EmblemHealth

2025 HMO D-SNP Formulary

Lista de medicamentos HMO D-SNP 2025

2025 HMO D-SNP 药物名册

(List of Covered Drugs/Lista de medicamentos cubiertos /承保药物清单)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN. / LEA LO SIGUIENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN. / 请阅读：本文件包含关于我们在这个计划中承保的药物的信息。

25285, V7

This formulary was updated on / Esta farmacopea se actualizó el / 该药物名册已于 08/24/2024.

For more recent information or other questions, please contact EmblemHealth Medicare HMO at **877-344-7364** (TTY users should call **711)**. From Oct.1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, you can call us Monday through Saturday from 8 a.m. to 8 p.m., or visit **emblemhealth.com/medicare**.

Para obtener información más reciente o para hacer otras preguntas, comuníquese con EmblemHealth Medicare HMO al **877-344-7364** (los usuarios de TTY deben llamar al **711)**. Del 1 de octubre al 31 de marzo, puede llamarnos los siete días de la semana de 8 a.m. a 8 p.m. Del 1 de abril al 30 de septiembre, puede llamarnos de lunes a sábado, de 8 a.m. a 8 p.m., o visite **emblemhealth.com/medicare**.

如需更多最新信息或有其他疑问，请联系安保联邦医疗保险（Medicare，即红蓝卡）HMO，电话：**877-344-7364**（TTY 用户应致电 **711**）。从 10 月 1 日至 3 月 31 日，您可以每周 7 天从 8 a.m. 至 8 p.m. 致电我们。从 4 月 1 日至 9 月 30 日，您可以周一至周六从 8 a.m. 至 8 p.m. 致电我们，或访问 **emblemhealth.com/medicare**。

List of Covered Drugs for / Lista de medicamentos cubiertos para / 承保药物清单，适用:

EmblemHealth VIP Dual (HMO D-SNP), EmblemHealth VIP Dual Enhanced (HMO D-SNP), and EmblemHealth VIP Dual Reserve (HMO D-SNP).

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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 Health Insurance Plan of Greater New York (HIP). When it refers to "plan" or "our plan," it means EmblemHealth VIP Dual Reserve (HMO D-SNP), EmblemHealth VIP Dual (HMO D-SNP), and EmblemHealth VIP Dual Enhanced (HMO D-SNP).

This document includes a Drug List (formulary) for our plan, which is current as of 08/24/2024. 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 Jan. 1, 2026, and from time to time during the year.

What is the EmblemHealth VIP Dual Reserve (HMO D-SNP), EmblemHealth VIP Dual (HMO D-SNP), and EmblemHealth VIP Dual Enhanced (HMO D-SNP) 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 our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan 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 our plan may add or remove drugs on the formulary during the year or add new restrictions. We must follow Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: **emblemhealth.com/medicare**.

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 and 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 or 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 version 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, EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual and EmblemHealth VIP Dual Enhanced 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 any 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. 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 formulary, 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 VIP Dual Reserve, EmblemHealth VIP Dual, and EmblemHealth VIP Dual Enhanced 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 formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 08/24/2024. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages.

Note: In the event of a mid-year, non-maintenance formulary change, the change is added to a comprehensive list of changes that have been made since the formulary was printed. The list of changes is included with the formulary booklet that is available online. New members receive a notice in the welcome kit with information on how to access the formulary or how to request one. Existing members can view the updated formulary by visiting us on the web at **emblemhealth.com/medicare**. The formulary that is posted on our website is updated.

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

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

What are generic drugs?

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 Section 3.1, "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, our plan may not cover the drug.

- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 30 tablets per prescription for JANUVIA®. 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, our 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 1. 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, EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual, and EmblemHealth VIP Dual Enhanced Formulary?" on page v for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that our plan 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 us 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 EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual and VIP Dual Enhanced Formulary?

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

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

- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit 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.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or 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 for 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 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.

If you are a current member in our plan and you experience a change in the level of care, such as an admission or discharge from the long-term care facility, we will provide you with one-time temporary supply of your medications, as needed, to assist with your transition to the new level of care.

For more information

For more detailed information about your EmblemHealth EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual, and EmblemHealth VIP Dual Enhanced 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.

EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual and EmblemHealth VIP Dual Enhanced Formulary

The formulary that begins on page 1 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 Index 1.

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

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

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

List of Abbreviations

B/D PA: This prescription drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or please call Customer Service at **877-344-7364** (TTY users should call **711**). From Oct. 1 to March 31, you can call us from 8 a.m. to 8 p.m., seven days a week. From April 1 to Sept. 30, you can call us from 8 a.m. to 8 p.m., Monday through Saturday or visit **emblemhealth.com/medicare.**

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

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

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

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

LDS: Limited Day Supply. For certain drugs, the plan limits the days' supply we will cover to one month at a time.

V: The vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Preventions (CDC) Advisory Committee on Immunization Practices (ACIP).

Nota para los miembros existentes: Esta Farmacopea se ha cambiado desde el año pasado. Revise este documento para asegurarse de que aún se incluyan los medicamentos que usted toma.

Cuando esta Lista de medicamentos (Farmacopea) se refiera a “nosotros”, “nos” o “nuestro”, significa Health Insurance Plan of Greater New York (HIP). Cuando se refiere a “plan” o a “nuestro plan”, significa EmblemHealth VIP Dual Reserve (HMO D-SNP), EmblemHealth VIP Dual (HMO D-SNP) y EmblemHealth VIP Dual Enhanced (HMO D-SNP).

El presente documento incluye una Lista de medicamentos (farmacopea) para nuestro plan que se encuentra vigente a partir del 08/24/2024. Para obtener una Lista de medicamentos (farmacopea) actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la última fecha en que hemos actualizado la Lista de medicamentos (farmacopea), aparece en la portada y la contratapa.

Para poder utilizar sus beneficios de medicamentos con receta, por lo general, deberá usar farmacias de la red. Los beneficios, la farmacopea, la red de farmacias o los copagos y el coseguro pueden cambiar a partir del 1.° de enero de 2026 y periódicamente durante el año.

¿Qué es la farmacopea de EmblemHealth VIP Dual Reserve (HMO D-SNP), EmblemHealth VIP Dual (HMO D-SNP) y EmblemHealth VIP Dual Enhanced (HMO D-SNP)?

En este documento, usamos los términos Lista de medicamentos y farmacopea para referirnos a lo mismo. La farmacopea es una lista de medicamentos cubiertos seleccionados por nuestro plan en colaboración con un equipo de proveedores de atención médica que representa los tratamientos con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Por lo general, nuestro plan cubre los medicamentos que se encuentran incluidos en nuestra farmacopea, siempre que el medicamento sea médicamente necesario, la receta se llene en una farmacia de la red y se respeten las demás reglas del plan. Para obtener más información sobre cómo llenar sus recetas, consulte su Evidencia de cobertura.

¿Puede hacer cambios la farmacopea?

La mayoría de los cambios en la cobertura de medicamentos ocurren el 1.° de enero, pero nuestro plan puede agregar o quitar medicamentos de la farmacopea durante el año o agregar nuevas restricciones. Debemos seguir las reglas de Medicare al hacer estos cambios. Las actualizaciones de la farmacopea se publican mensualmente en nuestro sitio web aquí: **emblemhealth.com/medicare**.

Cambios que pueden afectarle este año: En los casos que figuran a continuación, usted se verá afectado por los cambios de cobertura durante el año:

- **Sustituciones inmediatas de ciertas versiones nuevas de medicamentos de marca y productos biológicos originales.** Podremos eliminar de inmediato un medicamento de nuestra farmacopea si lo reemplazamos por una nueva versión de ese medicamento con las mismas o menos restricciones. Cuando agregamos una nueva versión de un medicamento a nuestra farmacopea, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestra farmacopea, pero moverlo inmediatamente o agregar nuevas restricciones.

Podemos hacer estos cambios inmediatos solo si agregamos una nueva versión genérica de un medicamento de marca o si agregamos cierta versión biosimilar nueva de un producto biológico original que ya estaba en la farmacopea (por ejemplo, si agregamos un biosimilar intercambiable que puede ser sustituido por un producto biológico original en una farmacia sin una nueva receta).

Si actualmente está tomando un medicamento de marca o producto biológico original, es posible que no le informemos con anticipación antes de hacer un cambio inmediato, pero luego le brindaremos información sobre los cambios específicos que hemos realizado.

Si realizamos dicho cambio, usted o el profesional autorizado para recetar pueden solicitarnos que hagamos una excepción y sigamos cubriendo para usted el medicamento que se cambiará. Para obtener más información, consulte la sección a continuación titulada "¿Cómo solicito una excepción a la Farmacopea de EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual y EmblemHealth VIP Dual Enhanced?

Algunos de estos tipos de medicamentos pueden ser nuevos para usted. Para obtener más información, consulte la sección a continuación titulada

"¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?"

- **Medicamentos retirados del mercado.** Si el fabricante o la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA) determinan que un medicamento debe retirarse de la venta por cualquier motivo de seguridad o eficacia, podemos eliminar de inmediato el medicamento de nuestra farmacopea y luego notificar a los miembros que lo toman.

- **Otros cambios.** Es posible que hagamos otros cambios que afecten a los miembros que actualmente toman un medicamento. Por ejemplo, podemos eliminar un medicamento de marca de la farmacopea al agregar un equivalente genérico o eliminar un producto biológico original al agregar un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original. También podemos hacer cambios basados en nuevas pautas clínicas. Si eliminamos medicamentos de nuestra farmacopea, si agregamos límites de cantidad o restricciones de tratamiento escalonado o autorización previa a un medicamento de la farmacopea, debemos notificar a los miembros afectados el cambio por lo menos 30 días antes de que el cambio entre en vigencia. Como alternativa, cuando un miembro solicite un resurtido del medicamento, puede recibir un suministro del medicamento para 30 días y una notificación del cambio.

Si realizamos estos otros cambios, usted o el profesional autorizado para recetar pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento que usted ha estado tomando. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y también puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción a la Farmacopea de VIP Dual Reserve, EmblemHealth VIP Dual y EmblemHealth VIP Dual Enhanced?".

Cambios que no le afectarán si actualmente está tomando el medicamento. Generalmente, si usted está tomando un medicamento de nuestra farmacopea 2025 que estaba cubierto al comienzo del año, no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2025, excepto como se describió anteriormente. Esto significa que estos medicamentos permanecerán disponibles con el mismo costo compartido y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. No obtendrá una notificación directa este año sobre los cambios que no lo afectan. Sin embargo, el 1.º de enero del próximo año, esos cambios le afectarían y es importante que revise la farmacopea del nuevo año del beneficio para ver los cambios en los medicamentos.

La farmacopea adjunta tendrá vigencia a partir del 08/24/2024. Para obtener la información más actualizada sobre los medicamentos cubiertos por nuestro plan, comuníquese con nosotros. Nuestra información de contacto aparece en la portada y la contratapa.

Nota: En caso de un cambio en la farmacopea que no sea por mantenimiento a mitad del año, dicho cambio se agregará a una lista exhaustiva de cambios que se han producido desde la impresión de la farmacopea. La lista de cambios se incluye con el folleto de la farmacopea que está disponible en línea. Los miembros nuevos reciben un aviso en el paquete de bienvenida con información sobre cómo acceder a la farmacopea o cómo solicitar una. Los miembros existentes pueden ver la farmacopea actualizada al visitarnos en nuestro sitio web en **emblemhealth.com/medicare**. La farmacopea que está publicada en nuestro sitio web está actualizada.

¿Cómo debo usar la Farmacopea?

Existen dos formas de encontrar su medicamento dentro de la farmacopea:

Afección médica

La farmacopea comienza en la página 1. Los medicamentos de esta farmacopea se agrupan en categorías, según el tipo de afección médica que suelen tratar. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca están enumerados en la categoría "Lípidos/Cardiovascular hipertensivo". Si conoce para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 1. Luego, busque su medicamento en el nombre de la categoría.

Lista por orden alfabético

Si no está seguro de la categoría en la que debe buscar, busque su medicamento en el Índice que comienza en la página 1. El Índice le brinda una lista por orden alfabético de todos los medicamentos incluidos en el presente documento. Los medicamentos de marca y los genéricos están enumerados en

el Índice. Busque en el Índice y encuentre su medicamento. Al lado de su medicamento, verá el número de página donde puede encontrar la información de la cobertura. Vaya a la página enumerada en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre los medicamentos de marca y los medicamentos genéricos. Un medicamento genérico está aprobado por la FDA como medicamento que contiene el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos funcionan tan bien como los medicamentos de marca y cuestan menos. Hay disponibles medicamentos genéricos sustitutos para muchos medicamentos de marca. Los medicamentos genéricos generalmente pueden sustituirse por el medicamento de marca en la farmacia sin necesidad de una nueva receta, según las leyes estatales.

¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?

En la farmacopea, cuando nos referimos a medicamentos, puede significar un medicamento o un producto biológico. Los productos biológicos son fármacos que son más complejos que los medicamentos típicos. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas que se denominan biosimilares. Por lo general, las versiones biosimilares son igual de eficaces que los productos biológicos originales y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, según las leyes estatales, pueden sustituirse por el producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden sustituirse por medicamentos de marca.

- Para obtener información sobre los tipos de medicamentos, consulte la Evidencia de cobertura, Capítulo 5, Sección 3.1: “La ‘Lista de medicamentos’ indica qué medicamentos de la Parte D están cubiertos”.

¿Existen algunas restricciones en mi cobertura?

Es posible que algunos medicamentos cubiertos tengan requisitos o límites adicionales sobre la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** Nuestro plan le exige a usted o a su profesional autorizado para recetar que obtengan una autorización previa para determinados medicamentos. Esto significa que deberá obtener aprobación de nuestro plan antes de llenar sus recetas. Si no obtiene la aprobación, es posible que nuestro plan no cubra el medicamento.

- **Límites de cantidad:** Para determinados medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Por ejemplo, nuestro plan proporciona 30 comprimidos por receta de JANUVIA®. Esto puede ser además del suministro estándar de uno o tres meses.

- **Tratamiento escalonado:** En algunos casos, nuestro plan le exige que pruebe primero determinados medicamentos para tratar su afección médica antes de que cubramos otro medicamento para esa

afección. Por ejemplo, si tanto el Medicamento A como el Medicamento B tratan su afección médica, es posible que nuestro plan no cubra el Medicamento B a menos que primero pruebe el Medicamento A. Si el Medicamento A no funciona para usted, entonces su plan cubrirá el Medicamento B.

Puede averiguar si su medicamento tiene algún requisito o límite adicional buscando en la farmacopea que comienza en la página 1. Además, puede obtener más información sobre las restricciones que se aplican a los medicamentos cubiertos específicos al visitar nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y tratamiento escalonado. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la última fecha en que hemos actualizado la farmacopea, aparece en la portada y la contratapa.

Puede solicitar a nuestro plan que haga una excepción sobre estas restricciones o límites, o para obtener una lista de otros medicamentos similares que puedan tratar su afección médica. Consulte la sección "¿Cómo solicito una excepción a la Farmacopea de EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual y EmblemHealth VIP Dual Enhanced?" de la página v para obtener más información sobre cómo puede solicitar una excepción.

¿Qué sucede si mi medicamento no aparece en la Farmacopea?

Si su medicamento no está incluido en la presente farmacopea (lista de medicamentos cubiertos), debería comunicarse primero con el Servicio de Atención al Cliente y consultar si su medicamento está cubierto.

Si sabe que nuestro plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar al Servicio de Atención al Cliente una lista de los medicamentos similares que están cubiertos por nuestro plan. Cuando reciba esa lista, muéstresela a su médico y pídale que 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 puede solicitar una excepción.

¿Cómo solicito una excepción a la Farmacopea de EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual y VIP Dual Enhanced?

Puede solicitarle a nuestro plan que haga una excepción a las reglas de cobertura. Existen varios tipos de excepciones que puede solicitarnos que hagamos.

- Puede solicitarnos que cubramos un medicamento incluso si no está en nuestra farmacopea. Si se aprueba, se cubrirá este medicamento en un nivel de costo compartido predeterminado, y no podrá pedirnos que brindemos el medicamento a un nivel de costo compartido más bajo.

- Puede solicitarnos que eximamos una restricción de cobertura, incluida la autorización previa, el tratamiento escalonado o un límite de cantidad de su medicamento. Por ejemplo, para determinados medicamentos, nuestro plan limita la cantidad del medicamento que cubriremos. Si un medicamento tiene un límite de cantidad, puede solicitarnos que renunciemos a ese límite y cubramos un monto mayor.

Generalmente, nuestro plan solamente aprobará su solicitud de excepción si los medicamentos alternativos incluidos en la farmacopea del plan, el medicamento de costo compartido más bajo o aplicar las restricciones no serían tan eficaces para usted o le producirían efectos adversos.

Usted o su profesional autorizado para recetar deben comunicarse con nosotros para solicitar una excepción a la farmacopea, incluida una excepción a una restricción de cobertura. **Cuando solicita una excepción, su profesional autorizado para recetar deberá explicar los motivos médicos por los cuales usted necesita la excepción.** Por lo general, debemos tomar una decisión dentro de las 72 horas de haber recibido la declaración de apoyo del profesional autorizado para recetar. Puede solicitar una decisión acelerada (rápida) si usted cree que esperar una decisión hasta 72 horas podría perjudicar gravemente su salud y si nosotros estamos de acuerdo. Si aceptamos, o si su profesional autorizado para recetar solicita una decisión acelerada, debemos darle una decisión a más tardar 24 horas después de recibir la declaración de respaldo del profesional autorizado para recetar.

¿Qué puedo hacer si mi medicamento no está en la farmacopea o tiene una restricción?

Como un miembro nuevo o que continúa en nuestro plan, es posible que esté tomando medicamentos que no están en la farmacopea. O bien, es posible que esté tomando un medicamento que está en nuestra farmacopea pero que tiene una restricción de cobertura, como una autorización previa. Debe hablar con su profesional autorizado para recetar sobre solicitar una decisión de cobertura para demostrar que usted cumple con los criterios de aprobación, cambiar a un medicamento alternativo que cubramos o solicitar una excepción a la farmacopea para que cubramos el medicamento que toma. Mientras usted y su médico determinan el curso de acción adecuado para usted, es posible que cubramos sus medicamentos en determinados casos durante los primeros 90 días en que usted es miembro de nuestro plan.

Por cada uno de sus medicamentos que no esté en nuestra farmacopea o que tenga una restricción de cobertura, cubriremos un suministro temporal para 30 días. Si su receta médica fue hecha por pocos días, permitiremos varios resurtidos hasta un máximo de un suministro de 30 días del medicamento. Si no se aprueba la cobertura, luego de su primer suministro para 30 días, no pagaremos por estos medicamentos, incluso si hace menos de 90 días que usted es miembro del plan.

Si usted es residente de un centro de cuidados a largo plazo y necesita un medicamento que no está en nuestra farmacopea o si su capacidad para obtener sus medicamentos es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento mientras solicita una excepción a la farmacopea.

Si es un miembro actual de nuestro plan y experimenta algún cambio en el nivel de atención, como por ejemplo, ser admitido o dado de alta en un centro de cuidados a largo plazo, se le permitirá una renovación temporal por una única vez de sus medicamentos, según sea necesario, para ayudarle en su transición a un nuevo nivel de atención.

Para más información

Para obtener información más detallada sobre la cobertura de medicamentos con receta de EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual y EmblemHealth VIP Dual Enhanced, consulte su Evidencia de cobertura y los demás materiales del plan.

Si tiene preguntas sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la última fecha en que hemos actualizado la farmacopea, aparece en la portada y la contratapa.

Si tiene alguna pregunta en general sobre la cobertura de medicamentos con receta de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227) las 24 horas del día, los 7 días de la semana, los usuarios de TTY deben llamar al 1-877-486-2048. O bien, visite http://www.medicare.gov.

Farmacopea de EmblemHealth VIP Dual Reserve, EmblemHealth VIP Dual y EmblemHealth VIP Dual Enhanced

La farmacopea que comienza en la página 1 proporciona información sobre la cobertura de los medicamentos cubiertos por nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, consulte el Índice que comienza en la página 1 del Índice.

La primera columna del cuadro enumera el nombre del medicamento. Los medicamentos de marca se encuentran escritos con mayúsculas (p. ej., SYNTHROID) y los medicamentos genéricos se encuentran escritos en cursiva minúscula (p. ej., *levothyroxine*).

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

A continuación, aparece una lista de abreviaturas que pueden aparecer en las páginas siguientes dentro de la columna Requisitos/límites que le informa si hay algún requisito especial de cobertura para su medicamento.

Lista de abreviaturas

B/D PA: Este medicamento con receta puede estar cubierto por la Parte B o D de Medicare según las circunstancias. Es posible que se deba presentar la información que describa el uso y el entorno de la regulación del medicamento para tomar una determinación.

LA: Disponibilidad limitada. Esta receta solamente puede estar disponible en determinadas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame a Servicio de Atención al Cliente al **877-344-7364** (los usuarios de TTY deben llamar al **711**). Del 1.° de octubre al 31 de marzo, puede llamarnos de 8 a.m. a 8 p.m., los siete días de la semana. Del 1.° de abril al 30 de septiembre, puede llamarnos de 8 a.m. a 8 p.m., de lunes a sábado o visitar **emblemhealth.com/medicare.**

MO: Medicamento pedido por correo. Este medicamento con receta está disponible a través de nuestro servicio de pedido por correo, así como también a través de nuestras farmacias de venta minorista de la red. Considere usar los pedidos por correo para sus medicamentos a largo plazo (de mantenimiento) (como, por ejemplo, los medicamentos para la presión arterial alta). Las farmacias de venta minorista de la red pueden ser más adecuadas para medicamentos con receta a corto plazo (como, por ejemplo, los antibióticos).

PA: Autorización previa. El plan le exige a usted o a su médico que obtenga una autorización previa para determinados medicamentos. Esto significa que deberá obtener aprobación antes de llenar sus medicamentos con receta. Si no obtiene la aprobación, es posible que no cubramos el medicamento.

QL: Límite de cantidad. Para determinados medicamentos, el plan limita la cantidad del medicamento que cubriremos.

ST: Tratamiento escalonado. En algunos casos, el plan le exige que pruebe primero determinados medicamentos para tratar su afección médica antes de que cubramos otro medicamento para esa afección. Por ejemplo, si tanto el Medicamento A como el Medicamento B tratan su afección médica, es posible que el plan no cubra el Medicamento B a menos que primero pruebe el Medicamento A. Si el Medicamento A no funciona para usted, entonces cubriremos el Medicamento B.

LDS: Suministro con límite de días. Para determinados medicamentos, el plan limita el suministro diario que cubriremos por un mes por vez.

V: La vacuna se proporciona sin costo alguno a adultos cuando se administra en función de las recomendaciones del Comité Asesor sobre Prácticas de Inmunización (Advisory Committee on Immunization Practices, ACIP) de los Centros para el Control y la Prevención de Enfermedades (Centers for Disease Control and Preventions, CDC).

现有会员须知：此药物名册自去年起已发生变化。请查看本文件，以确保其中仍然包含您服用的药物。

当本药物清单（药物名册）提及“我们”或“我们的”时，它指的是大纽约健康保险 (HIP)。当它指“计划”或“我们的计划”时，它指的是安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve) (HMO D-SNP)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) (HMO D-SNP) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) (HMO D-SNP)。

本文件包含我们的计划截至<2024 年 8 月 24 日>的最新药物清单（药物名册）。如需更新版的药物清单（药物名册），请联系我们。我们的联系信息以及我们上次更新药物清单（药物名册）的日期显示在封面和封底。

您通常必须使用网内的药房来使用您的处方药物保险福利。保险福利、药物名册、药房网络和/或自付款/共同保险可能会在 2026 年 1 月 1 日发生变更，并在全年中不时更改。

什么是安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve) (HMO D-SNP)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) (HMO D-SNP) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) (HMO D-SNP) 药物名册？

在本文件中，我们使用术语“药物清单”和“药物名册”来表示相同的含义。药物名册是我们的计划与医疗服务提供方团队协商选择的承保药物列表，它代表了高质量治疗计划的必要组成部分的处方药疗法。只要药物在医疗上是必需的，且在网络内的药房配处方药，并遵循其他计划规则，我们的计划通常承保在我们的药物名册中的药物。有关如何配药的更多信息，请查看您的承保证明书。

药物名册可以改变吗？

药物承保范围的大多数变更发生在 1 月 1 日，但我们的计划可能在年内添加或删除药物名册上的药物或添加新的限制。在做出这些改变时，我们必须遵循联邦医疗保险（Medicare，即红蓝卡）规则。药物名册的更新每月发布到我们的网站上：emblemhealth.com/medicare

可能在本年度带给您影响的变更：在以下情况下，您将在本年度受承保内容变更的影响：

- **立即替代某些新版本的品牌药物和原始生物制品。** 如果我们要用一种新版本的药物来替代一种药物，而这种新版本药物将出现，并且具有相同或更少的限制，我们可能会立即将其从药物名册中删除。当我们向药物名册添加新版本的药物时，我们可能会决定将品牌药物或原始生物制品保留在我们的药物名册上，但会立即将其移动或添加新的限制。
  只有当我们添加新的非品牌版本的品牌药物，或添加已经在药物名册上的原始生物制品的某些新的生物仿制药版本时，我们才能立即做出这些改变（例如，添加一种可互换的生物仿制药，可以在没有新处方的情况下由药房取代原始生物制品）。

如果您目前正在服用该品牌药物或原始生物制品，我们可能不会在我们做出该立即变更之前提前通知您，但我们稍后会向您提供有关我们做出的具体变更的信息。

如果我们做出这样的变更，您或您的处方医生可以要求我们进行例外处理并继续为您承保要被变更的药物。有关更多信息，请参阅以下标题为“如何申请安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) 药物名册部分。

其中一些药物类型对您来说可能是新的。有关详细信息，请参阅以下标题为
“什么是原始生物制品？它们与生物仿制药有何关系？”

- **从市场上撤出的药物。**如果制造商或美国食品和药物管理局 (FDA) 出于任何安全或有效性原因决定将药物撤回销售，我们可能会立即从我们的药物名册中删除该药物，并随后向服用药物的会员发出通知。
- **其他变更。**我们可能会做出其他会影响正在服用药物的会员的变更。例如，在添加仿制药时，我们可能会从药物名册中删除品牌药品，或在添加生物仿制药时删除原始生物制品。我们还可能对品牌药物或原始生物制品应用新的限制。我们可能会根据新的临床指南进行更改。如果我们从药物名册中移除药物，在药物名册上增加事先授权、数量限制和/或阶梯治疗限制，或将药物移至更高分摊费用等级，我们必须在变更生效前至少 30 天通知受影响的会员这些变更。或者，当会员请求续配药时，他们可以收到 30 天的药物供应量和变更通知。

如果我们做出这些其他变更，您或您的处方医生可以要求我们对您进行例外处理并继续为您承保您正在服用的药物。我们提供的通知还将包括有关如何申请例外承保的信息，您也可以在以下标题为“如何申请安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) 药物名册的例外情况？”的部分中找到相关信息。

如果您目前正在服用药物，有些变更将不会对您产生影响。 一般来说，如果您正在服用我们 2025 年药物名册中在年初承保的药物，我们将不会在 2025 年承保年度内停止或减少该药物的承保，但上述情况除外。这意味着将继续以相同的分摊费用提供这些药物，并且在承保年度的剩余时间内，对服用这些药物的会员不会有新的限制。您不会在本年度直接收到那些对您没影响的变更通知。然而，在下一年的 1 月 1 日，此类变更将会影响您，因此请务必查阅新保险福利年度的药物名册是否有任何药物的变更。

随附的药物名册是截至<2024 年 8 月 24 日>的最新药物名册。要获取有关我们的计划承保药物的最新信息，请联系我们。封面和封底上有我们的联系信息。

注意：如果年中发生非维护药物名册变更，则此变更将添加到自该药物名册印刷以来所做更改的一份综合列表中。变更列表包含在在线提供的药物名册手册中。新会员将在欢迎资料夹中收到通知，其中包含如何访问药物名册或如何索取一份药物名册。现有会员可以通过 emblemhealth.com/medicare 访问我们，查看更新的药物名册。发布在我们网站上的药物名册已更新。

如何使用药物名册？

有两种方法可以在药物名册内找到您的药物：

病症

药物名册从第 1 页开始。此药物名册中的药物根据用于治疗的病症类型进行分类。例如，用于治疗心脏病的药物列在“心血管高血压/脂质”类别下。如果您知道您的药物用途，请从第 1 页开始的列表中查找类别名称。然后，在药品类别名称下查找您需要的药物。

字母顺序

如果不确定要在哪个类别下查找，您应该在索引 1 页面开始的索引中查找您的药物。该索引按字母顺序列出了本文件中包含的所有药物。品牌药物与非品牌药物均列在索引中。查看索引并找到您的药物。在药物旁边，您将看到页码，在那里您可以找到承保信息。转到索引中列出的页面，并在列表的第一列中找到您的药物名称。

什么是非品牌药物？

我们的计划承保品牌药物和非品牌药物。非品牌药物被美国食品和药物管理局 (FDA) 批准为与品牌药具有相同的活性成分。一般来说，非品牌药物的效果和品牌药一样好，而且通常比品牌药费用低。许多品牌药物都有非品牌药物的替代品。根据州法律，非品牌药物通常可以在药房代替品牌药物，而无需新处方。

什么是原始生物制品，它们与生物仿制药有何关系？

在药物名册上，当我们提到药物时，这可能意味着药物或生物制品。生物制品是比典型药物更复杂的药物。由于生物制品比典型药物更复杂，不具有通用形式，它们被称为生物仿制药。通常生物仿制药与原始生物制品一样有效，而且费用可能更低。有些原始生物制品有生物仿制药替代品。一些生物仿制药是可互换的生物仿制药，而且根据州法律，它们可以在药房用原始生物制品代替，而不需要新的处方，就像非品牌药物可以代替品牌药物一样。

- 有关药物类型的讨论，请参阅“承保证明”第 5 章第 3.1 节“‘药单’告诉您哪些 D 部分药物获得承保”。

我的承保范围是否有任何限制？

某些承保药物可能对承保范围有额外的要求或限制。这些要求和限制可能包括：

- **事先授权：**我们的计划要求您或您的处方医生获得针对某些药物的事先授权。这意味着您需要先获得我们的计划的批准，然后再配处方药。如果您未取得批准，我们的计划可能不承保您的药物。

- **数量限制：**对于某些药物，我们的计划限制了我们将承保的药物数量。例如，对于 JANUVIA®，我们的计划提供每个处方 30 片。这可能是一个月或三个月标准供应量的补充。

- **阶段式治疗：**在某些情况下，我们的计划要求您首先尝试某些药物来治疗您的病症，然后我们才能承保另一种治疗该疾病的药物。例如，如果药物 A 和药物 B 均治疗您的病症，我们的计划可能不会承保药物 B，除非您先尝试药物 A。若 A 药物对您无效，则我们的计划将承保 B 药物。

您可以通过查看从第 1 页开始的药物名册，了解您的药物是否有任何额外的要求或限制。您还可以访问我们的网站，获取有关适用于特定承保药物的限制的更多信息。我们已经发布了用于说明我们的事先授权和阶段式治疗限制的在线文件。 您也可以要求我们寄一份给您。我们的联系信息以及我们上次更新药物名册的日期显示在封面和封底。

您可以要求我们的计划对这些限制或限额作出例外处理，或者提供可能治疗您的健康状况的其他类似药物列表。请参阅 V 页上的“如何申请安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) 药物名册的例外情况？”的部分了解关于如何申请例外承保的信息。

如果我的药物不在药物名册上怎么办？

如果您的药物未包含在此药物名册（承保药物清单）中，您应首先联系客户服务部并询问您的药物是否被承保。

如果您了解到我们的计划不承保您的药物，您有两个选择：

- 您可以向客户服务部索取一份关于我们的计划承保的类似药物的名单。当您收到名单时，向您的医生出示，并要求其开具我们的计划承保的类似药物。
- 您可以要求我们例外处理，并承保您的药物。请参阅下文，了解关于如何申请例外的信息。

如何申请安保尊享联邦医疗保险双重资格专选计划（VIP Dual Reserve）、安保尊享联邦医疗保险双重资格计划（VIP Dual）和安保尊享联邦医疗保险双重资格补助计划（VIP Dual Enhanced）药物名册的例外承保？ 您可以要求我们的计划对我们的承保规则做出例外处理。您可以要求我们做出几种类型的例外处理。

- 您可以要求我们承保一种药物，即使它不在我们的药物名册上。如果获得批准，此药物将按预先确定的分摊费用等级获得承保，而您将无法要求我们以更低的分摊费用等级提供药物。
- 您可以要求我们放弃承保限制，包括事先授权、阶段式治疗或药物数量限制。例如，对于某些药物，我们的计划限制了我们将承保的药物数量。如果您的药物有数量限制，您可以要求我们免除限制并承保更高的数量。

一般来说，只有当我们的计划药物名册中包含的替代药物、更低的分摊费用药物或应用限制对您来说效果不佳和/或会导致您产生不良反应时，我们的计划才批准您的例外请求。

您或您的处方医生应联系我们，要求药物名册例外，包括承保限制的例外。**当你申请例外时，你的处方医生需要用医学原因解释为什么您的情况需要例外。**一般来说，我们必须收到您的处方医生的支持声明后 72 小时内做出裁定。如果您认为（我们也同意）等待 72 小时内做出裁定可能会严重损害您的健康，您可以申请加急（快速）决定。如果我们同意，或者如果您的处方医生要求快速做出决定，我们必须在收到处方医生的支持声明后 24 小时内做出决定。

如果我的药物不在药物名册上或有限制，我该怎么办？

作为我们的计划的新会员或继续投保我们的计划的会员，您可能正在服用不在我们药物名册上的药物。或者，您可能正在服用我们药物名册上但有承保限制的药物，例如事先授权。您应与您的处方医生讨论如何申请承保决定，以证明您符合批准标准，转用我们承保的替代药物或请求药物名册例外，以便我们承保您服用的药物。当您和您的医生确定适合您的行动方案时，在某些情况下，我们可能会在您成为我们的计划会员的最初 90 天内承保您的药物。

对于不在药物名册上或有承保限制的每种药物，我们将承保 30 天的临时供应量。若您的处方天数较短，我们将允许续配药以提供最长 30 天的药物供应。如果承保未获批准，在您首次 30 天供应后，我们将不会为这些药物支付费用，即使您加入该计划不到 90 天。

如果您是长期居住在护理院，并且您需要一种不在我们药物名册上的药物，或者如果您获得药物的能力有限，但您已经过了成为我们计划会员的最初 90 天，那么在您寻求药物名册例外承保时，我们将承保该药物的 31 天紧急供应。

如果您目前是我们计划的会员，并且您的护理水平发生了变化，例如长期护理院的住院或出院，我们将根据需要为您提供一次性临时药物供应，以帮助您过渡到新的护理水平。

更多信息

有关您的安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) 处方药物承保范围的更多详细信息，请查看您的承保证明和其他计划材料。

如果您对我们的计划有任何疑问，请联系我们。我们的联系信息以及我们上次更新药物名册的日期显示在封面和封底。

如果您对联邦医疗保险（Medicare，即红蓝卡）处方药物承保范围有常规疑问，请致电联邦医疗保险（Medicare，即红蓝卡），电话 1-800-MEDICARE (1-800-633-4227)，服务时间是每周 7 天、每天 24 小时，TTY 用户应致电 1-877-486-2048。或者，访问 http://www.medicare.gov。

安保尊享联邦医疗保险双重资格专选计划 (VIP Dual Reserve)、安保尊享联邦医疗保险双重资格计划 (VIP Dual) 和安保尊享联邦医疗保险双重资格补助计划 (VIP Dual Enhanced) 药物名册

从第 1 页开始的药物名册提供关于我们的计划承保的药物的承保信息。如果您在列表中查找药物时遇到问题，请转至索引 1 页面开始的索引。

图表的第一列列出了药物名称。品牌药物为大写字体（例如，SYNTHROID），非品牌药物以小写字母斜体列出（例如，*左甲状腺素*）。

“要求/限制”一列中的信息告诉您我们的计划是否对您的药物承保范围有任何特殊要求。

以下是可能在以下页面中“要求/限制”列出现的缩写列表，这些缩写会告诉您是否有关于您的药物承保范围的任何特殊要求。

缩略语列表

B/D PA：根据具体情况，联邦医疗保险 B 部分或 D 部分可能承保此处方药物。可能需要提交描述药物使用和设置的信息，以便做出裁决。

LA：有限库存。该处方药可能只在某些药房有售。如需了解更多信息，请查阅您的药房名录或致电 **877-344-7364** 联系客户服务部（TTY 用户应致电 **711**）。从 10 月 1 日到 3 月 31 日，您可以每周七天 8 a.m. 到 8 p.m. 致电我们。从 4 月 1 日至 9 月 30 日，您可以在周一至周六 8 a.m. 到 8 p.m. 致电我们，或访问 **emblemhealth.com/medicare。**

MO：邮购药物。这种处方药物可通过我们的邮购服务以及我们的零售网络药房获得。请考虑使用邮购来获取您的长期（维持）药物（如高血压药物）。零售网络药房可能更适合短期处方（如抗生素）。

PA：事先授权。我们的计划要求您或您的医生获得针对某些药物的事先授权。这意味着您需要先获得批准，然后再配处方药。如果您未取得批准，我们可能不承保您的药物。

QL：数量限制。对于某些药物，我们的计划限制了我们将承保的药物数量。

ST：阶段式治疗。在某些情况下，我们的计划要求您首先尝试某些药物来治疗您的病症，然后我们才能承保另一种治疗该疾病的药物。例如，如果药物 A 和药物 B 均治疗您的病症，我们可能不会承保药物 B，除非您先尝试药物 A。若 A 药物对您无效，则我们将承保 B 药物。

LDS：有限的供应天数。对于某些药物，该计划将我们每次承保的天数用量限制为一个月。

V：根据疾病预防与控制中心 (CDC) 免疫实践咨询委员会 (ACIP) 的建议，该疫苗在使用时免费提供给成人。

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-344-7364** (TTY: **711**; Oct. 1 through March 31: 8 a.m. to 8 p.m., seven days a week; April 1 through Sept. 30: 8 a.m. to 8 p.m., Monday through Saturday) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-344-7364** (TTY: **711**) o hable con su proveedor.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **877-344-7364**（文本电话：**711**）或咨询您的服务提供商。

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-344-7364** (TTY: **711**) или обратитесь к своему поставщику услуг.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **877-344-7364** (TTY: **711**) oswa pale avèk founisè w la.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-344-7364** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-344-7364** (tty: **711**) o parla con il tuo fornitore.

(**Yiddish**) **ייִדיש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פּראַווייַדינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן (TTY: **711**) **877-344-7364** אָדער רעדן מיט דיין טרעגער.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

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বাংলা (Bengali) মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। **877-344-7364** (TTY: **711**) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-344-7364** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-344-7364** (**711**) أو تحدث إلى مقدم الخدمة.

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-344-7364** (TTY: **711**) ou parlez à votre fournisseur.

اردو (Urdu)

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: **711**) **877-344-7364** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-344-7364** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-344-7364** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

SHQIP (Albanian) VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-344-7364** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

NOTICE OF NONDISCRIMINATION POLICY

Discrimination is Against the Law

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. EmblemHealth does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

EmblemHealth:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters.
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services contact the Civil Rights Coordinator by calling Medicare Connect Concierge at **877-344-7364** (TTY: **711**; Oct. 1 through March 31: 8 a.m. to 8 p.m., seven days a week; April 1 through Sept. 30: 8 a.m. to 8 p.m., Monday through Saturday).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to the EmblemHealth Grievance and Appeals Department, P.O. Box 2807, New York, NY 10116-2807; faxing them at **866-854-2763**; or calling Medicare Connect Concierge at **877-344-7364**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **800-368-1019** (TTY: **800-537-7697**).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

This notice is available on EmblemHealth's website at **emblemhealth.com/legal/nondiscrimination**.

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Aviso de disponibilidad de servicios de asistencia en idiomas y ayudas y servicios auxiliares

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-344-7364** (TTY: **711**; Oct. 1 through March 31: 8 a.m. to 8 p.m., seven days a week; April 1 through Sept. 30: 8 a.m. to 8 p.m., Monday through Saturday) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-344-7364** (TTY: **711**) o hable con su proveedor.

中文 (Simplified Chinese) 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 **877-344-7364**（文本电话：**711**）或咨询您的服务提供商。

РУССКИЙ (Russian) ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-344-7364** (TTY: **711**) или обратитесь к своему поставщику услуг.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan **877-344-7364** (TTY: **711**) oswa pale avèk founisè w la.

한국어 (Korean) 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-344-7364** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Italiano (Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-344-7364** (tty: **711**) o parla con il tuo fornitore.

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বাংলা (Bengali) মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। **877-344-7364** (TTY: **711**) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-344-7364** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

(**Arabic**) **العربية**

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-344-7364** (**711**) أو تحدث إلى مقدم الخدمة.

Français (French) ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-344-7364** (TTY: **711**) ou parlez à votre fournisseur.

(Urdu) اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: **711**) **877-344-7364** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-344-7364** (TTY: **711**) o makipag-usap sa iyong provider.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-344-7364** (TTY: **711**) ή απευθυνθείτε στον πάροχό σας.

SHQIP (Albanian) VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-344-7364** (TTY: **711**) ose bisedoni me ofruesin tuaj të shërbimit.

AVISO DE POLÍTICA DE NO DISCRIMINACIÓN

La discriminación es ilegal

EmblemHealth cumple con las leyes federales de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad o sexo, incluidas las características sexuales, como los rasgos intersexuales, embarazo o condiciones relacionadas, orientación sexual, identidad de género y estereotipos de sexo. EmblemHealth no excluye a las personas ni las trata menos favorablemente por motivos de raza, color, origen nacional, edad, discapacidad o sexo.

EmblemHealth:

- Proporciona a las personas con discapacidades modificaciones razonables y ayuda y servicios auxiliares adecuados y gratuitos para comunicarse eficazmente con nosotros, tales como:
    - Intérpretes calificados de lenguaje de señas.
    - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, entre otros).
- Ofrece servicios gratuitos de asistencia lingüística a personas cuyo idioma principal no es el inglés, lo que puede incluir:
    - Intérpretes calificados.
    - Información escrita en otros idiomas.

Si necesita modificaciones razonables, ayudas y servicios auxiliares apropiados o servicios de asistencia lingüística, comuníquese con el coordinador de derechos civiles llamando a Medicare Connect Concierge al **877-344-7364** (TTY: **711**; Horario de atención: del 1 de octubre al 31 de marzo, de 8 a.m. a 8 p.m., todos los días de la semana; del 1 de abril al 30 de septiembre, de 8 a.m. a 8 p.m., de lunes a sábado).

Si cree que EmblemHealth no ha proporcionado estos servicios o ha discriminado de otra manera por motivos de raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: el coordinador de derechos civiles por correo postal a la dirección EmblemHealth Grievance and Appeals Department, P.O. Box 2807, New York, NY 10116-2807; por fax al **866-854-2763**; o por teléfono a Medicare Connect Concierge al **877-344-7364**. (Marque **711** para los servicios TTY). Puede presentar una queja en persona o por correo, fax o el portal para miembros. Si necesita ayuda para presentar un reclamo, el Departamento de Reclamos y Apelaciones de EmblemHealth está disponible para asistirlo. También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. electrónicamente a través del portal de quejas de la Oficina de Derechos Civiles, disponible en **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, o por correo o teléfono a: **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**; **800-368-1019**, (TTY: **800-537-7697**).

Los formularios de quejas están disponibles en **hhs.gov/ocr/office/file/index.html**.

Este aviso está disponible en el sitio web de EmblemHealth: **espanol.emblemhealth.com/legal/nondiscrimination**.

EmblemHealth
安保健康保险

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语言协助服务及辅助设施和服务的可用性通知

English ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **877-344-7364** (TTY: **711**; Oct. 1 through March 31: 8 a.m. to 8 p.m., seven days a week; April 1 through Sept. 30: 8 a.m. to 8 p.m., Monday through Saturday) or speak to your provider.

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-344-7364** (TTY: **711**) o hable con su proveedor.

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安保健康保险计划、安保健康保险公司、安保健康保险服务公司以及大纽约健康保险 (HIP) 是安保健康保险旗下的公司。安保健康保险服务公司向安保健康保险旗下的公司提供行政管理服务。

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POLSKI (Polish) UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-344-7364** (TTY: **711**) lub porozmawiaj ze swoim dostawcą.

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反歧视政策通告

歧视是违法的

安保健康保险遵守联邦民权法，不会因种族、肤色、国籍、年龄、残疾或性别（包括性别特征，包括双性人特征；怀孕或相关状况；性取向；性别认同和性别刻板印象）而歧视他人。安保健康保险不会因为种族、肤色、国籍、年龄、残疾或性别而排斥他人或对其不利。

安保健康保险：

- 为残疾人士提供合理的通融及免费的适当的辅助设施和服务，以便他们与我们有效沟通，例如：
    - 合格的手语翻译。
    - 其他格式的书面信息（大字体、音频、可访问电子格式和其他格式）。
- 为母语非英语的人士提供免费语言协助服务，其中可能包括：
    - 合格的口译员。
    - 用其他语言编写的信息。

如果您需要合理的通融、适当的辅助设施和服务，或语言协助服务，请致电联邦医疗保险（Medicare，即红蓝卡）贵宾专属服务 **877-344-7364**（TTY：**711**；服务时间是 10 月 1 日至 3 月 31 日：每周七天、每天 8 a.m. 至 8 p.m.；4 月 1 日至 9 月 30 日：周一至周六 8 a.m. 至 8 p.m.）联系民权协调员。

如您认为安保健康保险未能提供这些服务，或因种族、肤色、国籍、年龄、残疾或性别而受到其他方面的歧视，您可以通过写信给安保健康保险申诉和上诉部（地址是 EmblemHealth Grievance and Appeals Department, P.O. Box 2807, New York, NY 10116-2807）向民权协调员提出申诉；通过 **866-854-2763** 给它们发送传真，或者致电 **877-344-7364** 联系联邦医疗保险（Medicare，即红蓝卡）贵宾专属服务。（如需使用 TTY 服务，请拨 **711**。） 您可以亲自、通过邮件、传真或通过您的安全会员平台提出申诉。如果您需要帮助来提交申诉，安保健康保险的申诉和上诉部门可以帮助您。您也可以通过公民权利投诉门户网站 **ocrportal.hhs.gov/ocr/portal/lobby.jsf** 向美国卫生与公众服务部公民权利办公室提交公民权利投诉，或者通过写信或电话方式联系美国卫生与公众服务部：**U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201**；**800-368-1019** (TTY: **800-537-7697**)。

投诉表格可于 **hhs.gov/ocr/office/file/index.html** 获取。

本通知可在安保健康保险的网站 **zt.emblemhealth.com/legal/nondiscrimination** 上获取。

Drug Name	Drug Tier	Requirements/Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET INTRAVENOUS SUSPENSION	1	B/D PA
amphotericin b injection recon soln	1	B/D PA; MO
caspofungin intravenous recon soln	1	
clotrimazole mucous membrane troche	1	MO
CRESEMBA ORAL CAPSULE	1	PA
fluconazole in nacl (iso-osm) intravenous piggyback 100 mg/50 ml, 400 mg/200 ml	1	PA
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml	1	PA; MO
fluconazole oral suspension for reconstitution	1	MO
fluconazole oral tablet	1	MO
flucytosine oral capsule	1	MO
griseofulvin microsize oral suspension	1	MO
griseofulvin microsize oral tablet	1	MO
griseofulvin ultramicrosize oral tablet	1	MO
itraconazole oral capsule	1	MO; QL (120 per 30 days)
itraconazole oral solution	1	MO
ketoconazole oral tablet	1	MO
micafungin intravenous recon soln	1	MO
nystatin oral suspension	1	MO
nystatin oral tablet	1	MO
posaconazole oral tablet,delayed release (dr/ec)	1	PA; MO; QL (96 per 30 days)
terbinafine hcl oral tablet	1	MO
voriconazole intravenous recon soln	1	PA; MO
voriconazole oral suspension for reconstitution	1	PA; MO
voriconazole oral tablet	1	PA; MO
ANTIVIRALS		
abacavir oral solution	1	MO
abacavir oral tablet	1	MO
abacavir-lamivudine oral tablet	1	MO
acyclovir oral capsule	1	MO
acyclovir oral suspension 200 mg/5 ml	1	MO
acyclovir oral tablet	1	MO

Brand-name drugs are CAPITALIZED. **Generic** drugs are lower-case italics. You can find information on what the symbols and abbreviations on this table mean by going to page vii.

This drug list was last updated on 08/24/2024.

Drug Name	Drug Tier	Requirements/Limits
acyclovir sodium intravenous solution	1	B/D PA; MO
adefovir oral tablet	1	MO
amantadine hcl oral capsule	1	MO
amantadine hcl oral solution	1	MO
amantadine hcl oral tablet	1	MO
APTIVUS ORAL CAPSULE	1	MO
atazanavir oral capsule	1	MO
BARACLUDE ORAL SOLUTION	1	MO
BIKTARVY ORAL TABLET	1	MO
CABENUVA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE	1	MO
cidofovir intravenous solution	1	B/D PA; MO
CIMDUO ORAL TABLET	1	MO
COMPLERA ORAL TABLET	1	MO
darunavir oral tablet	1	MO
DELSTRIGO ORAL TABLET	1	MO
DESCOVY ORAL TABLET	1	MO
DOVATO ORAL TABLET	1	MO
EDURANT ORAL TABLET	1	MO
efavirenz oral tablet	1	MO
efavirenz-emtricitabin-tenofov oral tablet	1	MO
efavirenz-lamivu-tenofov disop oral tablet	1	MO
emtricitabine oral capsule	1	MO
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg	1	MO
emtricitabine-tenofovir (tdf) oral tablet 133-200 mg, 167-250 mg, 200-300 mg	1	MO
EMTRIVA ORAL SOLUTION	1	MO
entecavir oral tablet	1	MO
etravirine oral tablet	1	MO
EVOTAZ ORAL TABLET	1	MO
famciclovir oral tablet	1	MO
fosamprenavir oral tablet	1	MO
FUZEON SUBCUTANEOUS RECON SOLN	1	MO
ganciclovir sodium intravenous recon soln	1	B/D PA; MO
ganciclovir sodium intravenous solution	1	B/D PA

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Drug Name	Drug Tier	Requirements/Limits
GENVOYA ORAL TABLET	1	MO
INTELENCE ORAL TABLET 25 MG	1	MO
ISENTRESS HD ORAL TABLET	1	MO
ISENTRESS ORAL POWDER IN PACKET	1	MO
ISENTRESS ORAL TABLET	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	1	MO
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	1	MO
JULUCA ORAL TABLET	1	MO
lamivudine oral solution	1	MO
lamivudine oral tablet	1	MO
lamivudine-zidovudine oral tablet	1	MO
LEDIPASVIR-SOFOSBUVIR ORAL TABLET	1	PA; MO; QL (28 per 28 days)
LIVTENCITY ORAL TABLET	1	PA; LA; QL (120 per 30 days)
lopinavir-ritonavir oral solution	1	MO
lopinavir-ritonavir oral tablet	1	MO
maraviroc oral tablet	1	MO
MAVYRET ORAL PELLETS IN PACKET	1	PA; MO; QL (168 per 28 days)
MAVYRET ORAL TABLET	1	PA; MO; QL (84 per 28 days)
nevirapine oral suspension	1	
nevirapine oral tablet	1	MO
nevirapine oral tablet extended release 24 hr 400 mg	1	MO
NORVIR ORAL POWDER IN PACKET	1	MO
ODEFSEY ORAL TABLET	1	MO
oseltamivir oral capsule	1	MO
oseltamivir oral suspension for reconstitution	1	MO
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	1	QL (20 per 90 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	1	QL (30 per 90 days)
PIFELTRO ORAL TABLET	1	MO
PREVYMIS INTRAVENOUS SOLUTION	1	PA
PREVYMIS ORAL TABLET	1	PA; MO; QL (30 per 30 days)
PREZCOBIX ORAL TABLET	1	MO

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Drug Name	Drug Tier	Requirements/Limits
PREZISTA ORAL SUSPENSION	1	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	1	MO
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE	1	MO
RETROVIR INTRAVENOUS SOLUTION	1	MO
REYATAZ ORAL POWDER IN PACKET	1	MO
ribavirin oral capsule	1	MO
ribavirin oral tablet 200 mg	1	MO
rimantadine oral tablet	1	MO
ritonavir oral tablet	1	MO
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR	1	MO
SELZENTRY ORAL SOLUTION	1	MO
SELZENTRY ORAL TABLET 25 MG, 75 MG	1	MO
SOFOSBUVIR-VELPATASVIR ORAL TABLET	1	PA; MO; QL (28 per 28 days)
STRIBILD ORAL TABLET	1	MO
SUNLENCA ORAL TABLET	1	
SUNLENCA SUBCUTANEOUS SOLUTION	1	
SYMTUZA ORAL TABLET	1	MO
SYNAGIS INTRAMUSCULAR SOLUTION	1	MO; LA
tenofovir disoproxil fumarate oral tablet	1	MO
TIVICAY ORAL TABLET 10 MG	1	
TIVICAY ORAL TABLET 25 MG, 50 MG	1	MO
TIVICAY PD ORAL TABLET FOR SUSPENSION	1	MO
TRIUMEQ ORAL TABLET	1	MO
TRIUMEQ PD ORAL TABLET FOR SUSPENSION	1	MO
TROGARZO INTRAVENOUS SOLUTION	1	MO; LA
valacyclovir oral tablet 1 gram	1	MO; QL (120 per 30 days)
valacyclovir oral tablet 500 mg	1	MO; QL (60 per 30 days)
valganciclovir oral recon soln	1	MO
valganciclovir oral tablet	1	MO
VEMLIDY ORAL TABLET	1	MO
VIRACEPT ORAL TABLET	1	MO

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Drug Name	Drug Tier	Requirements/Limits
VIREAD ORAL POWDER	1	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	MO
VOSEVI ORAL TABLET	1	PA; MO; QL (28 per 28 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	1	MO
zidovudine oral capsule	1	MO
zidovudine oral syrup	1	MO
zidovudine oral tablet	1	MO
CEPHALOSPORINS		
cefaclor oral capsule	1	MO
cefaclor oral suspension for reconstitution 250 mg/5 ml	1	
cefadroxil oral capsule	1	MO
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	1	MO
cefazolin in dextrose (iso-osm) intravenous piggyback 1 gram/50 ml, 2 gram/50 ml	1	MO
cefazolin injection recon soln 1 gram, 500 mg	1	MO
cefazolin injection recon soln 10 gram, 100 gram, 300 gram	1	
cefazolin intravenous recon soln 1 gram	1	
cefdinir oral capsule	1	MO
cefdinir oral suspension for reconstitution	1	MO
cefepime in dextrose (iso-osm) intravenous piggyback	1	
cefepime injection recon soln	1	MO
cefixime oral capsule	1	MO
cefixime oral suspension for reconstitution	1	MO
cefoxitin in dextrose (iso-osm) intravenous piggyback	1	PA
cefoxitin intravenous recon soln 1 gram, 2 gram	1	PA; MO
cefoxitin intravenous recon soln 10 gram	1	PA
cefpodoxime oral suspension for reconstitution	1	MO
cefpodoxime oral tablet	1	MO
cefprozil oral suspension for reconstitution	1	MO
cefprozil oral tablet	1	MO
ceftazidime injection recon soln 1 gram, 2 gram	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
ceftazidime injection recon soln 6 gram	1	PA
ceftriaxone in dextrose (iso-osm) intravenous piggyback	1	MO
ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg	1	MO
ceftriaxone injection recon soln 10 gram	1	
ceftriaxone intravenous recon soln	1	MO
cefuroxime axetil oral tablet	1	MO
cefuroxime sodium injection recon soln 750 mg	1	PA; MO
cefuroxime sodium intravenous recon soln 1.5 gram	1	PA; MO
cefuroxime sodium intravenous recon soln 7.5 gram	1	PA
cephalexin oral capsule 250 mg, 500 mg	1	MO
cephalexin oral suspension for reconstitution	1	MO
tazicef injection recon soln	1	PA; MO
tazicef intravenous recon soln	1	PA
TEFLARO INTRAVENOUS RECON SOLN	1	PA; MO
ERYTHROMYCINS / OTHER MACROLIDES		
azithromycin intravenous recon soln	1	PA; MO
azithromycin oral packet	1	MO
azithromycin oral suspension for reconstitution	1	MO
azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	MO
clarithromycin oral suspension for reconstitution	1	MO
clarithromycin oral tablet	1	MO
clarithromycin oral tablet extended release 24 hr	1	MO
DIFICID ORAL TABLET	1	MO; QL (20 per 10 days)
ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg	1	MO
erythrocin (as stearate) oral tablet 250 mg	1	
erythromycin ethylsuccinate oral tablet	1	MO
erythromycin oral capsule,delayed release(dr/ec)	1	MO
erythromycin oral tablet	1	MO
erythromycin oral tablet,delayed release (dr/ec)	1	MO

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Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS ANTIINFECTIVES		
albendazole oral tablet	1	MO
amikacin injection solution 1,000 mg/4 ml, 500 mg/2 ml	1	PA; MO
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION	1	PA; LA
atovaquone oral suspension	1	MO
atovaquone-proguanil oral tablet	1	MO
aztreonam injection recon soln	1	PA; MO
CAYSTON INHALATION SOLUTION FOR NEBULIZATION	1	PA; MO; LA; QL (84 per 56 days)
chloramphenicol sod succinate intravenous recon soln	1	
chloroquine phosphate oral tablet	1	MO
clindamycin hcl oral capsule	1	MO
clindamycin in 5 % dextrose intravenous piggyback	1	PA; MO
clindamycin phosphate injection solution	1	PA; MO
COARTEM ORAL TABLET	1	MO
colistin (colistimethate na) injection recon soln	1	PA; MO; QL (30 per 10 days)
dapsone oral tablet	1	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	1	MO
daptomycin intravenous recon soln 500 mg	1	MO
EMVERM ORAL TABLET,CHEWABLE	1	MO
ertapenem injection recon soln	1	PA; MO; QL (14 per 14 days)
ethambutol oral tablet	1	MO
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml	1	PA; MO
gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml	1	PA
gentamicin injection solution 40 mg/ml	1	PA; MO
gentamicin sulfate (ped) (pf) injection solution	1	PA; MO
hydroxychloroquine oral tablet 200 mg	1	MO
imipenem-cilastatin intravenous recon soln	1	PA; MO
isoniazid injection solution	1	

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Drug Name	Drug Tier	Requirements/Limits
isoniazid oral solution	1	MO
isoniazid oral tablet	1	MO
ivermectin oral tablet	1	PA; MO; QL (20 per 30 days)
lincomycin injection solution	1	PA
linezolid in dextrose 5% intravenous piggyback	1	PA; MO
linezolid oral suspension for reconstitution	1	MO
linezolid oral tablet	1	MO
linezolid-0.9% sodium chloride intravenous parenteral solution	1	PA
mefloquine oral tablet	1	
meropenem intravenous recon soln 1 gram	1	PA; QL (30 per 10 days)
meropenem intravenous recon soln 500 mg	1	PA; QL (10 per 10 days)
metro i.v. intravenous piggyback	1	PA; MO
metronidazole in nacl (iso-osm) intravenous piggyback	1	PA; MO
metronidazole oral tablet	1	MO
neomycin oral tablet	1	MO
nitazoxanide oral tablet	1	MO; QL (12 per 30 days)
pentamidine inhalation recon soln	1	B/D PA; MO; QL (1 per 28 days)
pentamidine injection recon soln	1	MO
praziquantel oral tablet	1	MO
PRIFTIN ORAL TABLET	1	MO
PRIMAQUINE ORAL TABLET	1	MO
pyrazinamide oral tablet	1	MO
pyrimethamine oral tablet	1	PA; MO
quinine sulfate oral capsule	1	MO
rifabutin oral capsule	1	MO
rifampin intravenous recon soln	1	MO
rifampin oral capsule	1	MO
SIRTURO ORAL TABLET	1	PA; LA
STREPTOMYCIN INTRAMUSCULAR RECON SOLN	1	PA; MO; QL (60 per 30 days)
tigecycline intravenous recon soln	1	PA; MO
tinidazole oral tablet	1	MO
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	1	MO; QL (224 per 56 days)

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Drug Name	Drug Tier	Requirements/Limits
tobramycin in 0.225 % nacl inhalation solution for nebulization	1	PA; MO; QL (280 per 28 days)
tobramycin inhalation solution for nebulization	1	PA; MO; QL (224 per 28 days)
tobramycin sulfate injection recon soln	1	PA; QL (9 per 14 days)
tobramycin sulfate injection solution	1	PA; MO
TRECATOR ORAL TABLET	1	MO
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 1 GRAM/200 ML	1	PA; QL (4000 per 10 days)
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 500 MG/100 ML	1	PA; QL (1000 per 10 days)
VANCOMYCIN IN 0.9 % SODIUM CHL INTRAVENOUS PIGGYBACK 750 MG/150 ML	1	PA; QL (4050 per 10 days)
vancomycin intravenous recon soln 1,000 mg	1	PA; MO; QL (20 per 10 days)
vancomycin intravenous recon soln 10 gram	1	PA; QL (2 per 10 days)
vancomycin intravenous recon soln 5 gram	1	PA; QL (4 per 10 days)
vancomycin intravenous recon soln 500 mg	1	PA; MO; QL (10 per 10 days)
vancomycin intravenous recon soln 750 mg	1	PA; MO; QL (27 per 10 days)
vancomycin oral capsule 125 mg	1	PA; MO; QL (40 per 10 days)
vancomycin oral capsule 250 mg	1	PA; MO; QL (80 per 10 days)
VIBATIV INTRAVENOUS RECON SOLN 750 MG	1	PA
XIFAXAN ORAL TABLET 200 MG	1	PA; MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	1	PA; MO; QL (90 per 30 days)
PENICILLINS		
amoxicillin oral capsule	1	MO
amoxicillin oral suspension for reconstitution	1	MO
amoxicillin oral tablet	1	MO
amoxicillin oral tablet,chewable 125 mg, 250 mg	1	MO
amoxicillin-pot clavulanate oral suspension for reconstitution	1	MO
amoxicillin-pot clavulanate oral tablet	1	MO
amoxicillin-pot clavulanate oral tablet extended release 12 hr	1	MO
amoxicillin-pot clavulanate oral tablet,chewable 200-28.5 mg	1	MO

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Drug Name	Drug Tier	Requirements/Limits
amoxicillin-pot clavulanate oral tablet,chewable 400-57 mg	1	
ampicillin oral capsule 500 mg	1	MO
ampicillin sodium injection recon soln	1	PA; MO
ampicillin sodium intravenous recon soln	1	PA
ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram	1	PA; MO
ampicillin-sulbactam injection recon soln 15 gram	1	PA
ampicillin-sulbactam intravenous recon soln	1	PA
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	1	MO
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML	1	PA; MO
BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML	1	PA
dicloxacillin oral capsule	1	MO
nafcillin in dextrose (iso-osm) intravenous piggyback 2 gram/100 ml	1	PA
nafcillin injection recon soln 1 gram, 2 gram	1	PA; MO
nafcillin injection recon soln 10 gram	1	PA
oxacillin in dextrose(iso-osm) intravenous piggyback	1	PA
oxacillin injection recon soln 1 gram, 10 gram	1	PA
oxacillin injection recon soln 2 gram	1	PA; MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	1	PA
penicillin g potassium injection recon soln	1	PA; MO
penicillin g sodium injection recon soln	1	PA; MO
penicillin v potassium oral recon soln	1	MO
penicillin v potassium oral tablet	1	MO
pfizerpen-g injection recon soln	1	PA
piperacillin-tazobactam intravenous recon soln 13.5 gram, 40.5 gram	1	
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram	1	MO

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Drug Name	Drug Tier	Requirements/Limits
QUINOLONES		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	MO
ciprofloxacin in 5 % dextrose intravenous piggyback	1	PA; MO
ciprofloxacin oral suspension,microcapsule recon 500 mg/5 ml	1	
levofloxacin in d5w intravenous piggyback 250 mg/50 ml	1	PA
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	1	PA; MO
levofloxacin intravenous solution	1	PA
levofloxacin oral solution	1	MO
levofloxacin oral tablet	1	MO
moxifloxacin oral tablet	1	MO
moxifloxacin-sod.chloride(iso) intravenous piggyback	1	PA; MO
SULFA'S / RELATED AGENTS		
sulfadiazine oral tablet	1	MO
sulfamethoxazole-trimethoprim intravenous solution	1	PA; MO
sulfamethoxazole-trimethoprim oral suspension	1	MO
sulfamethoxazole-trimethoprim oral tablet	1	MO
TETRACYCLINES		
demeclocycline oral tablet	1	MO
doxy-100 intravenous recon soln	1	PA; MO
doxycycline hyclate intravenous recon soln	1	PA
doxycycline hyclate oral capsule	1	MO
doxycycline hyclate oral tablet 100 mg, 20 mg, 50 mg	1	MO
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	MO
doxycycline monohydrate oral suspension for reconstitution	1	MO
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	1	MO
minocycline oral capsule	1	MO

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Drug Name	Drug Tier	Requirements/Limits
minocycline oral tablet	1	MO
mondoxyne nl oral capsule 100 mg	1	
tetracycline oral capsule	1	MO
URINARY TRACT AGENTS		
methenamine hippurate oral tablet	1	MO
methenamine mandelate oral tablet	1	MO
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	1	MO
nitrofurantoin monohyd/m-cryst oral capsule	1	MO
trimethoprim oral tablet	1	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
dexrazoxane hcl intravenous recon soln	1	B/D PA; MO
ELITEK INTRAVENOUS RECON SOLN	1	MO
KHAPZORY INTRAVENOUS RECON SOLN 175 MG	1	B/D PA
leucovorin calcium oral tablet	1	MO
levoleucovorin calcium intravenous recon soln	1	B/D PA; MO
levoleucovorin calcium intravenous solution	1	B/D PA
mesna intravenous solution	1	B/D PA; MO
MESNEX ORAL TABLET	1	MO
XGEVA SUBCUTANEOUS SOLUTION	1	B/D PA; MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
abiraterone oral tablet 250 mg	1	PA; MO; QL (120 per 30 days)
abiraterone oral tablet 500 mg	1	PA; MO; QL (60 per 30 days)
ABRAXANE INTRAVENOUS SUSPENSION FOR RECONSTITUTION	1	B/D PA; MO
ADCETRIS INTRAVENOUS RECON SOLN	1	B/D PA; MO
ADSTILADRIN INTRAVESICAL SUSPENSION	1	PA
AKEEGA ORAL TABLET	1	PA; LA; QL (60 per 30 days)
ALECENSA ORAL CAPSULE	1	PA; MO; QL (240 per 30 days)
ALIQOPA INTRAVENOUS RECON SOLN	1	B/D PA; LA

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Drug Name	Drug Tier	Requirements/Limits
ALUNBRIG ORAL TABLET 180 MG, 90 MG	1	PA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	1	PA; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	1	PA; QL (30 per 180 days)
anastrozole oral tablet	1	MO
ANKTIVA INTRAVESICAL SOLUTION	1	PA; MO
arsenic trioxide intravenous solution 1 mg/ml	1	B/D PA
arsenic trioxide intravenous solution 2 mg/ml	1	B/D PA; MO
ASPARLAS INTRAVENOUS SOLUTION	1	PA
AUGTYRO ORAL CAPSULE	1	PA; MO; QL (240 per 30 days)
AYVAKIT ORAL TABLET	1	PA; LA; QL (30 per 30 days)
azacitidine injection recon soln	1	B/D PA; MO
azathioprine oral tablet 50 mg	1	B/D PA; MO
azathioprine sodium injection recon soln	1	B/D PA; MO
BALVERSA ORAL TABLET	1	PA; LA
BAVENCIO INTRAVENOUS SOLUTION	1	B/D PA; LA
BELEODAQ INTRAVENOUS RECON SOLN	1	B/D PA
bendamustine intravenous recon soln	1	B/D PA; MO
BENDEKA INTRAVENOUS SOLUTION	1	B/D PA; MO
BESPONSA INTRAVENOUS RECON SOLN	1	B/D PA; MO; LA
bexarotene oral capsule	1	PA; MO
bexarotene topical gel	1	PA; MO
bicalutamide oral tablet	1	MO
bleomycin injection recon soln	1	B/D PA
BLINCYTO INTRAVENOUS KIT	1	B/D PA
BORTEZOMIB INJECTION RECON SOLN 1 MG, 2.5 MG	1	B/D PA
bortezomib injection recon soln 3.5 mg	1	B/D PA; MO
BOSULIF ORAL CAPSULE 100 MG	1	PA; MO; QL (180 per 30 days)
BOSULIF ORAL CAPSULE 50 MG	1	PA; MO; QL (330 per 30 days)
BOSULIF ORAL TABLET 100 MG	1	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	1	PA; MO; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE	1	PA; MO; LA; QL (180 per 30 days)
BRUKINSA ORAL CAPSULE	1	PA; LA; QL (120 per 30 days)
busulfan intravenous solution	1	B/D PA

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Drug Name	Drug Tier	Requirements/Limits
CABOMETYX ORAL TABLET	1	PA; MO; LA; QL (30 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET	1	PA; LA; QL (60 per 30 days)
CALQUENCE ORAL CAPSULE	1	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	1	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	1	PA; LA; QL (30 per 30 days)
carboplatin intravenous solution	1	B/D PA; MO
carmustine intravenous recon soln 100 mg	1	B/D PA; MO
cisplatin intravenous solution	1	B/D PA; MO
cladribine intravenous solution	1	B/D PA; MO
clofarabine intravenous solution	1	B/D PA
COLUMVI INTRAVENOUS SOLUTION	1	PA; MO
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	1	PA; MO; QL (56 per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	1	PA; MO; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	1	PA; MO; QL (84 per 28 days)
COPIKTRA ORAL CAPSULE	1	PA; LA; QL (60 per 30 days)
COTELLIC ORAL TABLET	1	PA; MO; LA; QL (63 per 28 days)
cyclophosphamide intravenous recon soln	1	B/D PA; MO
cyclophosphamide oral capsule	1	B/D PA; MO
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG	1	B/D PA
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	1	B/D PA; MO
cyclosporine modified oral capsule	1	B/D PA; MO
cyclosporine modified oral solution	1	B/D PA
cyclosporine oral capsule	1	B/D PA; MO
CYRAMZA INTRAVENOUS SOLUTION	1	B/D PA; MO
cytarabine (pf) injection solution 100 mg/5 ml (20 mg/ml), 2 gram/20 ml (100 mg/ml)	1	B/D PA; MO
cytarabine (pf) injection solution 20 mg/ml	1	B/D PA
cytarabine injection solution	1	B/D PA; MO
dacarbazine intravenous recon soln	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements/Limits
dactinomycin intravenous recon soln	1	B/D PA; MO
DANYELZA INTRAVENOUS SOLUTION	1	B/D PA
DARZALEX INTRAVENOUS SOLUTION	1	B/D PA; MO; LA
daunorubicin intravenous solution	1	B/D PA
DAURISMO ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	1	PA; MO; QL (60 per 30 days)
decitabine intravenous recon soln	1	B/D PA; MO
docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 80 mg/8 ml (10 mg/ml)	1	B/D PA
docetaxel intravenous solution 160 mg/8 ml (20 mg/ml), 20 mg/2 ml (10 mg/ml), 20 mg/ml (1 ml), 80 mg/4 ml (20 mg/ml)	1	B/D PA; MO
doxorubicin intravenous recon soln 10 mg	1	B/D PA
doxorubicin intravenous recon soln 50 mg	1	B/D PA; MO
doxorubicin intravenous solution 10 mg/5 ml, 20 mg/10 ml, 50 mg/25 ml	1	B/D PA; MO
doxorubicin intravenous solution 2 mg/ml	1	B/D PA
doxorubicin, peg-liposomal intravenous suspension	1	B/D PA; MO
DROXIA ORAL CAPSULE	1	MO
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE	1	PA; MO
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE	1	PA; MO
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE	1	PA; MO
ELIGARD SUBCUTANEOUS SYRINGE	1	PA; MO
ELREXFIO SUBCUTANEOUS SOLUTION	1	PA
ELZONRIS INTRAVENOUS SOLUTION	1	B/D PA; LA
EMPLICITI INTRAVENOUS RECON SOLN	1	B/D PA; MO
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR	1	B/D PA; MO
epirubicin intravenous solution 200 mg/100 ml	1	B/D PA
EPKINLY SUBCUTANEOUS SOLUTION	1	PA
ERBITUX INTRAVENOUS SOLUTION	1	B/D PA; MO
eribulin intravenous solution	1	B/D PA
ERIVEDGE ORAL CAPSULE	1	PA; MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
ERLEADA ORAL TABLET 240 MG	1	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 60 MG	1	PA; MO; QL (120 per 30 days)
erlotinib oral tablet 100 mg, 150 mg	1	PA; MO; QL (30 per 30 days)
erlotinib oral tablet 25 mg	1	PA; MO; QL (60 per 30 days)
ERWINASE INJECTION RECON SOLN	1	B/D PA
ETOPOPHOS INTRAVENOUS RECON SOLN	1	B/D PA; MO
etoposide intravenous solution	1	B/D PA; MO
everolimus (antineoplastic) oral tablet	1	PA; MO; QL (30 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg	1	PA; MO; QL (330 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	1	PA; MO; QL (240 per 30 days)
everolimus (antineoplastic) oral tablet for suspension 5 mg	1	PA; MO; QL (180 per 30 days)
everolimus (immunosuppressive) oral tablet 0.25 mg	1	B/D PA; MO
everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg	1	B/D PA; MO
exemestane oral tablet	1	MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	1	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	1	PA; MO
floxuridine injection recon soln	1	B/D PA
fludarabine intravenous recon soln	1	B/D PA; MO
fludarabine intravenous solution	1	B/D PA
fluorouracil intravenous solution 1 gram/20 ml, 500 mg/10 ml	1	B/D PA; MO
fluorouracil intravenous solution 2.5 gram/50 ml, 5 gram/100 ml	1	B/D PA
FOTIVDA ORAL CAPSULE	1	PA; LA; QL (21 per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	1	PA; QL (84 per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	1	PA; QL (21 per 28 days)
fulvestrant intramuscular syringe	1	B/D PA; MO
FYARRO INTRAVENOUS SUSPENSION FOR RECONSTITUTION	1	PA
GAVRETO ORAL CAPSULE	1	PA; LA; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
GAZYVA INTRAVENOUS SOLUTION	1	B/D PA; MO
gefitinib oral tablet	1	PA; MO; QL (30 per 30 days)
gemcitabine intravenous recon soln 1 gram, 200 mg	1	B/D PA; MO
gemcitabine intravenous recon soln 2 gram	1	B/D PA
gemcitabine intravenous solution 1 gram/26.3 ml (38 mg/ml), 2 gram/52.6 ml (38 mg/ml), 200 mg/5.26 ml (38 mg/ml)	1	B/D PA; MO
GEMCITABINE INTRAVENOUS SOLUTION 100 MG/ML	1	B/D PA
gengraf oral capsule	1	B/D PA; MO
gengraf oral solution	1	B/D PA; MO
GILOTRIF ORAL TABLET	1	PA; MO; QL (30 per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG	1	MO
GLEOSTINE ORAL CAPSULE 100 MG, 40 MG	1	MO
hydroxyurea oral capsule	1	MO
IBRANCE ORAL CAPSULE	1	PA; MO; QL (21 per 28 days)
IBRANCE ORAL TABLET	1	PA; MO; QL (21 per 28 days)
ICLUSIG ORAL TABLET	1	PA; QL (30 per 30 days)
idarubicin intravenous solution	1	B/D PA; MO
IDHIFA ORAL TABLET	1	PA; MO; LA; QL (30 per 30 days)
ifosfamide intravenous recon soln	1	B/D PA; MO
ifosfamide intravenous solution 1 gram/20 ml	1	B/D PA; MO
ifosfamide intravenous solution 3 gram/60 ml	1	B/D PA
imatinib oral tablet 100 mg	1	PA; MO; QL (180 per 30 days)
imatinib oral tablet 400 mg	1	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	1	PA; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	1	PA; QL (30 per 30 days)
IMBRUVICA ORAL SUSPENSION	1	PA; QL (324 per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	1	PA; QL (30 per 30 days)
IMDELLTRA INTRAVENOUS RECON SOLN	1	PA
IMFINZI INTRAVENOUS SOLUTION	1	B/D PA; MO; LA
IMJUDO INTRAVENOUS SOLUTION	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
INLYTA ORAL TABLET 1 MG	1	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	1	PA; MO; QL (120 per 30 days)
INQOVI ORAL TABLET	1	PA; MO; QL (5 per 28 days)
INREBIC ORAL CAPSULE	1	PA; MO; LA; QL (120 per 30 days)
irinotecan intravenous solution 100 mg/5 ml	1	B/D PA; MO
irinotecan intravenous solution 300 mg/15 ml, 500 mg/25 ml	1	B/D PA
irinotecan intravenous solution 40 mg/2 ml	1	B/D PA; MO
ISTODAX INTRAVENOUS RECON SOLN	1	B/D PA; MO
IWILFIN ORAL TABLET	1	PA; LA; QL (240 per 30 days)
IXEMPRA INTRAVENOUS RECON SOLN	1	B/D PA; MO
JAKAFI ORAL TABLET	1	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 100 MG	1	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	1	PA; MO; QL (30 per 30 days)
JEMPERLI INTRAVENOUS SOLUTION	1	PA; MO
JEVTANA INTRAVENOUS SOLUTION	1	B/D PA; MO
JYLAMVO ORAL SOLUTION	1	B/D PA
KADCYLA INTRAVENOUS RECON SOLN	1	PA; MO
KEYTRUDA INTRAVENOUS SOLUTION	1	PA
KIMMTRAK INTRAVENOUS SOLUTION	1	B/D PA
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	1	PA; MO; QL (49 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	1	PA; MO; QL (70 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	1	PA; MO; QL (91 per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	1	PA; MO; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	1	PA; MO; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	1	PA; MO; QL (63 per 28 days)
KOSELUGO ORAL CAPSULE	1	PA
KRAZATI ORAL TABLET	1	PA; QL (180 per 30 days)
KYPROLIS INTRAVENOUS RECON SOLN	1	B/D PA
lanreotide subcutaneous syringe 120 mg/0.5 ml	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
lapatinib oral tablet	1	PA; MO; QL (180 per 30 days)
lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg	1	PA; MO; QL (28 per 28 days)
lenalidomide oral capsule 2.5 mg, 20 mg	1	PA; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	1	PA; MO; QL (30 per 30 days)
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X2), 24 MG/DAY(10 MG X 2-4 MG X 1)	1	PA; MO; QL (90 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)	1	PA; MO; QL (60 per 30 days)
letrozole oral tablet	1	MO
LEUKERAN ORAL TABLET	1	MO
leuprolide subcutaneous kit	1	PA; MO
LIBTAYO INTRAVENOUS SOLUTION	1	PA; LA
LONSURF ORAL TABLET	1	PA; MO
LOQTORZI INTRAVENOUS SOLUTION	1	PA
LORBRENA ORAL TABLET 100 MG	1	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	1	PA; MO; QL (90 per 30 days)
LUMAKRAS ORAL TABLET 120 MG	1	PA; MO; QL (240 per 30 days)
LUMAKRAS ORAL TABLET 320 MG	1	PA; MO; QL (90 per 30 days)
LUNSUMIO INTRAVENOUS SOLUTION	1	PA; MO
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT	1	PA; MO
LYNPARZA ORAL TABLET	1	PA; MO; QL (120 per 30 days)
LYSODREN ORAL TABLET	1	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	1	PA; LA; QL (84 per 28 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	1	PA; LA; QL (112 per 28 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	1	PA; LA; QL (140 per 28 days)
MARGENZA INTRAVENOUS SOLUTION	1	B/D PA
MATULANE ORAL CAPSULE	1	
megestrol oral suspension 400 mg/10 ml (10 ml)	1	PA

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Drug Name	Drug Tier	Requirements/Limits
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	1	PA; MO
megestrol oral suspension 625 mg/5 ml (125 mg/ml)	1	PA; MO
megestrol oral tablet	1	PA; MO
MEKINIST ORAL RECON SOLN	1	PA; MO; QL (1200 per 30 days)
MEKINIST ORAL TABLET 0.5 MG	1	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	1	PA; MO; QL (30 per 30 days)
MEKTOVI ORAL TABLET	1	PA; MO; LA; QL (180 per 30 days)
melphalan hcl intravenous recon soln	1	B/D PA
mercaptopurine oral tablet	1	MO
methotrexate sodium (pf) injection recon soln	1	B/D PA
methotrexate sodium (pf) injection solution	1	B/D PA; MO
methotrexate sodium injection solution	1	B/D PA
methotrexate sodium oral tablet	1	B/D PA; MO
mitomycin intravenous recon soln 20 mg, 5 mg	1	B/D PA; MO
mitomycin intravenous recon soln 40 mg	1	B/D PA; MO
mitoxantrone intravenous concentrate	1	B/D PA; MO
MONJUVI INTRAVENOUS RECON SOLN	1	PA; LA
mycophenolate mofetil (hcl) intravenous recon soln	1	B/D PA; MO
mycophenolate mofetil oral capsule	1	B/D PA; MO
mycophenolate mofetil oral suspension for reconstitution	1	B/D PA; MO
mycophenolate mofetil oral tablet	1	B/D PA; MO
mycophenolate sodium oral tablet,delayed release (dr/ec)	1	B/D PA; MO
MYLOTARG INTRAVENOUS RECON SOLN	1	B/D PA; MO; LA
nelarabine intravenous solution	1	B/D PA; MO
NERLYNX ORAL TABLET	1	PA; MO; LA
nilutamide oral tablet	1	PA; MO
NINLARO ORAL CAPSULE	1	PA; MO; QL (3 per 28 days)
NUBEQA ORAL TABLET	1	PA; MO; LA; QL (120 per 30 days)
NULOJIX INTRAVENOUS RECON SOLN	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements/Limits
octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml	1	PA; MO
octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml	1	PA; MO
octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml)	1	PA; MO
octreotide acetate injection syringe 500 mcg/ml (1 ml)	1	PA; MO
ODOMZO ORAL CAPSULE	1	PA; MO; LA; QL (30 per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	1	PA; QL (96 per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	1	PA; QL (16 per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	1	PA; QL (20 per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	1	PA; QL (24 per 28 days)
OJJAARA ORAL TABLET	1	PA; QL (30 per 30 days)
ONCASPAR INJECTION SOLUTION	1	B/D PA
ONIVYDE INTRAVENOUS DISPERSION	1	B/D PA
ONUREG ORAL TABLET	1	PA; MO; QL (14 per 28 days)
OPDIVO INTRAVENOUS SOLUTION	1	PA; MO
OPDUALAG INTRAVENOUS SOLUTION	1	PA; MO
ORGOVYX ORAL TABLET	1	PA; LA; QL (30 per 28 days)
ORSERDU ORAL TABLET 345 MG	1	PA; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	1	PA; QL (90 per 30 days)
oxaliplatin intravenous recon soln 100 mg	1	B/D PA
oxaliplatin intravenous recon soln 50 mg	1	B/D PA; MO
oxaliplatin intravenous solution 100 mg/20 ml, 50 mg/10 ml (5 mg/ml)	1	B/D PA; MO
oxaliplatin intravenous solution 200 mg/40 ml	1	B/D PA
paclitaxel intravenous concentrate	1	B/D PA; MO
PADCEV INTRAVENOUS RECON SOLN	1	PA; MO
paraplatin intravenous solution	1	B/D PA
pazopanib oral tablet	1	PA; MO; QL (120 per 30 days)
PEMAZYRE ORAL TABLET	1	PA; LA; QL (28 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
pemetrexed disodium intravenous recon soln 1,000 mg, 500 mg	1	B/D PA; MO
pemetrexed disodium intravenous recon soln 100 mg	1	B/D PA; MO
pemetrexed disodium intravenous recon soln 750 mg	1	B/D PA
PERJETA INTRAVENOUS SOLUTION	1	B/D PA; MO
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	1	PA; MO; QL (28 per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	1	PA; MO; QL (56 per 28 days)
POLIVY INTRAVENOUS RECON SOLN	1	PA; MO
POMALYST ORAL CAPSULE	1	PA; MO; LA; QL (21 per 28 days)
PORTRAZZA INTRAVENOUS SOLUTION	1	B/D PA; MO
POTELIGEO INTRAVENOUS SOLUTION	1	PA
PRALATREXATE INTRAVENOUS SOLUTION	1	B/D PA; MO
PROGRAF INTRAVENOUS SOLUTION	1	B/D PA; MO
PROGRAF ORAL GRANULES IN PACKET	1	B/D PA; MO
PURIXAN ORAL SUSPENSION	1	
QINLOCK ORAL TABLET	1	PA; LA; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	1	PA; MO; LA; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	1	PA; MO; LA; QL (120 per 30 days)
REVLIMID ORAL CAPSULE	1	PA; MO; LA; QL (28 per 28 days)
REZLIDHIA ORAL CAPSULE	1	PA; QL (60 per 30 days)
REZUROCK ORAL TABLET	1	PA; LA; QL (30 per 30 days)
romidepsin intravenous recon soln	1	B/D PA
ROZLYTREK ORAL CAPSULE 100 MG	1	PA; MO; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	1	PA; MO; QL (90 per 30 days)
ROZLYTREK ORAL PELLETS IN PACKET	1	PA; MO; QL (336 per 28 days)
RUBRACA ORAL TABLET	1	PA; MO; LA; QL (120 per 30 days)
RUXIENCE INTRAVENOUS SOLUTION	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
RYBREVANT INTRAVENOUS SOLUTION	1	PA; MO
RYDAPT ORAL CAPSULE	1	PA; MO; QL (224 per 28 days)
RYLAZE INTRAMUSCULAR SOLUTION	1	B/D PA
SANDIMMUNE ORAL SOLUTION	1	B/D PA
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE RECON	1	PA; MO
SARCLISA INTRAVENOUS SOLUTION	1	PA; LA
SCEMBLIX ORAL TABLET 100 MG	1	PA; QL (120 per 30 days)
SCEMBLIX ORAL TABLET 20 MG	1	PA; QL (600 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	1	PA; QL (300 per 30 days)
SIGNIFOR SUBCUTANEOUS SOLUTION	1	PA
SIMULECT INTRAVENOUS RECON SOLN	1	B/D PA; MO
sirolimus oral solution	1	B/D PA; MO
sirolimus oral tablet	1	B/D PA; MO
SOLTAMOX ORAL SOLUTION	1	MO
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML, 90 MG/0.3 ML	1	PA; MO
sorafenib oral tablet	1	PA; MO; QL (120 per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	1	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	1	PA; MO; QL (60 per 30 days)
STIVARGA ORAL TABLET	1	PA; MO; QL (84 per 28 days)
sunitinib malate oral capsule	1	PA; MO; QL (30 per 30 days)
TABLOID ORAL TABLET	1	MO
TABRECTA ORAL TABLET	1	PA; MO
tacrolimus oral capsule	1	B/D PA; MO
TAFINLAR ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	1	PA; MO; QL (840 per 28 days)
TAGRISSO ORAL TABLET	1	PA; MO; LA; QL (30 per 30 days)
TALVEY SUBCUTANEOUS SOLUTION	1	PA
TALZENNA ORAL CAPSULE	1	PA; MO; QL (30 per 30 days)
tamoxifen oral tablet	1	MO

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Drug Name	Drug Tier	Requirements/Limits
TASIGNA ORAL CAPSULE 150 MG, 200 MG	1	PA; MO; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	1	PA; MO; QL (120 per 30 days)
TAZVERIK ORAL TABLET	1	PA; LA
TECENTRIQ INTRAVENOUS SOLUTION	1	B/D PA; MO; LA
TECVAYLI SUBCUTANEOUS SOLUTION	1	PA
TEMODAR INTRAVENOUS RECON SOLN	1	B/D PA; MO
temsirolimus intravenous recon soln	1	B/D PA; MO
TEPMETKO ORAL TABLET	1	PA; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	1	PA; MO; QL (28 per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	1	PA; QL (56 per 28 days)
thiotepa injection recon soln 100 mg	1	B/D PA
thiotepa injection recon soln 15 mg	1	B/D PA; MO
TIBSOVO ORAL TABLET	1	PA
TIVDAK INTRAVENOUS RECON SOLN	1	PA; MO
topotecan intravenous recon soln	1	B/D PA; MO
topotecan intravenous solution	1	B/D PA; MO
toremifene oral tablet	1	MO
TRAZIMERA INTRAVENOUS RECON SOLN	1	B/D PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	PA; MO
tretinoin (antineoplastic) oral capsule	1	MO
TRODELVY INTRAVENOUS RECON SOLN	1	PA; LA
TRUQAP ORAL TABLET	1	PA; QL (64 per 28 days)
TUKYSA ORAL TABLET 150 MG	1	PA; LA; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	1	PA; LA; QL (300 per 30 days)
TURALIO ORAL CAPSULE 125 MG	1	PA; LA; QL (120 per 30 days)
UNITUXIN INTRAVENOUS SOLUTION	1	B/D PA
valrubicin intravesical solution	1	B/D PA; MO
VANFLYTA ORAL TABLET	1	PA; QL (56 per 28 days)
VECTIBIX INTRAVENOUS SOLUTION	1	B/D PA; MO
VENCLEXTA ORAL TABLET 10 MG	1	PA; LA; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA ORAL TABLET 100 MG	1	PA; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	1	PA; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK	1	PA; LA; QL (42 per 180 days)
VERZENIO ORAL TABLET	1	PA; MO; LA; QL (60 per 30 days)
vinblastine intravenous solution	1	B/D PA; MO
vincristine intravenous solution	1	B/D PA; MO
vinorelbine intravenous solution	1	B/D PA; MO
VITRAKVI ORAL CAPSULE 100 MG	1	PA; MO; LA; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	1	PA; MO; LA; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	1	PA; MO; LA; QL (300 per 30 days)
VIZIMPRO ORAL TABLET	1	PA; MO; QL (30 per 30 days)
VONJO ORAL CAPSULE	1	PA; QL (120 per 30 days)
VYXEOS INTRAVENOUS RECON SOLN	1	B/D PA
WELIREG ORAL TABLET	1	PA; LA
XALKORI ORAL CAPSULE	1	PA; MO; QL (60 per 30 days)
XALKORI ORAL PELLET 150 MG	1	PA; MO; QL (180 per 30 days)
XALKORI ORAL PELLET 20 MG, 50 MG	1	PA; MO; QL (120 per 30 days)
XERMELO ORAL TABLET	1	PA; LA; QL (84 per 28 days)
XOSPATA ORAL TABLET	1	PA; LA; QL (90 per 30 days)
XPOVIO ORAL TABLET	1	PA; LA
XTANDI ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	1	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	1	PA; MO; QL (60 per 30 days)
YERVOY INTRAVENOUS SOLUTION	1	B/D PA; MO
YONDELIS INTRAVENOUS RECON SOLN	1	B/D PA
ZALTRAP INTRAVENOUS SOLUTION	1	B/D PA; MO
ZANOSAR INTRAVENOUS RECON SOLN	1	B/D PA; MO
ZEJULA ORAL TABLET	1	PA; MO; LA; QL (30 per 30 days)
ZELBORAF ORAL TABLET	1	PA; MO; QL (240 per 30 days)
ZEPZELCA INTRAVENOUS RECON SOLN	1	PA

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Drug Name	Drug Tier	Requirements/Limits
ZIRABEV INTRAVENOUS SOLUTION	1	B/D PA; MO
ZOLADEX SUBCUTANEOUS IMPLANT	1	PA; MO
ZOLINZA ORAL CAPSULE	1	PA; MO; QL (120 per 30 days)
ZYDELIG ORAL TABLET	1	PA; MO; QL (60 per 30 days)
ZYKADIA ORAL TABLET	1	PA; MO; QL (90 per 30 days)
ZYNLONTA INTRAVENOUS RECON SOLN	1	PA; LA
ZYNYZ INTRAVENOUS SOLUTION	1	PA
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG	1	MO; QL (180 per 30 days)
APTIOM ORAL TABLET 400 MG	1	MO; QL (90 per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	1	MO; QL (60 per 30 days)
BRIVIACT INTRAVENOUS SOLUTION	1	MO; QL (600 per 30 days)
BRIVIACT ORAL SOLUTION	1	MO; QL (600 per 30 days)
BRIVIACT ORAL TABLET	1	MO; QL (60 per 30 days)
carbamazepine oral capsule, er multiphase 12 hr	1	MO
carbamazepine oral suspension 100 mg/5 ml	1	MO
carbamazepine oral suspension 100 mg/5 ml (5 ml), 200 mg/10 ml	1	
carbamazepine oral tablet	1	MO
carbamazepine oral tablet extended release 12 hr	1	MO
carbamazepine oral tablet,chewable	1	MO
clobazam oral suspension	1	PA; MO; QL (480 per 30 days)
clobazam oral tablet	1	PA; MO; QL (60 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	1	MO; QL (90 per 30 days)
clonazepam oral tablet 2 mg	1	MO; QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	MO; QL (90 per 30 days)
clonazepam oral tablet,disintegrating 2 mg	1	MO; QL (300 per 30 days)
DIACOMIT ORAL CAPSULE	1	PA; LA
DIACOMIT ORAL POWDER IN PACKET	1	PA; LA
diazepam rectal kit	1	MO
DILANTIN 30 MG ORAL CAPSULE	1	MO
divalproex oral capsule, delayed release sprinkle	1	MO

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Drug Name	Drug Tier	Requirements/Limits
divalproex oral tablet extended release 24 hr	1	MO
divalproex oral tablet,delayed release (dr/ec)	1	MO
EPIDIOLEX ORAL SOLUTION	1	PA; MO; LA
epitol oral tablet	1	MO
EPRONTIA ORAL SOLUTION	1	PA; MO
ethosuximide oral capsule	1	MO
ethosuximide oral solution	1	MO
felbamate oral suspension	1	MO
felbamate oral tablet	1	MO
FINTEPLA ORAL SOLUTION	1	PA; LA; QL (360 per 30 days)
fosphenytoin injection solution	1	MO
FYCOMPA ORAL SUSPENSION	1	MO; QL (720 per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	1	MO; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG	1	MO; QL (60 per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG	1	MO; QL (60 per 30 days)
gabapentin oral capsule 100 mg, 400 mg	1	MO; QL (270 per 30 days)
gabapentin oral capsule 300 mg	1	MO; QL (360 per 30 days)
gabapentin oral solution 250 mg/5 ml	1	MO; QL (2160 per 30 days)
gabapentin oral solution 250 mg/5 ml (5 ml), 300 mg/6 ml (6 ml)	1	QL (2160 per 30 days)
gabapentin oral tablet 600 mg	1	MO; QL (180 per 30 days)
gabapentin oral tablet 800 mg	1	MO; QL (120 per 30 days)
gabapentin oral tablet extended release 24 hr 300 mg	1	PA; MO; QL (30 per 30 days)
gabapentin oral tablet extended release 24 hr 600 mg	1	PA; MO; QL (90 per 30 days)
lacosamide intravenous solution	1	MO; QL (1200 per 30 days)
lacosamide oral solution	1	MO; QL (1200 per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg	1	MO; QL (60 per 30 days)
lacosamide oral tablet 50 mg	1	MO; QL (120 per 30 days)
lamotrigine oral tablet	1	MO
lamotrigine oral tablet, chewable dispersible	1	MO
lamotrigine oral tablet,disintegrating	1	MO
levetiracetam in nacl (iso-osm) intravenous piggyback 1,000 mg/100 ml, 500 mg/100 ml	1	MO

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Drug Name	Drug Tier	Requirements/Limits
levetiracetam in nacl (iso-osm) intravenous piggyback 1,500 mg/100 ml	1	
levetiracetam intravenous solution	1	MO
levetiracetam oral solution 100 mg/ml	1	MO
levetiracetam oral solution 500 mg/5 ml (5 ml)	1	
levetiracetam oral tablet	1	MO
levetiracetam oral tablet extended release 24 hr	1	MO
LIBERVANT BUCCAL FILM	1	PA; QL (10 per 30 days)
methsuximide oral capsule	1	MO
NAYZILAM NASAL SPRAY,NON-AEROSOL	1	PA; MO; QL (10 per 30 days)
oxcarbazepine oral suspension	1	MO
oxcarbazepine oral tablet	1	MO
phenobarbital oral elixir	1	PA; MO
phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg	1	PA
phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg	1	PA; MO
phenobarbital sodium injection solution 130 mg/ml	1	MO
phenobarbital sodium injection solution 65 mg/ml	1	
phenytoin oral suspension 100 mg/4 ml	1	
phenytoin oral suspension 125 mg/5 ml	1	MO
phenytoin oral tablet,chewable	1	MO
phenytoin sodium extended oral capsule 100 mg	1	MO
phenytoin sodium extended oral capsule 200 mg, 300 mg	1	
phenytoin sodium intravenous solution	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	MO; QL (90 per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	MO; QL (60 per 30 days)
pregabalin oral solution	1	MO; QL (900 per 30 days)
PRIMIDONE ORAL TABLET 125 MG	1	MO
primidone oral tablet 250 mg, 50 mg	1	MO
roweepra oral tablet 500 mg	1	MO
rufinamide oral suspension	1	PA; MO
rufinamide oral tablet 200 mg	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
rufinamide oral tablet 400 mg	1	PA; MO
SPRITAM ORAL TABLET FOR SUSPENSION	1	MO
subvenite oral tablet	1	MO
SYMPAZAN ORAL FILM 10 MG, 20 MG	1	PA; MO; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	1	PA; MO; QL (60 per 30 days)
tiagabine oral tablet	1	MO
topiramate oral capsule, sprinkle	1	PA; MO
topiramate oral tablet	1	PA; MO
valproate sodium intravenous solution	1	MO
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	MO
valproic acid (as sodium salt) oral solution 250 mg/5 ml (5 ml), 500 mg/10 ml (10 ml)	1	
valproic acid oral capsule	1	MO
VALTOCO NASAL SPRAY,NON-AEROSOL	1	PA; MO; QL (10 per 30 days)
vigabatrin oral powder in packet	1	PA; MO; LA
vigabatrin oral tablet	1	PA; MO; LA
vigadrone oral powder in packet	1	PA; LA
vigadrone oral tablet	1	PA; LA
vigpoder oral powder in packet	1	PA; LA
XCOPRI MAINTENANCE PACK ORAL TABLET	1	MO; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG	1	MO; QL (30 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	1	MO; QL (60 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	1	MO; QL (28 per 180 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	1	MO; QL (28 per 180 days)
ZONISADE ORAL SUSPENSION	1	PA; MO
zonisamide oral capsule	1	PA; MO
ZTALMY ORAL SUSPENSION	1	PA; LA; QL (1100 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
ANTIPARKINSONISM AGENTS		
benztropine injection solution	1	MO
benztropine oral tablet	1	PA; MO
bromocriptine oral capsule	1	MO
bromocriptine oral tablet	1	MO
carbidopa oral tablet	1	MO
carbidopa-levodopa oral tablet	1	MO
carbidopa-levodopa oral tablet extended release	1	MO
carbidopa-levodopa oral tablet,disintegrating	1	
carbidopa-levodopa-entacapone oral tablet	1	MO
entacapone oral tablet	1	MO
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	1	PA; QL (300 per 30 days)
NEUPRO TRANSDERMAL PATCH 24 HOUR	1	MO
pramipexole oral tablet	1	MO
rasagiline oral tablet	1	MO
ropinirole oral tablet	1	MO
ropinirole oral tablet extended release 24 hr	1	MO
selegiline hcl oral capsule	1	MO
selegiline hcl oral tablet	1	MO
trihexyphenidyl oral tablet	1	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; QL (1 per 30 days)
dihydroergotamine injection solution	1	
dihydroergotamine nasal spray,non-aerosol	1	QL (8 per 28 days)
EMGALITY SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	1	PA; MO; QL (2 per 30 days)
ergotamine-caffeine oral tablet	1	MO
naratriptan oral tablet	1	MO; QL (18 per 28 days)
NURTEC ODT ORAL TABLET,DISINTEGRATING	1	PA; QL (16 per 30 days)
QULIPTA ORAL TABLET	1	PA; MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
rizatriptan oral tablet	1	MO; QL (24 per 28 days)
rizatriptan oral tablet,disintegrating	1	MO; QL (24 per 28 days)
sumatriptan nasal spray,non-aerosol	1	MO; QL (18 per 28 days)
sumatriptan succinate oral tablet	1	MO; QL (18 per 28 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	1	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	1	QL (8 per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	1	QL (8 per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	1	MO; QL (8 per 28 days)
sumatriptan succinate subcutaneous solution	1	MO; QL (8 per 28 days)
UBRELVY ORAL TABLET	1	PA; QL (20 per 30 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
BRIUMVI INTRAVENOUS SOLUTION	1	PA; MO; QL (24 per 180 days)
dalfampridine oral tablet extended release 12 hr	1	PA; MO; QL (60 per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	1	PA; MO; QL (14 per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	1	PA; MO; QL (120 per 180 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	1	PA; MO; QL (60 per 30 days)
donepezil oral tablet 10 mg, 5 mg	1	MO
donepezil oral tablet 23 mg	1	MO
donepezil oral tablet,disintegrating	1	MO
fingolimod oral capsule	1	PA; MO; QL (30 per 30 days)
galantamine oral capsule, extended release pellets 24 hr	1	MO
galantamine oral solution	1	MO
galantamine oral tablet	1	MO
glatiramer subcutaneous syringe 20 mg/ml	1	PA; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	1	PA; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml	1	PA; MO; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml	1	PA; MO; QL (12 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
INGREZZA INITIATION PK(TARDIV) ORAL CAPSULE,DOSE PACK	1	PA; LA; QL (28 per 180 days)
INGREZZA ORAL CAPSULE	1	PA; LA; QL (30 per 30 days)
INGREZZA SPRINKLE ORAL CAPSULE, SPRINKLE	1	PA; LA; QL (30 per 30 days)
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (1.6 per 28 days)
memantine oral capsule,sprinkle,er 24hr	1	PA; MO
memantine oral solution	1	PA; MO
memantine oral tablet	1	PA; MO
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK	1	PA
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR	1	PA; MO
NUEDEXTA ORAL CAPSULE	1	PA; MO
RADICAVA ORS ORAL SUSPENSION	1	PA; MO
RADICAVA ORS STARTER KIT SUSP ORAL SUSPENSION	1	PA; MO
rivastigmine tartrate oral capsule	1	MO
rivastigmine transdermal patch 24 hour	1	MO
teriflunomide oral tablet	1	PA; MO; QL (30 per 30 days)
tetrabenazine oral tablet 12.5 mg	1	PA; MO; QL (240 per 30 days)
tetrabenazine oral tablet 25 mg	1	PA; MO; QL (120 per 30 days)
VUMERITY ORAL CAPSULE,DELAYED RELEASE(DR/EC)	1	PA; MO; QL (120 per 30 days)
ZEPOSIA ORAL CAPSULE	1	PA; MO; QL (30 per 30 days)
ZEPOSIA STARTER KIT (28-DAY) ORAL CAPSULE,DOSE PACK	1	PA; MO; QL (28 per 180 days)
ZEPOSIA STARTER PACK (7-DAY) ORAL CAPSULE,DOSE PACK	1	PA; MO; QL (7 per 180 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	MO
cyclobenzaprine oral tablet 10 mg, 5 mg	1	PA; MO
dantrolene intravenous recon soln	1	
dantrolene oral capsule	1	MO
pyridostigmine bromide oral tablet 60 mg	1	MO

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Drug Name	Drug Tier	Requirements/Limits
pyridostigmine bromide oral tablet extended release	1	
revonto intravenous recon soln	1	
tizanidine oral tablet	1	MO
NARCOTIC ANALGESICS		
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	MO; QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	1	MO; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	1	MO; QL (180 per 30 days)
BELBUCA BUCCAL FILM	1	PA; MO; QL (60 per 30 days)
buprenorphine hcl injection syringe	1	
buprenorphine hcl sublingual tablet	1	MO
buprenorphine transdermal patch weekly	1	PA; MO; QL (4 per 28 days)
endocet oral tablet	1	MO; QL (360 per 30 days)
fentanyl citrate (pf) injection solution	1	
fentanyl citrate (pf) intravenous syringe 100 mcg/2 ml (50 mcg/ml)	1	
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg	1	PA; MO; QL (120 per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	1	PA; MO; QL (120 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	PA; MO; QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	1	MO; QL (5550 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	MO; QL (360 per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	1	MO; QL (50 per 30 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml, 2 mg/ml	1	
hydromorphone injection solution 1 mg/ml	1	
hydromorphone injection solution 2 mg/ml	1	MO
hydromorphone injection syringe 1 mg/ml, 4 mg/ml	1	MO
hydromorphone injection syringe 2 mg/ml	1	
hydromorphone oral liquid	1	MO; QL (2400 per 30 days)
hydromorphone oral tablet	1	MO; QL (180 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
hydromorphone oral tablet extended release 24 hr	1	PA; MO; QL (60 per 30 days)
methadone injection solution	1	
methadone intensol oral concentrate	1	PA; MO; QL (90 per 30 days)
methadone oral concentrate	1	PA; QL (90 per 30 days)
methadone oral solution 10 mg/5 ml	1	PA; MO; QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	1	PA; MO; QL (1200 per 30 days)
methadone oral tablet 10 mg	1	PA; MO; QL (120 per 30 days)
methadone oral tablet 5 mg	1	PA; MO; QL (240 per 30 days)
methadose oral concentrate	1	PA; MO; QL (90 per 30 days)
morphine (pf) injection solution 0.5 mg/ml	1	
morphine (pf) injection solution 1 mg/ml	1	MO
morphine concentrate oral solution	1	MO; QL (900 per 30 days)
morphine injection syringe 4 mg/ml	1	MO
morphine intravenous solution 10 mg/ml, 4 mg/ml	1	MO
morphine intravenous syringe 10 mg/ml, 2 mg/ml, 4 mg/ml	1	
morphine oral solution	1	MO; QL (900 per 30 days)
morphine oral tablet	1	MO; QL (180 per 30 days)
morphine oral tablet extended release	1	PA; MO; QL (120 per 30 days)
oxycodone oral capsule	1	MO; QL (360 per 30 days)
oxycodone oral concentrate	1	MO; QL (180 per 30 days)
oxycodone oral solution	1	MO; QL (1200 per 30 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg	1	MO; QL (180 per 30 days)
oxycodone oral tablet 5 mg	1	MO; QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	MO; QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg	1	QL (360 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	1	PA; MO; QL (90 per 30 days)
OXYCONTIN ORAL TABLET, EXTENDED RELEASE 12 HR 80 MG	1	PA; MO; QL (60 per 30 days)
NON-NARCOTIC ANALGESICS		
buprenorphine-naloxone sublingual film 12-3 mg	1	MO; QL (60 per 30 days)
buprenorphine-naloxone sublingual film 2-0.5 mg	1	MO; QL (360 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg	1	MO; QL (90 per 30 days)
buprenorphine-naloxone sublingual tablet 2-0.5 mg	1	MO; QL (360 per 30 days)
buprenorphine-naloxone sublingual tablet 8-2 mg	1	MO; QL (90 per 30 days)
butorphanol injection solution	1	MO
butorphanol nasal spray,non-aerosol	1	MO; QL (10 per 28 days)
celecoxib oral capsule	1	MO
clonidine (pf) epidural solution 5,000 mcg/10 ml	1	
diclofenac potassium oral tablet 50 mg	1	MO
diclofenac sodium oral tablet extended release 24 hr	1	MO
diclofenac sodium oral tablet,delayed release (dr/ec)	1	MO
diclofenac sodium topical gel 1 %	1	MO; QL (1000 per 28 days)
diclofenac sodium topical solution in metered-dose pump	1	MO; QL (224 per 28 days)
diclofenac-misoprostol oral tablet, ir, delayed release, biphasic	1	MO
diflunisal oral tablet	1	MO
etodolac oral capsule	1	MO
etodolac oral tablet	1	MO
etodolac oral tablet extended release 24 hr	1	MO
flurbiprofen oral tablet 100 mg	1	MO
ibu oral tablet	1	MO
ibuprofen oral suspension	1	MO
ibuprofen oral tablet 400 mg, 800 mg	1	MO
ibuprofen oral tablet 600 mg	1	
meloxicam oral tablet	1	MO; QL (30 per 30 days)
nabumetone oral tablet	1	MO
nalbuphine injection solution	1	
naloxone injection solution	1	MO
naloxone injection syringe	1	MO
naloxone nasal spray,non-aerosol	1	MO
naltrexone oral tablet	1	MO
naproxen oral tablet	1	MO
naproxen oral tablet,delayed release (dr/ec)	1	MO

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Drug Name	Drug Tier	Requirements/Limits
naproxen sodium oral tablet 275 mg, 550 mg	1	MO
oxaprozin oral tablet	1	MO
piroxicam oral capsule	1	MO
salsalate oral tablet	1	MO
sulindac oral tablet	1	MO
tramadol oral tablet 50 mg	1	MO; QL (240 per 30 days)
tramadol-acetaminophen oral tablet	1	MO; QL (240 per 30 days)
VIVITROL INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE RECON	1	MO
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG	1	MO; QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	1	MO; QL (60 per 30 days)
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	1	MO; QL (2.4 per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	1	MO; QL (3.2 per 56 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE RECON	1	MO; QL (1 per 28 days)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRINGE	1	MO; QL (1 per 28 days)
alprazolam oral tablet	1	MO
alprazolam oral tablet extended release 24 hr	1	MO
alprazolam oral tablet,disintegrating	1	MO
amitriptyline oral tablet	1	MO
amoxapine oral tablet	1	MO
aripiprazole oral solution	1	MO
aripiprazole oral tablet	1	MO; QL (30 per 30 days)
aripiprazole oral tablet,disintegrating	1	MO; QL (60 per 30 days)
ARISTADA INITIO INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING	1	MO; QL (4.8 per 365 days)

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

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Drug Name	Drug Tier	Requirements/Limits
clozapine oral tablet,disintegrating	1	
desipramine oral tablet	1	MO
desvenlafaxine succinate oral tablet extended release 24 hr	1	MO; QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	1	MO
dextroamphetamine-amphetamine oral tablet	1	MO
diazepam injection solution	1	PA
diazepam injection syringe	1	PA
diazepam intensol oral concentrate	1	PA; MO; QL (240 per 30 days)
diazepam oral concentrate	1	PA; QL (240 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	1	PA; MO; QL (1200 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml, 5 ml)	1	PA; QL (1200 per 30 days)
diazepam oral tablet	1	PA; MO; QL (120 per 30 days)
doxepin oral capsule	1	MO
doxepin oral concentrate	1	MO
doxepin oral tablet	1	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	1	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	MO; QL (90 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	1	MO; QL (60 per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR	1	MO
escitalopram oxalate oral solution	1	MO
escitalopram oxalate oral tablet	1	MO; QL (30 per 30 days)
eszopiclone oral tablet	1	MO; QL (30 per 30 days)
FANAPT ORAL TABLET	1	ST; MO; QL (60 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	1	ST; MO; QL (8 per 180 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	1	MO; QL (28 per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	1	MO; QL (30 per 30 days)
flumazenil intravenous solution	1	
fluoxetine oral capsule 10 mg	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
fluoxetine oral capsule 20 mg	1	MO; QL (90 per 30 days)
fluoxetine oral capsule 40 mg	1	MO; QL (60 per 30 days)
fluoxetine oral solution	1	MO
fluphenazine decanoate injection solution	1	MO
fluphenazine hcl injection solution	1	MO
fluphenazine hcl oral concentrate	1	MO
fluphenazine hcl oral elixir	1	MO
fluphenazine hcl oral tablet	1	MO
fluvoxamine oral tablet 100 mg	1	MO; QL (90 per 30 days)
fluvoxamine oral tablet 25 mg	1	MO; QL (30 per 30 days)
fluvoxamine oral tablet 50 mg	1	MO; QL (60 per 30 days)
haloperidol decanoate intramuscular solution 100 mg/ml (1 ml)	1	
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml, 50 mg/ml(1ml)	1	MO
haloperidol lactate injection solution	1	MO
haloperidol lactate intramuscular syringe	1	
haloperidol lactate oral concentrate	1	MO
haloperidol oral tablet	1	MO
imipramine hcl oral tablet	1	MO
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	1	MO; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	1	MO; QL (5 per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	1	MO; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	1	MO; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	1	MO; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	1	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	1	MO; QL (0.5 per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	1	MO; QL (0.88 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	1	MO; QL (1.32 per 90 days)

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Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	1	MO; QL (1.75 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	1	MO; QL (2.63 per 90 days)
lithium carbonate oral capsule	1	MO
lithium carbonate oral tablet	1	MO
lithium carbonate oral tablet extended release	1	MO
lithium citrate oral solution	1	
lorazepam injection solution	1	PA; MO
lorazepam injection syringe 2 mg/ml	1	PA; MO
lorazepam intensol oral concentrate	1	PA; QL (150 per 30 days)
lorazepam oral concentrate	1	PA; MO; QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	PA; MO; QL (90 per 30 days)
lorazepam oral tablet 2 mg	1	PA; MO; QL (150 per 30 days)
loxapine succinate oral capsule	1	MO
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	1	MO; QL (30 per 30 days)
lurasidone oral tablet 80 mg	1	MO; QL (60 per 30 days)
MARPLAN ORAL TABLET	1	MO
methylphenidate hcl oral capsule,er biphasic 50-50	1	MO
methylphenidate hcl oral solution	1	MO
methylphenidate hcl oral tablet	1	MO
methylphenidate hcl oral tablet extended release	1	MO
methylphenidate hcl oral tablet,chewable	1	MO
mirtazapine oral tablet	1	MO
mirtazapine oral tablet,disintegrating	1	MO
modafinil oral tablet 100 mg	1	PA; MO; QL (30 per 30 days)
modafinil oral tablet 200 mg	1	PA; MO; QL (60 per 30 days)
molindone oral tablet 10 mg, 25 mg	1	
molindone oral tablet 5 mg	1	MO
nefazodone oral tablet	1	MO
nortriptyline oral capsule	1	MO
nortriptyline oral solution	1	MO
NUPLAZID ORAL CAPSULE	1	PA; MO; QL (30 per 30 days)
NUPLAZID ORAL TABLET	1	PA; MO; QL (30 per 30 days)
olanzapine intramuscular recon soln	1	MO

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Drug Name	Drug Tier	Requirements/Limits
olanzapine oral tablet	1	MO; QL (30 per 30 days)
olanzapine oral tablet,disintegrating	1	MO; QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	1	MO; QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 6 mg	1	MO; QL (60 per 30 days)
paroxetine hcl oral suspension	1	MO
paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg	1	MO; QL (30 per 30 days)
paroxetine hcl oral tablet 30 mg	1	MO; QL (60 per 30 days)
paroxetine hcl oral tablet extended release 24 hr	1	MO; QL (60 per 30 days)
pentobarbital sodium injection solution	1	
perphenazine oral tablet	1	MO
phenelzine oral tablet	1	MO
pimozide oral tablet	1	MO
protriptyline oral tablet	1	MO
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	MO; QL (90 per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	MO; QL (60 per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	1	MO; QL (30 per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	1	MO; QL (60 per 30 days)
ramelteon oral tablet	1	MO; QL (30 per 30 days)
REXULTI ORAL TABLET	1	MO; QL (30 per 30 days)
risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml	1	MO; QL (2 per 28 days)
risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml	1	MO; QL (2 per 28 days)
risperidone oral solution	1	MO
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet 4 mg	1	MO; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	MO; QL (60 per 30 days)
risperidone oral tablet,disintegrating 4 mg	1	MO; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
SECUADO TRANSDERMAL PATCH 24 HOUR	1	MO; QL (30 per 30 days)
sertraline oral concentrate	1	MO
sertraline oral tablet 100 mg, 50 mg	1	MO; QL (60 per 30 days)
sertraline oral tablet 25 mg	1	MO; QL (30 per 30 days)
SODIUM OXYBATE (PREFERRED NDCS STARTING WITH 00054) ORAL SOLUTION	1	PA; LA; QL (540 per 30 days)
SPRAVATO NASAL SPRAY,NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)	1	PA; MO
thioridazine oral tablet	1	MO
thiothixene oral capsule	1	MO
tranylcypromine oral tablet	1	MO
trazodone oral tablet	1	MO
trifluoperazine oral tablet	1	MO
trimipramine oral capsule	1	MO
TRINTELLIX ORAL TABLET	1	MO; QL (30 per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML	1	MO; QL (0.28 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML	1	MO; QL (0.35 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML	1	MO; QL (0.42 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML	1	MO; QL (0.56 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML	1	MO; QL (0.7 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML	1	MO; QL (0.14 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML	1	MO; QL (0.21 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	1	MO; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	1	MO; QL (90 per 30 days)
venlafaxine oral tablet	1	MO; QL (90 per 30 days)
VERSACLOZ ORAL SUSPENSION	1	
vilazodone oral tablet	1	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	1	MO; QL (30 per 30 days)
zaleplon oral capsule 10 mg	1	MO; QL (60 per 30 days)
zaleplon oral capsule 5 mg	1	MO; QL (30 per 30 days)
ziprasidone hcl oral capsule	1	MO; QL (60 per 30 days)
ziprasidone mesylate intramuscular recon soln	1	MO
zolpidem oral tablet	1	MO; QL (30 per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	1	PA; MO; QL (28 per 365 days)
ZURZUVAE ORAL CAPSULE 30 MG	1	PA; MO; QL (14 per 365 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	1	MO; QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	1	MO; QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	1	MO; QL (1 per 28 days)
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
adenosine intravenous solution	1	
adenosine intravenous syringe	1	
amiodarone intravenous solution	1	B/D PA; MO
amiodarone oral tablet 100 mg, 200 mg	1	MO
amiodarone oral tablet 400 mg	1	
dofetilide oral capsule	1	MO
flecainide oral tablet	1	MO
ibutilide fumarate intravenous solution	1	
lidocaine (pf) intravenous solution	1	

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Drug Name	Drug Tier	Requirements/Limits
lidocaine (pf) intravenous syringe	1	
lidocaine in 5 % dextrose (pf) intravenous parenteral solution 4 mg/ml (0.4 %), 8 mg/ml (0.8 %)	1	
mexiletine oral capsule	1	MO
MULTAQ ORAL TABLET	1	MO
pacerone oral tablet 100 mg, 200 mg, 400 mg	1	MO
procainamide injection solution	1	
propafenone oral capsule,extended release 12 hr	1	MO
propafenone oral tablet	1	MO
quinidine sulfate oral tablet	1	MO
sotalol af oral tablet	1	
sotalol oral tablet	1	MO
ANTIHYPERTENSIVE THERAPY		
acebutolol oral capsule	1	MO
aliskiren oral tablet	1	MO
amiloride oral tablet	1	MO
amiloride-hydrochlorothiazide oral tablet	1	MO
amlodipine oral tablet	1	MO
amlodipine-benazepril oral capsule	1	MO
amlodipine-olmesartan oral tablet	1	MO
amlodipine-valsartan oral tablet	1	MO
amlodipine-valsartan-hydrochlorothiazide oral tablet	1	MO
atenolol oral tablet	1	MO
atenolol-chlorthalidone oral tablet	1	MO
benazepril oral tablet	1	MO
benazepril-hydrochlorothiazide oral tablet	1	MO
betaxolol oral tablet	1	MO
bisoprolol fumarate oral tablet	1	MO
bisoprolol-hydrochlorothiazide oral tablet	1	MO
bumetanide injection solution	1	MO
bumetanide oral tablet	1	MO
candesartan oral tablet	1	MO
candesartan-hydrochlorothiazide oral tablet	1	MO
captopril oral tablet	1	MO

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Drug Name	Drug Tier	Requirements/Limits
captopril-hydrochlorothiazide oral tablet	1	
cartia xt oral capsule,extended release 24hr	1	MO
carvedilol oral tablet	1	MO
chlorothiazide sodium intravenous recon soln	1	MO
chlorthalidone oral tablet 25 mg, 50 mg	1	MO
clonidine (pf) epidural solution 1,000 mcg/10 ml (100 mcg/ml)	1	
clonidine hcl oral tablet	1	MO
clonidine transdermal patch weekly	1	MO; QL (4 per 28 days)
diltiazem hcl intravenous recon soln	1	
diltiazem hcl intravenous solution	1	
diltiazem hcl oral capsule,ext.rel 24h degradable	1	MO
diltiazem hcl oral capsule,extended release 12 hr	1	MO
diltiazem hcl oral capsule,extended release 24 hr	1	MO
diltiazem hcl oral capsule,extended release 24hr 120 mg	1	
diltiazem hcl oral capsule,extended release 24hr 180 mg, 240 mg, 300 mg, 360 mg	1	MO
diltiazem hcl oral tablet	1	MO
diltiazem hcl oral tablet extended release 24 hr	1	MO
dilt-xr oral capsule, extended release 24h degradable	1	MO
doxazosin oral tablet 1 mg, 2 mg, 4 mg	1	MO; QL (30 per 30 days)
doxazosin oral tablet 8 mg	1	MO; QL (60 per 30 days)
EDARBI ORAL TABLET	1	MO
EDARBYCLOR ORAL TABLET	1	MO
enalapril maleate oral tablet	1	MO
enalaprilat intravenous solution	1	
enalapril-hydrochlorothiazide oral tablet 5-12.5 mg	1	MO
eplerenone oral tablet	1	MO
esmolol intravenous solution	1	
ethacrynate sodium intravenous recon soln	1	
felodipine oral tablet extended release 24 hr	1	MO
fosinopril oral tablet	1	MO
fosinopril-hydrochlorothiazide oral tablet	1	MO
furosemide injection solution	1	MO

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Drug Name	Drug Tier	Requirements/Limits
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	1	MO
furosemide oral tablet	1	MO
hydralazine injection solution	1	MO
hydralazine oral tablet	1	MO
hydrochlorothiazide oral capsule	1	MO
hydrochlorothiazide oral tablet	1	MO
indapamide oral tablet	1	MO
irbesartan oral tablet	1	MO
irbesartan-hydrochlorothiazide oral tablet	1	MO
isosorbide-hydralazine oral tablet	1	MO; QL (180 per 30 days)
isradipine oral capsule	1	MO
KERENDIA ORAL TABLET	1	PA; QL (30 per 30 days)
labetalol intravenous solution	1	
labetalol intravenous syringe 20 mg/4 ml (5 mg/ml)	1	
labetalol oral tablet	1	MO
lisinopril oral tablet	1	MO
lisinopril-hydrochlorothiazide oral tablet	1	MO
losartan oral tablet	1	MO
losartan-hydrochlorothiazide oral tablet	1	MO
mannitol 20 % intravenous parenteral solution	1	
mannitol 25 % intravenous solution	1	MO
matzim la oral tablet extended release 24 hr	1	MO
metolazone oral tablet	1	MO
metoprolol succinate oral tablet extended release 24 hr	1	MO
metoprolol tartrate intravenous solution	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	MO
metoprolol tartrate-hydrochlorothiazide oral tablet	1	MO
metyrosine oral capsule	1	PA; MO
minoxidil oral tablet	1	MO
moexipril oral tablet 15 mg	1	
moexipril oral tablet 7.5 mg	1	MO
nadolol oral tablet	1	MO

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Drug Name	Drug Tier	Requirements/Limits
nebivolol oral tablet	1	MO
nicardipine intravenous solution	1	
nicardipine oral capsule	1	MO
nifedipine oral tablet extended release	1	MO
nifedipine oral tablet extended release 24hr	1	MO
nimodipine oral capsule	1	MO
olmesartan oral tablet	1	MO
olmesartan-amlodipine-hydrochlorothiazide oral tablet	1	MO
olmesartan-hydrochlorothiazide oral tablet	1	MO
osmitrol 20 % intravenous parenteral solution	1	
perindopril erbumine oral tablet	1	MO
phentolamine injection recon soln	1	
pindolol oral tablet	1	MO
prazosin oral capsule	1	MO
propranolol intravenous solution	1	
propranolol oral capsule,extended release 24 hr	1	MO
propranolol oral solution	1	MO
propranolol oral tablet	1	MO
quinapril oral tablet	1	
quinapril-hydrochlorothiazide oral tablet	1	
ramipril oral capsule	1	MO
spironolactone oral tablet	1	MO
spironolacton-hydrochlorothiaz oral tablet	1	MO
telmisartan oral tablet	1	MO
telmisartan-amlodipine oral tablet	1	MO
telmisartan-hydrochlorothiazide oral tablet	1	MO
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	MO; QL (30 per 30 days)
terazosin oral capsule 10 mg	1	MO; QL (60 per 30 days)
tiadylt er oral capsule,extended release 24 hr	1	MO
timolol maleate oral tablet	1	MO
torsemide oral tablet	1	MO
trandolapril oral tablet	1	MO
trandolapril-verapamil oral tablet, ir - er, biphasic 24hr	1	MO
treprostinil sodium injection solution	1	PA; MO; LA

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Drug Name	Drug Tier	Requirements/Limits
triamterene-hydrochlorothiazid oral capsule	1	MO
triamterene-hydrochlorothiazid oral tablet	1	MO
UPTRAVI ORAL TABLET	1	PA; MO; LA; QL (60 per 30 days)
UPTRAVI ORAL TABLETS,DOSE PACK	1	PA; MO; LA; QL (200 per 180 days)
valsartan oral tablet	1	MO
valsartan-hydrochlorothiazide oral tablet	1	MO
veletri intravenous recon soln	1	B/D PA; MO
verapamil intravenous solution	1	
verapamil intravenous syringe	1	
verapamil oral capsule, 24 hr er pellet ct	1	MO
verapamil oral capsule, extended release pellets 24 hr	1	MO
verapamil oral tablet	1	MO
verapamil oral tablet extended release	1	MO
COAGULATION THERAPY		
aminocaproic acid intravenous solution	1	MO
aminocaproic acid oral solution	1	MO
aminocaproic acid oral tablet	1	MO
aspirin-dipyridamole oral capsule, er multiphase 12 hr	1	MO
BRILINTA ORAL TABLET	1	MO
CABLIVI INJECTION KIT	1	PA; LA
CEPROTIN (BLUE BAR) INTRAVENOUS RECON SOLN	1	PA; MO
CEPROTIN (GREEN BAR) INTRAVENOUS RECON SOLN	1	PA; MO
cilostazol oral tablet	1	MO
clopidogrel oral tablet 300 mg	1	MO
clopidogrel oral tablet 75 mg	1	MO; QL (30 per 30 days)
dabigatran etexilate oral capsule	1	MO; QL (60 per 30 days)
dipyridamole intravenous solution	1	
dipyridamole oral tablet	1	MO
DOPTELET (10 TAB PACK) ORAL TABLET	1	PA; MO; LA

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Drug Name	Drug Tier	Requirements/Limits
DOPTELET (15 TAB PACK) ORAL TABLET	1	PA; MO; LA
DOPTELET (30 TAB PACK) ORAL TABLET	1	PA; MO; LA
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	1	MO; QL (74 per 180 days)
ELIQUIS ORAL TABLET	1	MO; QL (60 per 30 days)
enoxaparin subcutaneous solution	1	MO; QL (30 per 30 days)
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	1	MO; QL (28 per 28 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	1	MO; QL (22.4 per 28 days)
enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml	1	MO; QL (16.8 per 28 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	1	MO; QL (11.2 per 28 days)
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	1	MO
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	1	MO
heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml)	1	
heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)	1	MO
heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml	1	MO
heparin (porcine) in nacl (pf) intravenous parenteral solution 2,000 unit/1,000 ml	1	
heparin (porcine) injection cartridge	1	MO
heparin (porcine) injection solution	1	MO
heparin (porcine) injection syringe 5,000 unit/ml	1	MO
HEPARIN(PORCINE) IN 0.45% NACL INTRAVENOUS PARENTERAL SOLUTION 12,500 UNIT/250 ML	1	
heparin(porcine) in 0.45% nacl intravenous parenteral solution 25,000 unit/250 ml, 25,000 unit/500 ml	1	MO
heparin, porcine (pf) injection solution 1,000 unit/ml	1	

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Drug Name	Drug Tier	Requirements/Limits
heparin, porcine (pf) injection solution 5,000 unit/0.5 ml	1	MO
heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml	1	MO
HEPARIN, PORCINE (PF) INJECTION SYRINGE 5,000 UNIT/ML	1	
HEPARIN, PORCINE (PF) SUBCUTANEOUS SYRINGE	1	MO
jantoven oral tablet	1	MO
pentoxifylline oral tablet extended release	1	MO
prasugrel oral tablet	1	MO
PROMACTA ORAL POWDER IN PACKET	1	PA; MO; LA
PROMACTA ORAL TABLET	1	PA; MO; LA
protamine intravenous solution	1	
warfarin oral tablet	1	MO
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK	1	MO; QL (51 per 180 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	1	MO; QL (775 per 28 days)
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	1	MO; QL (30 per 30 days)
XARELTO ORAL TABLET 2.5 MG	1	MO; QL (60 per 30 days)
LIPID/CHOLESTEROL LOWERING AGENTS		
amlodipine-atorvastatin oral tablet	1	MO; QL (30 per 30 days)
atorvastatin oral tablet	1	MO; QL (30 per 30 days)
cholestyramine (with sugar) oral powder	1	MO
cholestyramine (with sugar) oral powder in packet	1	MO
cholestyramine light oral powder	1	
cholestyramine light oral powder in packet	1	
cholestyramine-aspartame oral powder in packet	1	
colesevelam oral powder in packet	1	MO
colesevelam oral tablet	1	MO
colestipol oral granules	1	MO
colestipol oral packet	1	
colestipol oral tablet	1	MO

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Drug Name	Drug Tier	Requirements/Limits
ezetimibe oral tablet	1	MO
ezetimibe-simvastatin oral tablet	1	MO; QL (30 per 30 days)
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	1	MO
fenofibrate nanocrystallized oral tablet	1	MO
fenofibrate oral tablet 160 mg, 54 mg	1	MO
fenofibric acid (choline) oral capsule,delayed release(dr/ec)	1	MO
fenofibric acid oral tablet	1	
fluvastatin oral capsule 20 mg	1	MO; QL (30 per 30 days)
fluvastatin oral capsule 40 mg	1	MO; QL (60 per 30 days)
gemfibrozil oral tablet	1	MO
icosapent ethyl oral capsule	1	MO
lovastatin oral tablet 10 mg	1	MO; QL (30 per 30 days)
lovastatin oral tablet 20 mg, 40 mg	1	MO; QL (60 per 30 days)
NEXLETOL ORAL TABLET	1	PA; MO
NEXLIZET ORAL TABLET	1	PA; MO
niacin oral tablet 500 mg	1	MO
niacin oral tablet extended release 24 hr	1	MO
omega-3 acid ethyl esters oral capsule	1	MO
pitavastatin calcium oral tablet	1	MO; QL (30 per 30 days)
pravastatin oral tablet	1	MO; QL (30 per 30 days)
prevalite oral powder	1	MO
prevalite oral powder in packet	1	MO
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR	1	PA; QL (7 per 28 days)
REPATHA SUBCUTANEOUS SYRINGE	1	PA; QL (6 per 28 days)
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR	1	PA; QL (6 per 28 days)
rosuvastatin oral tablet	1	MO; QL (30 per 30 days)
simvastatin oral tablet	1	MO; QL (30 per 30 days)
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR ORAL TABLET	1	MO; QL (60 per 30 days)
digoxin oral solution	1	MO
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	1	MO

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Drug Name	Drug Tier	Requirements/Limits
dobutamine in d5w intravenous parenteral solution 1,000 mg/250 ml (4,000 mcg/ml), 250 mg/250 ml (1 mg/ml), 500 mg/250 ml (2,000 mcg/ml)	1	B/D PA
dobutamine intravenous solution	1	B/D PA
dopamine in 5 % dextrose intravenous solution 200 mg/250 ml (800 mcg/ml), 400 mg/250 ml (1,600 mcg/ml), 400 mg/500 ml (800 mcg/ml), 800 mg/500 ml (1,600 mcg/ml)	1	B/D PA
dopamine in 5 % dextrose intravenous solution 800 mg/250 ml (3,200 mcg/ml)	1	B/D PA; MO
dopamine intravenous solution 200 mg/5 ml (40 mg/ml)	1	B/D PA
dopamine intravenous solution 400 mg/10 ml (40 mg/ml)	1	B/D PA; MO
ENTRESTO ORAL TABLET	1	MO; QL (60 per 30 days)
milrinone in 5 % dextrose intravenous piggyback	1	B/D PA
milrinone intravenous solution	1	B/D PA
norepinephrine bitartrate intravenous solution	1	
ranolazine oral tablet extended release 12 hr	1	MO
sodium nitroprusside intravenous solution	1	B/D PA
VERQUVO ORAL TABLET	1	MO; QL (30 per 30 days)
VYNDAMAX ORAL CAPSULE	1	PA; MO
NITRATES		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	MO
isosorbide mononitrate oral tablet	1	MO
isosorbide mononitrate oral tablet extended release 24 hr	1	MO
nitro-bid transdermal ointment	1	MO
nitroglycerin in 5 % dextrose intravenous solution 100 mg/250 ml (400 mcg/ml), 25 mg/250 ml (100 mcg/ml), 50 mg/250 ml (200 mcg/ml)	1	B/D PA
nitroglycerin intravenous solution	1	B/D PA
nitroglycerin sublingual tablet	1	MO
nitroglycerin transdermal patch 24 hour	1	MO
nitroglycerin translingual spray,non-aerosol	1	MO

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Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
acitretin oral capsule	1	MO
calcipotriene scalp solution	1	MO; QL (120 per 30 days)
calcipotriene topical cream	1	MO; QL (120 per 30 days)
calcipotriene topical ointment	1	MO; QL (120 per 30 days)
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE	1	PA; MO; QL (10 per 28 days)
COSENTYX INTRAVENOUS SOLUTION	1	PA; QL (20 per 28 days)
COSENTYX (2 PENS) SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (10 per 28 days)
COSENTYX SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (5 per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML	1	PA; MO; QL (5 per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	1	PA; MO; QL (2.5 per 28 days)
COSENTYX UNOREADY PEN SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (10 per 28 days)
selenium sulfide topical lotion	1	MO
SKYRIZI SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (2 per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	1	PA; MO; QL (2 per 28 days)
SOTYKTU ORAL TABLET	1	PA; MO; QL (30 per 30 days)
STELARA INTRAVENOUS SOLUTION	1	PA; MO; QL (104 per 180 days)
STELARA SUBCUTANEOUS SOLUTION	1	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; MO; QL (1 per 28 days)
TREMFYA SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; QL (2 per 28 days)
TREMFYA SUBCUTANEOUS SYRINGE	1	PA; MO; QL (2 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS DERMATOLOGICALS		
ADBRY SUBCUTANEOUS AUTO-INJECTOR	1	PA; QL (6 per 28 days)
ADBRY SUBCUTANEOUS SYRINGE	1	PA; MO; QL (6 per 28 days)
ammonium lactate topical cream	1	MO
ammonium lactate topical lotion	1	MO
chloroprocaine (pf) injection solution	1	
CIBINQO ORAL TABLET	1	PA; MO; QL (30 per 30 days)
dermacinrx lidocan topical adhesive patch,medicated	1	PA; QL (90 per 30 days)
diclofenac sodium topical gel 3 %	1	PA; MO; QL (100 per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	1	PA; QL (1.34 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; MO; QL (8 per 28 days)
fluorouracil topical cream 5 %	1	MO
fluorouracil topical solution	1	MO
glydo mucous membrane jelly in applicator	1	MO; QL (60 per 30 days)
imiquimod topical cream in packet 5 %	1	MO
lidocaine (pf) injection solution	1	
lidocaine hcl injection solution	1	
lidocaine hcl laryngotracheal solution	1	
lidocaine hcl mucous membrane jelly in applicator	1	MO; QL (60 per 30 days)
lidocaine hcl mucous membrane solution 2 %	1	MO
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	1	MO
lidocaine topical adhesive patch,medicated 5 %	1	PA; MO; QL (90 per 30 days)
lidocaine topical ointment	1	MO; QL (36 per 30 days)
lidocaine viscous mucous membrane solution	1	

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Drug Name	Drug Tier	Requirements/Limits
lidocaine-epinephrine (pf) injection solution 1.5 %-1:200,000, 2 %-1:200,000	1	
lidocaine-epinephrine injection solution	1	
lidocaine-prilocaine topical cream	1	MO; QL (30 per 30 days)
lidocan iii topical adhesive patch,medicated	1	PA; QL (90 per 30 days)
lidocan iv topical adhesive patch,medicated	1	PA; QL (90 per 30 days)
lidocan v topical adhesive patch,medicated	1	PA; QL (90 per 30 days)
methoxsalen oral capsule, liquid-filled, rapid release	1	MO
PANRETIN TOPICAL GEL	1	PA; MO
pimecrolimus topical cream	1	PA; MO; QL (100 per 30 days)
podofilox topical solution	1	MO
polocaine injection solution 1 % (10 mg/ml)	1	
polocaine-mpf injection solution	1	
REGRANEX TOPICAL GEL	1	QL (15 per 30 days)
SANTYL TOPICAL OINTMENT	1	MO; QL (180 per 30 days)
silver sulfadiazine topical cream	1	MO
ssd topical cream	1	MO
tacrolimus topical ointment	1	PA; MO; QL (100 per 30 days)
tridacaine ii topical adhesive patch,medicated	1	PA; QL (90 per 30 days)
tridacaine iii topical adhesive patch,medicated	1	PA; QL (90 per 30 days)
VALCHLOR TOPICAL GEL	1	PA; MO
THERAPY FOR ACNE		
accutane oral capsule	1	
amnesteem oral capsule	1	
azelaic acid topical gel	1	MO
claravis oral capsule	1	
clindamycin phosphate topical gel	1	MO; QL (120 per 30 days)
clindamycin phosphate topical gel, once daily	1	MO; QL (150 per 30 days)
clindamycin phosphate topical lotion	1	MO; QL (120 per 30 days)
clindamycin phosphate topical solution	1	MO; QL (120 per 30 days)
ery pads topical swab	1	MO
erythromycin with ethanol topical solution	1	MO
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	1	
metronidazole topical cream	1	MO

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Drug Name	Drug Tier	Requirements/Limits
metronidazole topical gel	1	MO
metronidazole topical gel with pump	1	MO
metronidazole topical lotion	1	MO
tazarotene topical cream	1	PA; MO
tazarotene topical gel	1	PA; MO
tretinoin topical cream 0.025 %, 0.05 %, 0.1 %	1	PA; MO
tretinoin topical gel 0.01 %, 0.025 %, 0.05 %	1	PA; MO
zenatane oral capsule	1	
TOPICAL ANTIBACTERIALS		
gentamicin topical cream	1	MO; QL (60 per 30 days)
gentamicin topical ointment	1	MO; QL (60 per 30 days)
mupirocin topical ointment	1	MO; QL (44 per 30 days)
sulfacetamide sodium (acne) topical suspension	1	MO
TOPICAL ANTIFUNGALS		
ciclodan topical solution	1	MO; QL (6.6 per 28 days)
ciclopirox topical cream	1	MO; QL (90 per 28 days)
ciclopirox topical gel	1	MO; QL (100 per 28 days)
ciclopirox topical shampoo	1	MO; QL (120 per 28 days)
ciclopirox topical solution	1	MO; QL (6.6 per 28 days)
ciclopirox topical suspension	1	MO; QL (60 per 28 days)
clotrimazole topical cream	1	MO; QL (45 per 28 days)
clotrimazole topical solution	1	MO; QL (30 per 28 days)
clotrimazole-betamethasone topical cream	1	MO; QL (45 per 28 days)
clotrimazole-betamethasone topical lotion	1	MO; QL (60 per 28 days)
econazole topical cream	1	MO; QL (85 per 28 days)
ketoconazole topical cream	1	MO; QL (60 per 28 days)
ketoconazole topical shampoo	1	MO; QL (120 per 28 days)
klayesta topical powder	1	MO; QL (180 per 30 days)
naftifine topical gel 2 %	1	MO; QL (60 per 28 days)
nyamyc topical powder	1	MO; QL (180 per 30 days)
nystatin topical cream	1	MO; QL (30 per 28 days)
nystatin topical ointment	1	MO; QL (30 per 28 days)
nystatin topical powder	1	MO; QL (180 per 30 days)
nystatin-triamcinolone topical cream	1	MO; QL (60 per 28 days)
nystatin-triamcinolone topical ointment	1	MO; QL (60 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
nystop topical powder	1	MO; QL (180 per 30 days)
TOPICAL ANTIVIRALS		
acyclovir topical ointment	1	PA; MO; QL (30 per 30 days)
penciclovir topical cream	1	MO; QL (5 per 30 days)
TOPICAL CORTICOSTEROIDS		
ala-cort topical cream 1 %	1	MO
ala-cort topical cream 2.5 %	1	
alclometasone topical cream	1	MO
alclometasone topical ointment	1	MO
betamethasone dipropionate topical cream	1	MO
betamethasone dipropionate topical lotion	1	MO
betamethasone dipropionate topical ointment	1	MO
betamethasone valerate topical cream	1	MO
betamethasone valerate topical lotion	1	MO
betamethasone valerate topical ointment	1	MO
betamethasone, augmented topical cream	1	MO
betamethasone, augmented topical gel	1	MO
betamethasone, augmented topical lotion	1	MO
betamethasone, augmented topical ointment	1	MO
clobetasol scalp solution	1	MO; QL (100 per 28 days)
clobetasol topical cream	1	MO; QL (120 per 28 days)
clobetasol topical foam	1	MO; QL (100 per 28 days)
clobetasol topical gel	1	MO; QL (120 per 28 days)
clobetasol topical lotion	1	MO; QL (118 per 28 days)
clobetasol topical ointment	1	MO; QL (120 per 28 days)
clobetasol topical shampoo	1	MO; QL (236 per 28 days)
clobetasol-emollient topical cream	1	MO; QL (120 per 28 days)
desonide topical cream	1	MO
desonide topical ointment	1	MO
fluocinolone and shower cap scalp oil	1	MO
fluocinolone topical cream	1	MO
fluocinolone topical oil	1	MO
fluocinolone topical ointment	1	MO
fluocinolone topical solution	1	MO
fluocinonide topical cream 0.05 %	1	MO; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
fluocinonide topical gel	1	MO; QL (120 per 30 days)
fluocinonide topical ointment	1	MO; QL (120 per 30 days)
fluocinonide topical solution	1	MO; QL (120 per 30 days)
fluocinonide-e topical cream	1	QL (120 per 30 days)
fluocinonide-emollient topical cream	1	MO; QL (120 per 30 days)
fluticasone propionate topical cream	1	MO
fluticasone propionate topical ointment	1	MO
halobetasol propionate topical cream	1	MO
halobetasol propionate topical ointment	1	MO
hydrocortisone topical cream 1 %, 2.5 %	1	MO
hydrocortisone topical lotion 2.5 %	1	MO
hydrocortisone topical ointment 1 %, 2.5 %	1	MO
mometasone topical cream	1	MO
mometasone topical ointment	1	MO
mometasone topical solution	1	MO
prednicarbate topical ointment	1	
triamcinolone acetonide topical cream	1	MO
triamcinolone acetonide topical lotion	1	MO
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	1	MO
triderm topical cream	1	
TOPICAL SCABICIDES / PEDICULICIDES		
malathion topical lotion	1	MO
permethrin topical cream	1	MO; QL (60 per 30 days)
DIAGNOSTICS / MISCELLANEOUS AGENTS		
ANTIDOTES		
acetylcysteine intravenous solution	1	
IRRIGATING SOLUTIONS		
lactated ringers irrigation solution	1	
neomycin-polymyxin b gu irrigation solution	1	
ringer's irrigation solution	1	MO
MISCELLANEOUS AGENTS		
acamprosate oral tablet,delayed release (dr/ec)	1	MO

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Drug Name	Drug Tier	Requirements/Limits
acetic acid irrigation solution	1	MO
anagrelide oral capsule	1	MO
caffeine citrate intravenous solution	1	
caffeine citrate oral solution	1	MO
carglumic acid oral tablet, dispersible	1	PA; MO
cevimeline oral capsule	1	MO
CHEMET ORAL CAPSULE	1	PA
CLINIMIX 4.25%/D5W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
d10 %-0.45 % sodium chloride intravenous parenteral solution	1	
d2.5 %-0.45 % sodium chloride intravenous parenteral solution	1	
d5 % and 0.9 % sodium chloride intravenous parenteral solution	1	MO
d5 %-0.45 % sodium chloride intravenous parenteral solution	1	MO
deferasirox oral granules in packet	1	PA; MO
deferasirox oral tablet	1	PA; MO
deferasirox oral tablet, dispersible 125 mg	1	PA; MO
deferasirox oral tablet, dispersible 250 mg, 500 mg	1	PA; MO
deferiprone oral tablet	1	PA; MO
deferoxamine injection recon soln	1	B/D PA; MO
dextrose 10 % and 0.2 % nacl intravenous parenteral solution	1	
dextrose 10 % in water (d10w) intravenous parenteral solution	1	
dextrose 25 % in water (d25w) intravenous syringe	1	
dextrose 5 % in water (d5w) intravenous parenteral solution	1	MO
dextrose 5 % in water (d5w) intravenous piggyback	1	MO
dextrose 5 %-lactated ringers intravenous parenteral solution	1	MO

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Drug Name	Drug Tier	Requirements/Limits
dextrose 5%-0.2 % sod chloride intravenous parenteral solution	1	
dextrose 5%-0.3 % sod.chloride intravenous parenteral solution	1	
dextrose 50 % in water (d50w) intravenous parenteral solution	1	
dextrose 50 % in water (d50w) intravenous syringe	1	
dextrose 70 % in water (d70w) intravenous parenteral solution	1	
disulfiram oral tablet 250 mg	1	MO
disulfiram oral tablet 500 mg	1	
droxidopa oral capsule	1	PA; MO
ENDARI ORAL POWDER IN PACKET	1	PA; MO
INCRELEX SUBCUTANEOUS SOLUTION	1	MO; LA
levocarnitine (with sugar) oral solution	1	MO
levocarnitine oral solution 100 mg/ml	1	MO
levocarnitine oral tablet	1	MO
LOKELMA ORAL POWDER IN PACKET	1	MO
midodrine oral tablet	1	MO
nitisinone oral capsule	1	PA; MO
pilocarpine hcl oral tablet	1	MO
PROLASTIN-C INTRAVENOUS SOLUTION	1	PA; MO; LA
REZDIFFRA ORAL TABLET	1	PA; MO; QL (30 per 30 days)
riluzole oral tablet	1	PA; MO
risedronate oral tablet 30 mg	1	MO; QL (30 per 30 days)
sodium benzoate-sod phenylacet intravenous solution	1	
sodium chloride 0.9 % intravenous parenteral solution	1	MO
sodium chloride 0.9 % intravenous piggyback	1	MO
sodium chloride irrigation solution	1	MO
sodium phenylbutyrate oral powder	1	PA; MO
sodium phenylbutyrate oral tablet	1	PA
sodium polystyrene sulfonate oral powder	1	MO
sps (with sorbitol) oral suspension	1	MO

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Drug Name	Drug Tier	Requirements/Limits
sps (with sorbitol) rectal enema	1	
trientine oral capsule 250 mg	1	PA; MO
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 8.4 GRAM	1	MO
VELTASSA ORAL POWDER IN PACKET 25.2 GRAM	1	
water for irrigation, sterile irrigation solution	1	MO
XIAFLEX INJECTION RECON SOLN	1	PA
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml	1	PA; MO
SMOKING DETERRENTS		
bupropion hcl (smoking deter) oral tablet extended release 12 hr	1	MO
NICOTROL INHALATION CARTRIDGE	1	
NICOTROL NS NASAL SPRAY,NON-AEROSOL	1	MO
varenicline oral tablet 0.5 mg, 1 mg	1	MO
varenicline oral tablet 1 mg (56 pack)	1	
varenicline oral tablets,dose pack	1	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	1	MO; QL (60 per 30 days)
azelastine nasal spray,non-aerosol 205.5 mcg (0.15 %)	1	QL (60 per 30 days)
chlorhexidine gluconate mucous membrane mouthwash	1	MO
denta 5000 plus dental cream	1	MO
dentagel dental gel	1	MO
fluoride (sodium) dental cream	1	
fluoride (sodium) dental gel	1	
fluoride (sodium) dental paste	1	MO
ipratropium bromide nasal spray,non-aerosol	1	MO; QL (30 per 30 days)
kourzeq dental paste	1	
oralone dental paste	1	
periogard mucous membrane mouthwash	1	MO

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Drug Name	Drug Tier	Requirements/Limits
sf 5000 plus dental cream	1	MO
sf dental gel	1	MO
sodium fluoride 5000 dry mouth dental paste	1	MO
sodium fluoride 5000 plus dental cream	1	
sodium fluoride-pot nitrate dental paste	1	MO
triamcinolone acetonide dental paste	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
acetic acid otic (ear) solution	1	MO
flac oil otic (ear) drops	1	
fluocinolone acetonide oil otic (ear) drops	1	MO
hydrocortisone-acetic acid otic (ear) drops	1	MO
ofloxacin otic (ear) drops	1	MO
OTIC STEROID / ANTIBIOTIC		
ciprofloxacin-dexamethasone otic (ear) drops,suspension	1	MO; QL (7.5 per 7 days)
neomycin-polymyxin-hc otic (ear) drops,suspension	1	MO
neomycin-polymyxin-hc otic (ear) solution	1	MO
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
cortisone oral tablet	1	
dexamethasone intensol oral drops	1	MO
dexamethasone oral elixir	1	MO
dexamethasone oral solution	1	MO
dexamethasone oral tablet	1	MO
dexamethasone sodium phos (pf) injection solution 10 mg/ml	1	MO
dexamethasone sodium phosphate injection solution	1	MO
dexamethasone sodium phosphate injection syringe	1	MO
fludrocortisone oral tablet	1	MO
hydrocortisone oral tablet	1	MO
methylprednisolone acetate injection suspension	1	MO
methylprednisolone oral tablet	1	B/D PA; MO

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Drug Name	Drug Tier	Requirements/Limits
methylprednisolone oral tablets,dose pack	1	MO
methylprednisolone sodium succ injection recon soln 125 mg, 40 mg	1	MO
methylprednisolone sodium succ intravenous recon soln	1	MO
prednisolone oral solution	1	MO
prednisolone sodium phosphate oral solution 15 mg/5 ml (3 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	1	MO
prednisolone sodium phosphate oral solution 15 mg/5 ml (5 ml)	1	
prednisone intensol oral concentrate	1	MO
prednisone oral solution	1	MO
prednisone oral tablet	1	MO
prednisone oral tablets,dose pack	1	MO
triamcinolone acetonide injection suspension 40 mg/ml	1	MO
ANTITHYROID AGENTS		
methimazole oral tablet 10 mg, 5 mg	1	MO
propylthiouracil oral tablet	1	MO
DIABETES THERAPY		
acarbose oral tablet 100 mg	1	MO; QL (90 per 30 days)
acarbose oral tablet 25 mg	1	MO; QL (360 per 30 days)
acarbose oral tablet 50 mg	1	MO; QL (180 per 30 days)
alcohol pads topical pads, medicated	1	PA
BAQSIMI NASAL SPRAY,NON-AEROSOL	1	MO
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	1	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	1	PA; MO; QL (1.2 per 30 days)
diazoxide oral suspension	1	MO
FARXIGA ORAL TABLET 10 MG	1	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS PEN	1	
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	1	MO
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION	1	
glimepiride oral tablet 1 mg	1	MO; QL (240 per 30 days)
glimepiride oral tablet 2 mg	1	MO; QL (120 per 30 days)
glimepiride oral tablet 4 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet 10 mg	1	MO; QL (120 per 30 days)
glipizide oral tablet 5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 5 mg	1	MO; QL (120 per 30 days)
glipizide-metformin oral tablet 2.5-250 mg	1	MO; QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	MO; QL (120 per 30 days)
glucagon emergency kit (human) injection recon soln	1	MO
GLYXAMBI ORAL TABLET	1	MO; QL (30 per 30 days)
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML	1	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 1 MG/0.2 ML	1	MO
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR	1	MO
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	MO
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	MO
GVOKE SUBCUTANEOUS SOLUTION	1	MO
INPEFA ORAL TABLET	1	PA; MO; QL (30 per 30 days)
JANUMET ORAL TABLET	1	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	1	MO; QL (60 per 30 days)
JANUVIA ORAL TABLET	1	MO; QL (30 per 30 days)
JARDIANCE ORAL TABLET	1	MO; QL (30 per 30 days)
JENTADUETO ORAL TABLET	1	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	1	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	1	MO; QL (30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS PEN	1	MO
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION	1	MO
metformin oral tablet 1,000 mg	1	MO; QL (75 per 30 days)
metformin oral tablet 500 mg	1	MO; QL (150 per 30 days)
metformin oral tablet 850 mg	1	MO; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	MO; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	MO; QL (60 per 30 days)
MOUNJARO SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (2 per 28 days)
nateglinide oral tablet 120 mg	1	MO; QL (90 per 30 days)
nateglinide oral tablet 60 mg	1	MO; QL (180 per 30 days)
NOVO PEN NEEDLE	1	MO
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION	1	MO
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	1	MO
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN	1	MO
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION	1	MO
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN	1	MO
NOVOLIN R REGULAR U100 INSULIN INJECTION SOLUTION	1	MO

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Drug Name	Drug Tier	Requirements/Limits
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS PEN	1	MO
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION	1	MO
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN	1	MO
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE	1	MO
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION	1	MO
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)	1	PA; MO; QL (3 per 28 days)
pioglitazone oral tablet	1	MO; QL (30 per 30 days)
repaglinide oral tablet 0.5 mg	1	MO; QL (960 per 30 days)
repaglinide oral tablet 1 mg	1	MO; QL (480 per 30 days)
repaglinide oral tablet 2 mg	1	MO; QL (240 per 30 days)
RYBELSUS ORAL TABLET	1	PA; MO; QL (30 per 30 days)
saxagliptin oral tablet	1	MO; QL (30 per 30 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg	1	MO; QL (60 per 30 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg	1	MO; QL (30 per 30 days)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG	1	MO; QL (60 per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	1	MO; QL (120 per 30 days)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN	1	MO; QL (90 per 30 days)
STEGLATRO ORAL TABLET	1	MO; QL (30 per 30 days)
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (6 per 30 days)
SYNJARDY ORAL TABLET	1	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	1	MO; QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN	1	MO
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS PEN	1	MO
TRADJENTA ORAL TABLET	1	MO; QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	1	MO; QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	1	MO; QL (60 per 30 days)
TRULICITY SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (2 per 28 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	1	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	1	MO; QL (60 per 30 days)
MISCELLANEOUS HORMONES		
ALDURAZYME INTRAVENOUS SOLUTION	1	PA; MO
cabergoline oral tablet	1	MO
calcitonin (salmon) injection solution	1	MO
calcitonin (salmon) nasal spray,non-aerosol	1	MO
calcitriol intravenous solution 1 mcg/ml	1	
calcitriol oral capsule	1	MO
calcitriol oral solution	1	
cinacalcet oral tablet 30 mg, 60 mg	1	PA; MO
cinacalcet oral tablet 90 mg	1	PA; MO
clomid oral tablet	1	PA; MO
CRYSVITA SUBCUTANEOUS SOLUTION	1	PA; MO; LA
danazol oral capsule	1	MO
desmopressin injection solution	1	MO
desmopressin nasal spray with pump	1	MO
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	1	
desmopressin oral tablet	1	MO
doxercalciferol intravenous solution	1	

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Drug Name	Drug Tier	Requirements/Limits
doxercalciferol oral capsule	1	MO
ELAPRASE INTRAVENOUS SOLUTION	1	PA; MO
FABRAZYME INTRAVENOUS RECON SOLN	1	PA; MO
KANUMA INTRAVENOUS SOLUTION	1	PA; MO
LUMIZYME INTRAVENOUS RECON SOLN	1	PA; MO
MEPSEVII INTRAVENOUS SOLUTION	1	PA; MO
mifepristone oral tablet 300 mg	1	PA; MO
NAGLAZYME INTRAVENOUS SOLUTION	1	PA; MO; LA
pamidronate intravenous solution	1	MO
paricalcitol intravenous solution	1	
paricalcitol oral capsule	1	MO
sapropterin oral powder in packet	1	PA; MO
sapropterin oral tablet,soluble	1	PA; MO
SOMAVERT SUBCUTANEOUS RECON SOLN	1	PA; MO
STRENSIQ SUBCUTANEOUS SOLUTION	1	PA; LA
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	1	PA; MO
testosterone cypionate intramuscular oil 200 mg/ml (1 ml)	1	PA
testosterone enanthate intramuscular oil	1	PA; MO
testosterone transdermal gel	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	1	PA; MO; QL (150 per 30 days)
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	1	PA; MO; QL (300 per 30 days)
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)	1	PA; MO; QL (37.5 per 30 days)
testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)	1	PA; MO; QL (150 per 30 days)
testosterone transdermal solution in metered pump w/app	1	PA; MO; QL (180 per 30 days)
tolvaptan oral tablet	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
VIMIZIM INTRAVENOUS SOLUTION	1	PA; MO; LA
zoledronic acid intravenous solution	1	B/D PA; MO
zoledronic acid-mannitol-water intravenous piggyback 4 mg/100 ml	1	B/D PA; MO
THYROID HORMONES		
euthyrox oral tablet	1	MO
levo-t oral tablet	1	
levothyroxine intravenous recon soln	1	
levothyroxine oral tablet	1	MO
levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	1	MO
liothyronine intravenous solution	1	MO
liothyronine oral tablet	1	MO
SYNTHROID ORAL TABLET	1	MO
unithroid oral tablet	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
atropine injection solution 0.4 mg/ml	1	
atropine injection syringe 0.1 mg/ml	1	
atropine intravenous solution 0.4 mg/ml	1	
atropine intravenous syringe 0.25 mg/5 ml (0.05 mg/ml)	1	
dicyclomine intramuscular solution	1	MO
dicyclomine oral capsule	1	MO
dicyclomine oral solution	1	MO
dicyclomine oral tablet	1	MO
diphenoxylate-atropine oral liquid	1	MO
diphenoxylate-atropine oral tablet	1	MO
glycopyrrolate (pf) in water intravenous syringe 0.4 mg/2 ml (0.2 mg/ml)	1	MO
glycopyrrolate injection solution	1	MO
glycopyrrolate oral tablet 1 mg, 2 mg	1	MO
loperamide oral capsule	1	MO
opium oral tincture	1	MO

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Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS GASTROINTESTINAL AGENTS		
alosetron oral tablet 0.5 mg	1	PA; MO
alosetron oral tablet 1 mg	1	PA; MO
aprepitant oral capsule	1	B/D PA; MO
aprepitant oral capsule,dose pack	1	B/D PA; MO
balsalazide oral capsule	1	MO
betaine oral powder	1	MO
budesonide oral capsule, delayed, extended release	1	MO
budesonide oral tablet,delayed and ext.release	1	MO
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT	1	PA; MO; QL (2 per 28 days)
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE	1	PA; MO; QL (3 per 180 days)
CIMZIA SUBCUTANEOUS SYRINGE KIT	1	PA; MO; QL (2 per 28 days)
CINVANTI INTRAVENOUS EMULSION	1	MO
compro rectal suppository	1	MO
constulose oral solution	1	MO
CORTIFOAM RECTAL FOAM	1	MO
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC)	1	MO
cromolyn oral concentrate	1	MO
dimenhydrinate injection solution	1	MO
dronabinol oral capsule	1	B/D PA
droperidol injection solution	1	MO
ENTYVIO INTRAVENOUS RECON SOLN	1	PA; MO; QL (2 per 28 days)
enulose oral solution	1	MO
fosaprepitant intravenous recon soln	1	MO
GATTEX 30-VIAL SUBCUTANEOUS KIT	1	PA; MO
GATTEX ONE-VIAL SUBCUTANEOUS KIT	1	PA; MO
gavilyte-c oral recon soln	1	MO
gavilyte-g oral recon soln	1	MO
gavilyte-n oral recon soln	1	
generlac oral solution	1	

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Drug Name	Drug Tier	Requirements/Limits
granisetron (pf) intravenous solution 1 mg/ml (1 ml)	1	MO
granisetron hcl intravenous solution 1 mg/ml	1	MO
granisetron hcl intravenous solution 1 mg/ml (1 ml)	1	
granisetron hcl oral tablet	1	B/D PA; MO
hydrocortisone rectal enema	1	MO
hydrocortisone topical cream with perineal applicator	1	MO
lactulose oral solution 10 gram/15 ml	1	MO
lactulose oral solution 10 gram/15 ml (15 ml), 20 gram/30 ml	1	
LINZESS ORAL CAPSULE	1	MO; QL (30 per 30 days)
lubiprostone oral capsule	1	MO; QL (60 per 30 days)
meclizine oral tablet 12.5 mg, 25 mg	1	MO
mesalamine oral capsule (with del rel tablets)	1	MO
mesalamine oral capsule, extended release	1	
mesalamine oral capsule,extended release 24hr	1	MO
mesalamine oral tablet,delayed release (dr/ec)	1	MO
mesalamine rectal enema	1	MO
mesalamine rectal suppository	1	MO
mesalamine with cleansing wipe rectal enema kit	1	MO
metoclopramide hcl injection solution	1	MO
metoclopramide hcl injection syringe	1	
metoclopramide hcl oral solution	1	MO
metoclopramide hcl oral tablet	1	MO
nitroglycerin rectal ointment	1	MO
OCALIVA ORAL TABLET	1	PA; MO; LA; QL (30 per 30 days)
ondansetron hcl (pf) injection solution	1	MO
ondansetron hcl (pf) injection syringe	1	
ondansetron hcl intravenous solution	1	MO
ondansetron hcl oral solution	1	B/D PA; MO
ondansetron hcl oral tablet 4 mg, 8 mg	1	B/D PA; MO
ondansetron oral tablet,disintegrating 4 mg, 8 mg	1	B/D PA; MO
palonosetron intravenous solution 0.25 mg/5 ml	1	MO
palonosetron intravenous syringe	1	

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Drug Name	Drug Tier	Requirements/Limits
peg 3350-electrolytes oral recon soln	1	
peg-electrolyte oral recon soln	1	MO
prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)	1	MO
prochlorperazine maleate oral tablet	1	MO
prochlorperazine rectal suppository	1	MO
procto-med hc topical cream with perineal applicator	1	MO
proctosol hc topical cream with perineal applicator	1	MO
proctozone-hc topical cream with perineal applicator	1	MO
RELISTOR SUBCUTANEOUS SOLUTION	1	ST; MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	1	ST; MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	1	ST; MO; QL (12 per 30 days)
REMICADE INTRAVENOUS RECON SOLN	1	PA; MO; QL (20 per 28 days)
SANCUSO TRANSDERMAL PATCH WEEKLY	1	MO
scopolamine base transdermal patch 3 day	1	MO
SKYRIZI INTRAVENOUS SOLUTION	1	PA; MO; QL (30 per 180 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	1	PA; MO; QL (1.2 per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	1	PA; MO; QL (2.4 per 56 days)
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram	1	MO
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram 2 pack (480ml)	1	
SUCRAID ORAL SOLUTION	1	PA
sulfasalazine oral tablet	1	MO
sulfasalazine oral tablet,delayed release (dr/ec)	1	MO
SYMPROIC ORAL TABLET	1	MO; QL (30 per 30 days)
TRULANCE ORAL TABLET	1	MO; QL (30 per 30 days)
ursodiol oral capsule 300 mg	1	MO
ursodiol oral tablet	1	MO

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Drug Name	Drug Tier	Requirements/Limits
VARUBI ORAL TABLET	1	B/D PA
VIBERZI ORAL TABLET	1	MO; QL (60 per 30 days)
VOWST ORAL CAPSULE	1	PA; LA
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	1	MO
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 60,000-189,600- 252,600 UNIT	1	MO
ZYMFENTRA SUBCUTANEOUS PEN INJECTOR KIT	1	PA; MO; QL (2 per 28 days)
ZYMFENTRA SUBCUTANEOUS SYRINGE KIT	1	PA; MO; QL (2 per 28 days)
ULCER THERAPY		
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg	1	MO; QL (30 per 30 days)
esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg	1	MO; QL (60 per 30 days)
esomeprazole sodium intravenous recon soln 40 mg	1	MO
famotidine (pf) intravenous solution	1	MO
famotidine (pf)-nacl (iso-osm) intravenous piggyback	1	MO
famotidine intravenous solution	1	MO
famotidine oral tablet 20 mg, 40 mg	1	MO
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	1	MO; QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	1	MO; QL (60 per 30 days)
misoprostol oral tablet	1	MO
nizatidine oral capsule	1	MO
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg	1	MO; QL (30 per 30 days)
omeprazole oral capsule,delayed release(dr/ec) 40 mg	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
pantoprazole intravenous recon soln	1	MO
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	MO; QL (30 per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	MO; QL (60 per 30 days)
sucralfate oral suspension	1	MO
sucralfate oral tablet	1	MO
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE SUBCUTANEOUS SOLUTION	1	PA; MO
ARCALYST SUBCUTANEOUS RECON SOLN	1	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	1	PA; MO; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	1	PA; MO; QL (1 per 28 days)
BESREMI SUBCUTANEOUS SYRINGE	1	PA; LA
BETASERON SUBCUTANEOUS KIT	1	PA; MO; QL (14 per 28 days)
FULPHILA SUBCUTANEOUS SYRINGE	1	PA; MO
ILARIS (PF) SUBCUTANEOUS SOLUTION	1	PA; MO; LA; QL (2 per 28 days)
NIVESTYM INJECTION SOLUTION	1	PA; MO
NIVESTYM SUBCUTANEOUS SYRINGE	1	PA; MO
NYVEPRIA SUBCUTANEOUS SYRINGE	1	PA; MO
OMNITROPE SUBCUTANEOUS CARTRIDGE	1	PA; MO
OMNITROPE SUBCUTANEOUS RECON SOLN	1	PA; MO
PEGASYS SUBCUTANEOUS SOLUTION	1	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	1	MO; QL (2 per 28 days)
PLEGRIDY INTRAMUSCULAR SYRINGE	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	1	PA; MO; QL (1 per 180 days)

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Drug Name	Drug Tier	Requirements/Limits
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	1	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	1	PA; MO; QL (1 per 180 days)
plerixafor subcutaneous solution	1	B/D PA; MO
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	1	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	1	PA; MO
RELEUKO SUBCUTANEOUS SYRINGE	1	PA; MO
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	1	PA; MO
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	1	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ABRYSVO (PF) INTRAMUSCULAR RECON SOLN	1	V
ACTHIB (PF) INTRAMUSCULAR RECON SOLN	1	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION	1	V
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE	1	V
AREXVY (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	V
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTION	1	V
BEXSERO INTRAMUSCULAR SYRINGE	1	V
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION	1	V
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	1	V
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION	1	

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Drug Name	Drug Tier	Requirements/Limits
DENGVAXIA (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	1	
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION	1	B/D PA; V
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	1	B/D PA; V
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	1	B/D PA; V
fomepizole intravenous solution	1	
GAMASTAN INTRAMUSCULAR SOLUTION	1	MO
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION	1	V
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE	1	V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1	V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	1	
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE	1	B/D PA; V
HIBERIX (PF) INTRAMUSCULAR RECON SOLN	1	
HIZENTRA SUBCUTANEOUS SOLUTION	1	B/D PA; MO
HIZENTRA SUBCUTANEOUS SYRINGE	1	B/D PA; MO
HYPERHEP B INTRAMUSCULAR SOLUTION	1	
HYPERHEP B NEONATAL INTRAMUSCULAR SYRINGE	1	
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN	1	V
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	1	
IPOL INJECTION SUSPENSION	1	V
IXCHIQ (PF) INTRAMUSCULAR RECON SOLN	1	V
IXIARO (PF) INTRAMUSCULAR SYRINGE	1	V

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Drug Name	Drug Tier	Requirements/Limits
JYNNEOS (PF) SUBCUTANEOUS SUSPENSION	1	B/D PA; V
KINRIX (PF) INTRAMUSCULAR SYRINGE	1	
MENACTRA (PF) INTRAMUSCULAR SOLUTION	1	V
MENQUADFI (PF) INTRAMUSCULAR SOLUTION	1	V
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	1	V
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR SOLUTION	1	V
M-M-R II (PF) SUBCUTANEOUS RECON SOLN	1	V
MRESVIA (PF) INTRAMUSCULAR SYRINGE	1	V
PEDIARIX (PF) INTRAMUSCULAR SYRINGE	1	
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION	1	
PENBRAYA (PF) INTRAMUSCULAR KIT	1	V
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	1	
PREHEVBRIO (PF) INTRAMUSCULAR SUSPENSION	1	B/D PA; V
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	1	V
PRIVIGEN INTRAVENOUS SOLUTION	1	PA; MO
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	1	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	1	
QUADRACEL (PF) INTRAMUSCULAR SYRINGE	1	
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	V
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION	1	B/D PA; V

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Drug Name	Drug Tier	Requirements/Limits
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	1	B/D PA; V
ROTARIX ORAL SUSPENSION	1	
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION	1	
ROTATEQ VACCINE ORAL SOLUTION	1	
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	1	V; QL (2 per 720 days)
TDVAX INTRAMUSCULAR SUSPENSION	1	V
TENIVAC (PF) INTRAMUSCULAR SUSPENSION	1	V
TENIVAC (PF) INTRAMUSCULAR SYRINGE	1	V
TETANUS,DIPHTHERIA TOX PED(PF) INTRAMUSCULAR SUSPENSION	1	
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION	1	B/D PA
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	1	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	1	V
TRUMENBA INTRAMUSCULAR SYRINGE	1	V
TWINRIX (PF) INTRAMUSCULAR SYRINGE	1	V
TYPHIM VI INTRAMUSCULAR SOLUTION	1	V
TYPHIM VI INTRAMUSCULAR SYRINGE	1	V
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	1	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	1	V
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	1	
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1	V
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	1	V

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Drug Name	Drug Tier	Requirements/Limits
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION	1	V
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
NOVO PEN NEEDLE	1	PA; MO
GAUZE PADS 2 X 2	1	PA
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1/2 ML 28 GAUGE	1	PA
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 1 ML 29 GAUGE X 1/2"	1	PA; MO
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	1	PA
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
allopurinol oral tablet 100 mg, 300 mg	1	MO
allopurinol sodium intravenous recon soln	1	
aloprim intravenous recon soln	1	
colchicine oral tablet	1	MO
febuxostat oral tablet	1	MO
probenecid oral tablet	1	MO
probenecid-colchicine oral tablet	1	MO
OSTEOPOROSIS THERAPY		
alendronate oral solution	1	MO; QL (300 per 28 days)
alendronate oral tablet 10 mg	1	MO; QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	MO; QL (4 per 28 days)
ibandronate intravenous solution	1	PA
ibandronate intravenous syringe	1	PA; MO
ibandronate oral tablet	1	MO; QL (1 per 30 days)
PROLIA SUBCUTANEOUS SYRINGE	1	PA; MO; QL (1 per 180 days)
raloxifene oral tablet	1	MO
risedronate oral tablet 150 mg	1	MO; QL (1 per 30 days)
risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)	1	MO; QL (4 per 28 days)
risedronate oral tablet 5 mg	1	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
risedronate oral tablet,delayed release (dr/ec)	1	MO; QL (4 per 28 days)
TERIPARATIDE SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (620MCG/2.48ML)	1	PA; QL (2.48 per 28 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (3.6 per 28 days)
ACTEMRA INTRAVENOUS SOLUTION	1	PA; MO; QL (160 per 28 days)
ACTEMRA SUBCUTANEOUS SYRINGE	1	PA; MO; QL (3.6 per 28 days)
BENLYSTA INTRAVENOUS RECON SOLN	1	PA; MO
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO
BENLYSTA SUBCUTANEOUS SYRINGE	1	PA; MO
CYLTEZO(CF) PEN CROHN'S-UC-HS SUBCUTANEOUS PEN INJECTOR KIT	1	PA; QL (6 per 180 days)
CYLTEZO(CF) PEN PSORIASIS-UV SUBCUTANEOUS PEN INJECTOR KIT	1	PA; QL (4 per 180 days)
CYLTEZO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	1	PA; MO; QL (4 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	1	PA; MO; QL (2 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; QL (4 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
ENBREL MINI SUBCUTANEOUS CARTRIDGE	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	1	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	1	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR	1	PA; MO; QL (8 per 28 days)
HUMIRA (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA PEN (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT	1	PA; MO; QL (4 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	1	PA; MO; QL (2 per 28 days)
HUMIRA(CF) (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEN (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	1	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEN (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	1	PA; MO; QL (2 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT	1	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT	1	PA; MO; QL (4 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT	1	PA; MO; QL (3 per 180 days)
leflunomide oral tablet	1	MO; QL (30 per 30 days)
ORENCIA (WITH MALTOSE) INTRAVENOUS RECON SOLN	1	PA; MO; QL (12 per 28 days)
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	1	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	1	PA; MO; QL (1.6 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	1	PA; MO; QL (2.8 per 28 days)
OTEZLA ORAL TABLET 30 MG	1	PA; MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	1	PA; MO; QL (55 per 180 days)
penicillamine oral tablet	1	PA; MO
RIDAURA ORAL CAPSULE	1	MO
RINVOQ LQ ORAL SOLUTION	1	PA; MO; QL (360 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	1	PA; MO; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	1	PA; MO; QL (84 per 180 days)
SAVELLA ORAL TABLET	1	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	1	MO; QL (55 per 180 days)
TYENNE AUTOINJECTOR SUBCUTANEOUS PEN INJECTOR	1	PA; QL (3.6 per 28 days)
TYENNE INTRAVENOUS SOLUTION	1	PA; QL (160 per 28 days)
TYENNE SUBCUTANEOUS SYRINGE	1	PA; QL (3.6 per 28 days)
XELJANZ ORAL SOLUTION	1	PA; MO; QL (480 per 24 days)
XELJANZ ORAL TABLET	1	PA; MO; QL (60 per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR	1	PA; MO; QL (30 per 30 days)
YUFLYMA(CF) AI CROHN'S-UC-HS SUBCUTANEOUS AUTO-INJECTOR, KIT	1	PA; QL (3 per 180 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	1	PA; QL (4 per 28 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	1	PA; QL (2 per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	1	PA; QL (2 per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; QL (4 per 28 days)
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
camila oral tablet	1	MO
deblitane oral tablet	1	MO
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE	1	MO

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Drug Name	Drug Tier	Requirements/Limits
dotti transdermal patch semiweekly	1	PA; MO; QL (8 per 28 days)
DUAVEE ORAL TABLET	1	MO
emzahh oral tablet	1	
errin oral tablet	1	MO
estradiol oral tablet	1	PA; MO
estradiol transdermal patch semiweekly	1	PA; MO; QL (8 per 28 days)
estradiol transdermal patch weekly	1	PA; MO; QL (4 per 28 days)
estradiol vaginal cream	1	MO
estradiol vaginal tablet	1	MO
estradiol valerate intramuscular oil	1	MO
estradiol-norethindrone acet oral tablet	1	PA; MO
fyavolv oral tablet	1	PA; MO
heather oral tablet	1	MO
IMVEXXY MAINTENANCE PACK VAGINAL INSERT	1	MO
IMVEXXY STARTER PACK VAGINAL INSERT, DOSE PACK	1	MO
incassia oral tablet	1	MO
jencycla oral tablet	1	MO
jinteli oral tablet	1	PA; MO
lyleq oral tablet	1	MO
lyllana transdermal patch semiweekly	1	PA; MO; QL (8 per 28 days)
lyza oral tablet	1	
medroxyprogesterone intramuscular suspension	1	MO
medroxyprogesterone intramuscular syringe	1	MO
medroxyprogesterone oral tablet	1	MO
mimvey oral tablet	1	PA; MO
nora-be oral tablet	1	MO
norethindrone (contraceptive) oral tablet	1	
norethindrone acetate oral tablet	1	MO
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	PA; MO
PREMARIN ORAL TABLET	1	MO
PREMARIN VAGINAL CREAM	1	MO
PREMPHASE ORAL TABLET	1	MO
PREMPRO ORAL TABLET	1	MO

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Drug Name	Drug Tier	Requirements/Limits
progesterone intramuscular oil	1	MO
progesterone micronized oral capsule	1	MO
sharobel oral tablet	1	MO
yuvafem vaginal tablet	1	MO
MISCELLANEOUS OB/GYN		
clindamycin phosphate vaginal cream	1	MO
eluryng vaginal ring	1	MO
etonogestrel-ethinyl estradiol vaginal ring	1	
LILETTA INTRAUTERINE DEVICE	1	MO
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	1	MO
mifepristone oral tablet 200 mg	1	LA
MYFEMBREE ORAL TABLET	1	PA; MO
NEXPLANON SUBDERMAL IMPLANT	1	
terconazole vaginal cream	1	MO
terconazole vaginal suppository	1	MO
tranexamic acid oral tablet	1	MO
xulane transdermal patch weekly	1	MO
zafemy transdermal patch weekly	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
altavera (28) oral tablet	1	MO
alyacen 1/35 (28) oral tablet	1	MO
alyacen 7/7/7 (28) oral tablet	1	MO
amethyst (28) oral tablet	1	MO
apri oral tablet	1	MO
aranelle (28) oral tablet	1	MO
aubra eq oral tablet	1	MO
aviane oral tablet	1	MO
azurette (28) oral tablet	1	MO
camrese oral tablets,dose pack,3 month	1	MO
cryselle (28) oral tablet	1	MO
cyred eq oral tablet	1	MO
dasetta 1/35 (28) oral tablet	1	MO
dasetta 7/7/7 (28) oral tablet	1	MO
daysee oral tablets,dose pack,3 month	1	MO

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Drug Name	Drug Tier	Requirements/Limits
desog-e.estradiol/e.estradiol oral tablet	1	
desogestrel-ethinyl estradiol oral tablet	1	
drospirenone-e.estradiol-lm.fa oral tablet 3-0.03-0.451 mg (21) (7)	1	MO
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg	1	MO
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	1	
elinest oral tablet	1	MO
enpresse oral tablet	1	MO
enskyce oral tablet	1	MO
estarylla oral tablet	1	MO
ethynodiol diac-eth estradiol oral tablet	1	
falmina (28) oral tablet	1	MO
introvale oral tablets,dose pack,3 month	1	
isibloom oral tablet	1	MO
jasmiel (28) oral tablet	1	MO
jolessa oral tablets,dose pack,3 month	1	MO
juleber oral tablet	1	MO
kalliga oral tablet	1	
kariva (28) oral tablet	1	MO
kelnor 1/35 (28) oral tablet	1	MO
kelnor 1/50 (28) oral tablet	1	MO
kurvelo (28) oral tablet	1	MO
l norgestl/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)	1	
l norgestl/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg	1	MO
larin 1.5/30 (21) oral tablet	1	MO
larin 1/20 (21) oral tablet	1	MO
larin 24 fe oral tablet	1	MO
larin fe 1.5/30 (28) oral tablet	1	MO
larin fe 1/20 (28) oral tablet	1	MO
lessina oral tablet	1	MO
levonest (28) oral tablet	1	MO
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	1	MO

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Drug Name	Drug Tier	Requirements/Limits
levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg	1	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	1	
levonorg-eth estrad triphasic oral tablet	1	
levora-28 oral tablet	1	MO
loryna (28) oral tablet	1	MO
low-ogestrel (28) oral tablet	1	MO
lo-zumandimine (28) oral tablet	1	MO
lutera (28) oral tablet	1	MO
marlissa (28) oral tablet	1	MO
microgestin 1.5/30 (21) oral tablet	1	MO
microgestin 1/20 (21) oral tablet	1	MO
microgestin fe 1.5/30 (28) oral tablet	1	MO
microgestin fe 1/20 (28) oral tablet	1	MO
mili oral tablet	1	MO
mono-linyah oral tablet	1	MO
nikki (28) oral tablet	1	MO
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	1	MO
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.25-35 mg-mcg	1	
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	MO
nortrel 0.5/35 (28) oral tablet	1	MO
nortrel 1/35 (21) oral tablet	1	MO
nortrel 1/35 (28) oral tablet	1	MO
nortrel 7/7/7 (28) oral tablet	1	MO
philith oral tablet	1	MO
pimtrea (28) oral tablet	1	MO
portia 28 oral tablet	1	MO
reclipsen (28) oral tablet	1	MO
setlakin oral tablets,dose pack,3 month	1	MO
sprintec (28) oral tablet	1	MO
sronyx oral tablet	1	MO

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Drug Name	Drug Tier	Requirements/Limits
syeda oral tablet	1	MO
tarina fe 1-20 eq (28) oral tablet	1	MO
tilia fe oral tablet	1	MO
tri-estarylla oral tablet	1	MO
tri-legest fe oral tablet	1	MO
tri-linyah oral tablet	1	MO
tri-lo-estarylla oral tablet	1	MO
tri-lo-marzia oral tablet	1	MO
tri-lo-sprintec oral tablet	1	
tri-sprintec (28) oral tablet	1	MO
trivora (28) oral tablet	1	MO
turqoz (28) oral tablet	1	MO
velivet triphasic regimen (28) oral tablet	1	MO
vestura (28) oral tablet	1	MO
vienva oral tablet	1	MO
viorele (28) oral tablet	1	MO
wera (28) oral tablet	1	MO
zovia 1-35 (28) oral tablet	1	MO
zumandimine (28) oral tablet	1	MO
OXYTOCICS		
methylergonovine oral tablet	1	PA
OPHTHALMOLOGY		
ANTIBIOTICS		
bacitracin ophthalmic (eye) ointment	1	MO
bacitracin-polymyxin b ophthalmic (eye) ointment	1	MO
ciprofloxacin hcl ophthalmic (eye) drops	1	MO
erythromycin ophthalmic (eye) ointment	1	MO; QL (3.5 per 14 days)
gatifloxacin ophthalmic (eye) drops	1	MO
gentamicin ophthalmic (eye) drops	1	MO; QL (70 per 30 days)
levofloxacin ophthalmic (eye) drops	1	
moxifloxacin ophthalmic (eye) drops	1	MO
moxifloxacin ophthalmic (eye) drops, viscous	1	
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION	1	

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Drug Name	Drug Tier	Requirements/Limits
neomycin-bacitracin-polymyxin ophthalmic (eye) ointment	1	MO
neomycin-polymyxin-gramicidin ophthalmic (eye) drops	1	MO
neo-polycin ophthalmic (eye) ointment	1	
ofloxacin ophthalmic (eye) drops	1	MO
polycin ophthalmic (eye) ointment	1	
polymyxin b sulf-trimethoprim ophthalmic (eye) drops	1	MO
tobramycin ophthalmic (eye) drops	1	MO; QL (10 per 14 days)
ANTIVIRALS		
trifluridine ophthalmic (eye) drops	1	MO
ZIRGAN OPHTHALMIC (EYE) GEL	1	MO
BETA-BLOCKERS		
betaxolol ophthalmic (eye) drops	1	MO
carteolol ophthalmic (eye) drops	1	MO
levobunolol ophthalmic (eye) drops 0.5 %	1	MO
timolol maleate ophthalmic (eye) drops (timoptic generic)	1	MO
timolol maleate ophthalmic (eye) gel forming solution (timoptic generic)	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
atropine ophthalmic (eye) drops 1 %	1	MO
azelastine ophthalmic (eye) drops	1	MO
bss intraocular solution	1	
CIMERLI INTRAVITREAL SOLUTION	1	PA; MO
cromolyn ophthalmic (eye) drops	1	
cyclosporine ophthalmic (eye) dropperette	1	MO; QL (60 per 30 days)
CYSTARAN OPHTHALMIC (EYE) DROPS	1	PA
epinastine ophthalmic (eye) drops	1	MO
EYLEA INTRAVITREAL SOLUTION	1	PA; MO
EYLEA INTRAVITREAL SYRINGE	1	PA; MO
MIEBO (PF) OPHTHALMIC (EYE) DROPS	1	MO; QL (12 per 30 days)
OXERVATE OPHTHALMIC (EYE) DROPS	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	1	MO
sulfacetamide sodium ophthalmic (eye) drops	1	MO
sulfacetamide sodium ophthalmic (eye) ointment	1	
sulfacetamide-prednisolone ophthalmic (eye) drops	1	MO
XDEMVY OPHTHALMIC (EYE) DROPS	1	PA; QL (10 per 42 days)
XIIDRA OPHTHALMIC (EYE) DROPPERETTE	1	MO; QL (60 per 30 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
bromfenac ophthalmic (eye) drops	1	MO
diclofenac sodium ophthalmic (eye) drops	1	MO
flurbiprofen sodium ophthalmic (eye) drops	1	MO
ketorolac ophthalmic (eye) drops	1	MO
ORAL DRUGS FOR GLAUCOMA		
acetazolamide oral capsule, extended release	1	MO
acetazolamide oral tablet	1	MO
acetazolamide sodium injection recon soln	1	MO
methazolamide oral tablet	1	MO
OTHER GLAUCOMA DRUGS		
dorzolamide ophthalmic (eye) drops	1	
dorzolamide-timolol ophthalmic (eye) drops	1	MO
latanoprost ophthalmic (eye) drops	1	MO
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	1	MO
miostat intraocular solution	1	
RHOPRESSA OPHTHALMIC (EYE) DROPS	1	MO
ROCKLATAN OPHTHALMIC (EYE) DROPS	1	MO
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION	1	MO
travoprost ophthalmic (eye) drops	1	MO

Drug Name	Drug Tier	Requirements/Limits
STEROID-ANTIBIOTIC COMBINATIONS		
neomycin-bacitracin-poly-hc ophthalmic (eye) ointment	1	MO
neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension	1	MO
neomycin-polymyxin b-dexameth ophthalmic (eye) ointment	1	MO
neomycin-polymyxin-hc ophthalmic (eye) drops,suspension	1	MO
neo-polycin hc ophthalmic (eye) ointment	1	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	1	MO; QL (3.5 per 14 days)
tobramycin-dexamethasone ophthalmic (eye) drops,suspension	1	MO; QL (10 per 14 days)
STEROIDS		
dexamethasone sodium phosphate ophthalmic (eye) drops	1	MO
fluorometholone ophthalmic (eye) drops,suspension	1	MO
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION	1	MO
loteprednol etabonate ophthalmic (eye) drops,gel	1	MO
loteprednol etabonate ophthalmic (eye) drops,suspension	1	MO
OZURDEX INTRAVITREAL IMPLANT	1	MO
prednisolone acetate ophthalmic (eye) drops,suspension	1	MO
prednisolone sodium phosphate ophthalmic (eye) drops	1	MO
SYMPATHOMIMETICS		
apraclonidine ophthalmic (eye) drops	1	MO
brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %	1	MO
brimonidine ophthalmic (eye) drops 0.2 %	1	MO

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Drug Name	Drug Tier	Requirements/Limits
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
adrenalin injection solution 1 mg/ml	1	
adrenalin injection solution 1 mg/ml (1 ml)	1	MO
cetirizine oral solution 1 mg/ml	1	MO
diphenhydramine hcl injection solution 50 mg/ml	1	MO
diphenhydramine hcl injection syringe	1	MO
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)	1	MO; QL (2 per 30 days)
epinephrine injection solution 1 mg/ml	1	
hydroxyzine hcl oral tablet	1	PA; MO
levocetirizine oral solution	1	MO
levocetirizine oral tablet	1	MO; QL (30 per 30 days)
promethazine injection solution	1	MO
promethazine oral syrup	1	PA; MO
promethazine oral tablet	1	PA; MO
PULMONARY AGENTS		
acetylcysteine solution	1	B/D PA; MO
ADEMPAS ORAL TABLET	1	PA; MO; LA; QL (90 per 30 days)
ADVAIR HFA AEROSOL INHALER	1	MO; QL (12 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	1	MO; QL (17 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)	1	QL (13.4 per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml	1	B/D PA; MO
albuterol sulfate inhalation solution for nebulization 5 mg/ml	1	B/D PA
albuterol sulfate oral syrup	1	MO
albuterol sulfate oral tablet	1	MO
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	1	MO; QL (12.2 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	1	MO; QL (6.1 per 30 days)
alyq oral tablet	1	PA; QL (60 per 30 days)
ambrisentan oral tablet	1	PA; MO; LA; QL (30 per 30 days)
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE	1	MO; QL (60 per 30 days)
arformoterol inhalation solution for nebulization	1	B/D PA; MO; QL (120 per 30 days)
ASMANEX HFA AEROSOL INHALER	1	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30)	1	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	1	MO; QL (2 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (14)	1	QL (2 per 28 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (60)	1	QL (1 per 30 days)
ATROVENT HFA AEROSOL INHALER	1	MO; QL (25.8 per 30 days)
BEVESPI AEROSPHERE HFA AEROSOL INHALER	1	MO; QL (10.7 per 30 days)
bosentan oral tablet	1	PA; MO; LA; QL (60 per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE	1	MO; QL (60 per 30 days)
breyna inhalation hfa aerosol inhaler	1	MO; QL (10.3 per 30 days)
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER	1	MO; QL (10.7 per 30 days)
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml	1	B/D PA; MO; QL (120 per 30 days)
budesonide inhalation suspension for nebulization 1 mg/2 ml	1	B/D PA; MO; QL (60 per 30 days)
budesonide-formoterol inhalation hfa aerosol inhaler	1	QL (10.2 per 30 days)
CINRYZE INTRAVENOUS RECON SOLN	1	PA; MO

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Drug Name	Drug Tier	Requirements/Limits
COMBIVENT RESPIMAT INHALATION MIST	1	MO; QL (8 per 30 days)
cromolyn inhalation solution for nebulization	1	B/D PA; MO
DULERA INHALATION HFA AEROSOL INHALER	1	MO; QL (13 per 30 days)
ELIXOPHYLLIN ORAL ELIXIR	1	
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; QL (1 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	1	PA; MO; QL (0.5 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	1	PA; MO; QL (1 per 28 days)
flunisolide nasal spray,non-aerosol	1	MO; QL (50 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	1	ST; MO; QL (12 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	1	ST; MO; QL (24 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	1	ST; MO; QL (10.6 per 30 days)
fluticasone propionate nasal spray,suspension	1	MO; QL (16 per 30 days)
fluticasone propion-salmeterol inhalation blister with device	1	MO; QL (60 per 30 days)
formoterol fumarate inhalation solution for nebulization	1	B/D PA; MO; QL (120 per 30 days)
icatibant subcutaneous syringe	1	PA; MO
ipratropium bromide inhalation solution	1	B/D PA; MO
ipratropium-albuterol inhalation solution for nebulization	1	B/D PA; MO
KALYDECO ORAL GRANULES IN PACKET	1	PA; MO; QL (56 per 28 days)
KALYDECO ORAL TABLET	1	PA; MO; QL (56 per 28 days)
mometasone nasal spray,non-aerosol	1	MO; QL (34 per 30 days)
montelukast oral granules in packet	1	MO
montelukast oral tablet	1	MO
montelukast oral tablet,chewable	1	MO

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Drug Name	Drug Tier	Requirements/Limits
NUCALA SUBCUTANEOUS AUTO-INJECTOR	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	1	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	1	PA; MO; LA; QL (0.4 per 28 days)
OFEV ORAL CAPSULE	1	PA; MO; QL (60 per 30 days)
OPSUMIT ORAL TABLET	1	PA; MO; LA; QL (30 per 30 days)
OPSYNVI ORAL TABLET	1	PA; MO; QL (30 per 30 days)
ORKAMBI ORAL GRANULES IN PACKET	1	PA; MO; QL (56 per 28 days)
ORKAMBI ORAL TABLET	1	PA; MO; QL (112 per 28 days)
pirfenidone oral capsule	1	PA; MO; QL (270 per 30 days)
pirfenidone oral tablet 267 mg	1	PA; MO; QL (270 per 30 days)
pirfenidone oral tablet 801 mg	1	PA; MO; QL (90 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	1	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	1	MO; QL (1 per 30 days)
PULMOZYME INHALATION SOLUTION	1	B/D PA; MO
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	1	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	1	MO; QL (21.2 per 30 days)
roflumilast oral tablet	1	PA; MO; QL (30 per 30 days)
sajazir subcutaneous syringe	1	PA; MO
sildenafil (pulmonary arterial hypertension) intravenous solution 10 mg/12.5 ml	1	PA
sildenafil (pulmonary arterial hypertension) oral tablet 20 mg	1	PA; MO; QL (90 per 30 days)
SPIRIVA RESPIMAT INHALATION MIST	1	MO; QL (4 per 30 days)
STIOLTO RESPIMAT INHALATION MIST	1	MO; QL (4 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
STRIVERDI RESPIMAT INHALATION MIST	1	MO; QL (4 per 30 days)
SYMDEKO ORAL TABLETS, SEQUENTIAL	1	PA; MO; QL (56 per 28 days)
tadalafil (pulmonary arterial hypertension) oral tablet 20 mg	1	PA; QL (60 per 30 days)
terbutaline oral tablet	1	MO
terbutaline subcutaneous solution	1	MO
theophylline oral elixir	1	
theophylline oral solution	1	
theophylline oral tablet extended release 12 hr	1	MO
theophylline oral tablet extended release 24 hr	1	MO
tiotropium bromide inhalation capsule, w/inhalation device	1	QL (90 per 90 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE	1	MO; QL (60 per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	1	PA; MO; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	1	PA; MO; QL (84 per 28 days)
TYVASO INHALATION SOLUTION FOR NEBULIZATION	1	B/D PA; MO; QL (81.2 per 28 days)
TYVASO INSTITUTIONAL START KIT INHALATION SOLUTION FOR NEBULIZATION	1	B/D PA; QL (11.6 per 180 days)
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION	1	B/D PA; MO; QL (81.2 per 28 days)
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION	1	B/D PA; MO; QL (81.2 per 180 days)
VENTOLIN HFA AEROSOL INHALER	1	MO; QL (36 per 30 days)
wixela inhub inhalation blister with device	1	QL (60 per 30 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	1	PA; MO; LA; QL (1 per 28 days)
XOLAIR SUBCUTANEOUS RECON SOLN	1	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	1	PA; MO; LA; QL (8 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	1	PA; MO; LA; QL (1 per 28 days)
zafirlukast oral tablet	1	MO
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
mirabegron oral tablet extended release 24 hr	1	MO
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	1	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	1	MO
oxybutynin chloride oral syrup	1	MO
oxybutynin chloride oral tablet 5 mg	1	MO
oxybutynin chloride oral tablet extended release 24hr	1	MO
solifenacin oral tablet	1	MO
tolterodine oral capsule,extended release 24hr	1	MO
tolterodine oral tablet	1	MO
trospium oral tablet	1	MO
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin oral tablet extended release 24 hr	1	MO
dutasteride oral capsule	1	MO
dutasteride-tamsulosin oral capsule, er multiphase 24 hr	1	MO
finasteride oral tablet 5 mg	1	MO
tamsulosin oral capsule	1	MO
MISCELLANEOUS UROLOGICALS		
bethanechol chloride oral tablet	1	MO
CYSTAGON ORAL CAPSULE	1	PA; LA
ELMIRON ORAL CAPSULE	1	MO
glycine urologic irrigation solution	1	
glycine urologic irrigation solution	1	
K-PHOS NO 2 ORAL TABLET	1	MO
K-PHOS ORIGINAL ORAL TABLET,SOLUBLE	1	MO

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Drug Name	Drug Tier	Requirements/Limits
potassium citrate oral tablet extended release	1	MO
RENACIDIN IRRIGATION SOLUTION	1	MO
tadalafil oral tablet 2.5 mg	1	PA; MO; QL (60 per 30 days)
tadalafil oral tablet 5 mg	1	PA; MO; QL (30 per 30 days)
VITAMINS, HEMATINICS / ELECTROLYTES		
BLOOD DERIVATIVES		
albumin, human 25 % intravenous parenteral solution	1	
alburx (human) 25 % intravenous parenteral solution	1	
alburx (human) 5 % intravenous parenteral solution	1	
albutein 25 % intravenous parenteral solution	1	
albutein 5 % intravenous parenteral solution	1	
ELECTROLYTES		
calcium chloride intravenous solution	1	
calcium chloride intravenous syringe	1	
calcium gluconate intravenous solution	1	
effer-k oral tablet, effervescent 25 meq	1	MO
klor-con 10 oral tablet extended release	1	MO
klor-con 8 oral tablet extended release	1	MO
klor-con m10 oral tablet,er particles/crystals	1	MO
klor-con m15 oral tablet,er particles/crystals	1	MO
klor-con m20 oral tablet,er particles/crystals	1	MO
klor-con oral packet	1	MO
klor-con/ef oral tablet, effervescent	1	MO
lactated ringers intravenous parenteral solution	1	MO
magnesium chloride injection solution	1	
MAGNESIUM SULFATE IN D5W INTRAVENOUS PIGGYBACK 1 GRAM/100 ML	1	
magnesium sulfate in water intravenous parenteral solution	1	
magnesium sulfate in water intravenous piggyback	1	

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Drug Name	Drug Tier	Requirements/Limits
magnesium sulfate injection solution	1	MO
magnesium sulfate injection syringe	1	
potassium acetate intravenous solution	1	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution	1	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	1	
potassium chloride in 5 % dex intravenous parenteral solution 10 meq/l, 20 meq/l	1	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	1	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 10 meq/50 ml, 20 meq/100 ml, 20 meq/50 ml, 40 meq/100 ml	1	
potassium chloride intravenous solution	1	
potassium chloride oral capsule, extended release	1	MO
potassium chloride oral liquid	1	MO
potassium chloride oral packet	1	
potassium chloride oral tablet extended release 10 meq, 8 meq	1	MO
potassium chloride oral tablet extended release 20 meq	1	
potassium chloride oral tablet,er particles/crystals 10 meq	1	MO
potassium chloride oral tablet,er particles/crystals 15 meq, 20 meq	1	
potassium chloride-0.45 % nacl intravenous parenteral solution	1	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	1	
potassium chloride-d5-0.9%nacl intravenous parenteral solution	1	
potassium phosphate m-/d-basic intravenous solution 3 mmol/ml	1	
ringer's intravenous parenteral solution	1	
sodium acetate intravenous solution	1	
sodium bicarbonate intravenous solution	1	
sodium bicarbonate intravenous syringe	1	

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Drug Name	Drug Tier	Requirements/Limits
sodium chloride 0.45 % intravenous parenteral solution	1	MO
sodium chloride 3 % hypertonic intravenous parenteral solution	1	
sodium chloride 5 % hypertonic intravenous parenteral solution	1	MO
sodium chloride intravenous solution	1	
sodium phosphate intravenous solution	1	MO
MISCELLANEOUS NUTRITION PRODUCTS		
CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
CLINIMIX 4.25%/D10W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
CLINIMIX 5%-D20W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
CLINIMIX 6%-D5W (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
CLINIMIX 8%-D10W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
CLINIMIX 8%-D14W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
electrolyte-148 intravenous parenteral solution	1	
electrolyte-48 in d5w intravenous parenteral solution	1	
electrolyte-a intravenous parenteral solution	1	
intralipid intravenous emulsion 20 %	1	B/D PA
ISOLYTE S PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	1	
ISOLYTE-P IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION	1	
ISOLYTE-S INTRAVENOUS PARENTERAL SOLUTION	1	

Drug Name	Drug Tier	Requirements/Limits
PLENAMINE INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
premasol 10 % intravenous parenteral solution	1	B/D PA
travasol 10 % intravenous parenteral solution	1	B/D PA
TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION	1	B/D PA
VITAMINS / HEMATINICS		
fluoride (sodium) oral tablet	1	
fluoride (sodium) oral tablet,chewable 1 mg (2.2 mg sod. fluoride)	1	MO
prenatal vitamin oral tablet	1	
wescap-pn dha oral capsule	1	MO

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For more recent information or other questions, please contact EmblemHealth Medicare HMO at **877-344-7364** (TTY users should call **711)**. From Oct.1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, you can call us Monday through Saturday from 8 a.m. to 8 p.m., or visit **emblemhealth.com/medicare**.

Para obtener información más reciente o para hacer otras preguntas, comuníquese con EmblemHealth Medicare HMO al **877-344-7364** (los usuarios de TTY deben llamar al **711)**. Del 1 de octubre al 31 de marzo, puede llamarnos los siete días de la semana de 8 a.m. a 8 p.m. Del 1 de abril al 30 de septiembre, puede llamarnos de lunes a sábado, de 8 a.m. a 8 p.m., o visite **emblemhealth.com/medicare**.

如需更多最新信息或有其他疑问，请联系安保联邦医疗保险（Medicare，即红蓝卡）HMO，电话：**877-344-7364**（TTY 用户应致电 **711**）。从 10 月 1 日至 3 月 31 日，您可以每周 7 天从 8 a.m. 至 8 p.m. 致电我们。从 4 月 1 日至 9 月 30 日，您可以周一至周六从 8 a.m. 至 8 p.m. 致电我们，或访问 **emblemhealth.com/medicare**。

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