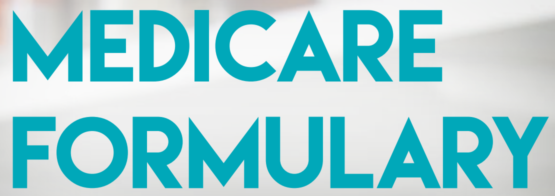

2017

plan ahead.

METROPLUS ADVANTAGE PLAN (HMO SNP)

METROPLUS PLATINUM PLAN (HMO)

SERVING NEW YORKERS FOR OVER 30 YEARS

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MetroPlus Health Plan

2017 Formulary

(List of Covered Drugs)

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

This formulary was updated on 01/01/2017. For more recent information or other questions, please contact MetroPlus Health Plan Member Services, at 1-866-986-0356 (TTY: 711), 8am-8pm, Monday-Saturday, February 15-September 30 and 8am-8pm, 7 days a week, October 1-February 14. After 8pm, Sundays & Holidays call our 24/7 Medical Answering Service at 1-800-442-2560. Or visit www.metroplusmedicare.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 MetroPlus Health Plan. When it refers to "plan" or "our plan," it means MetroPlus Health Plan.

This document includes list of the drugs (formulary) for our plan which is current as of 01/01/2017. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2018, and from time to time during the year.

MetroPlus Health Plan is a Medicare Advantage organization with a Medicare contract. Enrollment in MetroPlus Health Plan depends on contract renewal. This information is available for free in other languages.

What is the MetroPlus Health Plan Formulary?

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

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Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2017 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2017 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 01/01/2017. To get updated information about the drugs covered by MetroPlus Health Plan, please contact us. Our contact information appears on the front and back cover pages. We will send you a printed errata sheet in the event of mid-year non-maintenance formulary changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 7. 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". If you know what your drug is used for, look for the category name in the list that begins on page 7. 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 88. 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?

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

Are there any restrictions on my coverage?

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

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

- **Quantity Limits:** For certain drugs, MetroPlus Health Plan limits the amount of the drug that MetroPlus Health Plan will cover. For example MetroPlus Health Plan provides 120 per prescription for Colcrys. This may be in addition to a standard one-month or three-month supply.

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7. 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 MetroPlus Health Plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the MetroPlus Health Plan formulary?" on page 4 for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that MetroPlus Health Plan does not cover your drug, you have two options:

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

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

How do I request an exception to the MetroPlus Health Plan Formulary?

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

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

- You can ask us to cover a formulary drug at a lower cost-sharing level. If 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, MetroPlus Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary 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 91-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.

For more information

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

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

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

MetroPlus Health Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by MetroPlus Health Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 88.

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

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

- **PA**: MetroPlus requires your physician to get prior authorization for certain drugs. This means you will need to get approval from MetroPlus before you fill your prescriptions. If you don’t get approval, MetroPlus may not cover the drug.
- **QL**: For certain drugs, MetroPlus limits the amount of the drug that MetroPlus will cover. For example, MetroPlus provides one unit per day per prescription for pantoprazole. This may be in addition to a standard one month or three month supply.
- **ST**: In some cases, MetroPlus 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, MetroPlus may not cover Drug B unless you try Drug A first. If Drug A does not work for you, MetroPlus will then cover Drug B.

- **LA**: Limited Availability. This prescription may be available only at certain pharmacies. For more information consult your Provider/Pharmacy Directory or call Customer Services at 1-866-986-0356 8am-8pm, Monday-Saturday, February 15-September 30 and 8am-8pm, 7 days a week, October 1-February 14. After 8pm, Sundays & Holidays, call our 24/7 Medical Answering Service 1-800-442-2560. TTY users should call 711.
- **B/D**: This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- **NM**: This drug is not available via mail order.

MetroPlus Health Plan

Formulario para el 2017

(Lista de medicamentos cubiertos)

POR FAVOR, LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

Este formulario fue actualizado el 1 de enero de 2017. Para obtener información más reciente u otras preguntas, por favor póngase en contacto con Servicios al Miembro de MetroPlus Health Plan llamando al 1-866-986-0356 (para personas que utilizan TTY: 711) de 8 a. m. a 8 p. m., de lunes a sábado, del 15 de febrero al 30 de septiembre y de 8 a. m. a 8 p. m., los 7 días de la semana del 1 de octubre al 14 de febrero. Después de las 8 p. m., los domingos y días festivos, llame al Servicio de Recepción de Llamadas Médicas disponible las 24 horas del día, los 7 días de la semana, al 1-800-442-2560. O bien visite www.metroplusmedicare.org.

Nota dirigida a los miembros activos: Este formulario ha cambiado desde el año pasado. Por favor, revise este documento para asegurarse de que todavía contiene los medicamentos que usted toma.

Cuando en esta lista de medicamentos (formulario) se dice “nosotros” o “nuestro”, se está haciendo referencia a MetroPlus Health Plan. Cuando se dice “plan” o “nuestro plan”, se está haciendo referencia a MetroPlus Health Plan.

Este documento incluye una lista de medicamentos (formulario) de nuestro plan actualizada al 1 de enero del 2017. Para conocer un formulario actualizado, por favor póngase en contacto con nosotros. Nuestra información de contacto, junto con la fecha más reciente de actualización del formulario, aparece en las portadas delanteras y traseras.

Por lo general, debe acudir a las farmacias de la red para utilizar su beneficio de los medicamentos de venta con receta. Los beneficios, el formulario, la red de farmacias y/o los copagos/coseguros pueden cambiar el 1 de enero del 2018 y de vez en cuando durante el año.

El MetroPlus Health Plan es una organización Medicare Advantage con un contrato de Medicare. La inscripción en el MetroPlus Health Plan depende de la renovación del contrato. Esta información está disponible en otros idiomas sin costo.

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¿Qué es el formulario de MetroPlus Health Plan?

Un formulario es una lista de medicamentos cubiertos seleccionados por MetroPlus Health Plan después de consultar a un equipo de proveedores de atención médica, el cual representa las terapias a base de medicamentos de venta con receta que se creen necesarias para llevar a cabo un programa de tratamiento de calidad. MetroPlus Health Plan por lo general cubre los medicamentos listados en nuestro formulario siempre y cuando el medicamento sea necesario en términos médicos, los medicamentos de venta con receta se despachen en una farmacia de la red del plan, y se sigan otras reglas del plan. Para más información sobre cómo obtener los medicamentos de venta con receta, por favor revise su Evidencia de Cobertura.

¿Puede cambiar el formulario (lista de medicamentos)?

Por lo general, si usted está tomando un medicamento que está dentro de nuestro formulario del 2017 que estaba cubierto al comienzo del año, no suspenderemos ni reduciremos la cobertura del medicamento durante el año de cobertura 2017, excepto cuando esté disponible un medicamento genérico nuevo y menos costoso o cuando se publique información adversa sobre la seguridad y efectividad de un medicamento. Otro tipo de cambios en el formulario, como la eliminación de un medicamento de nuestro formulario, no afectará a los miembros que estén tomando el medicamento actualmente. Seguirá estando disponible al mismo costo compartido para aquellos miembros que lo estén tomando por el resto del año de la cobertura. Creemos que es importante que usted tenga acceso continuo por el resto del año de la cobertura a los medicamentos del formulario que estaban disponibles cuando usted escogió nuestro plan, exceptuando los casos en los que usted pueda ahorrar dinero adicional o podamos garantizar su seguridad.

Si quitamos medicamentos de nuestro formulario, o agregamos autorización previa, límites de cantidades y/o restricciones en terapias escalonadas de un medicamento o pasamos un medicamento a un nivel de costo compartido más elevado, debemos notificar a los miembros afectados sobre el cambio con al menos 60 días de antelación antes de que el cambio se haga efectivo, o cuando el miembro solicite los medicamentos de venta con receta, momento en el que el miembro recibirá un suministro de 60 días del medicamento. Si la Administración de Alimentos y Medicamentos considera que un medicamento de nuestro formulario no es seguro o si el fabricante del medicamento lo saca del mercado, quitaremos de inmediato el medicamento de nuestro formulario y avisaremos a los miembros que tomen el medicamento. El formulario adjunto está actualizado al 1 de enero de 2017. Para obtener información actualizada sobre los medicamentos cubiertos por MetroPlus Health Plan, por favor póngase en contacto con nosotros. Nuestra información de contacto aparece en las portadas delanteras y traseras. Le enviaremos una fe de errata impresa en caso de que se lleven a cabo cambios en el formulario a mitad de año que no sean de mantenimiento.

¿Cómo utilizo el formulario?

Hay dos maneras de encontrar su medicamento dentro del formulario:

Enfermedad

El formulario comienza en la página 7. Los medicamentos en este formulario están agrupados en categorías dependiendo del tipo de enfermedades para las que se utilizan. Por ejemplo, los medicamentos utilizados para tratar una enfermedad cardíaca están listados bajo la categoría “Cardiovascular”. Si sabe

para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 7. Luego busque su medicamento bajo el nombre de la categoría.

Lista en orden alfabético

Si no sabe en qué categoría buscar, debería buscar su medicamento en el Índice que comienza en la página 88. El Índice contiene una lista en orden alfabético de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca como los genéricos están listados en este Índice. Busque en el Índice y encuentre su medicamento. Al lado de su medicamento, verá el número de la página donde puede encontrar la información sobre la cobertura. Vaya a la página listada en el Índice y encontrará el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

MetroPlus Health Plan cubre tanto medicamentos de marca como medicamentos genéricos. Un medicamento genérico es aquel que contiene los mismos ingredientes activos que el medicamento de marca según la aprobación de la FDA (Administración de Alimentos y Medicamento). Por lo general, los medicamentos genéricos son más baratos que los de marca.

¿Existe alguna restricción en mi cobertura?

Algunos medicamentos cubiertos podrían tener requerimientos adicionales o límites de cobertura. Estos requerimientos o límites podrían incluir:

- **Autorización previa:** MetroPlus Health Plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que usted necesitará una aprobación por parte de MetroPlus Health Plan antes de obtener su medicamento de venta con receta. Si no obtiene esta aprobación, MetroPlus Health Plan podría no cubrir el medicamento.

- **Límites de cantidad:** Para ciertos medicamentos, MetroPlus Health Plan limita la cantidad del medicamento que cubrirá MetroPlus Health Plan. Por ejemplo, MetroPlus Health Plan proporciona 120 por la receta de Colcrys. Esto podría ser en adición a un suministro estándar para uno o tres meses.

- **Terapia escalonada:** En algunos casos, MetroPlus Health Plan exige que usted primero pruebe algunos medicamentos para tratar su enfermedad antes de que cubramos otro medicamento para esa enfermedad. Por ejemplo, si el medicamento A y el medicamento B sirven para el tratamiento de su enfermedad, MetroPlus Health Plan puede no cubrir el medicamento B, a menos que pruebe el medicamento A primero. Si el medicamento A no le sirve, entonces MetroPlus Health Plan cubrirá el medicamento B.

Puede averiguar si su medicamento tiene requisitos adicionales o límites buscando en el formulario que comienza en la página 7. También puede obtener más información sobre las restricciones que aplican a ciertos medicamentos cubiertos visitando nuestra página web. Hemos publicado documentos en línea que explican nuestras restricciones en cuanto a las autorizaciones previas y la terapia escalonada. También puede

pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha más reciente de actualización del formulario, aparece en las portadas delanteras y traseras.

Puede pedirle al plan que haga una excepción en cuanto a estas restricciones o límites o pedirle una lista de otros medicamentos similares que puedan servir para tratar su enfermedad. Vea la sección "¿Cómo solicitar una excepción para el formulario de MetroPlus Health Plan?" en la página 4 para obtener información sobre cómo solicitar una excepción.

¿Qué ocurre si mi medicamento no se encuentra en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe ponerse en contacto con Servicios al Miembro y preguntar si su medicamento está cubierto.

Si se entera de que MetroPlus Health Plan no cubre su medicamento, tiene dos opciones:

- Puede pedirle a Servicios al Miembro una lista de medicamentos similares que estén cubiertos por MetroPlus Health Plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por MetroPlus Health Plan.

- Puede pedirle a MetroPlus Health Plan que haga una excepción y cubra su medicamento. Revise más abajo para obtener información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción para el formulario de MetroPlus Health Plan?

Puede solicitarle a MetroPlus Health Plan que haga una excepción en cuanto a nuestras reglas para la cobertura. Existen varios tipos de excepciones que nos puede pedir que hagamos.

- Puede pedirnos que cubramos un medicamento aún si este no está en nuestro formulario. De aprobarse, este medicamento será cubierto a un nivel predeterminado de costo compartido y no podrá pedirnos que proporcionemos el medicamento a un nivel de costo compartido más bajo.

- Puede pedirnos que cubramos un medicamento del formulario a un costo compartido más bajo. De aprobarse, esto bajará el monto que debe pagar por su medicamento.

- Puede solicitarnos que no apliquemos las restricciones de cobertura o límites sobre su medicamento. Por ejemplo, para ciertos medicamentos, MetroPlus Health Plan limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitarnos que no apliquemos el límite y cubramos una cantidad mayor.

Generalmente, MetroPlus Health Plan solo aprobará su solicitud de una excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de costo compartido más bajo o las

restricciones de uso adicionales no serán efectivos para tratar su enfermedad y/o le causarán un efecto médico adverso.

Debe ponerse en contacto con nosotros con el fin de solicitarnos una decisión de cobertura inicial para una excepción en el formulario o en las restricciones de uso. **Cuando solicita una excepción en el formulario o en las restricciones de uso, debe enviar una declaración por parte de su médico que apoye su solicitud.** Por lo general, debemos tomar nuestra decisión dentro de las primeras 72 horas de haber recibido la declaración de apoyo de su médico. Puede solicitar una excepción expedita (rápida) si usted o su médico creen que su salud puede verse gravemente afectada si debe esperar 72 horas por una decisión. Si se le concede esta solicitud expedita, debemos darle a conocer una decisión a más tardar dentro de las 24 horas después de haber recibido la declaración de apoyo por parte de su médico u otra persona que haya emitido la receta.

¿Qué debo hacer antes de poder hablar con mi médico sobre cambiar mis medicamentos o solicitar una excepción?

Como miembro nuevo o regular de nuestro plan, podría estar tomando medicamentos que no están dentro de nuestro formulario. O podría estar tomando un medicamento que está en nuestro formulario, pero su capacidad para obtenerlo es limitada. Por ejemplo, podría necesitar una autorización previa de nuestra parte antes de que pueda obtener sus medicamentos de venta con receta. Es recomendable que hable con su médico para decidir si debería cambiar a un medicamento apropiado que cubramos o solicitar una excepción en el formulario para que cubramos el medicamento que usted toma. Mientras habla con su médico para determinar qué debe hacer, podríamos cubrir su medicamento en algunos casos durante los primeros 90 días en los que usted es miembro de nuestro plan.

Por cada uno de sus medicamentos que no estén en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, cubriremos un suministro temporal de 30 días (a menos que tenga una receta escrita por menos días) cuando acuda a una farmacia de la red. Después de su primer suministro de 30 días, no pagaremos por estos medicamentos, incluso si usted ha sido miembro del plan por menos de 90 días.

Si es residente de un centro de cuidados a largo plazo, le permitiremos reponer sus medicamentos de venta con receta hasta que le hayamos proporcionado un suministro de transición de 91 días, consecuente con un aumento en el despacho (a menos que tenga una receta escrita por menos días). Cubriremos más de una reposición de estos medicamentos durante los primeros 90 días en que usted sea miembro de nuestro plan. Si necesita un medicamento que no está en nuestro formulario o su capacidad de obtener los medicamentos es limitada, pero hace más de 90 días es miembro del plan, cubriremos un suministro de emergencia por 31 días para este medicamento (a menos de que tenga una receta escrita por menos días) mientras tramita una excepción al formulario.

Para más información

Para más información sobre la cobertura de medicamentos recetados de MetroPlus Health Plan, por favor revise su Evidencia de Cobertura y otros materiales sobre el plan.

Si tiene preguntas sobre MetroPlus Health Plan, por favor póngase en contacto con nosotros. Nuestra información de contacto, junto con la fecha más reciente de actualización del formulario, aparece en las portadas delanteras y traseras.

Si tiene preguntas generales sobre la cobertura de medicamentos de venta con receta de Medicare, por favor llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas al día, los 7 días a la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O bien visite www.metroplusmedicare.org.

Formulario de MetroPlus Health Plan

El formulario que comienza en la próxima página proporciona información sobre la cobertura de medicamentos por parte de MetroPlus Health Plan. Si tiene dificultades para encontrar su medicamento en la lista, pase al Índice que comienza en la página 88.

La primera columna del cuadro lista el nombre del medicamento. Los medicamentos de marca están en mayúscula (por ejemplo, DURAMORPH) y los medicamentos genéricos están en minúscula y cursiva (por ejemplo, *endocet*).

La información en la columna de Requerimientos/Límites le dice si nuestro plan tiene algún requerimiento especial para la cobertura de su medicamento.

- **PA (siglas en inglés de "aprobación previa"):** MetroPlus requiere que su médico obtenga una autorización previa para ciertos medicamentos. Esto significa que usted necesitará una aprobación antes de obtener su medicamento de venta con receta. Si no obtiene esta aprobación, puede que no cubramos el medicamento.
- **QL (siglas en inglés de "límites a la cantidad")** Para ciertos medicamentos, MetroPlus limita la cantidad del medicamento que cubriremos. Por ejemplo, MetroPlus proporciona una unidad por día por receta de pantoprazole. Esto podría ser en adición a un suministro estándar para uno o tres meses.
- **ST (siglas en inglés de "terapia escalonada"):** En algunos casos, MetroPlus exige que usted primero pruebe algunos medicamentos para tratar su enfermedad antes de que cubramos otro medicamento para esa enfermedad. Por ejemplo, si el medicamento A y el medicamento B sirven para el tratamiento de su enfermedad, MetroPlus podría no cubrir el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le sirve, entonces MetroPlus cubrirá el medicamento B.
- **LA (siglas en inglés de "disponibilidad limitada")**: Disponibilidad limitada. Estos medicamentos de venta con receta pueden estar disponibles solo en algunas farmacias. Para más información, consulte su Directorio de Proveedores/Farmacias o llame a Servicios al Cliente al 1-866-986-0356, de 8 a. m. a 8 p. m., de lunes a sábado, del 15 de febrero al 30 de septiembre y de 8 a. m. a 8 p. m., los 7 días de la semana, del 1 de octubre al 14 de febrero. Después de las 8 p. m., los domingos y días festivos, llame al Servicio de Recepción de Llamadas Médicas disponible las 24 horas del día, los 7 días de la semana, al 1-800-442-2560. Los usuarios de TTY deben llamar al 711.
- **B/D**: Este medicamento de venta con receta debe ser autorizado previamente por vía administrativa como Parte B o D. El medicamento podría estar cubierto bajo la Parte B o D de Medicare según las circunstancias. Podría ser necesario enviar información donde se describa el uso y tipo de medicamento para llevar a cabo la determinación.
- **NM (siglas en inglés de "no disponible por correo")**: Este medicamento no está disponible mediante el pedido por correo.

MetroPlus 保健計劃

2017 年處方一覽表

（承保藥品清單）

請閱讀：本文件含有關於
本計劃承保藥品的相關資訊

本處方一覽表更新於 1/1/2017。要取得最新資訊或提出其他問題，請聯絡 MetroPlus 保健計劃會員服務部，電話是 1-866-986-0356(TTY：711)，工作時間為 2 月 15 日至 9 月 30 日，週一至週六，早 8 點至晚 8 點，10 月 1 日至 2 月 14 日，一週 7 天，早 8 點至晚 8 點。晚上 8 點以後、週日及節假日，請致電以下號碼，聯絡我們的 24/7 醫療應答服務電話：1-800-442-2560。或者造訪 www.metroplusmedicare.org。

現有成員注意：此處方一覽表自去年以來發生了變更。請閱覽此文件，確保處方一覽表仍然包含您服用的藥品。

本藥品清單（處方一覽表）中的「我們」或「我們的」指代 MetroPlus 保健計劃。本藥品清單中的「計劃」或「我們的計劃」指代 MetroPlus 保健計劃。

本文件包含一份用於我們計劃的藥品清單（處方一覽表），最後更新日期為 01/01/2017。如需獲得最新處方一覽表，請聯絡我們。我們的聯絡方式和處方一覽表最新更新日期會分別出現在封面和封底。

一般情況下，您必須使用網路內藥店來使用您的處方藥福利。福利、處方一覽表、藥店網路和/或自付費用/共同保險費可能會在 2018 年 1 月 1 日發生變更，並在 2017 年多次發生變更。

MetroPlus 保健計劃是一家擁有 Medicare 合約的 Medicare Advantage 組織。參保 MetroPlus 保健計劃依照合約續約情況而定。本資訊也可以透過其他語言免費提供。

H0423_MEM2000c Accepted 09072016

何謂 MetroPlus 保健計劃處方一覽表？

處方一覽表是 MetroPlus 保健計劃在諮詢醫療保健提供者團隊後選擇的承保藥品清單，這個清單上列出了有效的治療計劃所必須的處方療法。MetroPlus 保健計劃一般會承保處方一覽表內列出的藥品，只要這些藥品屬於醫療必需藥品，且處方由 MetroPlus 保健計劃網路內的藥方開出，也符合其他的計劃規則。如想獲得關於如何開處方藥的更多資訊，請查閱您的承保福利說明。

處方一覽表（藥品清單）會發生變更嗎？

一般情況下，如果您正在服用我們的 2017 年處方一覽表上的藥品，且此藥品年初屬於承保藥品，我們不會在 2017 年保險年期間中斷或減少藥品承保，除非出現更新更低價的普通藥品或發佈關於該藥品安全性或有效性的新的負面資訊。其他類型的處方一覽表變更，例如將一種藥品從我們的處方一覽表上移除，不會對目前正在服用該藥品的會員產生影響。正在服用該藥品的會員能夠在該保險年的剩餘時間以相同的分攤費用取得該藥品。我們認為讓您在該保險年的剩餘時間繼續取得您在選擇我們的計劃時能夠從處方一覽表中取得的藥品是很重要的，您能夠節省額外費用或我們能夠確保您的安全的情況除外。

如果我們將藥品從處方一覽表中移除，增加了一種藥品的事先核准、數量限制以及/或者逐步治療限制，或將一種藥品移至更高的分攤費用等級，我們必須在變更生效前至少 60 天內通知受影響的會員這一變更情況，或在會員要求續開藥品時進行通知，在這種情況下，此會員將獲得 60 天的藥品供應量。如果食品與藥物管理局裁定我們處方一覽表上的一種藥品不安全或此藥品的製造商將藥品撤出市場，我們會立即將此藥品從我們的處方一覽表上移除並通知服用此藥品的會員。隨信附上的處方一覽表最後更新日期為 1/1/2017。如想獲得 MetroPlus 保健計劃藥品保險的最新資訊，請聯絡我們。我們的聯絡資料在封面和封底。 如果年中並未出現處方一覽表維護變更，我們將向您郵寄一份列印版勘誤表。

如何使用處方一覽表？

有兩個方法可以在處方一覽表中尋找您的藥品：

醫療狀況

處方一覽表從第 7 頁開始。此處方一覽表中的藥品根據它們用於治療的醫療狀況類型劃分為不同種類。例如，用於治療心臟狀況的藥品被列於「心血管」種類之下。如果您知道自己藥品的作用，則可從第 7 頁開始的清單中查詢類別名稱。然後在這一種類下方查詢您的藥品。

字母排列

如果您不確定應該在哪個種類下方查詢，您應該在從第 88 頁開始的索引中尋找您的藥品。索引提供了一份清單，將本文件包含的所有藥品按照字母順序進行排列。品牌藥品和普通藥品都列於此索引之中。查詢索引，找到您的藥品。在您的藥品旁邊，您將看到承保資訊所在頁面的頁碼。翻至索引中所列頁面，並在清單第一欄找到您的藥品名稱。

什麼是普通藥物?

MetroPlus 保健計劃承保品牌藥品和普通藥品。普通藥品是透過 FDA 審核的與品牌藥品具有相同活性成分的藥品。一般情況下，普通藥品的費用比品牌藥品低。

我的受保範圍是否有約束或限制?

部分承保藥品可能有額外承保要求或限制。這些要求和限制可能包括:

- **事前核准:** MetroPlus 保健計劃要求您或您的醫生為某些藥品獲得事前核准。這意味著您領取處方藥之前需要獲得 MetroPlus 保健計劃的核准。若您未獲得核准，MetroPlus 保健計劃可能不承保此藥品。

- **數量限制:** 對於某些藥品，MetroPlus 保健計劃的承保藥量有限。例如，MetroPlus 保健計劃將秋水仙鹼(Colcrys)的單次處方量限制為 120。這可能是對標準一個月或三個月供應量的補充。

- **分步治療:** 在某些情況下，MetroPlus 保健計劃會要求您在其承保治療您所患病症的藥物前先試用某些藥物。例如，如果藥品 A 和藥品 B 都可治療您的疾病情況，MetroPlus 保健計劃可能會要求您先試用藥品 A，否則就不承保藥品 B。如果藥品 A 對您無效，MetroPlus 保健計劃將承保藥品 B。

如想瞭解您的藥品是否有其他額外要求或限制，您可從第 7 頁開始檢視處方一覽表。您也可以造訪我們的網站，瞭解有關特定承保藥品所受約束的詳細資訊。我們已在網上發佈文件，解釋我們的事先核准和逐步治療限制。您也可以要求我們向您傳送一份副本。我們的聯絡方式和處方一覽表最新更新日期會分別出現在封面和封底。

您可以要求 MetroPlus 保健計劃對這些約束和限製作出特例處理，或對也許能夠治療您的健康狀況的其他類似藥品清單作出特例處理。參見第 4 頁的「如何向 MetroPlus 保健計劃請求特例處理」部分，瞭解請求特例處理的方法。

如果我的藥品未納入此處方一覽表該怎麼辦?

如果您的藥品未納入此處方一覽表（承保藥品清單），您首先應該聯絡會員服務部，詢問您的藥品是否在承保範圍內。

如果您瞭解到 MetroPlus 保健計劃不承保您的藥品，您有兩個選項：

- 您可以向會員服務部要求一份 MetroPlus 保健計劃承保的類似藥品清單。當您收到這份清單之後，將這份清單給您的醫生檢視並要求醫生開一種與 MetroPlus 保健計劃的承保藥品類似的藥品。

- 您可以向 MetroPlus 保健計劃請求特例處理並要求承保您的藥品。參見下方資訊，瞭解如何請求特例處理。

如何向 MetroPlus 保健計劃請求處方一覽表特例處理？

您可以向 MetroPlus 保健計劃請求對我們的承保規則進行特例處理。您可以向我們請求進行幾類特例處理。

- 即使一種藥品不在我們的處方一覽表之上，您也可以向我們請求承保此藥品。如果請求被核准，此藥品將以事先決定的費用分攤水準被承保，而您無法要求我們提供更低的費用分攤水準。

- 您能夠請求我們以更低的費用分攤水準承保一種處方藥品。如果請求被核准，這將降低您必須支付的藥品費用。

- 您可以向我們請求撤銷對您的藥品承保約束或限制。例如，對於某些藥品，MetroPlus 保健計劃限制我們承保的藥量。如果您的藥品有藥量限制，您可以向我們請求撤銷此限制並承保更大藥量。

一般情況下，只有當計劃處方一覽表上包含的替代藥品、分攤費用更低的藥品或額外使用約束對您的治療效果不佳以及/或者可能對您產生副作用，MetroPlus 保健計劃才會核准您的特例請求。

您應該聯絡我們，要求獲得一份有關處方一覽表或使用限制特例的初始保險決定。**當您請求一份處方一覽表或使用約束特例時，您應該提交一份您的開藥醫生或醫師出具的支持您請求的聲明。**一般情況下，我們必須在收到您的開藥醫生出具的支持性聲明後的 72 小時內作出決定。如果您或您的醫生認為等待 72 小時才能裁定可能會對您的健康造成嚴重傷害，您可以請求加急（快速）特例。如果您的加急請求得到許可，我們必須在收到您的醫生或其他開藥醫生出具的支持性聲明的 24 小時之內告知您我們的決定。

在我能夠和我的醫生討論變更我的藥品或請求特例之前我應該做什麼？

作為我們的計劃的新會員或持續會員，您可能正在服用不在我們的處方一覽表上的藥品。或者，您可能正在服用我們處方一覽表上的藥品，但您獲得該藥品的能力受限。例如，在開處方藥之前，您可能需要得到我們的事前核准。您應該向您的醫生諮詢，確認您是否應該更換為我們承保的合適藥品，或請求處方一覽表特例處理，要求我們承保您服用的藥品。在您向您的醫生諮詢並決定正確的處理措施之時，我們可能會在特定情況下在您成為我們的計劃會員的最初 90 天內承保您的藥品。

對於您所服用的不在我們處方一覽表上的每一種藥品或如果您獲得您的藥品的能力有限，我們將暫時承保 30 天的供應藥量（除非您的處方箋上註明的天數更少），您可在網絡內藥房配藥。結束您最初 30 天的供應藥量之後，我們不會為這些藥品支付費用，即使您成為本計劃會員的時間不超過 90 天亦如此。

如果您在長期護理設施住院，我們將允許您續配藥一直到您獲得 91 天的過渡供應藥量，使其與配藥增量保持一致（除非您的處方箋上註明的天數更少）。在您成為我們會員的最初 90 天，我們將承保一次以上的這些藥物續配藥。如果您需要的藥物並不在我們的處方一覽表上或者如果您獲得藥物的能力有限，而您加入我們計劃成為會員已經超過 90 天，在您尋求處方一覽表例外處理期間，我們將承保一次 31 天的急救用藥用量（除非您的處方箋上註明的天數更少）。

更多資訊

為取得關於您的 MetroPlus 保健計劃處方藥品承保的詳細資訊，請閱覽您的《承保福利說明》和其他計劃材料。

如果您對 MetroPlus 保健計劃有疑問，請聯絡我們。我們的聯絡方式和處方一覽表最新更新日期會分別出現在封面和封底。

如果您對 Medicare 處方藥品承保有一般性問題，請致電 Medicare，電話是 1-800-MEDICARE (1-800-633-4227)，每週 7 天、每天 24 小時開通。TTY 使用者應致電 1-877-486-2048。或者造訪 visit http://www.medicare.gov。

MetroPlus 保健計劃處方一覽表

從下頁開始的處方一覽表為您提供 MetroPlus 保健計劃承保的藥物資訊。如果您在藥物清單上找藥物有困難，請翻至第 88 頁，開始閱讀索引部分。

圖表第一列是藥品名稱。品牌藥品名稱大寫（如：DURAMORPH），普通藥品為斜體小寫（如：*endocet*）。

要求/限制欄中的資訊告知您 MetroPlus 保健計劃對您的藥品承保是否有任何特殊要求。

- **PA**：MetroPlus 要求您的醫生為某些藥品獲得事前核准。這意味著您領取處方藥之前需要獲得 MetroPlus 的核准。若您未獲得核准，MetroPlus 可能不承保此藥品。
- **QL**：對於某些藥品，MetroPlus 限制承保的藥量。例如，MetroPlus 每天為每一處方的泮托拉唑（pantoprazole）提供一個單位的藥量。這可能是對標準一個月或三個月供應量的補充。

- **ST**：在某些情況下，MetroPlus 會要求您在其承保治療您所患病症的藥物前先試用其他藥物。例如，如果藥品 A 和藥品 B 都可治療您的疾病情況，MetroPlus 可能會要求您先試用藥品 A，否則就不承保藥品 B。如果藥物 A 對您無效，MetroPlus 將承保藥物 B。
- **LA**：供應受限。該處方可能只允許在一些藥房配藥。如想取得更多資訊，請查詢您的提供者/藥房目錄，或致電客戶服務部，電話是 1-866-986-0356，2 月 15 日至 9 月 30 日，週一至週六，早 8 點至晚 8 點，10 月 1 日至 2 月 14 日，一週 7 天，早 8 點至晚 8 點。週日和假期晚 8 點之後，請致電 1-800-442- 2560 醫療代接服務，每週 7 天，每天 24 小時。TTY 使用者應致電 711。
- **B/D**：此處方藥品在核准要求之前有一個 B 部分與 D 部分的行政問題。視不同情況而定，此藥品可能根據 Medicare B 部分或 D 部進行承保。可能需要提交資訊，說明此藥品的用途和治療情況，以便作出決定。
- **NM**：此藥品不能郵購。

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
allopurinol tab	1	
colchicine w/ probenecid	1	
COLCRYS	1	QL (120 tabs / 30 days)
probenecid	1	
ULORIC	1	ST
NSAIDS		
celecoxib CAPS 50mg	1	QL (240 caps / 30 days)
celecoxib CAPS 100mg	1	QL (120 caps / 30 days)
celecoxib CAPS 200mg	1	QL (60 caps / 30 days)
celecoxib CAPS 400mg	1	QL (30 caps / 30 days)
diclofenac potassium	1	QL (120 tabs / 30 days)
diclofenac sodium TB24	1	
diclofenac sodium TBEC	1	
diflunisal	1	
etodolac	1	
etodolac er	1	
flurbiprofen TABS	1	
ibuprofen SUSP	1	
ibuprofen TABS 400mg, 600mg, 800mg	1	
ketoprofen CAPS	1	
MELOXICAM SUSP	1	
meloxicam TABS	1	
nabumetone TABS	1	
naproxen SUSP; TABS; TBEC	1	
naproxen sodium TABS 275mg, 550mg	1	
piroxicam CAPS	1	
sulindac TABS	1	
OPIOID ANALGESICS		
acetaminophen w/ codeine SOLN	1	QL (5000 mL / 30 days)
acetaminophen w/ codeine TABS	1	QL (400 tabs / 30 days)
butorphanol tartrate SOLN 1mg/ml, 2mg/ml	1	
nalbuphine hcl SOLN	1	
tramadol hcl TABS	1	QL (240 tabs / 30 days)
tramadol-acetaminophen	1	QL (240 tabs / 30 days)
OPIOID ANALGESICS, CII		
DURAMORPH	1	B/D
endocet	1	QL (360 tabs / 30 days)
fentanyl citrate LPOP	1	QL (120 lozenges / 30 days), PA
fentanyl patch 12 mcg/hr	1	QL (10 patches / 30 days)

Drug Name	Drug Tier	Requirements/Limits
fentanyl patch 25 mcg/hr	1	QL (10 patches / 30 days)
fentanyl patch 50 mcg/hr	1	QL (10 patches / 30 days), PA
fentanyl patch 75 mcg/hr	1	QL (10 patches / 30 days), PA
fentanyl patch 100 mcg/hr	1	QL (10 patches / 30 days), PA
FENTORA	1	QL (120 tabs / 30 days), PA
hydroco/apap tab 5-325mg	1	QL (360 tabs / 30 days)
hydroco/apap tab 7.5-325	1	QL (360 tabs / 30 days)
hydroco/apap tab 10-325mg	1	QL (360 tabs / 30 days)
hydrocodone-acetaminophen 7.5-325 mg/15ml	1	QL (5400 mL / 30 days)
hydrocodone-ibuprofen tab 7.5-200 mg	1	QL (150 tabs / 30 days)
hydromorphone hcl LIQD	1	
hydromorphone hcl SOLN 10mg/ml, 50mg/5ml, 500mg/50ml	1	B/D
hydromorphone hcl TABS	1	QL (270 tabs / 30 days)
lorcet plus tab 7.5-325	1	QL (360 tabs / 30 days)
lorcet tab 5-325mg	1	QL (360 tabs / 30 days)
lortab tab 5-325mg	1	QL (360 tabs / 30 days)
lortab tab 7.5-325	1	QL (360 tabs / 30 days)
lortab tab 10-325mg	1	QL (360 tabs / 30 days)
methadone hcl CONC	1	QL (120 mL / 30 days)
methadone hcl SOLN 5mg/5ml, 10mg/5ml	1	QL (600 mL / 30 days)
methadone hcl 5mg	1	QL (240 tabs / 30 days)
methadone hcl 10mg	1	QL (240 tabs / 30 days)
morphine ext-rel tab 15mg, 30mg, 60mg, 100mg	1	QL (90 tabs / 30 days)
morphine ext-rel tab 200mg	1	QL (60 tabs / 30 days)
MORPHINE SUL INJ 1MG/ML	1	B/D
MORPHINE SUL INJ 4MG/ML	1	B/D
MORPHINE SUL INJ 10MG/ML	1	B/D
MORPHINE SUL INJ 15MG/ML	1	B/D
MORPHINE SULFATE SOLN 2mg/ml, 8mg/ml, 150mg/30ml	1	B/D
morphine sulfate SOLN .5mg/ml, 1mg/ml, 4mg/ml, 8mg/ml	1	B/D
MORPHINE SULFATE TABS	1	QL (180 tabs / 30 days)
MORPHINE SULFATE ORAL SOL	1	
oxycodone hcl CAPS	1	QL (180 caps / 30 days)
oxycodone hcl CONC	1	
OXYCODONE HCL SOLN	1	
oxycodone hcl TABS	1	QL (180 tabs / 30 days)
oxycodone w/ acetaminophen 2.5-325mg	1	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen 5-325mg	1	QL (360 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
oxycodone w/ acetaminophen 7.5-325mg	1	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen 10-325mg	1	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen soln	1	QL (1800 mL / 30 days)

ANESTHETICS

LOCAL ANESTHETICS

Drug Name	Drug Tier	Requirements/Limits
lidocaine hcl (local anesth.)	1	B/D
lidocaine inj 0.5%	1	B/D
lidocaine inj 1%	1	B/D
lidocaine inj 1.5%	1	B/D
lidocaine inj 2%	1	B/D

ANTI-INFECTIVES

ANTI-BACTERIALS - MISCELLANEOUS

Drug Name	Drug Tier	Requirements/Limits
amikacin sulfate SOLN	1	
gentamicin in saline	1	
gentamicin sulfate SOLN	1	
gentamicin sulfate/0.9% s	1	
neomycin sulfate TABS	1	
paromomycin sulfate CAPS	1	
streptomycin sulfate SOLR	1	
sulfadiazine TABS	1	
tobramycin NEBU	1	NM, PA
tobramycin inj 1.2 gm/30ml	1	
tobramycin inj 1.2gm	1	
tobramycin inj 10mg/ml	1	
tobramycin inj 40mg/ml	1	
tobramycin inj 80mg/2ml	1	

ANTI-INFECTIVES - MISCELLANEOUS

Drug Name	Drug Tier	Requirements/Limits
ALBENZA	1	
ALINIA	1	
atovaquone SUSP	1	
AZACTAM IN ISO-OSMOTIC DE	1	
AZACTAM/DEX INJ 2GM	1	
aztreonam	1	
BILTRICIDE	1	
CAYSTON	1	NM, LA, PA
clindamycin cap 75mg	1	
clindamycin cap 300mg	1	
clindamycin hcl cap 150 mg	1	
clindamycin phosphate SOLN	1	
clindamycin phosphate in d5w	1	
clindamycin phosphate inj	1	
clindamycin sol 75mg/5ml	1	
colistimethate sodium SOLR	1	
CUBICIN	1	

Drug Name	Drug Tier	Requirements/Limits
dapsone TABS	1	
daptomycin	1	
emverm	1	
imipenem-cilastatin	1	
INVANZ	1	
ivermectin TABS	1	
linezolid SOLN	1	
LINEZOLID SUSR; TABS	1	
LINEZOLID IN SODIUM CHLORIDE	1	
meropenem	1	
methenamine hippurate	1	
metronidazole TABS	1	
metronidazole in nacl	1	
NEBUPENT	1	B/D
nitrofurantoin macrocrystal 50mg, 100mg	1	PA; PA applies if 65 years and older after a 90 day supply in a calendar year
nitrofurantoin monohyd macro	1	PA; PA applies if 65 years and older after a 90 day supply in a calendar year
PENTAM 300	1	
SIVEXTRO	1	
sulfamethoxazole-trimethop ds	1	
sulfamethoxazole-trimethoprim	1	
sulfamethoxazole-trimethoprim inj	1	
SYNERCID	1	
trimethoprim TABS	1	
TYGACIL	1	
vancomycin hcl CAPS; SOLR	1	
VANCOMYCIN IN NACL	1	
ANTIFUNGALS		
ABELCET	1	B/D
AMBISOME	1	B/D
amphotericin b SOLR	1	B/D
CANCIDAS	1	
fluconazole SUSR; TABS	1	
fluconazole in dextrose	1	
fluconazole inj nacl 100	1	
fluconazole inj nacl 200	1	
fluconazole inj nacl 400	1	
flucytosine CAPS	1	
griseofulvin microsize	1	
griseofulvin ultramicrosize	1	
itraconazole CAPS	1	PA
ketoconazole TABS	1	PA

Drug Name	Drug Tier	Requirements/Limits
MYCAMINE	1	
NOXAFIL SUSP; TBEC	1	
nystatin TABS	1	
terbinafine hcl TABS	1	QL (90 tabs / 365 days)
voriconazole SOLR; SUSR; TABS	1	
ANTIMALARIALS		
atovaquone-proguanil hcl	1	
chloroquine phosphate TABS	1	
COARTEM	1	
mefloquine hcl	1	
PRIMAQUINE PHOSPHATE	1	
quinine sulfate CAPS	1	PA
ANTIRETROVIRAL AGENTS		
abacavir sulfate	1	
APTIVUS	1	
CRIXIVAN	1	
didanosine	1	
EDURANT	1	
EMTRIVA	1	
FUZEON	1	NM
INTELENCE	1	
INVIRASE	1	
ISENTRESS	1	
lamivudine	1	
LEXIVA	1	
NEVIRAPINE SUSP	1	
nevirapine TABS; TB24	1	
NORVIR	1	
PREZISTA	1	
RESCRIPTOR	1	
RETROVIR IV INFUSION	1	
REYATAZ	1	
SELZENTRY	1	
stavudine	1	
SUSTIVA	1	
TIVICAY	1	
TYBOST	1	
VIDEX PEDIATRIC	1	
VIRACEPT	1	
VIREAD	1	
VITEKTA	1	
ZIAGEN SOLN	1	
zidovudine	1	
ANTIRETROVIRAL COMBINATION AGENTS		
ABACAVIR SULFATE-LAMIVUDINE	1	

Drug Name	Drug Tier	Requirements/Limits
abacavir sulfate-lamivudine-zidovudine	1	
ATRIPLA	1	
COMPLERA	1	
DESCOVY	1	
EPZICOM	1	
EVOTAZ	1	
GENVOYA	1	
KALETRA SOL	1	
KALETRA TAB 100-25MG	1	
KALETRA TAB 200-50MG	1	
lamivudine-zidovudine	1	
ODEFSEY	1	
PREZCOBIX	1	
STRIBILD	1	
TRIUMEQ	1	
TRUVADA TAB 100-150	1	QL (60 tabs / 30 days)
TRUVADA TAB 133-200	1	QL (30 tabs / 30 days)
TRUVADA TAB 167-250	1	QL (30 tabs / 30 days)
TRUVADA TAB 200-300	1	QL (30 tabs / 30 days)
ANTITUBERCULAR AGENTS		
CAPASTAT SULFATE	1	
cycloserine CAPS	1	
ethambutol hcl TABS	1	
isoniazid TABS	1	
isoniazid inj 100 mg/ml	1	
isoniazid syp 50mg/5ml	1	
paser d/r	1	
PRIFTIN	1	
pyrazinamide TABS	1	
rifabutin	1	
rifampin CAPS; SOLR	1	
RIFATER	1	
SIRTURO	1	LA, PA
TRECATOR	1	
ANTIVIRALS		
acyclovir CAPS	1	
acyclovir SUSP	1	
acyclovir TABS	1	
acyclovir sodium	1	B/D
adefovir dipivoxil	1	
BARACLUDE SOLN	1	
DAKLINZA	1	NM, PA
entecavir	1	
EPIVIR HBV SOLN	1	
famciclovir TABS	1	

Drug Name	Drug Tier	Requirements/Limits
ganciclovir inj 500mg	1	B/D
lamivudine (hbv)	1	
moderiba tab 200mg	1	NM
PEGASYS	1	NM, PA
PEGASYS PROCLICK	1	NM, PA
REBETOL SOLN	1	NM
RELENZA DISKHALER	1	
ribasphere	1	NM
ribavirin 200mg	1	NM
rimantadine hydrochloride	1	
SOVALDI	1	NM, PA
TAMIFLU	1	
TYZEKA	1	
valacyclovir hcl TABS	1	
VALCYTE SOLR	1	
valganciclovir hcl	1	
ZEPATIER	1	NM, PA
CEPHALOSPORINS		
cefaclor	1	
cefaclor monohydrate er	1	
cefadroxil	1	
CEFAZOLIN IN DEXTROSE 2GM/100ML-4%	1	
cefazolin inj	1	
cefazolin sodium 1gm, 20gm	1	
cefazolin sodium 1 gm/50ml	1	
cefdinir	1	
cefepime hcl	1	
cefixime	1	
cefotaxime sodium 1gm, 2gm, 500mg	1	
cefoxitin sodium	1	
cefpodoxime proxetil	1	
cefprozil	1	
ceftazidime	1	
CEFTAZIDIME/DEXTROSE	1	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	1	
cefuroxime axetil	1	
cefuroxime sodium 1.5gm, 7.5gm, 750mg	1	
cephalexin CAPS 250mg, 500mg	1	
cephalexin SUSR	1	
SUPRAX CAPS	1	
suprax CHEW	1	
SUPRAX SUSR 500mg/5ml	1	
tazicef SOLR	1	
tazicef vial	1	
TEFLARO	1	

Drug Name	Drug Tier	Requirements/Limits
ERYTHROMYCINS/MACROLIDES		
AZITHROMYCIN PACK	1	
azithromycin SOLR; SUSR; TABS	1	
clarithromycin TABS	1	
clarithromycin er	1	
clarithromycin for susp	1	
DIFICID	1	
e.e.s.	1	
ery-tab	1	
erythrocin lactobionate	1	
erythrocin stearate	1	
erythromycin base	1	
erythromycin cap 250mg ec	1	
erythromycin ethylsuccinate	1	
FLUOROQUINOLONES		
ciprofloxacin SUSR	1	
ciprofloxacin er	1	
ciprofloxacin hcl tab	1	
ciprofloxacin in d5w	1	
ciprofloxacin inj	1	
levofloxacin TABS	1	
levofloxacin in d5w	1	
levofloxacin inj 25mg/ml	1	
levofloxacin oral soln 25 mg/ml	1	
PENICILLINS		
amoxicillin	1	
amoxicillin & pot clavulanate	1	
ampicillin & sulbactam sodium	1	
ampicillin cap 250 mg	1	
ampicillin cap 500 mg	1	
ampicillin for susp 125 mg/5ml	1	
ampicillin for susp 250 mg/5ml	1	
ampicillin inj	1	
ampicillin sodium	1	
BICILLIN L-A	1	
dicloxacillin sodium	1	
nafcillin sodium	1	
oxacillin sodium	1	
PENICILLIN G POT IN DEXTROSE	1	
penicillin g procaine	1	
penicillin g sodium	1	
penicillin v potassium	1	
penicilln gk inj 5mu	1	
penicilln gk inj 20mu	1	
pfizerpen-g	1	

Drug Name	Drug Tier	Requirements/Limits
piperacillin sodium-tazobactam sodium	1	
TETRACYCLINES		
doxy	1	
doxycycline (monohydrate) CAPS 50mg, 100mg	1	
doxycycline (monohydrate) TABS	1	
doxycycline hyclate CAPS; SOLR; TABS	1	
minocycline hcl CAPS	1	
morgidox cap 1x50mg	1	

ANTINEOPLASTIC AGENTS

Drug Name	Drug Tier	Requirements/Limits
ALKYLATING AGENTS		
BENDEKA	1	B/D, NM
BICNU	1	B/D
BUSULFEX	1	B/D
CYCLOPHOSPHAMIDE CAPS	1	B/D
cyclophosphamide SOLR	1	B/D
dacarbazine	1	B/D
EMCYT	1	
GLEOSTINE	1	
HEXALEN	1	
IFEX INJ 3GM	1	B/D
ifosfamide inj 1gm	1	B/D
ifosfamide inj 1gm/20ml	1	B/D
IFOSFAMIDE INJ 3GM	1	B/D
ifosfamide inj 3gm/60ml	1	B/D
LEUKERAN	1	
melphalan hcl	1	B/D
MUSTARGEN	1	B/D
TREANDA	1	B/D, NM
ANTHRACYCLINES		
daunorubicin hcl	1	B/D
doxorubicin hcl 50mg	1	B/D
doxorubicin hcl liposomal inj 2mg/ml	1	B/D
doxorubicin inj 50mg	1	B/D
epirubicin hcl	1	B/D
idarubicin hcl	1	B/D
ANTIBIOTICS		
bleomycin sulfate	1	B/D
mitomycin SOLR	1	B/D
ANTIMETABOLITES		
adrucil	1	B/D
ALIMTA	1	B/D
azacitidine	1	B/D, NM
cladribine	1	B/D
cytarabine 20mg/ml	1	B/D

Drug Name	Drug Tier	Requirements/Limits
fludarabine phosphate	1	B/D
fluorouracil SOLN	1	B/D
GEMCITABINE HCL SOLN	1	B/D
gemcitabine hcl SOLR	1	B/D
mercaptopurine TABS	1	
METHOTREXATE SODIUM 50mg/2ml	1	B/D
methotrexate sodium 50mg/2ml, 100mg/4ml, 200mg/8ml, 250mg/10ml	1	B/D
methotrexate sodium inj	1	B/D
NIPENT	1	B/D
PURIXAN	1	NM
TABLOID	1	
ANTIMITOTIC, TAXOIDS		
ABRAXANE	1	B/D
DOCEFREZ	1	B/D
DOCETAXEL CONC 20mg/ml, 80mg/4ml, 160mg/8ml	1	B/D
docetaxel CONC 140mg/7ml	1	B/D
DOCETAXEL SOLN	1	B/D
DOCETAXEL SOLN 80MG/8ML	1	B/D
paclitaxel	1	B/D
TAXOTERE 80mg/4ml	1	B/D
ANTIMITOTIC, VINCA ALKALOIDS		
vinblastine sulfate	1	B/D
vincasar	1	B/D
vincristine sulfate	1	B/D
vinorelbine tartrate	1	B/D
BIOLOGIC RESPONSE MODIFIERS		
AVASTIN	1	NM, LA, PA
BELEODAQ	1	NM, PA
ERIVEDGE	1	NM, LA, PA
FARYDAK	1	NM, LA, PA
HERCEPTIN	1	NM, PA
IBRANCE	1	NM, LA, PA
ISTODAX	1	B/D, NM
KADCYLA	1	B/D, NM
KEYTRUDA	1	NM, PA
LYNPARZA	1	NM, LA, PA
NINLARO	1	NM, PA
PROLEUKIN	1	B/D, NM
RITUXAN	1	NM, LA, PA
TECENTRIQ	1	NM, LA, PA
VELCADE	1	NM, PA
VENCLEXTA	1	NM, LA, PA
VENCLEXTA STARTING PACK	1	NM, LA, PA
YERVOY	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
ZOLINZA	1	NM, PA
HORMONAL ANTINEOPLASTIC AGENTS		
anastrozole TABS	1	
bicalutamide	1	
DEPO-PROVERA INJ 400/ML	1	B/D
exemestane	1	
FARESTON	1	
FASLODEX	1	B/D
flutamide	1	
hydroxyprogesterone caproate (antineoplastic)	1	B/D
letrozole TABS	1	
leuprolide acetate KIT	1	NM, PA
LUPRON DEPOT 3.75mg	1	NM, PA
LUPRON DEPOT INJ 11.25MG (3-MONTH)	1	NM, PA
LYSODREN	1	
megestrol ac sus 40mg/ml	1	PA; PA if 65 years and older
megestrol ac tab 20mg	1	PA; PA if 65 years and older
megestrol ac tab 40mg	1	PA; PA if 65 years and older
MEGESTROL SUS 625MG/5ML	1	PA
NILANDRON	1	
nilutamide	1	
SOLTAMOX	1	
tamoxifen citrate TABS	1	
TRELSTAR DEP INJ 3.75MG	1	NM, PA
TRELSTAR LA INJ 11.25MG	1	NM, PA
XTANDI	1	NM, LA, PA
ZYTIGA	1	NM, LA, PA
KINASE INHIBITORS		
AFINITOR	1	NM, PA
AFINITOR DISPERZ	1	NM, PA
ALECENSA	1	NM, LA, PA
BOSULIF	1	NM, PA
CABOMETYX	1	NM, LA, PA
CAPRELSA	1	NM, LA, PA
COMETRIQ	1	NM, LA, PA
COTELLIC	1	NM, LA, PA
GILOTRIF TAB 20MG	1	NM, LA, PA
GILOTRIF TAB 30MG	1	NM, LA, PA
GILOTRIF TAB 40MG	1	NM, LA, PA
ICLUSIG	1	NM, LA, PA
imatinib mesylate 100mg	1	QL (90 tabs / 30 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
imatinib mesylate 400mg	1	QL (60 tabs / 30 days), NM, PA
IMBRUVICA CAP 140MG	1	NM, LA, PA
INLYTA	1	NM, LA, PA
IRESSA	1	NM, LA, PA
JAKAFI	1	NM, LA, PA
LENVIMA 8 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 10 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 14 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 18 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 20 MG DAILY DOSE	1	NM, LA, PA
LENVIMA 24 MG DAILY DOSE	1	NM, LA, PA
MEKINIST	1	NM, LA, PA
NEXAVAR	1	NM, LA, PA
SPRYCEL	1	NM, PA
STIVARGA	1	NM, LA, PA
SUTENT	1	NM, PA
TAFINLAR	1	NM, LA, PA
TAGRISSO	1	NM, LA, PA
TARCEVA	1	NM, LA, PA
TASIGNA	1	NM, PA
TYKERB	1	NM, LA, PA
VOTRIENT	1	NM, LA, PA
XALKORI	1	NM, LA, PA
ZELBORAF	1	NM, LA, PA
ZYDELIG	1	NM, LA, PA
ZYKADIA	1	NM, LA, PA
MISCELLANEOUS		
bexarotene	1	NM, PA
DROXIA	1	
hydroxyurea CAPS	1	
LONSURF	1	NM, PA
MATULANE	1	LA
mitoxantrone hcl	1	B/D, NM
ODOMZO	1	NM, LA, PA
SYLATRON KIT 200MCG	1	NM, PA
SYLATRON KIT 300MCG	1	NM, PA
SYLATRON KIT 600MCG	1	NM, PA
SYNRIBO	1	NM, PA
tretinoin (chemotherapy)	1	
TRISENOX	1	B/D
PLATINUM-BASED AGENTS		
carboplatin	1	B/D
cisplatin	1	B/D
oxaliplatin	1	B/D
PROTECTIVE AGENTS		

Drug Name	Drug Tier	Requirements/Limits
amifostine crystalline	1	B/D
dexrazoxane	1	B/D
ELITEK	1	B/D
FUSILEV	1	B/D, NM
leucovorin calcium SOLR	1	B/D
leucovorin calcium TABS	1	
leucovorin calcium for inj 500 mg	1	B/D
levoleucovorin calcium	1	B/D, NM
mesna	1	B/D
MESNEX TABS	1	
TOPOISOMERASE INHIBITORS		
etoposide SOLN	1	B/D
irinotecan inj 40mg/2ml	1	B/D
irinotecan inj 100/5ml	1	B/D
irinotecan inj 500mg/25ml	1	B/D
toposar	1	B/D
TOPOTECAN HCL SOLN	1	B/D
topotecan hcl SOLR	1	B/D

CARDIOVASCULAR

Drug Name	Drug Tier	Requirements/Limits
ACE INHIBITOR COMBINATIONS		
amlodipine--benazepril hcl cap 10-20 mg	1	
amlodipine-benazepril hcl cap 2.5-10 mg	1	
amlodipine-benazepril hcl cap 5-10 mg	1	
amlodipine-benazepril hcl cap 5-20 mg	1	
amlodipine-benazepril hcl cap 5-40 mg	1	
amlodipine-benazepril hcl cap 10-40mg	1	
benazepril & hydrochlorothiazide	1	
captopril & hydrochlorothiazide	1	
enalapril maleate & hydrochlorothiazide	1	
fosinopril sodium & hydrochlorothiazide	1	
lisinopril & hydrochlorothiazide	1	
moexipril-hydrochlorothiazide	1	
quinapril-hydrochlorothiazide	1	
ACE INHIBITORS		
benazepril hcl TABS	1	
captopril TABS	1	
enalapril maleate TABS	1	
fosinopril sodium	1	
lisinopril TABS	1	
moexipril hcl	1	
perindopril erbumine	1	
quinapril hcl	1	
ramipril	1	
trandolapril	1	

ALDOSTERONE RECEPTOR ANTAGONISTS

Drug Name	Drug Tier	Requirements/Limits
eplerenone	1	
spironolactone TABS	1	
ALPHA BLOCKERS		
doxazosin mesylate 1mg, 2mg, 4mg	1	QL (30 tabs / 30 days)
doxazosin mesylate 8mg	1	
prazosin hcl	1	
terazosin hcl	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-olmesartan medoxomil	1	
amlodipine besylate-valsartan tab 5-160 mg	1	
amlodipine besylate-valsartan tab 5-320 mg	1	
amlodipine besylate-valsartan tab 10-160 mg	1	
amlodipine besylate-valsartan tab 10-320 mg	1	
amlodipine-valsartan-hydrochlorothiazide 5-160-12.5mg	1	
amlodipine-valsartan-hydrochlorothiazide 5-160-25mg	1	
amlodipine-valsartan-hydrochlorothiazide 10-160-12.5mg	1	
amlodipine-valsartan-hydrochlorothiazide 10-160-25mg	1	
amlodipine-valsartan-hydrochlorothiazide 10-320-25mg	1	
ENTRESTO	1	
irbesartan-hydrochlorothiazide	1	
losartan-hydrochlorothiazide	1	
olmesartan medoxomil-amlodipine-hydrochlorothiazide	1	
olmesartan medoxomil-hydrochlorothiazide	1	
valsartan & hctz tab 80-12.5mg	1	
valsartan & hctz tab 160-12.5mg	1	
valsartan & hctz tab 160-25mg	1	
valsartan & hctz tab 320-12.5mg	1	
valsartan & hctz tab 320-25mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan	1	
losartan potassium	1	
olmesartan medoxomil	1	
valsartan	1	
ANTIARRHYTHMICS		
amiodarone hcl	1	
disopyramide phosphate	1	PA; PA if 65 years and older
DOFETILIDE	1	NM

Drug Name	Drug Tier	Requirements/Limits
flecainide acetate	1	
mexiletine hcl	1	
MULTAQ	1	
NORPACE CR	1	PA; PA if 65 years and older
pacerone	1	
propafenone hcl	1	
propafenone hcl 12hr	1	
quinidine gluconate TBCR	1	
quinidine sulfate TABS	1	
sorine	1	
sotalol hcl	1	
sotalol hcl (afib/afl)	1	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
atorvastatin calcium TABS	1	
lovastatin	1	
pravastatin sodium	1	
rosuvastatin calcium	1	QL (30 tabs / 30 days)
simvastatin TABS 5mg, 10mg, 20mg, 40mg	1	
simvastatin TABS 80mg	1	QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
cholestyramine	1	
cholestyramine light	1	
colestipol hcl	1	
fenofibrate TABS 48mg, 54mg, 145mg, 160mg	1	
fenofibrate micronized 67mg, 134mg, 200mg	1	
gemfibrozil TABS	1	
JUXTAPID	1	NM, LA, PA
KYNAMRO	1	NM, PA
niacin er (antihyperlipidemic) 500mg	1	QL (90 tabs / 30 days)
niacin er (antihyperlipidemic) 750mg, 1000mg	1	
niacor	1	
omega-3-acid ethyl esters	1	
PRALUENT	1	NM, PA
prevalite	1	
VASCEPA 1gm	1	
WELCHOL	1	
ZETIA TAB 10MG	1	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol & chlorthalidone	1	
bisoprolol & hydrochlorothiazide	1	
metoprolol & hctz tab 50-25mg	1	
metoprolol & hctz tab 100-25mg	1	

Drug Name	Drug Tier	Requirements/Limits
metoprolol & hctz tab 100-50mg	1	
propranolol & hydrochlorothiazide	1	
BETA-BLOCKERS		
acebutolol hcl CAPS	1	
atenolol TABS	1	
bisoprolol fumarate	1	
BYSTOLIC	1	
carvedilol	1	
labetalol hcl TABS	1	
metoprolol succinate	1	
metoprolol tartrate SOLN	1	
metoprolol tartrate TABS 25mg, 50mg, 100mg	1	
nadolol TABS	1	
pindolol	1	
propranolol cap er	1	
propranolol hcl SOLN; TABS	1	
propranolol oral sol	1	
timolol maleate TABS	1	
CALCIUM CHANNEL BLOCKERS		
afeditab cr	1	
amlodipine besylate TABS	1	
cartia xt cap 120/24hr	1	
cartia xt cap 180/24hr	1	
cartia xt cap 240/24hr	1	
cartia xt cap 300/24hr	1	
dilt-xr cap	1	
diltiazem cap 120mg cd	1	
diltiazem cap 180mg cd	1	
diltiazem cap 240mg cd	1	
diltiazem cap 300mg cd	1	
DILTIAZEM CAP 360MG CD	1	
diltiazem cap er/12hr	1	
diltiazem hcl SOLN; TABS	1	
diltiazem hcl cap sr 24hr	1	
diltiazem hcl coated beads cap sr 24hr	1	
diltiazem hcl extended release beads cap sr	1	
felodipine	1	
isradipine	1	
nicardipine hcl CAPS	1	
nifedical	1	
nifedipine TB24	1	
nifedipine er	1	
nimodipine CAPS	1	
NYMALIZE	1	
taztia	1	

Drug Name	Drug Tier	Requirements/Limits
verapamil cap er 100mg, 120mg, 180mg, 200mg, 240mg, 300mg	1	
VERAPAMIL CAP ER 360mg	1	
verapamil hcl SOLN; TABS; TBCR	1	
verapamil tab er	1	
DIGITALIS GLYCOSIDES		
digitek .25mg	1	PA; PA if 65 years and older
digitek .125mg	1	QL (30 tabs / 30 days)
digox 125mcg	1	QL (30 tabs / 30 days)
digox 250mcg	1	PA; PA if 65 years and older
digoxin TABS 125mcg	1	QL (30 tabs / 30 days)
digoxin TABS 250mcg	1	PA; PA if 65 years and older
digoxin inj	1	
DIGOXIN SOL 50MCG/ML	1	PA; PA if 65 years and older
DIURETICS		
acetazolamide CP12; TABS	1	
amiloride & hydrochlorothiazide	1	
amiloride hcl TABS	1	
bumetanide	1	
chlorothiazide tabs	1	
chlorthalidone 25mg, 50mg	1	
furosemide SOLN; TABS	1	
furosemide inj 10mg/ml	1	
FUROSEMIDE INJ 10mg/ml	1	
hydrochlorothiazide CAPS; TABS	1	
indapamide	1	
methazolamide TABS	1	
methyclothiazide	1	
metolazone	1	
spironolactone & hydrochlorothiazide	1	
torsemide tabs	1	
triamterene & hydrochlorothiazide TABS	1	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
MISCELLANEOUS		
clonidine hcl PTWK; TABS	1	
DEMSER	1	
hydralazine hcl SOLN; TABS	1	
midodrine hcl	1	
minoxidil TABS	1	
NORTHERA	1	NM, LA, PA
RANEXA	1	
NITRATES		

Drug Name	Drug Tier	Requirements/Limits
isosorb mononitrate tab	1	
isosorbide dinitrate	1	
isosorbide dinitrate er	1	
isosorbide mononitrate er	1	
minitran	1	
nitro-bid	1	
NITRO-DUR DIS 0.3MG/HR	1	
NITRO-DUR DIS 0.8MG/HR	1	
nitroglycerin SUBL	1	
nitroglycerin td patch	1	
NITROSTAT	1	
PULMONARY ARTERIAL HYPERTENSION		
ADCIRCA	1	NM, PA
ADEMPAS	1	QL (90 tabs / 30 days), NM, LA, PA
LETAIRIS	1	QL (30 tabs / 30 days), NM, LA, PA
OPSUMIT	1	NM, LA, PA
REMODULIN	1	NM, LA, PA
REVATIO SUSR	1	QL (224 mL / 30 days), NM, PA
sildenafil citrate (pulmonary hypertension) TABS	1	QL (90 tabs / 30 days), NM, PA
TRACLEER 62.5mg	1	QL (120 tabs / 30 days), NM, LA, PA
TRACLEER 125mg	1	QL (60 tabs / 30 days), NM, LA, PA
UPTRAVI TABS 200mcg	1	QL (480 tabs / 30 days), NM, LA, PA
UPTRAVI TABS 400mcg	1	QL (240 tabs / 30 days), NM, LA, PA
UPTRAVI TABS 600mcg	1	QL (150 tabs / 30 days), NM, LA, PA
UPTRAVI TABS 800mcg	1	QL (120 tabs / 30 days), NM, LA, PA
UPTRAVI TABS 1000mcg	1	QL (90 tabs / 30 days), NM, LA, PA
UPTRAVI TABS 1200mcg, 1400mcg, 1600mcg	1	QL (60 tabs / 30 days), NM, LA, PA
UPTRAVI TBPK	1	NM, LA, PA
VENTAVIS	1	NM, PA

CENTRAL NERVOUS SYSTEM

ANTIANXIETY

Drug Name	Drug Tier	Requirements/Limits
alprazolam tab 0.5mg	1	QL (240 tabs / 30 days)
alprazolam tab 0.25mg	1	QL (480 tabs / 30 days)
alprazolam tab 1mg	1	QL (120 tabs / 30 days)
alprazolam tab 2mg	1	QL (150 tabs / 30 days)
buspirone hcl TABS	1	

Drug Name	Drug Tier	Requirements/Limits
fluvoxamine maleate TABS 25mg, 50mg	1	QL (45 tabs / 30 days)
fluvoxamine maleate TABS 100mg	1	
lorazepam CONC	1	QL (150 mL / 30 days)
lorazepam SOLN	1	
lorazepam TABS	1	QL (150 tabs / 30 days)
ANTICONVULSANTS		
APTIOM 200mg	1	QL (180 tabs / 30 days)
APTIOM 400mg	1	QL (90 tabs / 30 days)
APTIOM 600mg, 800mg	1	QL (60 tabs / 30 days)
BANZEL SUS 40MG/ML	1	PA
BANZEL TAB 200MG	1	PA
BANZEL TAB 400MG	1	PA
BRIVIACT	1	PA
carbamazepine CHEW; CP12; SUSP; TABS; TB12	1	
CELONTIN	1	
clonazepam TABS 1mg	1	QL (120 tabs / 30 days)
clonazepam TABS 2mg	1	QL (300 tabs / 30 days)
clonazepam TABS .5mg	1	QL (240 tabs / 30 days)
clonazepam TBDP 1mg	1	QL (120 tabs / 30 days)
clonazepam TBDP 2mg	1	QL (300 tabs / 30 days)
clonazepam TBDP .5mg	1	QL (240 tabs / 30 days)
clonazepam TBDP .25mg	1	QL (480 tabs / 30 days)
clonazepam TBDP .125mg	1	QL (960 tabs / 30 days)
clorazepate dipotassium 3.75mg, 7.5mg	1	QL (120 tabs / 30 days), PA
clorazepate dipotassium 15mg	1	QL (180 tabs / 30 days), PA
diazepam CONC	1	QL (240 mL / 30 days), PA
diazepam SOLN 1mg/ml	1	QL (1200 mL / 30 days), PA
diazepam SOLN 5mg/ml	1	
diazepam TABS	1	QL (120 tabs / 30 days), PA
DIAZEPAM GEL	1	
dilantin	1	
DILANTIN-125 SUS 125/5ML	1	
divalproex sodium	1	
epitol	1	
ethosuximide CAPS; SOLN	1	
felbamate	1	
FYCOMPA SUSP	1	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	1	QL (180 tabs / 30 days), PA
FYCOMPA TABS 4mg	1	QL (90 tabs / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA TABS 6mg	1	QL (60 tabs / 30 days), PA
FYCOMPA TABS 8mg, 10mg, 12mg	1	QL (30 tabs / 30 days), PA
gabapentin CAPS 100mg	1	QL (1080 caps / 30 days)
gabapentin CAPS 300mg	1	QL (360 caps / 30 days)
gabapentin CAPS 400mg	1	QL (270 caps / 30 days)
gabapentin SOLN	1	QL (2160 mL / 30 days)
gabapentin TABS 600mg	1	QL (180 tabs / 30 days)
gabapentin TABS 800mg	1	QL (120 tabs / 30 days)
GABITRIL 12mg, 16mg	1	
lamotrigine CHEW; TABS; TB24	1	
levetiracetam SOLN; TABS; TB24	1	
LEVETIRACETAM IV	1	
levetiracetam oral soln 100 mg/ml	1	
LYRICA CAPS 25mg, 50mg, 75mg, 100mg, 150mg	1	QL (120 caps / 30 days)
LYRICA CAPS 200mg	1	QL (90 caps / 30 days)
LYRICA CAPS 225mg, 300mg	1	QL (60 caps / 30 days)
LYRICA SOLN	1	QL (946 mL / 30 days)
ONFI	1	PA
oxcarbazepine	1	
PEGANONE	1	
phenobarbital ELIX; TABS	1	PA; PA if 65 years and older
PHENOBARBITAL SODIUM SOLN 65mg/ml	1	PA; PA if 65 years and older
phenobarbital sodium SOLN 130mg/ml	1	PA; PA if 65 years and older
phenytek	1	
phenytoin CHEW; SUSP	1	
phenytoin sodium SOLN	1	
phenytoin sodium extended	1	
POTIGA 50mg	1	
POTIGA 200mg	1	QL (180 tabs / 30 days)
POTIGA 300mg, 400mg	1	QL (90 tabs / 30 days)
primidone TABS	1	
roweepra	1	
SABRIL PACK	1	QL (180 packets / 30 days), NM, LA, PA
SABRIL TABS	1	QL (180 tabs / 30 days), NM, LA, PA
SPRITAM	1	
TEGRETOL	1	
TEGRETOL-XR	1	
tiagabine hcl	1	
topiramate CPSP; TABS	1	

Drug Name	Drug Tier	Requirements/Limits
valproate sodium SOLN; SYRP	1	
valproic acid	1	
VIMPAT SOLN 10mg/ml	1	QL (1200 mL / 30 days)
VIMPAT SOLN 200mg/20ml	1	
VIMPAT TABS 50mg	1	QL (180 tabs / 30 days)
VIMPAT TABS 100mg, 150mg, 200mg	1	QL (60 tabs / 30 days)
zonisamide CAPS	1	
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg	1	QL (60 tabs / 30 days)
donepezil hydrochloride TABS 10mg, 23mg	1	
donepezil hydrochloride TBDP 5mg	1	QL (60 tabs / 30 days)
donepezil hydrochloride TBDP 10mg	1	
galantamine hydrobromide SOLN	1	
galantamine hydrobromide TABS 4mg	1	QL (180 tabs / 30 days)
galantamine hydrobromide TABS 8mg	1	QL (90 tabs / 30 days)
galantamine hydrobromide TABS 12mg	1	
galantamine hydrobromide er 8mg, 16mg	1	QL (30 caps / 30 days)
galantamine hydrobromide er 24mg	1	
memantine hcl SOLN	1	PA; PA if < 30 yrs
memantine hcl TABS 5mg	1	PA; PA if < 30 yrs
MEMANTINE HCL TABS 10mg	1	PA; PA if < 30 yrs
NAMENDA XR	1	PA; PA if < 30 yrs
NAMENDA XR TITRATION PACK	1	PA; PA if < 30 yrs
NAMZARIC CP24	1	
rivastigmine tartrate	1	
rivastigmine td patch 24hr 4.6 mg/24hr	1	QL (30 patches / 30 days)
rivastigmine td patch 24hr 9.5 mg/24hr	1	QL (30 patches / 30 days)
rivastigmine td patch 24hr 13.3 mg/24hr	1	QL (30 patches / 30 days)
ANTIDEPRESSANTS		
amitriptyline hcl TABS	1	PA; PA if 65 years and older
amoxapine tab 25mg	1	
amoxapine tab 50mg	1	
amoxapine tab 100mg	1	
amoxapine tab 150mg	1	
bupropion hcl TABS	1	
bupropion hcl TB12	1	
bupropion hcl TB24 150mg	1	QL (90 tabs / 30 days)
bupropion hcl TB24 300mg	1	QL (30 tabs / 30 days)
citalopram hydrobromide SOLN	1	
citalopram hydrobromide TABS 10mg, 20mg	1	QL (45 tabs / 30 days)
citalopram hydrobromide TABS 40mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
clomipramine hcl CAPS	1	PA; PA if 65 years and older
desipramine hcl TABS	1	
doxepin hcl CAPS; CONC	1	PA; PA if 65 years and older
duloxetine hcl CPEP 20mg	1	QL (180 caps / 30 days)
duloxetine hcl CPEP 30mg	1	QL (120 caps / 30 days)
duloxetine hcl CPEP 60mg	1	QL (60 caps / 30 days)
EMSAM	1	QL (30 patches / 30 days), PA
escitalopram oxalate SOLN	1	QL (600 mL / 30 days)
escitalopram oxalate TABS 5mg, 10mg	1	QL (45 tabs / 30 days)
escitalopram oxalate TABS 20mg	1	QL (60 tabs / 30 days)
FETZIMA 20mg	1	QL (180 caps / 30 days)
FETZIMA 40mg	1	QL (90 caps / 30 days)
FETZIMA 80mg, 120mg	1	QL (30 caps / 30 days)
FETZIMA TITRATION PACK	1	
fluoxetine cap 10mg	1	QL (30 caps / 30 days)
fluoxetine cap 20mg	1	QL (120 caps / 30 days)
fluoxetine cap 40mg	1	
fluoxetine hcl SOLN	1	
fluoxetine hcl TABS 10mg	1	QL (45 tabs / 30 days)
fluoxetine hcl TABS 20mg	1	
imipramine hcl TABS	1	PA; PA if 65 years and older
maprotiline hcl	1	
MARPLAN TAB 10MG	1	QL (180 tabs / 30 days)
mirtazapine TABS 7.5mg, 15mg	1	QL (45 tabs / 30 days)
mirtazapine TABS 30mg, 45mg	1	
mirtazapine TBDP 15mg	1	QL (30 tabs / 30 days)
mirtazapine TBDP 30mg, 45mg	1	
nefazodone hcl	1	
nortriptyline hcl CAPS; SOLN	1	
paroxetine hcl tabs 10mg, 20mg, 40mg	1	QL (45 tabs / 30 days)
paroxetine hcl tabs 30mg	1	QL (60 tabs / 30 days)
PAXIL SUSP	1	QL (900 mL / 30 days)
phenelzine sulfate TABS	1	
PRISTIQ	1	QL (30 tabs / 30 days)
protriptyline hcl	1	
sertraline hcl CONC	1	
sertraline hcl TABS 25mg, 50mg	1	QL (45 tabs / 30 days)
sertraline hcl TABS 100mg	1	
tranylcypromine sulfate	1	
trazodone hcl TABS 50mg, 100mg, 150mg	1	
trimipramine maleate CAPS 25mg	1	QL (240 caps / 30 days), PA; PA if 65 years and older

Drug Name	Drug Tier	Requirements/Limits
trimipramine maleate CAPS 50mg	1	QL (120 caps / 30 days), PA; PA if 65 years and older
trimipramine maleate CAPS 100mg	1	QL (60 caps / 30 days), PA; PA if 65 years and older
TRINTELLIX 5mg	1	QL (120 tabs / 30 days)
TRINTELLIX 10mg	1	QL (60 tabs / 30 days)
TRINTELLIX 20mg	1	QL (30 tabs / 30 days)
venlafaxine hcl CP24 37.5mg, 75mg	1	QL (30 caps / 30 days)
venlafaxine hcl CP24 150mg	1	QL (60 caps / 30 days)
venlafaxine hcl TABS	1	
VIIBRYD STARTER PACK	1	
VIIBRYD TAB	1	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
amantadine hcl CAPS	1	QL (120 caps / 30 days)
amantadine hcl SYRP; TABS	1	
APOKYN	1	NM, LA, PA
AZILECT	1	
BENZTROPINE MESYLATE SOLN	1	
benztropine mesylate TABS	1	PA; PA if 65 years and older
bromocriptine mesylate CAPS; TABS	1	
carbidopa-levodopa	1	
CARBIDOPA/LEVODOPA/ENTACAPONE	1	
ENTACAPONE	1	
NEUPRO	1	
pramipexole tab 0.5mg	1	
pramipexole tab 0.25mg	1	
pramipexole tab 0.75mg	1	
pramipexole tab 0.125mg	1	
pramipexole tab 1.5mg	1	
pramipexole tab 1mg	1	
ropinirole tab 0.5mg	1	
ropinirole tab 0.25mg	1	
ropinirole tab 1mg	1	
ropinirole tab 2mg	1	
ropinirole tab 3mg	1	
ropinirole tab 4mg	1	
ropinirole tab 5mg	1	
selegiline hcl CAPS; TABS	1	
ANTIPSYCHOTICS		
ABILIFY MAINTENA 300mg, 400mg	1	QL (1 syringe / 28 days)
ABILIFY MAINTENA 300mg, 400mg	1	QL (1 vial / 28 days)
aripiprazole odt	1	QL (60 tabs / 30 days)
aripiprazole oral solution 1 mg/ml	1	QL (900 mL / 30 days)
aripiprazole tab	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
chlorpromazine hcl TABS	1	
chlorpromazine inj	1	
CLOZAPINE ODT 12.5mg, 25mg	1	PA
CLOZAPINE ODT 100mg	1	QL (270 tabs / 30 days), PA
CLOZAPINE ODT 150mg	1	QL (180 tabs / 30 days), PA
CLOZAPINE ODT 200mg	1	QL (135 tabs / 30 days), PA
clozapine tab 25mg	1	
clozapine tab 50mg	1	
clozapine tab 100mg	1	QL (270 tabs / 30 days)
clozapine tab 200mg	1	QL (135 tabs / 30 days)
FANAPT	1	QL (60 tabs / 30 days)
FANAPT TITRATION PACK	1	
fluphenazine decanoate SOLN	1	
fluphenazine hcl	1	
GEODON SOLR	1	QL (6 mL / 3 days)
haloperidol TABS	1	
haloperidol decanoate SOLN	1	
haloperidol lactate inj 5 mg/ml	1	
haloperidol lactate oral conc 2 mg/ml	1	
INVEGA SUST INJ 39 MG/0.25 ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 78 MG/0.5 ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 117 MG/0.75 ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 156MG/ML	1	QL (1 injection / 28 days)
INVEGA SUST INJ 234 MG/1.5 ML	1	QL (1 injection / 28 days)
INVEGA TRINZA	1	QL (1 syringe / 90 days)
LATUDA 20mg	1	QL (240 tabs / 30 days)
LATUDA 40mg, 120mg	1	QL (30 tabs / 30 days)
LATUDA 60mg, 80mg	1	QL (60 tabs / 30 days)
loxapine succinate	1	
molindone hcl	1	
NUPLAZID	1	QL (60 tabs / 30 days), NM, LA, PA
olanzapine SOLR	1	QL (3 vials / 1 day)
olanzapine TABS 2.5mg	1	QL (240 tabs / 30 days)
olanzapine TABS 5mg	1	QL (120 tabs / 30 days)
olanzapine TABS 7.5mg	1	QL (30 tabs / 30 days)
olanzapine TABS 10mg, 15mg, 20mg	1	QL (60 tabs / 30 days)
olanzapine TBDP 5mg	1	QL (30 tabs / 30 days)
olanzapine TBDP 10mg, 15mg, 20mg	1	QL (60 tabs / 30 days)
paliperidone 1.5mg, 3mg, 9mg	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
paliperidone 6mg	1	QL (60 tabs / 30 days)
perphenazine TABS	1	
pimozide	1	
quetiapine fumarate TABS	1	QL (90 tabs / 30 days)
quetiapine fumarate TB24 50mg	1	QL (120 tabs / 30 days)
quetiapine fumarate TB24 150mg, 200mg	1	QL (30 tabs / 30 days)
quetiapine fumarate TB24 300mg, 400mg	1	QL (60 tabs / 30 days)
REXULTI 1mg	1	QL (90 tabs / 30 days)
REXULTI 2mg	1	QL (60 tabs / 30 days)
REXULTI 3mg, 4mg	1	QL (30 tabs / 30 days)
REXULTI .5mg	1	QL (180 tabs / 30 days)
REXULTI .25mg	1	QL (360 tabs / 30 days)
RISPERDAL INJ 12.5MG	1	QL (2 injections / 28 days)
RISPERDAL INJ 25MG	1	QL (2 injections / 28 days)
RISPERDAL INJ 37.5MG	1	QL (2 injections / 28 days)
RISPERDAL INJ 50MG	1	QL (2 injections / 28 days)
risperidone SOLN	1	QL (240 mL / 30 days)
risperidone TABS 1mg, 2mg, 3mg	1	QL (60 tabs / 30 days)
risperidone TABS 4mg	1	QL (120 tabs / 30 days)
risperidone TABS .25mg, .5mg	1	QL (90 tabs / 30 days)
risperidone TBDP 1mg, 2mg, 3mg	1	QL (60 tabs / 30 days)
risperidone TBDP 4mg	1	QL (120 tabs / 30 days)
risperidone TBDP .25mg, .5mg	1	QL (90 tabs / 30 days)
SAPHRIS 2.5mg	1	QL (240 tabs / 30 days)
SAPHRIS 5mg	1	QL (120 tabs / 30 days)
SAPHRIS 10mg	1	QL (60 tabs / 30 days)
SEROQUEL XR 50mg	1	QL (120 tabs / 30 days)
SEROQUEL XR 150mg, 200mg	1	QL (30 tabs / 30 days)
SEROQUEL XR 300mg, 400mg	1	QL (60 tabs / 30 days)
thioridazine hcl TABS	1	PA; PA if 65 years and older
thiothixene	1	
trifluoperazine hcl	1	
VERSACLOZ	1	QL (600 mL / 30 days), PA
VRAYLAR 1.5mg	1	QL (120 caps / 30 days)
VRAYLAR 3mg	1	QL (60 caps / 30 days)
VRAYLAR 4.5mg, 6mg	1	QL (30 caps / 30 days)
VRAYLAR THERAPY PACK	1	
ziprasidone hcl 20mg, 40mg	1	QL (60 caps / 30 days)
ziprasidone hcl 60mg, 80mg	1	QL (90 caps / 30 days)
ZYPREXA RELPREVV 300mg	1	QL (2 vials / 28 days), PA

Drug Name	Drug Tier	Requirements/Limits
ZYPREXA RELPREVV 405mg	1	QL (1 vial / 28 days), PA
ZYPREXA RELPREVV INJ 210MG	1	QL (2 vials / 28 days), PA
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine-dextroamphetamine cap sr 24hr 5 mg	1	QL (90 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 10 mg	1	QL (90 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 15 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 20 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 25 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 30 mg	1	QL (30 caps / 30 days)
amphetamine-dextroamphetamine tab 5 mg	1	QL (360 tabs / 30 days)
amphetamine-dextroamphetamine tab 7.5 mg	1	QL (240 tabs / 30 days)
amphetamine-dextroamphetamine tab 10 mg	1	QL (180 tabs / 30 days)
amphetamine-dextroamphetamine tab 12.5 mg	1	QL (144 tabs / 30 days)
amphetamine-dextroamphetamine tab 15 mg	1	QL (120 tabs / 30 days)
amphetamine-dextroamphetamine tab 20 mg	1	QL (90 tabs / 30 days)
amphetamine-dextroamphetamine tab 30 mg	1	QL (60 tabs / 30 days)
guanfacine er (adhd)	1	PA; PA if 65 years and older
metadate er tab 20mg	1	QL (90 tabs / 30 days)
methylphenidate hcl TABS 5mg, 10mg	1	QL (180 tabs / 30 days)
methylphenidate hcl TABS 20mg	1	QL (90 tabs / 30 days)
methylphenidate hcl TBCR	1	QL (90 tabs / 30 days)
methylphenidate hcl oral soln 5mg/5ml	1	QL (1800 mL / 30 days)
methylphenidate hcl oral soln 10mg/5ml	1	QL (900 mL / 30 days)
STRATTERA 10mg, 18mg, 25mg	1	QL (120 caps / 30 days)
STRATTERA 40mg	1	QL (60 caps / 30 days)
STRATTERA 60mg, 80mg, 100mg	1	QL (30 caps / 30 days)
HYPNOTICS		
HETLIOZ	1	NM, LA, PA
SILENOR 3mg	1	QL (60 tabs / 30 days)
SILENOR 6mg	1	QL (30 tabs / 30 days)
temazepam 7.5mg	1	QL (30 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year

Drug Name	Drug Tier	Requirements/Limits
temazepam 15mg	1	QL (60 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
zolpidem tartrate TABS	1	QL (30 tabs / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
MIGRAINE		
cafergot	1	
dihydroergotamine mesylate 1mg/ml	1	
migergot	1	
naratriptan hcl	1	QL (12 tabs / 30 days)
RELPAX	1	QL (12 tabs / 30 days)
rizatriptan benzoate	1	QL (18 tabs / 30 days)
SUMATRIPTAN SOLN 5mg/act	1	QL (24 inhalers / 30 days)
SUMATRIPTAN SOLN 20mg/act	1	QL (12 inhalers / 30 days)
SUMATRIPTAN INJ 4MG/0.5ML	1	QL (18 injections / 30 days)
sumatriptan inj 6mg/0.5ml	1	QL (12 injections / 30 days)
sumatriptan succinate TABS	1	QL (12 tabs / 30 days)
zolmitriptan TABS	1	QL (12 tabs / 30 days)
zolmitriptan odt	1	QL (12 tabs / 30 days)
MISCELLANEOUS		
lithium carbonate CAPS; TABS	1	
lithium carbonate er	1	
LITHIUM SOLN 8MEQ/5ML	1	
NUEDEXTA	1	PA
pyridostigmine tab 60mg	1	
riluzole	1	
TETRABENAZINE 12.5mg	1	QL (240 tabs / 30 days), NM, PA
TETRABENAZINE 25mg	1	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
AMPYRA	1	NM, LA, PA
BETASERON	1	QL (14 syringes / 28 days), NM, PA
COPAXONE INJ 40MG/ML	1	QL (12 syringes / 28 days), NM, PA
GILENYA CAP 0.5MG	1	QL (28 caps / 28 days), NM, PA
glatopa	1	QL (30 syringes / 30 days), NM, PA
TYSABRI	1	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
MUSCULOSKELETAL THERAPY AGENTS		
baclofen TABS	1	
cyclobenzaprine hcl TABS 5mg, 10mg	1	PA; PA if 65 years and older
dantrolene sodium CAPS	1	
tizanidine hcl TABS	1	
NARCOLEPSY/CATAPLEXY		
armodafinil 50mg	1	QL (150 tabs / 30 days), PA
armodafinil 150mg	1	QL (60 tabs / 30 days), PA
ARMODAFINIL 200mg	1	QL (30 tabs / 30 days), PA
armodafinil 250mg	1	QL (30 tabs / 30 days), PA
XYREM	1	QL (540 mL / 30 days), LA, PA
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium	1	
buprenorphine hcl SUBL	1	PA
buprenorphine hcl-naloxone hcl sl	1	QL (120 tabs / 30 days), PA
buproban	1	
bupropion hcl (smoking deterrent)	1	
CHANTIX	1	PA
CHANTIX CONTINUING MONTH	1	PA
CHANTIX STARTER PACK	1	PA
disulfiram TABS	1	
naloxone inj 0.4mg/ml	1	
naloxone inj 1mg/ml	1	
naltrexone hcl TABS	1	
NICOTROL INHALER	1	
NICOTROL NS	1	
SUBOXONE MIS 2-0.5MG	1	QL (120 SL films / 30 days), PA
SUBOXONE MIS 4-1MG	1	QL (120 SL films / 30 days), PA
SUBOXONE MIS 8-2MG	1	QL (120 SL films / 30 days), PA
SUBOXONE MIS 12-3MG	1	QL (60 SL films / 30 days), PA

ENDOCRINE AND METABOLIC

Drug Name	Drug Tier	Requirements/Limits
ANDROGENS		
ANADROL-50	1	PA
ANDRODERM	1	QL (30 patches / 30 days), PA
AXIRON	1	QL (440 mL / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
oxandrolone TABS	1	PA
testosterone cypionate SOLN	1	PA
testosterone enanthate SOLN	1	PA
ANTIDIABETICS, INJECTABLE		
ALCOHOL SWABS	1	
BYDUREON INJ	1	QL (4 vials / 28 days)
BYDUREON PEN	1	QL (4 pens / 28 days)
BYETTA	1	QL (1 pen / 30 days)
GAUZE PADS 2" X 2"	1	
HUMULIN R INJ U-500	1	B/D
HUMULIN R U-500 KWIKPEN	1	
INSULIN PEN NEEDLE	1	
INSULIN SAFETY NEEDLES	1	
INSULIN SYRINGE	1	
LANTUS	1	
LANTUS SOLOSTAR	1	
LEVEMIR	1	
LEVEMIR FLEXTOUCH	1	
NOVOLIN 70/30	1	(brand RELION not covered)
NOVOLIN N	1	(brand RELION not covered)
NOVOLIN R	1	(brand RELION not covered)
NOVOLOG	1	
NOVOLOG FLEXPEN	1	
NOVOLOG MIX 70/30	1	
NOVOLOG MIX 70/30 PREFILL	1	
NOVOLOG PENFILL	1	
SYMLINPEN 60	1	QL (8 pens / 30 days), PA
SYMLINPEN 120	1	QL (4 pens / 30 days), PA
TOUJEO SOLOSTAR	1	
TRESIBA FLEXTOUCH	1	
TRULICITY	1	QL (4 pens / 28 days)
VICTOZA	1	QL (3 pens / 30 days)
ANTIDIABETICS, ORAL		
acarbose	1	
FARXIGA 5mg	1	QL (60 tabs / 30 days)
FARXIGA 10mg	1	QL (30 tabs / 30 days)
glimepiride 1mg	1	QL (240 tabs / 30 days)
glimepiride 2mg	1	QL (120 tabs / 30 days)
glimepiride 4mg	1	QL (60 tabs / 30 days)
glip/metform tab 2.5-250m	1	QL (240 tabs / 30 days)
glip/metform tab 2.5-500m	1	QL (120 tabs / 30 days)
glip/metform tab 5-500mg	1	QL (120 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
glipizide TABS 5mg	1	QL (240 tabs / 30 days)
glipizide TABS 10mg	1	QL (120 tabs / 30 days)
glipizide TB24 2.5mg	1	QL (240 tabs / 30 days)
glipizide TB24 5mg	1	QL (120 tabs / 30 days)
glipizide TB24 10mg	1	QL (60 tabs / 30 days)
GLIPIZIDE XL TB24 2.5MG	1	QL (240 tabs / 30 days)
GLIPIZIDE XL TB24 5MG	1	QL (120 tabs / 30 days)
INVOKAMET TAB 50-500MG	1	QL (120 tabs / 30 days)
INVOKAMET TAB 50-1000MG	1	QL (60 tabs / 30 days)
INVOKAMET TAB 150-500MG	1	QL (60 tabs / 30 days)
INVOKAMET TAB 150-1000MG	1	QL (60 tabs / 30 days)
INVOKAMET XR TAB 50-500MG	1	QL (120 tabs / 30 days)
INVOKAMET XR TAB 50-1000MG	1	QL (60 tabs / 30 days)
INVOKAMET XR TAB 150-500MG	1	QL (60 tabs / 30 days)
INVOKAMET XR TAB 150-1000MG	1	QL (60 tabs / 30 days)
INVOKANA 100mg	1	QL (90 tabs / 30 days)
INVOKANA 300mg	1	QL (30 tabs / 30 days)
JANUMET	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	1	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	1	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	1	QL (30 tabs / 30 days)
JANUVIA	1	QL (30 tabs / 30 days)
JENTADUETO	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000 MG	1	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000 MG	1	QL (30 tabs / 30 days)
metformin er 500mg	1	QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin er 750mg	1	QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin hcl TABS 500mg	1	QL (150 tabs / 30 days)
metformin hcl TABS 850mg	1	QL (90 tabs / 30 days)
metformin hcl TABS 1000mg	1	QL (75 tabs / 30 days)
nateglinide	1	QL (90 tabs / 30 days)
pioglitazone hcl	1	QL (30 tabs / 30 days)
repaglinide 2mg	1	QL (240 tabs / 30 days)
repaglinide .5mg, 1mg	1	QL (120 tabs / 30 days)
TRADJENTA	1	QL (30 tabs / 30 days)
XIGDUO XR TAB 5-500MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	1	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	1	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000MG	1	QL (30 tabs / 30 days)
BISPHOSPHONATES		
alendronate sodium TABS 5mg, 10mg, 40mg	1	
alendronate sodium TABS 35mg, 70mg	1	QL (4 tabs / 28 days)

Drug Name	Drug Tier	Requirements/Limits
pamidronate disodium	1	B/D
zoledronic acid SOLN 5mg/100ml	1	B/D, NM
zoledronic acid SOLR	1	B/D, NM
zoledronic inj 4mg/5ml	1	B/D, NM
CALCIUM RECEPTOR AGONISTS		
SENSIPAR 30mg, 90mg	1	QL (120 tabs / 30 days), NM
SENSIPAR 60mg	1	QL (60 tabs / 30 days), NM
CHELATING AGENTS		
CHEMET	1	
DEPEN TITRATABS	1	
EXJADE	1	NM, LA, PA
FERRIPROX	1	NM, LA, PA
kionex	1	
sodium polystyrene sulfonate	1	
sps susp 15gm/60ml	1	
SYPRINE	1	
CONTRACEPTIVES		
altavera tab	1	
apri 28 day	1	
aranelle 28	1	
aubra 28 day	1	
aviane 28	1	
balziva 28 day	1	
bekyree 28 day	1	
blisovi 21 fe 1.5/30 28 day pack	1	
blisovi 21 fe 1/20 28 day pack	1	
briellyn 28 day	1	
camila 28 day	1	
caziant pak	1	
cryselle 28	1	
cyclafem 1/35 28 day	1	
cyclafem 7/7/7 28 day	1	
cyred tab	1	
deblitane 28 day	1	
delyla 28 day	1	
desogestrel-ethinyl estradiol (biphasic)	1	
drospirenone-ethinyl estradiol	1	
ELLA	1	
emoquette	1	
enpresse 28 day	1	
errin 28 day	1	
estarylla tab 0.25-35	1	
falmina 28 day	1	
GIANVI	1	

Drug Name	Drug Tier	Requirements/Limits
gildagia	1	
gildess 1.5/30 21 day	1	
heather	1	
introvale 91 day	1	
JOLESSA TAB 0.15-0.03 MG	1	
JOLIVETTE	1	
juleber 28 day	1	
junel 1.5/30 21 day	1	
junel 1/20 21 day	1	
junel fe 1.5/30 28 day	1	
junel fe 1/20 28 day	1	
kariva 28 day	1	
kelnor 1/35 28 day	1	
kimidess 28 day	1	
larin 1.5/30	1	
larin 1/20	1	
larin fe 1.5/30	1	
larin fe 1/20	1	
larissia tab	1	
LEENA	1	
lessina 28 day	1	
levonest 28 day	1	
levonor/ethi tab	1	
levonorgestrel & eth estradiol	1	
levonorgestrel (emergency oc)	1	
levonorgestrel-ethinyl estradiol (91-day)	1	
levora 0.15/30 28 day	1	
loryna 28 day	1	
low-ogestrel	1	
lutera 28 day	1	
lyza	1	
marlissa 28 day	1	
medroxyprogesterone acetate (contraceptive) SUSP	1	
MEDROXYPROGESTERONE ACETATE (CONTRACEPTIVE) SUSY	1	
MICROGESTIN 1.5/30	1	
MICROGESTIN 1/20	1	
MICROGESTIN FE 1.5/30	1	
MICROGESTIN FE 1/20	1	
mono-linyah tab 0.25-35	1	
MONONESSA	1	
myzilra	1	
necon 0.5/35 28 day	1	
necon 1/35 28 day	1	
NECON 7/7/7	1	

Drug Name	Drug Tier	Requirements/Limits
necon 10/11 28 day	1	
NECON TAB 1/50-28	1	
nikki 28 day	1	
NORA-BE TAB	1	
norethindrone (contraceptive)	1	
norgest/ethi tab 0.25/35	1	
norgestimate-ethinyl estradiol (triphasic)	1	
norlyroc 28 day	1	
nortrel 0.5/35 28 day	1	
nortrel 1/35 21 day	1	
nortrel 1/35 28 day	1	
nortrel 7/7/7 28 day	1	
NUVARING	1	
OCELLA TAB 3-0.03MG	1	
orsythia 28 day	1	
philith	1	
pimtrea pack	1	
pirmella 1/35 28 day	1	
portia 28 day	1	
previfem 28 day	1	
quasense 91 day	1	
reclipsen 28 day	1	
setlakin tab	1	
sharobel 28 day	1	
sprintec 28 day	1	
sronyx	1	
syeda	1	
tarina fe 1/20 28 day	1	
tri-legest 28 day	1	
tri-linyah	1	
tri-lo marzia	1	
tri-lo-estarylla	1	
tri-lo-sprintec 28 day	1	
tri-previfem 28 day	1	
tri-sprintec 28 day	1	
TRINESSA	1	
TRINESSA LO TAB	1	
trivora 28 day	1	
velivet 28 day	1	
vestura	1	
vienva 28 day	1	
viorele	1	
vyfemla 28 day	1	
xulane	1	
zarah	1	

Drug Name	Drug Tier	Requirements/Limits
zenchent 28 day	1	
zovia 1/35e 28 day	1	
zovia 1/50e 28 day	1	
ENDOMETRIOSIS		
danazol CAPS	1	
SYNAREL	1	
ENZYME REPLACEMENTS		
ADAGEN	1	NM, LA, PA
ALDURAZYME	1	NM, LA, PA
BUPHENYL TABS	1	NM, LA, PA
CARBAGLU	1	NM, LA, PA
CERDELGA	1	NM, PA
CEREZYME	1	NM, LA, PA
CYSTADANE	1	NM, LA
CYSTAGON	1	NM, LA, PA
FABRAZYME	1	NM, LA, PA
KUVAN	1	NM, LA, PA
levocarnitine (metabolic modifiers)	1	B/D
LUMIZYME	1	NM, LA, PA
NAGLAZYME	1	NM, LA, PA
ORFADIN	1	NM, LA, PA
RAVICTI	1	NM, PA
sodium phenylbutyrate	1	NM, PA
ZAVESCA	1	NM, LA, PA
ESTROGENS		
DELESTROGEN 10mg/ml	1	
estrace CREA	1	
estradiol PTWK	1	PA; PA if 65 years and older
estradiol TABS	1	PA; PA if 65 years and older
estradiol valerate OIL	1	
fyavolv tab 1-5mg	1	PA; PA if 65 years and older
jinteli	1	PA; PA if 65 years and older
norethindrone acetate-ethinyl estradiol	1	PA; PA if 65 years and older
VAGIFEM	1	
yuvafem vaginal tablet 10 mcg	1	
GLUCOCORTICOIDS		
a-hydrocort	1	
cortisone acetate TABS	1	
dexamethasone CONC; ELIX; SOLN; TABS	1	
dexamethasone sodium phosphate	1	
fludrocortisone acetate TABS	1	
hydrocortisone TABS	1	

Drug Name	Drug Tier	Requirements/Limits
methylpr ace inj 40mg/ml	1	B/D
methylpr ace inj 80mg/ml	1	B/D
methylpr ss inj 1gm	1	B/D
methylpr ss inj 40mg	1	B/D
methylpred pak 4mg	1	
methylpred tab 4mg	1	B/D
methylpred tab 8mg	1	B/D
methylpred tab 16mg	1	B/D
methylpred tab 32mg	1	B/D
methylprednisolone sod succ	1	B/D
pred sod pho sol 5mg/5ml	1	B/D
prednisolone sol 15mg/5ml	1	B/D
prednisolone sol 25mg/5ml	1	B/D
prednisolone syp 15mg/5ml	1	B/D
prednisone con 5mg/ml	1	B/D
prednisone pak 5mg	1	
prednisone pak 10mg	1	
prednisone sol 5mg/5ml	1	B/D
prednisone tab 1mg	1	B/D
prednisone tab 2.5mg	1	B/D
prednisone tab 5mg	1	B/D
prednisone tab 10mg	1	B/D
prednisone tab 20mg	1	B/D
prednisone tab 50mg	1	B/D
SOLU-CORTEF 250mg	1	
GLUCOSE ELEVATING AGENTS		
GLUCAGEN HYPOKIT	1	
GLUCAGON EMERGENCY KIT	1	
PROGLYCEM SUS 50MG/ML	1	
HUMAN GROWTH HORMONES		
NORDITROPIN FLEXPRO	1	NM, PA
MISCELLANEOUS		
cabergoline	1	
calcitonin (salmon)	1	B/D
FORTICAL	1	B/D
INCRELEX	1	NM, LA, PA
KORLYM	1	NM, LA, PA
LUPRON DEP-PED INJ 7.5MG	1	NM, PA
LUPRON DEP-PED INJ 11.25MG	1	NM, PA
LUPRON DEP-PED INJ 11.25MG (3-MONTH)	1	NM, PA
LUPRON DEP-PED INJ 15MG	1	NM, PA
LUPRON DEP-PED INJ 30MG (3-MONTH)	1	NM, PA
methylergonovine maleate TABS	1	
MIACALCIN 200unit/ml	1	B/D
octreotide acetate	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
PROLIA	1	QL (1 syringe / 180 days), NM
raloxifene hcl	1	
SANDOSTATIN LAR DEPOT	1	NM, PA
SIGNIFOR	1	NM, LA, PA
SOMATULINE DEPOT	1	NM, PA
SOMAVERT	1	NM, LA, PA
XGEVA	1	NM, PA
PARATHYROID HORMONES		
FORTEO	1	QL (1 pen / 28 days), NM, PA
NATPARA	1	NM, PA
PHOSPHATE BINDER AGENTS		
AURYXIA	1	
calcium acetate (phosphate binder)	1	
RENVELA PAK 0.8GM	1	
RENVELA PAK 2.4GM	1	
RENVELA TAB 800MG	1	
PROGESTINS		
medroxyprogesterone acetate tab	1	
norethindrone acetate TABS	1	
THYROID AGENTS		
levothyroxine sodium TABS 25mcg, 50mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	1	
LEVOTHYROXINE SODIUM TABS 75mcg, 300mcg	1	
LEVOXYL	1	
liothyronine sodium TABS	1	
methimazole TABS	1	
propylthiouracil TABS	1	
SYNTHROID	1	
UNITHROID	1	
VASOPRESSINS		
desmopressin acetate spray	1	
desmopressin acetate spray refrigerated	1	
desmopressin acetate tabs	1	
desmopressin inj 4mcg/ml	1	
DESMOPRESSIN SOL 0.01%	1	
STIMATE	1	NM

GASTROINTESTINAL

Drug Name	Drug Tier	Requirements/Limits
ANTIEMETICS		
compro	1	
dronabinol	1	B/D, QL (60 caps / 30 days)
EMEND SUSR	1	B/D

Drug Name	Drug Tier	Requirements/Limits
EMEND CAP 40MG	1	B/D
EMEND CAP 80MG	1	B/D
EMEND CAP 125MG	1	B/D
EMEND PAK 80 & 125	1	B/D
granisetron hcl SOLN	1	
granisetron hcl TABS	1	B/D
meclizine hcl TABS	1	
metoclopramide hcl SOLN; TABS	1	
metoclopramide inj	1	
ondansetron hcl TABS	1	B/D
ondansetron hcl inj	1	
ondansetron hcl oral soln	1	B/D
ondansetron odt	1	B/D
phenadoz	1	PA; PA if 65 years and older
phenergan SUPP	1	PA; PA if 65 years and older
prochlorperazine inj	1	
prochlorperazine maleate TABS	1	
prochlorperazine supp	1	
promethazine hcl SOLN; SUPP; SYRP; TABS	1	PA; PA if 65 years and older
promethegan	1	PA; PA if 65 years and older
TRANSDERM-SCOP	1	QL (10 patches / 30 days), PA; PA if 65 years and older
ANTISPASMODICS		
dicyclomine hcl CAPS	1	
dicyclomine hcl SOLN 10mg/5ml	1	
dicyclomine hcl TABS	1	
glycopyrrolate TABS	1	
glycopyrrolate inj	1	
H2-RECEPTOR ANTAGONISTS		
famotidine SOLN	1	
famotidine SUSR	1	
famotidine TABS 20mg, 40mg	1	
famotidine inj	1	
ranitidine hcl TABS 150mg, 300mg	1	
ranitidine hcl inj	1	
ranitidine syrup	1	
INFLAMMATORY BOWEL DISEASE		
APRISO	1	
ASACOL HD	1	
balsalazide disodium	1	
budesonide ec	1	
CANASA	1	

Drug Name	Drug Tier	Requirements/Limits
colocort enema 100mg	1	
DELZICOL	1	
DIPENTUM	1	
HYDROCORTISONE (ENEMA)	1	
MESALAMINE TBEC	1	
mesalamine enema	1	
mesalamine w/ cleanser	1	
sulfasalazine TABS	1	
sulfasalazine ec	1	
LAXATIVES		
constulose	1	
enulose	1	
gavilyte-c	1	
gavilyte-g	1	
gavilyte-h	1	
gavilyte-n	1	
generlac	1	
GOLYTELY	1	
lactulose	1	
lactulose (encephalopathy)	1	
MOVIPREP	1	
NULYTELY/FLAVOR PACKS	1	
PEG 3350-KCL-SOD BICARB-SOD CHLORIDE-SOD SULFATE	1	
peg 3350-potassium chloride-sod bicarbonate-sod chloride	1	
PEG 3350/ELECTROLYTES	1	
polyethylene glycol 3350 PACK; POWD	1	
SUPREP BOWEL PREP	1	
trilyte	1	
MISCELLANEOUS		
alosetron hcl	1	PA
AMITIZA CAP 8MCG	1	QL (60 caps / 30 days)
AMITIZA CAP 24MCG	1	QL (60 caps / 30 days)
cromolyn sodium (mastocytosis)	1	
diphenoxylate w/ atropine	1	
GATTEX	1	NM, LA, PA
LINZESS 145mcg	1	QL (60 caps / 30 days)
LINZESS 290mcg	1	QL (30 caps / 30 days)
loperamide hcl CAPS	1	
misoprostol TABS	1	
MOVANTIK 12.5mg	1	QL (60 tabs / 30 days)
MOVANTIK 25mg	1	QL (30 tabs / 30 days)
RELISTOR SOLN	1	PA
SUCRAID	1	LA
sucralfate TABS	1	

Drug Name	Drug Tier	Requirements/Limits
ursodiol CAPS; TABS	1	
XIFAXAN 550mg	1	PA
PANCREATIC ENZYMES		
CREON	1	
ZENPEP	1	
PROTON PUMP INHIBITORS		
DEXILANT	1	QL (30 caps / 30 days)
esomeprazole magnesium	1	QL (30 caps / 30 days)
esomeprazole sodium inj	1	
NEXIUM GRA 2.5MG DR	1	
NEXIUM GRA 5MG DR	1	
NEXIUM GRA 10MG DR	1	QL (30 packets / 30 days)
NEXIUM GRA 20MG DR	1	QL (30 packets / 30 days)
NEXIUM GRA 40MG DR	1	QL (30 packets / 30 days)
omeprazole cap 10mg	1	QL (30 caps / 30 days)
omeprazole cap 20mg	1	QL (60 caps / 30 days)
omeprazole cap 40mg	1	QL (30 caps / 30 days)
pantoprazole sodium tbec	1	QL (30 tabs / 30 days)

GENITOURINARY

Drug Name	Drug Tier	Requirements/Limits
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl	1	QL (30 tabs / 30 days)
dutasteride	1	QL (30 caps / 30 days)
dutasteride-tamsulosin hcl	1	QL (30 caps / 30 days)
finasteride TABS 5mg	1	
tamsulosin hcl	1	
MISCELLANEOUS		
bethanechol chloride TABS	1	
ELMIRON	1	
potassium citrate (alkalinizer) 15meq	1	
POTASSIUM CITRATE (ALKALINIZER) 540mg, 1080mg	1	
URINARY ANTISPASMODICS		
MYRBETRIQ 25mg	1	QL (60 tabs / 30 days)
MYRBETRIQ 50mg	1	QL (30 tabs / 30 days)
oxybutynin chloride SYRP	1	
oxybutynin chloride TABS	1	
oxybutynin chloride TB24 5mg	1	QL (30 tabs / 30 days)
oxybutynin chloride TB24 10mg, 15mg	1	QL (60 tabs / 30 days)
tolterodine tartrate cap er	1	QL (30 caps / 30 days)
tolterodine tartrate tabs	1	
TOVIAZ	1	QL (30 tabs / 30 days)
trospium chloride TABS	1	QL (60 tabs / 30 days)
VESICARE	1	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal	1	
metronidazole vaginal	1	
terconazole vaginal	1	
VANDAZOLE	1	
ZAZOLE CREAM 0.8%	1	

HEMATOLOGIC

Drug Name	Drug Tier	Requirements/Limits
ANTICOAGULANTS		
COUMADIN	1	
ELIQUIS	1	PA
enoxaparin sodium 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml	1	
ENOXAPARIN SODIUM 300mg/3ml	1	
fondaparinux sodium	1	
heparin sod (porcine) in d5w	1	
HEPARIN SOD (PORCINE) IN D5W	1	
heparin sod inj 1000/ml	1	B/D
heparin sod inj 5000/ml	1	B/D
heparin sod inj 10000/ml	1	B/D
heparin sod inj 20000/ml	1	B/D
HEPARIN SODIUM/D5W	1	
HEPARIN SODIUM/NACL 0.45%	1	
jantoven	1	
PRADAXA	1	
warfarin sodium	1	
XARELTO	1	
XARELTO STARTER PACK	1	
HEMATOPOIETIC GROWTH FACTORS		
GRANIX	1	NM, PA
LEUKINE	1	NM, PA
MOZOBIL	1	NM, PA
NEUPOGEN	1	NM, PA
PROCRIT	1	NM, PA
MISCELLANEOUS		
anagrelide hcl	1	
cilostazol	1	
CINRYZE	1	NM, LA, PA
FIRAZYR	1	NM, PA
pentoxifylline TBCR	1	
PROMACTA 12.5mg	1	QL (360 tabs / 30 days), NM, LA, PA
PROMACTA 25mg	1	QL (180 tabs / 30 days), NM, LA, PA
PROMACTA 50mg	1	QL (90 tabs / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
PROMACTA 75mg	1	QL (60 tabs / 30 days), NM, LA, PA
tranexamic acid SOLN; TABS	1	
PLATELET AGGREGATION INHIBITORS		
ASPIRIN-DIPYRIDAMOLE	1	
BRILINTA	1	
clopidogrel bisulfate 75mg	1	
EFFIENT	1	
ZONTIVITY	1	

IMMUNOLOGIC AGENTS

Drug Name	Drug Tier	Requirements/Limits
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
HUMIRA INJ 10MG/0.2ML	1	QL (2 boxes / 28 days), NM, PA
HUMIRA KIT 20MG/0.4ML	1	QL (2 boxes / 28 days), NM, PA
HUMIRA KIT 40MG/0.8ML	1	QL (6 boxes / 28 days), NM, PA
HUMIRA PEDIATRIC CROHNS DISEASE	1	NM, PA
HUMIRA PEN	1	QL (6 boxes / 28 days), NM, PA
HUMIRA PEN-CROHNS DISEASE	1	NM, PA
HUMIRA PEN-PSORIASIS STAR	1	NM, PA
hydroxychloroquine sulfate	1	
leflunomide TABS	1	
methotrexate sodium tabs	1	
REMICADE	1	NM, PA
XELJANZ	1	QL (60 tabs / 30 days), NM, PA
XELJANZ XR	1	QL (30 tabs / 30 days), NM, PA
IMMUNOGLOBULINS		
BIVIGAM	1	NM, PA
CARIMUNE NANOFILTERED	1	NM, PA
FLEBOGAMMA DIF	1	NM, PA
GAMASTAN S/D	1	B/D, NM
GAMMAGARD LIQUID	1	NM, PA
GAMMAGARD S/D	1	NM, PA
GAMMAKED	1	NM, PA
GAMMAPLEX 5gm/100ml, 10gm/200ml	1	NM, PA
GAMUNEX-C	1	NM, PA
OCTAGAM 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 10gm/200ml, 25gm/500ml	1	NM, PA
PRIVIGEN	1	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE	1	NM, LA, PA
ARCALYST	1	NM, PA

Drug Name	Drug Tier	Requirements/Limits
INTRON-A INJ 10MU	1	B/D, NM
INTRON-A INJ 18MU	1	B/D, NM
INTRON-A INJ 25MU	1	B/D, NM
INTRON-A INJ 50MU	1	B/D, NM
POMALYST CAP 1MG	1	NM, LA, PA
POMALYST CAP 2MG	1	NM, LA, PA
POMALYST CAP 3MG	1	NM, LA, PA
POMALYST CAP 4MG	1	NM, LA, PA
REVLIMID	1	NM, LA, PA
THALOMID	1	NM, PA
IMMUNOSUPPRESSANTS		
azathioprine SOLR; TABS	1	B/D
BENLYSTA	1	NM, PA
cyclosporine CAPS; SOLN	1	B/D
cyclosporine modified (for microemulsion)	1	B/D
gengraf	1	B/D
mycophenolate mofetil CAPS; SUSR; TABS	1	B/D
mycophenolate sodium	1	B/D
NEORAL	1	B/D
NULOJIX	1	B/D
PROGRAF CAPS	1	B/D
RAPAMUNE SOLN	1	B/D
SANDIMMUNE SOLN 100mg/ml	1	B/D
sirolimus TABS	1	B/D
tacrolimus CAPS	1	B/D
ZORTRESS TAB 0.5MG	1	B/D
ZORTRESS TAB 0.25MG	1	B/D
ZORTRESS TAB 0.75MG	1	B/D
VACCINES		
ACTHIB	1	
ADACEL	1	
BCG VACCINE	1	
BEXSERO	1	
BOOSTRIX	1	
CERVARIX	1	
DAPTACEL	1	
DIPHTHERIA/TETANUS TOXOID	1	B/D
ENGERIX-B SUSP	1	B/D
GARDASIL	1	
GARDASIL 9	1	
HAVRIX	1	
HIBERIX	1	
IMOVAX RABIES (H.D.C.V.)	1	
INFANRIX	1	
IPOL INACTIVATED IPV	1	

Drug Name	Drug Tier	Requirements/Limits
IXIARO	1	
KINRIX	1	
M-M-R II	1	
MENACTRA	1	
MENHIBRIX	1	
MENOMUNE-A/C/Y/W-135	1	
MENVEO	1	
PEDIARIX	1	
PEDVAX HIB	1	
PENTACEL	1	
PROQUAD	1	
QUADRACEL	1	
RABAVERT	1	
RECOMBIVAX HB	1	B/D
ROTARIX	1	
ROTATEQ	1	
SYNAGIS	1	NM
TENIVAC	1	B/D
TETANUS/DIPHTHERIA TOXOID	1	B/D
TRUMENBA	1	
TWINRIX INJ	1	
TYPHIM VI	1	
VAQTA	1	
VARIVAX	1	
YF-VAX	1	
ZOSTAVAX	1	QL (1 vial per lifetime)

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

Drug Name	Drug Tier	Requirements/Limits
KLOR-CON 8	1	
KLOR-CON 10	1	
klor-con m10	1	
klor-con m15	1	
klor-con m20	1	
klor-con pow 20 meq	1	
klor-con spr cap 8meq	1	
klor-con spr cap 10meq	1	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml, 50%	1	
magnesium sulfate SOLN 2gm/50ml, 50%	1	
MAGNESIUM SULFATE IN D5W	1	
potassium chloride CPCR	1	
POTASSIUM CHLORIDE SOLN 10%, 20%	1	
potassium chloride TBCR 8meq	1	
POTASSIUM CHLORIDE TBCR 20meq	1	

Drug Name	Drug Tier	Requirements/Limits
potassium chloride microencapsulated crystals cr	1	
POTASSIUM CHLORIDE TAB CR 10 MEQ	1	
SODIUM CHLORIDE SOLN 2.5meq/ml	1	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	1	
TPN ELECTROLYTES	1	B/D
IV NUTRITION		
AMINOSYN	1	B/D
AMINOSYN 7%/ELECTROLYTES	1	B/D
AMINOSYN 8.5%/ELECTROLYTE	1	B/D
AMINOSYN II	1	B/D
AMINOSYN II 8.5%/ELECTROL	1	B/D
AMINOSYN M	1	B/D
AMINOSYN-HBC	1	B/D
AMINOSYN-PF 7%	1	B/D
AMINOSYN-PF INJ 10%	1	B/D
AMINOSYN-RF	1	B/D
CLINIMIX 2.75%/DEXTROSE 5%	1	B/D
CLINIMIX 4.25%/DEXTROSE 5%	1	B/D
CLINIMIX 4.25%/DEXTROSE 25%	1	B/D
CLINIMIX 5%/DEXTROSE 15%	1	B/D
CLINIMIX 5%/DEXTROSE 20%	1	B/D
CLINIMIX 5%/DEXTROSE 25%	1	B/D
CLINIMIX INJ 4.25/D10	1	B/D
CLINIMIX INJ 4.25/D20	1	B/D
FREAMINE HBC 6.9%	1	B/D
FREAMINE III	1	B/D
HEPATAMINE	1	B/D
INTRALIPID INJ 20%	1	B/D
INTRALIPID INJ 30%	1	B/D
NEPHRAMINE	1	B/D
nutrilipid inj 20%	1	B/D
premasol sol 6%	1	B/D
premasol sol 10%	1	B/D
PROCALAMINE	1	B/D
PROSOL	1	B/D
TRAVASOL	1	B/D
TROPHAMINE INJ 10%	1	B/D
IV REPLACEMENT SOLUTIONS		
DEXTROSE 2.5%/NACL 0.45%	1	
DEXTROSE 5%	1	
DEXTROSE 5% /ELECTROLYTE	1	
DEXTROSE 5%/LACTATED RING	1	
DEXTROSE 5%/NACL 0.2%	1	
DEXTROSE 5%/NACL 0.3%	1	

Drug Name	Drug Tier	Requirements/Limits
DEXTROSE 5%/NACL 0.9%	1	
DEXTROSE 5%/NACL 0.33%	1	
DEXTROSE 5%/NACL 0.45%	1	
DEXTROSE 5%/NACL 0.225%	1	
DEXTROSE 5%/POTASSIUM CHL	1	
DEXTROSE 10% FLEX CONTAIN	1	
DEXTROSE 10%/NACL 0.2%	1	
DEXTROSE 10%/NACL 0.45%	1	
DEXTROSE 50%	1	
DEXTROSE INJ 70%	1	
IONOSOL-B/DEXTROSE 5%	1	
IONOSOL-MB/DEXTROSE 5%	1	
ISOLYTE P	1	
ISOLYTE S	1	
KCL0.15%/D5W/NACL0.2%	1	
KCL0.15%/D5W/NACL0.225%	1	
KCL 0.3%/D5W/NACL 0.9%	1	
KCL 0.3%/D5W/NACL 0.45%	1	
KCL 0.15%/D5W/NACL 0.9%	1	
KCL 0.075%/D5W/NACL 0.45%	1	
KCL IN NACL INJ .15-0.45	1	
KCL/D5W INJ 0.3%	1	
KCL/D5W/NACL INJ 0.22%/0.45%	1	
KCL/D5W/NACL INJ .15/.33%	1	
KCL/D5W/NACL INJ .15/.45%	1	
KCL/NACL INJ 0.3-0.9	1	
KCL/NACL INJ 0.15%-0.9%	1	
LACTATED RINGER'S INJ	1	
NORMOSOL-M IN D5W	1	
NORMOSOL-R	1	
NORMOSOL-R IN D5W	1	
PLASMA-LYTE A	1	
PLASMA-LYTE-56/D5W	1	
PLASMA-LYTE-148	1	
pot chloride inj 2meq/ml	1	
POTASSIUM CHLORIDE SOLN .4meq/ml, 10meq/100ml, 10meq/50ml, 20meq/100ml, 40meq/100ml	1	
potassium chloride in nacl	1	
RINGER'S	1	
SODIUM CHLORIDE SOLN 3%, 5%	1	
SODIUM CHLORIDE 0.45% VIA	1	
SODIUM CHLORIDE INJ 0.9%	1	
VITAMINS		
calcitriol CAPS	1	B/D
calcitriol inj	1	B/D

Drug Name	Drug Tier	Requirements/Limits
calcitriol oral soln 1 mcg/ml	1	B/D
paricalcitol CAPS	1	B/D
prenatal vitamin/folic acid > 0.8 mg (generic)	1	
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-poly-neomycin-hc	1	
blephamide OINT	1	
neomycin-polymy-dexameth	1	
neomycin-polymyxin-hc (ophth)	1	
sulfacetamide sod-prednisolone	1	
TOBRADEX OINT	1	
TOBRADEX ST	1	
tobramycin-dexamethasone	1	
ZYLET	1	
ANTI-INFECTIVES		
bacitracin (ophthalmic)	1	
bacitracin-polymyxin b (ophth)	1	
BESIVANCE	1	
CILOXAN OINT	1	
ciprofloxacin hcl (ophth)	1	
erythromycin (ophth)	1	
gatifloxacin (ophth)	1	
gentak	1	
gentamicin sulfate (ophth)	1	
ilotycin	1	
MOXEZA	1	
NATACYN	1	
neomycin-bacitracin zn-polymyxin	1	
neomycin-polymyxin-gramicidin	1	
ofloxacin (ophth)	1	
polymyxin b-trimethoprim	1	
sulfacet sod oin 10% op	1	
sulfacetamide sodium (ophth)	1	
tobramycin (ophth)	1	
TOBREX OINT	1	
trifluridine SOLN	1	
VIGAMOX	1	
ZIRGAN	1	
ANTI-INFLAMMATORIES		
ALREX	1	
bromfenac sodium (ophth)	1	
dexamethasone sodium phosphate (ophth)	1	
diclofenac sodium (ophth)	1	
DUREZOL	1	

Drug Name	Drug Tier	Requirements/Limits
FLUOROMETHOLONE	1	
flurbiprofen sodium	1	
ILEVRO	1	
ketorolac tromethamine (ophth)	1	
LOTEMAX	1	
MAXIDEX	1	
PREDNISOLONE ACETATE (OPHTH)	1	
prednisolone sodium phosphate (ophth)	1	
ANTIALLERGICS		
azelastine drop 0.05%	1	
BEPREVE	1	
cromolyn sodium (ophth)	1	
LASTACAFT	1	
PATADAY	1	
PAZEO	1	
ANTIGLAUCOMA		
ALPHAGAN P SOL 0.1%	1	
AZOPT	1	
betaxolol hcl (ophth)	1	
BETOPTIC-S	1	
brimonidine sol 0.2%	1	
BRIMONIDINE SOL 0.15%	1	
carteolol hcl (ophth)	1	
COMBIGAN	1	
dorzolamide hcl	1	
dorzolamide hcl-timolol maleate	1	
ISTALOL	1	
latanoprost SOLN	1	
levobunolol hcl	1	
LUMIGAN	1	
metipranolol	1	
PHOSPHOLINE IODIDE	1	
PILOCARPINE HCL SOLN	1	
SIMBRINZA	1	
timolol maleate (ophth) soln	1	
TIMOLOL MALEATE GEL	1	
TRAVATAN Z	1	
MISCELLANEOUS		
CYSTARAN	1	NM, LA, PA
naphazoline 0.1%	1	
PROLENSA	1	
proparacaine hcl SOLN	1	
RESTASIS	1	QL (64 vials / 30 days)

RESPIRATORY

ANTICHOLINERGIC/BETA AGONIST COMBINATIONS

Drug Name	Drug Tier	Requirements/Limits
ANORO ELLIPTA	1	QL (60 inhalations / 30 days)
BEVESPI	1	QL (1 inhaler / 30 days)
COMBIVENT RESPIMAT	1	QL (2 inhalers / 30 days)
ipratropium-albuterol nebu	1	B/D
ANTICHOLINERGICS		
ATROVENT HFA	1	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA	1	QL (1 inhaler / 30 days)
ipratropium bromide SOLN	1	B/D
ipratropium bromide (nasal)	1	
ANTIHISTAMINES		
azelastine spr 0.1%	1	
azelastine spr 0.15%	1	
cetirizine syrup	1	
cyproheptadine hcl SYRP; TABS	1	PA; PA if 65 years and older
diphenhydramine inj	1	
hydroxyzine hcl SOLN; SYRP; TABS	1	PA; PA if 65 years and older
hydroxyzine pamoate CAPS	1	PA; PA if 65 years and older
levocetirizine dihydrochloride	1	
BETA AGONISTS		
albuterol sulfate NEBU	1	B/D
albuterol sulfate SYRP; TABS; TB12	1	
levalbuterol conc 1.25mg/0.5ml	1	B/D
LEVALBUTEROL TARTRATE HFA	1	QL (2 inhalers / 30 days)
SEREVENT DISKUS	1	QL (60 inhalations / 30 days)
terbutaline sulfate SOLN; TABS	1	
VENTOLIN HFA	1	QL (2 inhalers / 30 days)
XOPENEX HFA	1	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		
montelukast sodium CHEW; PACK; TABS	1	
zafirlukast	1	
MAST CELL STABILIZERS		
cromolyn sodium nebu	1	B/D
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	1	B/D
ARALAST NP	1	NM, LA, PA
DALIRESP	1	
EPIPEN 2-PAK	1	
EPIPEN-JR 2-PAK	1	

Drug Name	Drug Tier	Requirements/Limits
ESBRIET	1	NM, PA
KALYDECO	1	NM, PA
OFEV	1	NM, PA
ORKAMBI	1	NM, PA
PROLASTIN-C	1	NM, LA, PA
PULMOZYME	1	NM, PA
XOLAIR	1	NM, LA, PA
ZEMAIRA	1	NM, LA, PA
NASAL STEROIDS		
flunisolide (nasal)	1	QL (2 bottles / 30 days)
fluticasone propionate (nasal)	1	QL (1 bottle / 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA	1	QL (30 inhalations / 30 days)
budesonide (inhalation) .25mg/2ml, .5mg/2ml	1	B/D
FLOVENT DISKUS 50mcg/blist, 100mcg/blist	1	QL (120 inhalations / 30 days)
FLOVENT DISKUS 250mcg/blist	1	QL (240 inhalations / 30 days)
FLOVENT HFA	1	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER	1	QL (2 inhalers / 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKUS	1	QL (60 inhalations / 30 days)
ADVAIR HFA	1	QL (1 inhaler / 30 days)
BREO ELLIPTA	1	QL (60 blisters / 30 days)
SYMBICORT	1	QL (1 inhaler / 30 days)
XANTHINES		
aminophylline inj	1	
elixophyllin	1	
theo-24	1	
theophylline	1	

TOPICAL

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGY, ACNE		
adapalene CREA	1	
adapalene GEL .1%	1	
AVITA	1	PA
benzoyl peroxide-erythromycin	1	
claravis	1	PA
clindacin-p pad 1%	1	
clindamax	1	
clindamycin phosphate (topical) GEL; LOTN; SOLN; SWAB	1	

Drug Name	Drug Tier	Requirements/Limits
ery pad 2%	1	
erythromycin (acne aid)	1	
myorisan	1	PA
sulfacetamide sodium (acne)	1	
tretinoin CREA	1	PA
TRETINOIN GEL .01%	1	PA
tretinoin GEL .025%	1	PA
zenatane	1	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical)	1	
mupirocin OINT	1	
SILVER SULFADIAZINE CREA	1	
SSD	1	
SULFAMYLON	1	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox CREA; GEL; SUSP	1	
ciclopirox shampoo 1%	1	
clotrimazole (topical)	1	
ketoconazole cream	1	
nyamyc	1	
nystatin (topical)	1	
nystop	1	
DERMATOLOGY, ANTIPRURITIC		
DOXEPIN HCL (ANTIPRURITIC)	1	
procto-med	1	
procto-pak	1	
proctosol hc cre 2.5%	1	
proctozone hc	1	
DERMATOLOGY, ANTIPSORIATICS		
acitretin	1	PA
calcipotriene CREA	1	
calcipotriene SOLN	1	
8-MOP	1	
TAZORAC CREA	1	PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole shampoo	1	
selenium sulfide LOTN	1	
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort	1	
alclometasone dipropionate	1	
betamethasone dipropionate (topical)	1	
betamethasone dipropionate augmented CREA; GEL; LOTN	1	
BETAMETHASONE DIPROPIONATE AUGMENTED OINT	1	

Drug Name	Drug Tier	Requirements/Limits
betamethasone valerate CREA; LOTN; OINT	1	
desoximetasone CREA	1	
desoximetasone GEL	1	
DESOXIMETASONE OINT .05%	1	
desoximetasone OINT .25%	1	
fluocinolone acetonide CREA; OIL; OINT; SOLN	1	
fluocinonide CREA .05%	1	
fluocinonide GEL	1	
fluocinonide SOLN	1	
fluocinonide emulsified base	1	
fluticasone propionate CREA	1	
fluticasone propionate OINT	1	
halobetasol propionate	1	
hydrocortisone (topical)	1	
hydrocortisone butyrate	1	
hydrocortisone valerate	1	
mometasone furoate CREA; OINT; SOLN	1	
texacort soln 2.5%	1	
triamcinolone acetonide (topical) CREA; LOTN; OINT	1	
triderm	1	
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine PTCH	1	QL (3 patches / 1 day), PA
lidocaine hcl GEL	1	PA
lidocaine hcl SOLN 4%	1	PA
lidocaine oint 5%	1	PA
lidocaine-prilocaine	1	PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
ammonium lactate CREA; LOTN	1	
diclofenac sodium (topical) 1% gel	1	PA
fluorouracil (topical) CREA 5%	1	
fluorouracil (topical) SOLN	1	
imiquimod CREA	1	
metronidazole (topical) CREA; LOTN	1	
metronidazole gel 0.75%	1	
PANRETIN	1	
podofilox SOLN	1	
rosadan cre 0.75%	1	
tacrolimus (topical)	1	
TARGRETIN GEL	1	NM, PA
VALCHLOR	1	NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
EURAX	1	

Drug Name	Drug Tier	Requirements/Limits
malathion	1	
permethrin	1	
DERMATOLOGY, WOUND CARE AGENTS		
ACETIC ACID .25%	1	
REGRANEX	1	PA
SANTYL	1	
SODIUM CHLORIDE 0.9%	1	
STERILE WATER IRRIGATION	1	
MOUTH/THROAT/DENTAL AGENTS		
cevimeline hcl	1	
chlorhexidine gluconate (mouth-throat)	1	
clotrimazole TROC	1	
lidocaine hcl (mouth-throat)	1	
nystatin (mouth-throat)	1	
paroex sol 0.12%	1	
periogard	1	
PILOCARPINE HCL (ORAL) 5mg	1	
pilocarpine hcl (oral) 7.5mg	1	
triamcinolone acetonide (mouth)	1	
OTIC		
ACETIC ACID (OTIC)	1	
acetic acid-aluminum acetate	1	
CIPRODEX	1	
fluocinolone acetonide (otic)	1	
neomycin-polymyxin-hc (otic)	1	
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