2023

CHRISTUS® Health Plan

Generations (HMO)
Generations Plus (HMO)

ABRIDGED FORMULARY

CHRISTUS Health Plan covers members in the following counties:

Bernalillo
Los Alamos
Rio Arriba
Sandoval
San Miguel
Santa Fe
Taos

CHRISTUS HEALTH PLAN
Medicare Advantage Plans

CHRISTUS Health Plan

METHOD	MEMBER SERVICES – CONTACT INFORMATION
CALL	844.282.3026 - Calls to this number are free. The CHRISTUS Health Plan Member Services department is available to assist you seven days a week, 8 a.m. to 8 p.m., local time, from Oct. 1 – Mar. 31, and Mon. - Fri., 8 a.m. to 8 p.m., local time, from Apr. 1 – Sept. 30. A voice response system is available after hours. Messages left will be responded to within one business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Relay New Mexico This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available to assist you seven days a week, 8 a.m. to 8 p.m., local time, from Oct. 1 – Mar. 31, and Mon. - Fri., 8 a.m. to 8 p.m., local time, from Apr. 1 – Sept. 30.
FAX	469.282.3013
WRITE	Christus Health Plan Guardian, Attention: Member Services P.O. Box 169001 Irving | TX 75016
WEBSITE	CHRISTUShealthplan.org

THE NEW MEXICO AGING AND LONG-TERM SERVICES DEPARTMENT

The New Mexico Aging and Long-Term Services Department is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

METHOD	CONTACT INFORMATION
CALL	866.451.2901 - Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New Mexico Aging and Long-Term Services Department P.O. Box 27118 Santa Fe | NM 87502-7118
WEBSITE	nmaging.state.nm.us

CHRISTUS Health Plan Generations (HMO)

CHRISTUS Health Plan Generations Plus (HMO)

2023 Abridged Formulary

(Partial List of Covered Drugs)

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

HPMS Approved Formulary File Submission ID 23054, Version Number 6

This abridged formulary was updated on 08/18/2022. We have made no changes to this abridged formulary since 08/18/2022. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact CHRISTUS Health Plan Generations (HMO) / CHRISTUS Health Plan Generations Plus (HMO) Member Services, at 1-844-282-3026 or, for TTY users, 711, 8 a.m. – 8 p.m. local time, seven days a week, from October 1 – March 31, and 8 a.m. – 8 p.m. local time, Monday – Friday, from April 1- September 30, or visit christushealthplan.org.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter the cost-sharing tier.

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 CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO). When it refers to "plan" or "our plan," it means CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO).

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

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2023, and from time to time during the year.

What is the CHRISTUS Health Plan Generations (HMO) / CHRISTUS Health Plan Generations Plus (HMO) Abridged Formulary?

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

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

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance

before we make that change, but we will later provide you with information about the specific change(s) we have made.

  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled "How do I request an exception to the CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO)'s Formulary?"

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

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a new generic drug to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. We may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, [or] add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive 31-day supply of the drug.

  - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO)'s Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 08/18/2022. To get updated information about the drugs covered by CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 9. 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, Antihypertensive Therapy. If you know what your drug is used for, look for the category name in the list that begins on 9. 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 73. 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?

CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

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

- **Quantity Limits:** For certain drugs, CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) limits the amount of the drug that CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) will cover. For example, CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) provides 31 tablets per prescription for AFINITOR. This may be in addition to a standard one-month or three-month supply.

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

for you, CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) 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 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explains our prior authorization restriction. 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 CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) formulary?" on page 5 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO)'s may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO)'s does not cover your drug, you have two options:

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

- You can ask CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO)'s Formulary?

You can ask CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

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

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

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

You should contact us to ask us for an initial coverage decision for a formulary, 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 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31-day supply of medication. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

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

Enrollees whose transition window has expired and are either being admitted to a LTC setting or being discharged from a long term care setting are provided an additional transition fill due to that level of care change. While the claim will initially reject as the member is no longer transition eligible according to plan enrollment dates, the pharmacist is instructed to enter an override code to allow the transition supply to process accordingly. Early refill edits are not applied in a long-term care setting.

For more information

For more detailed information about your CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO), please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) Formulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs covered by CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO). If you have trouble finding your drug in the list, turn to the Index that begins on page 73.

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

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

The information in the Requirements/Limits column tells you if CHRISTUS Health Plan Generations (HMO)/CHRISTUS Health Plan Generations Plus (HMO) has any special requirements for coverage of your drug.

Tier Number	Tier Name	Copay for a one-month supply filled at a network pharmacy with standard cost-sharing
1	Preferred Generic	$4
2	Non-Preferred Generic	$10
2	Preferred Brand	$47
4	Non-Preferred Brand	$100
5	Specialty Drug Tier	33% of the total cost

Below is a list of abbreviations that may appear on the following pages in the Requirements/Limits column that tells you if there are any special requirements for coverage of your drug.

List of Abbreviations

31D: Este medicamento no esta disponible para un suministro prolongado. Solo puede obtener un suministro de 31 dias.

B/D PA: This prescription 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.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.

MO: Mail-Order Drug. This prescription drug is available through our mail-order service, as well as through our retail network pharmacies. Consider using mail order for your long-term (maintenance) medications (such as high blood pressure medications). Retail network pharmacies may be more appropriate for short-term prescriptions (such as antibiotics).

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

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

ST: Step Therapy. In some cases, the 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	4	B/D PA; MO
amphotericin b	4	B/D PA; MO
caspofungin intravenous recon soln 50 mg	5	31D
caspofungin intravenous recon soln 70 mg	4	
clotrimazole mucous membrane	2	MO
CRESEMBA ORAL	4	PA; 31D
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml	4	PA; MO
fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml	4	PA
fluconazole oral suspension for reconstitution	3	MO
fluconazole oral tablet	2	MO
flucytosine	5	MO; 31D
griseofulvin microsize	4	MO
griseofulvin ultramicrosize	4	MO
itraconazole oral capsule	4	MO; QL (120 per 30 days)
itraconazole oral solution	4	MO
ketoconazole oral	2	MO
micafungin	5	MO; 31D
nystatin oral	2	MO
posaconazole oral tablet,delayed release (dr/ec)	5	PA; MO; 31D; QL (96 per 30 days)
terbinafine hcl oral	2	MO
voriconazole intravenous	5	PA; MO; 31D
voriconazole oral suspension for reconstitution	5	PA; MO; 31D
voriconazole oral tablet	4	PA; MO
ANTIVIRALS		
abacavir	3	MO
abacavir-lamivudine	3	MO
acyclovir oral capsule	2	MO
acyclovir oral suspension 200 mg/5 ml	4	MO
acyclovir oral tablet	2	MO
acyclovir sodium intravenous solution	4	B/D PA; MO
adefovir	4	MO
amantadine hcl oral capsule	3	MO
amantadine hcl oral solution	3	MO
APTIVUS	5	MO; 31D
atazanavir	4	MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
BARACLUDE ORAL SOLUTION	5	MO; 31D
BIKTARVY	5	MO; 31D
CIMDUO	5	MO; 31D
COMPLERA	4	MO; 31D
DELSTRIGO	5	MO; 31D
DESCOVY ORAL TABLET 200-25 MG	5	MO; 31D
DOVATO	5	MO; 31D
EDURANT	5	MO; 31D
efavirenz	4	MO
efavirenz-emtricitabin-tenofov	5	MO; 31D
efavirenz-lamivu-tenofov disop	5	MO; 31D
emtricitabine	4	MO
emtricitabine-tenofovir (tdf)	5	MO; 31D
EMTRIVA ORAL SOLUTION	3	MO
entecavir	4	MO
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	5	PA; MO; 31D; QL (28 per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	5	PA; MO; 31D; QL (56 per 28 days)
EPCLUSA ORAL TABLET 200-50 MG	5	PA; MO; 31D; QL (56 per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	5	PA; MO; 31D; QL (28 per 28 days)
EPIVIR HBV ORAL SOLUTION	4	MO
etravirine	5	MO; 31D
EVOTAZ	5	MO; 31D
famciclovir	3	MO
fosamprenavir	5	MO; 31D
FUZEON SUBCUTANEOUS RECON SOLN	5	MO; 31D
GENVOYA	5	MO; 31D
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	5	PA; MO; 31D; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	5	PA; MO; 31D; QL (56 per 28 days)
HARVONI ORAL TABLET 45-200 MG	5	PA; MO; 31D; QL (56 per 28 days)
HARVONI ORAL TABLET 90-400 MG	5	PA; MO; 31D; QL (28 per 28 days)
INTELENCE ORAL TABLET 25 MG	4	MO
ISENTRESS HD	5	MO; 31D
ISENTRESS ORAL POWDER IN PACKET	5	MO; 31D
ISENTRESS ORAL TABLET	5	MO; 31D

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5	MO; 31D
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	3	MO
JULUCA	5	MO; 31D
lamivudine	3	MO
lamivudine-zidovudine	3	MO
LEXIVA ORAL SUSPENSION	4	MO
lopinavir-ritonavir oral solution	4	MO
lopinavir-ritonavir oral tablet	3	MO
maraviroc	5	MO; 31D
nevirapine oral suspension	4	
nevirapine oral tablet	3	MO
nevirapine oral tablet extended release 24 hr	4	MO
NORVIR ORAL POWDER IN PACKET	4	MO
NORVIR ORAL SOLUTION	4	MO
ODEFSEY	5	MO; 31D
oseltamivir	3	MO
PIFELTRO	5	MO; 31D
PREVYMIS ORAL	5	MO; 31D; QL (30 per 30 days)
PREZCOBIX	5	MO; 31D
PREZISTA ORAL SUSPENSION	5	MO; 31D
PREZISTA ORAL TABLET 150 MG, 75 MG	4	MO
PREZISTA ORAL TABLET 600 MG, 800 MG	5	MO; 31D
RELENZA DISKHALER	4	MO
REYATAZ ORAL POWDER IN PACKET	5	MO; 31D
ribavirin oral capsule	3	
ribavirin oral tablet 200 mg	3	MO
rimantadine	4	MO
ritonavir	3	MO
RUKOBIA	5	MO; 31D
SELZENTRY ORAL SOLUTION	3	MO
SELZENTRY ORAL TABLET 25 MG, 75 MG	3	MO
STRIBILD	5	MO; 31D
SYMTUZA	4	MO; 31D
tenofovir disoproxil fumarate	4	MO
TIVICAY ORAL TABLET 10 MG	3	MO
TIVICAY ORAL TABLET 25 MG, 50 MG	5	MO; 31D

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
TIVICAY PD	5	MO; 31D
TRIUMEQ	5	MO; 31D
TRIUMEQ PD	5	MO; 31D
TRIZIVIR	5	MO; 31D
valacyclovir oral tablet 1 gram	3	MO; QL (120 per 30 days)
valacyclovir oral tablet 500 mg	3	MO; QL (60 per 30 days)
valganciclovir oral recon soln	5	MO; 31D
valganciclovir oral tablet	3	MO
VEMLIDY	5	MO; 31D
VIRACEPT ORAL TABLET	5	MO; 31D
VIREAD ORAL POWDER	5	MO; 31D
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	5	MO; 31D
VOSEVI	5	PA; MO; 31D; QL (28 per 28 days)
zidovudine oral capsule	4	MO
zidovudine oral syrup	4	MO
zidovudine oral tablet	2	MO
CEPHALOSPORINS		
cefaclor oral capsule	3	MO
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	4	MO
cefaclor oral suspension for reconstitution 375 mg/5 ml	4	
cefadroxil oral capsule	2	MO
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	3	MO
cefazolin injection recon soln 1 gram, 500 mg	4	MO
cefazolin injection recon soln 10 gram	4	
cefdinir oral capsule	2	MO
cefdinir oral suspension for reconstitution	3	MO
cefepime injection	4	MO
cefixime	4	MO
cefoxitin intravenous recon soln 1 gram, 2 gram	4	PA; MO
cefoxitin intravenous recon soln 10 gram	4	PA
cefpodoxime	4	MO
cefprozil	3	MO
ceftazidime injection recon soln 1 gram, 2 gram	4	PA; MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ceftazidime injection recon soln 6 gram	4	PA
ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg	4	MO
ceftriaxone injection recon soln 10 gram	4	
cefuroxime axetil oral tablet	3	MO
cefuroxime sodium injection recon soln 750 mg	4	PA; MO
cefuroxime sodium intravenous recon soln 1.5 gram	4	PA; MO
cephalexin oral capsule 250 mg, 500 mg	2	MO
cephalexin oral suspension for reconstitution	2	MO
tazicef injection	4	PA; MO
TEFLARO	5	PA; MO; 31D
ERYTHROMYCINS / OTHER MACROLIDES		
azithromycin intravenous	4	PA; MO
azithromycin oral packet	3	MO
azithromycin oral suspension for reconstitution	2	MO
azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)	2	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	2	MO
clarithromycin oral suspension for reconstitution	4	MO
clarithromycin oral tablet	3	MO
clarithromycin oral tablet extended release 24 hr	3	MO
DIFICID ORAL TABLET	5	MO; 31D; QL (20 per 10 days)
e.e.s. 400 oral tablet	4	MO
ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg	4	MO
erythrocin (as stearate) oral tablet 250 mg	4	MO
erythromycin ethylsuccinate oral tablet	4	
erythromycin oral	4	MO
MISCELLANEOUS ANTIINFECTIVES		
albendazole	5	MO; 31D
amikacin injection solution 500 mg/2 ml	4	PA; MO
ARIKAYCE	4	PA; LA; 31D

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements /Limits
atovaquone	5	MO; 31D
atovaquone-proguanil	4	MO
aztreonam	4	PA; MO
CAYSTON	5	PA; MO; LA; 31D; QL (84 per 56 days)
chloroquine phosphate	4	MO
clindamycin hcl	2	MO
clindamycin in 5 % dextrose	4	PA; MO
clindamycin pediatric	4	MO
clindamycin phosphate injection	4	PA; MO
clindamycin phosphate intravenous solution 600 mg/4 ml	4	PA; MO
COARTEM	4	MO
colistin (colistimethate na)	4	PA; MO; QL (30 per 10 days)
dapsone oral	3	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	5	MO; 31D
daptomycin intravenous recon soln 500 mg	5	MO; 31D
EMVERM	5	MO; 31D
ertapenem	4	PA; MO; QL (14 per 14 days)
ethambutol	3	MO
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml	4	PA; MO
gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml	4	PA
gentamicin injection solution 40 mg/ml	4	PA; MO
hydroxychloroquine oral tablet 200 mg	2	PA; MO
imipenem-cilastatin	4	PA; MO
isoniazid oral solution	4	MO
isoniazid oral tablet	2	MO
ivermectin oral	3	PA; MO; QL (20 per 30 days)
linezolid in dextrose 5%	4	PA
linezolid oral suspension for reconstitution	5	MO; 31D
linezolid oral tablet	4	MO
mefloquine	2	MO
meropenem intravenous recon soln 1 gram	4	PA; MO; QL (30 per 10 days)
meropenem intravenous recon soln 500 mg	4	PA; MO; QL (10 per 10 days)

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Drug Name	Drug Tier	Requirements /Limits
metronidazole in nacl (iso-os)	4	PA; MO
metronidazole oral tablet	2	MO
neomycin	2	MO
nitazoxanide	5	MO; 31D
paromomycin	4	MO
PASER	3	MO
pentamidine inhalation	4	B/D PA; MO; QL (1 per 28 days)
pentamidine injection	4	MO
praziquantel	4	MO
PRIFTIN	3	MO
PRIMAQUINE	3	MO
pyrazinamide	4	MO
pyrimethamine	5	PA; MO; 31D
quinine sulfate	4	MO
rifabutin	4	MO
rifampin intravenous	4	MO
rifampin oral	3	MO
SIRTURO	5	PA; LA; 31D
STREPTOMYCIN	5	PA; MO; QL (60 per 30 days)
tigecycline	5	PA; MO; 31D
tinidazole	3	MO
tobramycin in 0.225 % nacl	5	PA; MO; 31D; QL (280 per 28 days)
tobramycin inhalation	5	PA; MO; 31D; QL (224 per 28 days)
tobramycin sulfate injection solution	4	PA; MO
TRECATOR	4	MO
vancomycin intravenous recon soln 1,000 mg	4	PA; MO; QL (20 per 10 days)
vancomycin intravenous recon soln 10 gram	4	PA; QL (2 per 10 days)
vancomycin intravenous recon soln 500 mg	4	PA; MO; QL (10 per 10 days)
vancomycin intravenous recon soln 750 mg	4	PA; MO; QL (27 per 10 days)
vancomycin oral capsule 125 mg	4	PA; MO; QL (40 per 10 days)
vancomycin oral capsule 250 mg	4	PA; MO; QL (80 per 10 days)
XIFAXAN ORAL TABLET 200 MG	5	MO; 31D; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	MO; 31D; QL (90 per 30 days)
PENICILLINS		
amoxicillin oral capsule	2	MO
amoxicillin oral suspension for reconstitution	2	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
amoxicillin oral tablet	2	MO
amoxicillin oral tablet,chewable 125 mg, 250 mg	2	MO
amoxicillin-pot clavulanate oral suspension for reconstitution	2	MO
amoxicillin-pot clavulanate oral tablet	2	MO
amoxicillin-pot clavulanate oral tablet extended release 12 hr	4	MO
amoxicillin-pot clavulanate oral tablet,chewable	2	MO
ampicillin oral capsule 500 mg	2	MO
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	4	PA; MO
ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram	4	PA; MO
ampicillin-sulbactam injection recon soln 15 gram	4	PA
BICILLIN C-R	3	PA; MO
BICILLIN L-A	4	PA; MO
dicloxacillin	2	MO
nafcillin injection recon soln 1 gram, 2 gram	4	PA; MO
nafcillin injection recon soln 10 gram	5	PA; 31D
oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml	4	PA
oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml	4	PA; MO
oxacillin injection recon soln 1 gram, 10 gram	4	PA
oxacillin injection recon soln 2 gram	4	PA; MO
penicillin g potassium injection recon soln 20 million unit	4	PA; MO
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	4	PA; MO
penicillin g sodium	4	PA; MO
penicillin v potassium	2	MO
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram	4	MO
piperacillin-tazobactam intravenous recon soln 40.5 gram	4	

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Drug Name	Drug Tier	Requirements /Limits
QUINOLONES		
ciprofloxacin hcl oral tablet 100 mg	4	MO
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	2	MO
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	4	PA; MO
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	4	PA; MO
levofloxacin intravenous	4	PA; MO
levofloxacin oral solution	4	MO
levofloxacin oral tablet	2	MO
moxifloxacin oral	3	MO
moxifloxacin-sod.chloride(iso)	4	PA; MO
SULFA'S / RELATED AGENTS		
sulfadiazine	4	MO
sulfamethoxazole-trimethoprim oral suspension	3	MO
sulfamethoxazole-trimethoprim oral tablet	1	MO
TETRACYCLINES		
doxy-100	4	PA; MO
doxycycline hyclate oral capsule	2	MO
doxycycline hyclate oral tablet 20 mg, 50 mg	2	MO
doxycycline monohydrate oral capsule 100 mg, 50 mg	2	MO
doxycycline monohydrate oral suspension for reconstitution	4	MO
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	2	MO
minocycline oral capsule	2	MO
minocycline oral tablet	4	MO
tetracycline	4	MO
URINARY TRACT AGENTS		
methenamine hippurate	3	MO
nitrofurantoin	4	MO
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	3	MO
nitrofurantoin monohyd/m-cryst	3	MO
trimethoprim	2	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ADJUNCTIVE AGENTS		
leucovorin calcium oral	3	MO
MESNEX ORAL	5	MO; 31D
XGEVA	5	B/D PA; MO; 31D
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
abiraterone oral tablet 250 mg	4	PA; MO; 31D; QL (120 per 30 days)
abiraterone oral tablet 500 mg	4	PA; MO; 31D; QL (60 per 30 days)
ALECENSA	5	PA; MO; 31D; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA; 31D; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA; 31D; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	5	PA; 31D; QL (30 per 180 days)
anastrozole	2	MO
AYVAKIT	5	PA; LA; 31D; QL (30 per 30 days)
azathioprine oral tablet 50 mg	2	B/D PA; MO
BALVERSA	5	PA; LA; 31D
bexarotene	5	PA; MO; 31D
bicalutamide	2	MO
BOSULIF ORAL TABLET 100 MG	5	PA; MO; 31D; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PA; MO; 31D; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; MO; LA; 31D; QL (180 per 30 days)
BRUKINSA	5	PA; LA; 31D
CABOMETYX	5	PA; MO; LA; 31D; QL (30 per 30 days)
CALQUENCE	5	PA; LA; 31D; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	5	PA; LA; 31D; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA; LA; 31D; QL (30 per 30 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	5	PA; MO; 31D; QL (56 per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	5	PA; MO; 31D; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	5	PA; MO; 31D; QL (84 per 28 days)
COPIKTRA	5	PA; LA; 31D; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
COTELLIC	5	PA; MO; LA; 31D; QL (63 per 28 days)
cyclophosphamide oral capsule	3	B/D PA; MO
CYCLOPHOSPHAMIDE ORAL TABLET	3	B/D PA; MO
cyclosporine modified oral capsule	4	B/D PA; MO
cyclosporine modified oral solution	4	B/D PA
cyclosporine oral capsule	4	B/D PA; MO
DAURISMO ORAL TABLET 100 MG	5	PA; MO; 31D; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	5	PA; MO; 31D; QL (60 per 30 days)
DROXIA	3	MO
EMCYT	5	MO; 31D
ERIVEDGE	5	PA; MO; 31D; QL (30 per 30 days)
ERLEADA	5	PA; MO; 31D; QL (120 per 30 days)
erlotinib oral tablet 100 mg, 150 mg	5	PA; MO; 31D; QL (30 per 30 days)
erlotinib oral tablet 25 mg	5	PA; MO; 31D; QL (60 per 30 days)
everolimus (antineoplastic) oral tablet	5	PA; MO; 31D; QL (30 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg	5	PA; MO; 31D; QL (330 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	5	PA; MO; 31D; QL (240 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 5 mg	5	PA; MO; 31D; QL (180 per 30 days)
everolimus (immunosuppressive)	5	B/D PA; MO; 31D
exemestane	4	MO
EXKIVITY	5	PA; LA; 31D; QL (120 per 30 days)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	B/D PA; MO; 31D
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	B/D PA; MO
FOTIVDA	5	PA; LA; 31D; QL (21 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
GAVRETO	5	PA; MO; LA; 31D; QL (120 per 30 days)
gengraf	4	B/D PA; MO
GILOTRIF	5	PA; MO; 31D; QL (30 per 30 days)
hydroxyurea	2	MO
IBRANCE	5	PA; MO; 31D; QL (21 per 28 days)
ICLUSIG	5	PA; 31D; QL (30 per 30 days)
IDHIFA	5	PA; MO; LA; 31D; QL (30 per 30 days)
imatinib oral tablet 100 mg	5	PA; MO; 31D; QL (180 per 30 days)
imatinib oral tablet 400 mg	5	PA; MO; 31D; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; 31D; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; 31D; QL (30 per 30 days)
IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG	5	PA; 31D; QL (30 per 30 days)
INLYTA ORAL TABLET 1 MG	5	PA; MO; 31D; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	5	PA; MO; 31D; QL (120 per 30 days)
INQOVI	5	PA; MO; 31D; QL (5 per 28 days)
INREBIC	5	PA; MO; LA; 31D; QL (120 per 30 days)
IRESSA	5	PA; MO; 31D; QL (30 per 30 days)
JAKAFI	5	PA; MO; 31D; QL (60 per 30 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	5	PA; MO; 31D; QL (49 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	5	PA; MO; 31D; QL (70 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	5	PA; MO; 31D; QL (91 per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA; MO; 31D; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PA; MO; 31D; QL (42 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PA; MO; 31D; QL (63 per 28 days)
lapatinib	5	PA; MO; 31D; QL (180 per 30 days)
lenalidomide	5	PA; MO; LA; 31D; QL (28 per 28 days)
LENVIMA	5	PA; MO; 31D
letrozole	2	MO
LEUKERAN	5	MO; 31D
leuprolide subcutaneous kit	5	PA; MO; 31D
LONSURF	5	PA; MO; 31D
LORBRENA ORAL TABLET 100 MG	5	PA; MO; 31D; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA; MO; 31D; QL (90 per 30 days)
LUMAKRAS	5	PA; MO; 31D
LUPRON DEPOT	5	PA; MO; 31D
LUPRON DEPOT (3 MONTH)	5	PA; MO; 31D
LUPRON DEPOT (4 MONTH)	5	PA; MO; 31D
LUPRON DEPOT (6 MONTH)	5	PA; MO; 31D
LYNPARZA	5	PA; MO; 31D; QL (120 per 30 days)
LYSODREN	5	
MATULANE	5	31D
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	3	PA; MO
megestrol oral suspension 625 mg/5 ml (125 mg/ml)	4	PA; MO
megestrol oral tablet	3	PA; MO
MEKINIST ORAL TABLET 0.5 MG	5	PA; MO; 31D; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PA; MO; 31D; QL (30 per 30 days)
MEKTOVI	5	PA; MO; LA; 31D; QL (180 per 30 days)
mercaptopurine	3	MO
methotrexate sodium	2	B/D PA; MO
methotrexate sodium (pf) injection solution	2	B/D PA; MO
mycophenolate mofetil oral capsule	3	B/D PA; MO
mycophenolate mofetil oral suspension for reconstitution	5	B/D PA; MO; 31D
mycophenolate mofetil oral tablet	3	B/D PA; MO
mycophenolate sodium	4	B/D PA; MO
NERLYNX	5	PA; MO; LA; 31D
nilutamide	5	PA; MO; 31D

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Drug Name	Drug Tier	Requirements /Limits
NINLARO	5	PA; MO; 31D; QL (3 per 28 days)
NUBEQA	5	PA; MO; LA; 31D; QL (120 per 30 days)
octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml	5	PA; MO; 31D
octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml	4	PA; MO
ODOMZO	5	PA; MO; LA; 31D; QL (30 per 30 days)
ONUREG	4	PA; MO; 31D; QL (14 per 28 days)
ORGOVYX	5	PA; LA; 31D; QL (30 per 28 days)
PEMAZYRE	5	PA; LA; 31D; QL (14 per 21 days)
PIQRAY	5	PA; MO; 31D
POMALYST	5	PA; MO; LA; 31D
PROGRAF ORAL GRANULES IN PACKET	4	B/D PA; MO
PURIXAN	5	31D
QINLOCK	5	PA; LA; 31D; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	5	PA; MO; LA; 31D; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5	PA; MO; LA; 31D; QL (120 per 30 days)
REVLIMID	5	PA; MO; LA; 31D; QL (28 per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	5	PA; MO; 31D; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5	PA; MO; 31D; QL (90 per 30 days)
RUBRACA	5	PA; MO; LA; 31D; QL (120 per 30 days)
RUXIENCE	5	PA; MO; 31D
RYDAPT	5	PA; MO; 31D
SANDIMMUNE ORAL SOLUTION	4	B/D PA; MO
SCEMBLIX ORAL TABLET 20 MG	5	PA; MO; 31D; QL (600 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5	PA; MO; 31D; QL (300 per 30 days)
SIGNIFOR	5	PA; 31D
sirolimus oral solution	5	B/D PA; MO; 31D
sirolimus oral tablet	4	B/D PA; MO
SOLTAMOX	5	MO; 31D
SOMATULINE DEPOT	5	PA; MO; 31D

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Drug Name	Drug Tier	Requirements /Limits
sorafenib	5	PA; MO; 31D; QL (120 per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	5	PA; MO; 31D; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	5	PA; MO; 31D; QL (60 per 30 days)
STIVARGA	5	PA; MO; 31D; QL (84 per 28 days)
sunitinib	5	PA; MO; 31D; QL (30 per 30 days)
SYNRIBO	5	B/D PA; 31D
TABLOID	4	MO
TABRECTA	5	PA; MO; 31D
tacrolimus oral	4	B/D PA; MO
TAFINLAR	5	PA; MO; 31D; QL (120 per 30 days)
TAGRISSO	5	PA; MO; LA; 31D; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG	5	PA; MO; 31D; QL (90 per 30 days)
TALZENNA ORAL CAPSULE 0.5 MG, 0.75 MG, 1 MG	5	PA; MO; 31D; QL (30 per 30 days)
tamoxifen	2	MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PA; MO; 31D; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	5	PA; MO; 31D; QL (120 per 30 days)
TAZVERIK	5	PA; LA; 31D
TEPMETKO	5	PA; LA; 31D
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; MO; 31D; QL (28 per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5	PA; MO; 31D; QL (56 per 28 days)
TIBSOVO	5	PA; 31D
toremifene	5	MO; 31D
TRAZIMERA	5	B/D PA; MO; 31D
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	5	B/D PA; MO; 31D
tretinoin (antineoplastic)	5	MO; 31D
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)	5	PA; LA; 31D; QL (21 per 28 days)
TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)	5	PA; LA; 31D; QL (42 per 28 days)
TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)	5	PA; LA; 31D; QL (63 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
TUKYSA ORAL TABLET 150 MG	5	PA; LA; 31D; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	5	PA; LA; 31D; QL (300 per 30 days)
TURALIO	5	PA; LA; 31D; QL (120 per 30 days)
VENCLEXTA ORAL TABLET 10 MG	4	PA; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA; 31D; QL (120 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5	PA; LA; 31D; QL (30 per 30 days)
VENCLEXTA STARTING PACK	5	PA; LA; 31D; QL (42 per 180 days)
VERZENIO	5	PA; MO; LA; 31D; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 100 MG	5	PA; MO; LA; 31D; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PA; MO; LA; 31D; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	5	PA; MO; LA; 31D; QL (300 per 30 days)
VIZIMPRO	5	PA; MO; 31D; QL (30 per 30 days)
VONJO	5	PA; 31D; QL (120 per 30 days)
VOTRIENT	5	PA; MO; 31D; QL (120 per 30 days)
WELIREG	5	PA; LA; 31D
XALKORI	5	PA; MO; 31D; QL (60 per 30 days)
XATMEP	4	B/D PA; MO
XERMELO	5	PA; LA; 31D; QL (90 per 30 days)
XOSPATA	5	PA; LA; 31D
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)	4	PA; LA; 31D
XTANDI ORAL CAPSULE	5	PA; MO; 31D; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA; MO; 31D; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
XTANDI ORAL TABLET 80 MG	5	PA; MO; 31D; QL (60 per 30 days)
YONSA	5	PA; MO; 31D; QL (120 per 30 days)
ZEJULA	5	PA; MO; LA; 31D; QL (90 per 30 days)
ZELBORAF	5	PA; MO; 31D; QL (240 per 30 days)
ZIRABEV	5	B/D PA; MO; 31D
ZOLINZA	5	PA; MO; 31D
ZYDELIG	5	PA; MO; 31D; QL (60 per 30 days)
ZYKADIA ORAL TABLET	5	PA; MO; 31D; QL (90 per 30 days)
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG	4	MO; 31D; QL (180 per 30 days)
APTIOM ORAL TABLET 400 MG	4	MO; 31D; QL (90 per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	4	MO; 31D; QL (60 per 30 days)
BRIVIACT INTRAVENOUS	4	QL (600 per 30 days)
BRIVIACT ORAL SOLUTION	5	MO; 31D; QL (600 per 30 days)
BRIVIACT ORAL TABLET	5	MO; 31D; QL (60 per 30 days)
carbamazepine oral capsule, er multiphase 12 hr	4	MO
carbamazepine oral suspension 100 mg/5 ml	4	MO
carbamazepine oral tablet	3	MO
carbamazepine oral tablet extended release 12 hr	4	MO
carbamazepine oral tablet,chewable	3	MO
CELONTIN ORAL CAPSULE 300 MG	4	MO
clobazam oral suspension	4	PA; MO; QL (480 per 30 days)
clobazam oral tablet	4	PA; MO; QL (60 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	2	MO; QL (90 per 30 days)
clonazepam oral tablet 2 mg	2	MO; QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	4	MO; QL (90 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
clonazepam oral tablet,disintegrating 2 mg	4	MO; QL (300 per 30 days)
DIACOMIT	5	PA; LA; 31D
diazepam rectal	4	MO
DILANTIN 30 MG	3	MO
divalproex oral capsule, delayed rel sprinkle	2	
divalproex oral tablet extended release 24 hr	2	MO
divalproex oral tablet,delayed release (dr/ec)	2	MO
EPIDIOLEX	4	PA; MO; LA; 31D
epitol	3	MO
EPRONTIA	4	PA; MO
ethosuximide	3	MO
felbamate oral suspension	5	MO; 31D
felbamate oral tablet	4	MO
FINTEPLA	5	PA; LA; 31D; QL (360 per 30 days)
FYCOMPA ORAL SUSPENSION	5	MO; 31D; QL (720 per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	5	MO; 31D; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG	4	MO; QL (60 per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG	5	MO; 31D; QL (60 per 30 days)
gabapentin oral capsule 100 mg, 400 mg	2	MO; QL (270 per 30 days)
gabapentin oral capsule 300 mg	2	MO; QL (360 per 30 days)
gabapentin oral solution 250 mg/5 ml	3	MO; QL (2160 per 30 days)
gabapentin oral tablet 600 mg	2	MO; QL (180 per 30 days)
gabapentin oral tablet 800 mg	2	MO; QL (120 per 30 days)
lacosamide oral solution	5	MO; 31D; QL (1200 per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg	4	MO; QL (60 per 30 days)
lacosamide oral tablet 50 mg	3	MO; QL (120 per 30 days)
lamotrigine oral tablet	1	MO
lamotrigine oral tablet extended release 24hr	4	MO
lamotrigine oral tablet, chewable dispersible	2	MO
lamotrigine oral tablet,disintegrating	4	MO
levetiracetam oral solution 100 mg/ml	2	MO
levetiracetam oral tablet	2	MO

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Drug Name	Drug Tier	Requirements /Limits
levetiracetam oral tablet extended release 24 hr	3	MO
NAYZILAM	5	PA; MO; 31D; QL (10 per 30 days)
oxcarbazepine oral suspension	4	MO
oxcarbazepine oral tablet	3	MO
phenobarbital oral elixir	4	PA; MO
phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg	3	PA
phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg	3	PA; MO
phenytoin oral suspension 125 mg/5 ml	2	MO
phenytoin oral tablet,chewable	3	MO
phenytoin sodium extended	2	MO
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	3	MO; QL (90 per 30 days)
pregabalin oral capsule 225 mg, 300 mg	3	MO; QL (60 per 30 days)
pregabalin oral solution	3	MO; QL (900 per 30 days)
primidone	2	MO
roweepra oral tablet 500 mg	2	MO
rufinamide oral suspension	5	PA; MO; 31D
rufinamide oral tablet 200 mg	4	PA; MO; 31D
rufinamide oral tablet 400 mg	5	PA; MO; 31D
SPRITAM	4	MO
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PA; MO; 31D; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	PA; MO; QL (60 per 30 days)
tiagabine	4	MO
topiramate oral capsule, sprinkle	2	PA; MO
topiramate oral tablet	2	PA; MO
valproic acid	2	MO
valproic acid (as sodium salt) oral solution 250 mg/5 ml	2	MO
VALTOCO	5	PA; MO; 31D; QL (10 per 30 days)
vigabatrin	5	MO; LA; 31D
vigadrone	5	LA; 31D

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Drug Name	Drug Tier	Requirements /Limits
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	5	MO; 31D; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG	5	MO; QL (120 per 30 days)
XCOPRI ORAL TABLET 150 MG	5	MO; QL (60 per 30 days)
XCOPRI ORAL TABLET 200 MG	5	MO; 31D; QL (60 per 30 days)
XCOPRI ORAL TABLET 50 MG	5	MO; QL (240 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	MO; QL (28 per 180 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	MO; QL (28 per 180 days)
zonisamide	2	PA; MO
ANTIPARKINSONISM AGENTS		
benztropine oral	2	PA; MO
bromocriptine	4	MO
carbidopa	4	MO
carbidopa-levodopa oral tablet	2	MO
carbidopa-levodopa oral tablet extended release	2	MO
carbidopa-levodopa oral tablet,disintegrating	4	MO
carbidopa-levodopa-entacapone	4	MO
entacapone	4	MO
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA; MO; 31D; QL (150 per 30 days)
NEUPRO	4	MO
pramipexole oral tablet	2	MO
rasagiline	4	MO
ropinirole oral tablet	2	MO
selegiline hcl	3	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
dihydroergotamine nasal	5	31D; QL (8 per 28 days)
EMGALITY PEN	3	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	3	PA; MO; QL (2 per 30 days)
ergotamine-caffeine	3	MO
naratriptan	3	MO; QL (18 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
NURTEC ODT	3	PA; QL (16 per 30 days)
rizatriptan oral tablet	2	MO; QL (36 per 28 days)
rizatriptan oral tablet,disintegrating	3	MO; QL (36 per 28 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation	4	MO; QL (18 per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	4	MO; QL (36 per 28 days)
sumatriptan succinate oral	2	MO; QL (18 per 28 days)
sumatriptan succinate subcutaneous cartridge	4	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous pen injector	4	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous solution	4	MO; QL (8 per 28 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUBAGIO	5	PA; MO; 31D; QL (30 per 30 days)
dalfampridine	3	PA; MO; 31D; QL (60 per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	5	PA; MO; 31D; QL (14 per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	5	PA; MO; 31D; QL (120 per 180 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	5	PA; MO; 31D; QL (60 per 30 days)
donepezil oral tablet 10 mg, 5 mg	2	MO
donepezil oral tablet,disintegrating	2	MO
FIRDAPSE	5	PA; LA; 31D
galantamine oral capsule,ext rel. pellets 24 hr	3	MO
galantamine oral solution	4	MO
galantamine oral tablet	3	MO
GILENYA ORAL CAPSULE 0.5 MG	5	PA; MO; 31D; QL (30 per 30 days)
glatiramer subcutaneous syringe 20 mg/ml	5	PA; 31D; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	5	PA; 31D; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml	5	PA; MO; 31D; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
glatopa subcutaneous syringe 40 mg/ml	5	PA; MO; 31D; QL (12 per 28 days)
memantine oral capsule,sprinkle,er 24hr	4	PA; MO
memantine oral solution	4	PA; MO
memantine oral tablet	3	PA; MO
NAMZARIC	3	PA; MO
NUEDEXTA	5	PA; MO; 31D
rivastigmine	4	MO
rivastigmine tartrate	3	MO
tetrabenazine oral tablet 12.5 mg	5	PA; MO; 31D; QL (240 per 30 days)
tetrabenazine oral tablet 25 mg	5	PA; MO; 31D; QL (120 per 30 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
baclofen oral tablet	2	MO
cyclobenzaprine oral tablet 10 mg, 5 mg	4	PA; MO
dantrolene oral	4	MO
pyridostigmine bromide oral tablet 60 mg	3	MO
pyridostigmine bromide oral tablet extended release	3	MO
tizanidine oral tablet	2	MO
NARCOTIC ANALGESICS		
acetaminophen-codeine oral solution 120-12 mg/5 ml	3	MO; QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	3	MO; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	3	MO; QL (180 per 30 days)
buprenorphine hcl sublingual	2	MO
endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	3	MO; QL (360 per 30 days)
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg	5	PA; MO; 31D; QL (120 per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	4	PA; MO; QL (120 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	4	PA; MO; QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	3	MO; QL (5550 per 30 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	3	MO; QL (390 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	3	MO; QL (360 per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	3	MO; QL (50 per 30 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	4	QL (240 per 30 days)
hydromorphone oral liquid	4	MO; QL (2400 per 30 days)
hydromorphone oral tablet	3	MO; QL (180 per 30 days)
hydromorphone oral tablet extended release 24 hr	4	PA; MO; QL (60 per 30 days)
methadone oral solution 10 mg/5 ml	3	PA; MO; QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	3	PA; MO; QL (1200 per 30 days)
methadone oral tablet 10 mg	3	PA; MO; QL (120 per 30 days)
methadone oral tablet 5 mg	3	PA; MO; QL (240 per 30 days)
morphine concentrate oral solution	3	MO; QL (900 per 30 days)
morphine oral solution	3	MO; QL (900 per 30 days)
morphine oral tablet	3	MO; QL (180 per 30 days)
morphine oral tablet extended release	3	PA; MO; QL (120 per 30 days)
oxycodone oral capsule	3	MO; QL (360 per 30 days)
oxycodone oral concentrate	4	MO; QL (180 per 30 days)
oxycodone oral solution	3	MO; QL (1200 per 30 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg	3	MO; QL (180 per 30 days)
oxycodone oral tablet 5 mg	3	MO; QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	3	MO; QL (360 per 30 days)
NON-NARCOTIC ANALGESICS		
buprenorphine-naloxone sublingual film 12-3 mg	3	MO; QL (60 per 30 days)
buprenorphine-naloxone sublingual film 2-0.5 mg	3	MO; QL (360 per 30 days)
buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg	3	MO; QL (90 per 30 days)
buprenorphine-naloxone sublingual tablet 2-0.5 mg	2	MO; QL (360 per 30 days)
buprenorphine-naloxone sublingual tablet 8-2 mg	2	MO; QL (90 per 30 days)
butorphanol nasal	4	MO; QL (10 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
celecoxib	3	MO
diclofenac potassium oral tablet 50 mg	2	MO
diclofenac sodium oral	2	MO
diclofenac sodium topical gel 1 %	3	MO; QL (1000 per 28 days)
diflunisal	3	MO
etodolac oral capsule	3	MO
etodolac oral tablet	3	MO
flurbiprofen oral tablet 100 mg	2	MO
ibu oral tablet 600 mg, 800 mg	1	MO
ibuprofen oral suspension	2	MO
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	MO
meloxicam oral tablet 15 mg	1	MO
meloxicam oral tablet 7.5 mg	1	MO; QL (30 per 30 days)
nabumetone	2	MO
naloxone injection solution	2	MO
naloxone injection syringe	2	MO
naloxone nasal	2	MO
naltrexone	2	MO
naproxen oral tablet	1	MO
naproxen oral tablet,delayed release (dr/ec) 375 mg	2	MO
naproxen oral tablet,delayed release (dr/ec) 500 mg	2	
oxaprozin	4	MO
piroxicam	3	MO
sulindac	2	MO
tramadol oral tablet 50 mg	2	MO; QL (240 per 30 days)
tramadol-acetaminophen	2	MO; QL (240 per 30 days)
VIVITROL	5	MO; 31D
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY MAINTENA	5	MO; 31D; QL (1 per 28 days)
amitriptyline	2	MO
amoxapine	3	MO
aripiprazole oral solution	4	MO
aripiprazole oral tablet	3	MO; QL (30 per 30 days)
aripiprazole oral tablet,disintegrating	5	MO; 31D; QL (60 per 30 days)
ARISTADA INITIO	5	MO; 31D; QL (4.8 per 365 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	5	MO; 31D; QL (3.9 per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	5	MO; 31D; QL (1.6 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	5	MO; 31D; QL (2.4 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	5	MO; 31D; QL (3.2 per 28 days)
armodafinil	4	PA; MO; QL (30 per 30 days)
asenapine maleate	4	MO; QL (60 per 30 days)
atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg	4	MO; QL (60 per 30 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	4	MO; QL (30 per 30 days)
bupropion hcl oral tablet	2	MO
bupropion hcl oral tablet extended release 24 hr 150 mg	2	MO; QL (90 per 30 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	2	MO; QL (30 per 30 days)
bupropion hcl oral tablet sustained-release 12 hr	2	MO; QL (60 per 30 days)
buspirone	2	MO
CAPLYTA ORAL CAPSULE 42 MG	4	MO; 31D; QL (30 per 30 days)
chlorpromazine oral concentrate	4	MO; 31D
chlorpromazine oral tablet	4	MO
citalopram oral solution	3	MO
citalopram oral tablet	1	MO; QL (30 per 30 days)
clomipramine	4	MO
clonidine hcl oral tablet extended release 12 hr	4	MO
clorazepate dipotassium oral tablet 15 mg	4	PA; MO; QL (180 per 30 days)
clorazepate dipotassium oral tablet 3.75 mg	4	PA; MO; QL (90 per 30 days)
clorazepate dipotassium oral tablet 7.5 mg	4	PA; MO; QL (360 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
clozapine oral tablet	3	
clozapine oral tablet,disintegrating	4	
desipramine	4	MO
desvenlafaxine succinate	4	MO; QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	4	MO
dextroamphetamine-amphetamine oral tablet	3	MO
diazepam intensol	2	PA; MO; QL (240 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	2	PA; MO; QL (1200 per 30 days)
diazepam oral tablet	2	PA; MO; QL (120 per 30 days)
doxepin oral capsule	4	MO
doxepin oral concentrate	4	MO
doxepin oral tablet	3	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	4	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	4	MO; QL (90 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	2	MO; QL (60 per 30 days)
EMSAM	5	MO; 31D
escitalopram oxalate oral solution	4	MO
escitalopram oxalate oral tablet	2	MO; QL (30 per 30 days)
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG	4	MO; QL (60 per 30 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	4	MO; 31D; QL (60 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	4	MO; QL (8 per 180 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	4	MO; QL (28 per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	4	MO; QL (30 per 30 days)
fluoxetine oral capsule 10 mg	1	MO; QL (30 per 30 days)
fluoxetine oral capsule 20 mg	1	MO; QL (90 per 30 days)
fluoxetine oral capsule 40 mg	1	MO; QL (60 per 30 days)
fluoxetine oral solution	2	MO
fluphenazine decanoate	4	MO
fluphenazine hcl	4	MO

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Drug Name	Drug Tier	Requirements /Limits
fluvoxamine oral tablet 100 mg	3	MO; QL (90 per 30 days)
fluvoxamine oral tablet 25 mg	3	MO; QL (30 per 30 days)
fluvoxamine oral tablet 50 mg	3	MO; QL (60 per 30 days)
haloperidol	2	MO
haloperidol decanoate intramuscular solution 100 mg/ml (1 ml)	4	
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml, 50 mg/ml(1ml)	4	MO
haloperidol lactate injection	4	MO
haloperidol lactate oral	2	MO
HETLIOZ	5	PA; MO; 31D; QL (30 per 30 days)
imipramine hcl	4	MO
imipramine pamoate	4	MO
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5	MO; 31D; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5	MO; 31D; QL (5 per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	MO; 31D; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	MO; 31D; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	MO; 31D; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	MO; 31D; QL (0.5 per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5	MO; 31D; QL (0.88 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5	MO; 31D; QL (1.32 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	MO; 31D; QL (1.75 per 90 days)

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Drug Name	Drug Tier	Requirements /Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5	MO; 31D; QL (2.63 per 90 days)
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	4	MO; 31D; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	4	MO; 31D; QL (60 per 30 days)
lithium carbonate	2	MO
lorazepam intensol	2	PA; QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	2	PA; MO; QL (90 per 30 days)
lorazepam oral tablet 2 mg	2	PA; MO; QL (150 per 30 days)
loxapine succinate	2	MO
MARPLAN	4	MO
methylphenidate hcl oral capsule,er biphasic 50-50	4	MO
methylphenidate hcl oral solution	4	MO
methylphenidate hcl oral tablet	3	MO
methylphenidate hcl oral tablet extended release	4	MO
methylphenidate hcl oral tablet,chewable	4	MO
mirtazapine oral tablet	2	MO
mirtazapine oral tablet,disintegrating	3	MO
modafinil oral tablet 100 mg	3	PA; MO; QL (30 per 30 days)
modafinil oral tablet 200 mg	3	PA; MO; QL (60 per 30 days)
molindone	4	MO
nefazodone	4	MO
nortriptyline oral capsule	2	MO
nortriptyline oral solution	4	MO
NUPLAZID	4	PA; MO; 31D; QL (30 per 30 days)
olanzapine intramuscular	4	MO
olanzapine oral tablet	2	MO; QL (30 per 30 days)
olanzapine oral tablet,disintegrating	4	MO; QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	4	MO; QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 6 mg	4	MO; QL (60 per 30 days)
paroxetine hcl oral suspension	4	MO
paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg	2	MO; QL (30 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
paroxetine hcl oral tablet 30 mg	2	MO; QL (60 per 30 days)
perphenazine	4	MO
PERSERIS	5	MO; 31D; QL (1 per 30 days)
phenelzine	3	MO
pimozide	4	MO
protriptyline	4	MO
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	MO; QL (90 per 30 days)
quetiapine oral tablet 300 mg, 400 mg	2	MO; QL (60 per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	4	MO; QL (30 per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	4	MO; QL (60 per 30 days)
ramelteon	3	MO; QL (30 per 30 days)
REXULTI	4	MO; 31D; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	3	MO; QL (2 per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	5	MO; 31D; QL (2 per 28 days)
risperidone oral solution	2	MO
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet 4 mg	1	MO; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	4	MO; QL (60 per 30 days)
risperidone oral tablet,disintegrating 4 mg	4	MO; QL (120 per 30 days)
SECUADO	5	MO; 31D; QL (30 per 30 days)
sertraline oral concentrate	4	MO
sertraline oral tablet 100 mg, 50 mg	1	MO; QL (60 per 30 days)
sertraline oral tablet 25 mg	1	MO; QL (30 per 30 days)
thioridazine	3	MO
thiothixene	4	MO
tranylcypromine	4	MO
trazodone	1	MO
trifluoperazine	3	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
trimipramine	4	MO
TRINTELLIX	3	MO; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	2	MO; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	2	MO; QL (90 per 30 days)
venlafaxine oral tablet	2	MO; QL (90 per 30 days)
VERSACLOZ	5	31D
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	3	MO; QL (30 per 180 days)
vilazodone	3	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	4	MO; 31D; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	4	MO; QL (7 per 180 days)
XYREM	5	PA; LA; 31D; QL (540 per 30 days)
zaleplon oral capsule 10 mg	4	MO; QL (60 per 30 days)
zaleplon oral capsule 5 mg	4	MO; QL (30 per 30 days)
ziprasidone hcl	4	MO; QL (60 per 30 days)
ziprasidone mesylate	4	MO
zolpidem oral tablet	2	MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	3	MO; QL (2 per 28 days)
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
amiodarone oral tablet 100 mg, 400 mg	4	
amiodarone oral tablet 200 mg	2	MO
dofetilide	4	MO
flecainide	3	MO
mexiletine	3	MO
pacerone oral tablet 100 mg, 400 mg	4	MO
pacerone oral tablet 200 mg	2	MO
propafenone oral capsule,extended release 12 hr	4	MO
propafenone oral tablet	3	MO
quinidine sulfate oral tablet	2	MO
sorine oral tablet 120 mg, 160 mg, 80 mg	2	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
sorine oral tablet 240 mg	2	
sotalol af	2	
sotalol oral	2	MO
ANTIHYPERTENSIVE THERAPY		
acebutolol	2	MO
aliskiren	4	MO
amiloride	2	MO
amiloride-hydrochlorothiazide	2	MO
amlodipine	1	MO
amlodipine-benazepril	1	MO
amlodipine-olmesartan	2	MO
amlodipine-valsartan	1	MO
atenolol	1	MO
atenolol-chlorthalidone	2	MO
benazepril	1	MO
benazepril-hydrochlorothiazide	1	MO
betaxolol oral	3	MO
bisoprolol fumarate	2	MO
bisoprolol-hydrochlorothiazide	1	MO
bumetanide injection	4	MO
bumetanide oral	2	MO
candesartan	2	MO
candesartan-hydrochlorothiazid	2	MO
captopril	2	MO
cartia xt	2	MO
carvedilol	1	MO
chlorthalidone oral tablet 25 mg, 50 mg	2	MO
clonidine	4	MO; QL (4 per 28 days)
clonidine hcl oral tablet	1	MO
diltiazem hcl oral capsule,extended release 12 hr	2	MO
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	2	MO
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	2	MO
diltiazem hcl oral tablet	2	MO
diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg	2	
dilt-xr	2	MO
doxazosin oral tablet 1 mg, 2 mg, 4 mg	2	MO; QL (30 per 30 days)
doxazosin oral tablet 8 mg	2	MO; QL (60 per 30 days)
enalapril maleate oral tablet	1	MO
enalapril-hydrochlorothiazide	1	MO

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Drug Name	Drug Tier	Requirements /Limits
eplerenone	3	MO
felodipine	2	MO
fosinopril	1	MO
fosinopril-hydrochlorothiazide	2	MO
furosemide injection	4	MO
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	2	MO
furosemide oral tablet	1	MO
hydralazine oral	2	MO
hydrochlorothiazide	1	MO
indapamide	1	MO
irbesartan	1	MO
irbesartan-hydrochlorothiazide	1	MO
KERENDIA	3	PA; QL (30 per 30 days)
labetalol oral	2	MO
lisinopril	1	MO
lisinopril-hydrochlorothiazide	1	MO
losartan	1	MO
losartan-hydrochlorothiazide	1	MO
matzim la	2	MO
metolazone	3	MO
metoprolol succinate	1	MO
metoprolol ta-hydrochlorothiaz	2	MO
metoprolol tartrate oral	1	MO
metyrosine	5	PA; MO; 31D
minoxidil oral	2	MO
moexipril	1	MO
nadolol	4	MO
nebivolol	2	
nicardipine oral	4	MO
nifedipine oral tablet extended release	2	MO
nifedipine oral tablet extended release 24hr	2	MO
nimodipine	4	MO
olmesartan	1	MO
olmesartan-amlodipin-hcthiazid	2	MO
olmesartan-hydrochlorothiazide	1	MO
perindopril erbumine	1	MO
pindolol	3	MO
prazosin	2	MO
propranolol oral capsule,extended release 24 hr	2	MO
propranolol oral solution	2	MO
propranolol oral tablet	1	MO
quinapril	1	MO
quinapril-hydrochlorothiazide	1	MO
ramipril	1	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
spironolactone	1	MO
spironolacton-hydrochlorothiaz	2	MO
taztia xt	2	MO
telmisartan	2	MO
telmisartan-amlodipine	2	MO
telmisartan-hydrochlorothiazid	2	MO
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	MO; QL (30 per 30 days)
terazosin oral capsule 10 mg	1	MO; QL (60 per 30 days)
tiadylt er	2	MO
timolol maleate oral	4	MO
torsemide oral	2	MO
trandolapril	1	MO
treprostinil sodium	5	PA; MO; 31D
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	1	MO
triamterene-hydrochlorothiazid oral tablet	1	MO
UPTRAVI ORAL	5	PA; MO; LA; 31D
valsartan oral tablet	1	MO
valsartan-hydrochlorothiazide	1	MO
verapamil oral capsule, 24 hr er pellet ct	2	MO
verapamil oral capsule,ext rel. pellets 24 hr	2	MO
verapamil oral tablet	1	MO
verapamil oral tablet extended release	2	MO
COAGULATION THERAPY		
aspirin-dipyridamole	4	MO
BRILINTA	3	MO
CABLIVI INJECTION KIT	5	PA; LA; 31D
cilostazol	2	MO
clopidogrel oral tablet 75 mg	1	MO; QL (30 per 30 days)
dipyridamole oral	4	MO
DOPTELET (10 TAB PACK)	5	PA; MO; LA; 31D
DOPTELET (15 TAB PACK)	5	PA; MO; LA; 31D
DOPTELET (30 TAB PACK)	5	PA; MO; LA; 31D
ELIQUIS	3	MO
ELIQUIS DVT-PE TREAT 30D START	3	MO
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	4	MO; QL (28 per 28 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	4	MO; QL (22.4 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml	4	MO; QL (16.8 per 28 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	4	MO; QL (11.2 per 28 days)
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	5	MO; 31D
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	4	MO
heparin (porcine) injection solution	3	MO
jantoven	1	MO
pentoxifylline	2	MO
prasugrel	3	MO
PROMACTA	5	PA; MO; LA; 31D
warfarin	1	MO
XARELTO	3	MO
XARELTO DVT-PE TREAT 30D START	3	MO
LIPID/CHOLESTEROL LOWERING AGENTS		
atorvastatin	1	MO; QL (30 per 30 days)
cholestyramine (with sugar) oral powder in packet	3	MO
cholestyramine light oral powder in packet	3	MO
colesevelam	4	MO
colestipol oral packet	4	MO
colestipol oral tablet	4	MO
ezetimibe	3	MO
ezetimibe-simvastatin	2	MO; QL (30 per 30 days)
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	2	MO
fenofibrate nanocrystallized	2	MO
fenofibrate oral tablet 160 mg, 54 mg	2	MO
fenofibric acid (choline)	4	MO
fluvastatin oral capsule 20 mg	2	MO; QL (30 per 30 days)
fluvastatin oral capsule 40 mg	2	MO; QL (60 per 30 days)
gemfibrozil	1	MO
icosapent ethyl	2	MO
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	5	PA; MO; LA; 31D
lovastatin oral tablet 10 mg	1	MO; QL (30 per 30 days)
lovastatin oral tablet 20 mg, 40 mg	1	MO; QL (60 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
niacin oral tablet 500 mg	2	MO
niacin oral tablet extended release 24 hr	4	MO
omega-3 acid ethyl esters	2	MO
pravastatin	1	MO; QL (30 per 30 days)
prevalite oral powder in packet	3	MO
REPATHA	3	PA; QL (3 per 28 days)
REPATHA PUSHTRONEX	3	PA; QL (3.5 per 28 days)
REPATHA SURECLICK	3	PA; QL (3 per 28 days)
rosuvastatin	1	MO; QL (30 per 30 days)
simvastatin oral tablet	1	MO; QL (30 per 30 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	3	MO
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR ORAL SOLUTION	3	QL (450 per 30 days)
CORLANOR ORAL TABLET	3	MO; QL (60 per 30 days)
digitek	2	MO
digox	2	MO
digoxin oral solution	3	MO
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	2	MO
digoxin oral tablet 62.5 mcg (0.0625 mg)	3	MO
ENTRESTO	3	MO; QL (60 per 30 days)
ranolazine	4	MO
VECAMYL	5	31D
VYNDAMAX	4	PA; MO; 31D
NITRATES		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	2	MO
isosorbide mononitrate	1	MO
nitro-bid	3	MO
nitroglycerin sublingual	2	MO
nitroglycerin transdermal patch 24 hour	2	MO
nitroglycerin translingual	4	MO
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
acitretin	4	MO
calcipotriene scalp	3	MO; QL (120 per 30 days)
calcipotriene topical cream	4	MO; QL (120 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
calcipotriene topical ointment	4	MO; QL (120 per 30 days)
selenium sulfide topical lotion	2	MO
SKYRIZI SUBCUTANEOUS PEN INJECTOR	5	PA; MO; 31D; QL (2 per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; MO; 31D; QL (2 per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE KIT	5	PA; MO; 31D; QL (2 per 28 days)
STELARA INTRAVENOUS	5	PA; MO; 31D; QL (104 per 180 days)
STELARA SUBCUTANEOUS SOLUTION	5	PA; MO; 31D; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; MO; 31D; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; MO; 31D; QL (1 per 28 days)
TALTZ AUTOINJECTOR	5	PA; MO; 31D; QL (1 per 28 days)
TALTZ SYRINGE	5	PA; MO; 31D; QL (1 per 28 days)
MISCELLANEOUS DERMATOLOGICALS		
ammonium lactate	2	MO
DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	5	PA; MO; 31D; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; MO; 31D; QL (8 per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	5	PA; MO; 31D; QL (1.34 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; MO; 31D; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; MO; 31D; QL (8 per 28 days)
fluorouracil topical cream 5 %	3	MO
fluorouracil topical solution	3	MO
imiquimod topical cream in packet 5 %	3	MO
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	3	MO
lidocaine topical adhesive patch,medicated 5 %	4	PA; MO; QL (90 per 30 days)
lidocaine topical ointment	4	MO; QL (36 per 30 days)
lidocaine viscous	2	MO

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Drug Name	Drug Tier	Requirements /Limits
lidocaine-prilocaine topical cream	3	MO; QL (30 per 30 days)
methoxsalen	5	MO; 31D
PANRETIN	5	PA; MO; 31D
pimecrolimus	4	PA; MO; QL (100 per 30 days)
podofilox	3	MO
REGRANEX	5	MO; 31D
SANTYL	3	MO; QL (180 per 30 days)
silver sulfadiazine	2	MO
ssd	2	MO
tacrolimus topical	4	PA; MO; QL (100 per 30 days)
VALCHLOR	5	PA; MO; 31D
THERAPY FOR ACNE		
accutane	4	
amnesteem	4	
avita topical cream	4	PA; MO
claravis	4	
clindamycin phosphate topical gel	3	MO; QL (120 per 30 days)
clindamycin phosphate topical lotion	3	MO; QL (120 per 30 days)
clindamycin phosphate topical solution	3	MO; QL (120 per 30 days)
ery pads	3	MO
erythromycin with ethanol topical solution	2	MO
isotretinoin	4	
ivermectin topical cream	2	MO; QL (60 per 30 days)
metronidazole topical cream	4	MO
metronidazole topical gel	4	MO
metronidazole topical lotion	4	MO
myorisan	4	
tazarotene topical cream	4	PA; MO
tretinoin topical cream 0.025 %, 0.05 %, 0.1 %	4	PA; MO
tretinoin topical gel 0.01 %, 0.025 %, 0.05 %	3	PA; MO
zenatane	4	
TOPICAL ANTIBACTERIALS		
gentamicin topical cream	4	MO; QL (60 per 30 days)
gentamicin topical ointment	3	MO; QL (60 per 30 days)
mupirocin	2	MO; QL (44 per 30 days)
sulfacetamide sodium (acne)	4	MO
TOPICAL ANTIFUNGALS		
ciclopirox topical cream	2	MO; QL (90 per 28 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ciclopirox topical gel	3	MO; QL (45 per 28 days)
ciclopirox topical shampoo	3	MO; QL (120 per 28 days)
ciclopirox topical solution	2	MO; QL (6.6 per 28 days)
ciclopirox topical suspension	3	MO; QL (60 per 28 days)
clotrimazole topical cream	2	MO; QL (45 per 28 days)
clotrimazole topical solution	2	MO; QL (30 per 28 days)
clotrimazole-betamethasone topical cream	3	MO; QL (45 per 28 days)
clotrimazole-betamethasone topical lotion	4	MO; QL (60 per 28 days)
econazole	4	MO; QL (85 per 28 days)
ketoconazole topical cream	2	MO; QL (60 per 28 days)
ketoconazole topical shampoo	2	MO; QL (120 per 28 days)
nyamyc	3	MO; QL (180 per 30 days)
nystatin topical cream	2	MO; QL (30 per 28 days)
nystatin topical ointment	2	MO; QL (30 per 28 days)
nystatin topical powder	3	QL (180 per 30 days)
nystatin-triamcinolone	3	MO; QL (60 per 28 days)
nystop	3	MO; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
TOPICAL ANTIVIRALS		
acyclovir topical ointment	4	PA; MO; QL (30 per 30 days)
DENAVIR	4	MO; QL (5 per 30 days)
TOPICAL CORTICOSTEROIDS		
ala-cort topical cream 1 %	2	MO
ala-cort topical cream 2.5 %	2	
alclometasone	3	MO
betamethasone dipropionate	3	MO
betamethasone valerate topical cream	3	MO
betamethasone valerate topical lotion	3	MO
betamethasone valerate topical ointment	3	MO
betamethasone, augmented topical cream	2	MO
betamethasone, augmented topical gel	3	MO
betamethasone, augmented topical lotion	4	MO
betamethasone, augmented topical ointment	4	MO

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Drug Name	Drug Tier	Requirements /Limits
clobetasol scalp	4	MO; QL (100 per 28 days)
clobetasol topical cream	4	MO; QL (120 per 28 days)
clobetasol topical foam	4	MO; QL (100 per 28 days)
clobetasol topical gel	4	MO; QL (120 per 28 days)
clobetasol topical lotion	4	MO; QL (118 per 28 days)
clobetasol topical ointment	4	MO; QL (120 per 28 days)
clobetasol topical shampoo	4	MO; QL (236 per 28 days)
clobetasol-emollient topical cream	4	MO; QL (120 per 28 days)
clodan	4	MO; QL (236 per 28 days)
desonide	4	MO
desrx	4	MO
fluocinolone and shower cap	4	MO
fluocinolone topical cream	4	MO
fluocinolone topical ointment	4	MO
fluocinolone topical solution	4	MO
fluocinonide topical cream 0.05 %	4	MO; QL (120 per 30 days)
fluocinonide topical gel	4	MO; QL (120 per 30 days)
fluocinonide topical ointment	4	MO; QL (120 per 30 days)
fluocinonide topical solution	4	MO; QL (120 per 30 days)
fluocinonide-emollient	4	MO; QL (120 per 30 days)
halobetasol propionate topical cream	4	MO
halobetasol propionate topical ointment	4	MO
hydrocortisone topical cream 1 %	2	MO
hydrocortisone topical lotion 2.5 %	2	MO
hydrocortisone topical ointment 1 %, 2.5 %	2	MO
mometasone topical	2	MO
prednicarbate topical ointment	4	MO
triamcinolone acetonide topical cream	2	MO
triamcinolone acetonide topical lotion	2	MO
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	2	MO
triderm topical cream	2	MO
TOPICAL SCABICIDES / PEDICULICIDES		
crotan	2	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
lindane topical shampoo	4	MO
malathion	4	MO
permethrin	3	MO
DIAGNOSTICS / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
acamprosate	4	MO
anagrelide	3	MO
carglumic acid	5	PA; 31D
CHEMET	3	PA
CLINIMIX 4.25%/D5W SULFIT FREE	4	B/D PA
d10 %-0.45 % sodium chloride	4	MO
d2.5 %-0.45 % sodium chloride	4	
d5 % and 0.9 % sodium chloride	4	MO
d5 %-0.45 % sodium chloride	4	MO
deferasirox oral tablet 180 mg, 360 mg	5	PA; MO; 31D
deferasirox oral tablet 90 mg	4	PA; MO; 31D
deferiprone	5	PA; MO; 31D
dextrose 10 % and 0.2 % nacl	4	
dextrose 10 % in water (d10w)	4	
dextrose 5 % in water (d5w) intravenous piggyback	4	MO
dextrose 5%-0.2 % sod chloride	4	
disulfiram oral tablet 250 mg	3	MO
disulfiram oral tablet 500 mg	3	
droxidopa	5	PA; MO; 31D
INCRELEX	5	MO; LA; 31D
levocarnitine (with sugar)	4	MO
levocarnitine oral tablet	4	MO
LOKELMA	3	MO
midodrine	3	MO
nitisinone	5	PA; MO; 31D
pilocarpine hcl oral	4	MO
PROLASTIN-C INTRAVENOUS RECON SOLN	5	PA; LA; 31D
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; 31D
RAVICTI	5	PA; MO; 31D
REVCOVI	5	PA; LA; 31D
riluzole	3	PA; MO
sevelamer carbonate oral tablet	4	MO; QL (270 per 30 days)
sodium chloride 0.9 % intravenous piggyback	4	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
sodium chloride irrigation	4	MO
sodium phenylbutyrate oral powder	5	PA; MO; 31D
sodium phenylbutyrate oral tablet	5	PA; 31D
sodium polystyrene sulfonate oral powder	3	MO
sps (with sorbitol) oral	3	MO
trientine	5	PA; MO; 31D
SMOKING DETERRENTS		
bupropion hcl (smoking deter)	2	MO
NICOTROL	4	MO
NICOTROL NS	4	MO
varenicline	4	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine nasal	3	MO; QL (60 per 30 days)
chlorhexidine gluconate mucous membrane	2	MO
ipratropium bromide nasal	2	MO; QL (30 per 30 days)
periogard	2	MO
triamcinolone acetonide dental	2	MO

Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS OTIC PREPARATIONS		
acetic acid otic (ear)	2	MO
ciprofloxacin hcl otic (ear)	4	MO
flac otic oil	4	
fluocinolone acetonide oil	4	MO
hydrocortisone-acetic acid	4	MO
ofloxacin otic (ear)	3	MO
OTIC STEROID / ANTIBIOTIC		
ciprofloxacin-dexamethasone	3	MO
neomycin-polymyxin-hc otic (ear)	3	MO
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
dexamethasone oral solution	2	MO
dexamethasone oral tablet	2	MO
fludrocortisone	2	MO
hydrocortisone oral	2	MO
methylprednisolone oral tablet	2	B/D PA; MO
methylprednisolone oral tablets,dose pack	2	MO
prednisolone oral solution	3	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	3	MO
prednisone	2	MO
prednisone intensol	4	MO
ANTITHYROID AGENTS		
methimazole oral tablet 10 mg, 5 mg	1	MO
propylthiouracil	3	MO
DIABETES THERAPY		
acarbose oral tablet 100 mg	2	MO; QL (90 per 30 days)
acarbose oral tablet 25 mg	2	MO; QL (360 per 30 days)
acarbose oral tablet 50 mg	2	MO; QL (180 per 30 days)
alcohol pads	3	
BYDUREON BCISE	3	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	3	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	3	PA; MO; QL (1.2 per 30 days)
diazoxide	4	MO
DROPSAFE ALCOHOL PREP PADS	3	
FARXIGA ORAL TABLET 10 MG	3	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	3	MO; QL (60 per 30 days)
FREESTYLE INSULINX STRIP	3	MO
FREESTYLE INSULINX TEST STRIPS	3	MO
FREESTYLE LITE STRIPS	3	MO
FREESTYLE PRECISION NEO STRIPS	3	MO
FREESTYLE TEST	3	MO
glimepiride oral tablet 1 mg	1	MO; QL (240 per 30 days)
glimepiride oral tablet 2 mg	1	MO; QL (120 per 30 days)
glimepiride oral tablet 4 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet 10 mg	1	MO; QL (120 per 30 days)
glipizide oral tablet 5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 5 mg	1	MO; QL (120 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
glipizide-metformin oral tablet 2.5-250 mg	1	MO; QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	MO; QL (120 per 30 days)
GVOKE	3	
GVOKE HYPOPEN 2-PACK	3	MO
GVOKE PFS 1-PACK SYRINGE	3	MO
HUMALOG JUNIOR KWIKPEN U-100	3	MO
HUMALOG KWIKPEN INSULIN	3	MO
HUMALOG MIX 50-50 INSULN U-100	3	MO
HUMALOG MIX 50-50 KWIKPEN	3	MO
HUMALOG MIX 75-25 KWIKPEN	3	MO
HUMALOG MIX 75-25(U-100)INSULN	3	MO
HUMALOG U-100 INSULIN	3	MO
HUMULIN 70/30 U-100 INSULIN	3	MO
HUMULIN 70/30 U-100 KWIKPEN	3	MO
HUMULIN N NPH INSULIN KWIKPEN	3	MO
HUMULIN N NPH U-100 INSULIN	3	MO
HUMULIN R REGULAR U-100 INSULN	3	MO
HUMULIN R U-500 (CONC) INSULIN	3	MO
HUMULIN R U-500 (CONC) KWIKPEN	3	MO
JANUMET	3	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	MO; QL (60 per 30 days)
JANUVIA	3	MO; QL (30 per 30 days)
JARDIANCE	3	MO; QL (30 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	3	MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	3	MO; QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN	3	MO

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Drug Name	Drug Tier	Requirements /Limits
LANTUS U-100 INSULIN	3	MO
LYUMJEV KWIKPEN U-100 INSULIN	3	MO
LYUMJEV KWIKPEN U-200 INSULIN	3	MO
LYUMJEV U-100 INSULIN	3	MO
metformin oral tablet 1,000 mg	1	MO; QL (75 per 30 days)
metformin oral tablet 500 mg	1	MO; QL (150 per 30 days)
metformin oral tablet 850 mg	1	MO; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	MO; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	MO; QL (60 per 30 days)
nateglinide oral tablet 120 mg	2	MO; QL (90 per 30 days)
nateglinide oral tablet 60 mg	2	MO; QL (180 per 30 days)
ONETOUCH ULTRA TEST	3	MO
ONETOUCH VERIO TEST STRIPS	3	MO
ONGLYZA	3	MO; QL (30 per 30 days)
pioglitazone	1	MO; QL (30 per 30 days)
PRECISION XTRA TEST	3	MO
repaglinide oral tablet 0.5 mg	2	MO; QL (960 per 30 days)
repaglinide oral tablet 1 mg	2	MO; QL (480 per 30 days)
repaglinide oral tablet 2 mg	2	MO; QL (240 per 30 days)
SOLIQUA 100/33	3	MO; QL (90 per 30 days)
SYNJARDY	3	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	3	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	3	MO; QL (30 per 30 days)
TOUJEO MAX U-300 SOLOSTAR	3	MO
TOUJEO SOLOSTAR U-300 INSULIN	3	MO
TRULICITY	3	PA; MO; QL (2 per 28 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	MO; QL (30 per 30 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	3	MO; QL (60 per 30 days)
MISCELLANEOUS HORMONES		
cabergoline	3	MO
calcitonin (salmon) nasal	3	MO
calcitriol oral capsule	2	MO
calcitriol oral solution	4	
cinacalcet oral tablet 30 mg	4	PA; MO
cinacalcet oral tablet 60 mg, 90 mg	4	PA; MO; 31D
danazol	4	MO
desmopressin nasal spray with pump	4	MO
desmopressin oral	3	MO
doxercalciferol oral	4	MO
KORLYM	5	PA; 31D
MYALEPT	5	PA; MO; LA; 31D
NATPARA	5	PA; MO; LA; 31D
oxandrolone oral tablet 10 mg	4	PA; MO
oxandrolone oral tablet 2.5 mg	3	PA; MO
paricalcitol oral	4	MO
sapropterin	5	PA; MO; 31D
SOMAVERT	5	PA; MO; 31D
SYNAREL	5	PA; MO; 31D
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	3	PA; MO
testosterone cypionate intramuscular oil 200 mg/ml (1 ml)	3	PA
testosterone enanthate	3	PA; MO
testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation	4	PA; MO; QL (120 per 30 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	4	PA; MO; QL (150 per 30 days)
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	4	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)	4	PA; MO; QL (37.5 per 30 days)
testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)	4	PA; MO; QL (150 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
testosterone transdermal solution in metered pump w/app	4	PA; MO; QL (180 per 30 days)
tolvaptan	5	PA; MO; 31D
THYROID HORMONES		
euthyrox	1	MO
levo-t	1	
levothyroxine oral tablet	1	MO
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO
liothyronine oral	2	MO
unithroid	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
dicyclomine oral capsule	2	MO
dicyclomine oral solution	4	MO
dicyclomine oral tablet	2	MO
diphenoxylate-atropine oral liquid	4	MO
diphenoxylate-atropine oral tablet	3	MO
glycopyrrolate oral tablet 1 mg, 2 mg	3	MO
glycopyrrolate oral tablet 1.5 mg	3	
loperamide oral capsule	2	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
alosetron	5	PA; MO; 31D
aprepitant	4	B/D PA; MO
balsalazide	4	MO
betaine	5	MO; 31D
budesonide oral capsule,delayed,extend.release	4	MO
budesonide oral tablet,delayed and ext.release	5	31D
CHENODAL	5	PA; LA; 31D
CHOLBAM ORAL CAPSULE 250 MG	5	PA; 31D
CHOLBAM ORAL CAPSULE 50 MG	5	PA; 31D; QL (120 per 30 days)
compro	4	MO
constulose	2	MO
CORTIFOAM	3	MO
CREON	3	MO
cromolyn oral	4	MO
dronabinol	4	B/D PA; MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	4	B/D PA
enulose	2	MO
GATTEX 30-VIAL	5	PA; MO; 31D
gavilyte-c	2	MO

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Drug Name	Drug Tier	Requirements /Limits
gavilyte-g	2	MO
generlac	2	MO
granisetron hcl oral	4	B/D PA; MO
hydrocortisone rectal	4	MO
hydrocortisone topical cream with perineal applicator 2.5 %	2	MO
INFLECTRA	5	PA; MO; 31D; QL (20 per 28 days)
lactulose oral solution 10 gram/15 ml	2	MO
meclizine oral tablet 12.5 mg, 25 mg	2	MO
mesalamine oral capsule (with del rel tablets)	4	MO
mesalamine oral capsule,extended release 24hr	4	MO
mesalamine oral tablet,delayed release (dr/ec)	4	MO
mesalamine rectal	4	MO
metoclopramide hcl oral solution	2	MO
metoclopramide hcl oral tablet	1	MO
MOVANTIK	3	MO; QL (30 per 30 days)
OCALIVA	4	PA; MO; LA; 31D; QL (30 per 30 days)
ondansetron	2	B/D PA; MO
ondansetron hcl oral solution	4	B/D PA; MO
ondansetron hcl oral tablet 4 mg, 8 mg	2	B/D PA; MO
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	2	MO
peg3350-sod sul-nacl-kcl-asb-c	4	MO
peg-electrolyte	2	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	4	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	5	MO; 31D
prochlorperazine	4	MO
prochlorperazine maleate oral	2	MO
procto-med hc	2	MO
procto-pak	2	MO
proctosol hc topical	2	MO
proctozone-hc	2	MO
RECTIV	3	MO
RELISTOR SUBCUTANEOUS SOLUTION	5	MO; 31D; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	5	MO; 31D; QL (18 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	5	MO; 31D; QL (12 per 30 days)
scopolamine base	4	MO
SUCRAID	5	PA; 31D
sulfasalazine	2	MO
TRULANCE	3	MO
ursodiol oral capsule 300 mg	3	MO
ursodiol oral tablet	3	MO
VARUBI	3	B/D PA
VIOKACE	3	MO
ULCER THERAPY		
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg	3	MO; QL (30 per 30 days)
esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg	3	MO
famotidine oral suspension	4	MO
famotidine oral tablet 20 mg, 40 mg	1	MO
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	3	MO; QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	3	MO
misoprostol	3	MO
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg	1	MO; QL (30 per 30 days)
omeprazole oral capsule,delayed release(dr/ec) 40 mg	1	MO
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	MO; QL (30 per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	MO
sucralfate oral suspension	4	MO
sucralfate oral tablet	2	MO
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE	5	B/D PA; MO; 31D
ARCALYST	5	PA; MO; 31D
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	5	PA; MO; 31D; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	5	PA; MO; 31D; QL (1 per 28 days)
BESREMI	5	PA; LA; 31D
BETASERON SUBCUTANEOUS KIT	5	PA; MO; 31D; QL (14 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
INTRON A INJECTION RECON SOLN	5	B/D PA; MO; 31D
LEUKINE INJECTION RECON SOLN	5	PA; MO; 31D
NIVESTYM	5	PA; MO; 31D
NYVEPRIA	5	PA; MO; 31D
OMNITROPE	5	PA; MO; 31D
PEGASYS SUBCUTANEOUS SOLUTION	5	MO; 31D; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	5	MO; 31D; QL (2 per 28 days)
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	5	PA; MO; 31D
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
RETACRIT INJECTION SOLUTION 20,000 UNIT/ML	3	PA; MO; 31D
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	5	PA; MO; 31D
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	3	MO
ADACEL(TDAP ADOLESN/ADULT)(PF)	3	MO
BCG VACCINE, LIVE (PF)	3	MO
BEXSERO	3	MO
BOOSTRIX TDAP	3	MO
DAPTACEL (DTAP PEDIATRIC) (PF)	3	MO
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	3	B/D PA; MO
ENGERIX-B PEDIATRIC (PF)	3	B/D PA; MO
GARDASIL 9 (PF)	3	MO
HAVRIX (PF)	3	MO
HIBERIX (PF)	3	MO
IMOVAX RABIES VACCINE (PF)	3	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	3	MO
IPOL	3	

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Drug Name	Drug Tier	Requirements /Limits
IXIARO (PF)	3	
KINRIX (PF) INTRAMUSCULAR SYRINGE	3	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	3	MO
MENQUADFI (PF)	3	MO
MENVEO A-C-Y-W-135-DIP (PF)	3	MO
M-M-R II (PF)	3	MO
PEDIARIX (PF)	3	MO
PEDVAX HIB (PF)	3	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	3	
PREHEVBRIO (PF)	3	B/D PA; MO
PRIVIGEN	5	PA; MO; 31D
PROQUAD (PF)	3	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	3	
RABAVERT (PF)	3	MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	3	B/D PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML	3	B/D PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	3	B/D PA
ROTARIX	3	
ROTATEQ VACCINE	3	MO
SHINGRIX (PF)	3	MO
TDVAX	3	MO
TENIVAC (PF) INTRAMUSCULAR SYRINGE	3	MO
TETANUS,DIPHTHERIA TOX PED(PF)	3	MO
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	3	MO
TRUMENBA	3	MO
TWINRIX (PF)	3	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	3	
TYPHIM VI INTRAMUSCULAR SYRINGE	3	MO
VAQTA (PF)	3	MO
VARIVAX (PF)	3	
YF-VAX (PF)	3	
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
BD AUTOSHIELD DUO PEN NEEDLE	3	MO

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Drug Name	Drug Tier	Requirements /Limits
BD INSULIN SYRINGE (HALF UNIT)	3	MO
BD INSULIN SYRINGE U-500	3	MO
BD INSULIN ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2"	3	MO
BD NANO 2ND GEN PEN NEEDLE	3	MO
BD ULTRA-FINE MICRO PEN NEEDLE	3	MO
BD ULTRA-FINE MINI PEN NEEDLE	3	MO
BD ULTRA-FINE NANO PEN NEEDLE	3	MO
BD ULTRA-FINE SHORT PEN NEEDLE	3	MO
BD VEO INSULIN SYR (HALF UNIT)	3	MO
BD VEO INSULIN SYRINGE UF	3	MO
FREESTYLE FREEDOM	3	
FREESTYLE FREEDOM LITE	3	MO
FREESTYLE INSULINX	3	MO
FREESTYLE LIBRE 14 DAY READER	3	MO
FREESTYLE LIBRE 14 DAY SENSOR	3	MO
FREESTYLE LIBRE 2 READER	3	MO
FREESTYLE LIBRE 2 SENSOR	3	MO
FREESTYLE LITE METER	3	MO
GAUZE PADS 2 X 2	3	
INSULIN PEN NEEDLE	3	MO
INSULIN SYRINGE (DISP) U-100 0.3 ML, 1/2 ML	3	
INSULIN SYRINGE (DISP) U-100 1 ML	3	MO
NEEDLES, INSULIN DISP.,SAFETY	3	MO
NOVOFINE 32	3	MO
NOVOFINE PLUS	3	MO
OMNIPOD 5 G6 INTRO KIT (GEN 5)	3	MO; QL (1 per 720 days)
OMNIPOD 5 G6 PODS (GEN 5)	3	MO
OMNIPOD CLASSIC PDM KIT(GEN 3)	3	MO

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
OMNIPOD CLASSIC PODS (GEN 3)	3	MO
OMNIPOD DASH INTRO KIT (GEN 4)	3	MO; QL (1 per 720 days)
OMNIPOD DASH PODS (GEN 4)	3	MO
ONETOUCH ULTRA2 METER	3	MO
ONETOUCH ULTRAMINI	3	MO
ONETOUCH VERIO FLEX METER	3	MO
ONETOUCH VERIO IQ METER	3	MO
ONETOUCH VERIO METER	3	MO
ONETOUCH VERIO REFLECT METER	3	MO
PRECISION XTRA MONITOR	3	MO
V-GO 20	3	MO
V-GO 30	3	MO
V-GO 40	3	MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
allopurinol	1	MO
colchicine oral tablet	3	MO
febuxostat	3	MO
probenecid	3	MO
probenecid-colchicine	3	MO
OSTEOPOROSIS THERAPY		
alendronate oral tablet 10 mg	1	MO; QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	MO; QL (4 per 28 days)
ibandronate oral	3	MO; QL (1 per 30 days)
PROLIA	3	PA; MO; QL (1 per 180 days)
raloxifene	3	MO
TERIPARATIDE	5	PA; MO; 31D; QL (2.48 per 28 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA ACTPEN	5	PA; MO; 31D; QL (3.6 per 28 days)
ACTEMRA SUBCUTANEOUS	5	PA; MO; 31D; QL (3.6 per 28 days)
BENLYSTA SUBCUTANEOUS	5	PA; MO; 31D
ENBREL MINI	5	PA; MO; 31D; QL (8 per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	5	PA; MO; 31D; QL (16 per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	5	PA; MO; 31D; QL (8 per 28 days)

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This drug list was last updated on 08/18/2022.

Drug Name	Drug Tier	Requirements /Limits
ENBREL SUBCUTANEOUS SYRINGE	5	PA; MO; 31D; QL (8 per 28 days)
ENBREL SURECLICK	5	PA; MO; 31D; QL (8 per 28 days)
HUMIRA PEN	5	PA; MO; 31D; QL (4 per 28 days)
HUMIRA PEN CROHNS-UC-HS START	5	PA; MO; 31D; QL (6 per 180 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS	5	PA; MO; 31D; QL (4 per 180 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; MO; 31D; QL (4 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	5	PA; MO; 31D; QL (3 per 180 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; MO; 31D; QL (2 per 180 days)
HUMIRA(CF) PEN CROHNS-UC-HS	5	PA; MO; 31D; QL (3 per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC	5	PA; MO; 31D; QL (4 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	5	PA; MO; 31D; QL (3 per 180 days)
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	5	PA; MO; 31D; QL (4 per 28 days)
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; MO; 31D; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5	PA; MO; 31D; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; MO; 31D; QL (4 per 28 days)
leflunomide	3	MO; QL (30 per 30 days)
ORENCIA CLICKJECT	5	PA; MO; 31D; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	5	PA; MO; 31D; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	5	PA; MO; 31D; QL (1.6 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	5	PA; MO; 31D; QL (2.8 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
OTEZLA	5	PA; MO; 31D; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; MO; 31D; QL (55 per 180 days)
penicillamine oral tablet	5	PA; MO; 31D
RIDAURA	5	MO; 31D
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	5	PA; MO; 31D; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	5	PA; MO; 31D; QL (56 per 180 days)
XELJANZ ORAL SOLUTION	5	PA; MO; 31D; QL (300 per 30 days)
XELJANZ ORAL TABLET	5	PA; MO; 31D; QL (60 per 30 days)
XELJANZ XR	5	PA; MO; 31D; QL (30 per 30 days)
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
amabelz	3	PA; MO
camila	2	MO
deblitane	2	MO
dotti	3	PA; MO; QL (8 per 28 days)
errin	2	MO
estradiol oral	4	PA; MO
estradiol transdermal patch semiweekly	3	PA; MO; QL (8 per 28 days)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	3	PA; QL (4 per 28 days)
estradiol transdermal patch weekly 0.0375 mg/24 hr	3	PA; MO; QL (4 per 28 days)
estradiol vaginal	4	MO
estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml	4	MO
estradiol-norethindrone acet	3	PA; MO
fyavolv	4	PA; MO
incassia	2	MO
jinteli	4	PA; MO
lyleq	2	MO
lyllana	3	PA; MO; QL (8 per 28 days)
lyza	2	
medroxyprogesterone	2	MO
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	3	PA; MO

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Drug Tier	Requirements /Limits
mimvey	3	PA; MO
nora-be	2	MO
norethindrone (contraceptive)	2	
norethindrone acetate	2	MO
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg	4	PA
norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg	4	PA; MO
progesterone micronized	3	MO
sharobel	2	MO
yuvafem	4	MO
MISCELLANEOUS OB/GYN		
clindamycin phosphate vaginal	4	MO
eluryng	4	MO
etonogestrel-ethinyl estradiol	4	
metronidazole vaginal	3	MO
terconazole	3	MO
tranexamic acid oral	3	MO
vandazole	3	MO
xulane	4	MO
zafemy	4	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
altavera (28)	2	MO
alyacen 1/35 (28)	2	MO
apri	2	MO
aranelle (28)	2	MO
aubra eq	2	MO
aviane	2	MO
caziant (28)	2	MO
cryselle (28)	2	MO
cyred eq	2	MO
desog-e.estradiol/e.estradiol	2	
desogestrel-ethinyl estradiol	2	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg	2	MO
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	2	
emoquette	2	MO
enpresse	2	MO
enskyce	2	MO
estarylla	2	MO
ethynodiol diac-eth estradiol	2	
falmina (28)	2	MO
femynor	2	MO
introvale	2	MO
isibloom	2	MO
jasmiel (28)	2	MO
juleber	2	MO
kariva (28)	2	MO
kelnor 1/35 (28)	2	MO

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Drug Name	Drug Tier	Requirements /Limits
kelnor 1-50 (28)	2	MO
kurvelo (28)	2	MO
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	2	
larin 1.5/30 (21)	2	MO
larin 1/20 (21)	2	MO
larin fe 1.5/30 (28)	2	MO
larin fe 1/20 (28)	2	MO
larissia	2	MO
lessina	2	MO
levonest (28)	2	MO
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	2	MO
levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg	2	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	2	MO
levonorg-eth estrad triphasic	2	
levora-28	2	MO
loryna (28)	2	MO
low-ogestrel (28)	2	MO
lutera (28)	2	MO
marlissa (28)	2	MO
microgestin 1.5/30 (21)	2	MO
microgestin 1/20 (21)	2	MO
microgestin fe 1.5/30 (28)	2	MO
microgestin fe 1/20 (28)	2	MO
mili	2	MO
nikki (28)	2	MO
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	2	MO
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.25-35 mg-mcg	2	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	2	MO
nortrel 0.5/35 (28)	2	MO
nortrel 1/35 (21)	2	MO
nortrel 1/35 (28)	2	MO
nortrel 7/7/7 (28)	2	MO
pimtrea (28)	2	MO
pirmella oral tablet 1-35 mg-mcg	2	MO
portia 28	2	MO
reclipsen (28)	2	MO
setlakin	2	MO
sprintec (28)	2	MO

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Drug Name	Drug Tier	Requirements /Limits
sronyx	2	MO
syeda	2	MO
tarina fe 1-20 eq (28)	2	MO
tilia fe	4	MO
tri-estarylla	2	MO
tri-legest fe	4	MO
tri-lo-estarylla	2	MO
tri-lo-sprintec	2	MO
tri-sprintec (28)	2	MO
trivora (28)	2	MO
velivet triphasic regimen (28)	2	MO
vestura (28)	2	MO
vienva	2	MO
zovia 1-35 (28)	2	MO
OPHTHALMOLOGY		
ANTIBIOTICS		
bacitracin ophthalmic (eye)	3	MO
bacitracin-polymyxin b	2	MO
ciprofloxacin hcl ophthalmic (eye)	2	MO
erythromycin ophthalmic (eye)	2	MO; QL (3.5 per 14 days)
gentak ophthalmic (eye) ointment	2	MO; QL (3.5 per 30 days)
gentamicin ophthalmic (eye) drops	2	MO; QL (70 per 30 days)
levofloxacin ophthalmic (eye) drops 0.5 %	3	MO
moxifloxacin ophthalmic (eye) drops	3	MO
NATACYN	4	
neomycin-bacitracin-polymyxin	3	MO
neomycin-polymyxin-gramicidin	3	MO
ofloxacin ophthalmic (eye)	2	MO
polymyxin b sulf-trimethoprim	2	MO
tobramycin ophthalmic (eye)	2	MO; QL (10 per 14 days)
ANTIVIRALS		
trifluridine	3	MO
ZIRGAN	4	MO
BETA-BLOCKERS		
betaxolol ophthalmic (eye)	3	MO
carteolol	2	MO
levobunolol ophthalmic (eye) drops 0.5 %	2	MO
timolol maleate ophthalmic (eye) drops	1	MO
timolol maleate ophthalmic (eye) gel forming solution	4	MO

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Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS OPHTHALMOLOGICS		
atropine ophthalmic (eye) drops	3	MO
azelastine ophthalmic (eye)	3	MO
cromolyn ophthalmic (eye)	2	MO
cyclosporine ophthalmic (eye)	3	QL (60 per 30 days)
CYSTARAN	5	PA; 31D
epinastine	3	MO
olopatadine ophthalmic (eye)	3	MO
OXERVATE	4	PA; MO; 31D
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	3	MO
sulfacetamide sodium ophthalmic (eye)	2	MO
sulfacetamide-prednisolone	2	MO
XIIDRA	3	MO; QL (60 per 30 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
diclofenac sodium ophthalmic (eye)	2	MO
flurbiprofen sodium	2	MO
ketorolac ophthalmic (eye)	2	MO
ORAL DRUGS FOR GLAUCOMA		
acetazolamide	3	MO
methazolamide	4	MO
OTHER GLAUCOMA DRUGS		
dorzolamide	2	MO
dorzolamide-timolol	2	MO
latanoprost	1	MO
travoprost	3	MO
STEROID-ANTIBIOTIC COMBINATIONS		
neomycin-bacitracin-poly-hc	3	MO
neomycin-polymyxin b-dexameth	2	MO
neomycin-polymyxin-hc ophthalmic (eye)	4	MO
tobramycin-dexamethasone	3	MO; QL (10 per 14 days)
STEROIDS		
dexamethasone sodium phosphate ophthalmic (eye)	2	MO
fluorometholone	3	MO
loteprednol etabonate	3	MO
prednisolone acetate	2	MO
prednisolone sodium phosphate ophthalmic (eye)	2	MO
SYMPATHOMIMETICS		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	3	MO
apraclonidine	3	MO

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Drug Name	Drug Tier	Requirements /Limits
brimonidine ophthalmic (eye) drops 0.15 %	3	
brimonidine ophthalmic (eye) drops 0.2 %	2	MO
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
cetirizine oral solution 1 mg/ml	2	MO
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)	3	MO; QL (2 per 30 days)
hydroxyzine hcl oral tablet	2	PA; MO
levocetirizine oral solution	4	MO
levocetirizine oral tablet	2	MO; QL (30 per 30 days)
promethazine oral	4	PA; MO
SYMJEPI	4	MO; QL (2 per 30 days)
PULMONARY AGENTS		
acetylcysteine	3	B/D PA; MO
ADEMPAS	5	PA; MO; LA; 31D
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	3	MO; QL (17 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation package size 6.7 gm	3	QL (13.4 per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml	2	B/D PA; MO
albuterol sulfate oral syrup	2	MO
albuterol sulfate oral tablet	4	MO
alyq	5	PA; 31D; QL (60 per 30 days)
ambrisentan	5	PA; MO; LA; 31D
arformoterol	5	B/D PA; MO
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION	3	MO; QL (13 per 30 days)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 50 MCG/ACTUATION	3	QL (13 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	3	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	3	MO; QL (2 per 30 days)
ATROVENT HFA	4	MO; QL (25.8 per 30 days)
bosentan	5	PA; MO; LA; 31D
BREZTRI AEROSPHERE	3	MO; QL (10.7 per 30 days)
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml	4	B/D PA; MO; QL (120 per 30 days)
budesonide inhalation suspension for nebulization 1 mg/2 ml	4	B/D PA; MO; QL (60 per 30 days)
CINRYZE	5	PA; MO; 31D
COMBIVENT RESPIMAT	3	MO; QL (8 per 30 days)
cromolyn inhalation	5	B/D PA; MO; 31D
DALIRESP	4	PA; MO; QL (30 per 30 days)
DULERA	3	MO; QL (13 per 30 days)
ESBRIET ORAL CAPSULE	5	PA; MO; 31D; QL (270 per 30 days)
flunisolide	3	MO; QL (50 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	4	ST; QL (12 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	4	ST; QL (24 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	4	ST; QL (10.6 per 30 days)
fluticasone propionate nasal	2	MO; QL (16 per 30 days)
fluticasone propion-salmeterol inhalation blister with device	3	QL (60 per 30 days)
formoterol fumarate	5	B/D PA; MO
icatibant	5	PA; MO; 31D

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Drug Name	Drug Tier	Requirements /Limits
ipratropium bromide inhalation	2	B/D PA; MO
ipratropium-albuterol	2	B/D PA; MO
KALYDECO ORAL GRANULES IN PACKET	5	PA; MO; 31D; QL (56 per 28 days)
KALYDECO ORAL TABLET	5	PA; MO; 31D; QL (60 per 30 days)
montelukast oral granules in packet	4	MO
montelukast oral tablet	2	MO
montelukast oral tablet,chewable	2	MO
OFEV	5	PA; MO; 31D; QL (60 per 30 days)
OPSUMIT	5	PA; MO; LA; 31D
ORKAMBI ORAL GRANULES IN PACKET	5	PA; MO; 31D; QL (56 per 28 days)
ORKAMBI ORAL TABLET	5	PA; MO; 31D; QL (112 per 28 days)
ORLADEYO	5	PA; LA; 31D
pirfenidone oral tablet 267 mg	5	PA; MO; 31D; QL (270 per 30 days)
pirfenidone oral tablet 801 mg	5	PA; MO; 31D; QL (90 per 30 days)
PULMOZYME	5	B/D PA; MO; 31D
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	3	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	3	MO; QL (21.2 per 30 days)
sajazir	5	PA; 31D
sildenafil (pulmonary arterial hypertension) oral tablet	3	PA; MO; QL (90 per 30 days)
SPIRIVA RESPIMAT	3	MO; QL (4 per 30 days)
SPIRIVA WITH HANDIHALER	3	MO; QL (90 per 90 days)
STIOLTO RESPIMAT	3	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	3	MO; QL (4 per 30 days)
SYMBICORT	3	MO; QL (10.2 per 30 days)
SYMDEKO	5	PA; MO; 31D; QL (56 per 28 days)
tadalafil (pulmonary arterial hypertension) oral tablet 20 mg	5	PA; 31D; QL (60 per 30 days)
terbutaline oral	4	MO

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Drug Name	Drug Tier	Requirements /Limits
THEO-24	3	MO
theophylline oral solution	4	
theophylline oral tablet extended release 12 hr 300 mg, 450 mg	2	MO
theophylline oral tablet extended release 24 hr	2	MO
TRIKAFTA	5	PA; MO; 31D; QL (84 per 28 days)
wixela inhub	3	QL (60 per 30 days)
XOLAIR SUBCUTANEOUS RECON SOLN	5	PA; MO; LA; 31D; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; MO; LA; 31D; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; MO; LA; 31D; QL (1 per 28 days)
zafirlukast	4	MO
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	3	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	3	MO
oxybutynin chloride	2	MO
tolterodine	4	MO
trospium oral tablet	2	MO
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin	2	MO
dutasteride	2	MO
finasteride oral tablet 5 mg	2	MO
tamsulosin	2	MO
MISCELLANEOUS UROLOGICALS		
bethanechol chloride	3	MO
CYSTAGON	4	PA; LA
ELMIRON	3	MO
potassium citrate oral tablet extended release	2	MO
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
calcium acetate(phosphat bind)	3	MO; QL (360 per 30 days)
klor-con 10	2	MO
klor-con 8	2	MO
klor-con m10	2	MO
klor-con m15	2	MO
klor-con m20	2	MO

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Drug Name	Drug Tier	Requirements /Limits
klor-con oral packet 20	4	MO
magnesium sulfate injection solution	4	MO
magnesium sulfate injection syringe	4	
potassium chlorid-d5-0.45%nacl	4	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	4	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	4	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	4	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	4	
potassium chloride intravenous	4	
potassium chloride oral capsule, extended release	2	MO
potassium chloride oral liquid	4	MO
potassium chloride oral packet	4	MO
potassium chloride oral tablet extended release 10 meq, 8 meq	2	MO
potassium chloride oral tablet extended release 20 meq	2	
potassium chloride oral tablet,er particles/crystals 10 meq	2	MO
potassium chloride oral tablet,er particles/crystals 15 meq, 20 meq	2	
potassium chloride-0.45 % nacl	4	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	4	
potassium chloride-d5-0.9%nacl	4	
sodium chloride 0.45 % intravenous parenteral solution	4	MO
sodium chloride 3 % hypertonic	4	
sodium chloride 5 % hypertonic	4	MO
MISCELLANEOUS NUTRITION PRODUCTS		
CLINIMIX 5%/D15W SULFITE FREE	4	B/D PA

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Drug Name	Drug Tier	Requirements /Limits
CLINIMIX 4.25%/D10W SULF FREE	4	B/D PA
CLINIMIX 5%-D20W(SULFITE-FREE)	4	B/D PA
intralipid intravenous emulsion 20 %	4	B/D PA
ISOLYTE S PH 7.4	4	
ISOLYTE-P IN 5 % DEXTROSE	4	
PLASMA-LYTE 148	3	
PLASMA-LYTE A	3	
PLENAMINE	4	B/D PA
premasol 10 %	4	B/D PA
travasol 10 %	4	B/D PA
TROPHAMINE 10 %	4	B/D PA
VITAMINS / HEMATINICS		
fluoride (sodium) oral tablet	2	
prenatal vitamin oral tablet	2	

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This abridged formulary was updated on 08/18/2022. We have made no changes to this abridged formulary since 08/18/2022. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact CHRISTUS Health Plan Generations (HMO) / CHRISTUS Health Plan Generations Plus (HMO) Member Services, at 1-844-282-3026 or, for TTY users, 711, 8 a.m. – 8 p.m. local time, seven days a week, from October 1 – March 31, and 8 a.m. – 8 p.m. local time, Monday – Friday, from April 1-September 30, or visit christushealthplan.org.