Stanford Health Care Advantage
2018 Abridged Formulary
Partial List of Covered Drugs

Stanford
HEALTH CARE ADVANTAGE

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

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This abridged formulary was updated on 04/01/2018. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact Stanford Health Care Advantage Member Care Services, at 1-855-996-8422 or, for TTY users, 711, 8 am to 8 pm, seven days a week (except Thanksgiving and Christmas) from October 1 through February 14 and Monday through Friday (except holidays) from February 15 through September 30, or visit StanfordHealthCareAdvantage.org.

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 Stanford Health Care Advantage (HMO). When it refers to "plan" or "our plan," it means Stanford Health Care Advantage Platinum or Stanford Health Care Advantage Gold.

This document includes a partial list of the drugs (formulary) for our plan which is current as of April 1, 2018. For a complete, 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, 2018, and from time to time during the year.

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What is the Stanford Health Care Advantage (HMO) Abridged Formulary?

A formulary is a list of covered drugs selected by Stanford Health Care Advantage (HMO) 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 Stanford Health Care Advantage (HMO) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Stanford Health Care Advantage (HMO). For a complete listing of all prescription drugs covered by our plan, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2018 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2018 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

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 60 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 60-day supply of the drug. 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. The enclosed formulary is current as of 4/1/2018. 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 we make a non-maintenance change to the formulary, we will post an errata sheet to our Website and mail a letter to members.

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page I-1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Stanford Health Care Advantage (HMO) 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:** Stanford Health Care Advantage (HMO) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, Stanford Health Care Advantage (HMO) limits the amount of the drug that our plan will cover. For example, we provide 30 per prescription for SILENOR. This may be in addition to a standard one-month or three-month supply.

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

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 Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Stanford Health Care Advantage (HMO) 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 Stanford Health Care Advantage (HMO) formulary?" on page v 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. This document includes only a partial list of covered drugs, so Stanford Health Care Advantage (HMO) may cover your drug. For more information, 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 learn that Stanford Health Care Advantage (HMO) does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Stanford Health Care Advantage (HMO). When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Stanford Health Care Advantage (HMO).

- You can ask Stanford Health Care Advantage (HMO) 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 Stanford Health Care Advantage HMO Formulary?

You can ask Stanford Health Care Advantage (HMO) to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

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

- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Stanford Health Care Advantage (HMO) 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, Stanford Health Care Advantage (HMO) will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with a 91-day transition supply, and may be as much as a 98-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

In circumstances where you are changing from one treatment setting to another, Stanford Health Care Advantage (HMO) will ensure a transition process for approving non-formulary Part D drugs. This process shall also apply to formulary Part D drugs that require prior authorization or step-therapy.

Examples of level of care changes include: you are discharged from a hospital to a home; you end your skilled nursing facility Medicare Part A stay and need to revert to your Part D plan formulary; you end a long-term care facility stay and return to the community; and, you are discharged from psychiatric hospitals with medication regimens that are highly individualized.

The pharmacy benefit manager for Stanford Health Care Advantage (HMO) will provide pharmacies with access to representatives of the plan who have the ability to override pharmacy claims processing issues. This access will allow pharmacies to obtain prescription claims overrides at the point-of-sale and ensure that members receive reliable access to medications.

For more information

For more detailed information about your Stanford Health Care Advantage (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Stanford Health Care Advantage (HMO), 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.

Stanford Health Care Advantage (HMO) Formulary

The abridged formulary below provides coverage information about some of the drugs covered by Stanford Health Care Advantage (HMO). If you have trouble finding your drug in the list, turn to the Index that begins on page I-1.

Remember: This is only a partial list of drugs covered by Stanford Health Care Advantage (HMO). If your prescription is not in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

The information in the Requirements/Limits column tells you if Stanford Health Care Advantage (HMO) has any special requirements for coverage of your drug.

The second column of the chart lists the drug tier. Every drug on the plan's Drug List is in one of six cost-sharing tiers. The tables below provide an explanation of each tier.

Network Retail Pharmacy Drug Tier Copayment Levels

Tier	Copay for up to a *one-month* supply	Copay for up to a *three-month* supply
Tier 1 (Preferred Generic)	$5	$15
Tier 2 (NON-Preferred Generic)	$15	$45
Tier 3 (Preferred Brand)	$47	$141
Tier 4 (NON-Preferred Brand Name)	$100	$300
Tier 5 (Specialty)	33% of cost (Platinum) 28% of cost (Gold)	Not available
Tier 6 (Select Care)	$2	$6

Network Mail Order Drug Tier Copayment Levels

Tier	Copay for up to a *one-month* supply	Copay for up to a *three-month* supply
Tier 1 (Preferred Generic)	$5	$10
Tier 2 (NON-Preferred Generic)	$15	$30
Tier 3 (Preferred Brand)	$47	$94
Tier 4 (NON-Preferred Brand Name)	$100	$200
Tier 5 (Specialty)	33% of cost (Platinum) 28% of cost (Gold)	Not available
Tier 6 (Select Care)	$2	$4

The following Utilization Management abbreviations may be found within the body of this document

COVERAGE NOTES ABBREVIATIONS

ABBREVIATION	DESCRIPTION	EXPLANATION
Utilization Management Restrictions		
PA	Prior Authorization Restriction	You (or your physician) are required to get prior authorization from Stanford Health Care Advantage (HMO) before you fill your prescription for this drug. Without prior approval, Stanford Health Care Advantage (HMO) may not cover this drug.
PA BvD	Prior Authorization Restriction for Part B vs Part D Determination	This drug may be eligible for payment under Medicare Part B or Part D. You (or your physician) are required to get prior authorization from Stanford Health Care Advantage (HMO) to determine whether this drug is covered under Medicare Part D before you fill your prescription for

ABBREVIATION	DESCRIPTION	EXPLANATION
		this drug. Without prior approval, Stanford Health Care Advantage (HMO) may not cover this drug.
PA-HRM	Prior Authorization Restriction for High Risk Medications	This drug has been deemed by CMS to be potentially harmful and therefore, a High Risk Medication for Medicare beneficiaries 65 years or older. Members age 65 years or older are required to get prior authorization from Stanford Health Care Advantage (HMO) before filling your prescription for this drug. Without prior approval, Stanford Health Care Advantage (HMO) may not cover this drug.
PA NSO	Prior Authorization Restriction for New Starts Only	If you are a new member or if you have not taken this drug previously, you (or your physician) are required to get prior authorization from Stanford Health Care Advantage (HMO) before you fill your prescription for this drug. Without prior approval, Stanford Health Care Advantage (HMO) may not cover this drug.
QL	Quantity Limit Restriction	Stanford Health Care Advantage (HMO) limits the amount of this drug that is covered per prescription, or within a specific time frame.
ST	Step Therapy Restriction	Before Stanford Health Care Advantage (HMO) will provide coverage for this drug, you must first try another drug(s) to treat your medical condition. This drug may only be covered if the other drug(s) does not work for you.

The following additional coverage note abbreviations may be found within the body of this document
OTHER SPECIAL REQUIREMENTS FOR COVERAGE

ABBREVIATION	DESCRIPTION	EXPLANATION
Other Coverage Abbreviations		
EX	Excluded Part D 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, *Extra Help* is not available to help pay for this drug

ABBREVIATION	DESCRIPTION	EXPLANATION
LA	Limited Access Drug	This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Member Services at 1-855-996-8422 8a.m. to 8p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Please dial 711 for TTY services.
GC	Gap Coverage	We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.
NM	Non-Mail Order Drug	You may be able to receive greater than a 1-month supply of most of the drugs on your formulary via mail order at a reduced cost share. Drugs not available via your mail order benefit are noted with "NM" in the Requirements/Limits column of your formulary.
HI	Home Infusion Drug	This prescription drug may be covered under our medical benefit. For more information, call Member Services at 1-855-996-8422 8a.m. to 8p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Please dial 711 for TTY services.

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Drug Name		Drug Tier	Requirements/Limits
Analgesics			
Analgesics, Miscellaneous			
acetaminophen-codeine oral solution 120-12 mg/5 ml		2	QL (2700 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg		2	QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-30 mg	(Tylenol-Codeine #3)	2	QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	(Tylenol-Codeine #4)	2	QL (180 per 30 days)
butalbital-acetaminophen-caff oral capsule 50-325-40 mg	(Capacet)	2	QL (180 per 30 days)
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	(Esgic)	2	QL (180 per 30 days)
endocet oral tablet 10-325 mg		2	QL (240 per 30 days)
endocet oral tablet 5-325 mg		2	QL (360 per 30 days)
endocet oral tablet 7.5-325 mg		2	QL (300 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	(Hycet)	2	QL (2700 per 30 days)
hydrocodone-acetaminophen oral tablet 10-300 mg	(Vicodin HP)	2	QL (390 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg	(Lorcet HD)	2	QL (360 per 30 days)
hydrocodone-acetaminophen oral tablet 2.5-325 mg	(Verdrocet)	2	QL (360 per 30 days)
hydrocodone-acetaminophen oral tablet 5-300 mg	(Vicodin)	2	QL (390 per 30 days)
hydrocodone-acetaminophen oral tablet 5-325 mg	(Lorcet (hydrocodone))	2	QL (360 per 30 days)
hydrocodone-acetaminophen oral tablet 7.5-300 mg	(Vicodin ES)	2	QL (390 per 30 days)
hydrocodone-acetaminophen oral tablet 7.5-325 mg	(Lorcet Plus)	2	QL (360 per 30 days)
lorcet (hydrocodone) oral tablet 5-325 mg		2	QL (360 per 30 days)
lorcet hd oral tablet 10-325 mg		2	QL (360 per 30 days)
lorcet plus oral tablet 7.5-325 mg		2	QL (360 per 30 days)
morphine 2 mg/ml carpuject outer, l/f, p/f, sdv 2 mg/ml		2	
morphine 4 mg/ml carpuject outer,l/f,p/f, sdv 4 mg/ml		2	

Drug Name		Drug Tier	Requirements/Limits
morphine 8 mg/ml carpuject sdv, l/f, outer 8 mg/ml		2	
morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)		2	QL (180 per 30 days)
morphine intravenous syringe 10 mg/ml, 2 mg/ml, 4 mg/ml, 8 mg/ml		2	
morphine oral solution 10 mg/5 ml		2	QL (700 per 30 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)		2	QL (300 per 30 days)
MORPHINE ORAL TABLET 15 MG		4	QL (180 per 30 days)
MORPHINE ORAL TABLET 30 MG		4	QL (120 per 30 days)
morphine oral tablet extended release 100 mg, 200 mg, 60 mg	(MS Contin)	2	QL (60 per 30 days)
morphine oral tablet extended release 15 mg, 30 mg	(MS Contin)	2	QL (90 per 30 days)
morphine sulfate 10 mg/ml vial 10 mg/ml		2	
oxycodone oral capsule 5 mg		2	QL (180 per 30 days)
oxycodone oral concentrate 20 mg/ml		2	QL (120 per 30 days)
oxycodone oral solution 5 mg/5 ml		2	QL (1300 per 30 days)
oxycodone oral tablet 10 mg		2	QL (180 per 30 days)
oxycodone oral tablet 15 mg, 30 mg	(Roxicodone)	2	QL (120 per 30 days)
oxycodone oral tablet 20 mg		2	QL (120 per 30 days)
oxycodone oral tablet 5 mg	(Roxicodone)	2	QL (180 per 30 days)
oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg	(OxyContin)	2	QL (60 per 30 days)
oxycodone oral tablet,oral only,ext.rel.12 hr 80 mg	(OxyContin)	5	NM; NDS; QL (120 per 30 days)
oxycodone-acetaminophen oral solution 5-325 mg/5 ml		2	QL (1800 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg	(Endocet)	2	QL (240 per 30 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	(Endocet)	2	QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 7.5-325 mg	(Endocet)	2	QL (300 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG		3	QL (60 per 30 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG		3	QL (120 per 30 days)
tramadol oral tablet 50 mg	(Ultram)	1	GC; QL (240 per 30 days)
vicodin es oral tablet 7.5-300 mg		2	QL (390 per 30 days)
vicodin hp oral tablet 10-300 mg		2	QL (390 per 30 days)
vicodin oral tablet 5-300 mg		2	QL (390 per 30 days)
zebutal oral capsule 50-325-40 mg		2	QL (180 per 30 days)
Nonsteroidal Anti-Inflammatory Agents			
diclofenac sodium oral tablet extended release 24 hr 100 mg	(Voltaren-XR)	2	
diclofenac sodium oral tablet,delayed release (dr/ec) 25 mg, 50 mg, 75 mg		2	
ibuprofen oral suspension 100 mg/5 ml	(Child Ibuprofen)	2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg		1	GC
indomethacin oral capsule 25 mg		1	GC; QL (240 per 30 days)
indomethacin oral capsule 50 mg		1	GC; QL (120 per 30 days)
indomethacin oral capsule, extended release 75 mg		2	QL (60 per 30 days)
meloxicam oral tablet 15 mg, 7.5 mg	(Mobic)	1	GC
nabumetone oral tablet 500 mg, 750 mg		2	
naproxen oral suspension 125 mg/5 ml	(Naprosyn)	2	
naproxen oral tablet 250 mg, 375 mg		1	GC
naproxen oral tablet 500 mg	(Naprosyn)	1	GC
naproxen oral tablet,delayed release (dr/ec) 375 mg, 500 mg	(EC-Naprosyn)	2	
Anesthetics			
Local Anesthetics			
lidocaine hcl injection solution 20 mg/ml (2 %)	(Xylocaine)	2	
lidocaine hcl mucous membrane jelly 2 %		2	
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)		2	
lidocaine topical adhesive patch,medicated 5 %	(Lidoderm)	2	PA; QL (90 per 30 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name	Drug Tier	Requirements/Limits
lidocaine topical ointment 5 %	2	PA; QL (90 per 30 days)
lidocaine viscous mucous membrane solution 2 %	2	
Anti-Addiction/Substance Abuse Treatment Agents		
Anti-Addiction/Substance Abuse Treatment Agents		
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	3	QL (30 per 30 days)
BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	3	QL (60 per 30 days)
buprenorphine hcl sublingual tablet 2 mg, 8 mg	2	QL (90 per 30 days)
buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg	2	QL (90 per 30 days)
CHANTIX CONTINUING MONTH BOX ORAL TABLET 1 MG	3	QL (168 per 84 days)
CHANTIX ORAL TABLET 0.5 MG, 1 MG	3	QL (168 per 84 days)
CHANTIX STARTING MONTH BOX ORAL TABLETS,DOSE PACK 0.5 MG (11)- 1 MG (42)	3	QL (53 per 28 days)
SUBOXONE SUBLINGUAL FILM 12-3 MG, 8-2 MG	3	QL (60 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG	3	QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG	3	QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	3	QL (60 per 30 days)
Antianxiety Agents		
Benzodiazepines		
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg (Xanax)	1	GC; QL (120 per 30 days)
alprazolam oral tablet 2 mg (Xanax)	1	GC; QL (150 per 30 days)
alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg (Xanax XR)	2	QL (120 per 30 days)

Drug Name		Drug Tier	Requirements/Limits
alprazolam oral tablet extended release 24 hr 3 mg	(Xanax XR)	2	QL (90 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	(Klonopin)	1	GC; QL (90 per 30 days)
clonazepam oral tablet 2 mg	(Klonopin)	1	GC; QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg		2	QL (90 per 30 days)
clonazepam oral tablet,disintegrating 2 mg		2	QL (300 per 30 days)
DIASTAT ACUDIAL RECTAL KIT 12.5-15-17.5-20 MG, 5-7.5-10 MG		4	
DIASTAT RECTAL KIT 2.5 MG		4	
diazepam intensol oral concentrate 5 mg/ml		2	QL (1200 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)		2	QL (1200 per 30 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	(Valium)	1	GC; QL (120 per 30 days)
lorazepam oral concentrate 2 mg/ml	(Lorazepam Intensol)	2	QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	(Ativan)	1	GC; QL (90 per 30 days)
lorazepam oral tablet 2 mg	(Ativan)	1	GC; QL (150 per 30 days)
Antibacterials			
Aminoglycosides			
BETHKIS INHALATION SOLUTION FOR NEBULIZATION 300 MG/4 ML		5	PA BvD; NM; NDS
neomycin oral tablet 500 mg		1	GC
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG		5	NM; NDS; QL (224 per 28 days)
Antibacterials, Miscellaneous			
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	(Cleocin HCl)	2	
metronidazole oral tablet 250 mg, 500 mg	(Flagyl)	2	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	(Macrodantin)	2	QL (120 per 30 days)
nitrofurantoin monohyd/m-cryst oral capsule 100 mg	(Macrobid)	2	QL (60 per 30 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
trimethoprim oral tablet 100 mg		1	GC
XIFAXAN ORAL TABLET 200 MG		5	PA; NM; NDS; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG		5	PA; NM; NDS
Cephalosporins			
cefadroxil oral capsule 500 mg		2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml		2	
cefadroxil oral tablet 1 gram		2	
cefdinir oral capsule 300 mg		2	
cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		2	
cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		2	
cefprozil oral tablet 250 mg, 500 mg		2	
cefuroxime axetil oral tablet 250 mg, 500 mg		2	
cephalexin oral capsule 250 mg, 500 mg	(Keflex)	1	GC
cephalexin oral capsule 750 mg	(Keflex)	2	
cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		2	
cephalexin oral tablet 250 mg, 500 mg		2	
Macrolides			
azithromycin intravenous recon soln 500 mg	(Zithromax)	2	
azithromycin oral packet 1 gram	(Zithromax)	2	
azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml	(Zithromax)	2	
azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)		2	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	(Zithromax)	2	
clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		2	
clarithromycin oral tablet 250 mg, 500 mg		2	
clarithromycin oral tablet extended release 24 hr 500 mg		2	

Drug Name	Drug Tier	Requirements/Limits
Miscellaneous B-Lactam Antibiotics		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML	5	NM; LA; NDS
INVANZ INJECTION RECON SOLN 1 GRAM	4	
Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	GC
amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml	1	GC
amoxicillin oral tablet 500 mg, 875 mg	1	GC
amoxicillin oral tablet,chewable 125 mg, 250 mg	1	GC
amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 400-57 mg/5 ml	2	
amoxicillin-pot clavulanate oral suspension for reconstitution 250-62.5 mg/5 ml (Augmentin)	2	
amoxicillin-pot clavulanate oral suspension for reconstitution 600-42.9 mg/5 ml (Augmentin ES-600)	2	
amoxicillin-pot clavulanate oral tablet 250-125 mg	2	
amoxicillin-pot clavulanate oral tablet 500-125 mg, 875-125 mg (Augmentin)	2	
amoxicillin-pot clavulanate oral tablet extended release 12 hr 1,000-62.5 mg (Augmentin XR)	2	
amoxicillin-pot clavulanate oral tablet,chewable 200-28.5 mg, 400-57 mg	2	
dicloxacillin oral capsule 250 mg, 500 mg	2	
penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml	2	
penicillin v potassium oral tablet 250 mg, 500 mg	2	
Quinolones		
ciprofloxacin hcl oral tablet 100 mg, 750 mg	1	GC
ciprofloxacin hcl oral tablet 250 mg, 500 mg (Cipro)	1	GC

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
levofloxacin intravenous solution 25 mg/ml		2	
levofloxacin oral solution 250 mg/10 ml		2	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	(Levaquin)	2	
ofloxacin oral tablet 300 mg, 400 mg		2	
Sulfonamides			
sulfadiazine oral tablet 500 mg		2	
sulfamethoxazole-trimethoprim intravenous solution 400-80 mg/5 ml		2	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml	(Sulfatrim)	2	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg	(Bactrim)	1	GC
sulfamethoxazole-trimethoprim oral tablet 800-160 mg	(Bactrim DS)	1	GC
Tetracyclines			
doxy-100 intravenous recon soln 100 mg		2	
doxycycline hyclate oral capsule 100 mg, 50 mg	(Morgidox)	2	
doxycycline hyclate oral tablet 100 mg, 20 mg		2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 150 mg, 75 mg		2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 200 mg, 50 mg	(Doryx)	2	
minocycline oral capsule 100 mg, 50 mg, 75 mg	(Minocin)	2	
minocycline oral tablet 100 mg, 50 mg, 75 mg		2	
minocycline oral tablet extended release 24 hr 135 mg, 45 mg, 90 mg	(CoreMino)	2	
Anticancer Agents			
Anticancer Agents			
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG		5	PA NSO; NM; NDS; QL (112 per 28 days)
AFINITOR ORAL TABLET 10 MG		5	PA NSO; NM; NDS; QL (56 per 28 days)
AFINITOR ORAL TABLET 2.5 MG, 5 MG, 7.5 MG		5	PA NSO; NM; NDS; QL (28 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
anastrozole oral tablet 1 mg	(Arimidex)	1	GC
bicalutamide oral tablet 50 mg	(Casodex)	2	
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG		3	
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG		4	
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG		4	
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG		4	
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)		4	
ERIVEDGE ORAL CAPSULE 150 MG		5	PA NSO; NM; NDS; QL (30 per 30 days)
exemestane oral tablet 25 mg	(Aromasin)	2	
FARESTON ORAL TABLET 60 MG		5	NM; NDS
hydroxyurea oral capsule 500 mg	(Hydrea)	2	
INLYTA ORAL TABLET 1 MG		5	PA NSO; NM; NDS; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG		5	PA NSO; NM; NDS; QL (60 per 30 days)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG		5	PA NSO; NM; NDS; QL (60 per 30 days)
letrozole oral tablet 2.5 mg	(Femara)	2	
LEUKERAN ORAL TABLET 2 MG		4	
leuprolide subcutaneous kit 1 mg/0.2 ml		2	
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 22.5 MG		5	NM; NDS
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG		5	NM; NDS
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG		5	NM; NDS
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG, 7.5 MG		5	NM; NDS
LYSODREN ORAL TABLET 500 MG		5	NM; NDS
megestrol oral tablet 20 mg, 40 mg		2	

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Drug Name	Drug Tier	Requirements/Limits
mercaptopurine oral tablet 50 mg	2	
methotrexate sodium injection solution 25 mg/ml	2	PA BvD
methotrexate sodium oral tablet 2.5 mg	2	PA BvD; ST
NEXAVAR ORAL TABLET 200 MG	5	PA NSO; NM; NDS; QL (120 per 30 days)
paclitaxel intravenous concentrate 6 mg/ml	2	
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA NSO; NM; NDS; QL (21 per 28 days)
PURIXAN ORAL SUSPENSION 20 MG/ML	5	NM; NDS
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA NSO; NM; LA; NDS
SOLTAMOX ORAL SOLUTION 10 MG/5 ML	4	
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG	5	PA NSO; NM; NDS; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG	5	PA NSO; NM; NDS; QL (60 per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA NSO; NM; NDS; QL (84 per 28 days)
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG	5	PA NSO; NM; NDS; QL (30 per 30 days)
TABLOID ORAL TABLET 40 MG	4	
tamoxifen oral tablet 10 mg, 20 mg	2	
TARCEVA ORAL TABLET 100 MG, 25 MG	5	PA NSO; NM; NDS; QL (60 per 30 days)
TARCEVA ORAL TABLET 150 MG	5	PA NSO; NM; NDS; QL (90 per 30 days)
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PA NSO; NM; NDS; QL (112 per 28 days)
tretinoin (chemotherapy) oral capsule 10 mg	5	NM; NDS
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	4	PA BvD; ST
TYKERB ORAL TABLET 250 MG	5	NM; NDS
VOTRIENT ORAL TABLET 200 MG	5	PA NSO; NM; NDS; QL (120 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
XALKORI ORAL CAPSULE 200 MG, 250 MG		5	PA NSO; NM; NDS; QL (60 per 30 days)
XTANDI ORAL CAPSULE 40 MG		5	PA NSO; NM; NDS; QL (120 per 30 days)
ZELBORAF ORAL TABLET 240 MG		5	PA NSO; NM; NDS; QL (240 per 30 days)
ZYTIGA ORAL TABLET 250 MG		5	PA NSO; NM; NDS; QL (120 per 30 days)
Anticholinergic Agents			
Antimuscarinics/Antispasmodics			
atropine injection syringe 0.05 mg/ml		2	
propantheline oral tablet 15 mg		2	
Anticonvulsants			
Anticonvulsants			
carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg	(Carbatrol)	2	
carbamazepine oral suspension 100 mg/5 ml	(Tegretol)	2	
carbamazepine oral tablet 200 mg	(Epitol)	2	
carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg	(Tegretol XR)	2	
carbamazepine oral tablet,chewable 100 mg		2	
DILANTIN ORAL CAPSULE 30 MG		2	
divalproex oral capsule, delayed rel sprinkle 125 mg	(Depakote Sprinkles)	2	
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	(Depakote ER)	2	
divalproex oral tablet,delayed release (dr/ec) 125 mg, 250 mg, 500 mg	(Depakote)	2	
epitol oral tablet 200 mg		2	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	(Neurontin)	2	
gabapentin oral solution 250 mg/5 ml	(Neurontin)	2	
gabapentin oral tablet 600 mg, 800 mg	(Neurontin)	2	
GRALISE 30-DAY STARTER PACK ORAL TABLET EXTENDED RELEASE 24 HR 300 MG (9)- 600 MG (69)		4	ST; QL (78 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 600 MG		4	ST; QL (90 per 30 days)
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	(Lamictal)	2	
lamotrigine oral tablet extended release 24hr 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	(Lamictal XR)	2	
lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg	(Lamictal)	2	
lamotrigine oral tablet,disintegrating 100 mg, 200 mg, 25 mg, 50 mg	(Lamictal ODT)	2	
levetiracetam intravenous solution 500 mg/5 ml	(Keppra)	2	
levetiracetam oral solution 100 mg/ml	(Keppra)	2	
levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg	(Keppra)	2	
levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg	(Keppra XR)	2	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG		3	QL (90 per 30 days)
LYRICA ORAL SOLUTION 20 MG/ML		3	QL (900 per 30 days)
phenytoin sodium extended oral capsule 100 mg	(Dilantin Extended)	2	
phenytoin sodium extended oral capsule 200 mg, 300 mg	(Phenytek)	2	
ROWEEPRA ORAL TABLET 1,000 MG, 500 MG, 750 MG		2	
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG		4	ST; QL (60 per 30 days)
SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG, 750 MG		4	ST; QL (120 per 30 days)
topiramate oral capsule, sprinkle 15 mg, 25 mg	(Topamax)	2	
topiramate oral capsule,sprinkle,er 24hr 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	(Qudexy XR)	2	
topiramate oral tablet 100 mg, 200 mg, 50 mg	(Topamax)	2	

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Drug Name		Drug Tier	Requirements/Limits
topiramate oral tablet 25 mg	(Topamax)	1	GC
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 25 MG, 50 MG		4	QL (30 per 30 days)
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG		5	NM; NDS; QL (60 per 30 days)
Antidementia Agents			
Antidementia Agents			
donepezil oral tablet 10 mg, 23 mg, 5 mg	(Aricept)	2	QL (30 per 30 days)
donepezil oral tablet,disintegrating 10 mg, 5 mg		2	QL (30 per 30 days)
memantine oral solution 2 mg/ml		2	QL (360 per 30 days)
memantine oral tablet 10 mg, 5 mg	(Namenda)	2	QL (60 per 30 days)
memantine oral tablets,dose pack 5-10 mg	(Namenda Titration Pak)	2	QL (49 per 28 days)
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7-14-21-28 MG		3	QL (28 per 28 days)
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 14 MG, 21 MG, 28 MG, 7 MG		3	QL (30 per 30 days)
Antidepressants			
Antidepressants			
amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg		2	
bupropion hcl oral tablet 100 mg, 75 mg		2	
bupropion hcl oral tablet extended release 12 hr 100 mg, 150 mg, 200 mg	(Wellbutrin SR)	2	
bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg	(Wellbutrin XL)	2	
citalopram oral solution 10 mg/5 ml		2	QL (600 per 30 days)
citalopram oral tablet 10 mg, 20 mg, 40 mg	(Celexa)	1	GC; QL (30 per 30 days)
escitalopram oxalate oral solution 5 mg/5 ml		2	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	(Lexapro)	1	GC
fluoxetine oral capsule 10 mg, 20 mg, 40 mg	(Prozac)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
fluoxetine oral capsule,delayed release(dr/ec) 90 mg		2	QL (4 per 28 days)
fluoxetine oral solution 20 mg/5 ml (4 mg/ml)		2	
fluoxetine oral tablet 10 mg, 20 mg	(Sarafem)	2	
FLUOXETINE ORAL TABLET 60 MG		4	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	(Paxil)	1	GC
paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg	(Paxil CR)	2	
PAXIL ORAL SUSPENSION 10 MG/5 ML		4	
sertraline oral concentrate 20 mg/ml	(Zoloft)	2	
sertraline oral tablet 100 mg, 25 mg, 50 mg	(Zoloft)	1	GC
trazodone oral tablet 100 mg, 50 mg		1	GC
trazodone oral tablet 150 mg, 300 mg		2	
venlafaxine oral capsule,extended release 24hr 150 mg	(Effexor XR)	2	QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 37.5 mg, 75 mg	(Effexor XR)	2	QL (90 per 30 days)
venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg		2	
venlafaxine oral tablet extended release 24hr 150 mg, 37.5 mg, 75 mg		2	
venlafaxine oral tablet extended release 24hr 225 mg		4	
Antidiabetic Agents			
Antidiabetic Agents, Miscellaneous			
INVOKANA ORAL TABLET 100 MG		3	ST; QL (60 per 30 days)
INVOKANA ORAL TABLET 300 MG		3	ST; QL (30 per 30 days)
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG		3	QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG		3	QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG		3	QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG		3	QL (30 per 30 days)
metformin oral tablet 1,000 mg	(Glucophage)	6	GC; QL (75 per 30 days)
metformin oral tablet 500 mg	(Glucophage)	6	GC; QL (150 per 30 days)
metformin oral tablet 850 mg	(Glucophage)	6	GC; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	(Glucophage XR)	6	GC; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	(Glucophage XR)	6	GC; QL (90 per 30 days)
pioglitazone oral tablet 15 mg, 30 mg, 45 mg	(Actos)	2	QL (30 per 30 days)
TRADJENTA ORAL TABLET 5 MG		3	QL (30 per 30 days)
VICTOZA SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)		3	QL (9 per 30 days)
Insulins			
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT 100 UNIT/ML		4	ST; QL (30 per 28 days)
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML, 200 UNIT/ML (3 ML)		4	ST; QL (30 per 28 days)
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML		4	ST; QL (30 per 28 days)
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML		4	ST; QL (40 per 28 days)
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)		3	QL (30 per 28 days)
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML		3	QL (40 per 28 days)
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML		3	QL (30 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML		3	QL (30 per 28 days)
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML		3	QL (40 per 28 days)
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)		3	QL (13.5 per 28 days)
Sulfonylureas			
glimepiride oral tablet 1 mg, 2 mg	(Amaryl)	6	GC; QL (30 per 30 days)
glimepiride oral tablet 4 mg	(Amaryl)	6	GC; QL (60 per 30 days)
glipizide oral tablet 10 mg	(Glucotrol)	6	GC; QL (120 per 30 days)
glipizide oral tablet 5 mg	(Glucotrol)	6	GC; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	(Glucotrol XL)	6	GC; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg, 5 mg	(Glucotrol XL)	6	GC; QL (30 per 30 days)
Antifungals			
Antifungals			
clotrimazole mucous membrane troche 10 mg		2	
clotrimazole topical cream 1 %	(Antifungal (clotrimazole))	2	
clotrimazole topical solution 1 %		2	
clotrimazole-betamethasone topical cream 1-0.05 %	(Lotrisone)	2	
clotrimazole-betamethasone topical lotion 1-0.05 %		2	
fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml	(Diflucan)	2	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	(Diflucan)	2	
ketoconazole oral tablet 200 mg		2	
ketoconazole topical cream 2 %		2	
ketoconazole topical shampoo 2 %	(Nizoral)	2	

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Drug Name		Drug Tier	Requirements/Limits
nyamyc topical powder 100,000 unit/gram		2	
nystatin oral suspension 100,000 unit/ml		2	
nystatin oral tablet 500,000 unit		2	
nystatin topical cream 100,000 unit/gram		2	
nystatin topical ointment 100,000 unit/gram		2	
nystatin topical powder 100,000 unit/gram	(Nyamyc)	2	
nystop topical powder 100,000 unit/gram		2	
terbinafine hcl oral tablet 250 mg	(Lamisil)	1	GC
Antigout Agents			
Antigout Agents, Other			
allopurinol oral tablet 100 mg, 300 mg	(Zyloprim)	1	GC
COLCRYS ORAL TABLET 0.6 MG		2	
Antihistamines			
Antihistamines			
hydroxyzine hcl intramuscular solution 25 mg/ml, 50 mg/ml		2	
hydroxyzine hcl oral solution 10 mg/5 ml		2	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg		2	
levocetirizine oral solution 2.5 mg/5 ml	(Xyzal)	2	
levocetirizine oral tablet 5 mg	(Xyzal)	1	GC
Anti-Infectives (Skin And Mucous Membrane)			
Anti-Infectives (Skin And Mucous Membrane)			
metronidazole vaginal gel 0.75 %	(Metrogel Vaginal)	2	
terconazole vaginal cream 0.4 %	(Terazol 7)	2	
terconazole vaginal cream 0.8 %		2	
terconazole vaginal suppository 80 mg		2	
Antimigraine Agents			
Antimigraine Agents			
rizatriptan oral tablet 10 mg, 5 mg	(Maxalt)	2	QL (18 per 28 days)
rizatriptan oral tablet,disintegrating 10 mg, 5 mg	(Maxalt-MLT)	2	QL (18 per 28 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	(Imitrex)	2	QL (18 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml	(Imitrex STATdose Kit Refill)	2	QL (4 per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml	(Imitrex STATdose Pen)	2	QL (4 per 28 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5 ml	(Imitrex)	2	QL (4 per 28 days)
Antimycobacterials			
Antimycobacterials			
dapsone oral tablet 100 mg, 25 mg		2	
isoniazid oral solution 50 mg/5 ml		2	
isoniazid oral tablet 100 mg, 300 mg		1	GC
rifampin intravenous recon soln 600 mg	(Rifadin)	2	
rifampin oral capsule 150 mg, 300 mg	(Rifadin)	2	
Antinausea Agents			
Antinausea Agents			
meclizine oral tablet 12.5 mg		2	
meclizine oral tablet 25 mg	(Dramamine Less Drowsy)	2	
ondansetron oral tablet,disintegrating 4 mg, 8 mg	(Zofran ODT)	2	PA BvD
phenadoz rectal suppository 12.5 mg		2	
prochlorperazine maleate oral tablet 10 mg, 5 mg	(Compazine)	1	GC
promethazine injection solution 25 mg/ml, 50 mg/ml	(Phenergan)	2	
promethazine oral tablet 12.5 mg, 25 mg, 50 mg		2	
promethazine rectal suppository 12.5 mg, 25 mg	(Phenadoz)	2	
promethazine rectal suppository 50 mg	(Phenergan)	2	
promethegan rectal suppository 25 mg, 50 mg		2	
Antiparasite Agents			
Antiparasite Agents			
ALBENZA ORAL TABLET 200 MG		5	NM; NDS
atovaquone-proguanil oral tablet 250-100 mg	(Malarone)	2	
atovaquone-proguanil oral tablet 62.5-25 mg	(Malarone Pediatric)	2	
hydroxychloroquine oral tablet 200 mg	(Plaquenil)	2	

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Drug Name		Drug Tier	Requirements/Limits
mefloquine oral tablet 250 mg		2	
Antiparkinsonian Agents			
Antiparkinsonian Agents			
benztropine injection solution 2 mg/2 ml	(Cogentin)	2	
benztropine oral tablet 0.5 mg, 1 mg, 2 mg		2	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	(Sinemet)	2	
carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg	(Sinemet CR)	2	
carbidopa-levodopa oral tablet,disintegrating 10-100 mg, 25-100 mg, 25-250 mg		2	
pramipexole oral tablet 0.125 mg, 0.25 mg, 0.75 mg, 1 mg, 1.5 mg	(Mirapex)	2	
pramipexole oral tablet 0.5 mg	(Mirapex)	1	GC
ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	(Requip)	2	
ropinirole oral tablet extended release 24 hr 12 mg, 2 mg, 4 mg, 6 mg, 8 mg	(Requip XL)	2	
Antipsychotic Agents			
Antipsychotic Agents			
chlorpromazine injection solution 25 mg/ml		2	
chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg		2	
clozapine oral tablet 100 mg	(Clozaril)	2	QL (270 per 30 days)
clozapine oral tablet 200 mg		2	QL (135 per 30 days)
clozapine oral tablet 25 mg	(Clozaril)	2	QL (90 per 30 days)
clozapine oral tablet 50 mg		2	QL (90 per 30 days)
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg	(FazaClo)	2	ST; QL (90 per 30 days)
clozapine oral tablet,disintegrating 150 mg	(FazaClo)	2	ST; QL (180 per 30 days)
clozapine oral tablet,disintegrating 200 mg	(FazaClo)	2	ST; QL (120 per 30 days)
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg		2	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG		3	QL (30 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
olanzapine intramuscular recon soln 10 mg	(Zyprexa)	2	QL (30 per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	(Zyprexa)	2	QL (30 per 30 days)
olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg	(Zyprexa Zydis)	2	QL (30 per 30 days)
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	(Seroquel)	2	QL (90 per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 50 mg	(Seroquel XR)	2	QL (30 per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg	(Seroquel XR)	2	QL (60 per 30 days)
risperidone oral solution 1 mg/ml	(Risperdal)	2	QL (480 per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	(Risperdal)	2	QL (60 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 2 mg		2	QL (60 per 30 days)
risperidone oral tablet,disintegrating 0.5 mg, 1 mg	(Risperdal M-TAB)	2	QL (60 per 30 days)
risperidone oral tablet,disintegrating 3 mg, 4 mg	(Risperdal M-TAB)	2	QL (120 per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML		5	ST; NM; NDS; QL (540 per 30 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	(Geodon)	2	QL (60 per 30 days)
Antivirals (Systemic)			
Antiretrovirals			
atazanavir oral capsule 150 mg, 200 mg, 300 mg	(Reyataz)	5	NM; NDS
ATRIPLA ORAL TABLET 600-200-300 MG		5	NM; NDS
COMPLERA ORAL TABLET 200-25-300 MG		5	NM; NDS
INTELENCE ORAL TABLET 100 MG, 200 MG		5	NM; NDS
INTELENCE ORAL TABLET 25 MG		3	
ISENTRESS ORAL POWDER IN PACKET 100 MG		3	
ISENTRESS ORAL TABLET 400 MG		5	NM; NDS

Drug Name	Drug Tier	Requirements/Limits
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG	3	
KALETRA ORAL TABLET 100-25 MG	3	
KALETRA ORAL TABLET 200-50 MG	5	NM; NDS
lopinavir-ritonavir oral solution 400-100 mg/5 ml (Kaletra)	2	
NORVIR ORAL CAPSULE 100 MG	3	
NORVIR ORAL SOLUTION 80 MG/ML	3	
NORVIR ORAL TABLET 100 MG	3	
PREZISTA ORAL SUSPENSION 100 MG/ML	4	
PREZISTA ORAL TABLET 150 MG, 75 MG	3	
PREZISTA ORAL TABLET 600 MG, 800 MG	5	NM; NDS
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	5	NM; NDS
REYATAZ ORAL POWDER IN PACKET 50 MG	5	NM; NDS
STRIBILD ORAL TABLET 150-150-200-300 MG	5	NM; NDS
tenofovir disoproxil fumarate oral tablet 300 mg (Viread)	5	NM; NDS
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG, 200-300 MG	5	NM; NDS
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM)	5	NM; NDS
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG, 300 MG	5	NM; NDS
Antivirals, Miscellaneous		
oseltamivir oral capsule 30 mg (Tamiflu)	2	QL (84 per 180 days)
oseltamivir oral capsule 45 mg (Tamiflu)	2	QL (48 per 180 days)
oseltamivir oral capsule 75 mg (Tamiflu)	2	QL (42 per 180 days)
oseltamivir oral suspension for reconstitution 6 mg/ml (Tamiflu)	2	QL (540 per 180 days)

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Drug Name	Drug Tier	Requirements/Limits
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML	5	PA; NM; NDS
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION 6 MG/ML	3	QL (540 per 180 days)
Hcv Antivirals		
DAKLINZA ORAL TABLET 30 MG, 60 MG, 90 MG	5	PA; NM; NDS; QL (28 per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	5	PA; NM; NDS; QL (28 per 28 days)
HARVONI ORAL TABLET 90-400 MG	5	PA; NM; NDS; QL (30 per 30 days)
MAVYRET ORAL TABLET 100-40 MG	5	PA; NM; NDS; QL (84 per 28 days)
OLYSIO ORAL CAPSULE 150 MG	5	PA; NM; NDS; QL (28 per 28 days)
SOVALDI ORAL TABLET 400 MG	5	PA; NM; NDS; QL (28 per 28 days)
TECHNIVIE ORAL TABLET 12.5-75-50 MG	5	PA; NM; NDS; QL (56 per 28 days)
VIEKIRA PAK ORAL TABLETS,DOSE PACK 12.5 MG-75 MG -50 MG/250 MG	5	PA; NM; NDS; QL (112 per 28 days)
VIEKIRA XR ORAL TABLET, IR - ER, BIPHASIC 24HR 8.33 MG-50 MG- 33.33 MG-200 MG	5	PA; NM; NDS; QL (84 per 28 days)
VOSEVI ORAL TABLET 400-100-100 MG	5	PA; NM; NDS; QL (28 per 28 days)
ZEPATIER ORAL TABLET 50-100 MG	5	PA; NM; NDS; QL (30 per 30 days)
Interferons		
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML), 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	5	PA NSO; NM; NDS
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	5	PA NSO; NM; NDS
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 135 MCG/0.5 ML, 180 MCG/0.5 ML	5	NM; NDS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML		5	NM; NDS
Nucleosides And Nucleotides			
acyclovir oral capsule 200 mg	(Zovirax)	2	
acyclovir oral suspension 200 mg/5 ml	(Zovirax)	2	
acyclovir oral tablet 400 mg, 800 mg	(Zovirax)	2	
famciclovir oral tablet 125 mg, 250 mg, 500 mg		2	
valacyclovir oral tablet 1 gram, 500 mg	(Valtrex)	2	
Blood Products/Modifiers/Volume Expanders			
Anticoagulants			
enoxaparin subcutaneous solution 300 mg/3 ml	(Lovenox)	2	
enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml	(Lovenox)	2	
jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg		1	GC
warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	(Coumadin)	1	GC
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG		3	
XARELTO ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9)		3	
Blood Formation Modifiers			
EPOGEN 10,000 UNITS/ML VIAL SDV, P/F, OUTER 10,000 UNIT/ML		3	PA; QL (12 per 28 days)
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML		3	PA; QL (12 per 28 days)
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6ML		5	NM; NDS
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML		5	NM; NDS
NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML		5	NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML		3	PA; QL (12 per 28 days)
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML		5	PA; NM; NDS; QL (12 per 28 days)
PROCRIT INJECTION SOLUTION 40,000 UNIT/ML		5	PA; NM; NDS; QL (6 per 28 days)
Hematologic Agents, Miscellaneous			
anagrelide oral capsule 0.5 mg	(Agrylin)	2	
anagrelide oral capsule 1 mg		2	
tranexamic acid intravenous solution 1,000 mg/10 ml (100 mg/ml)	(Cyklokapron)	2	
tranexamic acid oral tablet 650 mg	(Lysteda)	2	QL (30 per 30 days)
Platelet-Aggregation Inhibitors			
clopidogrel oral tablet 300 mg	(Plavix)	2	
clopidogrel oral tablet 75 mg	(Plavix)	1	GC
EFFIENT ORAL TABLET 10 MG, 5 MG		4	QL (30 per 30 days)
prasugrel oral tablet 10 mg, 5 mg	(Effient)	2	QL (30 per 30 days)
Caloric Agents			
Caloric Agents			
CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 %		4	PA BvD
CLINIMIX E 4.25%/D25W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %		4	PA BvD
CLINIMIX E 5%/D15W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 5 %		4	PA BvD
CLINIMIX E 5%/D20W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 5 %		4	PA BvD
CLINISOL SF 15 % INTRAVENOUS PARENTERAL SOLUTION 15 %		4	PA BvD
dextrose 5 % in water (d5w) intravenous piggyback 5 %		2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %		4	PA BvD
NUTRILIPID INTRAVENOUS EMULSION 20 %		4	PA BvD

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Drug Name		Drug Tier	Requirements/Limits
PLENAMINE INTRAVENOUS PARENTERAL SOLUTION 15 %		4	PA BvD
PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION		4	PA BvD
TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %		4	PA BvD
TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %		4	PA BvD
Cardiovascular Agents			
Alpha-Adrenergic Agents			
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	(Catapres)	1	GC
doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg	(Cardura)	2	
Angiotensin Ii Receptor Antagonists			
irbesartan oral tablet 150 mg, 300 mg, 75 mg	(Avapro)	6	GC
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	(Avalide)	2	
losartan oral tablet 100 mg, 25 mg, 50 mg	(Cozaar)	6	GC
losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	(Hyzaar)	6	GC
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	(Diovan HCT)	2	
Angiotensin-Converting Enzyme Inhibitors			
benazepril oral tablet 10 mg, 5 mg		6	GC
benazepril oral tablet 20 mg, 40 mg	(Lotensin)	6	GC
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	(Vasotec)	2	
lisinopril oral tablet 10 mg, 20 mg, 5 mg	(Prinivil)	6	GC
lisinopril oral tablet 2.5 mg, 30 mg, 40 mg	(Zestril)	6	GC
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	(Zestoretic)	6	GC
QBRELIS ORAL SOLUTION 1 MG/ML		4	ST
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	(Altace)	6	GC

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Drug Name		Drug Tier	Requirements/Limits
Antiarrhythmic Agents			
amiodarone intravenous solution 50 mg/ml		2	
amiodarone oral tablet 100 mg, 400 mg	(Pacerone)	2	
amiodarone oral tablet 200 mg	(Pacerone)	1	GC
flecainide oral tablet 100 mg, 150 mg, 50 mg		2	
pacerone oral tablet 100 mg, 400 mg		2	
pacerone oral tablet 200 mg		1	GC
propafenone oral capsule,extended release 12 hr 225 mg, 325 mg, 425 mg	(Rythmol SR)	2	
propafenone oral tablet 150 mg, 225 mg, 300 mg		2	
Beta-Adrenergic Blocking Agents			
atenolol oral tablet 100 mg, 25 mg, 50 mg	(Tenormin)	1	GC
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	(Coreg)	1	GC
metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg	(Toprol XL)	2	
metoprolol tartrate intravenous solution 5 mg/5 ml	(Lopressor)	2	
metoprolol tartrate intravenous syringe 5 mg/5 ml		2	
metoprolol tartrate oral tablet 100 mg, 50 mg	(Lopressor)	1	GC
metoprolol tartrate oral tablet 25 mg		1	GC
propranolol intravenous solution 1 mg/ml		2	
propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg	(Inderal LA)	2	
propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)		2	
propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg		2	
Calcium-Channel Blocking Agents			
cartia xt oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg		2	
diltiazem hcl intravenous solution 5 mg/ml		2	
diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg		2	

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Drug Name		Drug Tier	Requirements/Limits
diltiazem hcl oral capsule,extended release 24 hr 360 mg	(Taztia XT)	2	
diltiazem hcl oral capsule,extended release 24 hr 420 mg	(Tiazac)	2	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	(Cardizem CD)	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg	(Cardizem)	1	GC
diltiazem hcl oral tablet 90 mg		1	GC
dilt-xr oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 mg		2	
matzim la oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg		2	
taztia xt oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg		2	
verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg	(Verelan PM)	2	
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg, 360 mg	(Verelan)	2	
verapamil oral tablet 120 mg, 80 mg	(Calan)	1	GC
verapamil oral tablet 40 mg		1	GC
verapamil oral tablet extended release 120 mg, 180 mg, 240 mg	(Calan SR)	1	GC
Cardiovascular Agents, Miscellaneous			
epinephrine injection auto-injector 0.15 mg/0.3 ml	(EpiPen Jr)	2	QL (4 per 30 days)
epinephrine injection auto-injector 0.3 mg/0.3 ml	(Auvi-Q)	2	QL (4 per 30 days)
EPIPEN 2-PAK INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML		2	QL (4 per 30 days)
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML		2	QL (4 per 30 days)
hydralazine injection solution 20 mg/ml		2	
hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg		2	
RANEXA ORAL TABLET EXTENDED RELEASE 12 HR 1,000 MG, 500 MG		3	

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Drug Name		Drug Tier	Requirements/Limits
Dihydropyridines			
afeditab cr oral tablet extended release 30 mg, 60 mg		2	
amlodipine oral tablet 10 mg, 2.5 mg, 5 mg	(Norvasc)	1	GC
amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 5-10 mg, 5-20 mg, 5-40 mg	(Lotrel)	2	
amlodipine-benazepril oral capsule 2.5-10 mg		2	
nifedipine oral capsule 10 mg	(Procardia)	2	
nifedipine oral capsule 20 mg		2	
nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg	(Procardia XL)	2	
nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg	(Adalat CC)	2	
Diuretics			
furosemide injection solution 10 mg/ml		2	
furosemide injection syringe 10 mg/ml		2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)		2	
furosemide oral tablet 20 mg, 40 mg, 80 mg	(Lasix)	1	GC
hydrochlorothiazide oral capsule 12.5 mg	(Microzide)	1	GC
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg		1	GC
spironolactone oral tablet 100 mg	(Aldactone)	2	
spironolactone oral tablet 25 mg, 50 mg	(Aldactone)	1	GC
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	(Dyazide)	1	GC
triamterene-hydrochlorothiazid oral capsule 50-25 mg		2	
triamterene-hydrochlorothiazid oral tablet 37.5-25 mg	(Maxzide-25mg)	1	GC
triamterene-hydrochlorothiazid oral tablet 75-50 mg	(Maxzide)	1	GC
Dyslipidemics			
atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	(Lipitor)	6	GC
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg		2	

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Drug Name		Drug Tier	Requirements/Limits
fenofibrate oral tablet 160 mg, 54 mg		2	
gemfibrozil oral tablet 600 mg	(Lopid)	1	GC
lovastatin oral tablet 10 mg, 20 mg, 40 mg		6	GC
pravastatin oral tablet 10 mg		2	
pravastatin oral tablet 20 mg, 40 mg, 80 mg	(Pravachol)	2	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	(Zocor)	6	GC
simvastatin oral tablet 80 mg	(Zocor)	6	GC; QL (30 per 30 days)
Renin-Angiotensin-Aldosterone System Inhibitors			
eplerenone oral tablet 25 mg, 50 mg	(Inspra)	2	
TEKTURNA ORAL TABLET 150 MG, 300 MG		3	ST
Vasodilators			
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg		2	
isosorbide dinitrate oral tablet 5 mg	(Isordil Titradose)	2	
isosorbide dinitrate oral tablet extended release 40 mg	(ISOCHRON)	2	
isosorbide mononitrate oral tablet 10 mg		2	
isosorbide mononitrate oral tablet 20 mg		1	GC
isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 60 mg		2	
isosorbide mononitrate oral tablet extended release 24 hr 30 mg		1	GC
Central Nervous System Agents			
Central Nervous System Agents			
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML		5	PA; NM; NDS
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML		5	PA; NM; NDS
dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg	(Focalin)	2	QL (60 per 30 days)
dextroamphetamine oral capsule, extended release 10 mg, 15 mg, 5 mg	(Dexedrine Spansule)	2	QL (120 per 30 days)
dextroamphetamine oral tablet 10 mg, 5 mg	(Zenzedi)	2	QL (180 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 5 mg	(Adderall XR)	2	QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr 20 mg, 25 mg, 30 mg	(Adderall XR)	2	QL (60 per 30 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	(Adderall)	2	QL (60 per 30 days)
lithium carbonate oral capsule 150 mg, 300 mg		1	GC
lithium carbonate oral capsule 600 mg		2	
lithium carbonate oral tablet 300 mg		2	
lithium carbonate oral tablet extended release 300 mg	(Lithobid)	2	
lithium carbonate oral tablet extended release 450 mg		2	
methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 40 mg, 50 mg, 60 mg		2	QL (30 per 30 days)
methylphenidate hcl oral capsule, er biphasic 30-70 30 mg		2	QL (60 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg, 40 mg	(Ritalin LA)	2	QL (30 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg	(Ritalin LA)	2	QL (60 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg		2	QL (30 per 30 days)
methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml	(Methylin)	2	QL (900 per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	(Ritalin)	2	QL (90 per 30 days)
methylphenidate hcl oral tablet extended release 10 mg		2	QL (90 per 30 days)
methylphenidate hcl oral tablet extended release 20 mg	(Metadate ER)	2	QL (90 per 30 days)
methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 54 mg	(Concerta)	2	QL (30 per 30 days)
methylphenidate hcl oral tablet extended release 24hr 36 mg	(Concerta)	2	QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	3	QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)	3	QL (60 per 30 days)
Contraceptives		
Contraceptives		
altavera (28) oral tablet 0.15-0.03 mg	2	
aubra oral tablet 0.1-20 mg-mcg	2	
aviane oral tablet 0.1-20 mg-mcg	2	
blisovi 24 fe oral tablet 1 mg-20 mcg (24)|75 mg (4)	2	
blisovi fe 1.5|30 (28) oral tablet 1.5 mg-30 mcg (21)|75 mg (7)	2	
blisovi fe 1|20 (28) oral tablet 1 mg-20 mcg (21)|75 mg (7)	2	
delyla (28) oral tablet 0.1-20 mg-mcg	2	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg (Gianvi (28))	2	
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg (Ocella)	2	
enpresse oral tablet 50-30 (6)|75-40 (5)|125-30(10)	2	
falmina (28) oral tablet 0.1-20 mg-mcg	2	
femynor oral tablet 0.25-35 mg-mcg	2	
gianvi (28) oral tablet 3-0.02 mg	2	
introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg	2	QL (91 per 84 days)
junel fe 1.5|30 (28) oral tablet 1.5 mg-30 mcg (21)|75 mg (7)	2	
junel fe 1|20 (28) oral tablet 1 mg-20 mcg (21)|75 mg (7)	2	
junel fe 24 oral tablet 1 mg-20 mcg (24)|75 mg (4)	2	
kurvelo oral tablet 0.15-0.03 mg	2	
larin fe 1.5|30 (28) oral tablet 1.5 mg-30 mcg (21)|75 mg (7)	2	
larin fe 1|20 (28) oral tablet 1 mg-20 mcg (21)|75 mg (7)	2	
larissia oral tablet 0.1-20 mg-mcg	2	

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Drug Name		Drug Tier	Requirements/Limits
lessina oral tablet 0.1-20 mg-mcg		2	
levonest (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)		2	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	(Aubra)	2	
levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg	(Altavera (28))	2	QL (91 per 84 days)
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg	(Introvale)	2	QL (91 per 84 days)
levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)	(Enpresse)	2	QL (91 per 84 days)
levora-28 oral tablet 0.15-0.03 mg		2	
loryna (28) oral tablet 3-0.02 mg		2	
lutera (28) oral tablet 0.1-20 mg-mcg		2	
marlissa oral tablet 0.15-0.03 mg		2	
microgestin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)		1	GC
microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)		2	
mononessa (28) oral tablet 0.25-35 mg-mcg		2	
nikki (28) oral tablet 3-0.02 mg		2	
noreth-estrad-fe 1-0.02(21)-75 1 mg-20 mcg (21)/75 mg (7)	(Blisovi Fe 1/20 (28))	2	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (24)/75 mg (4)	(Blisovi 24 Fe)	2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg	(Ortho Tri-Cyclen LO (28))	2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(Ortho Tri-Cyclen (28))	2	
norgestimate-ethinyl estradiol oral tablet 0.25-35 mg-mcg	(Estarylla)	2	
ocella oral tablet 3-0.03 mg		2	
orsythia oral tablet 0.1-20 mg-mcg		2	
portia oral tablet 0.15-0.03 mg		2	
previfem oral tablet 0.25-35 mg-mcg		2	
quasense oral tablets,dose pack,3 month 0.15 mg-30 mcg		2	QL (91 per 84 days)
setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg		2	QL (91 per 84 days)

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Drug Name		Drug Tier	Requirements/Limits
sprintec (28) oral tablet 0.25-35 mg-mcg		2	
sronyx oral tablet 0.1-20 mg-mcg		2	
tarina fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)		2	
tri-legest fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)		2	
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg		2	
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg		2	
trinessa (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)		2	
tri-previfem (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)		2	
tri-sprintec (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)		2	
trivora (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)		2	
vestura (28) oral tablet 3-0.02 mg		2	
vienva oral tablet 0.1-20 mg-mcg		2	
zarah oral tablet 3-0.03 mg		2	
Dental And Oral Agents			
Dental And Oral Agents			
chlorhexidine gluconate mucous membrane mouthwash 0.12 %	(Paroex Oral Rinse)	2	
periogard mucous membrane mouthwash 0.12 %		2	
triamcinolone acetonide dental paste 0.1 %	(Oralone)	2	
Dermatological Agents			
Dermatological Agents, Other			
acyclovir topical ointment 5 %	(Zovirax)	2	QL (30 per 30 days)
ammonium lactate topical cream 12 %	(Geri-Hydrolac)	2	
ammonium lactate topical lotion 12 %	(AmLactin)	2	
calcipotriene scalp solution 0.005 %		2	
calcipotriene topical cream 0.005 %	(Dovonex)	2	
calcipotriene topical ointment 0.005 %	(Calcitrene)	2	
diclofenac sodium topical drops 1.5 %		2	QL (300 per 30 days)
diclofenac sodium topical gel 3 %	(Solaraze)	5	PA; NM; NDS; QL (100 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
FLECTOR TRANSDERMAL PATCH 12 HOUR 1.3 %		3	PA
fluorouracil topical cream 0.5 %	(Carac)	5	NM; NDS
fluorouracil topical cream 5 %	(Efudex)	2	
fluorouracil topical solution 2 %, 5 %		2	
imiquimod topical cream in packet 5 %	(Aldara)	2	PA NSO; QL (24 per 30 days)
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)		5	PA; NM; NDS; QL (224 per 28 days)
TOLAK TOPICAL CREAM 4 %		4	
VOLTAREN TOPICAL GEL 1 %		2	
ZOVIRAX TOPICAL CREAM 5 %		5	NM; NDS; QL (5 per 4 days)
Dermatological Antibacterials			
clindamycin phosphate topical foam 1 %	(Evoclin)	2	
clindamycin phosphate topical gel 1 %	(Cleocin T)	2	
clindamycin phosphate topical lotion 1 %	(Cleocin T)	2	
clindamycin phosphate topical solution 1 %	(Cleocin T)	2	
clindamycin phosphate topical swab 1 %	(Cleocin T)	2	
clindamycin-benzoyl peroxide topical gel 1.2 %(1 % base) -5 %	(Duac)	2	
clindamycin-benzoyl peroxide topical gel 1-5 %	(Benzaclin)	2	
metronidazole topical cream 0.75 %	(MetroCream)	2	
metronidazole topical gel 0.75 %	(Rosadan)	2	
metronidazole topical gel 1 %	(Metrogel)	2	
metronidazole topical lotion 0.75 %	(MetroLotion)	2	
neuac topical gel 1.2 %(1 % base) -5 %		2	
Dermatological Anti-Inflammatory Agents			
ala-cort topical cream 1 %		2	
ala-cort topical cream 2.5 %		1	GC
ala-scalp topical lotion 2 %		2	
clobetasol 0.05% cream 0.05 %	(Temovate)	2	
clobetasol scalp solution 0.05 %	(Cormax)	2	
clobetasol topical foam 0.05 %	(Olux)	2	
clobetasol topical gel 0.05 %		2	
clobetasol topical lotion 0.05 %	(Clobex)	2	
clobetasol topical ointment 0.05 %	(Temovate)	2	

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Drug Name		Drug Tier	Requirements/Limits
clobetasol topical shampoo 0.05 %	(Clobex)	2	
clobetasol-emollient topical cream 0.05 %		2	
desonide topical cream 0.05 %	(DesOwen)	2	
desonide topical lotion 0.05 %	(DesOwen)	2	
desonide topical ointment 0.05 %		2	
fluocinonide topical gel 0.05 %		2	
fluocinonide topical ointment 0.05 %		2	
fluocinonide topical solution 0.05 %		2	
hydrocortisone topical cream 1 %, 2.5 %	(Ala-Cort)	1	GC
hydrocortisone topical lotion 2.5 %		2	
hydrocortisone topical ointment 1 %	(Anti-Itch (HC))	1	GC
hydrocortisone topical ointment 2.5 %		1	GC
mometasone topical cream 0.1 %	(Elocon)	2	
mometasone topical ointment 0.1 %	(Elocon)	2	
mometasone topical solution 0.1 %		2	
procto-med hc topical cream with perineal applicator 2.5 %		2	
procto-pak topical cream with perineal applicator 1 %		2	
proctosol hc topical cream with perineal applicator 2.5 %		2	
proctozone-hc topical cream with perineal applicator 2.5 %		2	
triamcinolone acetonide topical cream 0.025 %		1	GC
triamcinolone acetonide topical cream 0.1 %, 0.5 %	(Triderm)	2	
triamcinolone acetonide topical lotion 0.025 %, 0.1 %		2	
triamcinolone acetonide topical ointment 0.025 %		1	GC
triamcinolone acetonide topical ointment 0.1 %, 0.5 %		2	
tridesilon topical cream 0.05 %		2	
Dermatological Retinoids			
adapalene topical cream 0.1 %	(Differin)	2	
adapalene topical gel 0.1 %	(Differin)	2	
tretinoin topical cream 0.025 %	(Avita)	2	PA
tretinoin topical cream 0.05 %, 0.1 %	(Retin-A)	2	PA
tretinoin topical gel 0.01 %	(Retin-A)	2	PA

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Drug Name		Drug Tier	Requirements/Limits
tretinoin topical gel 0.025 %	(Avita)	2	PA
Scabicides And Pediculicides			
malathion topical lotion 0.5 %	(Ovide)	2	
permethrin topical cream 5 %	(Elimite)	2	
Devices			
Devices			
BD INSULIN SYR 0.5 ML 6MMX31G 1/2 ML 31 GAUGE X 15/64"		2	
BD ULTRA-FINE PEN NDL 4MMX32G NANO 32 GAUGE X 5/32"		2	
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 1/2 ML 28 GAUGE	(Lite Touch Insulin Syringe)	2	
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	(1st Tier Unifine Pentips)	2	
Enzyme Replacement/Modifiers			
Enzyme Replacement/Modifiers			
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 - 60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT		3	
FABRAZYME INTRAVENOUS RECON SOLN 35 MG		5	NM; NDS
KUVAN ORAL TABLET,SOLUBLE 100 MG		5	NM; NDS
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG		5	PA; NM; NDS
ORFADIN ORAL SUSPENSION 4 MG/ML		5	PA; NM; NDS
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 16,000-57,500-60,500 UNIT		5	NM; NDS

Drug Name	Drug Tier	Requirements/Limits
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 4,000-14,375-15,125 UNIT, 8,000-28,750- 30,250 UNIT	4	
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA BvD; NM; NDS
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-34,000 - 55,000 UNIT, 15,000-51,000 -82,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-85,000- 136,000 UNIT, 3,000-10,000- 16,000 UNIT, 40,000-126,000-168,000 UNIT, 40,000-136,000- 218,000 UNIT, 5,000-17,000 -27,000 UNIT	3	
Eye, Ear, Nose, Throat Agents		
Eye, Ear, Nose, Throat Agents, Miscellaneous		
azelastine nasal aerosol,spray 137 mcg (0.1 %)	2	QL (30 per 25 days)
azelastine nasal spray,non-aerosol 0.15 % (205.5 mcg) (Astepro)	2	QL (30 per 25 days)
azelastine ophthalmic (eye) drops 0.05 %	2	
cromolyn ophthalmic (eye) drops 4 %	2	
ipratropium bromide nasal spray,non-aerosol 0.03 %	2	QL (30 per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	2	QL (15 per 10 days)
olopatadine nasal spray,non-aerosol 0.6 % (Patanase)	2	QL (30.5 per 30 days)
olopatadine ophthalmic (eye) drops 0.1 % (Patanol)	2	
Eye, Ear, Nose, Throat Anti-Infectives Agents		
erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)	2	
gentak ophthalmic (eye) ointment 0.3 % (3 mg/gram)	2	
gentamicin ophthalmic (eye) drops 0.3 %	2	

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Drug Name		Drug Tier	Requirements/Limits
MOXEZA OPHTHALMIC (EYE) DROPS, VISCOUS 0.5 %		3	
moxifloxacin ophthalmic (eye) drops 0.5 %	(Vigamox)	2	
neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %	(Maxitrol)	2	
neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %	(Maxitrol)	2	
neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml		2	
neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%		2	
neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%		2	
ofloxacin ophthalmic (eye) drops 0.3 %	(Ocuflox)	2	
ofloxacin otic (ear) drops 0.3 %	(Floxin)	2	
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 %		4	
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.05 %		3	
tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %	(TobraDex)	2	
VIGAMOX OPHTHALMIC (EYE) DROPS 0.5 %		3	
Eye, Ear, Nose, Throat Anti-Inflammatory Agents			
fluticasone nasal spray,suspension 50 mcg/actuation	(24 Hour Allergy Relief)	1	GC
ketorolac ophthalmic (eye) drops 0.4 %	(Acular LS)	2	
ketorolac ophthalmic (eye) drops 0.5 %	(Acular)	2	
prednisolone acetate ophthalmic (eye) drops,suspension 1 %	(Omnipred)	2	
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 %		3	QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
Gastrointestinal Agents			
Antiulcer Agents And Acid Suppressants			
famotidine oral suspension 40 mg/5 ml (8 mg/ml)	(Pepcid)	2	
famotidine oral tablet 20 mg	(Acid Controller)	1	GC
famotidine oral tablet 40 mg	(Pepcid)	1	GC
omeprazole oral capsule,delayed release(dr/ec) 10 mg		2	
omeprazole oral capsule,delayed release(dr/ec) 20 mg, 40 mg		1	GC
pantoprazole intravenous recon soln 40 mg	(Protonix)	2	
pantoprazole oral tablet,delayed release (dr/ec) 20 mg, 40 mg	(Protonix)	1	GC
ranitidine hcl injection solution 50 mg/2 ml (25 mg/ml)	(Zantac)	2	
ranitidine hcl oral syrup 15 mg/ml		2	
ranitidine hcl oral tablet 150 mg	(Acid Control (ranitidine))	1	GC
ranitidine hcl oral tablet 300 mg	(Zantac)	1	GC
Gastrointestinal Agents, Other			
constulose oral solution 10 gram/15 ml		2	
dicyclomine oral capsule 10 mg		2	
dicyclomine oral solution 10 mg/5 ml		2	
dicyclomine oral tablet 20 mg		2	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml		2	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	(Lomotil)	2	
enulose oral solution 10 gram/15 ml		2	
generlac oral solution 10 gram/15 ml		2	
lactulose oral solution 10 gram/15 ml	(Constulose)	2	
loperamide oral capsule 2 mg	(Anti-Diarrheal (loperamide))	2	
metoclopramide hcl injection solution 5 mg/ml		2	
metoclopramide hcl oral solution 5 mg/5 ml		1	GC
metoclopramide hcl oral tablet 10 mg, 5 mg	(Reglan)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
ursodiol oral capsule 300 mg	(Actigall)	2	
ursodiol oral tablet 250 mg	(URSO 250)	2	
ursodiol oral tablet 500 mg	(URSO Forte)	2	
Laxatives			
gavilyte-c oral recon soln 240-22.72-6.72 -5.84 gram		2	
gavilyte-g oral recon soln 236-22.74-6.74 -5.86 gram		2	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	(GaviLyte-G)	2	
peg 3350-electrolytes oral recon soln 240-22.72-6.72 -5.84 gram	(Colyte with Flavor Packs)	1	GC
polyethylene glycol 3350 oral powder 17 gram/dose	(ClearLax)	2	
Phosphate Binders			
calcium acetate oral capsule 667 mg		2	
calcium acetate oral tablet 667 mg	(Calphron)	2	
PHOSLYRA ORAL SOLUTION 667 MG (169 MG CALCIUM)/5 ML		4	
RENVELA ORAL TABLET 800 MG		3	
sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram	(Renvela)	2	
sevelamer carbonate oral tablet 800 mg	(Renvela)	2	
Genitourinary Agents			
Antispasmodics, Urinary			
oxybutynin chloride oral syrup 5 mg/5 ml		1	GC
oxybutynin chloride oral tablet 5 mg		2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg	(Ditropan XL)	2	
VESICARE ORAL TABLET 10 MG, 5 MG		3	
Genitourinary Agents, Miscellaneous			
finasteride oral tablet 5 mg	(Proscar)	1	GC
tamsulosin oral capsule,extended release 24hr 0.4 mg	(Flomax)	2	
Heavy Metal Antagonists			
Heavy Metal Antagonists			
CUPRIMINE ORAL CAPSULE 250 MG		5	PA; NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
DEPEN TITRATABS ORAL TABLET 250 MG		5	PA; NM; NDS
EXJADE ORAL TABLET, DISPERSIBLE 125 MG, 250 MG, 500 MG		5	PA; NM; NDS
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG		5	PA; NM; NDS
JADENU SPRINKLE ORAL GRANULES IN PACKET 180 MG, 360 MG, 90 MG		5	PA; NM; NDS
Hormonal Agents, Stimulant/Replacement/Modifying			
Androgens			
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR		3	PA; QL (30 per 30 days)
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)		3	PA; QL (150 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)		3	PA; QL (150 per 30 days)
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	(Depo-Testosterone)	2	PA
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	(AndroGel)	2	PA; QL (300 per 30 days)
Estrogens And Antiestrogens			
ESTRACE VAGINAL CREAM 0.01 % (0.1 MG/GRAM)		3	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	(Estrace)	2	
estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	(Alora)	2	QL (8 per 28 days)
estradiol transdermal patch semiweekly 0.0375 mg/24 hr	(Minivelle)	2	QL (8 per 28 days)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	(Climara)	2	QL (4 per 28 days)

Drug Name		Drug Tier	Requirements/Limits
estradiol vaginal cream 0.01 % (0.1 mg/gram)	(Estrace)	2	
estradiol vaginal tablet 10 mcg	(Vagifem)	2	QL (18 per 28 days)
ESTRING VAGINAL RING 2 MG (7.5 MCG /24 HOUR)		4	QL (1 per 84 days)
PREMARIN INJECTION RECON SOLN 25 MG		3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG		3	
PREMARIN VAGINAL CREAM 0.625 MG/GRAM		3	
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14)		3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG		3	
yuvafem vaginal tablet 10 mcg		2	QL (18 per 28 days)
Glucocorticoids/Mineralocorticoids			
dexamethasone oral elixir 0.5 mg/5 ml		2	PA BvD
dexamethasone oral tablet 0.5 mg, 0.75 mg, 4 mg	(Decadron)	1	PA BvD; GC
dexamethasone oral tablet 1 mg, 1.5 mg		1	PA BvD; GC
dexamethasone oral tablet 2 mg		2	PA BvD
dexamethasone oral tablet 6 mg	(Decadron)	2	PA BvD
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	(Medrol)	2	PA BvD
methylprednisolone oral tablets,dose pack 4 mg	(Medrol (Pak))	2	PA BvD
prednisolone 15 mg/5 ml soln a/f, d/f 15 mg/5 ml (3 mg/ml)		2	PA BvD
prednisolone oral solution 15 mg/5 ml		2	PA BvD
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml)		2	PA BvD
prednisolone sodium phosphate oral solution 5 mg base/5 ml (6.7 mg/5 ml)	(Pediapred)	2	PA BvD
prednisone oral solution 5 mg/5 ml		2	PA BvD
prednisone oral tablet 1 mg		2	PA BvD
prednisone oral tablet 10 mg, 2.5 mg, 5 mg, 50 mg		1	PA BvD; GC
prednisone oral tablet 20 mg	(Deltasone)	1	PA BvD; GC

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Drug Name	Drug Tier	Requirements/Limits
prednisone oral tablets,dose pack 10 mg, 10 mg (48 pack), 5 mg, 5 mg (48 pack)	2	PA BvD
Pituitary		
desmopressin 10 mcg/0.1 ml spr 10 mcg/spray (0.1 ml) (DDAVP)	2	
desmopressin injection solution 4 mcg/ml (DDAVP)	2	
desmopressin nasal solution 0.1 mg/ml (refrigerate) (DDAVP)	2	
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	2	
desmopressin oral tablet 0.1 mg, 0.2 mg (DDAVP)	2	
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	5	PA; NM; NDS
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML), 5 MG/ML (15 UNIT/ML)	5	PA; NM; NDS
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT), 6 MG (18 UNIT)	5	PA; NM; NDS
HUMATROPE INJECTION RECON SOLN 5 (15 UNIT) MG	5	PA; NM; NDS
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML)	5	PA; NM; NDS
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 5 MG/1.5 ML (3.3 MG/ML)	4	PA
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 20 MG/2 ML (10 MG/ML), 5 MG/2 ML (2.5 MG/ML)	5	PA; NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)		5	PA; NM; NDS
OMNITROPE SUBCUTANEOUS RECON SOLN 5.8 MG		5	PA; NM; NDS
SAIZEN CLICK.EASY SUBCUTANEOUS CARTRIDGE 8.8 MG/1.51 ML (FINAL CONC.)		5	PA; NM; NDS
SAIZEN SUBCUTANEOUS RECON SOLN 5 MG, 8.8 MG		5	PA; NM; NDS
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG		5	PA; NM; NDS
STIMATE NASAL SPRAY,NON-AEROSOL 150 MCG/SPRAY (0.1 ML)		4	
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG		5	PA; NM; NDS
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG		4	PA
ZORBTIVE SUBCUTANEOUS RECON SOLN 8.8 MG		5	PA; NM; NDS
Progestins			
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML		4	QL (10 per 28 days)
medroxyprogesterone intramuscular suspension 150 mg/ml	(Depo-Provera)	2	QL (1 per 84 days)
medroxyprogesterone intramuscular syringe 150 mg/ml	(Depo-Provera)	2	QL (1 per 84 days)
medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg	(Provera)	1	GC
progesterone micronized oral capsule 100 mg, 200 mg	(Prometrium)	2	
Thyroid And Antithyroid Agents			
levothyroxine intravenous recon soln 100 mcg		5	NM; NDS
levothyroxine oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	(Levo-T)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
liothyronine intravenous solution 10 mcg/ml	(Triostat)	2	
liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg	(Cytomel)	2	
Immunological Agents			
Immunological Agents			
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG, 5 MG		4	PA BvD
azathioprine oral tablet 50 mg	(Imuran)	2	PA BvD
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS)		5	PA; NM; NDS
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)		5	PA; NM; NDS
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	(Gengraf)	2	PA BvD
cyclosporine modified oral solution 100 mg/ml	(Gengraf)	2	PA BvD
ENBREL SUBCUTANEOUS RECON SOLN 25 MG (1 ML)		5	PA; NM; NDS
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)		5	PA; NM; NDS
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (0.98 ML)		5	PA; NM; NDS
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG		4	PA BvD
gengraf oral capsule 100 mg, 25 mg, 50 mg		2	PA BvD
gengraf oral solution 100 mg/ml		2	PA BvD
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)		5	PA; NM; NDS
HUMIRA PEN CROHN'S-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML		5	PA; NM; NDS

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NM; NDS
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NM; NDS
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML	5	PA; NM; NDS
leflunomide oral tablet 10 mg, 20 mg (Arava)	2	
mycophenolate mofetil oral capsule 250 mg (CellCept)	2	PA BvD
mycophenolate mofetil oral suspension for reconstitution 200 mg/ml (CellCept)	5	PA BvD; NM; NDS
mycophenolate mofetil oral tablet 500 mg (CellCept)	2	PA BvD
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR 125 MG/ML	5	PA; NM; NDS
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML	5	PA; NM; NDS
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML	4	PA BvD
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML	5	PA; NM; NDS
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML	5	PA; NM; NDS
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML	5	PA; NM; NDS
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg (Prograf)	2	PA BvD
XELJANZ ORAL TABLET 5 MG	5	PA; NM; NDS; QL (60 per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG	5	PA; NM; NDS; QL (30 per 30 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name	Drug Tier	Requirements/Limits
Vaccines		
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	3	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	3	
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML	3	
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	3	
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	3	PA BvD
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	3	PA BvD
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	3	
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	3	
MENACTRA (PF) INTRAMUSCULAR SOLUTION 4 MCG/0.5 ML	3	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	3	
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	3	PA BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	3	PA BvD
RECOMBIVAX HB 5 MCG/0.5 ML VL OUTER, P/F, SDV 5 MCG/0.5 ML	3	PA BvD

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name	Drug Tier	Requirements/Limits
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT -20 MCG/ML	3	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	3	
TYPHIM VI INTRAMUSCULAR SYRINGE 25 MCG/0.5 ML	3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 50 UNIT/ML	3	
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML, 50 UNIT/ML	3	
ZOSTAVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 19,400 UNIT/0.65 ML	3	QL (1 per 365 days)
Inflammatory Bowel Disease Agents		
Inflammatory Bowel Disease Agents		
APRISO ORAL CAPSULE,EXTENDED RELEASE 24HR 0.375 GRAM	3	
CANASA RECTAL SUPPOSITORY 1,000 MG	3	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS) 400 MG	3	
LIALDA ORAL TABLET,DELAYED RELEASE (DR/EC) 1.2 GRAM	2	
mesalamine oral tablet,delayed release (dr/ec) 800 mg (Asacol HD)	2	
sulfasalazine oral tablet 500 mg (Azulfidine)	2	
sulfasalazine oral tablet,delayed release (dr/ec) 500 mg (Azulfidine EN-tabs)	2	
Irrigating Solutions		
Irrigating Solutions		
sodium chloride irrigation solution 0.9% (Sterile Saline)	2	
water for irrigation, sterile irrigation solution (Curity Sterile Water)	2	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate oral solution 70 mg/75 ml	2	QL (300 per 28 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
alendronate oral tablet 10 mg, 5 mg		1	GC
alendronate oral tablet 35 mg		1	GC; QL (4 per 28 days)
alendronate oral tablet 40 mg		2	
alendronate oral tablet 70 mg	(Fosamax)	1	GC; QL (4 per 28 days)
calcitonin (salmon) nasal spray,non-aerosol 200 unit/actuation		2	QL (3.7 per 28 days)
calcitriol intravenous solution 1 mcg/ml		2	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	(Rocaltrol)	2	
calcitriol oral solution 1 mcg/ml	(Rocaltrol)	2	
ibandronate intravenous solution 3 mg/3 ml		2	QL (3 per 84 days)
ibandronate oral tablet 150 mg	(Boniva)	2	QL (1 per 28 days)
MIACALCIN INJECTION SOLUTION 200 UNIT/ML		3	
SENSIPAR ORAL TABLET 30 MG		3	QL (60 per 30 days)
SENSIPAR ORAL TABLET 60 MG		5	NM; NDS; QL (60 per 30 days)
SENSIPAR ORAL TABLET 90 MG		5	NM; NDS; QL (120 per 30 days)
Miscellaneous Therapeutic Agents			
Miscellaneous Therapeutic Agents			
ELMIRON ORAL CAPSULE 100 MG		4	
hydroxyzine pamoate oral capsule 100 mg		2	
hydroxyzine pamoate oral capsule 25 mg, 50 mg	(Vistaril)	2	
leucovorin calcium 200 mg vial latex-free, p/f, sdv 200 mg		2	
leucovorin calcium injection recon soln 100 mg, 350 mg		2	
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg		2	
levocarnitine (with sugar) oral solution 100 mg/ml	(Carnitor)	2	
levocarnitine oral tablet 330 mg	(Carnitor)	2	
MESTINON ORAL SYRUP 60 MG/5 ML		5	NM; NDS
pyridostigmine bromide oral tablet 60 mg	(Mestinon)	2	
pyridostigmine bromide oral tablet extended release 180 mg	(Mestinon Timespan)	2	

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
Ophthalmic Agents			
Antiglaucoma Agents			
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %		3	
bimatoprost ophthalmic (eye) drops 0.03 %		2	
brimonidine ophthalmic (eye) drops 0.15 %	(Alphagan P)	2	
brimonidine ophthalmic (eye) drops 0.2 %		1	GC
dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml	(Cosopt)	2	
latanoprost ophthalmic (eye) drops 0.005 %	(Xalatan)	2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %		3	QL (2.5 per 25 days)
timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %	(Timoptic)	1	GC
timolol maleate ophthalmic (eye) drops, once daily 0.5 %	(Istalol)	1	GC
timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %	(Timoptic-XE)	2	
Replacement Preparations			
Replacement Preparations			
d5 %-0.45 % sodium chloride intravenous parenteral solution		2	
dextrose 5 %-lactated ringers intravenous parenteral solution		2	
klor-con m10 oral tablet,er particles/crystals 10 meq		2	
klor-con m15 oral tablet,er particles/crystals 15 meq		2	
klor-con m20 oral tablet,er particles/crystals 20 meq		2	
klor-con sprinkle oral capsule, extended release 10 meq, 8 meq		2	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 20 meq/l, 30 meq/l, 40 meq/l		2	

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
potassium chloride intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml		2	
potassium chloride intravenous solution 2 meq/ml		2	
potassium chloride oral capsule, extended release 10 meq, 8 meq	(Klor-Con Sprinkle)	2	
potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml		2	
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	(K-Tab)	2	
potassium chloride oral tablet,er particles/crystals 10 meq	(Klor-Con M10)	2	
potassium chloride oral tablet,er particles/crystals 20 meq	(Klor-Con M20)	2	
potassium citrate oral tablet extended release 10 meq (1,080 mg)	(Urocit-K 10)	2	
potassium citrate oral tablet extended release 15 meq	(Urocit-K 15)	2	
potassium citrate oral tablet extended release 5 meq (540 mg)	(Urocit-K 5)	2	
sodium chloride 0.45 % intravenous parenteral solution 0.45 %		2	
sodium chloride 0.9 % intravenous piggyback		2	
sodium chloride intravenous parenteral solution 2.5 meq/ml		2	
Respiratory Tract Agents			
Anti-Inflammatories, Inhaled Corticosteroids			
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE		3	QL (60 per 30 days)
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION		3	QL (12 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	3	QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	3	QL (120 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	3	QL (12 per 28 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	3	QL (24 per 28 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	3	QL (21.2 per 28 days)
QVAR INHALATION AEROSOL 40 MCG/ACTUATION, 80 MCG/ACTUATION	3	QL (17.4 per 25 days)
Antileukotrienes		
montelukast oral granules in packet 4 mg (Singulair)	2	
montelukast oral tablet 10 mg (Singulair)	1	GC
montelukast oral tablet,chewable 4 mg, 5 mg (Singulair)	2	
zafirlukast oral tablet 10 mg, 20 mg (Accolate)	2	
Bronchodilators		
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml	2	PA BvD
albuterol sulfate oral syrup 2 mg/5 ml	2	
albuterol sulfate oral tablet 2 mg, 4 mg	2	
albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg	2	
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION	3	QL (25.8 per 28 days)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 per 30 days)
ipratropium bromide inhalation solution 0.02 %	2	PA BvD

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name		Drug Tier	Requirements/Limits
PROAIR HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION		3	
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION		3	
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION		3	
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG		3	
VENTOLIN HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION		4	ST
Respiratory Tract Agents, Other			
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)		2	PA BvD
DALIRESP ORAL TABLET 500 MCG		3	QL (30 per 30 days)
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG		5	PA; NM; NDS
Skeletal Muscle Relaxants			
Skeletal Muscle Relaxants			
cyclobenzaprine oral tablet 10 mg, 5 mg		2	
cyclobenzaprine oral tablet 7.5 mg	(Fexmid)	2	
methocarbamol oral tablet 500 mg	(Robaxin)	2	
methocarbamol oral tablet 750 mg	(Robaxin-750)	2	
Sleep Disorder Agents			
Sleep Disorder Agents			
zaleplon oral capsule 10 mg, 5 mg	(Sonata)	2	QL (60 per 30 days)
zolpidem oral tablet 10 mg, 5 mg	(Ambien)	2	QL (30 per 30 days)
zolpidem oral tablet,ext release multiphase 12.5 mg, 6.25 mg	(Ambien CR)	2	QL (30 per 30 days)
Vasodilating Agents			
Vasodilating Agents			
ADCIRCA ORAL TABLET 20 MG		5	PA; NM; NDS; QL (60 per 30 days)

You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document

Drug Name	Drug Tier	Requirements/Limits
CIALIS ORAL TABLET 2.5 MG, 5 MG	3	PA; QL (30 per 30 days)
sildenafil (antihypertensive) intravenous solution 10 mg/12.5 ml (Revatio)	5	PA; NM; NDS; QL (37.5 per 1 day)
sildenafil (antihypertensive) oral tablet 20 mg (Revatio)	2	PA; QL (90 per 30 days)
TRACLEER ORAL TABLET 125 MG, 62.5 MG	5	PA; NM; LA; NDS; QL (60 per 30 days)
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG	5	PA; NM; NDS; QL (112 per 28 days)
Vitamins And Minerals		
Vitamins And Minerals		
fluoride (sodium) oral tablet 1 mg (2.2 mg sod. fluoride)	2	
pnv prenatal plus multivit tab s/f, gluten-free 27 mg iron- 1 mg	3	ALL RX PRENATAL VITAMINS COVERABLE UNDER PART D
prenatal vitamin plus low iron oral tablet 27 mg iron- 1 mg	3	ALL RX PRENATAL VITAMINS COVERABLE UNDER PART D
sodium fluoride 0.5 mg/ml drop d/f, s/f,gluten-free 0.5 mg (1.1 mg sod.fluorid)/ml	2	

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1- 855-996-8422
Advantage@stanfordhealthcare.org

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

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

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English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-996-8422 (TTY: 711).

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Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-996-8422（TTY:711）まで、お電話にてご連絡ください。

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-996-8422 (رقم هاتف الصم والبكم: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-996-8422 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer, Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-996-8422 (TTY: 711)។

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-996-8422 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-996-8422 (TTY: 711) पर कॉल करें।

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Stanford
HEALTH CARE ADVANTAGE

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StanfordHealthCareAdvantage.org

Stanford Health Care Advantage is an HMO with a Medicare Contract. Enrollment in Stanford Health Care Advantage depends on contract renewal.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-996-8422 o, para los usuarios de 711, de 8:00 a.m. a 8:00 p.m., los 7 días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1 de Octubre hasta el 14 de Febrero, y de lunes a viernes (excepto los días feriados) desde el 15 de Febrero hasta el 30 de Septiembre.

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This abridged formulary was updated on 04/01/2018. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact Stanford Health Care Advantage Member Care Services, at 1-855-996-8422 or, for TTY users, 711, 8 am to 8 pm, seven days a week (except Thanksgiving and Christmas) from October 1 through February 14 and Monday through Friday (except holidays) from February 15 through September 30, or visit StanfordHealthCareAdvantage.org.

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