(4 EA per 28 days); MO; GC
calcitonin-salmon solution	1	QL(3.7 ML per 30 days); MO; GC
calcitriol capsule 0.25mcg, 0.5mcg	1	MO; GC
calcitriol solution 1mcg/ml	2	MO
cinacalcet hydrochloride	3	MO
doxercalciferol capsule	3	MO
FORTEO INJECTION 600MCG/2.4ML	4	PA
ibandronate sodium tablet	1	QL(1 EA per 28 days); MO; GC

Drug Name	Drug Tier	Requirements/Limits
NATPARA	4	QL(2 EA per 28 days); PA
paricalcitol capsule	2	MO
PROLIA	2	QL(2 ML per 365 days); MO
risedronate sodium dr	2	QL(4 EA per 28 days); MO
risedronate sodium tablet 5mg	1	MO; GC
risedronate sodium tablet 35mg	1	QL(4 EA per 28 days); MO; GC
risedronate sodium tablet 30mg	2	MO
risedronate sodium tablet 150mg	2	QL(1 EA per 28 days); MO
teriparatide injection 600mcg/2.4ml	4	PA
XGEVA	4	PA
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		
alcohol prep pads	1	MO; GC
AUGTYRO	4	PA
b-d insulin syringe ultrafine ii/0.3ml/31g x 5/16"	1	QL(200 EA per 30 days); MO; GC
bd insulin syringe safetyglide/1ml/29g x 1/2"	1	QL(200 EA per 30 days); MO; GC
bd insulin syringe ultra-fine/0.5ml/30g x 12.7mm	1	QL(200 EA per 30 days); MO; GC
bd insulin syringe ultra-fine/1ml/31g x 8mm	1	QL(200 EA per 30 days); MO; GC
bd pen needle/original/ultra-fine/29g x 12.7mm	1	QL(200 EA per 30 days); MO; GC
CLINOLIPID	3	B/D; MO
curity gauze pads 2"x2" 12 ply	1	MO; GC
ELLA	2	MO
GIVLAARI	4	PA
INTRALIPID INJECTION 20GM/100ML	3	B/D; MO
LAGEVRIO	2	QL(40 EA per 5 days); MO
levocarnitine solution, tablet	1	MO; GC
NUTRILIPID	3	B/D; MO
OXLUMO	4	PA
PALFORZIA INITIAL DOSE ESCALATION	4	PA
PALFORZIA LEVEL 1	4	PA
PALFORZIA LEVEL 10	4	PA
PALFORZIA LEVEL 11 (MAINTENANCE)	4	PA
PALFORZIA LEVEL 11 (TITRATION)	4	PA
PALFORZIA LEVEL 2	4	PA
PALFORZIA LEVEL 3	4	PA
PALFORZIA LEVEL 4	4	PA
PALFORZIA LEVEL 5	4	PA
PALFORZIA LEVEL 6	4	PA
PALFORZIA LEVEL 7	4	PA
PALFORZIA LEVEL 8	4	PA
PALFORZIA LEVEL 9	4	PA

Drug Name	Drug Tier	Requirements/Limits
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(20 EA per 5 days); MO; $0 Copay
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(30 EA per 5 days); MO; $0 Copay
SKYCLARYS	4	QL(90 EA per 30 days); PA
sodium chloride 0.9%	1	MO; GC
VISTOGARD	4	
ZOKINVY	4	QL(120 EA per 30 days); PA
Ophthalmic Agents		
Ophthalmic Agents, Other		
ATROPINE SULFATE SOLUTION 1%	2	MO
bacitracin/polymyxin b	1	MO; GC
BEOVU SOLUTION	4	PA
BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	3	MO
BRIMONIDINE TARTRATE/TIMOLOL MALEATE	2	MO
CYSTARAN	4	QL(60 ML per 28 days)
dorzolamide hcl/timolol maleate	1	MO; GC
LACRISERT	3	MO
neo-polycin	1	MO; GC
neo-polycin hc	1	MO; GC
neomycin/bacitracin/polymyxin	1	MO; GC
neomycin/polymyxin/bacitracin/hydrocortisone	1	MO; GC
neomycin/polymyxin/dexamethasone	1	MO; GC
NEOMYCIN/POLYMYXIN/GRAMICIDIN	2	MO
neomycin/polymyxin/hydrocortisone ophthalmic suspension 1%; 3.5mg/ml; 10000unit/ml	1	MO; GC
polycin	1	MO; GC
polymyxin b sulfate/trimethoprim sulfate	1	MO; GC
proparacaine hcl	1	MO; GC
RESTASIS	2	MO
RESTASIS MULTIDOSE	2	MO
ROCKLATAN	3	QL(2.5 ML per 25 days); MO
SULFACETAMIDE SODIUM/PREDNISOLONE SODIUM PHOSPHATE	2	MO
TOBRADEX ST	3	MO
TOBRADEX OINTMENT	2	MO
tobramycin/dexamethasone	2	MO
XIIDRA	3	QL(60 EA per 30 days); MO
ZYLET	3	MO
Ophthalmic Anti-allergy Agents		
ALOCRIL	3	MO
ALOMIDE	3	MO

Drug Name	Drug Tier	Requirements/Limits
azelastine hcl ophthalmic solution 0.05%	1	MO; GC
bepotastine besilate	3	MO
cromolyn sodium solution 4%	1	MO; GC
epinastine hcl	1	MO; GC
olopatadine hcl ophthalmic solution 0.1%	1	MO; GC
olopatadine hydrochloride solution 0.2%	1	MO; GC
Ophthalmic Anti-Infectives		
AZASITE	3	MO
bacitracin	2	MO
ciprofloxacin hydrochloride solution 0.3%	1	MO; GC
erythromycin ointment 5mg/gm	1	MO; GC
gatifloxacin	1	MO; GC
gentak ointment	1	MO; GC
gentamicin sulfate ophthalmic solution 0.3%	1	MO; GC
KLARITY-A	3	MO
levofloxacin ophthalmic solution 0.5%	2	MO
MOXIFLOXACIN HYDROCHLORIDE SOLUTION 0.5%	2	MO
moxifloxacin hydrochloride solution 0.5%	1	MO; GC
NATACYN	3	MO
ofloxacin ophthalmic solution 0.3%	1	MO; GC
sulfacetamide sodium ointment 10%	1	MO; GC
sulfacetamide sodium solution 10%	1	MO; GC
tobramycin solution 0.3%	1	MO; GC
TOBREX OINTMENT	3	MO
trifluridine	1	MO; GC
ZIRGAN	3	MO
Ophthalmic Anti-inflammatories		
ALREX	2	MO
dexamethasone sodium phosphate solution	1	MO; GC
diclofenac sodium ophthalmic solution 0.1%	1	MO; GC
DIFLUPREDNATE	2	MO
FLAREX	2	MO
fluorometholone	1	MO; GC
flurbiprofen sodium	1	MO; GC
ILEVRO	2	QL(4 ML per 30 days); MO
ketorolac tromethamine ophthalmic solution 0.4%, 0.5%	1	MO; GC
loteprednol etabonate gel	3	QL(20 GM per 365 days); MO
LOTEPREDNOL ETABONATE SUSPENSION 0.5%	2	MO
loteprednol etabonate suspension 0.2%	2	MO
NEVANAC	2	QL(4 ML per 30 days); MO
PREDNISOLONE ACETATE	2	MO

Drug Name	Drug Tier	Requirements/Limits
prednisolone sodium phosphate ophthalmic solution 1%	1	MO; GC
PROLENSA	2	QL(12 ML per 365 days); MO
Ophthalmic Beta-Adrenergic Blocking Agents		
betaxolol hcl solution 0.5%	1	MO; GC
BETIMOL	2	MO
BETOPTIC-S	3	MO
carteolol hcl	1	MO; GC
levobunolol hcl solution 0.5%	1	MO; GC
TIMOLOL MALEATE OPHTHALMIC GEL FORMING	2	MO
timolol maleate solution 0.25%, 0.5%	1	MO; GC
Ophthalmic Intraocular Pressure Lowering Agents, Other		
acetazolamide er	2	MO
acetazolamide tablet 125mg	1	MO; GC
ALPHAGAN P SOLUTION 0.1%	2	MO
apraclonidine	1	MO; GC
brimonidine tartrate solution 0.15%, 0.2%	1	MO; GC
brimonidine tartrate solution 0.1%	2	MO
brinzolamide	2	MO
dorzolamide hydrochloride	1	MO; GC
IOPIDINE SOLUTION 1%	3	MO
methazolamide tablet	2	MO
PHOSPHOLINE IODIDE SOLUTION RECONSTITUTED 0.125%	3	MO
pilocarpine hcl solution 1%, 2%, 4%	1	MO; GC
RHOPRESSA	3	QL(2.5 ML per 25 days); MO
Ophthalmic Prostaglandin and Prostamide Analogs		
bimatoprost	2	QL(5 ML per 30 days); MO
latanoprost solution	1	MO; GC
LUMIGAN	2	QL(2.5 ML per 25 days); MO
travoprost	1	QL(2.5 ML per 25 days); MO; GC
Otic Agents		
Otic Agents		
acetic acid	1	MO; GC
CIPRO HC	3	MO
ciprofloxacin/dexamethasone	1	MO; GC
flac	1	MO; GC
fluocinolone acetonide oil 0.01%	1	MO; GC
hydrocortisone/acetic acid	2	MO
neomycin/polymyxin/hc	1	MO; GC
neomycin/polymyxin/hydrocortisone otic suspension 1%; 3.5mg/ml; 10000unit/ml	1	MO; GC
ofloxacin otic solution 0.3%	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	2	QL(30 EA per 30 days); MO
ASMANEX HFA	3	QL(13 GM per 30 days); MO
ASMANEX TWISTHALER 120 METERED DOSES	3	QL(1 EA per 30 days); MO
ASMANEX TWISTHALER 14 METERED DOSES	3	QL(1 EA per 30 days); MO
ASMANEX TWISTHALER 30 METERED DOSES	3	QL(1 EA per 30 days); MO
ASMANEX TWISTHALER 60 METERED DOSES	3	QL(1 EA per 30 days); MO
ASMANEX TWISTHALER 7 METERED DOSES	3	QL(1 EA per 30 days); MO
budesonide suspension 0.25mg/2ml, 0.5mg/2ml, 1mg/2ml	3	QL(120 ML per 30 days); B/D; MO
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 250MCG/BLIST	2	QL(240 EA per 30 days); MO
FLOVENT DISKUS AEROSOL POWDER BREATH ACTIVATED 100MCG/BLIST, 50MCG/BLIST	2	QL(60 EA per 30 days); MO
FLOVENT HFA AEROSOL 44MCG/ACT	2	QL(21.2 GM per 30 days); MO
FLOVENT HFA AEROSOL 110MCG/ACT, 220MCG/ACT	2	QL(24 GM per 30 days); MO
flunisolide solution 0.025%	1	QL(50 ML per 30 days); MO; GC
fluticasone propionate suspension 50mcg/act	1	MO; GC
mometasone furoate suspension 50mcg/act	2	QL(34 GM per 30 days); MO
QVAR REDIHALER	2	QL(21.2 GM per 30 days); ST; MO
Antihistamines		
azelastine hcl nasal solution 0.15%	1	QL(60 ML per 30 days); MO; GC
azelastine hydrochloride solution 0.1%	1	QL(60 ML per 30 days); MO; GC
cetirizine hydrochloride solution 1mg/ml	1	MO; GC
cyproheptadine hcl syrup	1	MO; GC
cyproheptadine hydrochloride tablet	1	MO; GC
desloratadine	1	MO; GC
DIPHENHYDRAMINE HCL INJECTION 50MG/ML	2	MO
hydroxyzine hcl tablet 50mg	1	MO; GC
hydroxyzine hydrochloride syrup	1	MO; GC
hydroxyzine hydrochloride tablet 10mg, 25mg	1	MO; GC
levocetirizine dihydrochloride solution, tablet	1	MO; GC
olopatadine hcl nasal solution 0.6%	3	QL(30.5 GM per 30 days); MO
Antileukotrienes		
montelukast sodium tablet chewable, tablet	1	MO; GC
montelukast sodium packet	3	MO
zafirlukast	1	MO; GC
Bronchodilators, Anticholinergic		
ATROVENT HFA	2	QL(25.8 GM per 30 days); MO
ipratropium bromide nasal solution	1	MO; GC

Drug Name	Drug Tier	Requirements/Limits
ipratropium bromide inhalation solution	1	QL(312.5 ML per 30 days); B/D; MO; GC
SPIRIVA HANDIHALER	2	QL(30 EA per 30 days); MO
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5MCG/ACT	2	MO
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25MCG/ACT	2	QL(8 GM per 30 days); MO
tiotropium bromide	2	QL(30 EA per 30 days); MO
Bronchodilators, Sympathomimetic		
ALBUTEROL SULFATE ER	2	MO
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(13.4 GM per 30 days); MO; GC
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(17 GM per 30 days); MO; GC
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(48 GM per 30 days); MO; GC
albuterol sulfate syrup, tablet	3	MO
albuterol sulfate nebulization solution 2.5mg/0.5ml	1	QL(100 EA per 30 days); B/D; MO; GC
albuterol sulfate nebulization solution 0.63mg/3ml, 1.25mg/3ml	1	QL(375 ML per 30 days); B/D; MO; GC
albuterol sulfate nebulization solution 0.083%	1	QL(525 ML per 30 days); B/D; MO; GC
ARCAPTA NEOHALER	3	MO
arformoterol tartrate	3	QL(120 ML per 30 days); PA; MO
EPINEPHRINE INJECTION 0.15MG/0.15ML	1	MO; GC
epinephrine injection 0.15mg/0.3ml, 0.3mg/0.3ml	1	MO; GC
formoterol fumarate nebulization solution	3	QL(120 ML per 30 days); B/D; MO
levalbuterol hcl nebulization solution 1.25mg/3ml	1	QL(270 ML per 30 days); B/D; MO; GC
levalbuterol hcl nebulization solution 0.31mg/3ml	1	QL(540 ML per 30 days); B/D; MO; GC
levalbuterol hydrochloride nebulization solution 0.63mg/3ml	1	QL(540 ML per 30 days); B/D; MO; GC
levalbuterol tartrate hfa	1	QL(30 GM per 30 days); MO; GC
levalbuterol nebulization solution	1	QL(90 EA per 30 days); B/D; MO; GC
PROAIR DIGIHALER	2	QL(2 EA per 30 days); MO
PROAIR RESPICLICK	2	QL(2 EA per 30 days); MO
SEREVENT DISKUS	2	QL(60 EA per 30 days); MO
terbutaline sulfate tablet	3	MO
Cystic Fibrosis Agents		
CAYSTON	4	PA
KALYDECO	4	PA
ORKAMBI TABLET	4	QL(112 EA per 28 days); PA
PULMOZYME	4	PA
TOBI PODHALER	4	QL(224 EA per 56 days)

Drug Name	Drug Tier	Requirements/Limits
tobramycin nebulization solution 300mg/4ml, 300mg/5ml	4	B/D
TRIKAFTA THERAPY PACK	4	QL(56 EA per 28 days); PA
TRIKAFTA TABLET THERAPY PACK	4	QL(84 EA per 28 days); PA
Mast Cell Stabilizers		
cromolyn sodium nebulization solution 20mg/2ml	4	B/D
Phosphodiesterase Inhibitors, Airways Disease		
elixophyllin	1	MO; GC
roflumilast	3	PA; MO
theophylline er tablet extended release 24 hour	1	MO; GC
THEOPHYLLINE ER TABLET EXTENDED RELEASE 12 HOUR 300MG	2	MO
theophylline elixir	1	MO; GC
theophylline solution	2	MO
Pulmonary Antihypertensives		
ADEMPAS	4	QL(90 EA per 30 days); PA
alyq	3	QL(60 EA per 30 days); PA; MO
ambrisentan	4	QL(30 EA per 30 days); PA
OPSUMIT	4	QL(30 EA per 30 days); PA
ORENITRAM TITRATION KIT MONTH 1	4	QL(336 EA per 365 days); PA
ORENITRAM TITRATION KIT MONTH 2	4	QL(672 EA per 365 days); PA
ORENITRAM TITRATION KIT MONTH 3	4	QL(504 EA per 365 days); PA
ORENITRAM TABLET EXTENDED RELEASE 0.125MG	3	PA; MO
ORENITRAM TABLET EXTENDED RELEASE 0.25MG, 1MG, 2.5MG, 5MG	4	PA
sildenafil citrate tablet 20mg	1	QL(90 EA per 30 days); PA; MO; GC
tadalafil tablet 20mg	3	QL(60 EA per 30 days); PA; MO
TADLIQ	4	QL(300 ML per 30 days); PA
UPTRAVI TITRATION PACK	4	QL(400 EA per 365 days); PA
UPTRAVI TABLET	4	QL(60 EA per 30 days); PA
VENTAVIS	4	QL(270 ML per 30 days); PA
Pulmonary Fibrosis Agents		
OFEV	4	PA
pirfenidone	4	PA
Respiratory Tract Agents, Other		
acetylcysteine solution	1	B/D; MO; GC
ANORO ELLIPTA	2	QL(60 EA per 30 days); MO
BREO ELLIPTA	2	QL(60 EA per 30 days); MO
BRONCHITOL	4	QL(560 EA per 28 days); PA
COMBIVENT RESPIMAT	2	QL(8 GM per 30 days); MO
FASENRA	4	PA
FASENRA PEN	4	PA

Drug Name	Drug Tier	Requirements/Limits
fluticasone propionate/salmeterol diskus	1	QL(60 EA per 30 days); MO; GC
fluticasone propionate/salmeterol aerosol powder breath activated 100mcg/act; 50mcg/act, 250mcg/act; 50mcg/act, 500mcg/act; 50mcg/act	1	QL(60 EA per 30 days); MO; GC
ipratropium bromide/albuterol sulfate	1	QL(540 ML per 30 days); B/D; MO; GC
STIOLTO RESPIMAT	2	QL(24 GM per 30 days); MO
SYMBICORT AEROSOL 160MCG/ACT; 4.5MCG/ACT	2	QL(12 GM per 30 days); MO
SYMBICORT AEROSOL 80MCG/ACT; 4.5MCG/ACT	2	QL(13.8 GM per 30 days); MO
TRELEGY ELLIPTA	2	QL(60 EA per 30 days); MO
wixela inhub	1	QL(60 EA per 30 days); MO; GC
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
carisoprodol tablet 350mg	1	PA; MO; GC
chlorzoxazone tablet 500mg	1	MO; GC
cyclobenzaprine hydrochloride tablet 10mg, 5mg	1	MO; GC
methocarbamol tablet 500mg, 750mg	1	MO; GC
orphenadrine citrate er	1	MO; GC
Sleep Disorder Agents		
Sleep Promoting Agents		
DOXEPIN HYDROCHLORIDE TABLET 3MG, 6MG	2	QL(30 EA per 30 days); MO
estazolam	1	QL(30 EA per 30 days); MO; GC
eszopiclone	1	QL(30 EA per 30 days); MO; GC
ramelteon	2	QL(30 EA per 30 days); MO
tasimelteon	4	QL(30 EA per 30 days); PA
temazepam capsule 15mg, 30mg	1	QL(30 EA per 30 days); MO; GC
temazepam capsule 7.5mg	2	QL(30 EA per 30 days); MO
zaleplon capsule 5mg	1	QL(30 EA per 30 days); MO; GC
zaleplon capsule 10mg	1	QL(60 EA per 30 days); MO; GC
zolpidem tartrate er	1	QL(30 EA per 30 days); MO; GC
zolpidem tartrate tablet	1	QL(30 EA per 30 days); MO; GC
Wakefulness Promoting Agents		
armodafinil tablet 50mg	1	QL(60 EA per 30 days); PA; MO; GC
armodafinil tablet 150mg, 200mg, 250mg	2	QL(30 EA per 30 days); PA; MO
modafinil tablet	2	QL(30 EA per 30 days); PA; MO
sodium oxybate	4	QL(540 ML per 30 days); PA
XYREM	4	QL(540 ML per 30 days); PA

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Ultimate Health Plans' Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-657-4170 (TTY: 711). Someone who speaks English or the needed language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-657-4170 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-657-4170 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-657-4170 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-657-4170 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-657-4170 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-657-4170 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-657-4170 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-657-4170 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-657-4170 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-657-4170 (برقياً :117). سيقوم شخص بمساعدتك. هذه خدمة مجانية ما يتحدث العربية

Hindi: हमारे स्वास्थ्य या दवा योजना से संबंधित आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त इंटरप्रेटर सेवाएं हैं। इंटरप्रेटर प्राप्त करने के लिए, हमें तुरंत 1-888-657-4170 (TTY: 711) पर कॉल करें। जो कोई भी व्यक्ति [हिंदी/गुजराती/थाई] बोलता हो, वह आपकी सहायता कर सकता है। यह सेवा बिलकुल मुफ्त है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-657-4170 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-657-4170 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-657-4170 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-657-4170 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-657-4170 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

ULTIMATE
HEALTH PLANS

Visit our website at www.ChooseUltimate.com
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Visite nuestro sitio web en www.ChooseUltimate.com
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To learn more, call

1-855-858-7526 (TTY 711)

October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.
April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.

Para obtener mas información, llame

1-855-858-7526 (TTY 711)

Octubre 1 - Marzo 31: Lunes - Domingo 8 a.m. - 8 p.m.
Abril 1 - Septiembre 30: Lunes - Viernes 8 a.m. - 8 p.m.

Community Outreach Offices
Oficina de Extensión Comunitaria

2713 Forest Rd
Spring Hill, FL 34606

4058 Tampa Rd, STE 7
Oldsmar, FL 34677

303 SE 17th St, STE 305
Ocala, FL 34471

600 N US Highway 1, STE A
Fort Pierce, FL 34950

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN. This formulary was updated on 03/19/2024. For more recent information or other questions, please contact Ultimate Health Plans Member Services at 1-888-657-4170 (TTY users should call 711), Monday through Sunday from 8 a.m. to 8 p.m. EST (during certain times of the year we may use alternative technologies to answer your call on weekends and Federal holidays) or visit www.ChooseUltimate.com.

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRE ESTE PLAN. Esta lista de medicamentos cubiertos se actualizó el 03/19/2024. Para obtener información más reciente o si tiene otras preguntas, comuníquese con Ultimate Health Plans Servicios para Miembros al 1-888-657-4170 y para usuarios TTY, 711, de lunes a domingo, de 8:00 a.m. a 8:00 p.m. hora del Este (en ciertos momentos del año podríamos usar tecnologías alternativas para responder sus llamadas los fines de semana y los feriados federales) o visite www.ChooseUltimate.com.