

Community Health Plan of Washington



2025 Medicare Advantage (HMO) Prescription Drug Formulary (5 Tier)



COMMUNITY HEALTH PLAN
of Washington™
MEDICARE ADVANTAGE

This formulary was updated on 05/27/2025. For more recent information or other questions, please contact Community Health Plan of Washington Medicare Advantage (HMO) Customer Service at 1-800-942-0247 or for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m. or visit our website at medicare.chpw.org.

Community Health Plan of Washington

Medicare Advantage (HMO)

2025 Formulary

List of Covered Drugs

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

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This formulary was updated on 05/27/2025. For more recent information or other questions, please contact Community Health Plan of Washington (CHPW) Medicare Advantage (MA) Customer Service at 1-800-942-0247 (TTY users should call 711), 7 days a week, 8 a.m. to 8 p.m., or visit medicare.chpw.org.

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

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Community Health Plan of Washington. When it refers to “plan” or “our plan,” it means Community Health Plan of Washington Medicare Advantage (HMO).

This document includes Drug List (formulary) for our plan which is current as of 05/27/2025. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (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, 2025, and from time to time during the year.

What is the Community Health Plan of Washington Medicare Advantage Formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by Community Health Plan of Washington Medicare Advantage 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. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Community Health Plan of Washington Medicare Advantage network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: medicare.chpw.org.

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate 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 for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Community Health Plan of Washington Medicare Advantage’s Formulary?”

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later 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 remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. 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 Community Health Plan of Washington Medicare Advantage’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 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 05/27/2025. To get updated information about the drugs covered by Community Health Plan of Washington Medicare Advantage, 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 19. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular, Hypertension/Lipids.” If you know what your drug is used for, look for the category name in the list that begins on page 19. 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 107. 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?

Our plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, “The ‘Drug List’ tells which Part D drugs are covered.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Our plan requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, the plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, the plan provides 30 tablets per prescription for simvastatin. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 19. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Community Health Plan of Washington Medicare Advantage's formulary?" on page 6 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 Customer Service and ask if your drug is covered.

If you learn that Community Health Plan of Washington Medicare Advantage does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by our plan.
- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Community Health Plan of Washington Medicare Advantage Formulary?

You can ask the Community Health Plan of Washington Medicare Advantage 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 waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- You can ask us to cover a formulary drug at a lower cost-sharing level. If approved, this would lower the amount you must pay for your drug.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary or, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask us for a tiering or formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

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 has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor 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 has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Our Policy Regarding Changes in Level of Care

You may have a change in your treatment setting due to the level of care you require. Such transitions include:

1. Being discharged from a hospital to a home;
2. Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacycharges) and now needing to use your Part D plan;
3. Giving up Hospice Status and reverting back to standard Medicare Part A and B coverage;
4. Being discharged from chronic psychiatric hospitals with highly individualized drug regimens.

For these unplanned transitions, you may need to request an exception or an appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis if you have had a change in your level of care and are stabilized on drug regimens that if altered, are known to have risks.

Please see the Community Health Plan of Washington Transition Policy (medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/) for more information.

Admission or discharge from a long-term care facility should not affect access to your Part D benefits.

For more information

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

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

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

Community Health Plan of Washington Medicare Advantage Formulary

The formulary that begins on page 19 provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 107.

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

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

List of Abbreviations

- **BvD PA:** This prescription may be covered under Medicare Part B or Medicare Part 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, consult your Pharmacy Directory or call Customer Service at 1-800-942-0247, 7 days a week, 8 a.m. to 8 p.m. TTY users should dial 711.
- **MO:** Mail-Order Drug. This prescription is available through our mail-order service, as well as 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.
- **PAns:** Prior Authorization for new starts. The plan requires you or your physician to get prior authorization for certain drugs if you are taking them for the first time. 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.
- **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.
- **QL:** Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

Drug Payment Stages and Drug Tiers

The amount you pay for a covered drug will depend on:

- **Drug payment stage.** There are different stages of drug coverage in your plan. The amount you pay will depend on the coverage stage you're in.
- **Drug tier.** There are five drug tiers. Each tier has a copay and/or coinsurance amount. The table below shows the differences between the tiers.

Please reference your Evidence of Coverage for more information about drug coverage and copay or coinsurance amounts for each tier.

Drug Tier	Includes
Tier 1	Tier 1 is the lowest tier and includes preferred generic drugs.
Tier 2	Tier 2 includes generic drugs.
Tier 3	Tier 3 includes preferred brand drugs and non-preferred generic drugs.
Tier 4	Tier 4 includes non-preferred brand drugs and non-preferred generic drugs.
Tier 5	Tier 5 is the highest tier. It contains very high-cost brand and generic drugs, which may require special handling and/or close monitoring.

Extra Help

Members who qualify will receive Extra Help for prescription drug, copays, and coinsurance. Please read the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), to learn about your costs. You may also call Customer Service. Our contact information appears on the front and back cover pages.

Community Health Plan of Washington

Medicare Advantage

(HMO) Formulario de 2025

Lista de medicamentos cubiertos

**LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE
LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN**

HPMS Approved Formulary File Submission ID 00025144, Version Number 15

Este formulario se actualizó el 27/05/2025. Para obtener información actualizada o hacer alguna pregunta, comuníquese con el Servicio de atención al cliente de Community Health Plan of Washington (CHPW) al 1-800-942-0247 (los usuarios de TTY deben llamar al 711) los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., o visite medicare.chpw.org.

Nota para miembros actuales: Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que todavía incluye los medicamentos que toma.

Cuando esta lista de medicamentos (formulario) dice “nosotros” “nos” o “nuestro”, hace referencia a Community Health Plan of Washington. Cuando menciona “plan” o “nuestro plan”, se refiere a Medicare Advantage de Community Health Plan of Washington (HMO).

Este documento incluye una lista de medicamentos (formulario) para nuestro plan que está vigente desde 27/05/2025. Para obtener un formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Por lo general, debe acudir a las farmacias de la red para usar el beneficio de medicamentos recetados. Los beneficios, el formulario, la red de farmacias, o los copagos/coseguros pueden cambiar el 1 de enero de 2025 y de vez en cuando durante el año.

¿Qué es el formulario de los de Community Health Plan of Washington?

Un formulario es una lista de medicamentos cubiertos seleccionados por nuestro plan, en colaboración con un equipo de proveedores de atención médica, que representa las terapias con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Generalmente cubriremos los medicamentos que se mencionan en nuestro formulario, siempre y cuando el medicamento sea médicalemente necesario, la receta se presente en una farmacia de la red del plan y se cumpla con otras normas del plan. Para obtener más información sobre cómo surtir sus recetas, revise su Evidencia de cobertura.

¿Puede el Formulario (lista de medicamentos) cambiar?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos añadir o retirar medicamentos de la lista de medicamentos durante el año, pasarlos a diferentes niveles de gastos compartidos o añadir nuevas restricciones. Debemos seguir las normas de Medicare a la hora de hacer estos cambios.

Los cambios que pueden afectarle este año: en los siguientes casos, se verá afectado por cambios los de cobertura durante el año:

- **Medicamentos genéricos nuevos.** Podemos retirar de inmediato un medicamento de marca de nuestra Lista de medicamentos si lo reemplazamos por un nuevo medicamento genérico que aparecerá en el mismo nivel de gasto compartido o en uno menor y con las mismas restricciones o menos. Además, al añadir el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero cambiarlo de inmediato a un nivel de gastos compartidos diferente o añadir nuevas restricciones. Si actualmente toma ese medicamento de marca, es posible que no informemos por adelantado que haremos ese cambio, pero luego le brindaremos información sobre los cambios específicos que hemos hecho.

- Si implementamos dicho cambio, usted u otra persona autorizada a dar recetas pueden solicitarle al plan que realice una excepción y siga cubriendo el medicamento de marca para usted. La notificación que le brindamos también incluirá información sobre cómo solicitar una excepción, además puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción al formulario de Medicare Advantage de Community Health Plan of Washington?”
- **Medicamentos retirados del mercado.** Si la Administración de Drogas y Alimentos (FDA) considera que un medicamento de nuestro formulario no es seguro, o si el fabricante del medicamento lo quita del mercado, eliminaremos inmediatamente dicho medicamento de nuestro formulario y enviaremos un aviso a los miembros que toman ese medicamento.
- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que toman actualmente un medicamento. Por ejemplo, podríamos añadir un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que figure actualmente en el formulario, o añadir nuevas restricciones al medicamento de marca o moverlo a un nivel de gastos compartidos diferente, o ambas opciones. O bien, podemos realizar cambios según nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, o agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, debemos notificar a los miembros afectados sobre el cambio, al menos 30 días antes de que el cambio esté vigente, o cuando el miembro solicite un resurtido del medicamento, en cuyo momento el miembro recibirá un suministro del medicamento para hasta 30 días.
 - Si realizamos estos cambios, usted y su proveedor pueden solicitar al plan que haga una excepción y siga cubriendo el medicamento de marca para usted. La notificación que le brindamos también incluirá información sobre cómo solicitar una excepción, y además puede encontrar información en la sección a continuación titulada “¿Cómo solicito una excepción al formulario de los planes de Community Health Plan of Washington?”

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si toma un medicamento que se encuentra en nuestro formulario de 2025 que estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2024, excepto en los casos que se describieron anteriormente. Esto significa que estos medicamentos permanecerán disponibles con los mismos gastos compartidos y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. No recibirá un aviso directo sobre los cambios que no le afecten este año. Sin embargo, dichos cambios podrían afectarle a partir del 1 de enero del año siguiente, y es importante que revise la Lista de medicamentos del nuevo año de beneficios para ver los cambios.

El formulario adjunto está vigente desde 27/05/2025. Para obtener información actualizada sobre los medicamentos cubiertos por el plan, comuníquese con nosotros. Nuestra información de contacto aparece en las páginas de portada y contraportada.

¿Cómo uso el Formulario?

Existen dos maneras de buscar un medicamento dentro del formulario:

Afección médica

El formulario comienza en la página 19. En este formulario, los medicamentos se dividen en categorías según el tipo de afección médica que tratan. Por ejemplo, los medicamentos que se utilizan para tratar una afección cardíaca se enumeran bajo la categoría: "Cardiovascular, Hipertensión/Lípidos". Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 19. Luego, busque el nombre del medicamento debajo del nombre de la categoría.

Orden alfabético

Si no está seguro en qué categoría debe buscar, busque el medicamento en el índice que comienza en la página 107. El índice le proporciona una lista en orden alfabético de todos los medicamentos incluidos en este documento. Allí se enumeran los medicamentos de marca y los medicamentos genéricos. Busque en el índice y encuentre su medicamento. Al lado de medicamento, verá el número de página en donde puede encontrar la información de cobertura. Vaya a la página que figura en el índice y busque el nombre del medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre medicamentos de marca y genéricos. La Administración de Alimentos y Medicamentos (FDA) aprueba un medicamento genérico cuando considera que contiene el mismo ingrediente activo que el medicamento de marca. En general, los medicamentos genéricos cuestan menos que los medicamentos de marca.

¿Existe alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales en la cobertura.

Estos requisitos y límites pueden incluir:

- **Autorización previa:** Nuestro plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener la aprobación de nuestro plan antes de surtir sus recetas. Si no obtiene la aprobación, es posible que el plan no cubra el medicamento.
- **Límites en la cantidad:** Para ciertos medicamentos, nuestro plan limita la cantidad de medicamento que cubriremos. Por ejemplo, el plan ofrece 30 comprimidos por receta de simvastatina. Esto puede ser adicional a un suministro estándar de uno o tres meses.
- **Tratamiento escalonado:** En algunos casos, nuestro plan requiere que primero pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para su afección. Por ejemplo, si el medicamento A y el medicamento B tratan su afección médica, es posible que nuestro plan no cubra el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le funciona, entonces el plan cubrirá el medicamento B.

Puede averiguar si un medicamento tiene límites o requisitos adicionales al consultar el formulario que comienza en la página 19. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos si visita nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y tratamiento escalonado. También puede solicitar que le envíemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Puede solicitar que hagamos una excepción a estos límites o restricciones, o que le demos una lista de medicamentos similares que puedan utilizarse para tratar su afección médica. Consulte la sección “¿Cómo solicito una excepción al formulario de los Medicare Advantage de Community Health Plan of Washington?” en la página 15 para obtener más información sobre cómo solicitar una excepción.

¿Qué pasa si mi medicamento no está en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicio de atención al cliente y preguntar si su medicamento está cubierto.

Si se le comunica que el plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar a Servicio de atención al cliente una lista de medicamentos similares cubiertos por el plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por nuestro plan.
- Puede solicitar que hagamos una excepción y cubramos su medicamento. Consulte a continuación para obtener más información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al formulario Medicare Advantage de Community Health Plan of Washington?

Puede solicitar que hagamos una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede pedirnos que cubramos un medicamento incluso si no figura en nuestro formulario. Si se aprueba, este medicamento se cubrirá a un nivel de costo compartido predeterminado, y no podrá solicitarnos que proporcionemos el medicamento a un nivel de costo compartido menor.
- Puede pedirnos que no apliquemos los límites o restricciones de cobertura de su medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad de medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que no apliquemos el límite y que cubramos un monto mayor.

En general, nuestro plan solo aprobará su solicitud de excepción si el medicamento alternativo incluido en el formulario del plan, o las restricciones de uso adicionales, no son tan efectivos para el tratamiento de su afección o si estos pueden causarle efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión de cobertura inicial sobre una excepción a nuestro formulario o a las restricciones de uso. **Cuando solicita una excepción a nuestro formulario o a las restricciones de uso, debe presentar una declaración de su médico o una persona autorizada a emitir recetas que respalde su solicitud.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de recibir la declaración de apoyo de su recetador. Puede solicitar una excepción acelerada (rápida) si usted o su médico creen que su salud podría ser perjudicada gravemente al esperar 72 horas por una decisión. Si se concede su solicitud de apelación acelerada, debemos comunicarle una decisión en un plazo máximo de 24 horas después de recibir una declaración de apoyo de su médico u otro recetador.

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

Como miembro nuevo o actual de nuestro plan, es posible que esté tomando medicamentos que no estén en nuestro formulario. O bien, puede estar tomando un medicamento que sí está en nuestro formulario, pero su capacidad para obtenerlo es limitada. Por ejemplo, es posible que necesite una autorización previa de nuestra parte antes de que pueda surtir sus medicamentos recetados. Debe hablar con su médico para decidir si debe cambiar a un medicamento adecuado que cubramos o solicitar una excepción para el formulario para que cubramos el medicamento que toma. Mientras habla con su médico para determinar el curso de acción correcto para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días tras convertirse en un miembro del nuestro plan.

Para cada uno de los medicamentos que no estén en nuestro formulario, o si su acceso a estos medicamentos es limitado, cubriremos un suministro temporal de 30 días. Si su receta está indicada para menos días, permitiremos obtener varias veces los medicamentos hasta llegar a un máximo de un suministro para 30 días del medicamento. Luego de su primer suministro de 30 días, no pagaremos por estos medicamentos, incluso si usted ha sido miembro del plan durante menos de 90 días.

Si es un residente de un centro de atención a largo plazo y necesita un medicamento que no está en nuestro formulario, o si su acceso a estos medicamentos es limitado, pero ya ha superado los primeros 90 días como miembro de nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento mientras intenta obtener una excepción al formulario.

Nuestra política con respecto a los cambios en el nivel de atención

Puede haber cambios en el entorno de su tratamiento debido al nivel de atención que requiere. Dichas transiciones incluyen las siguientes:

1. ser dado de alta de un hospital a su casa;
2. finalizar su estadía en un establecimiento de enfermería especializada de la Parte A (en la que los pagos incluyen todos los cargos farmacéuticos) a raíz de una necesidad de usar su plan de la Parte D;
3. renunciar al Estado de necesidad de cuidados paliativos y volver a la cobertura de la Parte A y B estándar de Medicare;
4. ser dado de alta de hospitales psiquiátricos con regímenes altos de medicamentos individualizados.

Para estas transiciones no planificadas, es posible que necesite solicitar una excepción o apelación para una cobertura continua de su medicamento. Además, revisaremos las solicitudes de continuación del tratamiento sobre una base de caso por caso si ha tenido un cambio en el nivel de atención y si está estable en un régimen de medicamento que, si es alterado, tiene riesgos conocidos.

Lea la política de transición de Community Health Plan of Washington (medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/) para obtener más información.

La admisión o el alta de un establecimiento de cuidados a largo plazo no debería afectar sus beneficios de la Parte D.

Para obtener más información

Para obtener información más detallada sobre la cobertura de medicamentos recetados de Medicare Advantage de Community Health Plan of Washington, revise su Evidencia de cobertura y otros materiales del plan.

Si tiene alguna pregunta sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

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

Formulario de Medicare Advantage de Community Health Plan of Washington

El formulario que comienza en la página 19 ofrece información de cobertura sobre los medicamentos cubiertos en nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, diríjase al índice que comienza en la página 107.

En la primera columna de la tabla aparece el nombre del medicamento. Los medicamentos de marca están escritos en mayúscula (por ejemplo, RISPERDAL) y los medicamentos genéricos están escritos en minúscula cursiva (por ejemplo, *risperidona*).

La información en la columna de Requisitos/límites indica si su plan tiene algún requisito especial para la cobertura de su medicamento.

Lista de abreviaturas

- **BvD PA:** esta receta puede estar cubierta por la Parte B o la Parte D de Medicare, según las circunstancias. Es posible que tenga que enviar información describiendo el uso y entorno del medicamento para realizar la determinación.
- **LA (Limited Availability):** disponibilidad limitada. Es posible que este medicamento recetado esté disponible solo en ciertas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame al Servicio de atención al cliente al 1-800-942-0247, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m. Los usuarios de TTY deben llamar al 711.
- **MO (Mail-Order):** medicamento de venta por correo. Esta receta está disponible a través de nuestro servicio de pedido por correo, así como de nuestras farmacias minoristas de la red. Considere utilizar el servicio de pedido por correo para sus medicamentos a largo plazo (medicamentos de mantenimiento), como los medicamentos para la presión arterial alta. Las farmacias minoristas de la red pueden ser más adecuadas para medicamentos recetados a corto plazo, como los antibióticos.
- **PA:** autorización previa. El plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener aprobación antes de surtir sus recetas. Si no obtiene la aprobación, puede que no cubramos el medicamento.
- **PAns:** Autorización Previa para nuevos inicios. El plan requiere que usted o su médico obtengan autorización previa para ciertos medicamentos si los está tomando por primera vez. Esto significa que deberá obtener la aprobación antes de surtir sus recetas. Si no obtiene la aprobación, es posible que no cubramos el medicamento.
- **ST (Step Therapy):** tratamiento escalonado. En algunos casos, el plan requiere que pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para su afección. Por ejemplo, si el medicamento A y el medicamento B tratan la misma afección médica, es posible que no cubramos el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le funciona, entonces cubriremos el medicamento B.
- **QL (Quantity Limit):** límites en la cantidad. Para ciertos medicamentos, el plan limita la cantidad del medicamento que cubriremos.

Etapas del pago de los medicamentos y niveles de los medicamentos

El monto que paga por un medicamento cubierto dependerá de lo siguiente:

- **Etapa del pago del medicamento.** Hay diferentes etapas de cobertura para los medicamentos de su plan. El monto que pague dependerá de la etapa de cobertura en la que se encuentre.
- **Nivel del medicamento.** Hay cinco niveles de medicamentos. Cada nivel tiene un monto de copago o coseguro. La siguiente tabla muestra las diferencias entre los niveles.

Consulte su Evidencia de cobertura para obtener más información sobre la cobertura de los medicamentos y los montos del copago o coseguro para cada nivel.

Nivel del medicamento	Incluye
Nivel 1	El Nivel 1 es el nivel más bajo e incluye los medicamentos genéricos preferidos.
Nivel 2	El Nivel 2 incluye los medicamentos genéricos.
Nivel 3	El Nivel 3 incluye los medicamentos de marca preferidos y los medicamentos genéricos no preferidos.
Nivel 4	El Nivel 4 incluye los medicamentos de marca no preferidos y los medicamentos genéricos no preferidos.
Nivel 5	El Nivel 5 es el nivel más alto. Contiene medicamentos genéricos y de marca de muy alto costo, que pueden requerir una administración especial o mucha supervisión.

Ayuda adicional

Los miembros que reúnan los requisitos recibirán Ayuda adicional para los medicamentos recetados, los copagos y el coseguro. Lea la “Cláusula de la Evidencia de cobertura para las personas que reciben Ayuda adicional para pagar los medicamentos recetados” (Cláusula LIS) para conocer sus costos. También puede llamar al servicio de atención al cliente. Nuestra información de contacto aparece en las páginas de portada y contraportada.

**COMMUNITY HEALTH PLAN OF
WASHINGTON**

**2025 PRESCRIPTION DRUG FORMULARY (5
Tier)**

CURRENT AS OF 5/27/2025

Drug Name	Drug Tier	Requirements/ Limits
Analgesics		
Analgesics		
ENDOCET	3	QL (360 EA per 30 days)
Nonsteroidal Anti-Inflammatory Drugs		
celecoxib	3	
diclofenac potassium oral tablet 50 mg	2	
diclofenac sodium oral	2	
diclofenac sodium topical solution in metered-dose pump	5	QL (224 GM per 28 days)
diflunisal	3	
etodolac oral capsule	3	
etodolac oral tablet	3	
flurbiprofen oral tablet 100 mg	2	
IBU ORAL TABLET 600 MG, 800 MG	1	
ibuprofen oral suspension	2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
meloxicam oral tablet	1	QL (30 EA per 30 days)
nabumetone	2	
naproxen oral tablet	1	

Drug Name	Drug Tier	Requirements/ Limits
naproxen oral tablet, delayed release (dr/ec)	2	
oxaprozin oral tablet	4	
piroxicam	3	
sulindac	2	
Opioid Analgesics, Long-Acting		
buprenorphine hcl sublingual	2	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	4	PA; QL (10 EA per 30 days)
hydromorphone (pf) injection solution 10 mg/ml	4	
hydromorphone oral tablet extended release 24 hr	4	PA; QL (60 EA per 30 days)
methadone oral solution 10 mg/5 ml	3	PA; QL (600 ML per 30 days)
methadone oral solution 5 mg/5 ml	3	PA; QL (1200 ML per 30 days)
methadone oral tablet 10 mg	3	PA; QL (120 EA per 30 days)
methadone oral tablet 5 mg	3	PA; QL (240 EA per 30 days)
morphine concentrate oral solution	3	QL (900 ML per 30 days)
morphine oral solution 10 mg/5 ml	3	QL (900 ML per 30 days)
morphine oral tablet 15 mg	3	QL (180 EA per 30 days)

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<i>morphine oral tablet extended release</i>	3	PA; QL (120 EA per 30 days)	<i>morphine concentrate oral solution</i>	3	QL (900 ML per 30 days)
Opioid Analgesics, Short-Acting					
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	3	QL (4500 ML per 30 days)	<i>morphine oral tablet</i>	3	QL (180 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	3	QL (360 EA per 30 days)	<i>oxycodone oral capsule</i>	3	QL (360 EA per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	3	QL (180 EA per 30 days)	<i>oxycodone oral concentrate</i>	4	QL (180 ML per 30 days)
<i>butorphanol nasal</i>	4	QL (10 ML per 28 days)	<i>oxycodone oral solution</i>	3	QL (1200 ML per 30 days)
<i>ENDOCET</i>	3	QL (360 EA per 30 days)	<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	3	QL (180 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	4	PA; QL (10 EA per 30 days)	<i>oxycodone oral tablet 5 mg</i>	3	QL (360 EA per 30 days)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml, 7.5-325 mg/15 ml</i>	3	QL (5550 ML per 30 days)	<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	3	QL (360 EA per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	3	QL (360 EA per 30 days)	<i>tramadol oral tablet 50 mg</i>	2	QL (240 EA per 30 days)
<i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i>	3	QL (50 EA per 30 days)	<i>tramadol-acetaminophen</i>	2	QL (240 EA per 30 days)
<i>hydromorphone (pf) injection solution 10 mg/ml</i>	4		Anesthetics		
<i>hydromorphone oral liquid</i>	4	QL (2400 ML per 30 days)	Local Anesthetics		
<i>hydromorphone oral tablet</i>	3	QL (180 EA per 30 days)	<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	3	
			<i>lidocaine topical adhesive patch, medicated 5 %</i>	4	PA; QL (90 EA per 30 days)
			<i>lidocaine topical ointment</i>	4	QL (36 GM per 30 days)
			<i>LIDOCAINE VISCOUS</i>	2	

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Drug Name	Drug Tier	Requirements/ Limits
<i>lidocaine-prilocaine topical cream</i>	3	QL (30 GM per 30 days)
LIDOCAN III	4	PA; QL (90 EA per 30 days)
TRIDACAIN II	4	PA; QL (90 EA per 30 days)
Anti-Addiction/ Substance Abuse Treatment Agents		
Alcohol Deterrents/Anti- Craving		
<i>acamprosate</i>	4	
<i>disulfiram</i>	3	
<i>naltrexone</i>	2	
VIVITROL	5	
Opioid Dependence		
<i>buprenorphine hcl sublingual</i>	2	
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	3	QL (60 EA per 30 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	3	QL (360 EA per 30 days)
<i>buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg</i>	3	QL (90 EA per 30 days)
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	2	QL (360 EA per 30 days)
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	2	QL (90 EA per 30 days)
<i>naltrexone</i>	2	
VIVITROL	5	

Drug Name	Drug Tier	Requirements/ Limits
Opioid Reversal Agents		
<i>naloxone injection solution</i>	2	
<i>naloxone injection syringe 0.4 mg/ml, 1 mg/ml</i>	2	
Smoking Cessation Agents		
<i>bupropion hcl (smoking deter)</i>	2	
NICOTROL NS	4	
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	4	
<i>varenicline tartrate oral tablets,dose pack</i>	4	
Antibacterials		
Aminoglycosides		
<i>amikacin injection solution 500 mg/2 ml</i>	4	PA
ARIKAYCE	5	PA
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	4	PA
<i>gentamicin injection</i>	4	PA
<i>gentamicin topical cream</i>	4	QL (60 GM per 30 days)
<i>gentamicin topical ointment</i>	3	QL (60 GM per 30 days)
<i>neomycin</i>	2	
<i>streptomycin</i>	5	PA; QL (60 EA per 30 days)
<i>tobramycin inhalation</i>	5	PA; QL (224 ML per 28 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>tobramycin sulfate injection solution</i>	4	PA	<i>nitrofurantoin monohyd/m-cryst</i>	3	
Antibacterials, Other					
<i>acetic acid otic (ear)</i>	2		<i>tigecycline</i>	5	PA
<i>aztreonam</i>	4	PA	<i>tinidazole</i>	3	
<i>clindamycin hcl</i>	2		<i>trimethoprim</i>	2	
<i>clindamycin in 5 % dextrose</i>	4	PA	<i>vancomycin intravenous recon soln 1,000 mg</i>	4	PA; QL (20 EA per 10 days)
<i>clindamycin phosphate injection</i>	4	PA	<i>vancomycin intravenous recon soln 10 gram</i>	4	PA; QL (2 EA per 10 days)
<i>clindamycin phosphate vaginal</i>	4		<i>vancomycin intravenous recon soln 500 mg</i>	4	PA; QL (10 EA per 10 days)
<i>colistin (colistimethate na)</i>	5	PA; QL (30 EA per 10 days)	<i>vancomycin intravenous recon soln 750 mg</i>	4	PA; QL (27 EA per 10 days)
<i>daptomycin</i>	5		<i>vancomycin oral capsule 125 mg</i>	4	PA; QL (40 EA per 10 days)
<i>linezolid in dextrose 5%</i>	4	PA	<i>vancomycin oral capsule 250 mg</i>	4	PA; QL (80 EA per 10 days)
<i>linezolid oral suspension for reconstitution</i>	5		<i>XIFAXAN ORAL TABLET 200 MG</i>	3	PA; QL (9 EA per 30 days)
<i>linezolid oral tablet</i>	4		<i>XIFAXAN ORAL TABLET 550 MG</i>	5	PA; QL (90 EA per 30 days)
<i>methenamine hippurate</i>	3		Beta-Lactam, Cephalosporins		
<i>metronidazole in nacl (iso-os)</i>	4	PA	<i>cefaclor oral capsule</i>	3	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	2		<i>cefaclor oral suspension for reconstitution 250 mg/5 ml</i>	4	
<i>metronidazole topical cream</i>	4		<i>cefadroxil oral capsule</i>	2	
<i>metronidazole topical gel</i>	4		<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	3	
<i>metronidazole topical lotion</i>	4		<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	4	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	3		<i>cefdinir oral capsule</i>	2	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	3		<i>cefdinir oral suspension for reconstitution</i>	3	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>cefepime injection</i>	4		<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	2	
<i>cefixime</i>	4		<i>amoxicillin-pot clavulanate oral tablet</i>	2	
<i>cefoxitin</i>	4	PA	<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	4	
<i>cefpodoxime</i>	4		<i>ampicillin oral capsule 500 mg</i>	2	
<i>cefprozil</i>	3		<i>ampicillin sodium injection recon soln 1 gram, 10 gram</i>	4	PA
<i>ceftazidime</i>	4	PA	<i>ampicillin-sulbactam injection</i>	4	PA
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	4		AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	4	
<i>cefuroxime axetil oral tablet</i>	3		BICILLIN L-A	4	PA
<i>cefuroxime sodium injection recon soln 750 mg</i>	4	PA	<i>dicloxacillin</i>	2	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	4	PA	<i>nafcillin injection recon soln 1 gram, 2 gram</i>	4	PA
<i>cephalexin oral capsule 250 mg, 500 mg</i>	2		<i>nafcillin injection recon soln 10 gram</i>	5	PA
<i>cephalexin oral suspension for reconstitution</i>	2		<i>oxacillin</i>	4	PA
TAZICEF INJECTION	4	PA	<i>oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml</i>	4	PA
TEFLARO	5	PA	<i>penicillin g potassium injection recon soln 20 million unit</i>	4	PA
Beta-Lactam, Penicillins			<i>penicillin g sodium</i>	4	PA
<i>amoxicillin oral capsule</i>	2		<i>penicillin v potassium</i>	2	
<i>amoxicillin oral suspension for reconstitution</i>	2				
<i>amoxicillin oral tablet</i>	2				
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	2				

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Drug Name	Drug Tier	Requirements/ Limits
piperacillin-tazobactam <i>intravenous recon soln</i> 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	4	
Carbapenems		
ertapenem	4	PA; QL (14 EA per 14 days)
imipenem-cilastatin	4	PA
meropenem intravenous <i>recon soln</i> 1 gram	3	PA; QL (30 EA per 10 days)
meropenem intravenous <i>recon soln</i> 500 mg	3	PA; QL (10 EA per 10 days)
Macrolides		
azithromycin <i>intravenous</i>	4	PA
azithromycin oral <i>suspension for reconstitution</i>	2	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	2	
clarithromycin oral <i>suspension for reconstitution</i>	4	
clarithromycin oral tablet	3	
clarithromycin oral tablet extended release 24 hr	3	
DIFICID ORAL TABLET	5	QL (20 EA per 10 days)
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	4	
erythromycin ethylsuccinate oral tablet	4	
erythromycin oral	4	

Drug Name	Drug Tier	Requirements/ Limits
Quinolones		
ciprofloxacin hcl ophthalmic (eye)	2	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	2	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	4	PA
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	4	PA
levofloxacin oral solution	4	
levofloxacin oral tablet	2	
moxifloxacin oral	3	
moxifloxacin-sod.chloride(iso)	4	PA
Sulfonamides		
sulfacetamide sodium (acne)	4	
sulfadiazine	4	
sulfamethoxazole-trimethoprim oral suspension	3	
sulfamethoxazole-trimethoprim oral tablet	1	
Tetracyclines		
DOXY-100	4	PA
doxycycline hyclate oral capsule	2	
doxycycline hyclate oral tablet 100 mg, 20 mg	2	
doxycycline monohydrate oral capsule 100 mg, 50 mg	2	

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>doxycycline monohydrate oral suspension for reconstitution</i>	4		<i>lamotrigine oral tablet, chewable dispersible</i>	2	
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	2		<i>lamotrigine oral tablet,disintegrating</i>	4	
<i>minocycline oral capsule</i>	2		<i>levetiracetam oral solution 100 mg/ml</i>	2	
<i>minocycline oral tablet</i>	4		<i>levetiracetam oral tablet</i>	2	
<i>tetracycline oral capsule</i>	4		<i>levetiracetam oral tablet extended release 24 hr</i>	3	
Anticonvulsants					
Anticonvulsants, Other					
<i>BRIVIACT ORAL SOLUTION</i>	5	QL (600 ML per 30 days)	<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	2	PAns
<i>BRIVIACT ORAL TABLET</i>	5	QL (60 EA per 30 days)	<i>topiramate oral tablet</i>	2	PAns
<i>DIACOMIT</i>	5	PAns	<i>valproic acid</i>	2	
<i>divalproex</i>	2		<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2	
<i>EPIDIOLEX</i>	5	PAns	<i>XCOPRI MAINTENANCE PACK</i>	5	QL (56 EA per 28 days)
<i>EPRONTIA</i>	4	PAns	<i>XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG</i>	5	QL (30 EA per 30 days)
<i>felbamate</i>	4		<i>XCOPRI ORAL TABLET 150 MG, 200 MG</i>	5	QL (60 EA per 30 days)
<i>FINTEPLA</i>	5	PAns; QL (360 ML per 30 days)	<i>XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)-25 MG (14)</i>	4	QL (28 EA per 180 days)
<i>FYCOMPA ORAL SUSPENSION</i>	5	QL (720 ML per 30 days)			
<i>FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG</i>	5	QL (30 EA per 30 days)			
<i>FYCOMPA ORAL TABLET 2 MG</i>	4	QL (60 EA per 30 days)			
<i>FYCOMPA ORAL TABLET 4 MG, 6 MG</i>	5	QL (60 EA per 30 days)			
<i>lamotrigine oral tablet</i>	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	QL (28 EA per 180 days)	<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	4	QL (90 EA per 30 days)
ZTALMY	5	PAbs; QL (1100 ML per 30 days)	<i>clonazepam oral tablet,disintegrating 2 mg</i>	4	QL (300 EA per 30 days)
Calcium Channel Modifying Agents					
<i>ethosuximide</i>	3		<i>clorazepate dipotassium oral tablet 15 mg</i>	4	PAbs; QL (180 EA per 30 days)
<i>methsuximide</i>	4		<i>clorazepate dipotassium oral tablet 3.75 mg</i>	4	PAbs; QL (90 EA per 30 days)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	3	QL (90 EA per 30 days)	<i>clorazepate dipotassium oral tablet 7.5 mg</i>	4	PAbs; QL (360 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	3	QL (60 EA per 30 days)	DIAZEPAM INTENSOL	2	PAbs; QL (240 ML per 30 days)
<i>pregabalin oral solution</i>	3	QL (900 ML per 30 days)	<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	PAbs; QL (1200 ML per 30 days)
ZONISADE	5	PAbs	<i>diazepam oral tablet</i>	2	PAbs; QL (120 EA per 30 days)
Gamma- Aminobutyric Acid (Gaba) Modulating Agents			<i>diazepam rectal</i>	4	
<i>clobazam oral suspension</i>	4	PAbs; QL (480 ML per 30 days)	<i>gabapentin oral capsule 100 mg, 400 mg</i>	2	QL (270 EA per 30 days)
<i>clobazam oral tablet</i>	4	PAbs; QL (60 EA per 30 days)	<i>gabapentin oral capsule 300 mg</i>	2	QL (360 EA per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)	<i>gabapentin oral solution 250 mg/5 ml</i>	3	QL (2160 ML per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)	<i>gabapentin oral tablet 600 mg</i>	2	QL (180 EA per 30 days)
			<i>gabapentin oral tablet 800 mg</i>	2	QL (120 EA per 30 days)
			LORAZEPAM INTENSOL	2	PA; QL (150 ML per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	2	PA; QL (90 EA per 30 days)	Sodium Channel Agents		
<i>lorazepam oral tablet 2 mg</i>	2	PA; QL (150 EA per 30 days)	APTIOM ORAL TABLET 200 MG	5	QL (180 EA per 30 days)
NAYZILAM	3	PAns; QL (10 EA per 30 days)	APTIOM ORAL TABLET 400 MG	5	QL (90 EA per 30 days)
<i>phenobarbital oral elixir</i>	4	PAns	APTIOM ORAL TABLET 600 MG, 800 MG	5	QL (60 EA per 30 days)
<i>phenobarbital oral tablet</i>	3	PAns	<i>carbamazepine oral capsule, er multiphase 12 hr</i>	4	
<i>pregabalin oral capsule 200 mg</i>	3	QL (90 EA per 30 days)	<i>carbamazepine oral suspension 100 mg/5 ml</i>	4	
<i>pregabalin oral capsule 300 mg</i>	3	QL (60 EA per 30 days)	<i>carbamazepine oral tablet</i>	3	
<i>pregabalin oral solution</i>	3	QL (900 ML per 30 days)	<i>carbamazepine oral tablet extended release 12 hr</i>	4	
<i>primidone oral tablet 125 mg</i>	4		<i>carbamazepine oral tablet, chewable 100 mg</i>	3	
<i>primidone oral tablet 250 mg, 50 mg</i>	2		DILANTIN	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PAns; QL (60 EA per 30 days)	EPITOL	3	
SYMPAZAN ORAL FILM 5 MG	4	PAns; QL (60 EA per 30 days)	<i>lacosamide oral solution</i>	4	QL (1200 ML per 30 days)
<i>tiagabine</i>	4		<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg</i>	4	QL (60 EA per 30 days)
VALTOCO	3	PAns; QL (10 EA per 30 days)	<i>lacosamide oral tablet 50 mg</i>	4	QL (120 EA per 30 days)
<i>vigabatrin</i>	5	PAns	<i>oxcarbazepine oral suspension</i>	4	
VIGADRONE	5	PAns	<i>oxcarbazepine oral tablet</i>	3	
VIGPODER	5	PAns	<i>phenytoin oral suspension 125 mg/5 ml</i>	2	
ZTALMY	5	PAns; QL (1100 ML per 30 days)	<i>phenytoin oral tablet, chewable</i>	3	

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Drug Name	Drug Tier	Requirements/ Limits
<i>phenytoin sodium extended oral capsule 100 mg</i>	2	
<i>rufinamide oral suspension</i>	5	PAns
<i>rufinamide oral tablet 200 mg</i>	4	PAns
<i>rufinamide oral tablet 400 mg</i>	5	PAns
ZONISADE	5	PAns
<i>zonisamide</i>	2	PAns
Antidementia Agents		
Antidementia Agents, Other		
<i>donepezil oral tablet 10 mg, 5 mg</i>	2	
<i>donepezil oral tablet,disintegrating</i>	2	
<i>memantine-donepezil</i>	3	PA
NAMZARIC ORAL CAPSULE,SPRINKLE, ER 24HR	3	PA
Cholinesterase Inhibitors		
<i>donepezil oral tablet 10 mg, 5 mg</i>	2	
<i>donepezil oral tablet,disintegrating</i>	2	
<i>galantamine oral capsule,ext rel. pellets 24 hr</i>	3	
<i>galantamine oral solution</i>	4	
<i>galantamine oral tablet</i>	3	
<i>rivastigmine</i>	4	
<i>rivastigmine tartrate</i>	3	

Drug Name	Drug Tier	Requirements/ Limits
N-Methyl-D-Aspartate (Nmda) Receptor Antagonist		
<i>memantine oral capsule,sprinkle,er 24hr</i>	4	PA
<i>memantine oral solution</i>	4	PA
<i>memantine oral tablet</i>	3	PA
Antidepressants		
Antidepressants, Other		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	5	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	5	QL (3.2 ML per 56 days)
ABILIFY MAINTENA	5	QL (1 EA per 28 days)
<i>ariPIPRAZOLE oral solution</i>	4	
<i>ariPIPRAZOLE oral tablet</i>	3	QL (30 EA per 30 days)
<i>ariPIPRAZOLE oral tablet,disintegrating</i>	4	QL (60 EA per 30 days)
AUVELITY	5	QL (60 EA per 30 days)
<i>bupropion hcl oral tablet</i>	2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	2	QL (90 EA per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	2	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
bupropion hcl oral tablet sustained-release 12 hr	2	QL (60 EA per 30 days)	desvenlafaxine succinate	4	QL (30 EA per 30 days)
mirtazapine oral tablet	2		DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	4	QL (60 EA per 30 days)
mirtazapine oral tablet,disintegrating	3		DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	4	QL (90 EA per 30 days)
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	2	QL (90 EA per 30 days)	duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	2	QL (60 EA per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	4	QL (30 EA per 30 days)	escitalopram oxalate oral solution	4	
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	4	QL (60 EA per 30 days)	escitalopram oxalate oral tablet	2	QL (30 EA per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	5	PAns; QL (28 EA per 365 days)	FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	4	QL (28 EA per 180 days)
ZURZUVAE ORAL CAPSULE 30 MG	5	PAns; QL (14 EA per 365 days)	FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	4	QL (30 EA per 30 days)
Monoamine Oxidase Inhibitors			fluoxetine oral capsule 10 mg	1	QL (30 EA per 30 days)
EMSAM	5		fluoxetine oral capsule 20 mg	1	QL (90 EA per 30 days)
MARPLAN	4		fluoxetine oral capsule 40 mg	1	QL (60 EA per 30 days)
phenelzine	3		fluoxetine oral solution	2	
tranylcypromine	4		fluvoxamine oral tablet 100 mg	3	QL (90 EA per 30 days)
Ssrис/Snris (Selective Serotonin Reuptake Inhibitors/Serotonin And Norepinephrine Reuptake Inhibitors)			fluvoxamine oral tablet 25 mg	3	QL (30 EA per 30 days)
citalopram oral solution	3		fluvoxamine oral tablet 50 mg	3	QL (60 EA per 30 days)
citalopram oral tablet	1	QL (30 EA per 30 days)			

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Drug Name	Drug Tier	Requirements/ Limits
<i>nefazodone</i>	4	
<i>paroxetine hcl oral suspension</i>	4	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	QL (30 EA per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	2	QL (60 EA per 30 days)
RALDESY	5	
<i>sertraline oral concentrate</i>	4	
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	QL (60 EA per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	QL (30 EA per 30 days)
<i>trazodone</i>	1	
TRINTELLIX	3	QL (30 EA per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	2	QL (30 EA per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	2	QL (90 EA per 30 days)
<i>venlafaxine oral tablet</i>	2	QL (90 EA per 30 days)
<i>vilazodone</i>	3	QL (30 EA per 30 days)
Tricyclics		
<i>amitriptyline</i>	2	
<i>amoxapine</i>	3	
<i>clomipramine</i>	4	
<i>desipramine</i>	4	
<i>doxepin oral capsule</i>	4	
<i>doxepin oral concentrate</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>doxepin oral tablet</i>	3	QL (30 EA per 30 days)
<i>imipramine hcl</i>	4	
<i>nortriptyline oral capsule</i>	2	
<i>nortriptyline oral solution</i>	4	
<i>protriptyline</i>	4	
<i>trimipramine</i>	4	
Antiemetics		
Antiemetics, Other		
<i>chlorpromazine oral</i>	4	
COMPRO	4	
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	
<i>metoclopramide hcl oral solution</i>	2	
<i>metoclopramide hcl oral tablet</i>	2	
<i>perphenazine</i>	4	
<i>prochlorperazine</i>	4	
<i>prochlorperazine maleate</i>	2	
<i>promethazine oral</i>	4	PA
<i>scopolamine base</i>	4	
Emetogenic Therapy Adjuncts		
<i>aprepitant</i>	4	BvD
<i>dronabinol</i>	4	BvD
<i>gransetron hcl oral</i>	4	BvD
<i>ondansetron hcl oral solution</i>	4	BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	2	BvD

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Drug Name	Drug Tier	Requirements/ Limits
<i>ondansetron oral tablet,disintegrating 4 mg, 8 mg</i>	2	BvD
VARUBI	3	BvD
Antifungals		
Antifungals		
ABELCET	4	BvD
<i>amphotericin b</i>	4	BvD
<i>caspofungin</i>	4	
<i>ciclopirox topical cream</i>	2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	3	QL (100 GM per 28 days)
<i>ciclopirox topical shampoo</i>	3	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	2	QL (6.6 ML per 28 days)
<i>ciclopirox topical suspension</i>	3	QL (60 ML per 28 days)
<i>clotrimazole mucous membrane</i>	2	
<i>clotrimazole topical cream</i>	2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	2	QL (30 ML per 28 days)
CRESEMBA ORAL	5	PA
<i>econazole nitrate</i>	4	QL (85 GM per 28 days)
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml</i>	4	PA
<i>fluconazole oral suspension for reconstitution</i>	3	
<i>fluconazole oral tablet</i>	2	
<i>flucytosine</i>	5	

Drug Name	Drug Tier	Requirements/ Limits
<i>griseofulvin microsize</i>	4	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	4	
<i>itraconazole oral capsule</i>	4	QL (120 EA per 30 days)
<i>itraconazole oral solution</i>	4	
<i>ketoconazole oral</i>	2	
<i>ketoconazole topical cream</i>	2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	2	QL (120 ML per 28 days)
<i>micafungin</i>	4	
<i>naftifine topical gel</i>	4	QL (60 GM per 28 days)
NYAMYC	3	QL (180 GM per 30 days)
<i>nystatin oral</i>	2	
<i>nystatin topical cream</i>	2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	3	QL (180 GM per 30 days)
NYSTOP	3	QL (180 GM per 30 days)
<i>posaconazole oral tablet,delayed release (dr/ec)</i>	5	PA; QL (96 EA per 30 days)
<i>terbinafine hcl oral</i>	2	
<i>terconazole</i>	3	
<i>voriconazole intravenous</i>	5	PA
<i>voriconazole oral suspension for reconstitution</i>	5	PA
<i>voriconazole oral tablet</i>	4	PA

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Antigout Agents					
Antigout Agents					
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1		<i>valproic acid</i>	2	
<i>colchicine oral tablet</i>	3		<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2	
<i>febuxostat</i>	3		Serotonin (5-HT) Receptor Agonist		
<i>probencid</i>	3		<i>naratriptan</i>	3	QL (18 EA per 28 days)
<i>probencid-colchicine</i>	3		<i>rizatriptan oral tablet</i>	2	QL (24 EA per 28 days)
Antimigraine Agents			<i>rizatriptan oral tablet,disintegrating</i>	3	QL (24 EA per 28 days)
Antimigraine Agents			<i>sumatriptan</i>	4	QL (18 EA per 28 days)
NURTEC ODT	3	PA; QL (16 EA per 30 days)	<i>sumatriptan succinate oral</i>	2	QL (18 EA per 28 days)
Calcitonin Gene- Related Peptide (Cgrp) Receptor Antagonists			<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	4	QL (8 ML per 28 days)
EMGALITY PEN	3	PA; QL (2 ML per 30 days)	<i>sumatriptan succinate subcutaneous pen injector</i>	4	QL (8 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	3	PA; QL (2 ML per 30 days)	<i>sumatriptan succinate subcutaneous solution</i>	4	QL (8 ML per 28 days)
NURTEC ODT	3	PA; QL (16 EA per 30 days)	Antimyasthenic Agents		
Ergot Alkaloids			Parasympathomimet ics		
<i>dihydroergotamine nasal</i>	5	QL (8 ML per 28 days)	<i>pyridostigmine bromide oral tablet 60 mg</i>	3	
<i>ergotamine-caffeine</i>	3		<i>pyridostigmine bromide oral tablet extended release</i>	3	
Prophylactic					
<i>divalproex</i>	2				
EPRONTIA	4	PAns			
<i>timolol maleate oral</i>	4				
<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	2	PAns			
<i>topiramate oral tablet</i>	2	PAns			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits			
Antimycobacteria ls								
Antimycobacterials, Other								
dapsone oral	3		ABIRTEGA	4	PAns; QL (120 EA per 30 days)			
PRIFTIN	3		bicalutamide	2				
rifabutin	4		ERLEADA ORAL TABLET 240 MG	5	PAns; QL (30 EA per 30 days)			
Antituberculars								
ethambutol	3		ERLEADA ORAL TABLET 60 MG	5	PAns; QL (120 EA per 30 days)			
isoniazid oral solution	4		EULEXIN	5				
isoniazid oral tablet	2		nilutamide	5	PAns			
PRIFTIN	3		NUBEQA	5	PAns; QL (120 EA per 30 days)			
pyrazinamide	4		toremifene	5				
rifampin intravenous	4		XTANDI ORAL CAPSULE	5	PAns; QL (120 EA per 30 days)			
rifampin oral	3		XTANDI ORAL TABLET 40 MG	5	PAns; QL (120 EA per 30 days)			
SIRTURO	5	PA	XTANDI ORAL TABLET 80 MG	5	PAns; QL (60 EA per 30 days)			
TRECATOR	4		Antiangiogenic Agents					
Antineoplastics								
Alkylating Agents								
cyclophosphamide oral	3	BvD	lenalidomide	5	PAns; QL (28 EA per 28 days)			
GLEOSTINE ORAL CAPSULE 10 MG	4		POMALYST	5	PAns; QL (21 EA per 28 days)			
GLEOSTINE ORAL CAPSULE 100 MG, 40 MG	5		REVLIMID	5	PAns; QL (28 EA per 28 days)			
LEUKERAN	5		THALOMID ORAL CAPSULE 100 MG	5	PAns; QL (112 EA per 28 days)			
MATULANE	5							
VALCHLOR	5	PAns						
Antiandrogens								
abiraterone oral tablet 250 mg	5	PAns; QL (120 EA per 30 days)						
abiraterone oral tablet 500 mg	5	PAns; QL (60 EA per 30 days)						

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
THALOMID ORAL CAPSULE 50 MG	5	PAns; QL (28 EA per 28 days)	INQOVI	5	PAns; QL (5 EA per 28 days)
Antiestrogens/Modifiers					
ORSERDU ORAL TABLET 345 MG	5	PAns; QL (30 EA per 30 days)	IWILFIN	5	PAns; QL (240 EA per 30 days)
ORSERDU ORAL TABLET 86 MG	5	PAns; QL (90 EA per 30 days)	JYLAMVO	4	BvD
SOLTAMOX	5		<i>leucovorin calcium oral</i>	3	
<i>tamoxifen</i>	2		LONSURF	5	PAns
<i>toremifene</i>	5		LUMAKRAS ORAL TABLET 240 MG	5	PAns; QL (120 EA per 30 days)
Antimetabolites					
BESREMI	5	PAns	LYNPARZA	5	PAns; QL (120 EA per 30 days)
<i>fluorouracil topical cream 5 %</i>	3		LYSODREN	5	
<i>fluorouracil topical solution</i>	3		<i>methotrexate sodium</i>	2	BvD
<i>hydroxyurea</i>	2		<i>methotrexate sodium (pf) injection solution</i>	2	BvD
<i>mercaptopurine oral suspension</i>	5		NINLARO	5	PAns; QL (3 EA per 28 days)
<i>mercaptopurine oral tablet</i>	3		OJJAARA	5	PAns; QL (30 EA per 30 days)
ONUREG	5	PAns; QL (14 EA per 28 days)	ORGOVYX	5	PAns; QL (30 EA per 28 days)
PURIXAN	5		RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	5	PAns; QL (60 EA per 30 days)
TABLOID	4		RETEVMO ORAL TABLET 40 MG	5	PAns; QL (90 EA per 30 days)
Antineoplastics, Other					
<i>hydroxyurea</i>	2		VORANIGO ORAL TABLET 10 MG	5	PAns; QL (60 EA per 30 days)
IDHIFA	5	PAns; QL (30 EA per 30 days)			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
VORANIGO ORAL TABLET 40 MG	5	PAbs; QL (30 EA per 30 days)	ALECENSA	5	PAbs; QL (240 EA per 30 days)
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)	5	PAbs	ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PAbs; QL (30 EA per 30 days)
XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)	5	PA	ALUNBRIG ORAL TABLET 30 MG	5	PAbs; QL (60 EA per 30 days)
ZOLINZA	5	PAbs; QL (120 EA per 30 days)	ALUNBRIG ORAL TABLETS,DOSE PACK	5	PAbs; QL (30 EA per 180 days)
Aromatase Inhibitors, 3Rd Generation			AUGTYRO ORAL CAPSULE 160 MG	5	PAbs; QL (60 EA per 30 days)
<i>anastrozole</i>	2		AUGTYRO ORAL CAPSULE 40 MG	5	PAbs; QL (240 EA per 30 days)
<i>exemestane</i>	4		AYVAKIT	5	PAbs; QL (30 EA per 30 days)
<i>letrozole</i>	2		BALVERSA	5	PAbs
Enzyme Inhibitors			BOSULIF ORAL CAPSULE 100 MG	5	PAbs; QL (180 EA per 30 days)
IBRANCE ORAL TABLET	5	PAbs; QL (21 EA per 28 days)	BOSULIF ORAL CAPSULE 50 MG	5	PAbs; QL (330 EA per 30 days)
TIBSOVO	5	PAbs	BOSULIF ORAL TABLET 100 MG	5	PAbs; QL (90 EA per 30 days)
Molecular Target Inhibitors			BOSULIF ORAL TABLET 400 MG, 500 MG	5	PAbs; QL (30 EA per 30 days)
AKEEGA	5	PAbs; QL (60 EA per 30 days)	BRAFTOVI	5	PAbs; QL (180 EA per 30 days)
			BRUKINSA	5	PAbs; QL (120 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
CABOMETYX	5	PAns; QL (30 EA per 30 days)	<i>dasatinib oral tablet 20 mg</i>	5	PAns; QL (90 EA per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	5	PAns; QL (60 EA per 30 days)	<i>dasatinib oral tablet 70 mg</i>	5	PAns; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG	5	PAns; QL (60 EA per 30 days)	DAURISMO ORAL TABLET 100 MG	5	PAns; QL (30 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PAns; QL (30 EA per 30 days)	DAURISMO ORAL TABLET 25 MG	5	PAns; QL (60 EA per 30 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	5	PAns; QL (56 EA per 28 days)	ERIVEDGE	5	PAns; QL (30 EA per 30 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	5	PAns; QL (112 EA per 28 days)	<i>erlotinib oral tablet 100 mg, 150 mg</i>	5	PAns; QL (30 EA per 30 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	5	PAns; QL (84 EA per 28 days)	<i>erlotinib oral tablet 25 mg</i>	5	PAns; QL (60 EA per 30 days)
COPIKTRA	5	PAns; QL (60 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet</i>	5	PAns; QL (30 EA per 30 days)
COTELLIC	5	PAns; QL (63 EA per 28 days)	<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	5	PAns; QL (330 EA per 30 days)
DANZITEN	5	PAns; QL (112 EA per 28 days)	<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	5	PAns; QL (240 EA per 30 days)
<i>dasatinib oral tablet 100 mg, 50 mg, 80 mg</i>	5	PAns; QL (30 EA per 30 days)	<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	5	PAns; QL (180 EA per 30 days)
<i>dasatinib oral tablet 140 mg</i>	5	PA; QL (30 EA per 30 days)	<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	3	BvD

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg	5	BvD	<i>imatinib oral tablet 100 mg</i>	5	PAns; QL (180 EA per 30 days)
FOTIVDA	5	PAns; QL (21 EA per 28 days)	<i>imatinib oral tablet 400 mg</i>	5	PAns; QL (60 EA per 30 days)
FRUZAQLA ORAL CAPSULE 1 MG	5	PAns; QL (84 EA per 28 days)	IMBRUVICA ORAL CAPSULE 140 MG	5	PAns; QL (120 EA per 30 days)
FRUZAQLA ORAL CAPSULE 5 MG	5	PAns; QL (21 EA per 28 days)	IMBRUVICA ORAL CAPSULE 70 MG	5	PAns; QL (30 EA per 30 days)
GAVRETO	5	PAns; QL (120 EA per 30 days)	IMBRUVICA ORAL SUSPENSION	5	PAns; QL (324 ML per 30 days)
gefitinib	5	PAns; QL (30 EA per 30 days)	IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PAns; QL (30 EA per 30 days)
GILOTRIF	5	PAns; QL (30 EA per 30 days)	IMKELDI	5	PAns; QL (280 ML per 28 days)
GOMEKLI ORAL CAPSULE 1 MG	5	PAns; QL (126 EA per 28 days)	INLYTA ORAL TABLET 1 MG	5	PAns; QL (180 EA per 30 days)
GOMEKLI ORAL CAPSULE 2 MG	5	PAns; QL (84 EA per 28 days)	INLYTA ORAL TABLET 5 MG	5	PAns; QL (120 EA per 30 days)
GOMEKLI ORAL TABLET FOR SUSPENSION	5	PAns; QL (168 EA per 28 days)	INREBIC	5	PAns; QL (120 EA per 30 days)
IBRANCE	5	PAns; QL (21 EA per 28 days)	ITOVEBI ORAL TABLET 3 MG	5	PAns; QL (60 EA per 30 days)
ICLUSIG	5	PAns; QL (30 EA per 30 days)	ITOVEBI ORAL TABLET 9 MG	5	PAns; QL (30 EA per 30 days)
IDHIFA	5	PAns; QL (30 EA per 30 days)	JAKAFI	5	PAns; QL (60 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
JAYPIRCA ORAL TABLET 100 MG	5	PAns; QL (60 EA per 30 days)	LENVIMA ORAL CAPSULE 14 MG/DAY(10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	5	PAns; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 50 MG	5	PAns; QL (30 EA per 30 days)	LORBRENA ORAL TABLET 100 MG	5	PAns; QL (30 EA per 30 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PAns; QL (21 EA per 28 days)	LORBRENA ORAL TABLET 25 MG	5	PAns; QL (90 EA per 30 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PAns; QL (42 EA per 28 days)	LUMAKRAS ORAL TABLET 120 MG	5	PAns; QL (240 EA per 30 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PAns; QL (63 EA per 28 days)	LUMAKRAS ORAL TABLET 240 MG	5	PAns; QL (120 EA per 30 days)
KOSELUGO	5	PAns	LUMAKRAS ORAL TABLET 320 MG	5	PAns; QL (90 EA per 30 days)
KRAZATI	5	PAns; QL (180 EA per 30 days)	LYNPARZA	5	PAns; QL (120 EA per 30 days)
lapatinib	5	PAns; QL (180 EA per 30 days)	LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	5	PAns; QL (84 EA per 28 days)
LAZCLUZE ORAL TABLET 240 MG	5	PAns; QL (30 EA per 30 days)	LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	5	PAns; QL (112 EA per 28 days)
LAZCLUZE ORAL TABLET 80 MG	5	PAns; QL (60 EA per 30 days)	LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	5	PAns; QL (140 EA per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	5	PAns; QL (30 EA per 30 days)	MEKINIST ORAL RECON SOLN	5	PAns; QL (1260 ML per 30 days)
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1)	5	PAns; QL (90 EA per 30 days)	MEKINIST ORAL TABLET 0.5 MG	5	PAns; QL (90 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
MEKINIST ORAL TABLET 2 MG	5	PAbs; QL (30 EA per 30 days)	PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	5	PAbs; QL (56 EA per 28 days)
MEKTOVI	5	PAbs; QL (180 EA per 30 days)	QINLOCK	5	PAbs; QL (90 EA per 30 days)
NERLYNX	5	PAbs	RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	5	PAbs; QL (60 EA per 30 days)
NINLARO	5	PAbs; QL (3 EA per 28 days)	RETEVMO ORAL TABLET 40 MG	5	PAbs; QL (90 EA per 30 days)
ODOMZO	5	PAbs; QL (30 EA per 30 days)	REVUFORJ ORAL TABLET 110 MG, 160 MG	5	PAbs; QL (60 EA per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	5	PAbs; QL (96 ML per 28 days)	REVUFORJ ORAL TABLET 25 MG	5	PAbs; QL (240 EA per 30 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	5	PAbs; QL (16 EA per 28 days)	REZLIDHIA	5	PAbs; QL (60 EA per 30 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	5	PAbs; QL (20 EA per 28 days)	REZUROCK	5	PA; QL (30 EA per 30 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	5	PAbs; QL (24 EA per 28 days)	ROMVIMZA	5	PAbs; QL (8 EA per 28 days)
OJJAARA	5	PAbs; QL (30 EA per 30 days)	ROZLYTREK ORAL CAPSULE 100 MG	5	PAbs; QL (150 EA per 30 days)
pazopanib	5	PAbs; QL (120 EA per 30 days)	ROZLYTREK ORAL CAPSULE 200 MG	5	PAbs; QL (90 EA per 30 days)
PEMAZYRE	5	PAbs; QL (28 EA per 28 days)	ROZLYTREK ORAL PELLETS IN PACKET	5	PAbs; QL (336 EA per 28 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PAbs; QL (28 EA per 28 days)	RUBRACA	5	PAbs; QL (120 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
RYDAPT	5	PAns; QL (224 EA per 28 days)	TALZENNA	5	PAns; QL (30 EA per 30 days)
SCEMBLIX ORAL TABLET 100 MG	5	PAns; QL (120 EA per 30 days)	TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PAns; QL (112 EA per 28 days)
SCEMBLIX ORAL TABLET 20 MG	5	PAns; QL (600 EA per 30 days)	TASIGNA ORAL CAPSULE 50 MG	5	PAns; QL (120 EA per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5	PAns; QL (300 EA per 30 days)	TAZVERIK	5	PAns
<i>sorafenib</i>	5	PAns; QL (120 EA per 30 days)	TEPMETKO	5	PAns
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	5	PAns; QL (30 EA per 30 days)	TIBSOVO	5	PAns
SPRYCEL ORAL TABLET 20 MG	5	PAns; QL (90 EA per 30 days)	TORPENZ	5	PAns; QL (30 EA per 30 days)
SPRYCEL ORAL TABLET 70 MG	5	PAns; QL (60 EA per 30 days)	TRUQAP	5	PAns; QL (64 EA per 28 days)
STIVARGA	5	PAns; QL (84 EA per 28 days)	TUKYSA ORAL TABLET 150 MG	5	PAns; QL (120 EA per 30 days)
<i>sunitinib malate</i>	5	PAns; QL (30 EA per 30 days)	TUKYSA ORAL TABLET 50 MG	5	PAns; QL (300 EA per 30 days)
TABRECTA	5	PAns	TURALIO ORAL CAPSULE 125 MG	5	PAns; QL (120 EA per 30 days)
TAFINLAR ORAL CAPSULE	5	PAns; QL (120 EA per 30 days)	VANFLYTA	5	PAns; QL (56 EA per 28 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	5	PAns; QL (840 EA per 28 days)	VENCLEXTA ORAL TABLET 10 MG	3	PAns; QL (60 EA per 30 days)
TAGRISSO	5	PAns; QL (30 EA per 30 days)	VENCLEXTA ORAL TABLET 100 MG	5	PAns; QL (180 EA per 30 days)
			VENCLEXTA ORAL TABLET 50 MG	5	PAns; QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
VENCLEXTA STARTING PACK	5	PAns; QL (42 EA per 180 days)	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)	5	PAns
VERZENIO	5	PAns; QL (60 EA per 30 days)	XPOVIO ORAL TABLET 40 MG/WEEK (10 MG X 4)	5	PA
VITRAKVI ORAL CAPSULE 100 MG	5	PAns; QL (60 EA per 30 days)	ZEJULA ORAL TABLET	5	PAns; QL (30 EA per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PAns; QL (180 EA per 30 days)	ZELBORAF	5	PAns; QL (240 EA per 30 days)
VITRAKVI ORAL SOLUTION	5	PAns; QL (300 ML per 30 days)	ZYDELIG	5	PAns; QL (60 EA per 30 days)
VIZIMPRO	5	PAns; QL (30 EA per 30 days)	ZYKADIA	5	PAns; QL (90 EA per 30 days)
VONJO	5	PAns; QL (120 EA per 30 days)	Retinoids		
WELIREG	5	PAns	<i>bexarotene</i>	5	PAns
XALKORI ORAL CAPSULE	5	PAns; QL (60 EA per 30 days)	PANRETIN	5	PAns
XALKORI ORAL PELLET 150 MG	5	PAns; QL (180 EA per 30 days)	<i>tretinoin</i> (antineoplastic)	5	
XALKORI ORAL PELLET 20 MG, 50 MG	5	PAns; QL (120 EA per 30 days)	Treatment Adjuncts		
XOSPATA	5	PAns; QL (90 EA per 30 days)	<i>leucovorin calcium oral</i>	3	
			<i>mesna oral</i>	5	
			MESNEX ORAL	5	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Antiparasitics					
Anthelmintics					
<i>albendazole</i>	5		<i>carbidopa</i>	4	
<i>EMVERM</i>	5		<i>carbidopa-levodopa-entacapone</i>	4	
<i>ivermectin oral tablet 3 mg</i>	3	PA; QL (20 EA per 30 days)	<i>entacapone</i>	4	
<i>praziquantel</i>	4		Dopamine Agonists		
Antiprotozoals					
<i>atovaquone</i>	4		<i>bromocriptine</i>	4	
<i>atovaquone-proguanil</i>	4		<i>NEUPRO</i>	4	
<i>chloroquine phosphate</i>	4		<i>pramipexole oral tablet</i>	2	
<i>COARTEM</i>	4		<i>ropinirole oral tablet</i>	2	
<i>hydroxychloroquine oral tablet 200 mg</i>	2		Dopamine Precursors And/Or L-Amino Acid Decarboxylase Inhibitors		
<i>mefloquine</i>	2		<i>carbidopa</i>	4	
<i>nitazoxanide</i>	5	QL (12 EA per 30 days)	<i>carbidopa-levodopa oral tablet</i>	2	
<i>pentamidine inhalation</i>	4	BvD; QL (1 EA per 28 days)	<i>carbidopa-levodopa oral tablet extended release</i>	2	
<i>pentamidine injection</i>	4		<i>carbidopa-levodopa oral tablet,disintegrating</i>	4	
<i>primaquine</i>	4		<i>INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE</i>	5	PA; QL (300 EA per 30 days)
<i>pyrimethamine</i>	5	PA	Monoamine Oxidase B (Mao-B) Inhibitors		
<i>quinine sulfate</i>	4		<i>rasagiline</i>	4	
Antiparkinson Agents			<i>selegiline hcl</i>	3	
Anticholinergics			Antipsychotics		
<i>benztropine oral</i>	2	PA	1St Generation/Typical		
<i>trihexyphenidyl oral tablet</i>	1		<i>chlorpromazine oral</i>	4	
Antiparkinson Agents, Other			<i>fluphenazine decanoate</i>	4	
<i>amantadine hcl oral capsule</i>	3				
<i>amantadine hcl oral solution</i>	3				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>fluphenazine hcl</i>	4		ARISTADA INITIO	5	QL (4.8 ML per 365 days)
<i>haloperidol</i>	2		ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	5	QL (3.9 ML per 56 days)
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml</i>	4		ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	5	QL (1.6 ML per 28 days)
<i>haloperidol lactate injection</i>	4		ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	5	QL (2.4 ML per 28 days)
<i>haloperidol lactate oral</i>	2		ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	5	QL (3.2 ML per 28 days)
<i>lozapine succinate</i>	2		<i>asenapine maleate</i>	4	QL (60 EA per 30 days)
<i>molindone</i>	4		CAPLYTA	4	QL (30 EA per 30 days)
<i>perphenazine</i>	4		COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG	4	QL (60 EA per 30 days)
<i>pimozide</i>	4		COBENFY ORAL CAPSULE 50-20 MG	4	
<i>prochlorperazine maleate</i>	2		COBENFY STARTER PACK	4	QL (56 EA per 180 days)
<i>thioridazine</i>	3		FANAPT ORAL TABLET	4	QL (60 EA per 30 days)
<i>thiothixene</i>	4		FANAPT ORAL TABLETS,DOSE PACK	4	QL (8 EA per 180 days)
<i>trifluoperazine</i>	3				
2Nd Generation/Atypical					
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	5	QL (2.4 ML per 56 days)			
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	5	QL (3.2 ML per 56 days)			
ABILIFY MAINTENA	5	QL (1 EA per 28 days)			
<i>ariPIPRAZOLE oral solution</i>	4				
<i>ariPIPRAZOLE oral tablet</i>	3	QL (30 EA per 30 days)			
<i>ariPIPRAZOLE oral tablet,disintegrating</i>	4	QL (60 EA per 30 days)			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5	QL (3.5 ML per 180 days)	INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5	QL (2.63 ML per 90 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5	QL (5 ML per 180 days)	<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	4	QL (30 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	QL (0.75 ML per 28 days)	<i>lurasidone oral tablet 80 mg</i>	4	QL (60 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	QL (1 ML per 28 days)	NUPLAZID	4	PAns; QL (30 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	QL (1.5 ML per 28 days)	<i>olanzapine intramuscular</i>	4	
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	QL (0.25 ML per 28 days)	<i>olanzapine oral tablet</i>	2	QL (30 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	QL (0.5 ML per 28 days)	<i>olanzapine oral tablet,disintegrating</i>	4	QL (30 EA per 30 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5	QL (0.88 ML per 90 days)	<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	4	QL (30 EA per 30 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5	QL (1.32 ML per 90 days)	<i>paliperidone oral tablet extended release 24hr 6 mg</i>	4	QL (60 EA per 30 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	QL (1.75 ML per 90 days)	<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	QL (90 EA per 30 days)
			<i>quetiapine oral tablet 300 mg, 400 mg</i>	2	QL (60 EA per 30 days)
			<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	4	QL (30 EA per 30 days)
			<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	4	QL (60 EA per 30 days)
			REXULTI ORAL TABLET	4	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml</i>	3	QL (2 EA per 28 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML	5	QL (0.42 ML per 56 days)
<i>risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml</i>	5	QL (2 EA per 28 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML	5	QL (0.56 ML per 56 days)
<i>risperidone oral solution</i>	2		UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML	5	QL (0.7 ML per 56 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	QL (60 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML	5	QL (0.14 ML per 28 days)
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	4	QL (60 EA per 30 days)	UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML	5	QL (0.21 ML per 28 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	4	QL (120 EA per 30 days)	VRAYLAR ORAL CAPSULE	4	QL (30 EA per 30 days)
<i>SECUADO</i>	5	QL (30 EA per 30 days)	<i>ziprasidone hcl</i>	4	QL (60 EA per 30 days)
<i>UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML</i>	5	QL (0.28 ML per 28 days)	<i>ziprasidone mesylate</i>	4	
<i>UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML</i>	5	QL (0.35 ML per 28 days)	Treatment-Resistant		
			<i>clozapine oral tablet</i>	3	
			<i>clozapine oral tablet,disintegrating</i>	4	
			<i>VERSACLOZ</i>	5	
Antispasticity Agents					
Antispasticity Agents					
			<i>baclofen oral tablet</i>	2	

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<i>dantrolene oral</i>	4		Mavyret Oral Tablet	5	PA; QL (84 EA per 28 days)
<i>tizanidine oral tablet</i>	2		<i>ribavirin oral capsule</i>	3	
Antivirals					
Anti-Cytomegalovirus (Cmv) Agents					
LIVTENCITY	5	PA; QL (120 EA per 30 days)	<i>sofosbuvir-velpatasvir</i>	5	PA; QL (28 EA per 28 days)
PREVYMIS ORAL TABLET	5	PA; QL (30 EA per 30 days)	VOSEVI	5	PA; QL (28 EA per 28 days)
<i>valganciclovir oral recon soln</i>	5		Antiherpetic Agents		
<i>valganciclovir oral tablet</i>	3		<i>acyclovir oral capsule</i>	2	
Anti-Hepatitis B (Hbv) Agents			<i>acyclovir oral suspension 200 mg/5 ml</i>	4	
<i>adefovir</i>	4		<i>acyclovir oral tablet</i>	2	
BARACLUDE ORAL SOLUTION	5		<i>acyclovir sodium intravenous solution</i>	4	BvD
<i>entecavir</i>	4		<i>famciclovir</i>	3	
<i>lamivudine</i>	3		<i>trifluridine</i>	3	
<i>tenofovir disoproxil fumarate</i>	4		<i>valacyclovir oral tablet 1 gram</i>	3	QL (120 EA per 30 days)
VEMLIDY	5		<i>valacyclovir oral tablet 500 mg</i>	3	QL (60 EA per 30 days)
VIREAD ORAL POWDER	5		Anti-Hiv Agents, Integrase Inhibitors (Insti)		
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	4		BIKTARVY	5	
Anti-Hepatitis C (Hcv) Agents			DOVATO	5	
<i>ledipasvir-sofosbuvir</i>	5	PA; QL (28 EA per 28 days)	GENVOYA	5	
MAVYRET ORAL PELLETS IN PACKET	5	PA; QL (168 EA per 28 days)	ISENTRESS HD	5	
			ISENTRESS ORAL POWDER IN PACKET	5	
			ISENTRESS ORAL TABLET	5	
			ISENTRESS ORAL TABLET,CHEWABLE 100 MG	5	

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ISENTRESS ORAL TABLET,CHEWABLE 25 MG	3		Anti-Hiv Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors (Nrti)		
JULUCA	5		<i>abacavir</i>	3	
STRIBILD	5		<i>abacavir-lamivudine</i>	3	
SYMTUZA	5		CIMDUO	5	
TIVICAY ORAL TABLET 50 MG	5		DELSTRIGO	5	
TIVICAY PD	5		DESCOVY	5	
Anti-Hiv Agents, Non-Nucleoside Reverse Transcriptase Inhibitors (Nnrti)			<i>efavirenz-emtricitabin-tenofovir</i>	5	
COMPLERA	5		<i>efavirenz-lamivu-tenofov disop</i>	5	
DELSTRIGO	5		<i>emtricitabine</i>	4	
EDURANT	5		<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg</i>	5	
<i>efavirenz oral tablet</i>	4		<i>emtricitabine-tenofovir (tdf) oral tablet 133-200 mg, 167-250 mg, 200-300 mg</i>	4	
<i>efavirenz-emtricitabin-tenofov</i>	5		EMTRIVA ORAL SOLUTION	3	
<i>efavirenz-lamivu-tenofov disop</i>	5		JULUCA	5	
<i>etravirine</i>	5		<i>lamivudine</i>	3	
INTELENCE ORAL TABLET 25 MG	4		<i>lamivudine-zidovudine</i>	3	
<i>nevirapine oral suspension</i>	4		ODEFSEY	5	
<i>nevirapine oral tablet</i>	3		<i>tenofovir disoproxil fumarate</i>	4	
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	4		TRIUMEQ	5	
PIFELTRO	5		TRIUMEQ PD	4	
			VIREAD ORAL POWDER	5	
			VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	4	

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Drug Name	Drug Tier	Requirements/ Limits
<i>zidovudine oral capsule</i>	4	
<i>zidovudine oral syrup</i>	4	
<i>zidovudine oral tablet</i>	2	
Anti-Hiv Agents, Other		
FUZEON SUBCUTANEOUS RECON SOLN	5	
<i>maraviroc</i>	5	
RUKOBIA	5	
SELZENTRY ORAL SOLUTION	3	
SUNLENCA ORAL TABLET 300 MG	5	
TRIUMEQ	5	
TRIUMEQ PD	4	
Anti-Hiv Agents, Protease Inhibitors (Pi)		
APTIVUS	5	
<i>atazanavir</i>	4	
<i>darunavir</i>	5	
EVOTAZ	5	
<i>fosamprenavir</i>	4	
<i>lopinavir-ritonavir oral tablet</i>	3	
NORVIR ORAL POWDER IN PACKET	4	
PREZCOBIX	5	
PREZISTA ORAL SUSPENSION	5	
PREZISTA ORAL TABLET 150 MG, 75 MG	4	
REYATAZ ORAL POWDER IN PACKET	5	

Drug Name	Drug Tier	Requirements/ Limits
<i>ritonavir</i>	3	
SYMTUZA	5	
VIRACEPT ORAL TABLET	5	
Anti-Influenza Agents		
<i>amantadine hcl oral capsule</i>	3	
<i>amantadine hcl oral solution</i>	3	
<i>oseltamivir</i>	3	
RELENZA DISKHALER	4	
<i>rimantadine</i>	4	
Antiviral, Coronavirus Agents		
LAGEVRIO (EUA)	2	QL (40 EA per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)- 100 MG (10)	2	QL (20 EA per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	2	QL (30 EA per 30 days)
Antivirals		
LAGEVRIO (EUA)	2	QL (40 EA per 30 days)
Anxiolytics		
Anxiolytics, Other		
<i>buspirone</i>	2	
<i>doxepin oral capsule</i>	4	
<i>doxepin oral concentrate</i>	4	
<i>doxepin oral tablet</i>	3	QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>hydroxyzine hcl oral tablet</i>	2	PA	<i>lorazepam oral tablet 2 mg</i>	2	PA; QL (150 EA per 30 days)
Benzodiazepines					
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	QL (90 EA per 30 days)	NAYZILAM	3	PAns; QL (10 EA per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 EA per 30 days)	VALTOCO	3	PAns; QL (10 EA per 30 days)
<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	4	QL (90 EA per 30 days)	Ssris/Snris (Selective Serotonin Reuptake Inhibitors/Serotonin And Norepinephrine Reuptake Inhibitors)		
<i>clonazepam oral tablet,disintegrating 2 mg</i>	4	QL (300 EA per 30 days)	DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	4	QL (60 EA per 30 days)
<i>clorazepate dipotassium oral tablet 15 mg</i>	4	PAns; QL (180 EA per 30 days)	DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	4	QL (90 EA per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	4	PAns; QL (90 EA per 30 days)	<i>duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	QL (60 EA per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	4	PAns; QL (360 EA per 30 days)	<i>escitalopram oxalate oral solution</i>	4	
DIAZEPAM INTENSOL	2	PAns; QL (240 ML per 30 days)	<i>escitalopram oxalate oral tablet</i>	2	QL (30 EA per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	PAns; QL (1200 ML per 30 days)	<i>paroxetine hcl oral suspension</i>	4	
<i>diazepam oral tablet</i>	2	PAns; QL (120 EA per 30 days)	<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	QL (30 EA per 30 days)
<i>diazepam rectal</i>	4		<i>paroxetine hcl oral tablet 30 mg</i>	2	QL (60 EA per 30 days)
LORAZEPAM INTENSOL	2	PA; QL (150 ML per 30 days)			
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	2	PA; QL (90 EA per 30 days)			

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<i>sertraline oral concentrate</i>	4		<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	4	QL (30 EA per 30 days)
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	QL (60 EA per 30 days)	<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	4	QL (60 EA per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	QL (30 EA per 30 days)	<i>risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml</i>	3	QL (2 EA per 28 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	2	QL (30 EA per 30 days)	<i>risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml</i>	5	QL (2 EA per 28 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	2	QL (90 EA per 30 days)	<i>risperidone oral solution</i>	2	
<i>venlafaxine oral tablet</i>	2	QL (90 EA per 30 days)	<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	QL (60 EA per 30 days)
Bipolar Agents			<i>risperidone oral tablet 4 mg</i>	1	QL (120 EA per 30 days)
Bipolar Agents, Other			<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	4	QL (60 EA per 30 days)
<i>asenapine maleate</i>	4	QL (60 EA per 30 days)	<i>risperidone oral tablet,disintegrating 4 mg</i>	4	QL (120 EA per 30 days)
<i>lamotrigine oral tablet 25 mg</i>	1		<i>SECUADO</i>	5	QL (30 EA per 30 days)
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	4	QL (30 EA per 30 days)	<i>ziprasidone hcl</i>	4	QL (60 EA per 30 days)
<i>lurasidone oral tablet 80 mg</i>	4	QL (60 EA per 30 days)	<i>ziprasidone mesylate</i>	4	
<i>olanzapine intramuscular</i>	4				
<i>olanzapine oral tablet</i>	2	QL (30 EA per 30 days)			
<i>olanzapine oral tablet,disintegrating</i>	4	QL (30 EA per 30 days)			
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	QL (90 EA per 30 days)			
<i>quetiapine oral tablet 300 mg, 400 mg</i>	2	QL (60 EA per 30 days)			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Mood Stabilizers					
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	4		FARXIGA ORAL TABLET 10 MG	3	QL (30 EA per 30 days)
<i>carbamazepine oral suspension 100 mg/5 ml</i>	4		FARXIGA ORAL TABLET 5 MG	3	QL (60 EA per 30 days)
<i>carbamazepine oral tablet</i>	3		<i>glimepiride oral tablet 1 mg</i>	1	QL (240 EA per 30 days)
<i>carbamazepine oral tablet extended release 12 hr 100 mg</i>	4		<i>glimepiride oral tablet 2 mg</i>	1	QL (120 EA per 30 days)
<i>carbamazepine oral tablet, chewable 100 mg</i>	3		<i>glimepiride oral tablet 4 mg</i>	1	QL (60 EA per 30 days)
<i>divalproex</i>	2		<i>glipizide oral tablet 10 mg</i>	1	QL (120 EA per 30 days)
EPITOL	3		<i>glipizide oral tablet 5 mg</i>	1	QL (240 EA per 30 days)
<i>lamotrigine oral tablet</i>	1		<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	QL (60 EA per 30 days)
<i>lamotrigine oral tablet, chewable dispersible</i>	2		<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	1	QL (240 EA per 30 days)
<i>lamotrigine oral tablet, disintegrating</i>	4		<i>glipizide oral tablet extended release 24hr 5 mg</i>	1	QL (120 EA per 30 days)
<i>lithium carbonate</i>	2		<i>glipizide-metformin oral tablet 2.5-250 mg</i>	1	QL (240 EA per 30 days)
<i>lithium citrate</i>	2		<i>glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1	QL (120 EA per 30 days)
SUBVENITE	1		GVOKE	3	
<i>valproic acid</i>	2		JANUMET	3	QL (60 EA per 30 days)
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2		JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	QL (30 EA per 30 days)
Blood Glucose Regulators					
Antidiabetic Agents					
<i>acarbose oral tablet 100 mg</i>	2	QL (90 EA per 30 days)			
<i>acarbose oral tablet 25 mg</i>	2	QL (360 EA per 30 days)			
<i>acarbose oral tablet 50 mg</i>	2	QL (180 EA per 30 days)			
<i>colesevelam</i>	4				

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JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	QL (60 EA per 30 days)	OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	PA; QL (3 ML per 28 days)
JANUVIA	3	QL (30 EA per 30 days)	<i>pioglitazone</i>	1	QL (30 EA per 30 days)
JARDIANCE	3	QL (30 EA per 30 days)	<i>repaglinide oral tablet 0.5 mg</i>	2	QL (960 EA per 30 days)
JENTADUETO	3	QL (60 EA per 30 days)	<i>repaglinide oral tablet 1 mg</i>	2	QL (480 EA per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	QL (60 EA per 30 days)	<i>repaglinide oral tablet 2 mg</i>	2	QL (240 EA per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	QL (30 EA per 30 days)	<i>saxagliptin</i>	3	QL (30 EA per 30 days)
<i>metformin oral tablet 1,000 mg</i>	1	QL (75 EA per 30 days)	<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	3	QL (60 EA per 30 days)
<i>metformin oral tablet 500 mg</i>	1	QL (150 EA per 30 days)	<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	3	QL (30 EA per 30 days)
<i>metformin oral tablet 850 mg</i>	1	QL (90 EA per 30 days)	SOLIQUA 100/33	3	QL (90 ML per 30 days)
<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	QL (120 EA per 30 days)	SYNJARDY	3	QL (60 EA per 30 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	QL (60 EA per 30 days)	SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (30 EA per 30 days)
MOUNJARO	3	PA; QL (2 ML per 28 days)	SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (60 EA per 30 days)
<i>nateglinide oral tablet 120 mg</i>	2	QL (90 EA per 30 days)			
<i>nateglinide oral tablet 60 mg</i>	2	QL (180 EA per 30 days)			

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
TRADJENTA	3	QL (30 EA per 30 days)	HUMALOG KWIKPEN INSULIN	3	
TRULICITY	3	PA; QL (2 ML per 28 days)	HUMALOG MIX 50-50 KWIKPEN	3	
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	QL (30 EA per 30 days)	HUMALOG MIX 75-25 KWIKPEN	3	
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	3	QL (60 EA per 30 days)	HUMALOG MIX 75-25(U-100)INSULN	3	
Blood Glucose Regulators			HUMALOG U-100 INSULIN	3	
ALCOHOL PADS	3	PA	HUMULIN 70/30 U-100 INSULIN	3	
GVOKE	3		HUMULIN 70/30 U-100 KWIKPEN	3	
<i>mifepristone oral tablet 300 mg</i>	5	PA	HUMULIN N NPH INSULIN KWIKPEN	3	
Glycemic Agents			HUMULIN N NPH U-100 INSULIN	3	
<i>diazoxide</i>	5		HUMULIN R REGULAR U-100 INSULIN	3	
GVOKE	3		HUMULIN R U-500 (CONC) INSULIN	3	
GVOKE HYPOPEN 2-PACK	3		HUMULIN R U-500 (CONC) KWIKPEN	3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	3		<i>insulin lispro subcutaneous solution</i>	3	
<i>mifepristone oral tablet 300 mg</i>	5	PA	<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	3	PA
Insulins			LANTUS SOLOSTAR U-100 INSULIN	3	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	3	PA	LANTUS U-100 INSULIN	3	
HUMALOG JUNIOR KWIKPEN U-100	3		LYUMJEV KWIKPEN U-100 INSULIN	3	
			LYUMJEV KWIKPEN U-200 INSULIN	3	

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Drug Name	Drug Tier	Requirements/ Limits
LYUMJEV U-100 INSULIN	3	
pen needle, diabetic needle 29 gauge x 1/2"	3	PA
SOLIQUA 100/33	3	QL (90 ML per 30 days)
TOUJEO MAX U-300 SOLOSTAR	3	
TOUJEO SOLOSTAR U-300 INSULIN	3	
Blood Products And Modifiers		
Anticoagulants		
dabigatran etexilate	4	QL (60 EA per 30 days)
ELIQUIS	3	QL (60 EA per 30 days)
ELIQUIS DVT-PE TREAT 30D START	3	QL (74 EA per 180 days)
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	4	QL (28 ML per 28 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	4	QL (22.4 ML per 28 days)
enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml	4	QL (16.8 ML per 28 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	4	QL (11.2 ML per 28 days)
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	4	

Drug Name	Drug Tier	Requirements/ Limits
heparin (porcine) injection solution	3	
JANTOVEN	1	
rivaroxaban	3	QL (60 EA per 30 days)
warfarin	1	
XARELTO DVT-PE TREAT 30D START	3	QL (51 EA per 180 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	3	QL (775 ML per 28 days)
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	3	QL (30 EA per 30 days)
XARELTO ORAL TABLET 2.5 MG	3	QL (60 EA per 30 days)
Blood Products And Modifiers		
PROMACTA	5	PA
Blood Products And Modifiers, Other		
anagrelide	3	
NIVESTYM	5	PA
NYVEPRIA	5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	5	PA
PROMACTA	5	PA

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Drug Name	Drug Tier	Requirements/ Limits
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	5	PA
Hemostasis Agents		
<i>tranexamic acid oral</i>	3	
Platelet Modifying Agents		
<i>aspirin-dipyridamole</i>	4	
BRILINTA	3	
CABLIVI INJECTION KIT	5	PA
<i>cilostazol</i>	2	
<i>clopidogrel oral tablet 75 mg</i>	1	QL (30 EA per 30 days)
<i>dipyridamole oral</i>	4	
DOPTELET (10 TAB PACK)	5	PA
DOPTELET (15 TAB PACK)	5	PA
DOPTELET (30 TAB PACK)	5	PA
<i>prasugrel hcl</i>	3	
Cardiovascular Agents		
Alpha-Adrenergic Agonists		
<i>clonidine</i>	4	QL (4 EA per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
<i>clonidine hcl oral tablet</i>	1	
<i>droxidopa</i>	5	PA
<i>midodrine</i>	3	
Alpha-Adrenergic Blocking Agents		
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	2	QL (30 EA per 30 days)
<i>doxazosin oral tablet 8 mg</i>	2	QL (60 EA per 30 days)
<i>prazosin</i>	2	
<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	QL (30 EA per 30 days)
<i>terazosin oral capsule 10 mg</i>	1	QL (60 EA per 30 days)
Angiotensin II Receptor Antagonists		
<i>candesartan</i>	1	
<i>irbesartan</i>	1	
<i>losartan</i>	1	
<i>olmesartan</i>	1	
<i>telmisartan</i>	1	
<i>valsartan oral tablet</i>	1	
Angiotensin- Converting Enzyme (ACE) Inhibitors		
<i>benazepril</i>	1	
<i>captopril</i>	1	
<i>enalapril maleate oral tablet</i>	1	
<i>fosinopril</i>	1	
<i>lisinopril</i>	1	
<i>moexipril</i>	1	
<i>perindopril erbumine</i>	1	
<i>quinapril</i>	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>ramipril</i>	1		<i>propafenone oral capsule,extended release 12 hr</i>	4	
<i>trandolapril</i>	1		<i>propafenone oral tablet</i>	3	
Antiarrhythmics					
<i>acebutolol</i>	2		<i>propranolol oral capsule,extended release 24 hr 120 mg</i>	2	
<i>amiodarone oral tablet 100 mg, 400 mg</i>	4		<i>quinidine sulfate oral tablet</i>	2	
<i>amiodarone oral tablet 200 mg</i>	2		<i>SOTALOL AF</i>	2	
<i>CARTIA XT</i>	2		<i>sotalol oral</i>	2	
<i>digoxin oral solution</i>	3		<i>TIADYLT ER</i>	2	
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	2		<i>verapamil oral capsule, 24 hr er pellet ct</i>	2	
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	2		<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	2	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	2		<i>verapamil oral tablet</i>	1	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	2		<i>verapamil oral tablet extended release</i>	2	
<i>diltiazem hcl oral tablet</i>	2		Beta-Adrenergic Blocking Agents		
<i>diltiazem hcl oral tablet extended release 24 hr</i>	2		<i>acebutolol</i>	2	
<i>DILT-XR</i>	2		<i>atenolol</i>	1	
<i>dofetilide</i>	4		<i>betaxolol oral</i>	3	
<i>flecainide</i>	3		<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	2	
<i>MATZIM LA</i>	2		<i>carvedilol</i>	1	
<i>mexiletine</i>	3		<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	2	
<i>PACERONE ORAL TABLET 100 MG, 400 MG</i>	4		<i>metoprolol succinate</i>	1	
<i>PACERONE ORAL TABLET 200 MG</i>	2		<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	

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Drug Name	Drug Tier	Requirements/ Limits
<i>propranolol oral capsule, extended release 24 hr</i>	2	
<i>propranolol oral solution</i>	2	
<i>propranolol oral tablet</i>	1	
<i>timolol maleate oral</i>	4	
Calcium Channel Blocking Agents, Dihydropyridines		
<i>amlodipine</i>	1	
<i>felodipine</i>	2	
<i>nicardipine oral</i>	4	
<i>nifedipine oral tablet extended release</i>	2	
<i>nifedipine oral tablet extended release 24hr</i>	2	
<i>nimodipine oral capsule</i>	4	
Calcium Channel Blocking Agents, Nondihydropyridine s		
<i>CARTIA XT</i>	2	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	2	
<i>diltiazem hcl oral capsule, extended release 24 hr 360 mg, 420 mg</i>	2	
<i>diltiazem hcl oral capsule, extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	2	
<i>diltiazem hcl oral tablet</i>	2	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	2	
<i>DILT-XR</i>	2	

Drug Name	Drug Tier	Requirements/ Limits
<i>MATZIM LA</i>	2	
<i>TIADYLT ER</i>	2	
<i>verapamil oral capsule, 24 hr er pellet ct</i>	2	
<i>verapamil oral capsule, ext rel. pellets 24 hr</i>	2	
<i>verapamil oral tablet</i>	1	
<i>verapamil oral tablet extended release</i>	2	
Cardiovascular Agents, Other		
<i>acetazolamide oral tablet</i>	3	
<i>aliskiren</i>	4	
<i>amiloride-hydrochlorothiazide</i>	2	
<i>amlodipine-benazepril</i>	1	
<i>amlodipine-olmesartan</i>	1	
<i>amlodipine-valsartan</i>	1	
<i>amlodipine-valsartan-hcthiazid</i>	2	
<i>atenolol-chlorthalidone</i>	1	
<i>benazepril-hydrochlorothiazide</i>	1	
<i>bisoprolol-hydrochlorothiazide</i>	1	
<i>CAMZYOS</i>	5	PA; QL (30 EA per 30 days)
<i>candesartan-hydrochlorothiazid</i>	2	
<i>digoxin oral solution</i>	3	
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	2	
<i>enalapril-hydrochlorothiazide</i>	1	

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Drug Name	Drug Tier	Requirements/ Limits
ENTRESTO	3	QL (60 EA per 30 days)
ENTRESTO SPRINKLE	3	QL (240 EA per 30 days)
<i>fosinopril-hydrochlorothiazide</i>	1	
<i>irbesartan-hydrochlorothiazide</i>	1	
<i>ivabradine</i>	3	QL (60 EA per 30 days)
<i>lisinopril-hydrochlorothiazide</i>	1	
<i>losartan-hydrochlorothiazide</i>	1	
<i>metoprolol tar-hydrochlorothiazide</i>	2	
<i>metyrosine</i>	5	PA
<i>olmesartanamlodipin-hcthiazid</i>	2	
<i>olmesartan-hydrochlorothiazide</i>	1	
<i>pentoxifylline</i>	2	
<i>quinapril-hydrochlorothiazide</i>	1	
<i>ranolazine</i>	4	
<i>spironolacton-hydrochlorothiaz</i>	2	
<i>telmisartanamlodipine</i>	2	
<i>telmisartan-hydrochlorothiazid</i>	2	
<i>triamterene-hydrochlorothiazid</i>	1	
<i>valsartan-hydrochlorothiazide</i>	1	
VERQUVO	3	QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
Diuretics, Loop		
<i>bumetanide injection</i>	4	
<i>bumetanide oral</i>	2	
<i>furosemide injection solution</i>	4	
<i>furosemide oral solution</i> 10 mg/ml, 40 mg/5 ml (8 mg/ml)	2	
<i>furosemide oral tablet</i>	1	
<i>torsemide oral</i>	2	
Diuretics, Potassium-Sparing		
<i>amiloride</i>	2	
<i>eplerenone</i>	3	
<i>KERENDIA</i>	3	PA; QL (30 EA per 30 days)
<i>spironolactone oral tablet</i>	1	
Diuretics, Thiazide		
<i>chlorthalidone oral tablet</i> 25 mg, 50 mg	2	
<i>hydrochlorothiazide</i>	1	
<i>indapamide</i>	1	
<i>metolazone</i>	3	
Dyslipidemics, Fibrin Acid Derivatives		
<i>fenofibrate micronized oral capsule</i> 134 mg, 200 mg, 43 mg, 67 mg	2	
<i>fenofibrate nanocrystallized</i>	2	
<i>fenofibrate oral tablet</i> 160 mg, 54 mg	2	
<i>fenofibric acid (choline)</i>	4	
<i>gemfibrozil</i>	1	

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Dyslipidemics, Hmg Coa Reductase Inhibitors					
<i>atorvastatin</i>	1	QL (30 EA per 30 days)	<i>niacin oral tablet extended release 24 hr</i>	4	
<i>fluvastatin oral capsule 20 mg</i>	2	QL (30 EA per 30 days)	<i>omega-3 acid ethyl esters</i>	2	
<i>fluvastatin oral capsule 40 mg</i>	2	QL (60 EA per 30 days)	PREVALITE ORAL POWDER IN PACKET	3	
<i>lovastatin oral tablet 10 mg</i>	1	QL (30 EA per 30 days)	REPATHA PUSHTRONEX	3	PA; QL (7 ML per 28 days)
<i>lovastatin oral tablet 20 mg, 40 mg</i>	1	QL (60 EA per 30 days)	REPATHA SURECLICK	3	PA; QL (6 ML per 28 days)
<i>pitavastatin calcium</i>	1	QL (30 EA per 30 days)	REPATHA SYRINGE	3	PA; QL (6 ML per 28 days)
<i>pravastatin</i>	1	QL (30 EA per 30 days)	Mineralocorticoid Receptor Antagonists		
<i>rosuvastatin</i>	1	QL (30 EA per 30 days)	<i>eplerenone</i>	3	
<i>simvastatin</i>	1	QL (30 EA per 30 days)	KERENDIA	3	PA; QL (30 EA per 30 days)
Dyslipidemics, Other					
<i>cholestyramine (with sugar) oral powder in packet</i>	3		<i>spironolactone oral tablet</i>	1	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	3		Sodium-Glucose Co-Transporter 2 Inhibitors (Sgt2i)		
<i>colesevelam</i>	4		FARXIGA ORAL TABLET 10 MG	3	QL (30 EA per 30 days)
<i>colestipol oral packet</i>	4		FARXIGA ORAL TABLET 5 MG	3	QL (60 EA per 30 days)
<i>colestipol oral tablet</i>	4		Vasodilators, Direct-Acting Arterial		
<i>ezetimibe</i>	2		<i>hydralazine oral</i>	2	
<i>ezetimibe-simvastatin</i>	2	QL (30 EA per 30 days)	<i>minoxidil oral</i>	2	
<i>icosapent ethyl</i>	3		Vasodilators, Direct-Acting Arterial/Venous		
<i>niacin oral tablet 500 mg</i>	2		<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	2	

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Drug Name	Drug Tier	Requirements/ Limits
<i>isosorbide mononitrate</i>	1	
NITRO-BID	3	
<i>nitroglycerin rectal</i>	3	
<i>nitroglycerin sublingual</i>	2	
<i>nitroglycerin transdermal patch 24 hour</i>	2	
<i>nitroglycerin translingual</i>	4	
VERQUVO	3	QL (30 EA per 30 days)
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	4	
<i>dextroamphetamine-amphetamine oral tablet</i>	3	
Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines		
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	4	QL (60 EA per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	4	QL (30 EA per 30 days)
<i>clonidine hcl oral tablet extended release 12 hr</i>	4	
<i>methylphenidate hcl oral capsule,er biphasic 50-50</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>methylphenidate hcl oral solution</i>	4	
<i>methylphenidate hcl oral tablet</i>	3	
<i>methylphenidate hcl oral tablet extended release</i>	4	
<i>methylphenidate hcl oral tablet, chewable</i>	4	
Central Nervous System, Other		
AUSTEDO ORAL TABLET 12 MG, 9 MG	5	PA; QL (120 EA per 30 days)
AUSTEDO ORAL TABLET 6 MG	5	PA; QL (60 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	5	PA; QL (90 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG	5	PA; QL (30 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	5	PA; QL (60 EA per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	5	PA; QL (210 EA per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG	5	PA; QL (28 EA per 180 days)
<i>carbamazepine oral tablet extended release 12 hr 100 mg</i>	4	

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<i>gabapentin oral capsule 300 mg</i>	2	QL (360 EA per 30 days)	AVONEX INTRAMUSCULAR SYRINGE KIT	5	PA; QL (1 EA per 28 days)
<i>gabapentin oral capsule 400 mg</i>	2	QL (270 EA per 30 days)	BETASERON SUBCUTANEOUS KIT	5	PA; QL (14 EA per 28 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	3	QL (2160 ML per 30 days)	<i>dalfampridine</i>	3	PA; QL (60 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	2	QL (120 EA per 30 days)	<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg</i>	5	PA; QL (56 EA per 28 days)
NUEDEXTA	5	PA	<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	5	PA; QL (120 EA per 180 days)
NURTEC ODT	3	PA; QL (16 EA per 30 days)	<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 240 mg</i>	5	PA; QL (60 EA per 30 days)
RADICAVA ORS STARTER KIT SUSP	5	PA	<i>fingolimod</i>	5	PA; QL (30 EA per 30 days)
<i>riluzole</i>	3	PA	<i>glatiramer subcutaneous syringe 20 mg/ml</i>	5	PA; QL (30 ML per 30 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	5	PA; QL (240 EA per 30 days)	<i>glatiramer subcutaneous syringe 40 mg/ml</i>	5	PA; QL (12 ML per 28 days)
<i>tetrabenazine oral tablet 25 mg</i>	5	PA; QL (120 EA per 30 days)	GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	5	PA; QL (30 ML per 30 days)
Fibromyalgia Agents			GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	5	PA; QL (12 ML per 28 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	2	QL (60 EA per 30 days)	KESIMPTA PEN	5	PA; QL (1.6 ML per 28 days)
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	3	QL (90 EA per 30 days)	<i>teriflunomide</i>	5	PA; QL (30 EA per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	3	QL (60 EA per 30 days)			
<i>pregabalin oral solution</i>	3	QL (900 ML per 30 days)			
Multiple Sclerosis Agents					
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	5	PA; QL (1 EA per 28 days)			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Dental And Oral Agents					Dermatitis And Pruritus Agents
Dental And Oral Agents					
<i>chlorhexidine gluconate mucous membrane</i>	2		ADBRY SUBCUTANEOUS AUTO-INJECTOR	5	QL (6 ML per 28 days)
<i>doxycycline hyclate oral tablet 20 mg</i>	2		ALA-CORT TOPICAL CREAM 1 %	2	
KOURZEQ	2		<i>alclometasone</i>	3	
PERIOGARD	2		<i>ammonium lactate</i>	2	
<i>pilocarpine hcl oral</i>	4		<i>betamethasone dipropionate</i>	3	
<i>triamcinolone acetonide dental</i>	2		<i>betamethasone valerate topical cream</i>	3	
Dermatological Agents					<i>betamethasone valerate topical lotion</i>
Acne And Rosacea Agents					<i>betamethasone valerate topical ointment</i>
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	4		<i>betamethasone, augmented topical cream</i>	2	
<i>acitretin</i>	4		<i>betamethasone, augmented topical gel</i>	3	
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	4		<i>betamethasone, augmented topical lotion</i>	4	
CLARAVIS	4		<i>betamethasone, augmented topical ointment</i>	2	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4		<i>clobetasol scalp</i>	4	QL (100 ML per 28 days)
<i>tazarotene topical cream</i>	4	PA	<i>clobetasol topical cream 0.05 %</i>	4	QL (120 GM per 28 days)
<i>tazarotene topical gel</i>	4	PA	<i>clobetasol topical foam</i>	4	QL (100 GM per 28 days)
<i>tretinoi topical cream</i>	4	PA	<i>clobetasol topical gel</i>	4	QL (120 GM per 28 days)
<i>tretinoi topical gel</i>	3	PA	<i>clobetasol topical lotion</i>	4	QL (118 ML per 28 days)
ZENATANE	4				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>clobetasol topical ointment</i>	4	QL (120 GM per 28 days)	<i>fluocinonide topical solution</i>	4	QL (120 ML per 30 days)
<i>clobetasol topical shampoo</i>	4	QL (236 ML per 28 days)	<i>fluocinonide-emollient</i>	4	QL (120 GM per 30 days)
<i>clobetasol-emollient topical cream</i>	4	QL (120 GM per 28 days)	<i>halobetasol propionate topical cream</i>	4	
<i>desonide topical cream</i>	4		<i>halobetasol propionate topical ointment</i>	4	
<i>desonide topical ointment</i>	4		<i>hydrocortisone topical cream 1 %</i>	2	
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)	<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	2	
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)	<i>hydrocortisone topical lotion 2.5 %</i>	2	
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)	<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	2	
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)	<i>mometasone topical</i>	2	
<i>fluocinolone and shower cap</i>	4		<i>pimecrolimus</i>	4	PA; QL (100 GM per 30 days)
<i>fluocinolone topical cream</i>	4		PROCTO-MED HC	2	
<i>fluocinolone topical ointment</i>	4		PROCTOSOL HC TOPICAL	2	
<i>fluocinolone topical solution</i>	4		PROCTOZONE-HC	2	
<i>fluocinonide topical cream 0.05 %</i>	4	QL (120 GM per 30 days)	<i>selenium sulfide topical lotion</i>	2	
<i>fluocinonide topical gel</i>	4	QL (120 GM per 30 days)	<i>tacrolimus topical</i>	4	PA; QL (100 GM per 30 days)
<i>fluocinonide topical ointment</i>	4	QL (120 GM per 30 days)	<i>triamcinolone acetonide topical cream</i>	2	
			<i>triamcinolone acetonide topical lotion</i>	2	
			<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	2	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits	
TRIDERM TOPICAL CREAM 0.5 %	2		PANRETIN	5	PAns	
Dermatological Agents				<i>podo</i> filox topical solution	3	
ACCUTANE ORAL CAPSULE 20 MG, 40 MG	4		REGRANEX	5	QL (15 GM per 30 days)	
Dermatological Agents, Other				SANTYL	3	
ALCOHOL PADS	3	PA	<i>silver sulfadiazine</i>	2		
<i>calcipotriene scalp</i>	3	QL (120 ML per 30 days)	SSD	2		
<i>calcipotriene topical cream</i>	4	QL (120 GM per 30 days)	Pediculicides/Scabicides			
<i>calcipotriene topical ointment</i>	4	QL (120 GM per 30 days)	<i>malathion</i>	4		
<i>clotrimazole-betamethasone topical cream</i>	3	QL (45 GM per 28 days)	<i>permethrin</i>	3	QL (60 GM per 30 days)	
<i>clotrimazole-betamethasone topical lotion</i>	4	QL (60 ML per 28 days)	Topical Anti-Infectives			
<i>fluorouracil topical cream 5 %</i>	3		<i>acyclovir topical ointment</i>	4	PA; QL (30 GM per 30 days)	
<i>fluorouracil topical solution</i>	3		<i>ciclopirox topical cream</i>	2	QL (90 GM per 28 days)	
<i>imiquimod topical cream in packet 5 %</i>	3		<i>ciclopirox topical gel</i>	3	QL (100 GM per 28 days)	
<i>methoxsalen</i>	5		<i>ciclopirox topical shampoo</i>	3	QL (120 ML per 28 days)	
<i>nystatin-triamcinolone</i>	3	QL (60 GM per 28 days)	<i>ciclopirox topical solution</i>	2	QL (6.6 ML per 28 days)	
OTEZLA	5	PA; QL (60 EA per 30 days)	<i>ciclopirox topical suspension</i>	3	QL (60 ML per 28 days)	
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; QL (55 EA per 180 days)	<i>clindamycin phosphate topical gel</i>	3	QL (120 GM per 30 days)	
			<i>clindamycin phosphate topical gel, once daily</i>	3	QL (150 ML per 30 days)	
			<i>clindamycin phosphate topical lotion</i>	3	QL (120 ML per 30 days)	
			<i>clindamycin phosphate topical solution</i>	3	QL (120 ML per 30 days)	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
econazole nitrate	4	QL (85 GM per 28 days)	KLOR-CON 10	2	
ERY PADS	3		KLOR-CON 8	2	
erythromycin with ethanol topical solution	2		KLOR-CON M10	2	
mupirocin	2	QL (44 GM per 30 days)	KLOR-CON M15	2	
penciclovir	4	QL (5 GM per 30 days)	KLOR-CON M20	2	
Electrolytes/Minerals/Metals/Vitamins			levocarnitine oral tablet	4	
Electrolyte/ Mineral Replacement			magnesium sulfate injection	4	
carglumic acid	5	PA	potassium chlorid-d5-0.45%nacl	4	
d10 %-0.45 % sodium chloride	4		potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	4	
d2.5 %-0.45 % sodium chloride	4		potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	4	
d5 % and 0.9 % sodium chloride	4		potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	4	
d5 %-0.45 % sodium chloride	4		potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	4	
dextrose 10 % and 0.2 % nacl	4		potassium chloride intravenous solution 2 meq/ml	4	
dextrose 10 % in water (d10w)	4		potassium chloride oral capsule, extended release	2	
dextrose 5%-0.2 % sod chloride	4		potassium chloride oral liquid	4	
electrolyte-148	3		potassium chloride oral packet	4	
INTRALIPID INTRAVENOUS EMULSION 20 %	4	BvD			
ISOLYTE S PH 7.4	4				
ISOLYTE-P IN 5 % DEXTROSE	4				
KLOR-CON	4				

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	2		<i>potassium chloride oral tablet,er particles/crystals 15 meq</i>	2	
<i>potassium chloride oral tablet,er particles/crystals</i>	2		<i>tolvaptan</i>	5	PA
<i>potassium chloride-0.45 % nacl</i>	4		<i>trientine oral capsule 250 mg</i>	5	PA
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	4		Electrolytes/Minerals/Metals/Vitamins		
<i>potassium chloride-d5-0.9%nacl</i>	4		<i>CLINIMIX 5%/D15W SULFITE FREE</i>	4	BvD
<i>potassium citrate oral tablet extended release</i>	2		<i>CLINIMIX 4.25%/D10W SULF FREE</i>	4	BvD
<i>PREMASOL 10 %</i>	4	BvD	<i>CLINIMIX 4.25%/D5W SULFIT FREE</i>	4	BvD
<i>sodium chloride 0.45 % intravenous</i>	4		<i>CLINIMIX 5%-D20W(SULFITE-FREE)</i>	4	BvD
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	4		<i>d10 %-0.45 % sodium chloride</i>	4	
<i>sodium chloride 3 % hypertonic</i>	4		<i>d2.5 %-0.45 % sodium chloride</i>	4	
<i>sodium chloride 5 % hypertonic</i>	4		<i>d5 % and 0.9 % sodium chloride</i>	4	
<i>sodium chloride irrigation</i>	4		<i>d5 %-0.45 % sodium chloride</i>	4	
<i>TRAVASOL 10 %</i>	4	BvD	<i>dextrose 10 % and 0.2 % nacl</i>	4	
Electrolyte/Mineral/Metal Modifiers			<i>dextrose 10 % in water (d10w)</i>	4	
<i>CHEMET</i>	3	PA	<i>dextrose 5%-0.2 % sod chloride</i>	4	
<i>deferasirox oral tablet</i>	3	PA	<i>INTRALIPID INTRAVENOUS EMULSION 20 %</i>	4	BvD
<i>deferiprone</i>	5	PA	<i>ISOLYTE-P IN 5 % DEXTROSE</i>	4	
<i>KLOR-CON</i>	4				
<i>penicillamine oral tablet</i>	5	PA			

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Drug Name	Drug Tier	Requirements/ Limits
<i>levocarnitine (with sugar)</i>	4	
<i>levocarnitine oral tablet</i>	4	
PREMASOL 10 %	4	BvD
TRAVASOL 10 %	4	BvD
TROPHAMINE 10 %	4	BvD
Phosphate Binders		
<i>calcium acetate(phosphat bind) oral capsule</i>	3	
<i>calcium acetate(phosphat bind) oral tablet</i>	3	PA
<i>sevelamer carbonate oral tablet</i>	4	PA
Potassium Binders		
KIONEX (WITH SORBITOL)	3	
LOKELMA	3	
<i>sodium polystyrene sulfonate oral powder</i>	3	
SPS (WITH SORBITOL) ORAL	3	
Vitamins		
KLOR-CON 10	2	
<i>potassium chloride oral tablet,er particles/crystals 15 meq</i>	2	
PRENATAL VITAMIN PLUS LOW IRON	2	
Gastrointestinal Agents		
Anti-Constipation Agents		
CONSTULOSE	2	

Drug Name	Drug Tier	Requirements/ Limits
ENULOSE	2	
GAVILYTE-C	1	
GAVILYTE-G	1	
GAVILYTE-N	1	
GENERLAC	2	
<i>lactulose oral solution</i>	2	
LINZESS	4	ST; QL (30 EA per 30 days)
<i>lubiprostone</i>	4	QL (60 EA per 30 days)
<i>peg 3350-electrolytes</i>	1	
<i>peg-electrolyte soln</i>	1	
RELISTOR SUBCUTANEOUS SOLUTION	5	ST; QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	5	ST; QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	5	ST; QL (12 ML per 30 days)
<i>sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram</i>	4	
SYMPROIC	3	QL (30 EA per 30 days)
TRULANCE	3	QL (30 EA per 30 days)
Anti-Diarrheal Agents		
<i>alosetron oral tablet 0.5 mg</i>	4	PA
<i>alosetron oral tablet 1 mg</i>	5	PA
<i>diphenoxylate-atropine oral liquid</i>	4	

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
diphenoxylate-atropine oral tablet	3		ursodiol oral tablet	3	
loperamide oral capsule	2		VOWST	5	PA
XERMELO	5	PA; QL (84 EA per 28 days)	XIFAXAN ORAL TABLET 200 MG	3	PA; QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 200 MG	3	PA; QL (9 EA per 30 days)	XIFAXAN ORAL TABLET 550 MG	5	PA; QL (90 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; QL (90 EA per 30 days)	Histamine2 (H2) Receptor Antagonists		
Antispasmodics, Gastrointestinal			famotidine oral tablet 20 mg, 40 mg	1	
dicyclomine oral capsule	2		Protectants		
dicyclomine oral solution	4		misoprostol	3	
dicyclomine oral tablet	2		sucralfate oral suspension	4	
glycopyrrolate oral tablet 1 mg, 2 mg	3		sucralfate oral tablet	2	
scopolamine base	4		Proton Pump Inhibitors		
Gastrointestinal Agents, Other			esomeprazole magnesium oral capsule, delayed release(dr/ec) 20 mg	3	QL (30 EA per 30 days)
GATTEX 30-VIAL	5	PA	esomeprazole magnesium oral capsule, delayed release(dr/ec) 40 mg	3	QL (60 EA per 30 days)
GAVILYTE-C	1		lansoprazole oral capsule, delayed release(dr/ec) 15 mg	3	QL (30 EA per 30 days)
GAVILYTE-G	1		lansoprazole oral capsule, delayed release(dr/ec) 30 mg	3	QL (60 EA per 30 days)
GAVILYTE-N	1		omeprazole oral capsule, delayed release(dr/ec) 10 mg, 20 mg	1	QL (30 EA per 30 days)
metoclopramide hcl oral solution	2				
metoclopramide hcl oral tablet	2				
OCALIVA	5	PA; QL (30 EA per 30 days)			
peg 3350-electrolytes	1				
peg-electrolyte soln	1				
REZDIFFRA	5	PA; QL (30 EA per 30 days)			
ursodiol oral capsule 300 mg	3				

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Drug Name	Drug Tier	Requirements/ Limits
<i>omeprazole oral capsule, delayed release(dr/ec) 40 mg</i>	1	QL (60 EA per 30 days)
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg</i>	1	QL (30 EA per 30 days)
<i>pantoprazole oral tablet, delayed release (dr/ec) 40 mg</i>	1	QL (60 EA per 30 days)
Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment		
Genetic Or Enzyme Or Protein Disorder: Replacement, Modifiers, Treatment		
<i>betaine</i>	5	
<i>CREON</i>	3	
<i>cromolyn inhalation</i>	3	BvD
<i>cromolyn oral</i>	4	
<i>CYSTAGON</i>	4	PA
<i>CYSTARAN</i>	5	PA
<i>glutamine (sickle cell)</i>	5	PA
<i>nitisinone</i>	5	PA
<i>PLENAMINE</i>	4	BvD
<i>PROLASTIN-C INTRAVENOUS SOLUTION</i>	5	PA
<i>sapropterin</i>	5	PA
<i>sodium phenylbutyrate</i>	5	PA
<i>SUCRAID</i>	5	PA
<i>VYNDAMAX</i>	5	PA

Drug Name	Drug Tier	Requirements/ Limits
<i>WELIREG</i>	5	PAns
Genitourinary Agents		
Antispasmodics, Urinary		
<i>mirabegron</i>	3	
<i>MYRBETRIQ</i>	3	
<i>oxybutynin chloride oral syrup</i>	2	
<i>oxybutynin chloride oral tablet 5 mg</i>	2	
<i>oxybutynin chloride oral tablet extended release 24hr</i>	2	
<i>tolterodine</i>	4	
<i>trospium oral tablet</i>	2	
Benign Prostatic Hypertrophy Agents		
<i>alfuzosin</i>	2	
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	2	QL (30 EA per 30 days)
<i>doxazosin oral tablet 8 mg</i>	2	QL (60 EA per 30 days)
<i>dutasteride</i>	2	
<i>finasteride oral tablet 5 mg</i>	2	
<i>prazosin</i>	2	
<i>tadalafil oral tablet 2.5 mg</i>	4	PA; QL (60 EA per 30 days)
<i>tadalafil oral tablet 5 mg</i>	4	PA; QL (30 EA per 30 days)
<i>tamsulosin</i>	2	
<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	QL (30 EA per 30 days)
<i>terazosin oral capsule 10 mg</i>	1	QL (60 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits			
Genitourinary Agents, Other								
<i>bethanechol chloride</i>	3		PREDNISONE INTENSOL	4				
ELMIRON	3		<i>prednisone oral solution</i>	2				
<i>penicillamine oral tablet</i>	5	PA	<i>prednisone oral tablets, dose pack 10 mg, 5 mg</i>	2				
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)								
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)								
<i>budesonide oral capsule, delayed, extend.r release</i>	4		Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)					
<i>budesonide oral tablet, delayed and ext.release</i>	5		<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	4				
<i>dexamethasone oral solution</i>	2		<i>desmopressin oral</i>	3				
<i>dexamethasone oral tablet</i>	2		INCRELEX	5				
<i>fludrocortisone</i>	2		OMNITROPE	5	PA			
<i>hydrocortisone oral</i>	2		Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)					
<i>methylprednisolone oral tablet</i>	2	BvD	Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)					
<i>methylprednisolone oral tablets, dose pack</i>	2		<i>misoprostol oral tablet 200 mcg</i>	3				
<i>prednisolone oral solution</i>	3							
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	3							

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)					
Androgens					
<i>danazol</i>	4		DOTTI	3	PA; QL (8 EA per 28 days)
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	3	PA	<i>drosperone-ethinyl estradiol</i>	2	
<i>testosterone enanthate</i>	3	PAns	ELURYNG	3	
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	3	PA; QL (300 GM per 30 days)	<i>estradiol oral</i>	4	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	4	PA; QL (150 GM per 30 days)	<i>estradiol transdermal patch semiweekly</i>	3	PA; QL (8 EA per 28 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)</i>	4	PA; QL (300 GM per 30 days)	<i>estradiol transdermal patch weekly</i>	3	PA; QL (4 EA per 28 days)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	4	PA; QL (37.5 GM per 30 days)	<i>estradiol vaginal cream</i>	3	
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	4	PA; QL (150 GM per 30 days)	<i>estradiol vaginal tablet</i>	4	
<i>testosterone transdermal solution in metered pump w/app</i>	4	PA; QL (180 ML per 30 days)	<i>estradiol valerate</i>	4	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)					
ALTAVERA (28)			2		

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ALYACEN 1/35 (28)	2		<i>l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)</i>	2	
APRI	2		LARIN 1.5/30 (21)	2	
ARANELLE (28)	2		LARIN 1/20 (21)	2	
AUBRA EQ	2		LARIN FE 1.5/30 (28)	2	
AVIANE	2		LARIN FE 1/20 (28)	2	
AZURETTE (28)	2		LESSINA	2	
CRYSELLE (28)	2		LEVONEST (28)	2	
CYRED EQ	2		<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg</i>	2	
<i>desog-e.estradiol/e.estradiol</i>	2		<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	2	
<i>drospirenone-ethinyl estradiol</i>	2		<i>levonorg-eth estrad triphasic</i>	2	
ELURYNG	3		LEVORA-28	2	
ENPRESSE	2		LILETTA	3	
ENSKYCE	2		LORYNA (28)	2	
ESTARYLLA	2		LOW-OGESTREL (28)	2	
<i>estradiol-norethindrone acet</i>	3	PA	LUTERA (28)	2	
<i>ethynodiol diac-eth estradiol</i>	2		MARLISSA (28)	2	
<i>etonogestrel-ethinyl estradiol</i>	3		MICROGESTIN 1.5/30 (21)	2	
FALMINA (28)	2		MICROGESTIN 1/20 (21)	2	
FYAVOLV	4	PA	MICROGESTIN FE 1.5/30 (28)	2	
ISIBLOOM	2		MICROGESTIN FE 1/20 (28)	2	
JASMIEL (28)	2		MILI	2	
JINTELI	4	PA	MIMVEY	3	PA
JULEBER	2		NEXPLANON	3	
KARIVA (28)	2		NIKKI (28)	2	
KELNOR 1/35 (28)	2				
KELNOR 1/50 (28)	2				
KURVELO (28)	2				

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Drug Name	Drug Tier	Requirements/ Limits
<i>norelgestromin-ethin.estriadiol</i>	3	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	PA
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2	
<i>norgestimate-ethinyl estradiol</i>	2	
NORTREL 0.5/35 (28)	2	
NORTREL 1/35 (21)	2	
NORTREL 1/35 (28)	2	
NORTREL 7/7/7 (28)	2	
PIMTREA (28)	2	
PORTIA 28	2	
RECLIPSEN (28)	2	
SETLAKIN	2	
SPRINTEC (28)	2	
SRONYX	2	
SYEDA	2	
TARINA FE 1-20 EQ (28)	2	
TILIA FE	4	
TRI-ESTARYLLA	2	
TRI-LEGEST FE	4	
TRI-LO-ESTARYLLA	2	
TRI-LO-SPRINTEC	2	
TRI-SPRINTEC (28)	2	
TRIVORA (28)	2	
TURQOZ (28)	2	
VELIVET TRIPHASIC REGIMEN (28)	2	
VESTURA (28)	2	
VIENVA	2	

Drug Name	Drug Tier	Requirements/ Limits
XULANE	3	
ZAFEMY	3	
ZOVIA 1-35 (28)	2	
Progestins		
ALTAVERA (28)	2	
ALYACEN 1/35 (28)	2	
APRI	2	
ARANELLE (28)	2	
AUBRA EQ	2	
AVIANE	2	
CAMILA	2	
CRYSELLE (28)	2	
CYRED EQ	2	
DEBLITANE	2	
DEPO-SUBQ PROVERA 104	3	
<i>desog-e.estriadiol/e.estriadiol</i>	2	
ENPRESSE	2	
ENSKYCE	2	
ERRIN	2	
ESTARYLLA	2	
FALMINA (28)	2	
FYAVOLV	4	PA
GALLIFREY	2	
HEATHER	2	
INCASSIA	2	
ISIBLOOM	2	
JINTELI	4	PA
JULEBER	2	
KARIVA (28)	2	
KURVELO (28)	2	

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<i>l norgest/e.estriadiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)</i>	2		MICROGESTIN FE 1/20 (28)	2	
LARIN 1.5/30 (21)	2		MILI	2	
LARIN 1/20 (21)	2		NORA-BE	2	
LARIN FE 1.5/30 (28)	2		<i>norelgestromin-ethin.estriadiol</i>	3	
LARIN FE 1/20 (28)	2		<i>norethindrone (contraceptive)</i>	2	
LESSINA	2		<i>norethindrone acetate</i>	2	
LEVONEST (28)	2		<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1.5 mg-mcg</i>	4	PA
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg</i>	2		<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	2	
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	2		<i>norgestimate-ethinyl estradiol</i>	2	
LEVORA-28	2		NORTREL 0.5/35 (28)	2	
LOW-OGESTREL (28)	2		NORTREL 1/35 (21)	2	
LUTERA (28)	2		NORTREL 1/35 (28)	2	
LYLEQ	2		NORTREL 7/7/7 (28)	2	
LYZA	2		PIMTREA (28)	2	
MARLISSA (28)	2		PORTIA 28	2	
<i>medroxyprogesterone megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	3	PA	<i>progesterone micronized</i>	3	
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	4	PA	RECLIPSEN (28)	2	
<i>megestrol oral tablet</i>	3	PAns	SETLAKIN	2	
MICROGESTIN 1.5/30 (21)	2		SHAROBEL	2	
MICROGESTIN 1/20 (21)	2		SPRINTEC (28)	2	
MICROGESTIN FE 1.5/30 (28)	2		SRONYX	2	
			TARINA FE 1-20 EQ (28)	2	
			TRI-ESTARYLLA	2	
			TRI-LO-ESTARYLLA	2	
			TRI-LO-SPRINTEC	2	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
TRI-SPRINTEC (28)	2		Hormonal Agents, Suppressant (Adrenal Or Pituitary)		
TRIVORA (28)	2		Hormonal Agents, Suppressant (Adrenal Or Pituitary)		
TURQOZ (28)	2				
VELIVET TRIPHASIC REGIMEN (28)	2				
VIENVA	2				
XULANE	3				
ZAFEMY	3				
Selective Estrogen Receptor Modifying Agents					
raloxifene	3		<i>bromocriptine</i>	4	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)			<i>cabergoline</i>	3	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)			ELIGARD	3	PAns
EUTHYROX	1		ELIGARD (3 MONTH)	3	PAns
<i>levothyroxine oral tablet</i>	1		ELIGARD (4 MONTH)	3	PAns
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		ELIGARD (6 MONTH)	3	PAns
<i>liothyronine oral</i>	2		FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	PAns
UNITHROID	1		FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	PAns
			<i>leuprolide subcutaneous kit</i>	4	PAns
			LUPRON DEPOT	5	PAns
			LYSODREN	5	
			<i>mifepristone oral tablet 300 mg</i>	5	PA
			MYFEMBREE	5	PA
			<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	5	PA
			<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA
			SIGNIFOR	5	PA

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
SOMAVERT	5	PA	COSENTYX UNOREADY PEN	5	PA; QL (10 ML per 28 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	4	PAns	DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)
Hormonal Agents, Suppressant (Thyroid)			DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
Antithyroid Agents			DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)
<i>methimazole oral tablet 10 mg, 5 mg</i>	2		DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
<i>propylthiouracil</i>	3		LAGEVRIO (EUA)	2	QL (40 EA per 30 days)
Immunological Agents			<i>leflunomide</i>	3	QL (30 EA per 30 days)
Angioedema Agents			ORENCIA CLICKJECT	5	PA; QL (4 ML per 28 days)
CINRYZE	5	PA	ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	5	PA; QL (4 ML per 28 days)
<i>icatibant</i>	5	PA	ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	5	PA; QL (1.6 ML per 28 days)
SAJAZIR	5	PA	ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	5	PA; QL (2.8 ML per 28 days)
Immunoglobulins			PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)-100 MG (10)	2	QL (20 EA per 30 days)
PRIVIGEN	5	PA			
Immunological Agents, Other					
ARCALYST	5	PA			
BENLYSTA SUBCUTANEOUS	5	PA			
COSENTYX (2 SYRINGES)	5	PA; QL (10 ML per 28 days)			
COSENTYX PEN (2 PENS)	5	PA; QL (10 ML per 28 days)			
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; QL (2.5 ML per 28 days)			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	2	QL (30 EA per 30 days)	STELARA SUBCUTANEOUS SOLUTION	5	PA; QL (0.5 ML per 28 days)
RIDAURA	5		STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; QL (0.5 ML per 28 days)
RINVOQ LQ	5	PA; QL (360 ML per 30 days)	STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; QL (1 ML per 28 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	5	PA; QL (30 EA per 30 days)	TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML	5	PA; QL (2 ML per 28 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	5	PA; QL (84 EA per 180 days)	TREMFYA SUBCUTANEOUS	5	PA; QL (2 ML per 28 days)
SELARSDI SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; QL (0.5 ML per 28 days)	XELJANZ ORAL SOLUTION	5	PA; QL (480 ML per 24 days)
SELARSDI SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; QL (1 ML per 28 days)	XELJANZ ORAL TABLET	5	PA; QL (60 EA per 30 days)
SKYRIZI SUBCUTANEOUS PEN INJECTOR	5	PA; QL (2 ML per 28 days)	XELJANZ XR	5	PA; QL (30 EA per 30 days)
SKYRIZI SUBCUTANEOUS SYRINGE	5	PA; QL (2 ML per 28 days)	XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	5	PA; QL (1.2 ML per 56 days)	XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	5	PA; QL (1 ML per 28 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	5	PA; QL (2.4 ML per 56 days)	XOLAIR SUBCUTANEOUS RECON SOLN	5	PA; QL (8 EA per 28 days)
SOTYKTU	5	PA; QL (30 EA per 30 days)	XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	5	PA; QL (8 ML per 28 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; QL (1 ML per 28 days)	cyclosporine oral capsule	4	BvD
YESINTEK SUBCUTANEOUS SOLUTION	3	PA; QL (0.5 ML per 28 days)	CYLTEZO(CF) PEN	5	PA; QL (4 EA per 28 days)
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	3	PA; QL (0.5 ML per 28 days)	CYLTEZO(CF) PEN CROHN'S-UC-HS	5	PA; QL (6 EA per 180 days)
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; QL (1 ML per 28 days)	CYLTEZO(CF) PEN PSORIASIS-UV	5	PA; QL (4 EA per 180 days)
Immunostimulants			CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	5	PA; QL (2 EA per 28 days)
ACTIMMUNE	5	PA	CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML, 40 MG/0.8 ML	5	PA; QL (4 EA per 28 days)
BESREMI	5	PAns	DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION	5	QL (4 ML per 28 days)	DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	5	QL (2 ML per 28 days)	DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
Immunosuppressant s			ENBREL MINI	5	PA; QL (8 ML per 28 days)
ACTEMRA ACTPEN	5	PA; QL (3.6 ML per 28 days)	ENBREL SUBCUTANEOUS SOLUTION	5	PA; QL (8 ML per 28 days)
ACTEMRA SUBCUTANEOUS	5	PA; QL (3.6 ML per 28 days)	ENBREL SUBCUTANEOUS SYRINGE	5	PA; QL (8 ML per 28 days)
azathioprine oral tablet 50 mg	2	BvD	ENBREL SURECLICK	5	PA; QL (8 ML per 28 days)
BENLYSTA SUBCUTANEOUS	5	PA			
cyclosporine modified	4	BvD			
cyclosporine ophthalmic (eye)	3	QL (60 EA per 30 days)			

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
ENVARSUS XR	4	BvD	HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; QL (2 EA per 28 days)
<i>everolimus</i> <i>(antineoplastic) oral tablet</i>	5	PAbs; QL (30 EA per 30 days)	HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5	PA; QL (2 EA per 28 days)
<i>everolimus</i> <i>(antineoplastic) oral tablet for suspension 2 mg</i>	5	PAbs; QL (330 EA per 30 days)	HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (4 EA per 28 days)
<i>everolimus</i> <i>(antineoplastic) oral tablet for suspension 3 mg</i>	5	PAbs; QL (240 EA per 30 days)	<i>leflunomide</i>	3	QL (30 EA per 30 days)
<i>everolimus</i> <i>(antineoplastic) oral tablet for suspension 5 mg</i>	5	PAbs; QL (180 EA per 30 days)	<i>mercaptopurine oral tablet</i>	3	
<i>everolimus</i> <i>(immunosuppressive) oral tablet 0.25 mg</i>	3	BvD	<i>methotrexate sodium</i>	2	BvD
<i>everolimus</i> <i>(immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	5	BvD	<i>methotrexate sodium (pf) injection solution</i>	2	BvD
GENGRAF ORAL CAPSULE	4	BvD	<i>mycophenolate mofetil oral capsule</i>	3	BvD
HUMIRA PEN	5	PA; QL (4 EA per 28 days)	<i>mycophenolate mofetil oral suspension for reconstitution</i>	5	BvD
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (4 EA per 28 days)	<i>mycophenolate mofetil oral tablet</i>	3	BvD
HUMIRA(CF) PEN CROHNS-UC-HS	5	PA; QL (3 EA per 180 days)	<i>mycophenolate sodium</i>	4	BvD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	5	PA; QL (3 EA per 180 days)	MYHIBBIN	5	BvD
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	5	PA; QL (4 EA per 28 days)	OTEZLA ORAL TABLET 20 MG	5	PA; QL (60 EA per 30 days)
			OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; QL (55 EA per 180 days)
			PROGRAF ORAL GRANULES IN PACKET	4	BvD

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
REZUROCK	5	PA; QL (30 EA per 30 days)	ADACEL(TDAP ADOLESN/ADULT)(PF)	1	
<i>sirolimus oral solution</i>	5	BvD	AREXVY (PF)	1	
<i>sirolimus oral tablet</i>	4	BvD	<i>bcg vaccine, live (pf)</i>	1	
<i>tacrolimus oral capsule</i>	4	BvD	BEXSERO	1	
TORPENZ	5	PAbs; QL (30 EA per 30 days)	BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	1	
TYENNE AUTOINJECTOR	5	PA; QL (3.6 ML per 28 days)	DAPTACEL (DTAP PEDIATRIC) (PF)	3	
TYENNE SUBCUTANEOUS	5	PA; QL (3.6 ML per 28 days)	ENGERIX-B (PF)	1	BvD
YUFLYMA(CF) AI CROHN'S-UC-HS	5	PA; QL (3 EA per 180 days)	ENGERIX-B PEDIATRIC (PF)	1	BvD
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	5	PA; QL (4 EA per 28 days)	GARDASIL 9 (PF)	1	
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	5	PA; QL (2 EA per 28 days)	HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1	
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	5	PA; QL (2 EA per 28 days)	HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	3	
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (4 EA per 28 days)	HEPLISAV-B (PF)	1	BvD
ZYMFENTRA	5	PA; QL (2 EA per 28 days)	HIBERIX (PF)	3	
Vaccines			IMOVAX RABIES VACCINE (PF)	1	
ABRYSVO (PF)	1		INFANRIX (DTAP) (PF)	3	
ACTHIB (PF)	3		IPOL	1	
			IXCHIQ (PF)	1	
			IXIARO (PF)	1	
			JYNNEOS (PF)	1	BvD
			KINRIX (PF)	3	
			MENQUADFI (PF)	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	1		VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	3	
M-M-R II (PF)	1		VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1	
MRESVIA (PF)	1		VARIVAX (PF)	1	
PEDIARIX (PF)	3		VARIZIG	3	
PEDVAX HIB (PF)	3		VAXCHORA VACCINE	1	
PENBRAYA (PF)	1		VIMKUNYA	1	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-20MCG-5LF- 62 DU/0.5 ML	3		VIVOTIF	1	
PRIORIX (PF)	1		YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML	1	
PROQUAD (PF)	3				
QUADRACEL (PF)	3				
RABAVERT (PF)	1				
RECOMBIVAX HB (PF)	1	BvD			
ROTARIX ORAL SUSPENSION	3				
ROTAQUE VACCINE	3				
SHINGRIX (PF)	1	QL (2 EA per 720 days)			
TENIVAC (PF)	1				
TICOVAC	3				
TRUMENBA	1				
TWINRIX (PF)	1				
TYPHIM VI	1				
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	3				
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	1				

Inflammatory Bowel Disease Agents

Aminosalicylates

balsalazide	4	
mesalamine	4	
sulfasalazine	2	

Glucocorticoids

budesonide oral capsule,delayed,extend.r elease	4	
budesonide oral tablet,delayed and ext.release	5	
dexamethasone oral solution	2	
dexamethasone oral tablet	2	

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Drug Name	Drug Tier	Requirements/ Limits
<i>hydrocortisone oral</i>	2	
<i>hydrocortisone rectal</i>	4	
<i>methylprednisolone oral tablet</i>	2	BvD
<i>methylprednisolone oral tablets, dose pack</i>	2	
<i>prednisolone oral solution</i>	3	
<i>prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	3	
PREDNISONE INTENSOL	4	
<i>prednisone oral solution</i>	2	
<i>prednisone oral tablet</i>	2	
<i>prednisone oral tablets, dose pack 10 mg, 5 mg</i>	2	
PROCTO-MED HC	2	
PROCTOSOL HC TOPICAL	2	
PROCTOZONE-HC	2	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
<i>alendronate oral tablet 10 mg</i>	1	QL (30 EA per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	QL (4 EA per 28 days)
<i>calcitonin (salmon) nasal</i>	3	
<i>calcitriol oral capsule</i>	2	
<i>calcitriol oral solution</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	4	PA
<i>cinacalcet oral tablet 90 mg</i>	5	PA
<i>doxercalciferol oral</i>	4	
<i>ibandronate oral</i>	3	QL (1 EA per 30 days)
<i>paricalcitol oral</i>	4	
PROLIA	4	PA; QL (1 ML per 180 days)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i>	5	PA; QL (2.48 ML per 28 days)
XGEVA	5	BvD
Non-Frf		
Non-Frf		
2-IN-1 LANCET DEVICE	1	
2TEK CONTROL (HIGH-NORMAL)	1	
ACCU-CHEK AVIVA CONTROL SOLN	1	
ACCU-CHEK AVIVA PLUS TEST STRP	1	
ACCU-CHEK FASTCLIX LANCET DRUM	1	
ACCU-CHEK FASTCLIX LANCING DEV	1	
ACCU-CHEK GUIDE GLUCOSE METER	1	
ACCU-CHEK GUIDE L1-L2 CTRL SOL	1	
ACCU-CHEK GUIDE ME GLUCOSE MTR	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ACCU-CHEK GUIDE TEST STRIPS	1		ADVOCATE REDI-CODE PLUS	1	
ACCU-CHEK SAFE-T-PRO	1		ADVOCATE REDI-CODE PLUS CTRL L	1	
ACCU-CHEK SAFE-T-PRO PLUS	1		ADVOCATE REDI-CODE+ CTRL HIGH	1	
ACCU-CHEK SMARTVIEW CONTRL SOL	1		AGAMATRIX AMP TEST STRIPS	1	
ACCU-CHEK SMARTVIEW TEST STRIP	1		AGAMATRIX CONTROL SOLN-HIGH	1	
ACCU-CHEK SOFT DEV LANCETS	1		AGAMATRIX CONTROL SOLN-NORM-HI	1	
ACCU-CHEK SOFTCLIX LANCETS	1		<i>alprostadiol</i>	2	
ACCUTREND GLUCOSE CONTROL	1		ALTERNATE SITE LANCET	1	
ACCUTREND GLUCOSE TEST STRIPS	1		ALTERNATE SITE LANCING DEVICE	1	
ACTI-LANCE LANCETS	1		<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	2	
ADJUSTABLE LANCING DEVICE	1		<i>ampicillin sodium injection recon soln 125 mg</i>	4	PA
ADVANCED ALL-IN-ONE METER	1		AQUA LANCE LANCING DEVICE	1	
ADVANCED GLUC METER TEST STRIP	1		ASSURE 4 CONTROL SOLUTION	1	
ADVANCED GLUCOSE METER	1		ASSURE 4 STRIPS	1	
ADVANCED LANCING DEVICE	1		ASSURE DOSE NORMAL CONTROL	1	
ADVANCED TRAVEL LANCETS 28 GAUGE	1		ASSURE DOSE NORM-HI CONTROL	1	
ADVOCATE LANCET	1		ASSURE LANCE	1	
ADVOCATE LANCING DEVICE	1		ASSURE LANCE PLUS	1	

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ASSURE PLATINUM GLUCOSE METER	1		BLOOD GLUCOSE MONITORING	1	
ASSURE PLATINUM TEST STRIP	1		BLOOD GLUCOSE TEST	1	
ASSURE PRISM CONTROL 1-2 SOLN	1		<i>blood-glucose meter</i>	1	
ASSURE PRISM MULTI METER	1		BLULINK BG SYSTEM REFILL	1	
ASSURE PRISM MULTI STRIP	1		BLULINK DIABETIC TEST BUNDLE	1	
AUTO-LANCET MINI	1		BLULINK GLUCOSE MONITOR SYSTEM	1	
AUTOLET IMPRESSION LANC DEV	1		BLULINK GLUCOSE TEST STRIP	1	
AUTOLET LANCING DEVICE	1		BREEZE 2 CONTROL SOLUTION, LOW	1	
AUTOSOFT 30	1		BREEZE 2 CONTROL SOLUTION, NML	1	
AUTOSOFT 90	1		BREEZE 2 CONTROL SOLUTION,HIGH	1	
AUTOSOFT XC INFUSION SET 23"	1		BULLSEYE MINI SAFETY LANCETS	1	
AUTOSOFT XC INFUSION SET 32"	1		BUTTERFLY TOUCH LANCET	1	
AUTOSOFT XC INFUSION SET 43"	1		<i>calcium acetate(phosphat bind) oral capsule</i>	3	
<i>azithromycin oral packet</i>	3		<i>calcium acetate(phosphat bind) oral tablet</i>	3	PA
BD MICROTAINER LANCET	1		CAREONE LANCING DEVICE	1	
BIONIME RIGHTEST GM300 SYSTEM	1		CAREONE ULTRA THIN LANCET	1	
BIONIME RIGHTEST TEST STRIPS	1		CARESENS CONTROL A AND B	1	
BIOTEL CARE BGM-4 METER	1		CARESENS LANCETS	1	
<i>blood glucose contrl hi,normal</i>	1		CARESENS N	1	
<i>blood glucose control, normal</i>	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
CARESENS N FELIZ BT GLUC METER	1		CLEVER CHOICE GLUCOSE MONITOR	1	
CARESENS N FELIZ GLUCOSE METER	1		CLEVER CHOICE LEVEL 1 CONTROL	1	
CARESENS N TEST STRIPS	1		CLEVER CHOICE LEVEL 2 CONTROL	1	
CARESENS N VOICE	1		CLEVER CHOICE LEVEL 3 CONTROL	1	
CARETOUCH CONTROL SOLN L2-L3	1		CLEVER CHOICE MICRO	1	
CARETOUCH GLUCOSE MONITORING	1		CLEVER CHOICE MICRO TEST STRIP	1	
CARETOUCH LANCING DEVICE	1		CLEVER CHOICE PRO	1	
CARETOUCH SAFETY LANCETS	1		CLEVER CHOICE TALK GLUCOSE SYS	1	
CARETOUCH TEST STRIP	1		CLEVER CHOICE TALK TEST	1	
CARETOUCH TWIST LANCET	1		CLEVER CHOICE TEST STRIPS	1	
CHOSEN LANCET	1		CLEVER CHOICE VOICE PLUS TEST	1	
CHOSEN LANCING DEVICE	1		<i>clomiphene citrate</i>	2	PA
CHOSEN SAFETY LANCET	1		COAGUCHEK LANCETS	1	
<i>ciprofloxacin hcl otic (ear)</i>	4		COLOR LANCETS	1	
CLEVER CHEK BLOOD GLUCOSE	1		COMFORT EZ LANCETS 23 GAUGE, 28 GAUGE	1	
CLEVER CHEK BLOOD GLUCOSE SYST	1		COMFORT TOUCH PLUS SAFETY LANC	1	
CLEVER CHEK LANCETS	1		COMFORT TOUCH ULT THIN LANCETS	1	
CLEVER CHOICE BLOOD GLUC SYS	1		COMIRNATY 2024-25 (12Y UP)(PF)	1	
			CONTOUR CONTROL SOLUTION, HIGH	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
CONTOUR CONTROL SOLUTION, LOW	1		DEXCOM G7 RECEIVER	1	
CONTOUR CONTROL SOLUTION, NML	1		DEXCOM G7 SENSOR	1	
CONTOUR METER	1		<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	4	
CONTOUR NEXT EZ METER	1		DIATRUE CONTROL SOLN NORMAL	1	
CONTOUR NEXT GEN METER	1		DIATRUE CONTROL SOLUTION HIGH	1	
CONTOUR NEXT GLUCOSE METER	1		DIATRUE CONTROL SOLUTION LOW	1	
CONTOUR NEXT LEV 1 CONTROL SOL	1		DIATRUE PLUS BLOOD GLUCOSE MET	1	
CONTOUR NEXT LEV 2 CONTROL SOL	1		DIATRUE PLUS TEST STRIP	1	
CONTOUR NEXT LINK	1		DROPLET GENTEEL LANCING DEVICE	1	
CONTOUR NEXT LINK 2.4	1		DROPLET LANCETS	1	
CONTOUR NEXT METER	1		DROPLET LANCING DEVICE	1	
CONTOUR NEXT ONE METER	1		DROXIA	3	
CONTOUR NEXT TEST STRIPS	1		EASY COMFORT LANCETS	1	
CONTOUR PLUS BLUE METER	1		EASY MINI EJECT LANCING DEVICE	1	
CONTOUR PLUS TEST STRIP	1		EASY PLUS II BLOOD GLUCOSE MET	1	
CONTOUR TEST STRIPS	1		EASY PLUS II HIGH CONTROL	1	
D5 % (D-GLUCOSE)-0.9 % SODCHLR	4		EASY PLUS II LOW CONTROL	1	
DEXCOM G6 RECEIVER	1		EASY PLUS II TEST	1	
DEXCOM G6 SENSOR	1		EASY STEP	1	
DEXCOM G6 TRANSMITTER	1		EASY STEP BLOOD GLUCOSE METER	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
EASY STEP HIGH CONTROL SOLN	1		EASY TOUCH TEST STRIP	1	
EASY STEP LOW CONTROL SOLUTION	1		EASY TOUCH TWIST LANCETS	1	
EASY STEP NORMAL CONTROL SOLN	1		EASY TRAK BLOOD GLUCOSE METER	1	
EASY TALK BLOOD GLUCOSE METER	1		EASY TRAK GLUCOSE TEST	1	
EASY TALK GLUCOSE TEST	1		EASY TRAK HIGH CONTROL	1	
EASY TALK HIGH CONTROL	1		EASY TRAK II BLOOD GLUCOSE MTR	1	
EASY TALK LOW CONTROL	1		EASY TRAK II CTRL SOLN-NORMAL	1	
EASY TALK PLUS II HIGH CONTROL	1		EASY TRAK II TEST STRIP	1	
EASY TALK PLUS II LOW CONTROL	1		EASY TRAK LOW CONTROL	1	
EASY TALK PLUS II TEST STRIP	1		EASY TWIST AND CAP LANCETS	1	
EASY TOUCH BLU CTRL SOLN-L1,L3	1		EASYGLUCO METER	1	
EASY TOUCH BLULINK GLUC SYST	1		EASYGLUCO TEST	1	
EASY TOUCH BLULINK TEST STRIP	1		EASYMAX	1	
EASY TOUCH GLUCOSE MONITOR	1		EASYMAX 15 LEVEL 2	1	
EASY TOUCH HIGH-LOW CONTROL	1		EASYMAX 15 TEST STRIPS	1	
EASY TOUCH LANCETS	1		EASYMAX NG	1	
EASY TOUCH LANCING DEVICE	1		EASYMAX NORMAL CONTROL	1	
EASY TOUCH SAFETY LANCETS	1		EASYMAX T1	1	
			EASYMAX V SPEAKING GLUCOSE SYS	1	
			EASY-TOUCH BLOOD GLUCOSE METER	1	

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ELEMENT COMPACT GLUCOSE METER	1		EMBRACE LANCING DEVICE	1	
ELEMENT COMPACT HIGH CONTROL	1		EMBRACE PRO	1	
ELEMENT COMPACT NORMAL CONTROL	1		EMBRACE PRO GLUCOSE METER	1	
ELEMENT COMPACT TEST STRIPS	1		EMBRACE PRO TEST STRIPS	1	
ELEMENT COMPACT V GLUCOSE MTR	1		EMBRACE SAFETY LANCET	1	
ELEMENT HIGH CONTROL	1		EMBRACE TALK BLOOD GLUCOSE SYS	1	
ELEMENT LOW CONTROL	1		EMBRACE TALK CONTROL-HIGH (L2)	1	
ELEMENT NORMAL CONTROL	1		EMBRACE TALK CONTROL-LOW (L1)	1	
ELEMENT PLUS BLOOD GLUCOSE KIT	1		EMBRACE TALK GLUCOSE MONITOR	1	
ELEMENT TEST STRIPS	1		EMBRACE TALK TEST STRIPS	1	
EMBRACE BLOOD GLUCOSE SYSTEM	1		EMBRACE WAVE GLUCOSE TEST STRP	1	
EMBRACE EVO BLOOD GLUCOSE KIT	1		EMBRACE WAVE PLUS GLUCOSE MTR	1	
EMBRACE EVO GLUCOSE MONITOR	1		<i>epinephrine injection solution 1 mg/ml (1 ml)</i>	2	
EMBRACE EVO LEVEL 1	1		EVENCARE G2	1	
EMBRACE EVO TEST STRIPS	1		EVENCARE G2 STRIP	1	
EMBRACE GLUCOSE CONTROL HIGH	1		EVENCARE G3 CONTROL	1	
EMBRACE GLUCOSE CONTROL LOW	1		EVENCARE G3 GLUCOSE METER	1	
EMBRACE LANCETS	1		EVENCARE G3 TEST	1	
			EVENCARE MINI GLUCOSE TEST STR	1	
			EVENCARE MINI MONITOR SYSTEM	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
EVENCARE PROVIEW TEST STRIP	1		FORA GD50 BLOOD GLUCOSE SYSTEM	1	
EVOLUTION BLOOD GLUCOSE METER	1		FORA GD50 TEST STRIPS	1	
EVOLUTION NORMAL CONTROL	1		FORA GTEL GLUCOSE TEST STRIP	1	
EVOLUTION TEST STRIPS	1		FORA HIGH CONTROL	1	
EXTENDED RESERVOIR	1		FORA LANCING DEVICE	1	
E-Z JECT LANCETS	1		FORA LOW CONTROL	1	
E-Z JECT THIN LANCETS	1		FORA NORMAL CONTROL	1	
EZ SMART LANCETS	1		FORA PREMIUM V10 GLUCOSE METER	1	
EZ SMART PLUS SYSTEM	1		FORA TEST N'GO VOICE METER	1	
EZ SMART PLUS TEST	1		FORA TEST STRIP	1	
EZ SMART SYSTEM	1		FORA TN'G ADVAN PRO TEST STRIP	1	
EZ SMART TEST	1		FORA TN'G VOICE METER	1	
fentanyl citrate buccal lozenge on a handle 1,200 mcg	5	PA; QL (120 EA per 30 days)	FORA TN'G VOICE TEST STRIPS	1	
fentanyl citrate buccal lozenge on a handle 200 mcg	4	PA; QL (120 EA per 30 days)	FORA V10 STRIP	1	
FINGERSTIX LANCETS	1		FORA V10-V12-D10-D20 STRIPS	1	
FORA 6 CONNECT GLUCOSE STRIP	1		FORA V12 BLOOD GLUCOSE SYSTEM	1	
FORA 6CONN-GTEL-TN'G ADV STRIP	1		FORACARE GD20	1	
FORA D40-G31 TEST STRIPS	1		FORACARE GD20 GLUCOSE METER	1	
FORA G20	1		FORACARE GD40 TEST STRIPS	1	
FORA G30A	1		FORACARE GD40B GLUCOSE METER	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
FORACARE GDH HIGH CONTROL	1		FREESTYLE LIBRE 3 SENSOR	1	
FORACARE GDH LOW CONTROL	1		FREESTYLE LITE METER	1	
FORACARE GDH NORMAL CONTROL	1		FREESTYLE LITE STRIPS	1	
FORACARE LANCETS	1		FREESTYLE PRECISION NEO METER	1	
FRAICHE 5000	2		FREESTYLE PRECISION NEO STRIPS	1	
FREESTYLE CONTROL	1		FREESTYLE SIDEKICK II	1	
FREESTYLE FLASH SYSTEM	1		FREESTYLE SYSTEM KIT	1	
FREESTYLE FREEDOM	1		FREESTYLE TEST	1	
FREESTYLE FREEDOM LITE	1		FREESTYLE UNISTIK 2	1	
FREESTYLE INSULINX	1		GE100 BLOOD GLUCOSE SYSTEM	1	
FREESTYLE INSULINX TEST STRIPS	1		GE100 BLOOD GLUCOSE TEST STRIP	1	
FREESTYLE LANCETS	1		GE100 CONTROL SOLUTION NORMAL	1	
FREESTYLE LIBRE 14 DAY READER	1		GE333 BLOOD GLUCOSE SYSTEM	1	
FREESTYLE LIBRE 14 DAY SENSOR	1		GE333 BLOOD GLUCOSE TEST STRIP	1	
FREESTYLE LIBRE 2 PLUS SENSOR	3		GENGRAF ORAL SOLUTION	4	BvD
FREESTYLE LIBRE 2 READER	1		GENSTRIP TEST STRIP	1	
FREESTYLE LIBRE 2 SENSOR	1		GENTEEL VACUUM LANCING DEVICE	1	
FREESTYLE LIBRE 3 PLUS SENSOR	1		GLUCO NAVII GLUCOSE MONITOR	1	
FREESTYLE LIBRE 3 READER	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
GLUCONAVII TEST STRIP	1		GLUCOCOM LANCETS	1	
GLUCOCARD 01 HI-NORMAL CONTROL	1		GLUCOSE CONTROL	1	
GLUCOCARD 01 METER	1		GLUCOSE KETONE CONTROL SOLN	1	
GLUCOCARD 01 NORMAL CONTROL	1		GM100	1	
GLUCOCARD 01 SENSOR PLUS	1		GOJJI BLOOD GLUCOSE TEST STRIP	1	
GLUCOCARD EXPRESSION	1		GOJJI GLUCOSE CNTRL SOL-NORMAL	1	
GLUCOCARD SHINE	1		GOJJI LANCET-GLUCOSE TEST STRP	1	
GLUCOCARD SHINE CONNEX METER	1		GOJJI LANCETS	1	
GLUCOCARD SHINE EXPRESS METER	1		GOJJI LANCING DEVICE	1	
GLUCOCARD SHINE METER	1		GUARDIAN 4 GLUCOSE SENSOR	1	
GLUCOCARD SHINE METER KIT	1		GUARDIAN 4 TRANSMITTER	1	
GLUCOCARD SHINE TEST STRIPS	1		GUARDIAN LINK 3 TRANSMITTER	1	
GLUCOCARD SHINE XL METER	1		GUARDIAN SENSOR 3	1	
GLUCOCARD VITAL	1		HARMONY GLUCOSE TEST STRIP	1	
GLUCOCARD VITAL SENSOR	1		HEALTHPRO GLUCOSE MONITOR	1	
GLUCOCARD VITAL TEST STRIPS	1		HEALTHPRO HIGH-LOW CONTROL	1	
GLUCOCOM BLOOD GLUCOSE	1		HEALTHPRO TEST STRIPS	1	
GLUCOCOM CONTROL HIGH	1		HYPOLANCE AST LANCING	1	
GLUCOCOM CONTROL NORMAL	1		ILET INFUSION KIT-INSET 23"	1	
GLUCOCOM GLUCOSE	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ILET INFUSION KIT-INSET 32"	1		<i>lancing device with lancets kit</i>	1	
ILET INFUSION-CONTACT DTCH 23"	1		LANZO LANCING DEVICE	1	
ILET INSULIN PUMP	1		MEDISENSE	1	
INCONTROL LANCING DEVICE	1		MEDISENSE GLUCOSE KETONE	1	
INCONTROL SUPER THIN LANCETS	1		MEDISENSE MID CONTROL	1	
INCONTROL ULTRA THIN LANCETS	1		MEDISENSE THIN LANCETS	1	
INFINITY CONTROL SOLUTION HIGH	1		MEDLANCE PLUS LANCETS	1	
INFINITY CONTROL SOLUTION LOW	1		MEDLANCE PLUS SPECIAL BLADE	1	
INFINITY CONTROL SOLUTION NORM	1		MEDTRONIC EXT INFUSION SET 23"	1	
INFINITY METER KIT	1		MEDTRONIC EXT INFUSION SET 32"	1	
INFINITY STARTER KIT	1		MICRO BLOOD GLUCOSE	1	
INFINITY TEST STRIPS	1		MICRO THIN LANCETS	1	
INJECT EASE LANCETS	1		MICRODOT BLOOD GLUCOSE SYSTEM	1	
INVACARE LANCETS	1		MICRODOT BLOOD GLUCOSE SYSTEM STRIP	1	
JENTADUETO ORAL TABLET 2.5-850 MG	3	QL (60 EA per 30 days)	MICRODOT HIGH-LOW CONTROL	1	
<i>lancets</i>	1		MICRODOT NORMAL CONTROL	1	
LANCETS, SUPER THIN	1		MICRODOT XTRA BLOOD GLUCOSE	1	
LANCETS,THIN	1		MICROLET 2 LANCING DEVICE	1	
LANCETS,ULTRA THIN	1		MICROLET LANCET	1	
<i>lancing device</i>	1				
LANCING DEVICE WITH LANCETS	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
MICROLET NEXT LANCING DEVICE	1		MONOLET LANCETS	1	
MINI LANCING DEVICE	1		MONOLET THIN LANCETS	1	
MINIMED 630G INSULIN PUMP	1		MULTI-LANCET DEVICE 2	1	
MINIMED 770G INSULIN PUMP	1		MYGLUCOHEALTH	1	
MINIMED 780G INSULIN PUMP	1		MYGLUCOHEALTH CONTROL SOLUTION	1	
MINIMED MIO ADVANCE INF SET23"	1		MYGLUCOHEALTH LANCETS	1	
MINIMED MIO ADVANCE INF SET43"	1		<i>naloxone nasal</i>	2	
MINIMED QUICK SET 18"	1		NEUTEK 2TEK TEST STRIPS	1	
MINIMED QUICK SET 23"	1		NOVA MAX GLUCOSE TEST	1	
MINIMED QUICK SET 32"	1		NOVA SAFETY LANCETS	1	
MINIMED QUICK SET 43"	1		NOVA SUREFLEX LANCETS	1	
MINIMED SILHOUETTE 18"	1		NOVAMAX PLUS GLU-KET	1	
MINIMED SILHOUETTE 23"	1		NOVAVAX COVID 2024-25(PF)(EUA)	1	
MINIMED SILHOUETTE 32"	1		<i>octreotide,microspheres intramuscular suspension,extended rel recon 20 mg, 30 mg</i>	5	PA
MINIMED SILHOUETTE 43"	1		OMNIPOD 5 (G6/LIBRE 2 PLUS)	3	
MINIMED SURE T 18"	1		OMNIPOD 5 INTRO(G6/LIBRE2PL US)	3	QL (1 EA per 365 days)
MINIMED SURE T 23"	1		ON CALL EXPRESS CONTROL	1	
MINIMED SURE T 32"	1		ON CALL EXPRESS METER	1	
MOBILE LANCETS	1				
MODERNA COVID 24-25(6M-11Y)PF	1				

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ON CALL EXPRESS TEST STRIP	1		PARADIGM RESERVOIR	1	
ON CALL LANCET	1		PERFECT POINT SAFETY LANCETS	1	
ON CALL LANCING DEVICE	1		PFIZER COVID 2024-25(5Y-11Y)PF	1	
ONETOUCH DELICA PLUS LANCET	1		PFIZER COVID 2024-25(6MO-4Y)PF	1	
ONETOUCH DELICA SAFETY LANCET	1		PHARMACIST CHOICE	1	
ONETOUCH ULTRA CONTROL	1		PHARMACIST CHOICE GLUCOSE SYS	1	
ONETOUCH ULTRA TEST	1		<i>phenytoin sodium extended oral capsule 200 mg, 300 mg</i>	2	
ONETOUCH ULTRA2 METER	1		PIP BLOOD GLUCOSE MONITOR	1	
ONETOUCH ULTRASOFT 2 LANCET	1		PIP BLOOD GLUCOSE TEST STRIP	1	
ONETOUCH VERIO FLEX METER	1		PIP GLUCOSE CONTROL SOLN L1-L2	1	
ONETOUCH VERIO HIGH CONTROL	1		PIP LANCET	1	
ONETOUCH VERIO MID CONTROL	1		PRECISION PCX PLUS TEST	1	
ONETOUCH VERIO REFLECT METER	1		PRECISION PCX TEST	1	
ONETOUCH VERIO TEST STRIPS	1		PRECISION POINT OF CARE TEST	1	
ON-THE-GO LANCETS	1		PRECISION Q-I-D TEST	1	
OPTIUM EZ	1		PRECISION XTRA MONITOR	1	
OPTIUM TEST	1		PRECISION XTRA TEST	1	
<i>oxacillin in dextrose(iso-osm)</i> <i>intravenous piggyback 1 gram/50 ml</i>	4	PA	PREMIER BLU GLUCOSE METER	1	
<i>paclitaxel protein-bound</i>	5	BvD			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PREMIER CLASSIC GLUCOSE METER	1		PRODIGY TWIST TOP LANCET	1	
PREMIER COMPACT GLUCOSE METER	1		PRODIGY VOICE GLUCOSE METER	1	
PREMIER TEST STRIP	1		PURE COMFORT LANCETS	1	
PREMIER VOICE GLUCOSE METER	1		PURE COMFORT SAFETY LANCETS	1	
PREMIUM BLOOD GLUCOSE MONITOR	1		PUSH BUTTON SAFETY LANCETS 28 GAUGE	1	
PREMIUM V10	1		QUINTET AC	1	
PRESSURE ACTIVATED LANCETS	1		QUINTET BLOOD GLUCOSE METER	1	
PRO COMFORT LANCET	1		QUINTET GLUCOSE TEST STRIPS	1	
PRO COMFORT SAFETY LANCET	1		REFUAH PLUS	1	
PRO VOICE V8-V9 TEST STRIP	1		REFUAH PLUS GLUCOSE CONTROL	1	
PRO VOICE V9 GLUCOSE MONITOR	1		REFUAH PLUS GLUCOSE MONITOR	1	
PRODIGY AUTOCODE METER	1		RELIAMED LANCET 28 GAUGE, 30 GAUGE	1	
PRODIGY AUTOCODE MONITOR SYST	1		RELIAMED MINI LANCING DEVICE	1	
PRODIGY CONTROL SOLUTION, LOW	1		RELIAMED SAFETY SEAL LANCETS	1	
PRODIGY CONTROL SOLUTION, HIGH	1		RELION ALL-IN-ONE METER	1	
PRODIGY LANCETS	1		RELION CONFIRM	1	
PRODIGY LANCING DEVICE	1		RELION CONFIRM-MICRO	1	
PRODIGY NO CODING	1		RELION MICRO GLUCOSE MONITOR KIT	1	
PRODIGY POCKET METER	1		RELION PRIME METER	1	

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RELION PRIME TEST STRIPS	1		SMARTDIABETES VANTAGE	1	
RELION ULTIMA	1		SMARTEST CONTROL	1	
REVEAL BLOOD GLUCOSE METER	1		SMARTEST EJECT	1	
REVEAL TEST STRIP	1		SMARTEST LANCET	1	
RIGHTEST CONTROL SOLUTION HIGH	1		SMARTEST PERSONA STARTER	1	
RIGHTEST CONTROL SOLUTION NORM	1		SMARTEST PRONTO STARTER	1	
RIGHTEST GD500 LANCING DEVICE	1		SMARTEST PROTEGE	1	
RIGHTEST GL300 LANCETS	1		SMARTEST TEST	1	
RIGHTEST GM550 SYSTEM	1		SOLUS V2 AUDIBLE METER	1	
RIGHTEST GS550 TEST STRIPS	1		SOLUS V2 CONTROL SOLUTION, LOW	1	
RIGHTEST GT333 GLUCOSE METER	1		SOLUS V2 CONTROL SOLUTION,HIGH	1	
RIGHTEST GT333 TEST STRIP	1		SOLUS V2 LANCETS	1	
SAFETY LANCETS 21 GAUGE, 28 GAUGE	1		SOLUS V2 LANCING DEVICE	1	
SAFETY SEAL LANCETS	1		SOLUS V2 TEST STRIPS	1	
SAFETY-LET LANCETS	1		SPIKEVAX 2024-2025(12Y UP)(PF)	1	
<i>sevelamer carbonate oral tablet</i>	4	PA	STERILANCE TL	1	
<i>sildenafil (pulm.hypertension) intravenous</i>	5		SUBLOCADE	5	
SMART SENSE LANCETS	1		SUPER THIN LANCETS 30 GAUGE	1	
SMART SENSE MONITORING SYSTEM	1		SURE COMFORT LANCETS	1	
			SURE COMFORT LANCING PEN	1	
			SUREFLEX DEVICE WITH LANCETS	1	
			SURE-LANCE	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
SURE-LANCE ULTRA THIN	1		TELCARE CONTROL	1	
SURE-PEN LANCING DEVICE	1		TELCARE LANCETS	1	
SURE-TEST EASYPLUS MINI	1		TELCARE TEST STRIPS	1	
SURE-TEST EASYPLUS MINI METER	1		TEMPO WELCOME KIT	1	
SURE-TOUCH LANCET	1		TEST N'GO BLOOD GLUCOSE SYSTEM	1	
SYLVANT	5	BvD	TEST N'GO TEST	1	
T:FLEX	1		TEVIMBRA	5	PAns
T:SLIM X2	1		THIN LANCETS	1	
T:SLIM X2 BASAL-IQ INSULIN PMP	1		TOPCARE UNIVERSAL1 LANCET	1	
T:SLIM X2 CONTROL-IQ	1		TRUE COMFORT LANCET	1	
TANDEM MOBI AUTOSOFT 30 KT 23"	1		TRUE METRIX AIR GLUCOSE METER	1	
TANDEM MOBI AUTOSOFT XC KIT 5"	1		TRUE METRIX GLUCOSE METER	1	
TANDEM MOBI AUTOSOFT XC KT 23"	1		TRUE METRIX GLUCOSE TEST STRIP	1	
TANDEM MOBI CARTRIDGE	1		TRUE METRIX GO GLUCOSE METER	1	
TANDEM MOBI SYSTEM	1		TRUE METRIX LEVEL 1	1	
TANDEM MOBI TRUSTEEL KIT 23"	1		TRUE METRIX LEVEL 2	1	
TDVAX	1		TRUE METRIX LEVEL 3	1	
TECENTRIQ HYBREZA	5	BvD	TRUEDRAW LANCING DEVICE	1	
TECHLITE LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE	1		TRUEPLUS LANCETS	1	
			TRUERESULT BLOOD GLUCOSE SYSTM	1	

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TRUETEST TEST STRIPS	1		ULTRATRAK GLUCOSE METER	1	
TRUETRACK BLOOD GLUCOSE SYSTEM	1		ULTRATRAK HIGH-LOW CONTROL	1	
TRUETRACK SMART SYSTEM	1		ULTRATRAK NORMAL CONTROL	1	
TRUETRACK TEST	1		ULTRATRAK ULTIMATE	1	
TRUSTEEL INFUSION SET 23"	1		UNILET COMFORTOUCH LANCET	1	
TRUSTEEL INFUSION SET 32"	1		UNILET GP LANCET	1	
TWIST LANCETS	1		UNILET LANCET	1	
ULTI-LANCE	1		UNILET LANCETS	1	
ULTILET BASIC LANCETS	1		UNILET SUPER THIN LANCETS	1	
ULTILET CLASSIC LANCETS	1		UNISTIK 2 DEVICE	1	
ULTILET LANCETS	1		UNISTIK 2 NORMAL LANCET	1	
ULTILET SAFETY LANCETS	1		UNISTIK 3 COMFORT LANCET	1	
ULTIMA MONITOR	1		UNISTIK 3 EXTRA LANCET	1	
ULTIMA TEST STRIPS	1		UNISTIK 3 GENTLE	1	
ULTRA THIN II LANCETS	1		UNISTIK 3 NORMAL LANCET	1	
ULTRA THIN LANCETS	1		UNISTIK COMFORT LANCETS	1	
ULTRA THIN PLUS LANCETS	1		UNISTIK CZT LANCET	1	
ULTRA-CARE LANCETS	1		UNISTIK EXTRA LANCETS	1	
ULTRALANCE LANCETS	1		UNISTIK NORMAL LANCETS	1	
ULTRA-THIN II LANCETS	1		UNISTIK PRO LANCET	1	
ULTRATRAK	1		UNISTIK SAFETY	1	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
UNISTIK TOUCH LANCETS	1		VYVGART	5	PA
UNISTRIP LOW CONTROL	1		VYVGART HYTRULO SUBCUTANEOUS SOLUTION	5	PA
UNISTRIP1 TEST STRIP	1		WAVESENSE CONTROL SOLUTION	1	
UNIVERSAL 1 LANCETS	1		Ophthalmic Agents		
VARISOFT INFUSION SET 23"	1		Ophthalmic Agents, Other		
VARISOFT INFUSION SET 32"	1		<i>atropine ophthalmic (eye) drops 1 %</i>	3	
VARISOFT INFUSION SET 43"	1		<i>cyclosporine ophthalmic (eye)</i>	3	QL (60 EA per 30 days)
VARIZIG	3		CYSTARAN	5	PA
VERIFINE SAFETY LANCET MINI	1		<i>dorzolamide-timolol</i>	2	
VERIFINE UNIVERSAL LANCET	1		<i>neomycin-bacitracin- poly-hc</i>	3	
VIVAGUARD INO CTRL SOLN-L1,2,3	1		<i>neomycin-bacitracin- polymyxin</i>	3	
VIVAGUARD INO CTRL SOLN-L1,L3	1		<i>neomycin-polymyxin b- dexameth</i>	2	
VIVAGUARD INO CTRL SOLN-L2	1		<i>neomycin-polymyxin- gramicidin</i>	3	
VIVAGUARD INO GLUCOSE METER	1		<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	4	
VIVAGUARD INO SMART GLUC METER	1		NEO-POLYCIN	3	
VIVAGUARD INO TEST STRIP	1		NEO-POLYCIN HC	3	
VIVAGUARD LANCET	1		OXERVATE	5	PA
VIVAGUARD LANCING DEVICE	1		<i>polymyxin b sulf- trimethoprim</i>	2	
VIVAGUARD SAFETY LANCET	1		<i>sulfacetamide- prednisolone</i>	2	
			<i>tobramycin- dexamethasone</i>	3	QL (10 ML per 14 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
XDEMVY	5	PA; QL (10 ML per 42 days)	<i>sulfacetamide sodium ophthalmic (eye)</i>	2	
XiIDRA	3	QL (60 EA per 30 days)	<i>tobramycin ophthalmic (eye)</i>	2	QL (10 ML per 14 days)
Ophthalmic Anti- Allergy Agents					
<i>azelastine ophthalmic (eye)</i>	3		<i>trifluridine</i>	3	
<i>cromolyn ophthalmic (eye)</i>	2		XDEMVY	5	PA; QL (10 ML per 42 days)
<i>epinastine</i>	3		ZIRGAN	4	
Ophthalmic Anti- Infectives					
<i>bacitracin ophthalmic (eye)</i>	3		Ophthalmic Anti- Inflammatories		
<i>bacitracin-polymyxin b</i>	2		<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	2	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	2		<i>diclofenac sodium ophthalmic (eye)</i>	2	
<i>erythromycin ophthalmic (eye)</i>	2	QL (3.5 GM per 14 days)	<i>fluorometholone</i>	3	
<i>gentamicin ophthalmic (eye) drops</i>	2	QL (70 ML per 30 days)	<i>flurbiprofen sodium</i>	2	
<i>moxifloxacin ophthalmic (eye) drops</i>	3		<i>ketorolac ophthalmic (eye)</i>	2	
NATACYN	4		<i>loteprednol etabonate</i>	3	
<i>neomycin-bacitracin- polymyxin</i>	3		<i>prednisolone acetate</i>	2	
<i>neomycin-polymyxin- gramicidin</i>	3		<i>prednisolone sodium phosphate ophthalmic (eye)</i>	2	
NEO-POLYCIN	3		XiIDRA	3	QL (60 EA per 30 days)
<i>ofloxacin ophthalmic (eye)</i>	2		Ophthalmic Beta- Adrenergic Blocking Agents		
POLYCIN	2		<i>betaxolol ophthalmic (eye)</i>	3	
<i>polymyxin b sulf- trimethoprim</i>	2		<i>carteolol</i>	2	

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Drug Name	Drug Tier	Requirements/ Limits
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	4	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
<i>acetazolamide</i>	3	
<i>apraclonidine</i>	3	
<i>brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %</i>	3	
<i>brimonidine ophthalmic (eye) drops 0.2 %</i>	2	
<i>dorzolamide</i>	2	
<i>dorzolamide-timolol</i>	2	
<i>methazolamide</i>	4	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	3	
Ophthalmic Prostaglandin And Prostamide Analogs		
<i>latanoprost</i>	1	
<i>travoprost</i>	3	
Otic Agents		
Otic Agents		
<i>acetic acid otic (ear)</i>	2	
<i>ciprofloxacin hcl otic (ear)</i>	4	
<i>ciprofloxacin-dexamethasone</i>	3	QL (7.5 ML per 7 days)
<i>FLAC OTIC OIL</i>	4	
<i>fluocinolone acetonide oil</i>	4	
<i>hydrocortisone-acetic acid</i>	4	

Drug Name	Drug Tier	Requirements/ Limits
<i>neomycin-polymyxin-hc otic (ear)</i>	3	
<i>ofloxacin otic (ear)</i>	3	
Respiratory Tract/ Pulmonary Agents		
Antihistamines		
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	3	QL (60 ML per 30 days)
<i>cetirizine oral solution 1 mg/ml</i>	2	
<i>hydroxyzine hcl oral tablet</i>	2	PA
<i>levocetirizine oral solution</i>	4	
<i>levocetirizine oral tablet</i>	2	QL (30 EA per 30 days)
<i>promethazine oral</i>	4	PA
Anti-Inflammatories, Inhaled Corticosteroids		
<i>ASMANEX HFA</i>	3	QL (13 GM per 30 days)
<i>ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)</i>	3	QL (1 EA per 30 days)

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	3	QL (2 EA per 30 days)	Antileukotrienes		
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	4	BvD; QL (120 ML per 30 days)	<i>montelukast oral granules in packet</i>	4	
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	4	BvD; QL (60 ML per 30 days)	<i>montelukast oral tablet</i>	2	
<i>flunisolide</i>	3	QL (50 ML per 30 days)	<i>montelukast oral tablet, chewable</i>	2	
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	4	ST; QL (12 GM per 30 days)	<i>zafirlukast</i>	4	
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	4	ST; QL (24 GM per 30 days)	Bronchodilators, Anticholinergic		
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	4	ST; QL (10.6 GM per 30 days)	<i>ATROVENT HFA</i>	4	QL (25.8 GM per 30 days)
<i>fluticasone propionate nasal</i>	2	QL (16 GM per 30 days)	<i>COMBIVENT RESPIMAT</i>	3	QL (8 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	3	QL (10.6 GM per 30 days)	<i>ipratropium bromide inhalation</i>	2	BvD
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	3	QL (21.2 GM per 30 days)	<i>ipratropium bromide nasal</i>	2	QL (30 ML per 30 days)
			<i>ipratropium-albuterol</i>	2	BvD
			<i>SPIRIVA RESPIMAT</i>	3	QL (4 GM per 30 days)
			<i>tiotropium bromide</i>	3	QL (90 EA per 90 days)
			Bronchodilators, Sympathomimetic		
			<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	2	QL (17 GM per 30 days)
			<i>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</i>	2	BvD
			<i>albuterol sulfate oral syrup</i>	2	
			<i>albuterol sulfate oral tablet</i>	4	

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
<i>arformoterol</i>	4	BvD; QL (120 ML per 30 days)	PULMOZYME	5	BvD
DULERA	3	QL (13 GM per 30 days)	SYMDEKO	5	PA; QL (56 EA per 28 days)
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	3	QL (4 EA per 30 days)	<i>tobramycin in 0.225 % nacl</i>	5	PA; QL (280 ML per 28 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	4	ST; QL (12 GM per 30 days)	<i>tobramycin inhalation</i>	5	PA; QL (224 ML per 28 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	4	ST; QL (24 GM per 30 days)	TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	5	PA; QL (56 EA per 28 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	4	ST; QL (10.6 GM per 30 days)	TRIKAFTA ORAL TABLETS, SEQUENTIAL	5	PA; QL (84 EA per 28 days)
<i>formoterol fumarate</i>	4	BvD; QL (120 ML per 30 days)	Mast Cell Stabilizers		
STRIVERDI RESPIMAT	3	QL (4 GM per 30 days)	<i>cromolyn inhalation</i>	3	BvD
<i>terbutaline oral</i>	4		<i>cromolyn oral</i>	4	
Cystic Fibrosis Agents			Phosphodiesterase Inhibitors, Airways Disease		
CAYSTON	5	PA; QL (84 ML per 56 days)	<i>roflumilast</i>	4	PA; QL (30 EA per 30 days)
KALYDECO	5	PA; QL (56 EA per 28 days)	<i>theophylline oral solution</i>	4	
ORKAMBI ORAL GRANULES IN PACKET	5	PA; QL (56 EA per 28 days)	<i>theophylline oral tablet extended release 12 hr</i>	2	
ORKAMBI ORAL TABLET	5	PA; QL (112 EA per 28 days)	<i>theophylline oral tablet extended release 24 hr</i>	2	
Pulmonary Antihypertensives			ADEMPAS		
			ADEMPAS	5	PA; QL (90 EA per 30 days)
			ALYQ	5	PA; QL (60 EA per 30 days)
			<i>ambrisentan</i>	5	PA; QL (30 EA per 30 days)

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
<i>bosentan</i>	5	PA; QL (60 EA per 30 days)	COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
OPSUMIT	5	PA; QL (30 EA per 30 days)	DULERA	3	QL (13 GM per 30 days)
OPSYNVI	5	PA; QL (30 EA per 30 days)	DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
<i>sildenafil (pulm.hypertension) oral tablet</i>	3	PA; QL (90 EA per 30 days)	DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; QL (4.56 ML per 28 days)
<i>tadalafil (pulm. hypertension)</i>	5	PA; QL (60 EA per 30 days)	DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; QL (8 ML per 28 days)
UPTRAVI ORAL TABLET	5	PA; QL (60 EA per 30 days)	<i>fluticasone propion-salmeterol inhalation blister with device</i>	3	QL (60 EA per 30 days)
UPTRAVI ORAL TABLETS,DOSE PACK	5	PA; QL (200 EA per 180 days)	<i>ipratropium-albuterol</i>	2	BvD
Pulmonary Fibrosis Agents			STIOLTO RESPIMAT	3	QL (4 GM per 30 days)
OFEV	5	PA; QL (60 EA per 30 days)	TRELEGY ELLIPTA	3	QL (60 EA per 30 days)
<i>pirfenidone oral capsule</i>	5	PA; QL (270 EA per 30 days)	WIXELA INHUB	3	QL (60 EA per 30 days)
<i>pirfenidone oral tablet 267 mg</i>	5	PA; QL (270 EA per 30 days)	Respiratory Tract/ Pulmonary Agents		
<i>pirfenidone oral tablet 801 mg</i>	5	PA; QL (90 EA per 30 days)	BREZTRI AEROSPHERE	3	QL (10.7 GM per 30 days)
Respiratory Tract Agents, Other			COMBIVENT RESPIMAT	3	QL (8 GM per 30 days)
<i>acetylcysteine</i>	3	BvD	<i>ipratropium-albuterol</i>	2	BvD
BREYNA	3	QL (10.3 GM per 30 days)			
BREZTRI AEROSPHERE	3	QL (10.7 GM per 30 days)			
<i>budesonide-formoterol</i>	3	QL (10.2 GM per 30 days)			

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

Drug Name	Drug Tier	Requirements/ Limits
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	4	PA
Sleep Disorder Agents		
Sleep Promoting Agents		
BELSOMRA	3	PA; QL (30 EA per 30 days)
<i>doxepin oral tablet</i>	3	QL (30 EA per 30 days)
<i>ramelteon</i>	3	QL (30 EA per 30 days)
<i>zaleplon oral capsule 10 mg</i>	4	QL (60 EA per 30 days)
<i>zaleplon oral capsule 5 mg</i>	4	QL (30 EA per 30 days)
<i>zolpidem oral tablet</i>	2	QL (30 EA per 30 days)
Wakefulness Promoting Agents		
<i>armodafinil</i>	4	PA; QL (30 EA per 30 days)
<i>modafinil oral tablet 100 mg</i>	3	PA; QL (30 EA per 30 days)
<i>modafinil oral tablet 200 mg</i>	3	PA; QL (60 EA per 30 days)
<i>sodium oxybate</i>	5	PA; QL (540 ML per 30 days)

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

Index

2-IN-1 LANCET DEVICE	82	<i>acetaminophen-codeine</i>	20	<i>albendazole</i>	42
2TEK CONTROL (HIGH-NORMAL).....	82	<i>acetazolamide</i>	57, 101	<i>albuterol sulfate</i>	102
<i>abacavir</i>	47	<i>acetic acid</i>	22, 101	<i>alclometasone</i>	62
<i>abacavir-lamivudine</i>	47	<i>acetylcysteine</i>	104	ALCOHOL PADS	53, 64
ABELCET	31	<i>acitretin</i>	62	ALECENSA	35
ABILIFY ASIMTUFII	28, 43	ACTEMRA	78	<i>alendronate</i>	82
ABILIFY MAINTENA	28, 43	ACTEMRA ACTPEN	78	<i>alfuzosin</i>	69
<i>abiraterone</i>	33	ACTHIB (PF)	80	<i>aliskiren</i>	57
ABIRTEGA	33	ACTI-LANCE LANCETS	83	<i>allopurinol</i>	32
ABRYSVO (PF)	80	ACTIMMUNE	78	<i>alosetron</i>	67
<i>acamprosate</i>	21	<i>acyclovir</i>	46, 64	<i>alprostadil</i>	83
<i>acarbose</i>	51	<i>acyclovir sodium</i>	46	ALTAVERA (28)	71, 73
ACCU-CHEK AVIVA CONTROL SOLN	82	ADACEL(TDAP ADOLESN/ADULT)(PF)	80	ALTERNATE SITE LANCET	83
ACCU-CHEK AVIVA PLUS TEST STRP	82	ADBRY	62	ALTERNATE SITE LANCING DEVICE	83
ACCU-CHEK FASTCLIX LANCET DRUM	82	<i>adefovir</i>	46	ALUNBRIG	35
ACCU-CHEK FASTCLIX LANCING DEV	82	ADEMPAS	103	ALYACEN 1/35 (28)	72, 73
ACCU-CHEK GUIDE GLUCOSE METER	82	ADJUSTABLE LANCING DEVICE	83	ALYQ	103
ACCU-CHEK GUIDE L1-L2 CTRL SOL	82	ADVANCED ALL-IN-ONE METER	83	<i>amantadine hcl</i>	42, 48
ACCU-CHEK GUIDE ME GLUCOSE MTR	82	ADVANCED GLUC METER TEST STRIP	83	<i>ambrisentan</i>	103
ACCU-CHEK GUIDE TEST STRIPS	83	ADVANCED GLUCOSE METER	83	<i>amikacin</i>	21
ACCU-CHEK SAFE-T-PRO	83	ADVANCED LANCING DEVICE	83	<i>amiloride</i>	58
ACCU-CHEK SAFE-T-PRO PLUS	83	ADVANCED TRAVEL LANCETS	83	<i>amiloride-hydrochlorothiazide</i>	57
ACCU-CHEK SMARTVIEW CONTRL SOL	83	ADVOCATE LANCET	83	<i>amiodarone</i>	56
ACCU-CHEK SMARTVIEW TEST STRIP	83	ADVOCATE LANCING DEVICE	83	<i>amitriptyline</i>	30
ACCU-CHEK SOFT DEV LANCETS	83	ADVOCATE REDI-CODE PLUS	83	<i>amlodipine</i>	57
ACCU-CHEK SOFTCLIX LANCETS	83	ADVOCATE REDI-CODE PLUS CTRL L	83	<i>amlodipine-benazepril</i>	57
ACCUTANE	62, 64	ADVOCATE REDI-CODE+ CTRL HIGH	83	<i>amlodipine-olmesartan</i>	57
ACCUTREND GLUCOSE CONTROL	83	AGAMATRIX AMP TEST STRIPS	83	<i>amlodipine-valsartan</i>	57
ACCUTREND GLUCOSE TEST STRIPS	83	AGAMATRIX CONTROL SOLN-HIGH	83	<i>amlospirene-valsartan-hctiazid</i>	57
<i>acebutolol</i>	56	AGAMATRIX CONTROL SOLN-NORM-HI	83	<i>ammonium lactate</i>	62
		AKEEGA	35	AMNESTEEM	62
		ALA-CORT	62	<i>amoxapine</i>	30
				<i>amoxicillin</i>	23
				<i>amoxicillin-pot clavulanate</i>	23, 83
				<i>amphotericin b</i>	31
				<i>ampicillin</i>	23
				<i>ampicillin sodium</i>	23, 83
				<i>ampicillin-sulbactam</i>	23
				<i>anagrelide</i>	54
				<i>anastrozole</i>	35
				<i>apraclonidine</i>	101
				<i>aprepitant</i>	30
				APRI	72, 73
				APTIOM	27
				APTIVUS	48

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AQUA LANCE LANCING DEVICE	83	AUSTEDO	60	<i>bexarotene</i>	41
ARANELLE (28)	72, 73	AUSTEDO XR	60	BEXSERO	80
ARCALYST	76	AUSTEDO XR TITRATION		<i>bicalutamide</i>	33
AREXVY (PF)	80	KT(WK1-4)	60	BICILLIN L-A	23
<i>arformoterol</i>	103	AUTO-LANCET MINI	84	BIKTARVY	46
ARIKAYCE	21	AUTOLET IMPRESSION		BIONIME RIGHTEST GM300 SYSTEM	84
<i>ariPIPRAZOLE</i>	28, 43	LANC DEV	84	BIONIME RIGHTEST TEST STRIPS	84
ARISTADA	43	AUTOLET LANCING		BIOTEL CARE BGM-4	
ARISTADA INITIO	43	DEVICE	84	METER	84
<i>armodafinil</i>	105	AUTOSOFT 30	84	<i>bisoprolol fumarate</i>	56
<i>asenapine maleate</i>	43, 50	AUTOSOFT 90	84	<i>bisoprolol-hydrochlorothiazide</i>	57
ASMANEX HFA	101	AUTOSOFT XC INFUSION		<i>blood glucose contrl hi,normal</i>	84
ASMANEX TWISTHALER	101, 102	SET 23"	84	<i>blood glucose control, normal</i>	84
<i>aspirin-dipyridamole</i>	55	AUTOSOFT XC INFUSION		BLOOD GLUCOSE	
ASSURE 4 CONTROL SOLUTION	83	SET 32"	84	MONITORING	84
ASSURE 4 STRIPS	83	AUVELITY	28	BLOOD GLUCOSE TEST	84
ASSURE DOSE NORMAL CONTROL	83	AVIANE	72, 73	<i>blood-glucose meter</i>	84
ASSURE DOSE NORM-HI CONTROL	83	AVONEX	61	BLULINK BG SYSTEM	
ASSURE LANCE	83	AYVAKIT	35	REFILL	84
ASSURE LANCE PLUS	83	<i>azathioprine</i>	78	BLULINK DIABETIC TEST	
ASSURE PLATINUM GLUCOSE METER	84	<i>azelastine</i>	100, 101	BUNDLE	84
ASSURE PLATINUM TEST STRIP	84	<i>azithromycin</i>	24, 84	BLULINK GLUCOSE MONITOR SYSTEM	84
ASSURE PRISM CONTROL 1-2 SOLN	84	<i>aztreonam</i>	22	BLULINK GLUCOSE TEST	
ASSURE PRISM MULTI METER	84	AZURETTE (28)	72	STRIP	84
ASSURE PRISM MULTI STRIP	84	<i>bacitracin</i>	100	BOOSTRIX TDAP	80
atazanavir	48	<i>bacitracin-polymyxin b</i>	100	<i>bosentan</i>	104
atenolol	56	<i>baclofen</i>	45	BOSULIF	35
<i>atenolol-chlorthalidone</i>	57	<i>balsalazide</i>	81	BRAFTOVI	35
atomoxetine	60	BALVERSA	35	BREEZE 2 CONTROL	
atorvastatin	59	BARACLUDE	46	SOLUTION, LOW	84
atovaquone	42	<i>bcg vaccine, live (pf)</i>	80	BREEZE 2 CONTROL	
atovaquone-proguanil	42	BD MICROTAINER LANCET	84	SOLUTION, NML	84
atropine	99	BELSOMRA	105	BREEZE 2 CONTROL	
ATROVENT HFA	102	<i>benazepril</i>	55	SOLUTION,HIGH	84
AUBRA EQ	72, 73	benazepril-hydrochlorothiazide	57	BREYNA	104
AUGMENTIN	23	BENLYSTA	76, 78	BREZTRI AEROSPHERE	104
AUGTYRO	35	<i>benztropine</i>	42	BRILINTA	55
		BESREMI	34, 78	<i>brimonidine</i>	101
		<i>betaine</i>	69	BRIVIACT	25
		<i>betamethasone dipropionate</i>	62	<i>bromocriptine</i>	42, 75
		<i>betamethasone valerate</i>	62	BRUKINSA	35
		<i>betamethasone, augmented</i>	62	<i>budesonide</i>	70, 81, 102
		BETASERON	61	<i>budesonide-formoterol</i>	104
		<i>betaxolol</i>	56, 100		
		<i>bethanechol chloride</i>	70		

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

BULLSEYE MINI SAFETY	
LANCETS.....	84
bumetanide.....	58
buprenorphine hcl.....	19, 21
buprenorphine-naloxone	21
bupropion hcl.....	28, 29
bupropion hcl (smoking deter)....	21
buspirone.....	48
butorphanol.....	20
BUTTERFLY TOUCH	
LANCET.....	84
cabergoline.....	75
CABLIVI.....	55
CABOMETYX.....	36
calcipotriene.....	64
calcitonin (salmon).....	82
calcitriol.....	82
calcium acetate(phosphat bind).....	67, 84
CALQUENCE	
(ACALABRUTINIB MAL).....	36
CAMILA.....	73
CAMZYOS.....	57
candesartan.....	55
candesartan-hydrochlorothiazid.	57
CAPLYTA.....	43
CAPRELSA.....	36
captopril.....	55
carbamazepine	27, 51, 60
carbidopa.....	42
carbidopa-levodopa.....	42
carbidopa-levodopa-entacapone	42
CAREONE LANCING	
DEVICE.....	84
CAREONE ULTRA THIN	
LANCET.....	84
CARESENS CONTROL A	
AND B.....	84
CARESENS LANCETS	84
CARESENS N	84
CARESENS N FELIZ BT	
GLUC METER.....	85
CARESENS N FELIZ	
GLUCOSE METER.....	85
CARESENS N TEST STRIPS ...	85
CARESENS N VOICE.....	85
CARETOUCH CONTROL	
SOLN L2-L3.....	85
CARETOUCH GLUCOSE	
MONITORING.....	85
CARETOUCH LANCING	
DEVICE.....	85
CARETOUCH SAFETY	
LANCETS	85
CARETOUCH TEST STRIP	85
CARETOUCH TWIST	
LANCET.....	85
carglumic acid.....	65
carteolol.....	100
CARTIA XT.....	56, 57
carvedilol.....	56
caspofungin.....	31
CAYSTON.....	103
cefaclor.....	22
cefadroxil.....	22
cefazolin.....	22
cefdinir.....	22
cefepime	23
cefixime	23
cefoxitin.....	23
cefpodoxime	23
cefprozil.....	23
ceftazidime	23
ceftriaxone	23
cefuroxime axetil	23
cefuroxime sodium	23
celecoxib	19
cephalexin	23
cetirizine	101
CHEMET.....	66
chlorhexidine gluconate	62
chloroquine phosphate	42
chlorpromazine.....	30, 42
chlorthalidone	58
cholestyramine (with sugar).....	59
CHOLESTYRAMINE LIGHT ..	59
CHOSEN LANCET	85
CHOSEN LANCING DEVICE ..	85
CHOSEN SAFETY LANCET ...	85
ciclopirox	31, 64
cilostazol	55
CIMDUO	47
cinacalcet	82
CINRYZE.....	76
ciprofloxacin hcl... ..	24, 85, 100, 101
ciprofloxacin in 5 % dextrose	24
ciprofloxacin-dexamethasone ..	101
citalopram.....	29
CLARAVIS.....	62
clarithromycin.....	24
CLEVER CHEK BLOOD	
GLUCOSE.....	85
CLEVER CHEK BLOOD	
GLUCOSE SYST	85
CLEVER CHEK LANCETS	85
CLEVER CHOICE BLOOD	
GLUC SYS	85
CLEVER CHOICE GLUCOSE	
MONITOR.....	85
CLEVER CHOICE LEVEL 1	
CONTROL.....	85
CLEVER CHOICE LEVEL 2	
CONTROL.....	85
CLEVER CHOICE LEVEL 3	
CONTROL.....	85
CLEVER CHOICE MICRO	85
CLEVER CHOICE MICRO	
TEST STRIP	85
CLEVER CHOICE PRO	85
CLEVER CHOICE TALK	
GLUCOSE SYS	85
CLEVER CHOICE TALK	
TEST	85
CLEVER CHOICE TEST	
STRIPS	85
CLEVER CHOICE VOICE	
PLUS TEST	85
clindamycin hcl	22
clindamycin in 5 % dextrose	22
clindamycin phosphate	22, 64
CLINIMIX 5%/D15W	
SULFITE FREE	66
CLINIMIX 4.25%/D10W	
SULF FREE	66
CLINIMIX 4.25%/D5W	
SULFIT FREE	66
CLINIMIX 5%-	
D20W(SULFITE-FREE)	66
clobazam	26
clobetasol	62, 63

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

<i>clobetasol-emollient</i>	63	CONTOUR NEXT LEV 2	<i>d5 %-0.45 % sodium chloride</i>	
<i>clomiphene citrate</i>	85	CONTROL SOL	.....	65, 66
<i>clomipramine</i>	30	CONTOUR NEXT LINK	.....	86
<i>clonazepam</i>	26, 49	CONTOUR NEXT LINK 2.4	.....	86
<i>clonidine</i>	55	CONTOUR NEXT METER	.....	86
<i>clonidine hcl</i>	55, 60	CONTOUR NEXT ONE		
<i>clopidogrel</i>	55	METER	.....	86
<i>clorazepate dipotassium</i>	26, 49	CONTOUR NEXT TEST		
<i>clotrimazole</i>	31	STRIPS	.....	86
<i>clotrimazole-betamethasone</i>	64	CONTOUR PLUS BLUE		
<i>clozapine</i>	45	METER	.....	86
COAGUCHEK LANCETS	85	CONTOUR PLUS TEST		
COARTEM	42	STRIP	.....	86
COBENFY	43	CONTOUR TEST STRIPS	.....	86
COBENFY STARTER PACK	43	COPIKTRA	.....	36
<i>colchicine</i>	32	COSENTYX	.....	76
<i>colesevelam</i>	51, 59	COSENTYX (2 SYRINGES)	.....	76
<i>colestipol</i>	59	COSENTYX PEN (2 PENS)	.....	76
<i>colistin (colistimethate na)</i>	22	COSENTYX UNREADY		
COLOR LANCETS	85	PEN	.....	76
COMBIVENT RESPIMAT		COTELLIC	.....	36
	102, 104	CREON	.....	69
COMETRIQ	36	CRESEMBIA	.....	31
COMFORT EZ LANCETS	85	<i>cromolyn</i>	.....	69, 100, 103
COMFORT TOUCH PLUS		CRYSELLE (28)	.....	72, 73
SAFETY LANC	85	<i>cyclobenzaprine</i>	.....	105
COMFORT TOUCH ULT		<i>cyclophosphamide</i>	.....	33
THIN LANCETS	85	<i>cyclosporine</i>	.....	78, 99
COMIRNATY 2024-25 (12Y UP)(PF)	85	<i>cyclosporine modified</i>	.....	78
COMPLERA	47	CYLTEZO(CF)	.....	78
COMPRO	30	CYLTEZO(CF) PEN	.....	78
CONSTULOSE	67	CYLTEZO(CF) PEN		
CONTOUR CONTROL		CROHN'S-UC-HS	.....	78
SOLUTION, HIGH	85	CYLTEZO(CF) PEN		
CONTOUR CONTROL		PSORIASIS-UV	.....	78
SOLUTION, LOW	86	CYRED EQ	.....	72, 73
CONTOUR CONTROL		CYSTAGON	.....	69
SOLUTION, NML	86	CYSTARAN	.....	69, 99
CONTOUR METER	86	<i>d10 %-0.45 % sodium chloride</i>	.....	65, 66
CONTOUR NEXT EZ METER	86	<i>d2.5 %-0.45 % sodium chloride</i>	.....	65, 66
CONTOUR NEXT GEN		D5 % (D-GLUCOSE)-0.9 %	.....	65, 66
METER	86	SODCHLR	.....	86
CONTOUR NEXT GLUCOSE		<i>d5 % and 0.9 % sodium chloride</i>	65, 66
METER	86			
CONTOUR NEXT LEV 1				
CONTROL SOL	86			

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DIATRUE CONTROL		<i>drospernone-ethinyl estradiol</i>	EASY TOUCH GLUCOSE
SOLUTION LOW.....	8671, 72	MONITOR.....87
DIATRUE PLUS BLOOD		DROXIA.....86	EASY TOUCH HIGH-LOW
GLUCOSE MET.....	86	<i>droxidopa</i>.....55	CONTROL.....87
DIATRUE PLUS TEST STRIP..	86	DULERA.....103, 104	EASY TOUCH LANCETS.....87
<i>diazepam</i>	26, 49	<i>duloxetine</i>.....29, 49, 61	EASY TOUCH LANCING
DIAZEPAM INTENSOL....	26, 49	DUPIXENT PEN....63, 76, 78, 104	DEVICE.....87
<i>diazoxide</i>	53	DUPIXENT SYRINGE	EASY TOUCH SAFETY
<i>diclofenac potassium</i>	19	.....63, 76, 78, 104	LANCETS.....87
<i>diclofenac sodium</i>	19, 100	<i>dutasteride</i>.....69	EASY TOUCH TEST STRIP.....87
<i>dicloxacillin</i>	23	EASY COMFORT LANCETS...86	EASY TOUCH TWIST
<i>dicyclomine</i>	68	EASY MINI EJECT LANCING	LANCETS.....87
DIFICID.....	24	DEVICE.....86	EASY TRAK BLOOD
<i>diflunisal</i>	19	EASY PLUS II BLOOD	GLUCOSE METER.....87
<i>digoxin</i>	56, 57	GLUCOSE MET.....86	EASY TRAK GLUCOSE
<i>dihydroergotamine</i>	32	EASY PLUS II HIGH	TEST.....87
DILANTIN.....	27	CONTROL.....86	EASY TRAK HIGH
<i>diltiazem hcl</i>	56, 57	EASY PLUS II LOW	CONTROL.....87
DLIT-XR.....	56, 57	CONTROL.....86	EASY TRAK II BLOOD
<i>dimethyl fumarate</i>	61	EASY PLUS II TEST.....86	GLUCOSE MTR.....87
<i>diphenoxylate-atropine</i>	67, 68	EASY STEP.....86	EASY TRAK II CTRL SOLN-
<i>dipyridamole</i>	55	EASY STEP BLOOD	NORMAL.....87
<i>disulfiram</i>	21	GLUCOSE METER.....86	EASY TRAK II TEST STRIP.....87
<i>divalproex</i>	25, 32, 51	EASY STEP HIGH CONTROL	EASY TRAK LOW
<i>dofetilide</i>	56	SOLN.....87	CONTROL.....87
<i>donepezil</i>	28	EASY STEP LOW CONTROL	EASY TWIST AND CAP
DOPTOLET (10 TAB PACK)....	55	SOLUTION.....87	LANCETS.....87
DOPTOLET (15 TAB PACK)....	55	EASY STEP NORMAL	EASYGLUCO METER.....87
DOPTOLET (30 TAB PACK)....	55	CONTROL SOLN.....87	EASYGLUCO TEST.....87
<i>dorzolamide</i>	101	EASY TALK BLOOD	EASYMAX.....87
<i>dorzolamide-timolol</i>	99, 101	GLUCOSE METER.....87	EASYMAX 15 LEVEL 2.....87
DOTTI.....	71	EASY TALK GLUCOSE TEST	EASYMAX 15 TEST STRIPS.....87
DOVATO.....	46	EASY TALK HIGH	EASYMAX NG.....87
<i>doxazosin</i>	55, 69	CONTROL.....87	EASYMAX NORMAL
<i>doxepin</i>	30, 48, 105	EASY TALK LOW CONTROL	CONTROL.....87
<i>doxercalciferol</i>	82	EASY TALK PLUS II HIGH	EASYMAX T1.....87
DOXY-100.....	24	CONTROL.....87	EASYMAX V SPEAKING
<i>doxycycline hyclate</i>	24, 62	EASY TALK PLUS II LOW	GLUCOSE SYS.....87
<i>doxycycline monohydrate</i>	24, 25	CONTROL.....87	EASY-TOUCH BLOOD
DRIZALMA SPRINKLE....	29, 49	EASY TALK PLUS II TEST	GLUCOSE METER.....87
<i>dronabinol</i>	30	STRIP.....87	<i>econazole nitrate</i>.....31, 65
DROPLET GENTEEL		EASY TOUCH BLU CTRL	EDURANT.....47
LANCING DEVICE.....	86	SOLN-L1,L3.....87	<i>efavirenz</i>.....47
DROPLET LANCETS.....	86	EASY TOUCH BLULINK	<i>efavirenz-emtricitabin-tenofov</i>....47
DROPLET LANCING		GLUC SYST.....87	<i>efavirenz-lamivu-tenofov disop</i>47
DEVICE.....	86	EASY TOUCH BLULINK	<i>electrolyte-148</i>65
		TEST STRIP.....87	

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Puede encontrar información sobre lo que significan los símbolos y abreviaturas de esta tabla yendo a la página 17.

ELEMENT COMPACT	EMBRACE SAFETY	ERIVEDGE	36
GLUCOSE METER	LANCET	ERLEADA	33
ELEMENT COMPACT HIGH	EMBRACE TALK BLOOD	<i>erlotinib</i>	36
CONTROL	GLUCOSE SYS	ERRIN	73
ELEMENT COMPACT	EMBRACE TALK CONTROL-	<i>ertapenem</i>	24
NORMAL CONTROL	HIGH (L2)	ERY PADS	65
ELEMENT COMPACT TEST	EMBRACE TALK CONTROL-	ERY-TAB	24
STRIPS	LOW (L1)	<i>erythromycin</i>	24, 100
ELEMENT COMPACT V	EMBRACE TALK GLUCOSE	<i>erythromycin ethylsuccinate</i>	24
GLUCOSE MTR	MONITOR	<i>erythromycin with ethanol</i>	65
ELEMENT HIGH CONTROL	EMBRACE TALK TEST	<i>escitalopram oxalate</i>	29, 49
ELEMENT LOW CONTROL	STRIPS	<i>esomeprazole magnesium</i>	68
ELEMENT NORMAL	EMBRACE WAVE GLUCOSE	ESTARYLLA	72, 73
CONTROL	TEST STRP	<i>estradiol</i>	71
ELEMENT PLUS BLOOD	EMBRACE WAVE PLUS	<i>estradiol valerate</i>	71
GLUCOSE KIT	GLUCOSE MTR	<i>estradiol-norethindrone acet</i>	72
ELEMENT TEST STRIPS	EMGALITY PEN	<i>ethambutol</i>	33
ELIGARD	EMGALITY SYRINGE	<i>ethosuximide</i>	26
ELIGARD (3 MONTH)	EMSAM	<i>ethynodiol diac-eth estradiol</i>	71, 72
ELIGARD (4 MONTH)	<i>emtricitabine</i>	<i>etodolac</i>	19
ELIGARD (6 MONTH)	<i>emtricitabine-tenofovir (tdf)</i>	<i>etongestrel-ethinyl estradiol</i>	71, 72
ELIQUIS	EMTRIVA	<i>etravirine</i>	47
ELIQUIS DVT-PE TREAT	EMVERM	EULEXIN	33
30D START	<i>enalapril maleate</i>	EUTHYROX	75
ELMIRON	<i>enalapril-hydrochlorothiazide</i>	EVENCARE G2	88
ELURYNG	ENBREL	EVENCARE G3 CONTROL	88
EMBRACE BLOOD	ENBREL MINI	EVENCARE G3 GLUCOSE	
GLUCOSE SYSTEM	ENBREL SURECLICK	METER	88
EMBRACE EVO BLOOD	ENDOCET	EVENCARE G3 TEST	88
GLUCOSE KIT	ENGERIX-B (PF)	EVENCARE MINI GLUCOSE	
EMBRACE EVO GLUCOSE	ENGERIX-B PEDIATRIC (PF)	TEST STR	88
MONITOR	<i>enoxaparin</i>	EVENCARE MINI MONITOR	
EMBRACE EVO LEVEL 1	ENPRESSE	SYSTEM	88
EMBRACE EVO TEST	ENSKYCE	EVENCARE PROVIEW TEST	
STRIPS	<i>entacapone</i>	STRIP	89
EMBRACE GLUCOSE	<i>entecavir</i>	<i>everolimus (antineoplastic)</i>	36, 79
CONTROL HIGH	ENTRESTO	<i>everolimus</i>	
EMBRACE GLUCOSE	ENTRESTO SPRINKLE	<i>(immunosuppressive)</i>	36, 37, 79
CONTROL LOW	ENULOSE	EVOLUTION BLOOD	
EMBRACE LANCETS	ENVARSUS XR	GLUCOSE METER	89
EMBRACE LANCING	EPIDIOLEX	EVOLUTION NORMAL	
DEVICE	<i>epinastine</i>	CONTROL	89
EMBRACE PRO	<i>epinephrine</i>	EVOLUTION TEST STRIPS	89
EMBRACE PRO GLUCOSE	EPITOL	EVOTAZ	48
METER	<i>eplerenone</i>	<i>exemestane</i>	35
EMBRACE PRO TEST	EPRONTIA	EXTENDED RESERVOIR	89
STRIPS	<i>ergotamine-caffeine</i>	E-Z JECT LANCETS	89

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E-Z JECT THIN LANCETS	89	flurbiprofen sodium	100	FORACARE GDH LOW
EZ SMART LANCETS	89	fluticasone propionate	102, 103	CONTROL.....90
EZ SMART PLUS SYSTEM	89	fluticasone propion-salmeterol.	104	FORACARE GDH NORMAL
EZ SMART PLUS TEST	89	fluvastatin	59	CONTROL.....90
EZ SMART SYSTEM	89	fluvoxamine	29	FORACARE LANCETS
EZ SMART TEST	89	fondaparinux	54	90
<i>ezetimibe</i>	59	FORA 6 CONNECT		<i>formoterol fumarate</i>
<i>ezetimibe-simvastatin</i>	59	GLUCOSE STRIP	89	103
FALMINA (28).....	72, 73	FORA 6CONN-GTEL-TN'G		<i>fosamprenavir</i>
<i>famciclovir</i>	46	ADV STRIP	89	48
<i>famotidine</i>	68	FORA D40-G31 TEST STRIPS	89	<i>fosinopril</i>
FANAPT	43	FORA G20	89	55
FARXIGA	51, 59	FORA G30A	89	<i>fosinopril-hydrochlorothiazide</i>
<i>febuxostat</i>	32	FORA GD50 BLOOD		58
<i>felbamate</i>	25	GLUCOSE SYSTEM	89	FOTIVDA.....37
<i>felodipine</i>	57	FORA GD50 TEST STRIPS	89	FRAICHE 5000.....90
<i>fenofibrate</i>	58	FORA GTEL GLUCOSE TEST		FREESTYLE CONTROL.....90
<i>fenofibrate micronized</i>	58	STRIP	89	FREESTYLE FLASH
<i>fenofibrate nanocrystallized</i>	58	FORA HIGH CONTROL	89	SYSTEM.....90
<i>fenofibric acid (choline)</i>	58	FORA LANCING DEVICE	89	FREESTYLE FREEDOM
<i>fentanyl</i>	19, 20	FORA LOW CONTROL	89	90
<i>fentanyl citrate</i>	89	FORA NORMAL CONTROL	89	FREESTYLE FREEDOM LITE
FETZIMA	29	FORA PREMIUM V10		90
<i>finasteride</i>	69	GLUCOSE METER	89	FREESTYLE INSULINX
FINGERSTIX LANCETS	89	FORA TEST N'GO VOICE		90
<i>fingolimod</i>	61	METER	89	FREESTYLE INSULINX
FINTEPLA	25	FORA TEST STRIP	89	TEST STRIPS
FIRMAGON KIT W DILUENT		FORA TN'G ADVAN PRO		90
SYRINGE	75	TEST STRIP	89	FREESTYLE LIBRE 14 DAY
FLAC OTIC OIL	101	FORA TN'G VOICE METER	89	READER.....90
<i>flecainide</i>	56	FORA TN'G VOICE TEST		FREESTYLE LIBRE 14 DAY
<i>fluconazole</i>	31	STRIPS	89	SENSOR.....90
<i>fluconazole in nacl (iso-osm)</i>	31	FORA V10	89	FREESTYLE LIBRE 2 PLUS
<i>flucytosine</i>	31	FORA V10-V12-D10-D20		SENSOR.....90
<i>fludrocortisone</i>	70	STRIPS	89	FREESTYLE LIBRE 2
<i>flunisolide</i>	102	FORA V12 BLOOD		READER.....90
<i>fluocinolone</i>	63	GLUCOSE SYSTEM	89	FREESTYLE LIBRE 2
<i>fluocinolone acetonide oil</i>	101	FORACARE GD20	89	TEST STRIPS
<i>fluocinolone and shower cap</i>	63	FORACARE GD20 GLUCOSE		90
<i>fluocinonide</i>	63	METER	89	FREESTYLE PRECISION
<i>fluocinonide-emollient</i>	63	FORACARE GD40 TEST		NEO METER
<i>fluorometholone</i>	100	STRIPS	89	90
<i>fluorouracil</i>	34, 64	FORACARE GD40B		FREESTYLE PRECISION
<i>fluoxetine</i>	29	GLUCOSE METER	89	NEO STRIPS
<i>fluphenazine decanoate</i>	42	FORACARE GDH HIGH		90
<i>fluphenazine hcl</i>	43	CONTROL	90	FREESTYLE SIDEKICK II
<i>flurbiprofen</i>	19			90
				FREESTYLE SYSTEM KIT
				90
				FREESTYLE TEST
				90
				FREESTYLE UNISTIK 2
				90
				FRUZAQLA.....37

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furosemide	58	GLUCOCARD 01 NORMAL	griseofulvin ultramicrosize	31
FUZEON	48	CONTROL	GUARDIAN 4 GLUCOSE	
FYAVOLV	72, 73	GLUCOCARD 01 SENSOR	SENSOR	91
FYCOMPA	25	PLUS	GUARDIAN 4	
gabapentin	26, 61	GLUCOCARD EXPRESSION	TRANSMITTER	91
galantamine	28	GLUCOCARD SHINE	GUARDIAN LINK 3	
GALLIFREY	73	GLUCOCARD SHINE	TRANSMITTER	91
GARDASIL 9 (PF)	80	CONNEX METER	GUARDIAN SENSOR 3	91
GATTEX 30-VIAL	68	GLUCOCARD SHINE	GVOKE	51, 53
GAUZE PAD	53	EXPRESS METER	GVOKE HYPOEN 2-PACK	53
GAVILYTE-C	67, 68	GLUCOCARD SHINE METER	GVOKE PFS 1-PACK	
GAVILYTE-G	67, 68	GLUCOCARD SHINE METER	SYRINGE	53
GAVILYTE-N	67, 68	KIT	halobetasol propionate	63
GAVRETO	37	GLUCOCARD SHINE TEST	haloperidol	43
GE100 BLOOD GLUCOSE		STRIPS	haloperidol decanoate	43
SYSTEM	90	GLUCOCARD SHINE XL	haloperidol lactate	43
GE100 BLOOD GLUCOSE		METER	HARMONY GLUCOSE TEST	
TEST STRIP	90	GLUCOCARD VITAL	STRIP	91
GE100 CONTROL SOLUTION		GLUCOCARD VITAL	HAVRIX (PF)	80
NORMAL	90	SENSOR	HEALTHPRO GLUCOSE	
GE333 BLOOD GLUCOSE		GLUCOCARD VITAL TEST	MONITOR	91
SYSTEM	90	STRIPS	HEALTHPRO HIGH-LOW	
GE333 BLOOD GLUCOSE		GLUCOCOM BLOOD	CONTROL	91
TEST STRIP	90	GLUCOSE	HEALTHPRO TEST STRIPS	91
gefitinib	37	GLUCOCOM CONTROL	HEATHER	73
gemfibrozil	58	HIGH	heparin (porcine)	54
GENERLAC	67	GLUCOCOM CONTROL	HEPLISAV-B (PF)	80
GENGRAF	79, 90	NORMAL	HIBERIX (PF)	80
GENSTRIP TEST STRIP	90	GLUCOCOM GLUCOSE	HUMALOG JUNIOR	
gentamicin	21, 100	GLUCOCOM LANCETS	KWIKPEN U-100	53
gentamicin in nacl (iso-osm)	21	GLUCOSE CONTROL	HUMALOG KWIKPEN	
GENTEEL VACUUM		GLUCOSE KETONE	INSULIN	53
LANCING DEVICE	90	CONTROL SOLN	HUMALOG MIX 50-50	
GENVOYA	46	glutamine (sickle cell)	KWIKPEN	53
GILOTRIF	37	glycopyrrolate	HUMALOG MIX 75-25	
glatiramer	61	GM100	KWIKPEN	53
GLATOPA	61	GOJJI BLOOD GLUCOSE	HUMALOG MIX 75-25(U-100)INSULN	53
GLEOSTINE	33	TEST STRIP	HUMALOG U-100 INSULIN	53
glimepiride	51	GOJJI GLUCOSE CNTRL	HUMIRA	79
glipizide	51	SOL-NORMAL	HUMIRA PEN	79
glipizide-metformin	51	GOJJI LANCET-GLUCOSE	HUMIRA(CF)	79
GLUCO NAVII GLUCOSE		TEST STRP	HUMIRA(CF) PEN	79
MONITOR	90	GOJJI LANCETS	HUMIRA(CF) PEN CROHNS-UC-HS	79
GLUCO NAVII TEST STRIP	91	GOJJI LANCING DEVICE	HUMIRA(CF) PEN PSOR-UV-ADOL HS	79
GLUCOCARD 01 HI-NORMAL CONTROL	91	GOMEKLI		
GLUCOCARD 01 METER	91	granisetron hcl		
		griseofulvin microsize		

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HUMULIN 70/30 U-100		IMOVAX RABIES VACCINE		<i>isosorbide mononitrate</i>	60
INSULIN.....	53	(PF).....	80	<i>isotretinoin</i>	62
HUMULIN 70/30 U-100		INBRIJA.....	42	ITOVEBI.....	37
KWIKPEN.....	53	INCASSIA.....	73	<i>itraconazole</i>	31
HUMULIN N NPH INSULIN		INCONTROL LANCING		<i>ivabradine</i>	58
KWIKPEN.....	53	DEVICE.....	92	<i>ivermectin</i>	42
HUMULIN N NPH U-100		INCONTROL SUPER THIN		IWLFIN.....	34
INSULIN.....	53	LANCETS.....	92	IXCHIQ (PF).....	80
HUMULIN R REGULAR U-100 INSULN.....	53	INCONTROL ULTRA THIN		IXIARO (PF).....	80
HUMULIN R U-500 (CONC)		LANCETS.....	92	JAKAFI.....	37
INSULIN.....	53	INCRELEX.....	70	JANTOVEN.....	54
HUMULIN R U-500 (CONC)		<i>indapamide</i>	58	JANUMET.....	51
KWIKPEN.....	53	INFANRIX (DTAP) (PF).....	80	JANUMET XR.....	51, 52
<i>hydralazine</i>	59	INFINITY CONTROL		JANUVIA.....	52
<i>hydrochlorothiazide</i>	58	SOLUTION HIGH.....	92	JARDIANCE.....	52
<i>hydrocodone-acetaminophen</i>	20	INFINITY CONTROL		JASMIEL (28).....	71, 72
<i>hydrocodone-ibuprofen</i>	20	SOLUTION LOW.....	92	JAYPIRCA.....	38
<i>hydrocortisone</i>	63, 70, 82	INFINITY CONTROL		JENTADUETO.....	52, 92
<i>hydrocortisone-acetic acid</i>	101	SOLUTION NORM.....	92	JENTADUETO XR.....	52
<i>hydromorphone</i>	19, 20	INFINITY METER KIT.....	92	JINTELI.....	72, 73
<i>hydromorphone (pf)</i>	19, 20	INFINITY STARTER KIT.....	92	JULEBER.....	72, 73
<i>hydroxychloroquine</i>	42	INFINITY TEST STRIPS.....	92	JULUCA.....	47
<i>hydroxyurea</i>	34	INJECT EASE LANCETS.....	92	JYLAMVO.....	34
<i>hydroxyzine hcl</i>	49, 101	INLYTA.....	37	JYNNEOS (PF).....	80
HYPOLANCE AST LANCING.	91	INQOVI.....	34	KALYDECO.....	103
<i>ibandronate</i>	82	INREBIC.....	37	KARIVA (28).....	72, 73
IBRANCE.....	35, 37	<i>insulin lispro</i>	53	KELNOR 1/35 (28).....	71, 72
IBU.....	19	<i>insulin syringe-needle u-100</i>	53	KELNOR 1/50 (28).....	71, 72
<i>ibuprofen</i>	19	INTELENCE.....	47	KERENDIA.....	58, 59
<i>icatibant</i>	76	INTRALIPID.....	65, 66	KESIMPTA PEN.....	61
ICLUSIG.....	37	INVACARE LANCETS.....	92	<i>ketoconazole</i>	31
<i>icosapent ethyl</i>	59	INVEGA HAFYERA.....	44	<i>ketorolac</i>	100
IDHIFA.....	34, 37	INVEGA SUSTENNA.....	44	KINRIX (PF).....	80
ILET INFUSION KIT-INSET 23".....	91	INVEGA TRINZA.....	44	KIONEX (WITH SORBITOL) ..	67
ILET INFUSION KIT-INSET 32".....	92	IPOL.....	80	KISQALI.....	38
ILET INFUSION-CONTACT DTCH 23".....	92	<i>ipratropium bromide</i>	102	KLOR-CON.....	65, 66
ILET INSULIN PUMP.....	92	<i>ipratropium-albuterol</i>	102, 104	KLOR-CON 10.....	65, 67
<i>imatinib</i>	37	<i>irbesartan</i>	55	KLOR-CON 8.....	65
IMBRUVICA.....	37	<i>irbesartan-hydrochlorothiazide</i> ..	58	KLOR-CON M10.....	65
<i>imipenem-cilastatin</i>	24	ISENTRESS.....	46, 47	KLOR-CON M15.....	65
<i>imipramine hcl</i>	30	ISENTRESS HD.....	46	KLOR-CON M20.....	65
<i>imiQuimod</i>	64	ISIBLOOM.....	72, 73	KOSELUGO.....	38
IMKELDI.....	37	ISOLYTE S PH 7.4.....	65	KOURZEQ.....	62
		ISOLYTE-P IN 5 %		KRAZATI.....	38
		DEXTROSE.....	65, 66	KURVELO (28).....	72, 73
		<i>isoniazid</i>	33	<i>l norgest/e.estriadiol-e.estrad</i> ..	72, 74
		<i>isosorbide dinitrate</i>	59	<i>labetalol</i>	56

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<i>lacosamide</i>	27	LEVOXYL	75	<i>malathion</i>	64
<i>lactulose</i>	67	<i>lidocaine</i>	20	<i>maraviroc</i>	48
LAGEVRIO (EUA)	48, 76	<i>lidocaine hcl</i>	20	MARLISSA (28)	72, 74
<i>lamivudine</i>	46, 47	LIDOCaine VISCOUS	20	MARPLAN	29
<i>lamivudine-zidovudine</i>	47	<i>lidocaine-prilocaine</i>	21	MATULANE	33
<i>lamotrigine</i>	25, 50, 51	LIDOCAN III	21	MATZIM LA	56, 57
<i>lancets</i>	92	LILETTA	72	MAVYRET	46
LANCETS, SUPER THIN	92	<i>linezolid</i>	22	<i>meclizine</i>	30
LANCETS,THIN	92	<i>linezolid in dextrose 5%</i>	22	MEDISENSE	92
LANCETS,ULTRA THIN	92	LINZESSION	67	MEDISENSE GLUCOSE	
<i>lancing device</i>	92	<i>liothyronine</i>	75	KETONE	92
LANCING DEVICE WITH LANCETS	92	<i>lisinopril</i>	55	MEDISENSE MID CONTROL	92
<i>lancing device with lancets</i>	92	<i>lisinopril-hydrochlorothiazide</i>	58	MEDISENSE THIN LANCETS	92
<i>lansoprazole</i>	68	<i>lithium carbonate</i>	51	MEDLANCE PLUS LANCETS	92
LANTUS SOLOSTAR U-100 INSULIN	53	<i>lithium citrate</i>	51	MEDLANCE PLUS SPECIAL	
LANTUS U-100 INSULIN	53	LIVTENCITY	46	BLADE	92
LANZO LANCING DEVICE	92	LOKELMA	67	<i>medroxyprogesterone</i>	74
<i>lapatinib</i>	38	LONSURF	34	MEDTRONIC EXT INFUSION	
LARIN 1.5/30 (21)	72, 74	<i>loperamide</i>	68	SET 23"	92
LARIN 1/20 (21)	72, 74	<i>lopinavir-ritonavir</i>	48	MEDTRONIC EXT INFUSION	
LARIN FE 1.5/30 (28)	72, 74	<i>lorazepam</i>	27, 49	SET 32"	92
LARIN FE 1/20 (28)	72, 74	LORAZEPAM INTENSOL	26, 49	<i>mefloquine</i>	42
<i>latanoprost</i>	101	LORBRENA	38	<i>megestrol</i>	74
LAZCLUZE	38	LORYNA (28)	71, 72	MEKINIST	38, 39
<i>ledipasvir-sofosbuvir</i>	46	<i>losartan</i>	55	MEKTOVI	39
<i>leflunomide</i>	76, 79	<i>losartan-hydrochlorothiazide</i>	58	<i>meloxicam</i>	19
<i>lenalidomide</i>	33	<i>loteprednol etabonate</i>	100	<i>memantine</i>	28
LENVIMA	38	<i>lovastatin</i>	59	<i>memantine-donepezil</i>	28
LESSINA	72, 74	LOW-OGESTREL (28)	72, 74	MENQUADFI (PF)	80
<i>letrozole</i>	35	<i>loxapine succinate</i>	43	MENVEO A-C-Y-W-135-DIP (PF)	81
<i>leucovorin calcium</i>	34, 41	<i>lubiprostone</i>	67	<i>mercaptopurine</i>	34, 79
LEUKERAN	33	LUMAKRAS	34, 38	<i>meropenem</i>	24
<i>leuprolide</i>	75	LUPRON DEPOT	75	<i>mesalamine</i>	81
<i>levetiracetam</i>	25	<i>lurasidone</i>	44, 50	<i>mesna</i>	41
<i>levobunolol</i>	100	LUTERA (28)	72, 74	MESNEX	41
<i>levocarnitine</i>	65, 67	LYLEQ	74	<i>metformin</i>	52
<i>levocarnitine (with sugar)</i>	67	LYLLANA	71	<i>methadone</i>	19
<i>levocetirizine</i>	101	LYNPARZA	34, 38	<i>methazolamide</i>	101
<i>levofloxacin</i>	24	LYSODREN	34, 75	<i>methenamine hippurate</i>	22
<i>levofloxacin in d5w</i>	24	LYTGOBI	38	<i>methimazole</i>	76
LEVONEST (28)	72, 74	LYUMJEV KWIKPEN U-100		<i>methotrexate sodium</i>	34, 79
<i>levonorgestrel-ethinyl estrad</i>	72, 74	INSULIN	53	<i>methotrexate sodium (pf)</i>	34, 79
<i>levonorg-eth estrad triphasic</i>	72	LYUMJEV KWIKPEN U-200		<i>methoxsalen</i>	64
LEVORA-28	72, 74	INSULIN	53	<i>methylsuximide</i>	26
<i>levothyroxine</i>	75	LYUMJEV U-100 INSULIN	54	<i>methylphenidate hcl</i>	60
		LYZA	74	<i>methylprednisolone</i>	70, 82
		<i>magnesium sulfate</i>	65		

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<i>metoclopramide hcl</i>	30, 68	MINIMED QUICK SET 23"	93	<i>naftifine</i>	31
<i>metolazone</i>	58	MINIMED QUICK SET 32"	93	<i>naloxone</i>	21, 93
<i>metoprolol succinate</i>	56	MINIMED QUICK SET 43"	93	<i>naltrexone</i>	21
<i>metoprolol ta-hydrochlorothiaz</i>	58	MINIMED SILHOUETTE 18"	93	NAMZARIC	28
<i>metoprolol tartrate</i>	56	MINIMED SILHOUETTE 23"	93	<i>naproxen</i>	19
<i>metronidazole</i>	22	MINIMED SILHOUETTE 32"	93	<i>naratriptan</i>	32
<i>metronidazole in nacl (iso-os)</i>	22	MINIMED SILHOUETTE 43"	93	NATACYN	100
<i>metyrosine</i>	58	MINIMED SURE T 18"	93	<i>nateglinide</i>	52
<i>mexiletine</i>	56	MINIMED SURE T 23"	93	NAYZILAM	27, 49
<i>micafungin</i>	31	MINIMED SURE T 32"	93	<i>nebivolol</i>	56
MICRO BLOOD GLUCOSE	92	<i>minocycline</i>	25	<i>nefazodone</i>	30
MICRO THIN LANCETS	92	<i>minoxidil</i>	59	<i>neomycin</i>	21
MICRODOT BLOOD GLUCOSE SYSTEM	92	<i>mirabegron</i>	69	<i>neomycin-bacitracin-poly-hc</i>	99
MICRODOT HIGH-LOW CONTROL	92	<i>mirtazapine</i>	29	<i>neomycin-bacitracin-polymyxin</i>	99, 100
MICRODOT NORMAL CONTROL	92	<i>misoprostol</i>	68, 70	<i>neomycin-polymyxin b-</i>	
MICRODOT XTRA BLOOD GLUCOSE	92	M-M-R II (PF)	81	<i>dexameth</i>	99
MICROGESTIN 1.5/30 (21)	72, 74	MOBILE LANCETS	93	<i>neomycin-polymyxin-gramicidin</i>	99, 100
MICROGESTIN 1/20 (21)	72, 74	<i>modafinil</i>	105	<i>neomycin-polymyxin-hc</i>	99, 101
MICROGESTIN FE 1.5/30 (28)	72, 74	MODERNA COVID 24- 25(6M-11Y)PF	93	NEO-POLYCIN	99, 100
MICROGESTIN FE 1/20 (28)	72, 74	<i>moexipril</i>	55	NEO-POLYCIN HC	99
MICROLET 2 LANCING DEVICE	92	<i>molindone</i>	43	NERLYNX	39
MICROLET LANCET	92	<i>mometasone</i>	63	NEUPRO	42
MICROLET NEXT LANCING DEVICE	93	MONOLET LANCETS	93	NEUTEK 2TEK TEST STRIPS	93
<i>midodrine</i>	55	MONOLET THIN LANCETS	93	<i>nevirapine</i>	47
<i>mifepristone</i>	53, 75	<i>montelukast</i>	102	NEXPLANON	72
<i>MILI</i>	72, 74	<i>morphine</i>	19, 20	<i>niacin</i>	59
<i>MIMVEY</i>	72	<i>morphine concentrate</i>	19, 20	<i>nicardipine</i>	57
MINI LANCING DEVICE	93	MOUNJARO	52	NICOTROL NS	21
MINIMED 630G INSULIN PUMP	93	<i>moxifloxacin</i>	24, 100	<i>nifedipine</i>	57
MINIMED 770G INSULIN PUMP	93	<i>moxifloxacin-sod.chloride(iso)</i>	24	NIKKI (28)	71, 72
MINIMED 780G INSULIN PUMP	93	MRESVIA (PF)	81	<i>nilutamide</i>	33
MINIMED MIO ADVANCE INF SET23"	93	MULTI-LANCET DEVICE 2	93	<i>nimodipine</i>	57
MINIMED MIO ADVANCE INF SET43"	93	<i>mupirocin</i>	65	NINLARO	34, 39
MINIMED QUICK SET 18"	93	<i>mycophenolate mofetil</i>	79	<i>nitazoxanide</i>	42
		<i>mycophenolate sodium</i>	79	<i>nitisinone</i>	69
		MYFEMBREE	75	NITRO-BID	60
		MYGLUCOHEALTH	93	<i>nitrofurantoin macrocrystal</i>	22
		MYGLUCOHEALTH CONTROL SOLUTION	93	<i>nitrofurantoin monohyd/m-cryst</i>	22
		MYGLUCOHEALTH		<i>nitroglycerin</i>	60
		LANCETS	93	NIVESTYM	54
		MYHIBBIN	79	NORA-BE	74
		MYRBETRIQ	69	<i>norelgestromin-ethin.estradiol</i>	
		<i>nabumetone</i>	19		73, 74
		<i>nadolol</i>	56	<i>norethindrone (contraceptive)</i>	74
		<i>nafcillin</i>	23	<i>norethindrone acetate</i>	74

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<i>norethindrone ac-eth estradiol</i>	73, 74	ON CALL EXPRESS METER..	93	OXERVATE.....	99
<i>norgestimate-ethinyl estradiol</i>	73, 74	ON CALL EXPRESS TEST		<i>oxybutynin chloride</i>	69
NORTREL 0.5/35 (28).....	73, 74	STRIP.....	94	<i>oxycodone</i>	20
NORTREL 1/35 (21).....	73, 74	ON CALL LANCET	94	<i>oxycodone-acetaminophen</i>	20
NORTREL 1/35 (28).....	73, 74	ON CALL LANCING DEVICE.	94	OZEMPIC	52
NORTREL 7/7/7 (28).....	73, 74	<i>ondansetron</i>	31	PACERONE	56
<i>nortriptyline</i>	30	<i>ondansetron hcl</i>	30	<i>paclitaxel protein-bound</i>	94
NORVIR.....	48	ONETOUCH DELICA PLUS		<i>paliperidone</i>	44
NOVA MAX GLUCOSE TEST	93	LANCET	94	PANRETIN	41, 64
NOVA SAFETY LANCETS	93	ONETOUCH DELICA		<i>pantoprazole</i>	69
NOVA SUREFLEX LANCETS	93	SAFETY LANCET	94	PARADIGM RESERVOIR.....	94
NOVAMAX PLUS GLU-KET..	93	ONETOUCH ULTRA		<i>paricalcitol</i>	82
NOVAVAX COVID 2024-25(PF)(EUA).....	93	CONTROL.....	94	<i>paroxetine hcl</i>	30, 49
NUBEQA.....	33	ONETOUCH ULTRA TEST	94	PAXLOVID	48, 76, 77
NUEDEXTA.....	61	ONETOUCH ULTRA2		<i>pazopanib</i>	39
NUPLAZID	44	METER.....	94	PEDIARIX (PF).....	81
NURTEC ODT	32, 61	ONETOUCH ULTRASOFT 2		PEDVAX HIB (PF).....	81
NYAMYC.....	31	LANCET	94	<i>peg 3350-electrolytes</i>	67, 68
<i>nystatin</i>	31	ONETOUCH VERIO FLEX		PEGASYS	78
<i>nystatin-triamcinolone</i>	64	METER.....	94	<i>peg-electrolyte soln</i>	67, 68
NYSTOP.....	31	ONETOUCH VERIO HIGH		PEMAZYRE	39
NYVEPRIA	54	CONTROL.....	94	<i>pen needle, diabetic</i>	54
OCALIVA.....	68	ONETOUCH VERIO MID		PENBRAYA (PF).....	81
<i>octreotide acetate</i>	75	CONTROL.....	94	<i>penciclovir</i>	65
<i>octreotide,microspheres</i>	93	ONETOUCH VERIO		<i>penicillamine</i>	66, 70
ODEFSEY	47	REFLECT METER.....	94	<i>penicillin g potassium</i>	23
ODOMZO	39	ONETOUCH VERIO TEST		<i>penicillin g sodium</i>	23
OFEV	104	STRIPS	94	<i>penicillin v potassium</i>	23
<i>ofloxacin</i>	100, 101	ON-THE-GO LANCETS	94	PENTACEL (PF).....	81
OJEMDA.....	39	ONUREG	34	<i>pentamidine</i>	42
OJJAARA	34, 39	OPSUMIT	104	<i>pentoxifylline</i>	58
<i>olanzapine</i>	44, 50	OPSYNVI	104	PERFECT POINT SAFETY	
<i>olmesartan</i>	55	OPTIUM EZ.....	94	LANCETS	94
<i>olmesartan-amlodipin-hcthiazid</i> .58		OPTIUM TEST	94	<i>perindopril erbumine</i>	55
<i>olmesartan-hydrochlorothiazide</i> .58		ORENCIA	76	PERIOGARD	62
<i>omega-3 acid ethyl esters</i>	59	ORENCIA CLICKJECT	76	<i>permethrin</i>	64
<i>omeprazole</i>	68, 69	ORGOVYX	34	<i>perphenazine</i>	30, 43
OMNIPOD 5 (G6/LIBRE 2 PLUS).....	93	ORKAMBI.....	103	PFIZER COVID 2024-25(5Y-11Y)PF	94
OMNIPOD 5		ORSERDU	34	PFIZER COVID 2024-25(6MO-4Y)PF	94
INTRO(G6/LIBRE2PLUS).....	93	<i>oseltamivir</i>	48	PHARMACIST CHOICE	94
OMNITROPE	70	OTEZLA	64, 79	PHARMACIST CHOICE	
ON CALL EXPRESS CONTROL	93	OTEZLA STARTER	64, 79	GLUCOSE SYS	94
		<i>oxacillin</i>	23	<i>phenelzine</i>	29
		<i>oxacillin in dextrose(iso-osm)</i>	23, 94	<i>phenobarbital</i>	27
		<i>oxaprozin</i>	19	<i>phenytoin</i>	27
		<i>oxcarbazepine</i>	27		

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<i>phenytoin sodium extended</i> ...	28, 94
PIFELTRO	47
<i>pilocarpine hcl</i>	62, 101
<i>pimecrolimus</i>	63
<i>pimozide</i>	43
PIMTREA (28).....	73, 74
<i>pindolol</i>	56
<i>pioglitazone</i>	52
PIP BLOOD GLUCOSE MONITOR.....	94
PIP BLOOD GLUCOSE TEST STRIP	94
PIP GLUCOSE CONTROL SOLN L1-L2.....	94
PIP LANCET	94
<i>piperacillin-tazobactam</i>	24
PIQRAY	39
<i>pirfenidone</i>	104
<i>piroxicam</i>	19
<i>pitavastatin calcium</i>	59
PLENAMINE.....	69
<i>podofilox</i>	64
POLYCIN	100
<i>polymyxin b sulf-trimethoprim</i>	99, 100
POMALYST	33
PORTIA 28.....	73, 74
<i>posaconazole</i>	31
<i>potassium chlorid-d5-0.45%nacl</i>	65
<i>potassium chloride</i>	65, 66, 67
<i>potassium chloride in 0.9%nacl.</i>	65
<i>potassium chloride in 5 % dex</i>	65
<i>potassium chloride in lr-d5</i>	65
<i>potassium chloride in water</i>	65
<i>potassium chloride-0.45 % nacl.</i>	66
<i>potassium chloride-d5-0.2%nacl</i>	66
<i>potassium chloride-d5-0.9%nacl</i>	66
<i>potassium citrate</i>	66
<i>pramipexole</i>	42
<i>prasugrel hcl</i>	55
<i>pravastatin</i>	59
<i>praziquantel</i>	42
<i>prazosin</i>	55, 69
PRECISION PCX PLUS TEST..	94
PRECISION PCX TEST	94
PRECISION POINT OF CARE TEST	94
PRECISION Q-I-D TEST	94
PRECISION XTRA MONITOR	94
PRECISION XTRA TEST	94
<i>prednisolone</i>	70, 82
<i>prednisolone acetate</i>	100
<i>prednisolone sodium phosphate</i>	70, 82, 100
<i>prednisone</i>	70, 82
PREDNISONE INTENSOL.	70, 82
<i>pregabalin</i>	26, 27, 61
PREMASOL 10 %	66, 67
PREMIER BLU GLUCOSE METER.....	94
PREMIER CLASSIC GLUCOSE METER.....	95
PREMIER COMPACT GLUCOSE METER.....	95
PREMIER TEST STRIP	95
PREMIER VOICE GLUCOSE METER.....	95
PREMIUM BLOOD GLUCOSE MONITOR.....	95
PREMIUM V10.....	95
PRENATAL VITAMIN PLUS LOW IRON.....	67
PRESSURE ACTIVATED LANCETS	95
PREVALITE	59
PREVYMIS	46
PREZCOBIX	48
PREZISTA	48
PRIFTIN	33
<i>primaquine</i>	42
<i>primidone</i>	27
PRIORIX (PF).....	81
PRIVIGEN	76
PRO COMFORT LANCET	95
PRO COMFORT SAFETY LANCET	95
PRO VOICE V8-V9 TEST STRIP	95
PRO VOICE V9 GLUCOSE MONITOR	95
<i>probencid-colchicine</i>	32
<i>prochlorperazine</i>	30
<i>prochlorperazine maleate</i>	30, 43
PROCRIT	54
PROCTO-MED HC	63, 82
PROCTOSOL HC	63, 82
PROCTOZONE-HC	63, 82
PRODIGY AUTOCODE METER	95
PRODIGY AUTOCODE MONITOR SYST	95
PRODIGY CONTROL SOLUTION, LOW	95
PRODIGY CONTROL SOLUTION,HIGH.....	95
PRODIGY LANCETS	95
PRODIGY LANCING DEVICE	95
PRODIGY NO CODING	95
PRODIGY POCKET METER	95
PRODIGY TWIST TOP LANCET	95
PRODIGY VOICE GLUCOSE METER	95
<i>progesterone micronized</i>	74
PROGRAF	79
PROLASTIN-C	69
PROLIA	82
PROMACTA	54
<i>promethazine</i>	30, 101
<i>propafenone</i>	56
<i>propranolol</i>	56, 57
<i>propylthiouracil</i>	76
PROQUAD (PF)	81
<i>protriptyline</i>	30
PULMOZYME	103
PURE COMFORT LANCETS	95
PURE COMFORT SAFETY LANCETS	95
PURIXAN	34
PUSH BUTTON SAFETY LANCETS	95
<i>pyrazinamide</i>	33
<i>pyridostigmine bromide</i>	32
<i>pyrimethamine</i>	42
QINLOCK	39
QUADRACEL (PF)	81

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quetiapine	29, 44, 50	REPATHA SURECLICK	59	ROTARIX	81
quinapril	55	REPATHA SYRINGE	59	ROTATEQ VACCINE	81
quinapril-hydrochlorothiazide	58	RETACRIT	55	ROWEEPRA	25
quinidine sulfate	56	RETEVMO	34, 39	ROZLYTREK	39
quinine sulfate	42	REVEAL BLOOD GLUCOSE		RUBRACA	39
QUINTET AC	95	METER	96	rufinamide	28
QUINTET BLOOD GLUCOSE METER	95	REVEAL TEST STRIP	96	RUKOBIA	48
QUINTET GLUCOSE TEST STRIPS	95	REVLIMID	33	RYDAPT	40
QVAR REDIHALER	102	REVUFORJ	39	SAFETY LANCETS	96
RABAVERT (PF)	81	REXULTI	44	SAFETY SEAL LANCETS	96
RADICAVA ORS STARTER KIT SUSP	61	REYATAZ	48	SAFETY-LET LANCETS	96
RALDESY	30	REZDIFFRA	68	SAJAZIR	76
raloxifene	75	REZLIDHIA	39	SANTYL	64
ramelteon	105	REZUROCK	39, 80	sapropterin	69
ramipril	56	ribavirin	46	saxagliptin	52
ranolazine	58	RIDAURA	77	saxagliptin-metformin	52
rasagiline	42	rifabutin	33	SCEMBLIX	40
RECLIPSEN (28)	73, 74	rifampin	33	scopolamine base	30, 68
RECOMBIVAX HB (PF)	81	RIGHTEST CONTROL SOLUTION HIGH	96	SECUADO	45, 50
REFUAH PLUS	95	RIGHTEST CONTROL SOLUTION NORM	96	SELARSDI	77
REFUAH PLUS GLUCOSE CONTROL	95	RIGHTEST GD500 LANCING DEVICE	96	selegiline hcl	42
REFUAH PLUS GLUCOSE MONITOR	95	RIGHTEST GL300 LANCETS	96	selenium sulfide	63
REGRANEX	64	RIGHTEST GM550 SYSTEM	96	SELZENTRY	48
RELENZA DISKHALER	48	RIGHTEST GS550 TEST		sertraline	30, 50
RELIAMED LANCET	95	STRIPS	96	SETLAKIN	73, 74
RELIAMED MINI LANCING DEVICE	95	RIGHTEST GT333 GLUCOSE METER	96	sevelamer carbonate	67, 96
RELIAMED SAFETY SEAL LANCETS	95	RIGHTEST GT333 TEST		SHAROBEL	74
RELION ALL-IN-ONE METER	95	STRIP	96	SHINGRIX (PF)	81
RELION CONFIRM	95	riluzole	61	SIGNIFOR	75
RELION CONFIRM-MICRO	95	rimantadine	48	sildenafil (pulm.hypertension)	
RELION MICRO GLUCOSE MONITOR	95	RINVOQ	77	96, 104	
RELION PRIME METER	95	RINVOQ LQ	77	silver sulfadiazine	64
RELION PRIME TEST STRIPS	96	risperidone	45, 50	simvastatin	59
RELION ULTIMA	96	risperidone microspheres	45, 50	sirolimus	80
RELISTOR	67	ritonavir	48	SIRTURO	33
repaglinide	52	rivaroxaban	54	SKYRIZI	77
REPATHA PUSHTRONEX	59	rivastigmine	28	SMART SENSE LANCETS	96
		rivastigmine tartrate	28	SMART SENSE	
		rizatriptan	32	MONITORING SYSTEM	96
		roflumilast	103	SMARTDIABETES	
		ROMVIMZA	39	VANTAGE	96
		ropinirole	42	SMARTTEST CONTROL	96
		rosuvastatin	59	SMARTTEST EJECT	96
				SMARTTEST LANCET	96
				SMARTTEST PERSONA	
				STARTER	96

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SMARTEST PRONTO	
STARTER	96
SMARTEST PROTEGE	96
SMARTEST TEST	96
sodium chloride	66
sodium chloride 0.45 %	66
sodium chloride 0.9 %	66
sodium chloride 3 % hypertonic	66
sodium chloride 5 % hypertonic	66
sodium oxybate	105
sodium phenylbutyrate	69
sodium polystyrene sulfonate	67
sodium,potassium,mag sulfates	67
sofosbuvir-velpatasvir	46
SOLIQUA 100/33	52, 54
SOLTAMOX	34
SOLUS V2 AUDIBLE METER	96
SOLUS V2 CONTROL	
SOLUTION, LOW	96
SOLUS V2 CONTROL	
SOLUTION,HIGH	96
SOLUS V2 LANCETS	96
SOLUS V2 LANCING	
DEVICE	96
SOLUS V2 TEST STRIPS	96
SOMAVERT	76
sorafenib	40
sotalol	56
SOTALOL AF	56
SOTYKTU	77
SPIKEVAX 2024-2025(12Y	
UP)(PF)	96
SPIRIVA RESPIMAT	102
spironolactone	58, 59
spironolacton-hydrochlorothiaz.	58
SPRINTEC (28)	73, 74
SPRITAM	25
SPRYCEL	40
SPS (WITH SORBITOL)	67
SRONYX	73, 74
SSD	64
STELARA	77
STERILANCE TL	96
STIOLTO RESPIMAT	104
STIVARGA	40
streptomycin	21
STRIBILD	47
STRIVERDI RESPIMAT	103
SUBLOCADE	96
SUBVENITE	25, 51
SUCRAID	69
sucralfate	68
sulfacetamide sodium	100
sulfacetamide sodium (acne)	24
sulfacetamide-prednisolone	99
sulfadiazine	24
sulfamethoxazole-trimethoprim	24
sulfasalazine	81
sulindac	19
sumatriptan	32
sumatriptan succinate	32
sunitinib malate	40
SUNLENCA	48
SUPER THIN LANCETS	96
SURE COMFORT LANCETS	96
SURE COMFORT LANCING	
PEN	96
SUREFLEX DEVICE WITH	
LANCETS	96
SURE-LANCE	96
SURE-LANCE ULTRA THIN	97
SURE-PEN LANCING	
DEVICE	97
SURE-TEST EASYPLUS	
MINI	97
SURE-TEST EASYPLUS	
MINI METER	97
SURE-TOUCH LANCET	97
SYEDA	71, 73
SYLVANT	97
SYMDEKO	103
SYMPAZAN	27
SYMPROIC	67
SYMTUZA	47, 48
SYNJARDY	52
SYNJARDY XR	52
T:FLEX	97
T:SLIM X2	97
T:SLIM X2 BASAL-IQ	
INSULIN PMP	97
T:SLIM X2 CONTROL-IQ	97
TABLOID	34
TABRECTA	40
tacrolimus	63, 80
tadalafil	69
tadalafil (pulm. hypertension)	104
TAFINLAR	40
TAGRISSO	40
TALZENNA	40
tamoxifen	34
tamsulosin	69
TANDEM MOBI AUTOSOFT	
30 KT 23"	97
TANDEM MOBI AUTOSOFT	
XC KIT 5"	97
TANDEM MOBI AUTOSOFT	
XC KT 23"	97
TANDEM MOBI	
CARTRIDGE	97
TANDEM MOBI SYSTEM	97
TANDEM MOBI TRUSTEEL	
KIT 23"	97
TARINA FE 1-20 EQ (28)	73, 74
TASIGNA	40
tazarotene	62
TAZICEF	23
TAZVERIK	40
TDVAX	97
TECENTRIQ HYBREZA	97
TECHLITE LANCETS	97
TEFLARO	23
TEL CARE CONTROL	97
TEL CARE LANCETS	97
TEL CARE TEST STRIPS	97
telmisartan	55
telmisartan-amlodipine	58
telmisartan-hydrochlorothiazid	58
TEMPO WELCOME KIT	97
TENIVAC (PF)	81
tenofovir disoproxil fumarate	46, 47
TEPMETKO	40
terazosin	55, 69
terbinafine hcl	31
terbutaline	103
terconazole	31
teriflunomide	61
teriparatide	82
TEST N'GO BLOOD	
GLUCOSE SYSTEM	97
TEST N'GO TEST	97
testosterone	71

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<i>testosterone cypionate</i>	71	TRECATOR	33	TRUETRACK BLOOD
<i>testosterone enanthate</i>	71	TRELEGY ELLIPTA	104	GLUCOSE SYSTEM
<i>tetrabenazine</i>	61	TRELSTAR	76	TRUETRACK SMART
<i>tetracycline</i>	25	TREMFYA	77	SYSTEM
TEVIMBRA	97	TREMFYA PEN	77	TRUETRACK TEST
THALOMID	33, 34	<i>tretinoin</i>	62	TRULANCE
<i>theophylline</i>	103	<i>tretinoin (antineoplastic)</i>	41	TRULICITY
THIN LANCETS	97	<i>triamicinolone acetonide</i>	62, 63	TRUMENBA
<i>thioridazine</i>	43	<i>triamterene-hydrochlorothiazid</i>	58	TRUQAP
<i>thiothixene</i>	43	TRIDACAINE II	21	TRUSTEEL INFUSION SET
TIADYLT ER	56, 57	TRIDERM	64, 70	23"
<i>tiagabine</i>	27	<i>trientine</i>	66	TRUSTEEL INFUSION SET
TIBSOVO	35, 40	TRI-ESTARYLLA	73, 74	32"
TICOVAC	81	<i>trifluoperazine</i>	43	TUKYSA
<i>tigecycline</i>	22	<i>trifluridine</i>	46, 100	TURALIO
TILIA FE	73	<i>trihexyphenidyl</i>	42	TURQOZ (28)
<i>timolol maleate</i>	32, 57, 100, 101	TRIKAFTA	103	TWINRIX (PF)
<i>tinidazole</i>	22	TRI-LEGEST FE	73	TWIST LANCETS
<i>tropotropium bromide</i>	102	TRI-LO-ESTARYLLA	73, 74	TYENNE
TIVICAY	47	TRI-LO-SPRINTEC	73, 74	TYENNE AUTOINJECTOR
TIVICAY PD	47	<i>trimethoprim</i>	22	TYPHIM VI
<i>tizanidine</i>	46	<i>trimipramine</i>	30	ULTI-LANCE
<i>tobramycin</i>	21, 100, 103	TRINTELLIX	30	ULTILET BASIC LANCETS
<i>tobramycin in 0.225 % nacl</i>	103	TRI-SPRINTEC (28)	73, 75	ULTILET CLASSIC
<i>tobramycin sulfate</i>	22	TRIUMEQ	47, 48	LANCETS
<i>tobramycin-dexamethasone</i>	99	TRIUMEQ PD	47, 48	ULTILET LANCETS
<i>tolterodine</i>	69	TRIVORA (28)	73, 75	ULTILET SAFETY LANCETS
<i>tolvaptan</i>	66	TROPHAMINE 10 %	67	ULTIMA MONITOR
TOPCARE UNIVERSAL1 LANCET	97	<i>trospium</i>	69	ULTIMA TEST STRIPS
<i>topiramate</i>	25, 32	TRUE COMFORT LANCET	97	ULTRA THIN II LANCETS
<i>toremifene</i>	33, 34	TRUE METRIX AIR GLUCOSE METER	97	ULTRA THIN LANCETS
TORPENZ	40, 80	TRUE METRIX GLUCOSE METER	97	ULTRA THIN PLUS LANCETS
<i>torsemide</i>	58	TRUE METRIX GLUCOSE TEST STRIP	97	ULTRA-CARE LANCETS
TOUJEO MAX U-300		TRUE METRIX GO GLUCOSE METER	97	ULTRALANCE LANCETS
SOLOSTAR	54	TRUE METRIX LEVEL 1	97	ULTRA-THIN II LANCETS
TOUJEO SOLOSTAR U-300		TRUE METRIX LEVEL 2	97	ULTRATRAK
INSULIN	54	TRUE METRIX LEVEL 3	97	ULTRATRAK GLUCOSE METER
TRADJENTA	53	TRUEDRAW LANCING DEVICE	97	ULTRATRAK HIGH-LOW CONTROL
<i>tramadol</i>	20	TRUEPLUS LANCETS	97	ULTRATRAK NORMAL CONTROL
<i>tramadol-acetaminophen</i>	20	TRUERESULT BLOOD GLUCOSE SYSTM	97	ULTRATRAK ULTIMATE
<i>trandolapril</i>	56	TRUETEST TEST STRIPS	98	UNILET COMFORTOUCH LANCET
<i>tranexamic acid</i>	55			UNILET GP LANCET
<i>tranylcypromine</i>	29			98
TRAVASOL 10 %	66, 67			
<i>travoprost</i>	101			
<i>trazodone</i>	30			

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UNILET LANCET	98	VARISOFT INFUSION SET 43"	99	VIVAGUARD SAFETY LANCET	99
UNILET LANCETS	98	VARIVAX (PF)	81	VIVITROL	21
UNILET SUPER THIN LANCETS	98	VARIZIG	81, 99	VIVOTIF	81
UNISTIK 2 DEVICE	98	VARUBI	31	VIZIMPRO	41
UNISTIK 2 NORMAL LANCET	98	VAXCHORA VACCINE	81	VONJO	41
UNISTIK 3 COMFORT LANCET	98	VELIVET TRIPHASIC REGIMEN (28)	73, 75	VORANIGO	34, 35
UNISTIK 3 EXTRA LANCET ..	98	VEMLIDY	46	<i>voriconazole</i>	31
UNISTIK 3 GENTLE	98	VENCLEXTA	40	VOSEVI	46
UNISTIK 3 NORMAL LANCET	98	VENCLEXTA STARTING PACK	41	VOWST	68
UNISTIK COMFORT LANCETS	98	<i>venlafaxine</i>	30, 50	VRAYLAR	45
UNISTIK CZT LANCET	98	<i>verapamil</i>	56, 57	VYNDAMAX	69
UNISTIK EXTRA LANCETS ...	98	VERIFINE SAFETY LANCET MINI	99	VYVGART	99
UNISTIK NORMAL LANCETS	98	VERIFINE UNIVERSAL LANCET	99	VYVGART HYTRULO	99
UNISTIK PRO LANCET	98	VERQUVO	58, 60	<i>warfarin</i>	54
UNISTIK SAFETY	98	VERSACLOZ	45	WAVESENSE CONTROL SOLUTION	99
UNISTIK TOUCH LANCETS ...	99	VERZENIO	41	WELIREG	41, 69
UNISTRIP LOW CONTROL ...	99	VESTURA (28)	71, 73	WIXELA INHUB	104
UNISTRIP1 TEST STRIP	99	VIENVA	73, 75	XALKORI	41
UNITHROID	75	<i>vigabatrin</i>	27	XARELTO	54
UNIVERSAL 1 LANCETS	99	VIGADRONE	27	XARELTO DVT-PE TREAT 30D START	54
UPTRAVI	104	VIGPODER	27	XCOPRI	25
<i>ursodiol</i>	68	<i>vilazodone</i>	30	XCOPRI MAINTENANCE PACK	25
UZEDY	45	VIMKUNYA	81	XCOPRI TITRATION PACK	25, 26
<i>valacyclovir</i>	46	VIRACEPT	48	XDEMVY	100
VALCHLOR	33	VIREAD	46, 47	XELJANZ	77
<i>valganciclovir</i>	46	VITRAKVI	41	XELJANZ XR	77
valproic acid	25, 32, 51	VIVAGUARD INO CTRL SOLN-L1,2,3	99	XERMELO	68
valproic acid (as sodium salt)	25, 32, 51	VIVAGUARD INO CTRL SOLN-L1,L3	99	XGEVA	82
valsartan	55	VIVAGUARD INO CTRL SOLN-L2	99	XIFAXAN	22, 68
valsartan-hydrochlorothiazide ...	58	VIVAGUARD INO GLUCOSE METER	99	XIGDUO XR	53
VALTOCO	27, 49	VIVAGUARD INO SMART GLUC METER	99	XIIDRA	100
<i>vancomycin</i>	22	VIVAGUARD INO TEST STRIP	99	XOLAIR	77, 78
VANFLYTA	40	VIVAGUARD LANCET	99	XOSPATA	41
VAQTA (PF)	81	VIVAGUARD LANCING DEVICE	99	XPOVIO	35, 41
<i>varenicline tartrate</i>	21			XTANDI	33
VARISOFT INFUSION SET 23"	99			XULANE	73, 75
VARISOFT INFUSION SET 32"	99			YESINTEK	78
				YF-VAX (PF)	81
				YUFLYMA(CF)	80
				YUFLYMA(CF) AI CROHN'S- UC-HS	80

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YUFLYMA(CF)	
AUTOINJECTOR.....	80
YUVAFEM.....	71
ZAFEMY	73, 75
<i>zafirlukast</i>	102
<i>zaleplon</i>	105
ZEJULA.....	41
ZELBORAF.....	41
ZENATANE.....	62
<i>zidovudine</i>	48
<i>ziprasidone hcl</i>	45, 50
<i>ziprasidone mesylate</i>	45, 50
ZIRGAN.....	100
ZOLINZA.....	35
<i>zolpidem</i>	105
ZONISADE.....	26, 28
<i>zonisamide</i>	28
ZOVIA 1-35 (28).....	71, 73
ZTALMY.....	26, 27
ZURZUVAE.....	29
ZYDELIG.....	41
ZYKADIA.....	41
ZYMFENTRA.....	80

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Prospective Members:

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TTY: 711

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