Stanford Health Care Advantage 2019 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

00019120, 17

This abridged formulary was updated on 09/01/2019. 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 March 31 and Monday through Friday (except holidays) from April 1 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 September 1, 2019. 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, 2019, 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. Stanford Health Care Advantage (HMO) 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 Stanford Health Care Advantage (HMO), 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 2019 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2019 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, or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.). 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. Below are changes to the drug list that will also affect members currently taking a drug:

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

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

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 34-day supply of the drug.

The enclosed formulary is current as of 9/1/2019. To get updated information about the drugs covered by Stanford Health Care Advantage (HMO) please contact us. Our contact information appears on the front and back cover pages.

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 34-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 34-day supply of medication. After your first 34-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 34-day emergency supply of that drug 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 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.

ABBREVIATION	DESCRIPTION	EXPLANATION
		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
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 March 31, and Monday to Friday (except holidays) from April 1 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.

ABBREVIATION	DESCRIPTION	EXPLANATION
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 March 31, and Monday to Friday (except holidays) from April 1 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		1	GC; QL (4500 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)
endocet oral tablet 10-325 mg		2	QL (180 per 30 days)
endocet oral tablet 5-325 mg		2	QL (360 per 30 days)
endocet oral tablet 7.5-325 mg		2	QL (240 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml		2	QL (2700 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg	(Lorcet HD)	2	QL (180 per 30 days)
hydrocodone-acetaminophen oral tablet 5-325 mg	(Lorcet (hydrocodone))	2	QL (240 per 30 days)
hydrocodone-acetaminophen oral tablet 7.5-325 mg	(Lorcet Plus)	2	QL (180 per 30 days)
lorcet (hydrocodone) oral tablet 5-325 mg		2	QL (240 per 30 days)
lorcet hd oral tablet 10-325 mg		2	QL (180 per 30 days)
lorcet plus oral tablet 7.5-325 mg		2	QL (180 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, 80 mg	(OxyContin)	3	QL (60 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg	(Endocet)	2	QL (180 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 (240 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 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG		3	QL (60 per 30 days)
tramadol oral tablet 50 mg	(Ultram)	1	GC; QL (240 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	
diclofenac sodium topical drops 1.5 %		2	QL (300 per 30 days)
diclofenac sodium topical gel 1 %	(Voltaren)	2	
diclofenac sodium topical gel 3 %	(Solaraze)	2	PA; QL (100 per 28 days)
ibu oral tablet 600 mg, 800 mg		1	GC
ibuprofen oral suspension 100 mg/5 ml	(Children's Advil)	2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	(IBU)	1	GC
meloxicam oral tablet 15 mg, 7.5 mg	(Mobic)	1	GC
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	
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)		5	PA; NM; NDS; QL (224 per 28 days)
VOLTAREN TOPICAL GEL 1 %		2	
Anesthetics			
Local Anesthetics			
lidocaine hcl mucous membrane jelly 2 %		2	QL (30 per 30 days)
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)		2	
lidocaine topical adhesive patch,medicated 5 %	(Lidoderm)	2	PA; QL (90 per 30 days)
lidocaine topical ointment 5 %		2	PA; QL (90 per 30 days)
lidocaine viscous mucous membrane solution 2 %		2	
ZTLIDO TOPICAL ADHESIVE PATCH,MEDICATED 1.8 %		3	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
Anti-Addiction/Substance Abuse Treatment Agents			
Anti-Addiction/Substance Abuse Treatment Agents			
buprenorphine hcl sublingual tablet 2 mg, 8 mg		2	QL (90 per 30 days)
buprenorphine-naloxone sublingual film 12-3 mg, 8-2 mg	(Suboxone)	2	QL (60 per 30 days)
buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg	(Suboxone)	2	QL (30 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 (336 per 365 days)
CHANTIX ORAL TABLET 0.5 MG, 1 MG		3	QL (336 per 365 days)
CHANTIX STARTING MONTH BOX ORAL TABLETS,DOSE PACK 0.5 MG (11)- 1 MG (42)		3	QL (106 per 365 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)
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)
lorazepam oral tablet 0.5 mg, 1 mg	(Ativan)	1	GC; QL (90 per 30 days)

Drug Name		Drug Tier	Requirements/Limits
lorazepam oral tablet 2 mg	(Ativan)	1	GC; QL (150 per 30 days)
Antibacterials			
Aminoglycosides			
neomycin oral tablet 500 mg		1	GC
tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml	(Tobi)	5	PA BvD; NM; NDS
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)
Cephalosporins			
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 suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		2	
Macrolides			
azithromycin intravenous recon soln 500 mg	(Zithromax)	2	
azithromycin oral packet 1 gram	(Zithromax)	4	
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)		1	GC
azithromycin oral tablet 250 mg, 500 mg	(Zithromax)	1	GC
azithromycin oral tablet 600 mg		2	
clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		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
clarithromycin oral tablet 250 mg, 500 mg		2	
Miscellaneous B-Lactam Antibiotics			
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML		5	NM; LA; NDS
ertapenem injection recon soln 1 gram	(Invanz)	2	
meropenem intravenous recon soln 1 gram, 500 mg	(Merrem)	2	
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 600-42.9 mg/5 ml	(Augmentin ES-600)	2	
amoxicillin-pot clavulanate oral tablet 500-125 mg, 875-125 mg	(Augmentin)	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		1	GC
Quinolones			
ciprofloxacin hcl oral tablet 250 mg, 500 mg	(Cipro)	1	GC
ciprofloxacin hcl oral tablet 750 mg		1	GC
levofloxacin intravenous solution 25 mg/ml		2	
levofloxacin oral solution 250 mg/10 ml		2	
levofloxacin oral tablet 250 mg		1	GC
levofloxacin oral tablet 500 mg, 750 mg	(Levaquin)	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
ofloxacin oral tablet 300 mg, 400 mg		2	
Sulfonamides			
sulfadiazine oral tablet 500 mg		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	
minocycline oral capsule 100 mg, 75 mg		2	
minocycline oral capsule 50 mg	(Minocin)	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)
anastrozole oral tablet 1 mg	(Arimidex)	1	GC
bicalutamide oral tablet 50 mg	(Casodex)	2	
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG		4	
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	
erlotinib oral tablet 100 mg, 25 mg	(Tarceva)	5	PA NSO; NM; NDS; QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
erlotinib oral tablet 150 mg	(Tarceva)	5	PA NSO; NM; NDS; QL (90 per 30 days)
exemestane oral tablet 25 mg	(Aromasin)	2	
hydroxyurea oral capsule 500 mg	(Hydrea)	2	
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)	1	GC
LEUKERAN ORAL TABLET 2 MG		5	NM; NDS
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
megestrol oral tablet 20 mg, 40 mg		2	
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)
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; QL (28 per 28 days)
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 (90 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG		5	PA NSO; NM; NDS; QL (30 per 30 days)
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)
TASIGNA ORAL CAPSULE 50 MG		5	PA NSO; NM; NDS; QL (120 per 30 days)
VOTRIENT ORAL TABLET 200 MG		5	PA NSO; NM; NDS; QL (120 per 30 days)
XTANDI ORAL CAPSULE 40 MG		5	PA NSO; NM; NDS; QL (120 per 30 days)
ZYTIGA ORAL TABLET 250 MG, 500 MG		5	PA NSO; NM; NDS; QL (120 per 30 days)
Anticholinergic Agents			
Antimuscarinics/Antispasmodics			
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	
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)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
gabapentin oral solution 250 mg/5 ml	(Neurontin)	2	
gabapentin oral tablet 600 mg, 800 mg	(Neurontin)	2	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	(Lamictal)	1	GC
lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg	(Lamictal)	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)
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)	4	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	(Topamax)	1	GC
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG		5	ST; NM; NDS; QL (60 per 30 days)
Antidementia Agents			
Antidementia Agents			
donepezil oral tablet 10 mg, 5 mg	(Aricept)	1	GC; QL (30 per 30 days)
donepezil oral tablet,disintegrating 10 mg, 5 mg		2	QL (30 per 30 days)
galantamine oral capsule,ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg	(Razadyne ER)	2	QL (30 per 30 days)
galantamine oral solution 4 mg/ml		2	QL (200 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
galantamine oral tablet 12 mg, 4 mg, 8 mg	(Razadyne)	2	QL (60 per 30 days)
Antidepressants			
Antidepressants			
bupropion hcl oral tablet 100 mg, 75 mg		2	
bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg	(Wellbutrin XL)	2	
bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg	(Wellbutrin SR)	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
fluoxetine oral solution 20 mg/5 ml (4 mg/ml)		2	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	(Paxil)	1	GC
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, 150 mg, 50 mg		1	GC
trazodone oral tablet 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	
Antidiabetic Agents			
Antidiabetic Agents, Miscellaneous			
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG		3	QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
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)
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 (60 per 30 days)
pioglitazone oral tablet 15 mg, 30 mg, 45 mg	(Actos)	6	GC; 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			
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 ML)		3	QL (30 per 28 days)
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)		3	QL (40 per 28 days)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)		3	QL (30 per 28 days)
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML		3	QL (30 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML		3	QL (40 per 28 days)
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML)		3	QL (18 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)	2	QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg, 5 mg	(Glucotrol XL)	2	QL (30 per 30 days)
Antifungals			
Antifungals			
clotrimazole-betamethasone topical cream 1-0.05 %	(Lotrisone)	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	
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	

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Drug Name		Drug Tier	Requirements/Limits
nystatin topical powder 100,000 unit/gram	(Nyamyc)	2	
nystop topical powder 100,000 unit/gram		2	
terbinafine hcl oral tablet 250 mg		1	GC
Antigout Agents			
Antigout Agents, Other			
allopurinol oral tablet 100 mg, 300 mg	(Zyloprim)	1	GC
ULORIC ORAL TABLET 40 MG, 80 MG		3	QL (30 per 30 days)
Antihistamines			
Antihistamines			
hydroxyzine hcl oral solution 10 mg/5 ml		2	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg		1	GC
levocetirizine oral solution 2.5 mg/5 ml	(Xyzal)	2	
levocetirizine oral tablet 5 mg	(24HR Allergy Relief)	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 %, 0.8 %		2	
terconazole vaginal suppository 80 mg		2	
Antimigraine Agents			
Antimigraine Agents			
rizatriptan oral tablet 10 mg	(Maxalt)	2	QL (18 per 28 days)
rizatriptan oral tablet 5 mg		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)	1	GC; QL (18 per 28 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml	(Imitrex STATdose 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)
sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml		2	QL (4 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
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		2	PA BvD
phenadoz rectal suppository 12.5 mg		2	
promethazine oral tablet 12.5 mg, 25 mg, 50 mg		1	GC
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			
albendazole oral tablet 200 mg	(Albenza)	5	NM; NDS
atovaquone-proguanil oral tablet 250-100 mg	(Malarone)	2	
atovaquone-proguanil oral tablet 62.5-25 mg	(Malarone Pediatric)	2	
chloroquine phosphate oral tablet 250 mg, 500 mg		2	
hydroxychloroquine oral tablet 200 mg	(Plaquenil)	2	
mefloquine oral tablet 250 mg		2	
Antiparkinsonian Agents			
Antiparkinsonian Agents			
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	

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Drug Name		Drug Tier	Requirements/Limits
carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg	(Sinemet CR)	2	
pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	(Mirapex)	1	GC
ropinirole oral tablet 0.25 mg, 3 mg, 5 mg	(Requip)	2	
ropinirole oral tablet 0.5 mg, 1 mg, 2 mg, 4 mg		2	
Antipsychotic Agents			
Antipsychotic Agents			
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		3	QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG		3	QL (60 per 30 days)
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)
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg		2	
PERSERIS ABDOMINAL SUBCUTANEOUS SUSPENSION,EXTEND REL SYR KIT 120 MG, 90 MG		5	NM; NDS; QL (1 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)
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)	1	GC; QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg		2	QL (60 per 30 days)
risperidone oral tablet,disintegrating 3 mg, 4 mg		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			
abacavir oral solution 20 mg/ml	(Ziagen)	2	
abacavir oral tablet 300 mg	(Ziagen)	2	
ATRIPLA ORAL TABLET 600-200-300 MG		5	NM; NDS
COMPLERA ORAL TABLET 200-25-300 MG		5	NM; NDS
EPIVIR HBV ORAL SOLUTION 25 MG/5 ML (5 MG/ML)		4	
INTELENCE ORAL TABLET 100 MG, 200 MG		5	NM; NDS
INTELENCE ORAL TABLET 25 MG		4	
ISENTRESS HD ORAL TABLET 600 MG		5	NM; NDS
ISENTRESS ORAL POWDER IN PACKET 100 MG		4	
ISENTRESS ORAL TABLET 400 MG		5	NM; NDS
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG		4	
KALETRA ORAL TABLET 100-25 MG		4	
KALETRA ORAL TABLET 200-50 MG		5	NM; NDS
lamivudine oral solution 10 mg/ml	(Epivir)	2	
lamivudine oral tablet 100 mg	(Epivir HBV)	2	
lamivudine oral tablet 150 mg, 300 mg	(Epivir)	2	
lamivudine-zidovudine oral tablet 150-300 mg	(Combivir)	2	
lopinavir-ritonavir oral solution 400-100 mg/5 ml	(Kaletra)	5	NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
nevirapine oral suspension 50 mg/5 ml	(Viramune)	3	
nevirapine oral tablet 200 mg	(Viramune)	2	
nevirapine oral tablet extended release 24 hr 100 mg, 400 mg	(Viramune XR)	2	
NORVIR ORAL POWDER IN PACKET 100 MG		4	
NORVIR ORAL SOLUTION 80 MG/ML		4	
PREZISTA ORAL SUSPENSION 100 MG/ML		5	NM; NDS
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG		5	NM; NDS
ritonavir oral tablet 100 mg	(Norvir)	2	
STRIBILD ORAL TABLET 150-150-200-300 MG		5	NM; NDS
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG, 200-300 MG		5	NM; NDS
VIRAMUNE ORAL SUSPENSION 50 MG/5 ML		4	
Antivirals, Miscellaneous			
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION		4	
rimantadine oral tablet 100 mg	(Flumadine)	2	
Hcv Antivirals			
DAKLINZA ORAL TABLET 30 MG, 60 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)
ledipasvir-sofosbuvir oral tablet 90-400 mg	(Harvoni)	5	PA; NM; NDS; QL (30 per 30 days)
MAVYRET ORAL TABLET 100-40 MG		5	PA; NM; NDS; QL (84 per 28 days)
sofosbuvir-velpatasvir oral tablet 400-100 mg	(Epclusa)	5	PA; NM; NDS; QL (28 per 28 days)
SOVALDI ORAL TABLET 400 MG		5	PA; NM; NDS; QL (28 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
VIEKIRA PAK ORAL TABLETS,DOSE PACK 12.5 MG-75 MG -50 MG/250 MG		5	PA; NM; NDS; QL (112 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 10 MILLION UNIT/ML, 6 MILLION UNIT/ML		5	PA NSO; NM; NDS
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML		5	NM; NDS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML		5	NM; NDS
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	
valacyclovir oral tablet 1 gram, 500 mg	(Valtrex)	2	
Blood Products/Modifiers/Volume Expanders			
Anticoagulants			
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, 2.5 MG, 20 MG		3	
XARELTO ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9)		3	

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Drug Name	Drug Tier	Requirements/Limits
Blood Formation Modifiers		
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	4	PA; QL (12 per 28 days)
EPOGEN INJECTION SOLUTION 20,000 UNIT/ML	5	PA; NM; NDS; 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	PA; NM; NDS
NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; NM; NDS
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)
PROMACTA ORAL POWDER IN PACKET 12.5 MG	5	PA; NM; NDS; QL (360 per 30 days)
PROMACTA ORAL TABLET 12.5 MG	5	PA; NM; NDS; QL (30 per 30 days)
PROMACTA ORAL TABLET 25 MG	5	PA; NM; NDS; QL (120 per 30 days)
PROMACTA ORAL TABLET 50 MG	5	PA; NM; NDS; QL (90 per 30 days)
PROMACTA ORAL TABLET 75 MG	5	PA; NM; NDS; QL (60 per 30 days)
Hematologic Agents, Miscellaneous		
anagrelide oral capsule 0.5 mg (Agrylin)	2	
anagrelide oral capsule 1 mg	2	
tranexamic acid oral tablet 650 mg (Lysteda)	2	QL (30 per 30 days)
Platelet-Aggregation Inhibitors		
cilostazol oral tablet 100 mg, 50 mg	2	
clopidogrel oral tablet 75 mg (Plavix)	1	GC

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Drug Name	Drug Tier	Requirements/Limits
Caloric Agents		
Caloric Agents		
CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 %	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
dextrose 5 % in water (d5w) intravenous parenteral solution	2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	PA BvD
NUTRILIPID INTRAVENOUS EMULSION 20 %	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		
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, 20 mg, 40 mg (Lotensin)	6	GC

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Drug Name		Drug Tier	Requirements/Limits
benazepril oral tablet 5 mg		6	GC
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
Antiarrhythmic Agents			
amiodarone oral tablet 200 mg	(Pacerone)	1	GC
amiodarone oral tablet 400 mg	(Pacerone)	2	
flecainide oral tablet 100 mg, 150 mg, 50 mg		2	
pacerone oral tablet 200 mg		1	GC
pacerone oral tablet 400 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 oral tablet 100 mg, 50 mg	(Lopressor)	1	GC
metoprolol tartrate oral tablet 25 mg		1	GC
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 oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg		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)	2	

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Drug Name		Drug Tier	Requirements/Limits
diltiazem hcl oral tablet 90 mg		2	
dilt-xr oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 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	(Verelan)	2	
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	(Verelan)	4	
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			
digitek oral tablet 125 mcg, 250 mcg		2	
digox oral tablet 125 mcg, 250 mcg		2	
DIGOXIN ORAL SOLUTION 50 MCG/ML		4	
digoxin oral tablet 125 mcg, 250 mcg	(Digitek)	2	
hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg		2	
Dihydropyridines			
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	
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

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Drug Name		Drug Tier	Requirements/Limits
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg		1	GC
spironolactone oral tablet 100 mg, 25 mg, 50 mg	(Aldactone)	1	GC
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	(Dyazide)	1	GC
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 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		6	GC
pravastatin oral tablet 20 mg, 40 mg, 80 mg	(Pravachol)	6	GC
simvastatin oral tablet 10 mg, 20 mg, 40 mg	(Zocor)	6	GC
simvastatin oral tablet 5 mg		6	GC
simvastatin oral tablet 80 mg	(Zocor)	6	GC; QL (30 per 30 days)
Renin-Angiotensin-Aldosterone System Inhibitors			
aliskiren oral tablet 150 mg, 300 mg	(Tekturna)	2	
eplerenone oral tablet 25 mg, 50 mg	(Inspra)	2	
TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG, 300-12.5 MG, 300-25 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, 20 mg		1	GC

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Drug Name		Drug Tier	Requirements/Limits
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
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML		5	PA; NM; NDS; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML		5	PA; NM; NDS; QL (12 per 28 days)
dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg	(Focalin)	2	QL (60 per 30 days)
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)
glatiramer subcutaneous syringe 20 mg/ml	(Copaxone)	5	PA; NM; NDS; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	(Copaxone)	5	PA; NM; NDS; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml		5	PA; NM; NDS; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml		5	PA; NM; NDS; QL (12 per 28 days)
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg		1	GC
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	

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Drug Name	Drug Tier	Requirements/Limits
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 10 mg, 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)
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	
apri 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	
caziant (28) oral tablet 0.1/.125/.15-25 mg-mcg	2	
cyred 28 day tablet outer 0.15-0.03 mg	2	
cyred eq oral tablet 0.15-0.03 mg	2	
delyla (28) oral tablet 0.1-20 mg-mcg	2	
desogestrel-ethinyl estradiol oral tablet 0.15-0.03 mg (Apri)	2	
emoquette oral tablet 0.15-0.03 mg	2	
enpresse oral tablet 50-30 (6)/75-40 (5)/125-30(10)	2	

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Drug Name	Drug Tier	Requirements/Limits
enskyce oral tablet 0.15-0.03 mg	2	
estarylla oral tablet 0.25-35 mg-mcg	2	
falmina (28) oral tablet 0.1-20 mg-mcg	2	
femynor oral tablet 0.25-35 mg-mcg	2	
hailey 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	2	
introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	2	QL (91 per 84 days)
isibloom oral tablet 0.15-0.03 mg	2	
juleber oral tablet 0.15-0.03 mg	2	
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 (28) 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	
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 (Afirmelle)	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 (91) (Introvale)	2	QL (91 per 84 days)
levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10) (Enpresse)	2	
levora-28 oral tablet 0.15-0.03 mg	2	
lutera (28) oral tablet 0.1-20 mg-mcg	2	
marlissa (28) 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)	2	

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Drug Name	Drug Tier	Requirements/Limits
microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	2	
mili oral tablet 0.25-35 mg-mcg	2	
mononessa (28) oral tablet 0.25-35 mg-mcg	4	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (24)/75 mg (4) (Aurovela 24 Fe)	2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg (Tri-Lo-Estarylla)	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	
orsythia oral tablet 0.1-20 mg-mcg	2	
portia 28 oral tablet 0.15-0.03 mg	2	
previfem oral tablet 0.25-35 mg-mcg	2	
reclipsen (28) oral tablet 0.15-0.03 mg	2	
setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	2	QL (91 per 84 days)
sprintec (28) oral tablet 0.25-35 mg-mcg	2	
sronyx oral tablet 0.1-20 mg-mcg	2	
tarina 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	2	
tarina fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	2	
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	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	
tri-mili 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	

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Drug Name		Drug Tier	Requirements/Limits
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg		2	
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg (28)		2	
velivet triphasic regimen (28) oral tablet 0.1/.125/.15-25 mg-mcg		2	
vienva oral tablet 0.1-20 mg-mcg		2	
vylibra oral tablet 0.25-35 mg-mcg		2	
Dental And Oral Agents			
Dental And Oral Agents			
chlorhexidine gluconate mucous membrane mouthwash 0.12 %	(Paroex Oral Rinse)	1	GC
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	
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)
TOLAK TOPICAL CREAM 4 %		4	
Dermatological Antibacterials			
clindamycin phosphate topical solution 1 %	(Cleocin T)	2	
clindamycin phosphate topical swab 1 %	(Cleocin T)	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	
Dermatological Anti-Inflammatory Agents			
ala-cort topical cream 1 %, 2.5 %		1	GC
betamethasone dipropionate topical cream 0.05 %		2	

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Drug Name		Drug Tier	Requirements/Limits
betamethasone dipropionate topical lotion 0.05 %		2	
betamethasone dipropionate topical ointment 0.05 %		2	
betamethasone, augmented topical gel 0.05 %		2	
clobetasol scalp solution 0.05 %	(Cormax)	2	
clobetasol topical cream 0.05 %	(Temovate)	2	
hydrocortisone topical cream 1 %	(Ala-Cort)	1	GC
hydrocortisone topical cream 2.5 %		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 %		2	
mometasone topical solution 0.1 %		2	
procto-med hc topical cream with perineal applicator 2.5 %		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)	1	GC
triamcinolone acetonide topical lotion 0.025 %, 0.1 %		2	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %		2	
Dermatological Retinoids			
adapalene topical cream 0.1 %	(Differin)	2	
adapalene topical gel 0.1 %	(Differin)	2	
ALTRENO TOPICAL LOTION 0.05 %		4	PA
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
tretinoin topical gel 0.025 %	(Avita)	2	PA
tretinoin topical gel 0.05 %	(Atralin)	2	PA

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Drug Name		Drug Tier	Requirements/Limits
Scabicides And Pediculicides			
malathion topical lotion 0.5 %	(Ovide)	2	
permethrin topical cream 5 %	(Elimite)	2	
Devices			
Devices			
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"		2	
BD UF NANO PEN NEEDLE 4MMX32G 32 GAUGE X 5/32"		2	
BD VEO INS SYRN 0.5 ML 6MMX31G 1/2 ML 31 GAUGE X 15/64"		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	
NEEDLES, INSULIN DISP., SAFETY		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	
PULMOZYME INHALATION SOLUTION 1 MG/ML		5	PA BvD; NM; NDS
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000-168,000 UNIT, 5,000-17,000- 24,000 UNIT		3	

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
Eye, Ear, Nose, Throat Agents			
Eye, Ear, Nose, Throat Agents, Miscellaneous			
atropine ophthalmic (eye) drops 1 %	(Isopto Atropine)	4	
azelastine nasal aerosol,spray 137 mcg (0.1 %)		2	QL (30 per 25 days)
azelastine ophthalmic (eye) drops 0.05 %		2	
cromolyn ophthalmic (eye) drops 4 %		2	
Eye, Ear, Nose, Throat Anti-Infectives Agents			
CIPRODEX OTIC (EAR) DROPS,SUSPENSION 0.3-0.1 %		3	
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 %		1	GC
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 %		2	
Eye, Ear, Nose, Throat Anti-Inflammatory Agents			
fluticasone propionate 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 %	(Pred Forte)	4	

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Drug Name		Drug Tier	Requirements/Limits
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 %		3	QL (60 per 30 days)
Gastrointestinal Agents			
Antiulcer Agents And Acid Suppressants			
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg		1	GC
pantoprazole oral tablet,delayed release (dr/ec) 20 mg, 40 mg	(Protonix)	1	GC
Gastrointestinal Agents, Other			
constulose oral solution 10 gram/15 ml		2	
dicyclomine oral capsule 10 mg		1	GC
dicyclomine oral solution 10 mg/5 ml		2	
dicyclomine oral tablet 20 mg		1	GC
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 oral solution 5 mg/5 ml		2	
metoclopramide hcl oral tablet 10 mg, 5 mg	(Reglan)	1	GC
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)	4	
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM		3	

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Drug Name		Drug Tier	Requirements/Limits
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	
sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram	(Renvela)	5	NM; NDS
sevelamer carbonate oral tablet 800 mg	(Renvela)	2	
sevelamer hcl oral tablet 400 mg		2	
sevelamer hcl oral tablet 800 mg	(Renagel)	2	
VELPHORO ORAL TABLET,CHEWABLE 500 MG		3	
Genitourinary Agents			
Antispasmodics, Urinary			
oxybutynin chloride oral syrup 5 mg/5 ml		2	
oxybutynin chloride oral tablet 5 mg		2	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	(Ditropan XL)	2	
oxybutynin chloride oral tablet extended release 24hr 15 mg		2	
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG		3	
Genitourinary Agents, Miscellaneous			
finasteride oral tablet 5 mg	(Proscar)	1	GC
tamsulosin oral capsule 0.4 mg	(Flomax)	1	GC
Heavy Metal Antagonists			
Heavy Metal Antagonists			
CUPRIMINE ORAL CAPSULE 250 MG		5	PA; NM; NDS
deferasirox oral tablet, dispersible 125 mg, 250 mg, 500 mg	(Exjade)	5	PA; NM; NDS
DEPEN TITRATABS ORAL TABLET 250 MG		5	PA; NM; NDS
FERRIPROX ORAL SOLUTION 100 MG/ML		5	PA; NM; NDS
FERRIPROX ORAL TABLET 500 MG		5	PA; NM; NDS
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG		5	PA; NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
JADENU SPRINKLE ORAL GRANULES IN PACKET 180 MG, 360 MG, 90 MG		5	PA; NM; NDS
penicillamine oral capsule 250 mg	(Cuprimine)	5	PA; NM; NDS
Hormonal Agents, Stimulant/Replacement/Modifying			
Androgens			
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	(Depo-Testosterone)	2	PA
testosterone enanthate intramuscular oil 200 mg/ml		2	PA; QL (5 per 28 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	(AndroGel)	2	PA; QL (150 per 30 days)
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	(AndroGel)	2	PA; QL (300 per 30 days)
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)	(AndroGel)	2	PA; QL (150 per 30 days)
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML		3	PA; QL (4 per 28 days)
Estrogens And Antiestrogens			
dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr		2	QL (8 per 28 days)
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	(Estrace)	1	GC
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	(Dotti)	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)
estradiol vaginal cream 0.01 % (0.1 mg/gram)	(Estrace)	2	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG		3	

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Drug Name	Drug Tier	Requirements/Limits
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	
Glucocorticoids/Mineralocorticoids		
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg (Medrol)	2	
methylprednisolone oral tablets,dose pack 4 mg (Medrol (Pak))	2	
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), 5 mg base/5 ml (6.7 mg/5 ml)	2	PA BvD
prednisone oral solution 5 mg/5 ml	2	PA BvD
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg, 50 mg	1	PA BvD; GC
prednisone oral tablet 20 mg (Deltasone)	1	PA BvD; GC
prednisone oral tablets,dose pack 10 mg, 10 mg (48 pack), 5 mg, 5 mg (48 pack)	2	
Pituitary		
desmopressin 10 mcg/0.1 ml spr 10 mcg/spray (0.1 ml) (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

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Drug Name	Drug Tier	Requirements/Limits
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
NOCDURNA (MEN) SUBLINGUAL TABLET,DISINTEGRATING 55.3 MCG	3	QL (30 per 30 days)
NOCDURNA (WOMEN) SUBLINGUAL TABLET,DISINTEGRATING 27.7 MCG	3	QL (30 per 30 days)
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
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 SAIZENPREP 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
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	5	PA; NM; NDS

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Drug Name		Drug Tier	Requirements/Limits
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)	4	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 oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	(Euthyrox)	1	GC
levothyroxine oral tablet 300 mcg	(Levo-T)	1	GC
liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg	(Cytomel)	2	
Immunological Agents			
Immunological Agents			
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	(Gengraf)	2	PA BvD
cyclosporine modified oral capsule 50 mg		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

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Drug Name	Drug Tier	Requirements/Limits
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)	5	PA; NM; NDS
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML)	5	PA; NM; NDS
gengraf oral capsule 100 mg, 25 mg	2	PA BvD
gengraf oral solution 100 mg/ml	2	PA BvD
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)	5	PA; NM; NDS
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NM; NDS
HUMIRA PEN PSOR-UVEITS-ADOL HS 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
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; NM; NDS
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; NM; NDS
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; NM; NDS
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	5	PA; NM; NDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML	5	PA; NM; NDS
leflunomide oral tablet 10 mg, 20 mg (Arava)	2	

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Drug Name	Drug Tier	Requirements/Limits
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 ORAL CAPSULE 1 MG	4	PA BvD
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG	4	PA BvD
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg (Prograf)	2	PA BvD
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	

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Drug Name	Drug Tier	Requirements/Limits
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
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	
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS) 400 MG	2	
LIALDA ORAL TABLET,DELAYED RELEASE (DR/EC) 1.2 GRAM	2	

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Drug Name		Drug Tier	Requirements/Limits
mesalamine oral capsule (with del rel tablets) 400 mg	(Delzicol)	2	
mesalamine oral tablet,delayed release (dr/ec) 800 mg	(Asacol HD)	4	
mesalamine rectal suppository 1,000 mg	(Canasa)	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 %	(Aqua Care Sodium Chloride)	4	
Metabolic Bone Disease Agents			
Metabolic Bone Disease Agents			
alendronate oral tablet 10 mg, 5 mg		1	GC
alendronate oral tablet 35 mg		1	GC; QL (4 per 28 days)
alendronate oral tablet 70 mg	(Fosamax)	1	GC; QL (4 per 28 days)
calcitriol oral capsule 0.25 mcg, 0.5 mcg	(Rocaltrol)	2	
calcitriol oral solution 1 mcg/ml	(Rocaltrol)	2	
ibandronate oral tablet 150 mg	(Boniva)	2	QL (1 per 28 days)
Miscellaneous Therapeutic Agents			
Miscellaneous Therapeutic Agents			
ELMIRON ORAL CAPSULE 100 MG		4	
hydroxyzine pamoate oral capsule 100 mg		1	GC
hydroxyzine pamoate oral capsule 25 mg, 50 mg	(Vistaril)	1	GC
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	
pyridostigmine bromide oral syrup 60 mg/5 ml	(Mestinon)	2	
pyridostigmine bromide oral tablet 30 mg		2	
pyridostigmine bromide oral tablet 60 mg	(Mestinon)	2	
Ophthalmic Agents			
Antiglaucoma Agents			
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %		3	

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Drug Name		Drug Tier	Requirements/Limits
brimonidine ophthalmic (eye) drops 0.2 %		1	GC
dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml	(Cosopt)	1	GC
latanoprost ophthalmic (eye) drops 0.005 %	(Xalatan)	1	GC
timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %	(Timoptic)	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		4	
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 8 meq		2	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 20 meq/l, 30 meq/l, 40 meq/l		4	PA BvD
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l		4	PA BvD
potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml)		2	PA BvD
potassium chloride oral capsule, extended release 10 meq		2	
potassium chloride oral capsule, extended release 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	

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 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 %		1	GC
sodium chloride 0.9 % intravenous parenteral solution		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		2	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)
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)

Drug Name		Drug Tier	Requirements/Limits
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION, 80 MCG/ACTUATION		3	QL (21.2 per 30 days)
Antileukotrienes			
montelukast oral tablet 10 mg	(Singulair)	1	GC
montelukast oral tablet,chewable 4 mg, 5 mg	(Singulair)	1	GC
zafirlukast oral tablet 10 mg, 20 mg	(Accolate)	2	
Bronchodilators			
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	(ProAir HFA)	2	
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503), 90 mcg/actuation (nda020983)		2	
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 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
PROAIR HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION		2	
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION		3	
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION		3	

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
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG	3	
Respiratory Tract Agents, Other		
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)	2	PA BvD
DALIRESP ORAL TABLET 250 MCG	3	QL (28 per 28 days)
DALIRESP ORAL TABLET 500 MCG	3	QL (30 per 30 days)
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	5	PA; NM; NDS
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML	5	PA; NM; NDS
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
cyclobenzaprine oral tablet 10 mg, 5 mg	2	
methocarbamol oral tablet 500 mg	2	
methocarbamol oral tablet 750 mg (Robaxin-750)	2	
Sleep Disorder Agents		
Sleep Disorder Agents		
zaleplon oral capsule 10 mg, 5 mg	2	QL (60 per 30 days)
zolpidem oral tablet 10 mg, 5 mg (Ambien)	1	GC; QL (30 per 30 days)
Vasodilating Agents		
Vasodilating Agents		
alyq oral tablet 20 mg	5	PA; NM; NDS; QL (60 per 30 days)
sildenafil (antihypertensive) oral tablet 20 mg (Revatio)	2	PA; QL (90 per 30 days)
tadalafil (antihypertensive) oral tablet 20 mg (Adcirca)	5	PA; NM; NDS; QL (60 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)

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
Vitamins And Minerals		
Vitamins And Minerals		
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

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

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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।

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-996-8422 (TTY: 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-996-8422 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-996-8422（TTY：711）。

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This abridged formulary was updated on 09/01/2019. 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 March 31 and Monday through Friday (except holidays) from April 1 through September 30, or visit StanfordHealthCareAdvantage.org.

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