Choice (HMO) / Plus (HMO)
2022

MedicareRx Prescription Drug Coverage

Formulary (List of Covered Drugs)
Formulario (Lista de medicamentos cubiertos)
處方藥一覽表（承保藥物清單）
처방집(보장 약 목록)
Danh Mục Thuốc (Danh sách Thuốc được Bảo hiểm)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN
LEA ESTE DOCUMENTO QUE CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN
請閱讀：本文件包含有關本計劃承保藥物的資訊
내용을 확인하시기 바랍니다. 이 문서에는 이 플랜에서 보장하는 약에 관한 정보가 들어 있습니다.
XIN ĐỌC: TÀI LIỆU NÀY CÓ THÔNG TIN VỀ CÁC THUỐC ĐƯỢC CHÚNG TÔI BẢO HIỂM

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This formulary was updated on 12/01/2022. For more recent information or other questions, please contact CCA Health California Member Service at 1-866-333-3530 or, for TTY users, 711, 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m. Monday to Friday from April 1 through September 30, or visit www.ccahealthca.org.

Este formulario se actualizó el 12/01/2022. Para obtener información más reciente o si tiene cualquier otra pregunta, comuníquese con el Servicio para los miembros de CCA Health California al 1-866-333-3530. Los usuarios de TTY deben llamar al 711. Desde el 1.º de octubre hasta el 31 de marzo, el horario de atención es de 8:00 a. m. a 8:00 p. m., los siete días de la semana; y desde el 1.º de abril hasta el 30 de septiembre, el horario de atención es de 8:00 a. m. a 8:00 p. m., de lunes a viernes. También puede visitar www.ccahealthca.org.

本處方藥一覽表更新於 2022 年 12 月 01 日。如需最新資訊或有其他問題，請聯絡 CCA Health California 會員服務部，電話：1-866-333-3530，聽障人士可致電 711。10 月 1 日至 3 月 31 日期間，辦公時間為每週七天，上午 8 點至晚上 8 點；4 月 1 日至 9 月 30 日期間，辦公時間為週一至週五，上午 8 點至晚上 8 點，或者瀏覽 www.ccahealthca.org。

이 처방집은 2022년 12월 01일에 업데이트되었습니다. 더욱 최근의 정보를 원하시거나 기타 궁금한 사항이 있으시면 CCA Health California 가입자 서비스부에 1-866-333-3530번으로, TTY사용자는 711번으로 10월 1일부터 3월 31일까지는 주 7일 오전 8시-오후 8시 중에 그리고 4월 1일부터 9월 30일까지는 월요일-금요일 오전 8시-오후 8시 중에 전화해 주십시오. 또는 www.ccahealthca.org을 언제든 방문하실 수 있습니다.

Danh mục thuốc này được cập nhật vào ngày 12/01/2022. Để biết thông tin gần đây hoặc có thắc mắc gì khác, xin vui lòng gọi cho CCA Health California theo số 1-866-333-3530 hoặc, với người dùng TTY, 711, 8 giờ sáng đến 8 giờ tối., bảy ngày mỗi tuần từ ngày 1 tháng 10 đến ngày 31 tháng 3 và từ 8 giờ sáng đến 8 giờ tối, Thứ Hai đến Thứ Sáu, từ ngày 1 tháng 4 đến ngày 30 tháng 9, hoặc truy cập www.ccahealthca.org.

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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 CCA Health California. When it refers to "plan" or "our plan," it means Choice (HMO) San Joaquin (Plan 001), Choice (HMO) Santa Clara (Plan 002) or Plus (HMO) Plan 003.

This document includes list of the drugs (formulary) for our plan which is current as of 12/01/2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

What is the CCA Health California Formulary?

A formulary is a list of covered drugs selected by CCA Health California 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. CCA Health California will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a CCA Health California 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 (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

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

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

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a new generic drug to replace a brand name drug currently on the formulary; or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 12/01/2022. To get updated information about the drugs covered by CCA Health California, please contact us. Our contact information appears on the front and back cover pages. Every month CCA Health California mails you a report called the "Explanation of Benefits," or "EOB." The EOB tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Along with your EOB, we will send you a "Formulary Change Notice" if there have been any recent changes to our formulary. In addition, all formulary changes will be included on the monthly updated formulary available on our web site at www.ccahealthca.org.

How do I use the Formulary?

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

Medical Condition
The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, Cardiovascular Agents. If you know what your drug is used for, look for the category name in the list that begins on page 3. Then look under the category name for your drug.

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

What are generic drugs?

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

Are there any restrictions on my coverage?

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

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

- **Quantity Limits:** For certain drugs, CCA Health California limits the amount of the drug that CCA Health California will cover. For example, CCA Health California provides 30 tablets per prescription for Rabeprazole oral tablet. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, CCA Health California 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, CCA Health California may not cover Drug B unless you try Drug A first. If Drug A does not work for you, CCA Health California 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 3. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line a document that explains 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 CCA Health California 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 CCA Health California's formulary?" on page II-14 for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. CCA Health California pays for certain OTC drugs.

DRUG NAME	STRENGTH	DOSAGE FORM
CETIRIZINE HCL	5 MG/ML	SOLUTION
CETIRIZINE HCL	1 MG/ML	SOLUTION
CETIRIZINE HCL	5 MG	TAB CHEW
CETIRIZINE HCL	10 MG	TAB CHEW
CETIRIZINE HCL	5 MG	TABLET
CETIRIZINE HCL	10 MG	TABLET
CETIRIZINE HCL/PSEUDOEPHEDRINE	5 MG-120MG	TAB ER 12H
FEXOFENADINE HCL	30 MG/5 ML	ORAL SUSP
FEXOFENADINE HCL	30 MG	TAB RAPDIS
FEXOFENADINE HCL	60 MG	TABLET
FEXOFENADINE HCL	180 MG	TABLET
FEXOFENADINE/PSEUDOEPHEDRINE	60MG-120MG	TAB ER 12H
FEXOFENADINE/PSEUDOEPHEDRINE	180MG-240MG	TAB ER 24H
KETOTIFEN FUMARATE	0.03%	DROPS
LEVOCETIRIZINE DIHYDROCHLORIDE	5 MG	TABLET
LORATADINE	5 MG/5 ML	SOLUTION
LORATADINE	5 MG	TAB CHEW
LORATADINE	10 MG	TAB RAPDIS
LORATADINE	10 MG	TABLET
LORATADINE/PSEUDOEPHEDRINE	5 MG-120MG	TAB ER 12H
LORATADINE/PSEUDOEPHEDRINE	10MG-240MG	TAB ER 24H
OLOPATADINE HCL	0.70 %	DROPS
OLOPATADINE HCL	0.20 %	DROPS
OLOPATADINE HCL	0.10 %	DROPS

CCA Health California will provide these OTC drugs at no cost to you. The cost to CCA Health California of these OTC drugs will not count toward your total Part D drug costs (that is, the cost of the OTC drugs does not count for the coverage gap).

What if my drug is not on the Formulary?

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

If you learn that CCA Health California does not cover your drug, you have two options:

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

- You can ask CCA Health California 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 CCA Health California's Formulary?

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

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

- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, CCA Health California 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, CCA Health California will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. 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.

In circumstances where a beneficiary is changing from one treatment setting to another, CCA Health will ensure a fast process for approving non-formulary Part D drugs. This process shall also apply to formulary Part D drugs that require prior authorization or step-therapy. Examples of level of care changes are: beneficiaries who are discharged from a hospital to a home; beneficiaries who end their skilled nursing facility Medicare Part A stay and who need to revert to their Part D plan formulary; beneficiaries who end a long-term care facility stay and return to the community; and, beneficiaries who are discharged from psychiatric hospitals with medication regimens that are highly individualized.

CCA Health contracted pharmacies can insert an industry standard submission code at the point of sale to override the formulary restrictions. CCA Health contracted PBM's (MedImpact) after hours service will provide pharmacies with access to representatives who can override pharmacy claims processing issues. This access will allow pharmacies the ability to override claims at the point-of-sale and ensure beneficiaries receive reliable access to medications.

For more information

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

If you have questions about CCA Health California, 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.

CCA Health California Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by CCA Health California. If you have trouble finding your drug in the list, turn to the Index that begins on page I-1.

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

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

Abbreviation	Description	Explanation
PA	Prior Authorization Restriction	You (or your physician) are required to get prior authorization from CCA Health before you fill your prescription for this drug. Without prior approval, CCA Health may not cover this drug.
PA BvD	Prior Authorization Restriction for	This drug may be eligible for payment under Medicare Part B or Part D. You (or your physician) are required to get prior authorization

	Part B vs Part D Determination	from CCA Health to determine that this drug is covered under Medicare Part D before you fill your prescription for this drug. Without prior approval, CCA Health may not cover this drug.
PA-HRM	Prior Authorization Restriction for High Risk Medications	This drug has been deemed by CMS to be potentially harmful and therefore, a High Risk Medication for Medicare beneficiaries 65 years or older. Members age 65 yrs or older are required to get prior authorization from CCA Health before you fill your prescription for this drug. Without prior approval, CCA Health may not cover this drug
PA NSO	Prior Authorization Restriction for New Starts Only	If you are a new member or if you have not taken this drug before, you (or your physician) are required to get prior authorization from CCA Health before you fill your prescription for this drug. Without prior approval, CCA Health may not cover this drug.
PA NSO-HRM	Prior Authorization Restriction for High Risk Medications and for New Starts Only	This drug has been deemed by CMS to be potentially harmful and therefore, a High Risk Medication for Medicare beneficiaries 65 years or older. Members age 65 yrs or older are required to get prior authorization from CCA Health before you fill your prescription for this drug. Without prior approval, CCA Health may not cover this drug.
QL	Quantity Limit Restriction	CCA Health limits the amount of this drug that is covered per prescription, or within a specific time frame.
ST	Step Therapy Restriction	Before CCA Health will provide coverage for this drug, you must first try another drug(s) to treat your medical condition. This drug may only be covered if the other drug(s) does not work for you.
EX	Excluded Part D Drug	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
LA	Limited Access Drug	This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 888-254-9907. TTY users should call 888-254-9907.
Abbreviation	**Description**	**Explanation**
GC	Gap Coverage	We provide coverage of this prescription drug in the coverage gap. Choice Plan 001 covers GAP coverage for Tier 1 and 2 Choice Plan 002 covers GAP coverage for Tier 1 Plus Plan 003 does not have Gap coverage.

		Please refer to our Evidence of Coverage for more information about this coverage.
GC*	Additional Gap Coverage	We provide coverage of this prescription drug in the coverage gap. Choice Plan 001 covers GAP coverage for Tier 1 and 2 Plus Plan 003, does not have Gap coverage. Please refer to our Evidence of Coverage for more information about this coverage.
NEDS	Non-Extended Days Supply	You may be able to receive greater than a 1- month supply of most of the drugs on your formulary via mail order or retail at a reduced cost share. Drugs not available for extended days supply (greater than 1-month supply) via your mail order or retail pharmacy benefit are noted with "NEDS" in the Requirements/Limits column of your formulary.
HI	Home Infusion Drug	This prescription drug may be covered under our medical benefit. For more information, call
AGE	Age limit Restriction	This prescription drug will be limited to certain age groups.
CB	Capped Benefit	This drug has a maximum benefit.

This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

Drug Name	**Drug Tier**	**Requirements/Limits**
sildenafil oral tablet 100 mg (Viagra)	2	Quantity Limits (maximum 6 tablets per 30 days)
sildenafil oral tablet 50 mg (Viagra)	2	Quantity Limits (maximum 6 tablets per 30 days)
sildenafil oral tablet 25 mg (Viagra)	2	Quantity Limits (maximum 6 tablets per 30 days)

Copayments/Coinsurance for members of Choice (HMO), Plan 001 in San Joaquin County:

Tier	**Description**	**Copayment/Coinsurance**	
		30 day supply	90 day supply
Tier 1	Preferred Generic	$0	$0
Tier 2	Generic	$4	$8

Tier 3	Preferred Brand	$40	$80
Tier 4	Non-Preferred Drug	$100	$200
Tier 5	Specialty Tier	33%	Not Applicable

Copayments/Coinsurance for members of Choice (HMO), Plan 002 in Santa Clara County:

Tier	Description	Copayment/Coinsurance	
		30 day supply	90 day supply
Tier 1	Preferred Generic	$0	$0
Tier 2	Generic	$7	$14
Tier 3	Preferred Brand	$45	$90
Tier 4	Non-Preferred Drug	$100	$200
Tier 5	Specialty Tier	33%	Not Applicable

Copayments/Coinsurance for members of Plus (HMO), Plan 003 in San Joaquin and Santa Clara Counties:

Tier	Description	Copayment/Coinsurance	
		30 day supply	90 day supply
Tier 1	Preferred Generic	$0	$0
Tier 2	Generic	25%	25%
Tier 3	Preferred Brand	25%	25%
Tier 4	Non-Preferred Drug	25%	25%
Tier 5	Specialty Tier	25%	Not Applicable

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

Cuando esta lista de medicamentos (formulario) dice "nosotros", "nos" o "nuestro/a", hace referencia a CCA Health California. Cuando dice "plan" o "nuestro plan", hace referencia a Choice (HMO) San Joaquin (Plan 001), Choice (HMO) Santa Clara (Plan 002) o Plus (HMO) Plan 003.

Este documento incluye la lista de medicamentos (formulario) de nuestro plan, que está vigente desde el 12/01/2022. Para obtener el formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de la portada y la portada posterior.

En general, debe utilizar las farmacias de la red para usar su beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias o los copagos/coseguros pueden cambiar el 1 de enero de 2023 y, ocasionalmente, durante el año.

¿Qué es el formulario de CCA Health California?

El formulario es una lista de medicamentos cubiertos seleccionados por CCA Health California con la colaboración de un equipo de proveedores de atención médica, que representa los tratamientos recetados que se cree que son parte necesaria de un programa de tratamiento de calidad. Por lo general, CCA Health California cubrirá los medicamentos incluidos en el formulario, siempre y cuando el medicamento sea necesario por motivos médicos, se abastezca la receta en una farmacia de la red de CCA Health California y se cumpla con otras normas del plan. Para obtener más información sobre cómo abastecer una receta, consulte su Evidencia de cobertura.

¿Puede cambiar el formulario (la lista de medicamentos)?

La mayoría de los cambios en la cobertura para medicamentos ocurren el 1 de enero, pero podemos agregar o eliminar medicamentos de la Lista de medicamentos durante el año, moverlos a un nivel de costo compartido diferente o agregar nuevas restricciones. Debemos seguir las reglas de Medicare al hacer estos cambios.

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

- **Nuevos medicamentos genéricos.** Podemos eliminar de inmediato un medicamento de marca en nuestra Lista de medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de costo compartido o uno menor y con las mismas restricciones o menos. Además, al agregar el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero moverlo inmediatamente a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente está tomando ese medicamento de marca, es posible que no le informemos con anticipación antes de hacer ese cambio, pero luego le brindaremos información sobre los cambios específicos que hemos realizado.

    - Si hacemos dicho cambio, usted o el emisor de la receta pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción. También puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de CCA Health California?".

- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos (FDA) considera que un medicamento de nuestro formulario no es seguro o si el fabricante del medicamento lo retira del mercado, inmediatamente lo eliminaremos de nuestro formulario y les proporcionaremos un aviso 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 agregar un nuevo medicamento genérico para reemplazar un medicamento de marca actualmente incluido en el formulario, agregar nuevas restricciones al medicamento de marca o moverlo a un nivel de costo compartido diferente o ambos. O podemos hacer cambios basadosen nuevas pautas clínicas. Si eliminamos medicamentos de nuestro formulario, agregamos autorizaciones previas, límites de cantidad o restricciones de terapia escalonada en relación con un medicamento o si pasamos un medicamento a un nivel de costo compartido superior, debemos notificar sobre el cambio a los miembros afectados al menos 30 días antes de que el cambio entre en vigencia o cuando el miembro solicite un reabastecimiento del medicamento, momento en el cual el miembro recibirá un suministro del medicamento para 30 días.

    - Si hacemos estos otros cambios, usted o el emisor de la receta pueden solicitarnos que hagamos una excepción y sigamos cubriendo el medicamento de marca para usted. El aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción. También puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de CCA Health California?".

Cambios que no lo afectarán si actualmente está tomando un medicamento. Por lo general, si toma un medicamento que se encuentra en nuestro formulario de 2022 y que estaba cubierto al comienzo del año, no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2022, excepto lo descrito anteriormente. Esto significa que estos medicamentos continuarán estando disponibles al mismo costo compartido y sin nuevas restricciones para aquellos miembros que lo tomen por el resto del año de cobertura. Este año no recibirá un aviso directo sobre cambios que no le afecten. Sin embargo, el 1 de enero del próximo año, dichos cambios lo afectarían, y es importante que consulte la Lista de medicamentos para el nuevo año de beneficios para ver si hay cambios en los medicamentos.

El formulario adjunto está vigente desde el 12/01/2022. Para obtener información actualizada sobre los medicamentos cubiertos por CCA Health California, póngase en contacto con nosotros. Nuestra información de contacto aparece en las páginas de la portada y la portada posterior. Todos los meses, CCA Health California le envía por correo un informe que se denomina la "Explicación de beneficios" o "EOB". La EOB le informa el monto total que gastó en sus medicamentos con receta y el monto total que nosotros pagamos por cada uno de sus medicamentos con receta durante el mes. Junto con su EOB, le enviaremos un "Aviso de cambios del formulario" en caso de que haya habido cambios recientes en este. Además, todos los cambios en el formulario se incluirán en el formulario actualizado mensualmente que se encuentra disponible en nuestra página web en www.ccahealthca.org.

¿Cómo utilizo el formulario?

Hay dos formas para encontrar un medicamento dentro del formulario:

Afección
El formulario comienza en la página 1. Los medicamentos en este formulario están agrupados en categorías según el tipo de afecciones que traten. Por ejemplo, los medicamentos utilizados para tratar una enfermedad cardíaca están incluidos en la categoría Agentes cardiovasculares. Si usted sabe para qué se utiliza el medicamento, busque el nombre de la categoría en la lista que comienza en la página 3. Luego, busque su

medicamento bajo el nombre de esa categoría.

Listado alfabético
Si no está seguro de la categoría donde debe buscar, busque su medicamento en el Índice que comienza en la página I-1. El Índice proporciona un listado alfabético de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca como los genéricos se encuentran en el Índice. Consulte el Índice y busque su medicamento. Junto al medicamento, verá el número de página donde puede encontrar la información de cobertura. Vaya a la página que aparece en el Índice y busque el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

CCA Health California cubre tanto los medicamentos de marca como los genéricos. Un medicamento genérico está aprobado por la FDA, ya que se considera que tiene el mismo ingrediente activo que el medicamento de marca. En general, los medicamentos genéricos cuestan menos que los de marca.

¿Hay alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos adicionales o límites en la cobertura. Estos requisitos y límites pueden incluir lo siguiente:

- **Autorización previa:** CCA Health California exige que usted o su médico obtengan una autorización previa para determinados medicamentos. Esto significa que debe contar con la aprobación de CCA Health California antes de abastecer sus recetas. Si no obtiene la autorización, es posible que CCA Health California no cubra el medicamento.

- **Límites de cantidad:** Para determinados medicamentos, CCA Health California limita la cantidad del medicamento que cubrirá CCA Health California. Por ejemplo, CCA Health California suministra 30 comprimidos por receta de rabeprazol en comprimidos por vía oral. Esto puede ser complementario a un suministro estándar para un mes o tres meses.

- **Terapia escalonada:** En algunos casos, CCA Health California requiere que usted primero pruebe determinados medicamentos para tratar su afección antes de que cubramos otro medicamento para esa afección. Por ejemplo, si el medicamento A y el medicamento B tratan su afección, es posible que CCA Health California no cubra el medicamento B a menos que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, entonces CCA Health California cubrirá el medicamento B.

Puede averiguar si su medicamento tiene requisitos adicionales o límites consultando el formulario que comienza en la página 3. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos ingresando en nuestra página web. Hemos publicado un documento en línea que explica nuestra autorización previa y las restricciones de terapia escalonada. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de la portada y la portada posterior.

Puede pedirle a CCA Health California que haga una excepción a estas restricciones o límites, o puede solicitarle una lista de otros medicamentos similares que puedan tratar su afección. Consulte la sección "¿Cómo solicito una excepción al formulario de CCA Health California?" en la página II-23 para obtener información sobre cómo solicitar una excepción.

¿Qué son los medicamentos de venta libre (OTC)?

Los medicamentos de venta libre son medicamentos sin receta que, por lo general, no cubre un plan de medicamentos con receta de Medicare. CCA Health California cubre determinados medicamentos de venta libre.

NOMBRE DEL MEDICAMENTO	CONCENTRACIÓN	PRESENTACIÓN
CETIRIZINE HCL	5 mg/ml	SOLUCIÓN
CETIRIZINE HCL	1 mg/ml	SOLUCIÓN
CETIRIZINE HCL	5 mg	COMP. MASTICABLE
CETIRIZINE HCL	10 mg	COMP. MASTICABLE
CETIRIZINE HCL	5 mg	COMPRIMIDO
CETIRIZINE HCL	10 mg	COMPRIMIDO
CETIRIZINE HCL/PSEUDOEPHEDRINE	5 mg-120 mg	COMP. LIB. PROL. 12H
FEXOFENADINE HCL	30 mg/5 ml	SUSP. ORAL
FEXOFENADINE HCL	30 mg	COMP. DIS. RÁP.
FEXOFENADINE HCL	60 mg	COMPRIMIDO
FEXOFENADINE HCL	180 mg	COMPRIMIDO
FEXOFENADINE/PSEUDOEPHEDRINE	60 mg-120 mg	COMP. LIB. PROL. 12H
FEXOFENADINE/PSEUDOEPHEDRINE	180 mg-240 mg	COMP. LIB. PROL. 24H
KETOTIFEN FUMARATE	0.03 %	GOTAS
LEVOCETIRIZINE DIHYDROCHLORIDE	5 mg	COMPRIMIDO
LORATADINE	5 mg/5 ml	SOLUCIÓN
LORATADINE	5 mg	COMP. MASTICABLE
LORATADINE	10 mg	COMP. DIS. RÁP.
LORATADINE	10 mg	COMPRIMIDO
LORATADINE/PSEUDOEPHEDRINE	5 mg-120 mg	COMP. LIB. PROL. 12H
LORATADINE/PSEUDOEPHEDRINE	10 mg-240 mg	COMP. LIB. PROL. 24H
OLOPATADINE HCL	0.70 %	GOTAS
OLOPATADINE HCL	0.20 %	GOTAS
OLOPATADINE HCL	0.10 %	GOTAS

CCA Health California le proporcionará estos medicamentos de venta libre sin costo. El costo de estos medicamentos de venta libre para CCA Health California no se tiene en cuenta para los costos totales de los medicamentos de la Parte D (es decir, el costo de los medicamentos de venta libre no se tiene en cuenta para la etapa del periodo sin cobertura).

¿Qué sucede si mi medicamento no está incluido en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con el Departamento de Servicios para los miembros y consultar si su medicamento está cubierto.

Si resulta que CCA Health California no cubre su medicamento, tiene dos opciones:

- Puede pedirle al Departamento de Servicios para los miembros una lista de medicamentos similares cubiertos por CCA Health California. Al recibir la lista, muéstresela a su médico y pídale que le recete un medicamento similar cubierto por CCA Health California.

- Puede pedirle a CCA Health California que haga una excepción y cubra su medicamento. Consulte la información debajo sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al formulario de CCA Health California?

Puede solicitar a CCA Health California que haga una excepción a las reglas de cobertura. Existen varios tipos de excepciones que puede solicitarnos.

- Puede solicitarnos que cubramos un medicamento incluso si este no se encuentra en nuestro formulario. Si se aprueba, el medicamento estará cubierto a un nivel de costo compartido determinado previamente, y no podrá solicitar que se proporcione a un nivel de costo compartido menor.

- Puede solicitarnos que cubramos un medicamento del formulario a un nivel de costo compartido menor si este medicamento no está en el nivel de medicamentos especializados. Si se aprueba, esto reduciría el monto que usted debe pagar por su medicamento.

- Puede solicitarnos que no se apliquen restricciones o límites de cobertura en su medicamento. Por ejemplo, para un determinado medicamento, CCA Health California limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitarnos que no apliquemos el límite y que cubramos una cantidad mayor.

Generalmente, CCA Health California solo aprobará su solicitud de excepción si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de costo compartido menor o las restricciones de utilización adicionales no fueran tan eficaces para tratar su afección o pudieran causarle efectos médicos adversos.

Debe comunicarse con nosotros para solicitar una decisión de cobertura inicial para una excepción al formulario o a una restricción de utilización. **Cuando solicite una excepción al formulario o a las restricciones de utilización, debe presentar una declaración del emisor de la receta o de su médico que respalde su solicitud.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de obtener la declaración de respaldo del emisor de la receta. Puede solicitar una excepción acelerada (rápida) si usted o su médico consideran que esperar hasta 72 horas para obtener una decisión podría dañar gravemente su salud. Si se le concede la solicitud acelerada, debemos tomar una decisión antes de las 24 horas después de obtener una declaración de respaldo de su médico o de otro emisor de la receta.

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

Como miembro nuevo o que continúa en nuestro plan, es posible que tome medicamentos que no se encuentren en nuestro formulario. También puede suceder que el medicamento se encuentre en nuestro formulario, pero su capacidad de obtenerlo sea limitada. Por ejemplo, es posible que necesite nuestra autorización previa antes de poder abastecer su receta. Debe consultar con su médico para decidir si debe comenzar a tomar un medicamento apropiado que cubramos o solicitar una excepción al formulario para que

cubramos el medicamento que toma. Mientras usted consulta con su médico para determinar la acción más apropiada, podemos cubrir su medicamento en ciertos casos durante los primeros 90 días como miembro de nuestro plan.

Para cada uno de sus medicamentos que no se encuentre en nuestro formulario, o si su capacidad de obtenerlos es limitada, cubriremos un suministro temporal para 30 días. Si su receta está indicada para menos días, permitiremos reabastecimientos hasta llegar a un suministro máximo para 30 días del medicamento. Luego del primer suministro para 30 días, no pagaremos esos medicamentos, incluso si hace menos de *90* días que es miembro del plan.

Si usted es residente de un centro de atención a largo plazo y necesita un medicamento que no se encuentra en nuestro formulario o si su capacidad de obtenerlo es limitada, pero ya pasaron los primeros *90* días como miembro de nuestro plan, cubriremos un suministro de emergencia para *31* días de ese medicamento mientras usted intenta conseguir una excepción al formulario.

En circunstancias en las que un beneficiario cambie de entorno de tratamiento, CCA Health garantizará un proceso rápido para la aprobación de medicamentos de la Parte D que no figuren en el formulario. Este proceso también se aplica a los medicamentos de la Parte D del formulario que requieren autorización previa o terapia escalonada. Algunos ejemplos de cambios en el nivel de atención son los siguientes: beneficiarios que reciben el alta de un hospital y son trasladados a su hogar; beneficiarios que finalizan su estadía en un centro de atención de enfermería especializada (SNF) de la Parte A de Medicare y que necesitan cambiar al formulario del plan de la Parte D; beneficiarios que finalizan su estadía en un centro de atención a largo plazo y regresan a la comunidad; y beneficiarios que reciben el alta de hospitales psiquiátricos con regímenes de medicamentos altamente individualizados.

Las farmacias contratadas por CCA Health pueden ingresar un código de presentación estándar de la industria en el punto de venta para anular las restricciones en el formulario. El servicio fuera del horario de atención del administrador de beneficios de farmacia (PBM), MedImpact, contratado por CCA Health les brinda a las farmacias acceso a representantes que pueden resolver los problemas de procesamiento de las reclamaciones de farmacia. Este acceso les permitirá a las farmacias la posibilidad de anular las reclamaciones en el punto de venta y garantizar que los beneficiarios reciban acceso confiable a los medicamentos.

Para obtener más información

Para obtener información más detallada sobre su cobertura para medicamentos con receta de CCA Health California, revise su Evidencia de cobertura y otros materiales del plan.

Si tiene preguntas sobre CCA Health California, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de la portada y la portada posterior.

Si tiene alguna pregunta general sobre la cobertura para medicamentos con receta de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), durante 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.

Formulario de CCA Health California

El formulario que comienza en la página siguiente brinda información sobre la cobertura de los medicamentos que cubre CCA Health California. Si tiene alguna dificultad para encontrar en la lista el

medicamento que toma, consulte el Índice que comienza en la página I-1.

En la primera columna de esta tabla, se indica el nombre del medicamento. Los medicamentos de marca aparecen en letra mayúscula (por ejemplo, ELIQUIS), y los medicamentos genéricos aparecen en letra minúscula y cursiva (por ejemplo, *simvastatina*).

La información en la columna Requisitos/Límites le indica si CCA Health California tiene algún requisito especial para la cobertura de su medicamento.

Abreviatura	Descripción	Explicación
PA	Restricción de autorización previa	Usted (o su médico) debe obtener autorización previa de CCA Health antes de abastecer la receta para este medicamento. Sin la aprobación previa, es posible que CCA Health no cubra este medicamento.
PA BvD	Restricción de autorización previa para determinación de Parte B frente a Parte D	Este medicamento podría ser elegible para pagarse según la Parte B o la Parte D de Medicare. Usted (o su médico) debe obtener autorización previa de CCA Health a fin de determinar si este medicamento está cubierto en virtud de la Parte D de Medicare antes de abastecer la receta para este medicamento. Sin la aprobación previa, es posible que CCA Health no cubra este medicamento.
PA-HRM	Restricción de autorización previa para medicamentos de alto riesgo	Los Centros de Servicios de Medicare y Medicaid (Centers for Medicare and Medicaid Services, CMS) han considerado que este medicamento es potencialmente dañino, por lo que es un medicamento de alto riesgo para los beneficiarios de Medicare de 65 años o más. Los miembros de 65 años o más deben obtener autorización previa de CCA Health antes de abastecer la receta para este medicamento. Sin la aprobación previa, es posible que CCA Health no cubra este medicamento.
PA NSO	Restricción de autorización previa para nuevos comienzos únicamente	Si usted es un miembro nuevo o si no ha tomado este medicamento antes, usted (o su médico) debe obtener autorización previa de CCA Health antes de abastecer la receta para este medicamento. Sin la aprobación previa, es posible que CCA Health no cubra este medicamento.
PA NSO-HRM	Restricción de autorización previa para medicamentos de alto riesgo y nuevos comienzos únicamente	Los Centros de Servicios de Medicare y Medicaid (Centers for Medicare and Medicaid Services, CMS) han considerado que este medicamento es potencialmente dañino, por lo que es un medicamento de alto riesgo para los beneficiarios de Medicare de 65 años o más. Los miembros de 65 años o más deben obtener autorización previa de CCA Health antes de abastecer la receta para este medicamento. Sin la aprobación previa, es posible que CCA Health no cubra este medicamento.
QL	Restricción de límite de cantidad	CCA Health limita la cantidad de este medicamento que se cubre por receta, o en un plazo específico.

Abreviatura	Descripción	Explicación
ST	Restricción de terapia escalonada	Antes de que CCA Health brinde cobertura para este medicamento, usted deberá probar otro u otros medicamentos para tratar su afección. Es posible que este medicamento esté cubierto únicamente si los otros medicamentos no funcionaron en su caso.
EX	Medicamento excluido de la Parte D	Este medicamento con receta generalmente no está cubierto en un plan de medicamentos con receta de Medicare. El monto que paga cuando abastece una receta no se tiene en cuenta en sus costos totales de medicamentos (es decir, el monto que usted paga no le ayuda a reunir los requisitos para la cobertura en caso de catástrofe). Además, si recibe ayuda adicional para pagar sus medicamentos con receta, no recibirá ninguna ayuda adicional para pagar este medicamento.
LA	Medicamento de acceso limitado	Este medicamento con receta puede estar disponible solo en ciertas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame a Servicios para los miembros al 888-254-9907. Los usuarios de TTY deben llamar al 888-254-9907.
GC	Periodo sin cobertura	Brindamos cobertura para este medicamento con receta durante la etapa del periodo sin cobertura. Choice Plan 001, tiene cobertura para los Niveles 1 y 2. Choice Plan 002, tiene cobertura para el Nivel 1 Plus Plan 003, no tiene cobertura Gap. Consulte la Evidencia de cobertura para obtener más información sobre esta cobertura.
GC*	Periodo adicional sin cobertura	Brindamos cobertura para este medicamento con receta durante la etapa del periodo sin cobertura. Choice Plan 001, tiene cobertura para los Niveles 1 y 2. Plus Plan 003, no tiene cobertura Gap. Consulte la Evidencia de cobertura para obtener más información sobre esta cobertura.
NEDS	Suministro de días sin posibilidad de extensión	Es posible que reciba un suministro para más de 1 mes de la mayoría de los medicamentos que figuran en su formulario a través de un pedido por correo o en un minorista por un costo compartido menor. Los medicamentos que no están disponibles para suministro de días con posibilidad de extensión (suministro para más de 1 mes) a través del beneficio de pedido por correo o de farmacia minorista se indican con la sigla "NEDS" en la columna Requisitos/Límites del formulario.
HI	Medicamento de infusión en el hogar	Este medicamento con receta puede estar cubierto por nuestro beneficio médico. Para obtener más información, comuníquese por teléfono.
AGE	Restricción de límite de edad	Este medicamento con receta se limitará para determinados grupos etarios.
CB	Límite de beneficio	Este medicamento tiene un beneficio máximo.

Este medicamento con receta generalmente no está cubierto en un plan de medicamentos con receta de Medicare. El monto que paga cuando abastece una receta no se tiene en cuenta en sus costos totales de medicamentos (es decir, el monto que usted paga no le ayuda a reunir los requisitos para la cobertura en caso

de catástrofe). Además, si recibe ayuda adicional para pagar sus medicamentos con receta, no recibirá ninguna ayuda adicional para pagar este medicamento.

Nombre del medicamento	Nivel del medicamento	Requisitos/Límites
sildenafil comprimidos por vía oral 100 mg (Viagra)	2	Límites de cantidad (máximo de 6 comprimidos cada 30 días)
sildenafil comprimidos por vía oral 50 mg (Viagra)	2	Límites de cantidad (máximo de 6 comprimidos cada 30 días)
sildenafil comprimidos por vía oral 25 mg (Viagra)	2	Límites de cantidad (máximo de 6 comprimidos cada 30 días)

Copagos/Coseguros para los miembros de Choice (HMO), Plan 001 en el condado de San Joaquin:

Nivel	Descripción	Copago/Coseguro	
		Suministro para 30 días	Suministro para 90 días
Nivel 1	Medicamento genérico preferido	$0	$0
Nivel 2	Medicamento genérico	$7	$14
Nivel 3	Medicamento de marca preferido	$45	$90
Nivel 4	Medicamento no preferido	$100	$200
Nivel 5	Medicamento especializado	33 %	No corresponde

Copagos/Coseguros para los miembros de Choice (HMO), Plan 002 en el condado de Santa Clara:

Nivel	Descripción	Copago/Coseguro	
		Suministro para 30 días	Suministro para 90 días
Nivel 1	Medicamento genérico preferido	$0	$0
Nivel 2	Medicamento genérico	$7	$14
Nivel 3	Medicamento de marca preferido	$45	$90
Nivel 4	Medicamento no preferido	$100	$200
Nivel 5	Medicamento especializado	33 %	No corresponde

Copagos/Coseguros para los miembros de Plus (HMO), Plan 003 en los condados de San Joaquin y Santa Clara:

Nivel	Descripción	Copago/Coseguro	
		Suministro para 30 días	Suministro para 90 días

Nivel 1	Medicamento genérico preferido	$0	$0
Nivel 2	Medicamento genérico	25%	25%
Nivel 3	Medicamento de marca preferido	25%	25%
Nivel 4	Medicamento no preferido	25%	25%
Nivel 5	Medicamento especializado	25%	No corresponde

現有會員請注意：本處方藥一覽表自去年已變更。請閱讀本文件，確保本處方藥一覽表仍然包含您使用的藥物。

本藥物清單（處方藥一覽表）中，凡提述「我們」或「我們的」時，均指 CCA Health California。而「計劃」或「我們的計劃」指代 Choice (HMO) San Joaquin (Plan 001), Choice (HMO) Santa Clara (Plan 002) 或者 Plus (HMO) Plan 003.。

本文件載有我們計劃截至 2022 年 12 月 01 日的藥物清單（處方藥一覽表）。如需獲取最新的處方藥一覽表，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

一般情況下，您必須使用網絡內藥房才能享受處方藥福利。自 2023 年 1 月 1 日起和在該年內，福利、處方藥一覽表、藥房網絡和/或共付額/共同保險可能會不時有所調整。

什麼是 CCA Health California 處方藥一覽表？

處方藥一覽表是 CCA Health California 透過諮詢醫療提供者團隊所選出的受保藥物清單，是高品質治療計劃中不可或缺的處方藥治療。只要具有醫療必要性，且於 CCA Health California 網絡內藥房配藥，並遵守其他計劃規定，CCA Health California 通常會承保列於我們處方藥一覽表中的藥物。要瞭解有關如何按您的處方配藥的更多資訊，請查閱您的「承保範圍說明書」。

處方藥一覽表（藥物清單）是否會變更？

大多數藥物的承保範圍在 1 月 1 日作出更改，但是我們可能會在一年之中添加或刪除藥物清單上的藥物、更改分攤費用等級或增設限制。這些更改必須跟隨 Medicare 的既有規定。

今年可能會影響到您的變更：在下列情況中，您將受到當年承保範圍更改的影響：

- **新的普通藥。**如果我們計劃用新的普通藥取代某一品牌藥，而且這種普通藥出現在相同或更低的分攤費用等級上，並具有相同或更少的限制，我們可能會立即將該品牌藥從藥物清單上移除。另外，在加入新普通藥時，我們可能會決定將該品牌藥保留在藥物清單上，但會立即將其移至其他分攤費用等級或增設限制。如果您正在使用該品牌藥，在作出更改前我們可能不會提前告知您，但是之後我們會向您提供有關我們所作的具體更改的資訊。
    - 如果我們作出更改，您或您的處方醫生可以要求我們作出例外處理並繼續為您承保該品牌藥。我們向您發送的通知將詳細介紹如何申請例外處理，您也可以在後文的「如何申請 CCA Health California 的處方藥一覽表例外處理？」章節中查看更多資訊。
- **藥物退出市場。**若美國食品及藥物管理局認為我們處方藥一覽表上的某種藥物不安全，或藥物製造商從市場中撤除該藥物，我們會立即從我們的處方藥一覽表上刪除該藥物，並向使用該藥物的會員發出通知。
- **其他更改。**我們可能會作出影響目前正在使用藥物的會員的其他更改。例如，我們可能會添加一種新的普通藥以取代處方藥一覽表上現有的品牌藥，或對品牌藥添加新的限制條件，或是將其移至其他費用分攤等級或兩者。我們也可能會根據新的臨床指南作出更改。如果我們從處方

藥一覽表中移除了某些藥物，對某個藥物新增了事先授權、數量限制和/或階段療法限制，或提高某個藥物的費用分攤等級，則我們必須在該更改生效前至少 30 天或在會員要求再次配藥時，向受影響的會員發出通知（該名會員將收到 30 天份的藥物）。

- 如果我們作出其他更改，您或您的處方醫生可以要求我們作出例外處理並繼續為您承保該品牌藥。我們向您發送的通知將詳細介紹如何申請例外處理，您也可以在後文的「如何申請 CCA Health California 的處方藥一覽表例外處理？」章節中查看更多資訊。

如果您正在使用該藥物，這些變更將不會對您產生影響。一般而言，若您正在使用年初享受承保的 2022 年處方藥一覽表上的藥物，我們不會在 2022 年承保年度中終止或減少此藥物的承保，除非出現上文所述情況。換言之，在承保年度的剩餘時間內，此藥物將以相同的分攤費用向使用此藥物的會員提供，且不設新的限制。今年不會直接通知您不影響您的更改。 但是，在明年的 1 月 1 日，這樣的更改將影響您，因此請務必在新福利年度的藥品清單中查看是否有藥品更改。

本文件隨附的處方藥一覽表最後更新於 2022 年 12 月 01 日。如需獲得有關 CCA Health California 承保藥物的最新資訊，請聯絡我們。我們的□ 絡資訊在封面和封底頁均有提供。 CCA Health California 每個月都會向您郵寄一份名為「福利說明」（簡稱「EOB」）的報告。福利說明可告訴您當月您已花費在處方藥上的總金額，以及我們已為您每份處方藥支付的總金額。如果處方藥一覽表近期有所更改，我們會連同福利說明向您寄送一份「處方藥一覽表更改通知」。此外，所有的處方藥一覽表更改將包含在處方藥一覽表的每月更新中，詳見我們的網站 www.ccahealthca.org。

如何使用處方藥一覽表？

有兩種方法在處方藥一覽表中查找您所需的藥物：

病症
處方藥一覽表從第 1 頁開始。本處方藥一覽表中的藥物按照所治療的病症類型分類。例如：用來治療心臟病的藥物列在「心血管藥物」類別。若您瞭解藥物的用途，您可在從第 3 頁開始的清單中查找類別名稱。然後，在此類別名稱下查找所需的藥物。

按字母順序排列的清單
如果您不確定要尋找什麼類別，您可以利用自第 I-1 頁開始的索引來尋找您的藥物。該索引提供一份按字母順序排列的清單，其中有本文件包含的所有藥物。品牌藥和普通藥均列在該索引中。請在該索引中查找所需的藥物。在藥物旁邊，您將看到載有承保資訊的頁碼。轉到該索引中所列的頁碼，在清單的第一欄即可找到所需的藥物名稱。

什麼是普通藥？

CCA Health California 同時承保品牌藥和普通藥。普通藥是一種由 FDA 核准，具有與品牌藥相同活性成分的藥物。通常，普通藥的費用較品牌藥低。

我的承保範圍是否有任何限制？

某些承保藥物可能有其他要求或承保範圍限制。這些要求和限制可能包括：

- **事先授權：**對於某些藥物，CCA Health California 要求您或您的醫生取得事先授權。這表示您將需要在配藥前取得 CCA Health California 的核准。如果您未取得核准，CCA Health California 可能不會承保該藥物。

- **數量限制：**對於某些藥物，CCA Health California 限制了 CCA Health California 承保的藥物數量。例如：對於 Rabeprazole 口服藥片，CCA Health California 會為每份處方提供 30 片。這可以另外附加在標準的一個月或三個月的藥量上。

- **階段療法：**某些情況下，CCA Health California 會要求您先嘗試使用某些藥物治療您的病症，才會承保您使用另外一種藥物。例如，假設藥物 A 和藥物 B 都能治療您的病症，則在您嘗試使用藥物 A 前，CCA Health California 可能不會承保藥物 B。藥物 A 對您無效時，CCA Health California 才會承保藥物 B。

您可以透過第 3 頁開始的處方藥一覽表，查詢您的藥物是否有額外的要求或限制。您也可以前往我們的網站，進一步瞭解關於特定承保藥物限制的資訊。我們已在線上刊載文件，說明我們事先授權和階段療法的限制。您也可以要求我們寄一份給您。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

您可以要求 CCA Health California 對此類限制或使用上限作出例外處理，或索取可能治療您的病症的其他相似藥物清單。請參見第 II-32 頁的「如何申請 CCA Health California 處方藥一覽表例外處理？」章節，瞭解有關例外處理申請方式的資訊。

什麼是非處方 (OTC) 藥？

非處方藥是指無需醫生處方即可獲取的藥物，通常不受 Medicare 處方藥計劃承保。CCA Health California 會為某些非處方藥承保。

藥物名稱	規格	藥物劑型
CETIRIZINE HCL	5 MG/ML	溶液
CETIRIZINE HCL	1 MG/ML	溶液
CETIRIZINE HCL	5 MG	咀嚼片
CETIRIZINE HCL	10 MG	咀嚼片
CETIRIZINE HCL	5 MG	片劑
CETIRIZINE HCL	10 MG	片劑
CETIRIZINE HCL/PSEUDOEPHEDRINE	5 MG-120MG	12 小時緩釋片
FEXOFENADINE HCL	30 MG/5 ML	口服混懸液
FEXOFENADINE HCL	30 MG	速溶片
FEXOFENADINE HCL	60 MG	片劑
FEXOFENADINE HCL	180 MG	片劑
FEXOFENADINE/PSEUDOEPHEDRINE	60MG-120MG	12 小時緩釋片
FEXOFENADINE/PSEUDOEPHEDRINE	180MG-240MG	24 小時緩釋片
KETOTIFEN FUMARATE	0.03%	滴劑
LEVOCETIRIZINE DIHYDROCHLORIDE	5 MG	片劑
LORATADINE	5 MG/5 ML	溶液
LORATADINE	5 MG	咀嚼片
LORATADINE	10 MG	速溶片
LORATADINE	10 MG	片劑
LORATADINE/PSEUDOEPHEDRINE	5 MG-120MG	12 小時緩釋片
LORATADINE/PSEUDOEPHEDRINE	10MG-240MG	24 小時緩釋片
OLOPATADINE HCL	0.70 %	滴劑
OLOPATADINE HCL	0.20 %	滴劑
OLOPATADINE HCL	0.10 %	滴劑

CCA Health California 將免費為您提供這些非處方藥。CCA Health California 為這些非處方藥支付的費用將不計入您的 D 部分藥物總費用（即非處方藥的費用不計入達到承保範圍缺口的金額）。

若處方藥一覽表沒有列出我的藥物，該怎麼辦？

若您的藥物不在此處方藥一覽表（承保藥物清單）上，那麼您首先應該聯絡會員服務部，詢問您的藥物是否在承保範圍內。

如果您得知 CCA Health California 並未承保您的藥物，則您有兩種選擇：

- 向會員服務部索要一份由 CCA Health California 承保的相似藥物清單。收到該清單後請拿給您的醫生看，並要求醫生開處由 CCA Health California 承保的相似藥物。

- 您可以要求 CCA Health California 作出例外處理，並承保您的藥物。請查看以下關於如何申請例外處理的資訊。

如何申請 CCA Health California 處方藥一覽表例外處理？

您可以要求 CCA Health California 對我們的承保規則作出例外處理。您可以向我們提出數種例外處理申請。

- 您可以要求我們承保一種藥物，即使它不在我們的處方藥一覽表上。如獲批准，此藥物將按預定分攤費用等級獲得承保，且您不得要求我們以更低的分攤費用等級提供此藥物。

- 如果此藥物在處方藥一覽表上且不屬特殊藥物，您可要求我們按更低的分攤費用等級承保此藥。如獲批准，這會減少您必須為藥物支付的金額。

- 您可以要求我們撤銷對您的藥物的承保限制。例如，對於某些藥物，CCA Health California 限制了藥物的承保數量。若您的藥物有數量限制，您可以要求我們撤銷限制並承保更多數量。

通常，只有在替代藥物處於計劃的處方藥一覽表上時，或是較低分攤費用的藥物或額外的使用限制對於治療您的病症無法達到相同的效果時，和/或可能造成副作用時，CCA Health California 才會批准您的例外處理申請。

您應當聯絡我們，要求我們做出針對處方藥一覽表或使用限制例外處理的初始承保決定。**在提出針對處方藥一覽表或使用限制例外處理申請時，您應提交一份處方醫生或醫生的聲明以支持您的申請。**通常，我們在收到處方醫生的支持聲明後，必須在 72 小時內做出決定。若您或您的醫生認為等候 72 小時再做出決定會對您的健康造成嚴重傷害，您可以申請加急（快速）例外處理。如果您的加急申請獲得批准，我們在收到您的醫生或其他處方醫生的支持聲明後，必須在 24 小時內為您做出決定。

在向醫生提出變更藥物請求或提交例外處理申請之前，我應該做什麼？

作為我們計劃的新老會員，您可能正在使用我們處方藥一覽表上沒有的藥物。或者，您正在使用一種在我們處方藥一覽表上的藥物，但您獲取該藥物的能力受到限制。例如，您在配藥前可能要獲得我們的事先授權。您應當先和您的醫生談談，以決定您是否應該換用我們承保的適當藥物，或提出處方藥一覽表例外處理申請以使我們承保您使用的藥物。在您與醫生討論以確定何種措施適合您時，我們會在您成為計劃會員後的前 90 天內針對某些情況為您的藥物提供承保。

對於您使用的不在處方藥一覽表上的每種藥物，或因受限而難以足量獲取的藥物，我們將為您承保 30 天的藥量。如果為您開具的處方上藥物供應天數較少，我們將允許補充藥物，以提供最多 30 天份的供藥。在最初的 30 天供藥後，即使您成為計劃會員的天數還不足 *90* 天，我們將不再為這些藥物付費。

如果您居住在長期護理機構且處方藥一覽表沒有列出您所需的藥物，或您獲取藥物時受到限制，但您成為我們計劃的會員已超過 *90* 天，則在您尋求處方藥一覽表例外處理時，我們將會對該藥物承保 *31* 天份的緊急供藥。

如果受益人從一種治療環境轉至另一種環境，CCA Health 將確保遵循快速程序，以核准不在處方藥一覽表中的 D 部分藥物。此程序還適用於要求事先授權或階段療法的處方藥一覽表 D 部分藥物。護理等級變更的示例有：受益人出院回家；受益人結束專業護理機構 Medicare A 部分住院，並且需要恢復使用 D 部分的計劃處方藥一覽表的藥物；受益人結束長期護理機構住院，返回社區中；以及，受益人從精神病院出院，並且使用高度個人化的藥物治療方案。

與 CCA Health 簽有合約的藥房可在銷售點添加行業標準提交代碼，以免除處方藥一覽表上的限制。與 CCA Health 簽有合約的 PBM（藥房福利管理公司，MedImpact）的非工作時間服務會為藥房提供代表的聯絡方式，該代表能夠解決藥房索賠處理問題。這項服務能讓藥房能在銷售點解決索賠問題，確保受益人獲得可靠的藥物補給。

瞭解更多資訊

如需瞭解更多關於 CCA Health California 處方藥承保的詳細資訊，請查看您的「承保範圍說明書」及其他計劃資料。

如果您對 CCA Health California 有任何疑問，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

若您對 Medicare 處方藥承保範圍有任何疑問，請致電 Medicare，電話：1-800-MEDICARE (1-800-633-4227)（全天候開通）。聽障/語障人士可致電 1-877-486-2048。或瀏覽 http://www.medicare.gov。

CCA Health California 處方藥一覽表

從下一頁開始的處方藥一覽表介紹了 CCA Health California 承保藥物的承保資訊。若您在清單中尋找藥物時遇到困難，請閱讀從第 I-1 頁開始的索引。

表格的第一欄列出了藥物名稱。品牌藥用大寫字母表示（例如 ELIQUIS），普通藥則用小寫斜體字母表示（例如 *simvastatin*）。

要求/限制欄中的資訊說明了 CCA Health California 在承保您的藥物時是否有任何特殊要求。

縮寫	描述	說明
PA	事先授權限制	您（或您的醫生）必須先獲得 CCA Health 的事先授權，才可以配取該處方藥。若無事先授權，CCA Health 不會承保該藥物。
PA BvD	B 部分和 D 部分裁決的事先授權限制	此藥物可能享有 Medicare B 部分或 D 部分承保。您（或您的醫生）必須先獲得 CCA Health 的事先授權以裁決 Medicare D 部分是否承保此藥物，才可以配取該處方藥。若無事先授權，CCA Health 不會承保該藥物。
PA-HRM	高風險藥物的事先授權限制	CMS 認為該藥物有潛在危害，因此將它歸為 Medicare 65 歲或以上受益人的高風險藥物。65 歲或以上的會員必須先獲得 CCA Health 的事先授權，才可以配取該處方藥。若無事先授權，CCA Health 不會承保該藥物。
PA NSO	新會員特有的事先授權限制	如果您是新會員或您從未服用過此藥物，則您（或您的醫生）必須先獲得 CCA Health 的事先授權，才可以配取該處方藥。若無事先授權，CCA Health 不會承保該藥物。

縮寫	描述	說明
PA NSO-HRM	高風險藥物和新會員特有的事先授權限制	CMS 認為該藥物有潛在危害，因此將它歸為 Medicare 65 歲或以上受益人的高風險藥物。65 歲或以上的會員必須先獲得 CCA Health 的事先授權，才可以配取該處方藥。若無事先授權，CCA Health 不會承保該藥物。
QL	數量限制	CCA Health 限制了每份處方或指定時期內承保的藥物數量。
ST	階段療法限制	CCA Health 為該藥物提供承保前，您必須先嘗試用其他藥物來治療您的病症。該藥物只有在其他藥物對您無效的情況下才能獲得承保。
EX	被排除的 D 部分藥物	本處方藥物通常不由 Medicare 處方藥計劃承保。您在配取此藥物時所支付的金額不計入您的藥物花費總額（這表示您所支付的金額無法幫您取得災難承保資格）。此外，若您有接受額外補助以支付您的處方藥費用，您將無法為該藥物取得任何額外補助。
LA	具有取藥限制的藥物	本處方藥可能僅在某些藥房提供。如需更多資訊，請查看藥房目錄或致電我們的會員服務部，電話：888-254-9907。聽障/語障人士可致電 888-254-9907。
GC	缺口承保	我們為該處方藥提供承保缺口期間的承保。 Choice 計劃 001，涵蓋第 1 層和第 2 層。 Choice 計劃 002，涵蓋第 1 層 Plus 計劃 003，沒有 Gap 承保範圍。 關於此承保範圍的資訊，請參閱「承保範圍說明書」。
GC*	額外缺口承保	我們為該處方藥提供承保缺口期間的承保。 Choice 計劃 001，涵蓋第 1 層和第 2 層。 Plus 計劃 003，沒有 Gap 承保範圍。 關於此承保範圍的資訊，請參閱「承保範圍說明書」。
NEDS	不延長天數的供藥	您可以透過郵購或零售藥房以優惠價格獲得處方藥一覽表上的大多數藥物，且配取的藥量可大於 1 個月份量。如果藥物不能透過郵購或零售藥房福利享有延長天數供藥（超過 1 個月的份量），在處方藥一覽表的要求/限制欄中將註明「NEDS」。
HI	居家輸液藥物	該處方藥可能受我們的醫療福利承保。如需更多資訊，請致電。
AGE	年齡限制	該處方藥只面向某些年齡群體。
CB	福利限制	該藥物具有最高福利限制。

本處方藥物通常不由 Medicare 處方藥計劃承保。您在配取此藥物時所支付的金額不計入您的藥物花費總額（這表示您所支付的金額無法幫您取得災難承保資）。此外，若您有接受額外補助以支付您的處方藥費用，您將無法為該藥物取得任何額外補助。

藥物名稱	藥物等級	要求/限制

sildenafil oral tablet 100 mg (Viagra)	2	數量限制（每 30 天最多 6 片）
sildenafil oral tablet 50 mg (Viagra)	2	數量限制（每 30 天最多 6 片）
sildenafil oral tablet 25 mg (Viagra)	2	數量限制（每 30 天最多 6 片）

San Joaquin 郡 Choice (HMO), Plan 001 會員的共付額/共同保險：

等級	描述	共付額/共同保險	
		30 天份的藥量	90 天份的藥量
第 1 級	首選普通藥	$0	$0
第 2 級	普通藥	$7	$14
第 3 級	首選品牌藥	$45	$90
第 4 級	非首選藥物	$100	$200
第 5 級	特殊級藥	33%	不適用

Santa Clara 郡 Choice (HMO), Plan 002 會員的共付額/共同保險：

等級	描述	共付額/共同保險	
		30 天份的藥量	90 天份的藥量
第 1 級	首選普通藥	$0	$0
第 2 級	普通藥	$7	$14
第 3 級	首選品牌藥	$45	$90
第 4 級	非首選藥物	$100	$200
第 5 級	特殊級藥	33%	不適用

San Joaquin 和 Santa Clara 郡 Plus (HMO), Plan 003 會員的共付額/共同保險：

等級	描述	共付額/共同保險	
		30 天份的藥量	90 天份的藥量
第 1 級	首選普通藥	$0	$0
第 2 級	普通藥	25%	25%
第 3 級	首選品牌藥	25%	25%
第 4 級	非首選藥物	25%	25%
第 5 級	特殊級藥	25%	不適用

기존 가입자 참고 사항: 이 처방집은 작년 이후 변경되었습니다. 쓰시는 약이 처방집에 계속 포함된 상태인지 확인하기 위해 본 문서를 검토해 주십시오.

이 의약품 목록(처방집)에서 "저희" 또는 "당사"라고 칭할 때 그것은 CCA Health California를 의미합니다. "플랜" 또는 "저희 플랜"이라고 칭하는 것은 Choice (HMO) San Joaquin (Plan 001), Choice (HMO) Santa Clara (Plan 002) 또는 Plus (HMO) Plan 003 를 의미합니다.

이 문서는 2022년 12월 01일 현재 최신인 의약품 목록(처방집)을 포함합니다. 업데이트된 처방집을 원하시면 저희에게 문의해 주십시오. 처방집이 마지막으로 업데이트되었던 날짜와 함께 저희의 연락처 정보가 앞표지와 뒤표지에 표시됩니다.

처방약 혜택을 이용하시려면 일반적으로 네트워크 약국을 이용하셔야 합니다. 혜택, 처방집, 약국 네트워크 및/또는 자기부담금/공동보험액은 zzzz년 1월 1일 수요일 그리고 연중에 수시로 변경될 수 있습니다.

CCA Health California 처방집이란 무엇입니까?

처방집(formulary)은 CCA Health California가 의료제공자 팀과 협의해 선택한 보장약 목록으로서 양질의 치료 프로그램에서 필수적인 부분으로 여겨지는 처방약 치료법을 나타냅니다. CCA Health California는 해당 의약품이 의학적으로 필요하고, 가입자가 CCA Health California 네트워크 약국에서 처방약을 조제하고 기타 플랜 규칙을 준수하는 이상, 일반적으로 처방집에 수록된 의약품을 보장합니다. 처방약 조제에 관한 세부 정보가 궁금하시면 보장범위 증명(Evidence of Coverage, EOC)을 검토해 주십시오.

처방집(의약품 목록)은 변경될 수 있습니까?

대부분의 약 보장에 대한 변경은 1월 1일에 적용되지만, 연중에도 의약품 목록에 약을 추가 또는 제거하거나, 다른 비용 분담 단계로 약을 옮기거나, 새로운 제한을 추가할 수 있습니다. 이러한 변경시 메디케어 규칙을 반드시 따라야만 합니다.

올해에 가입자에게 영향을 줄 수 있는 변경 사항: 다음의 경우, 가입자는 해당 연도에 보장 변경의 영향을 받게 됩니다.

- **새로운 복제 약** 동일하거나 더 낮은 비용 분담 단계에 동일한 제한 또는 더 적은 제한으로 나타날 새로운 복제약으로 대체하는 경우, 당사는 의약품 목록에 있는 브랜드 약을 즉시 제거할 수 있습니다. 또한 새로운 복제약을 추가할 때 의약품 목록에 브랜드 약을 그대로 둘 수 있지만 이 브랜드 약을 다른 비용 분담 단계로 즉시 이동하거나 새로운 제한사항을 추가할 수 있습니다. 만약 귀하가 현재 그 브랜드 약을 복용하고 있다면, 변경 전에 미리 귀하에게 고지되지 않을 수도 있지만, 나중에 귀하께 당사가 만든 구체적인 변경에 대한 정보를 제공할 것입니다.

    - 그러한 변경이 있을 때, 가입자나 담당 처방의는 플랜에 예외 적용을 요구하거나 가입자에 대해 브랜드 약을 계속 보장해줄 것을 요구할 수 있습니다. 귀하께 제공하는 통지서에는 예외를 요청하는 방법에 대한 정보도 포함되어 있으며, "CCA Health California의 처방집에 대한 예외는 어떻게 요청하나요?"라는 제목의 섹션에서도 정보를 확인할 수 있습니다.

- **의약품이 시장에서 없어지는 경우.** 식품의약국이 처방집의 의약품이 안전하지 않다고 여기거나 의약품의 제조사가 시장에서 의약품을 철수하는 경우, 저희는 처방집에서 해당 의약품을 즉시 제외하고 해당 의약품을 복용 중인 가입자에게 관련 안내를 합니다.

- **기타 변경사항.** 저희는 현재 특정 의약품을 복용하는 가입자에게 영향을 줄 수 있는 기타 변경 조치를 취할 수 있습니다. 예를 들어, 현재 처방집에 있는 브랜드 약을 대체할 새로운 복제약을 추가하거나, 브랜드 약에 새로운 제한 사항을 추가하거나, 브랜드 약을 다른 비용 분담 단계로 변경할 수 있습니다. 또는 새로운 임상 지침을 근거로 변경을 할 수도 있습니다 아니면 둘다. 저희가 처방집에서 의약품을 없애거나 사전 승인 요건을 추가하거나 의약품의 분량 제한 및/또는 단계적 치료 제한 요건을 추가하거나 의약품을 상위의 비용 분담액 군으로 이동하는 경우 변경 사항이 발효되기 최소 30일전 또는 가입자가 해당 의약품의 리필을 요청하는 시점에 해당 변경으로 영향을 받게 되는 가입자에게 통지해드리며, 이때 해당 의약품 30일분을 받게 됩니다.

    - 그러한 변경이 있을 때, 가입자나 담당 처방의는 플랜에 예외 적용을 요구하거나 가입자에 대해 브랜드 약을 계속 보장해줄 것을 요구할 수 있습니다. 귀하께 제공하는 통지서에는 예외를 요청하는 방법에 대한 정보도 포함되어 있으며, CCA Health California의 처방집에 대한 예외는 어떻게 요청하나요?"라는 제목의 섹션에서도 정보를 확인할 수 있습니다.

현재 약을 복용하는 경우 귀하에게 영향을 주지 않는 변경 사항입니다. 일반적으로 연초에 보장되었던 2022년 처방집의 의약품을 복용하고 계신 경우, 저희는 2022년 보장연도 동안 해당 의약품 보장을 중단하거나 줄이지 않습니다. 즉, 해당 의약품을 복용하시는 가입자는 남은 보장연도 동안 동일한 비용 분담액으로 해당 약을 계속 이용하실 수 있습니다. 귀하에게 영향을 미치지 않는 변경 사항에 대해서는 올해 직접 통지하지 않습니다. 그러나 다음 해 1 월 1 일에 그러한 변경 사항이 귀하에게 영향을 미치므로 약품에 대한 변경 사항이 있는지 새로운 혜택 연도의 약품 목록을 확인하는 것이 중요합니다.

동봉된 처방집은 2022년 12월 01일 현재 최신입니다. CCA Health California가 보장하는 의약품에 대한 최신 정보를 원하시면 저희에게 연락해 주십시오. 저희 연락처 정보는 앞표지와 뒤표지에 나와 있습니다. 매월 CCA Health California에서 가입자에게 “혜택 설명서” 또는 “EOB”라고 하는 보고서를 우편으로 보내드립니다. 혜택 설명서는 해당 월에 가입자가 처방약에 지불한 총 금액과 가입자의 처방약 각각에 대해 당사가 지불한 총 금액을 알려줍니다. 당사의 처방집에 최근 변경이 있는 경우에는 혜택 설명서와 함께 “처방집 변경 사항 통지”를 보내드립니다. 또한 처방집의 모든 변경 사항은 웹 사이트 www.ccahealthca.org에 매월 업데이트되어 게시되는 처방집에 수록될 것입니다.

처방집은 어떻게 사용합니까?

처방집 안에서 의약품을 찾는 두 가지 방법이 있습니다.

의학적 증상

처방집은 1페이지에서 시작됩니다. 본 처방집의 의약품은 치료를 위해 사용되는 질환 종류에 따라 범주별로 분류됩니다. 예컨대 심장 질환의 치료에 사용되는 의약품은 심혈관계 약제 아래에 수록됩니다. 귀하의 의약품이 어디에 사용되는지 알고 있다면 3페이지에서 시작되는 목록에서 범주명을 찾으십시오. 그 다음 범주명 아래에서 귀하의 의약품이 있는지 찾아보십시오.

알파벳 순서의 목록
찾아야 할 하위 범주가 확실치 않다면 I-1페이지에서 시작되는 색인에서 의약품이 있는지 찾으셔야 합니다. 색인은 이 문서에 포함된 모든 의약품들의 알파벳순 목록을 제공합니다. 브랜드 약과 복제약 모두 색인에 기재되어 있습니다. 색인을 살펴보고 의약품을 찾으십시오. 의약품 이름 옆에 페이지 번호가 있고 그 페이지에서 보장 정보를 찾을 수 있습니다. 색인에 기재된 페이지로 가서 목록의 첫 번째 열에서 약품 명을 찾으십시오.

복제약이란 무엇인가요?

CCA Health California는 브랜드 약과 복제약 모두를 보장합니다. 복제약은 FDA가 브랜드 약과 동일한 활성 성분을 가졌다고 승인한 것입니다. 일반적으로 복제약은 브랜드 약보다 가격이 낮습니다.

제 보장에 어떤 제약이 있습니까?

일부 보장약에는 추가 요건이 있거나 보장 제한이 있습니다. 이러한 요건 및 제한에는 다음 사항이 포함될 수 있습니다.

- **사전 허가:** CCA Health California에서 귀하나 귀하의 의사가 특정 의약품에 대해 사전 허가를 받도록 규정합니다. 이는 처방약을 조제 받기 전 CCA Health California로부터 승인을 받으셔야 한다는 의미입니다. 승인을 얻지 못하면 CCA Health California는 약 비용을 보장하지 않을 수 있습니다.

- **분량 제한:** 특정 의약품의 경우, CCA Health California는 CCA Health California가 보장하게 될 의약품의 양을 제한합니다. 예를 들어, CCA Health California는 Rabeprazole 경구약을 처방전당 30정을 제공합니다. 이것은 기본적인 한달분 또는 석달분에 추가될 수 있습니다.

- **단계적 치료법:** 경우에 따라, CCA Health California에서 해당 질환에 대해 다른 약을 보장해드리기 전에 귀하의 질환을 치료하는 특정 약을 먼저 써보셔야 합니다. 예를 들어 A약과 B약 모두가 귀하의 의학적 증상을 치료하는 경우, CCA Health California는 귀하가 A약을 먼저 써보기 전까지는 B약을 보장하지 않을 수 있습니다. A약이 효과가 없는 경우, CCA Health California는 B약을 보장하게 됩니다.

귀하의 의약품에 어떤 추가 요건이 있는지 또는 제약이 있는지에 대해서는 3페이지에서 시작되는 처방집을 찾아보시면 확인하실 수 있습니다. 또한 보장되는 특정한 의약품에 해당되는 제약 사항에 대한 세부 정보는 저희 웹사이트를 방문하시면 확인하실 수 있습니다 사전 허가와 단계적 치료법 제한에 대해 설명한 온라인 문서를 게시해 두었습니다. 귀하께서는 저희에게 사본을 보내달라고 요청하실 수도 있습니다. 처방집이 마지막으로 업데이트되었던 날짜와 함께 저희의 연락처 정보가 앞표지와 뒤표지에 표시됩니다.

CCA Health California에 이러한 제약 사항 또는 제한의 예외를 요청하시거나 귀하의 질환을 치료할 수 있는 기타 유사한 의약품 목록을 요청하실 수 있습니다. 예외 요청 방법에 대한 정보는 II-40 페이지의 “CCA Health California의 처방집에 대한 예외는 어떻게 요청하나요?” 절을 참조하십시오.

비처방(OTC) 의약품이란 무엇인가요?

OTC 약은 Medicare 처방약 플랜에서 일반적으로 보장하지 않는 비처방약입니다. CCA Health California는 특정 OTC 약에 대한 비용을 지불합니다.

약 이름	강도	투여 형태
CETIRIZINE HCL	5 MG/ML	용액
CETIRIZINE HCL	1 MG/ML	용액
CETIRIZINE HCL	5 MG	씹어먹는 정제
CETIRIZINE HCL	10 MG	씹어먹는 정제
CETIRIZINE HCL	5 MG	정제
CETIRIZINE HCL	10 MG	정제
CETIRIZINE HCL/PSEUDOEPHEDRINE	5 MG-120MG	정제 ER 12H
FEXOFENADINE HCL	30 MG/5 ML	경구 현탁액
FEXOFENADINE HCL	30 MG	정제 RAPDIS
FEXOFENADINE HCL	60 MG	정제
FEXOFENADINE HCL	180 MG	정제
FEXOFENADINE/PSEUDOEPHEDRINE	60MG-120MG	정제 ER 12H
FEXOFENADINE/PSEUDOEPHEDRINE	180MG-240MG	정제 ER 24H
KETOTIFEN FUMARATE	0.03%	드롭스
LEVOCETIRIZINE DIHYDROCHLORIDE	5 MG	정제
LORATADINE	5 MG/5 ML	용액
LORATADINE	5 MG	씹어먹는 정제
LORATADINE	10 MG	정제 RAPDIS
LORATADINE	10 MG	정제
LORATADINE/PSEUDOEPHEDRINE	5 MG-120MG	정제 ER 12H
LORATADINE/PSEUDOEPHEDRINE	10MG-240MG	정제 ER 24H
OLOPATADINE HCL	0.70 %	드롭스
OLOPATADINE HCL	0.20 %	드롭스
OLOPATADINE HCL	0.10 %	드롭스

CCA Health California는 이러한 OTC 약을 가입자의 비용 부담없이 제공해드립니다. CCA Health California에서 부담하는 이러한 OTC 약의 비용은 귀하의 총 파트 D 약 비용에 산정되지 않습니다 (즉, OTC 약 비용은 보장 공백에 대해 누적되지 않음).

제 약이 처방집에 없으면 어떻게 하나요?

귀하의 의약품이 본 처방집(보장 약 목록)에 포함되어 있지 않은 경우, 먼저 가입자 서비스부에 연락해 귀하의 약이 보장되는지 문의하셔야 합니다.

CCA Health California가 귀하의 약을 보장하지 않는다는 것을 아셨다면, 두 가지 선택권이 있습니다.

- 가입자 서비스부에 CCA Health California가 보장하는 유사한 의약품 목록을 요청하실 수 있습니다. 이 목록을 받으시면 담당 의사에게 보여주시고,CCA Health California가 보장하는 유사한 의약품을 처방하도록 요청하십시오.
- 해당 약을 보장해달라는 예외를 적용해 달라고 CCA Health California에 요청할 수 있습니다. 예외 요청 방법에 관한 정보는 아래를 참조하십시오.

CCA Health California의 처방집에 대한 예외는 어떻게 요청하나요?

보장 규칙에 예외를 적용해 달라고 CCA Health California에 요청할 수 있습니다. 요청하실 수 있는 몇 가지 유형의 예외가 있습니다.

- 약이 처방집에 없는 경우라도 의약품 보장을 요청하실 수 있습니다. 승인을 받으면, 이 의약품은 사전에 결정된 비용 분담액 수준으로 보장되어, 더 낮은 비용 분담 수준으로 의약품을 제공하라고 요청하실 수 없을 것입니다.
- 이 의약품이 특수 분류에 없다면, 처방집 약을 더 낮은 비용 분담 수준으로 보장하도록 요청하실 수 있습니다. 승인된다면, 이러한 요청으로 귀하가 의약품에 지불해야 하는 금액이 낮춰질 것입니다.
- 저희에게 보장 제약이나 귀하의 의약품에 대한 제한을 면제하도록 요청하실 수 있습니다. 예컨대 특정 의약품의 경우, CCA Health California에서는 보장할 의약품의 양을 제한합니다. 귀하의 의약품에 분량 제한이 있다면, 저희에게 제한 철회와 더 많은 분량에 대한 보장을 요청하실 수 있습니다.

일반적으로 CCA Health California의 처방집에 포함된 대안적 의약품, 더 낮은 비용 분담액의 의약품 또는 의약품 사용에 관한 추가적 제한이 질환을 치료하는 데 있어 그만큼 효과적이지 않을 수 있거나 귀하에게 부정적인 의학적 효과를 야기할 수 있다면, 예외 요청을 승인할 것입니다.

저희에게 연락해 처방집에 대한 초기 보장 결정을 요청하시거나 의약품 사용 제한 예외를 요청하셔야 합니다. **처방집이나 의약품 사용 제한 예외를 요청하실 때, 그러한 요청을 뒷받침하는 처방자나 의사의 진술서를 제출하셔야 합니다.** 일반적으로 저희는 처방자의 근거 진술서를 획득한 지 72시간 내에 결정을 내려야 합니다. 귀하 또는 담당 의사가 결정에 대해 72시간까지 기다리는 것이 귀하의 건강을 심각하게 해칠 수 있을 것으로 믿는 경우, 귀하는 신속(빠른) 예외를 요청할 수 있습니다. 귀하의 신속 요청이 허가되는 경우, 저희는 담당 의사나 다른 처방자의 근거 진술서를 획득한 지 늦어도 24시간 내에 귀하에게 결정 내용을 전달해야 합니다.

저의 약을 변경하거나 예외를 요청하는 문제에 대해 의사와 상의하기 전 저는 어떻게 대처하나요?

저희 플랜의 신규 또는 기존 가입자로서 귀하는 처방집에 없는 의약품을 복용하고 계실 수도 있습니다. 또는 처방집에 있으나 이용에 제약이 있는 약을 복용하고 계실 수도 있습니다. 예컨대 처방전을 조제 받기 전, 저희로부터 사전 허가를 받으셔야 하는 경우입니다. 귀하께서는 보장이 되는 적절한 약으로 전환을 요청해야 하는지 아니면 복용하시는 약을 저희가 보장해주도록 처방집 예외 요청을 해야 하는지 담당 의사와 상의하셔야 합니다. 어떤 조치가 올바른지 담당 의사와 상의하시는 동안 귀하께서 저희 플랜 가입 후 최초 90일 동안은 경우에 따라 귀하의 약을 보장해드립니다.

저희 처방집에 없는 의약품이거나, 수령할 수 있는 의약품이 제한적일 경우 임시로 30일분을 보장할 것입니다. 처방전이 그보다 적은 기간에 대해 작성된 경우, 최대 30일치 약을 제공하기 위해 여러

차례 리필을 허락할 것입니다. 최초 30일분이 제공된 후에는 귀하가 *90*일이 안 된 플랜 가입자라도 이러한 의약품에 대해 저희가 더 이상 비용 지불을 하지 않습니다.

장기 치료 시설에 거주하고 있는 가입자로서 처방집에 없는 의약품이 필요하시거나 의약품 이용에 제약이 있지만, 플랜에 가입한 지 *90*일이 지난 상태에서 처방집 예외를 요청하시는 경우라면 저희는 *31*일분의 의약품 응급 공급분을 보장합니다.

수혜자가 치료 환경을 바꾸는 경우, CCA Health은 처방집에 없는 파트 D 약을 신속히 승인할 수 있도록 할 것입니다. 사전 허가나 단계적 치료법이 필요한 처방집 파트 D 약에도 이 절차를 적용합니다. 치료 수준 변경의 예: 병원에서 집으로 퇴원한 수혜자, 전문 요양 시설 Medicare 파트 A 이용 체류가 종료되고 파트 D 플랜 처방집으로 복귀해야 하는 수혜자, 장기 치료 시설 체류가 종료되고 지역으로 돌아오는 수혜자, 고도로 개별화된 약물 요법을 하는 정신병원에서 퇴원한 수혜자.

CCA Health 제휴 약국은 처방집 제한사항을 우선하기 위해 판매처에서 업계 표준 제출 코드를 삽입할 수 있습니다. CCA Health와 제휴한 PBM(MedImpact)의 영업 시간 이후 서비스는 약국이 약국 청구 처리 문제를 결정할 수 있는 담당자를 이용할 수 있도록 합니다. 이를 통해 약국은 판매처에서 청구건에 대해 최종 결정을 할 수 있으며 가입자가 의약품을 신뢰하고 이용할 수 있도록 할 것입니다.

자세한 정보

CCA Health California 처방약 보장에 관한 더욱 세부적인 정보가 궁금하시면 보장범위 증명과 기타 플랜 자료를 검토해 주십시오.

CCA Health California에 대한 질문은 저희에게 문의해 주십시오. 처방집이 마지막으로 업데이트되었던 날짜와 함께 저희의 연락처 정보가 앞표지와 뒤표지에 표시됩니다.

Medicare 처방약 보장에 관한 일반적인 궁금증은 Medicare 전화 1-800-MEDICARE (1-800-633-4227)번으로 주 7일, 하루 24시간 언제든 연락해 주십시오. TTY 이용자는 1-877-486-2048번으로 전화해 주십시오. 또는 http://www.medicare.gov를 방문해 주십시오.

CCA Health California 처방집

다음 페이지에서 시작되는 처방집에는 CCA Health California가 보장하는 일부 의약품에 대한 보장 정보가 제공됩니다. 이 목록에서 의약품을 찾는 데 어려움이 있는 경우, I-1 페이지부터 시작되는 색인을 참조하시기 바랍니다.

표의 첫 번째 열에 의약품 이름이 나와 있습니다. 브랜드 약은 대문자로 되어 있고(예: ELIQUIS), 복제약은 소문자 기울임꼴로 되어 있습니다(예: *simvastatin*).

요건/제한 열에 나와 있는 정보는 CCA Health California에서 의약품 보장에 특별한 요건을 두는지를 알려줍니다.

약어	설명	설명
PA	사전 승인 제한 사항	가입자는 이 의약품에 대한 처방 조제를 받기 전에 CCA Health으로부터 사전 승인을 받아야 합니다. 사전 승인을 얻지 못하면 CCA Health은 이 의약품 비용을 보장하지 않을 수 있습니다.
PA BvD	파트 B 및 파트 D 결정에 대한 사전 승인 제한 사항	이 의약품은 상황에 따라 Medicare 파트 B 또는 D에서 보장될 수 있습니다. 가입자(또는 주치의)는 이 의약품에 대한 처방 조제를 받기 전에 CCA Health으로부터 사전 허가를 받아야 합니다. 사전 승인을 얻지 못하면 CCA Health은 이 의약품 비용을 보장하지 않을 수 있습니다.
PA-HRM	고위험 약에 대한 사전 승인 제한 사항	이 의약품은 CMS가 잠정적 위험이 있는 것으로 판단했으며 65세 이상의 Medicare 수혜자에게 고위험 의약품으로 간주했습니다. 65세 이상의 가입자는 이 의약품에 대한 처방 조제를 받기 전에 CCA Health으로부터 사전 승인을 받아야 합니다. 사전 승인을 얻지 못하면 CCA Health은 이 의약품 비용을 보장하지 않을 수 있습니다.
PA NSO	신규 이용에 대한 사전 승인 제한 사항	신규 가입자이거나 이 의약품을 복용한 적이 없다면, 가입자(또는 담당 의사)는 처방약을 조제하기 전에 CCA Health의 사전 승인을 받아야 합니다. 사전 승인을 얻지 못하면 CCA Health은 이 의약품 비용을 보장하지 않을 수 있습니다.
PA NSO-HRM	고위험 약 및 신규 이용에 대한 사전 승인 제한 사항	이 의약품은 CMS가 잠정적 위험이 있는 것으로 판단했으며 65세 이상의 Medicare 수혜자에게 고위험 의약품으로 간주했습니다. 65세 이상의 가입자는 이 의약품에 대한 처방 조제를 받기 전에 CCA Health으로부터 사전 승인을 받아야 합니다. 사전 승인을 얻지 못하면 CCA Health은 이 의약품 비용을 보장하지 않을 수 있습니다.
QL	수량 제한 사항	CCA Health은 처방전으로 보장되는 이 의약품의 양 또는 기한을 제한합니다.
ST	단계적 치료법 제한 사항	CCA Health이 이 의약품에 대해 보장을 제공하기 전에, 가입자는 질병 치료를 위해 다른 약을 먼저 사용해보아야 합니다. 다른 약이 효능이 없는 경우에만 이 약이 보장됩니다.
EX	제외된 Medicare 파트 D 약	이 처방약은 일반적으로 Medicare 처방약 플랜으로 보장되지 않습니다. 이 처방약을 조제할 때 가입자가 지불하는 금액은 총 의약품 비용에 포함되지 않습니다(즉, 지불하는 금액은 재해성 보장에 포함되지 않음). 또한 처방약 비용을 지불하기 위해 추가 지원을 받고 있다면 이 약 비용을 위해 추가 지원을 받지 못합니다.

약어	설명	설명
LA	이용이 제한적인 의약품	이 처방약은 특정 약국에서만 구할 수 있습니다. 보다 자세한 정보는 약국 명부를 참조하시거나 가입자 서비스부에 1-888-254-9907번으로 문의해 주십시오. TTY 사용자는 888-254-9907번으로 전화하셔야 합니다.
GC	보장 공백 보장	보장 공백 중에 이 처방약의 보장을 제공해드립니다. Choice Plan 001은 계층 1 및 2에 대한 보장이 있습니다. Choice Plan 002, Tier 1에 대한 보장이 있습니다. Plus 003에는 갭 보장이 없습니다. 본 보장에 대한 자세한 정보는 보장범위 증명을 참조해 주십시오.
GC*	추가 보증 공백	보장 공백 중에 이 처방약의 보장을 제공해드립니다. Choice Plan 001은 계층 1 및 2에 대한 보장이 있습니다. Plus 003에는 갭 보장이 없습니다. 본 보장에 대한 자세한 정보는 보장범위 증명을 참조해 주십시오.
NEDS	비장기간 조제	처방집에 있는 대부분의 약은 1개월분 이상을 할인된 공동 분담액으로 소매 약국에서 또는 우편 주문을 통해 수령할 수 있습니다. 우편 주문 또는 소매 약국 혜택을 통한 장기 공급(1개월 이상 공급)에 해당되지 않는 약은 처방집의 요구 사항/제한 열에 "NEDS"으로 표시됩니다.
HI	가정 주입 의약품	이 처방약은 당사의 의료 혜택으로 보장을 받을 수 있습니다. 자세한 정보는 전화로 문의하십시오.
AGE	연령 제한 사항	이 처방약은 특정 연령 그룹으로 제한됩니다.
CB	혜택 한도	이 의약품에는 최대 혜택 한도가 있습니다.

이 처방약은 일반적으로 Medicare 처방약 플랜으로 보장되지 않습니다. 이 처방약을 조제할 때 가입자가 지불하는 금액은 총 의약품 비용에 포함되지 않습니다(즉, 지불하는 금액은 재해성 보장에 포함되지 않음). 또한 처방약 비용을 지불하기 위해 추가 지원을 받고 있다면 이 약 비용을 위해 추가 지원을 받지 못합니다.

의약품 이름	의약품 단계	요건/제한 사항
sildenafil 경구 정제 *100mg*(Viagra)	2	수량 한도(30일마다 최대 6정)
sildenafil 경구 정제 *50 mg*(Viagra)	2	수량 한도(30일마다 최대 6정)
sildenafil 경구 정제 *25 mg*(Viagra)	2	수량 한도(30일마다 최대 6정)

San Joaquin 카운티의 Choice (HMO), Plan 001 가입자의 자기부담금/공동보험액:

단계	설명	자기부담금/공동보험액	
		30일치	90일치
1단계	우선적 복제약	$0	$0
2단계	복제약	$7	$14
3단계	우선적 브랜드 약	$45	$90
4단계	비 우선적 약	$100	$200
5단계	특수 단계	33%	해당 안 됨

Santa Clara 카운티의 Choice (HMO), Plan 002 가입자의 자기부담금/공동보험액:

단계	설명	자기부담금/공동보험액	
		30일치	90일치
1단계	우선적 복제약	$0	$0
2단계	복제약	$7	$14
3단계	우선적 브랜드 약	$45	$90
4단계	비 우선적 약	$100	$200
5단계	특수 단계	33%	해당 안 됨

San Joaquin 및 Santa Clara 카운티의 Plus (HMO), Plan 003 가입자의 자기부담금/공동보험액:

단계	설명	자기부담금/공동보험액	
		30일치	90일치
1단계	우선적 복제약	$0	$0
2단계	복제약	25%	25%
3단계	우선적 브랜드 약	25%	25%
4단계	비 우선적 약	25%	25%
5단계	특수 단계	25%	해당 안

			됨

Hội viên hiện tại xin lưu ý: Danh mục thuốc này đã được thay đổi từ năm ngoái. Xin xem lại tài liệu này để bảo đảm nó vẫn chứa các thuốc mà quý vị sử dụng.

Khi danh sách thuốc (danh mục thuốc) này nói về "chúng tôi," "cho chúng tôi" hoặc "của chúng tôi," nó có nghĩa là CCA Health California. Khi đề cập "chương trình" hoặc "chương trình của chúng tôi" có nghĩa là chương trình Choice (HMO) San Joaquin (Plan 001), Choice (HMO) Santa Clara (Plan 002) hoặc Plus (HMO) Plan 003.

Tài liệu này bao gồm một phần danh sách thuốc (danh mục) trong chương trình của chúng tôi được cập nhật kể từ ngày 12/01/2022. Để có được danh mục thuốc mới nhất, xin quý vị liên lạc với chúng tôi. Thông tin liên lạc của chúng tôi, cùng với ngày cập nhật cuối cùng của danh mục thuốc, có in tại bìa trước và bìa sau.

Thông thường, quý vị phải sử dụng các nhà thuốc trong mạng lưới để sử dụng quyền lợi thuốc theo toa của quý vị. Các quyền lợi, danh sách thuốc, nhà thuốc trong mạng lưới, và/hoặc tiền đồng trả/đồng bảo hiểm có thể thay đổi vào ngày 1 tháng 1 năm 2023 và thay đổi theo thời gian trong năm.

Danh mục thuốc của CCA Health California là gì?

Danh mục Thuốc là danh sách các thuốc được bảo hiểm do CCA Health California lựa chọn cùng với sự cố vấn của các nhà cung cấp dịch vụ chăm sóc sức khỏe, nó thể hiện các liệu pháp chỉ định được tin là một bộ phận cần thiết của chương trình điều trị có chất lượng. Nói chung CCA Health California sẽ bảo hiểm cho các thuốc trong danh mục của chúng tôi với điều kiện thuốc đó là cần thiết về mặt y tế, được mua tại nhà thuốc trong mạng lưới của CCA Health California, và phù hợp với các quy định khác của chương trình. Để biết thêm về cách mua thuốc toa, xin xem Chứng từ Bảo hiểm của quý vị.

Danh mục Thuốc (danh sách thuốc) có thể thay đổi không?

Hầu hết các thay đổi về bảo hiểm thuốc diễn ra vào ngày 1 tháng 1 nhưng chúng tôi có thể thêm hoặc bớt thuốc khỏi Danh sách Thuốc trong năm, có thể chuyển sang bậc chia sẻ chi phí khác, hoặc thêm giới hạn mới. Chúng tôi phải tuân thủ luật lệ của Medicare về những thay đổi này

Các thay đổi có thể ảnh hưởng đến quý vị trong năm nay: Trong các trường hợp bên dưới, các thay đổi về bảo hiểm sẽ ảnh hưởng đến quý vị trong năm:

- **Thuốc gốc mới.** Chúng tôi có thể ngay lập tức loại bỏ một thuốc chính hiệu trong Danh sách Thuốc của chúng tôi nếu chúng tôi thay thế thuốc đó bằng một loại thuốc gốc mới sẽ xuất hiện với cùng một bậc chia sẻ chi phí hoặc bậc chia sẻ thấp hơn và với cùng mức hạn chế hoặc hạn chế ít hơn. Ngoài ra, khi thêm thuốc gốc mới, chúng tôi có thể quyết định giữ thuốc chính hiệu trong Danh sách Thuốc của chúng tôi, nhưng ngay lập tức chuyển thuốc đó sang một bậc chia sẻ chi phí khác hoặc thêm các hạn chế mới. Nếu quý vị hiện đang dùng thuốc chính hiệu, chúng tôi không thể cho quý vị biết trước khi chúng tôi thực hiện thay đổi, nhưng chúng tôi sẽ cung cấp cho quý vị thông tin về (các) thay đổi cụ thể mà chúng tôi đã thực hiện sau này.

    - Nếu chúng tôi thực hiện một thay đổi như vậy, quý vị hoặc bác sĩ kê đơn của quý vị có thể yêu cầu chúng tôi tạo một ngoại lệ và tiếp tục bảo hiểm thuốc chính hiệu đó cho quý vị. Thông báo chúng tôi cung cấp cho quý vị cũng sẽ bao gồm thông tin về cách yêu cầu ngoại lệ và quý vị cũng có thể tìm thông tin trong phần bên dưới có tiêu đề "Làm cách nào để yêu cầu ngoại lệ cho Danh mục Thuốc của CCA Health California's Formulary?"

- **Thuốc bị thu hồi khỏi thị trường.** Nếu Cơ quan Thực và Dược phẩm (Food and Drug Administration) thấy một loại thuốc trong danh mục của chúng tôi là không an toàn hoặc nhà sản xuất thu hồi thuốc khỏi thị trường, chúng tôi sẽ lập tức loại thuốc đó ra khỏi danh mục của chúng tôi và thông báo cho hội viên dùng thuốc đó biết.

- **Các thay đổi khác.** Chúng tôi có thể thực hiện các thay đổi khác ảnh hưởng đến các hội viên hiện đang dùng thuốc. Ví dụ, chúng tôi có thể thêm một loại thuốc gốc mới để thay thế thuốc chính hiệu hiện có trong danh mục thuốc hoặc thêm các hạn chế mới đối với thuốc chính hiệu hoặc chuyển thuốc sang một bậc chia sẻ chi phí khác hoặc cả hai. Hoặc chúng tôi có thể thực hiện các thay đổi dựa trên các hướng dẫn lâm sàng mới. Nếu chúng tôi loại bỏ các thuốc khỏi danh mục, thêm vào yêu cầu xin phép trước, giới hạn số lượng và/hoặc giới hạn loại thuốc cho việc trị liệu theo từng giai đoạn hoặc chuyển thuốc sang bậc chia sẻ cao hơn, chúng tôi phải thông báo tất cả các thay đổi này cho những hội viên hiện đang sử dụng các loại thuốc đó ít nhất 30 ngày trước ngày thay đổi có hiệu lực, hoặc vào lúc hội viên yêu cầu được mua thêm thuốc đó, lúc đó hội viên sẽ nhận được thuốc cho 30 ngày.

    - Nếu chúng tôi đưa ra các thay đổi khác, quý vị hoặc bác sĩ kê đơn của quý vị có thể yêu cầu chúng tôi tạo một ngoại lệ và tiếp tục bảo hiểm thuốc chính hiệu đó cho quý vị. Thông báo chúng tôi cung cấp cho quý vị cũng sẽ bao gồm thông tin về cách yêu cầu ngoại lệ và quý vị cũng có thể tìm thông tin trong phần bên dưới có tiêu đề “Làm cách nào để yêu cầu ngoại lệ cho Danh mục Thuốc của CCA Health California?”

Các thay đổi sẽ không ảnh hưởng đến quý vị nếu quý vị hiện đang dùng thuốc. Thông thường, nếu quý vị đang dùng một loại thuốc trong danh mục thuốc 2022 được bảo hiểm vào đầu năm, chúng tôi sẽ không giảm hoặc hủy liên tục của loại thuốc đó trong thời gian bảo hiểm của năm 2022 trừ khi được mô tả bên trên. Điều này có nghĩa là các thuốc đó sẽ vẫn được cung cấp ở cùng mức chia sẻ chi phí và không có giới hạn mới cho những hội viên đang dùng chúng cho phần còn lại của năm bảo hiểm. Quý vị không nhận được thông báo trực tiếp trong năm nay về những thay đổi không ảnh hưởng đến bạn. Tuy nhiên, vào ngày 1 tháng 1 năm sau, những thay đổi như vậy sẽ ảnh hưởng đến bạn, và điều quan trọng là phải kiểm tra Danh sách Thuốc cho năm phúc lợi mới để biết bất kỳ thay đổi nào đối với thuốc.

Kèm theo đây là danh mục kể từ ngày 12/01/2022. Để nhận thông tin cập nhật về thuốc được CCA Health California bảo hiểm, vui lòng liên hệ với chúng tôi. Thông tin liên lạc của chúng tôi có ghi tại các trang của bìa trước và bìa sau. Hàng tháng CCA Health California sẽ gửi qua bưu điện cho quý vị một báo cáo gọi là tờ “Giải thích Quyền lợi”, hay “EOB.” EOB cho quý vị biết tổng số tiền quý vị đã chi cho thuốc toa của quý vị và tổng số tiền chúng tôi đã trả cho mỗi loại thuốc toa của quý vị trong tháng đó. Cùng với EOB, chúng tôi sẽ gửi cho quý vị "Thông báo Thay đổi Danh mục Thuốc" (“Formulary Change Notice”) nếu mới có thay đổi nào được thực hiện cho danh mục thuốc của chúng tôi. Ngoài ra, tất cả các thay đổi về danh mục thuốc cũng sẽ được cập nhật hàng tháng trên trang mạng của chúng tôi tại www.ccahealthca.org.

Tôi sử dụng Danh mục Thuốc như thế nào?

Có hai cách để tìm thuốc của quý vị trong danh mục:

Theo Bệnh
Danh sách thuốc bắt đầu trên trang 1. Thuốc trong danh mục này được nhóm thành nhóm theo loại bệnh mà chúng được dùng để điều trị. Ví dụ, thuốc điều trị bệnh tim được đặt dưới phân loại “Thuốc điều trị tim mạch”. Nếu biết thuốc của mình sử dụng cho bệnh gì, tìm tên phân loại trong danh sách bắt đầu ở trang 3.

Rồi tìm tiếp thuốc của quý vị ở trong nhóm bệnh này.

Theo vần abc
Nếu quý vị không chắc chắn phân loại nào để tìm, quý vị nên tìm tên thuốc của mình trong Bảng danh mục bắt đầu ở trang I-1. Bảng chú dẫn này liệt kê theo bảng chữ cái tất cả các loại thuốc có trong tài liệu này. Cả thuốc chính hiệu và thuốc gốc đều được liệt kê trong Bảng chú dẫn này. Xem trong Bảng chú dẫn để tìm thuốc của quý vị. Bên cạnh tên thuốc, quý vị sẽ nhìn thấy số trang nơi quý vị có thể tìm thấy thông tin bảo hiểm. Lật sang trang được liệt kê trong Bảng chú dẫn và tìm tên thuốc của quý vị ở cột đầu tiên trong danh sách.

Thuốc gốc là gì?

CCA Health California bảo hiểm cho cả thuốc chính hiệu và thuốc gốc. Thuốc gốc theo phê chuẩn của FDA là thuốc có cùng thành phần hoạt chất với thuốc chính hiệu. Thuốc gốc thường rẻ hơn thuốc chính hiệu.

Có hạn chế nào về việc bảo hiểm cho tôi không?

Một số thuốc được bảo hiểm có thể có thêm các yêu cầu hoặc giới hạn về bảo hiểm. Các yêu cầu hoặc giới hạn này có thể bao gồm:

- **Xin phép trước:** CCA Health California yêu cầu quý vị hoặc bác sĩ quý vị phải xin phép trước đối với một số thuốc nào đó. Điều đó có nghĩa là quý vị phải được CCA Health California chấp thuận trước rồi mới được mua thuốc. Nếu không có sự chấp thuận này, CCA Health California sẽ không bảo hiểm thuốc cho quý vị.

- **Giới hạn Số lượng:** Với một số thuốc nào đó, CCA Health California có giới hạn số lượng thuốc mà CCA Health California sẽ đài thọ. Ví dụ, CCA Health California cung cấp 30 viên/đơn thuốc đối với thuốc uống Rabeprazole. Đây có thể là một giới hạn khác ngoài quy định về lượng cấp một tháng hoặc ba tháng thông thường.

- **Liệu pháp bước:** Trong một số trường hợp, CCA Health California yêu cầu quý vị phải thử dùng những loại thuốc nào đó trước để trị bệnh cho quý vị rồi mới đài thọ cho một loại thuốc khác trị bệnh đó. Ví dụ như, Thuốc A và Thuốc B đều trị bệnh của quý vị, CCA Health California có thể sẽ không đài thọ cho Thuốc B nếu quý vị không thử dùng Thuốc A trước. Nếu Thuốc A không trị được bệnh cho quý vị, CCA Health California sẽ đài thọ cho Thuốc B.

Quý vị có thể tìm hiểu xem thuốc của mình có thêm những yêu cầu hoặc giới hạn khác bằng cách tìm trong danh mục bắt đầu ở trang 3. Quý vị cũng có thể tìm xem thêm về các hạn chế được áp dụng cho thuốc được bảo hiểm cụ thể bằng cách xem trên trang mạng của chúng tôi. Chúng tôi đã đưa lên trang mạng một tài liệu giải thích các hạn chế của chúng tôi về việc xin phép trước và liệu pháp bước. Quý vị cũng có thể yêu cầu chúng tôi gửi cho quý vị một bản. Thông tin liên lạc của chúng tôi, cùng với ngày cập nhật cuối cùng của danh mục thuốc, có in tại bìa trước và bìa sau.

Quý vị có thể yêu cầu CCA Health California cho quý vị hưởng ngoại lệ đối với các hạn chế hoặc giới hạn này hoặc cho quý vị được sử dụng một danh sách các thuốc khác tương tự có thể trị được bệnh của quý vị. Xin quý vị xem mục, “Tôi xin hưởng ngoại lệ đối với danh mục thuốc của CCA Health California bằng cách nào?” trên trang II-49 để biết cách xin hưởng ngoại lệ.

Thuốc không cần toa (OTC) là gì?

Thuốc OTC là thuốc khi mua không cần phải có toa bác sĩ mà thường Chương trình Thuốc toa Medicare không đài thọ. CCA Health California thanh toán cho một số thuốc OTC nhất định.

TÊN THUỐC	HÀM LƯỢNG	DẠNG BÀO CHẾ
CETIRIZINE HCL	5 MG/ML	DUNG DỊCH
CETIRIZINE HCL	1 MG/ML	DUNG DỊCH
CETIRIZINE HCL	5 MG	VIÊN NÉN NHAI
CETIRIZINE HCL	10 MG	VIÊN NÉN NHAI
CETIRIZINE HCL	5 MG	VIÊN NÉN
CETIRIZINE HCL	10 MG	VIÊN NÉN
CETIRIZINE HCL/PSEUDOEPHEDRINE	5 MG-120MG	VIÊN NÉN ER 12H
FEXOFENADINE HCL	30 MG/5 ML	HỖN DỊCH UỐNG
FEXOFENADINE HCL	30 MG	VỈ THUỐC
FEXOFENADINE HCL	60 MG	VIÊN NÉN
FEXOFENADINE HCL	180 MG	VIÊN NÉN
FEXOFENADINE/PSEUDOEPHEDRINE	60MG-120MG	VIÊN NÉN ER 12H
FEXOFENADINE/PSEUDOEPHEDRINE	180MG-240MG	VIÊN NÉN ER 24H
KETOTIFEN FUMARATE	0,03%	NHỎ
LEVOCETIRIZINE DIHYDROCHLORIDE	5 MG	VIÊN NÉN
LORATADINE	5 MG/5 ML	DUNG DỊCH
LORATADINE	5 MG	VIÊN NÉN NHAI
LORATADINE	10 MG	VỈ THUỐC
LORATADINE	10 MG	VIÊN NÉN
LORATADINE/PSEUDOEPHEDRINE	5 MG-120MG	VIÊN NÉN ER 12H
LORATADINE/PSEUDOEPHEDRINE	10MG-240MG	VIÊN NÉN ER 24H
OLOPATADINE HCL	0.70 %	NHỎ
OLOPATADINE HCL	0.20 %	NHỎ
OLOPATADINE HCL	0.10 %	NHỎ

CCA Health California sẽ cung cấp miễn phí cho quý vị các thuốc OTC này. Chi phí mà CCA Health California chi trả cho các thuốc OTC này sẽ không được tính vào tổng chi phí thuốc Phần D của quý vị (tức là chi phí thuốc OTC này không dùng để tính giai đoạn không được trả bảo hiểm).

Điều gì xảy ra nếu thuốc của tôi không có trong Danh sách Thuốc?

Nếu thuốc của quý vị không có trong danh mục này (danh sách thuốc được bảo hiểm), trước tiên quý vị cần liên hệ với Ban Dịch vụ Hội viên để hỏi xem thuốc của mình có được bảo hiểm không.

Nếu CCA Health California không đài thọ cho thuốc của quý vị, quý vị có hai lựa chọn:

- Quý vị có thể đề nghị Ban Dịch vụ Hội viên cung cấp một danh sách thuốc tương tự được CCA Health California đài thọ. Khi nhận được danh sách đó, quý vị hãy đưa cho bác sĩ của quý vị xem và đề nghị họ kê cho quý vị một loại thuốc tương tự được CCA Health California đài thọ.

- Quý vị có thể đề nghị CCA Health California cho quý vị hưởng ngoại lệ là đài thọ cho thuốc của quý vị. Xem dưới đây để biết cách xin hưởng ngoại lệ.

Tôi xin hưởng ngoại lệ đối với danh mục thuốc của CCA Health California bằng cách nào?

Quý vị có thể đề nghị CCA Health California cho quý vị hưởng ngoại lệ đối với các quy định về đài thọ của chúng tôi. Có nhiều loại ngoại lệ mà quý vị có thể xin chúng tôi cho hưởng.

- Quý vị có thể yêu cầu chúng tôi bảo hiểm cho một loại thuốc ngay cả khi nó không nằm trong danh mục thuốc. Nếu được chấp thuận, thuốc đó sẽ được bảo hiểm với mức chia sẻ chi phí được xác định trước, và quý vị sẽ không thể yêu cầu chúng tôi cung cấp thuốc đó cho quý vị với mức chia sẻ chi phí thấp hơn.

- Quý vị có thể yêu cầu chúng tôi bảo hiểm cho một loại thuốc nằm trong danh mục với mức chia sẻ chi phí thấp hơn nếu thuốc đó không nằm trong bậc thuốc đặc trị. Nếu được chấp thuận, số tiền quý vị phải trả cho thuốc của quý vị sẽ ít hơn.

- Quý vị có thể yêu cầu chúng tôi bỏ hạn chế hoặc giới hạn bảo hiểm cho thuốc của quý vị. Ví dụ như, với một số thuốc nhất định, CCA Health California có giới hạn số lượng thuốc mà chúng tôi sẽ đài thọ. Nếu thuốc của quý vị có giới hạn về số lượng, quý vị có thể xin chúng tôi bỏ giới hạn đó mà bảo hiểm cho quý vị số lượng thuốc lớn hơn.

Nói chung, CCA Health California sẽ chỉ chấp thuận yêu cầu hưởng ngoại lệ của quý vị nếu thuốc thay thế có trong danh mục thuốc của chương trình, thuốc có mức chia sẻ chi phí thấp hơn hoặc khi các hạn chế về việc sử dụng khác sẽ không có hiệu quả trong việc trị bệnh cho quý vị và/hoặc sẽ gây cho quý vị các tác dụng bất lợi về mặt y tế.

Quý vị nên liên lạc với chúng tôi để đề nghị chúng tôi ra quyết định đài thọ lần đầu cho quý vị được hưởng ngoại lệ đối với các hạn chế về danh mục thuốc, sử dụng. **Khi quý vị yêu cầu trường hợp ngoại lệ về danh mục, hoặc về giới hạn sử dụng, quý vị nên gửi thêm hồ sơ hỗ trợ yêu cầu từ bác sĩ kê toa hoặc bác sĩ.** Nói chung, chúng tôi phải ra quyết định trong vòng 72 giờ kể từ khi nhận được giấy xác nhận ủng hộ của người kê thuốc cho quý vị. Quý vị có thể xin hưởng ngoại lệ xúc tiến (nhanh) nếu quý vị hoặc bác sĩ của quý vị tin rằng sức khỏe của quý vị có thể bị tổn hại nghiêm trọng khi phải chờ đợi đến 72 giờ để ra quyết định. Nếu yêu cầu xúc tiến của quý vị được chấp nhận, chúng tôi phải ra quyết định cho quý vị trong không quá 24 giờ sau khi chúng tôi nhận được giấy xác nhận ủng hộ của bác sĩ hay người kê thuốc cho quý vị.

Tôi sẽ được đối xử ra sao khi chưa bàn được với bác sĩ để đổi thuốc hay xin hưởng ngoại lệ?

Dù là hội viên mới hay cũ của chương trình, thuốc mà quý vị đang dùng cũng có thể không có trong danh mục của chúng tôi. Hoặc, thuốc mà quý vị đang dùng có thể có trong danh mục của chúng tôi nhưng quý vị ít có khả năng được nhận thuốc đó. Ví dụ như, quý vị có thể phải xin phép chúng tôi trước thì mới được mua thuốc toa của quý vị. Quý vị nên nói chuyện với bác sĩ của quý vị để quyết định xem quý vị có nên đổi sang dùng một loại thuốc phù hợp được chúng tôi bảo hiểm hoặc xin hưởng ngoại lệ danh mục thuốc hay không để chúng tôi sẽ bảo hiểm cho thuốc quý vị dùng. Trong khi quý vị trao đổi với bác sĩ của mình để xác định cách làm đúng đắn cho mình, chúng tôi có thể bảo hiểm cho thuốc của quý vị trong một số trường hợp nhất định trong vòng 90 ngày đầu sau khi quý vị trở thành hội viên của chương trình.

Đối với mỗi loại thuốc của quý vị không nằm trong danh mục hoặc số lượng thuốc bị giới hạn, chúng tôi sẽ bảo hiểm một số lượng tạm thời cho 30 ngày. Nếu toa thuốc của quý vị được kê cho số ngày ít hơn, chúng tôi sẽ cho phép mua tiếp để có được lượng cấp tối đa 30 ngày của thuốc đó. Sau khi bảo hiểm cho 30 ngày đầu tiên, chúng tôi sẽ không chi trả cho những loại thuốc này nữa ngay cả khi quý vị là hội viên của chúng tôi ít hơn *90* ngày.

Nếu quý vị là một người cư trú tại một cơ sở chăm sóc lâu dài và quý vị cần những loại thuốc không nằm trong danh mục hoặc nếu khả năng lấy được thuốc của quý vị bị giới hạn, nhưng quý vị đã là hội viên của chúng tôi hơn *90* ngày, chúng tôi sẽ bảo hiểm một số lượng khẩn cấp cho *31* ngày trong thời gian quý vị yêu cầu trường hợp ngoại lệ về danh mục.

Trong trường hợp người có bảo hiểm của chương trình sẽ chuyển từ cơ sở điều trị này sang cơ sở khác, CCA Health California sẽ bảo đảm sử dụng quy trình chấp thuận nhanh cho các thuốc Phần D không có trong danh mục. Thủ tục này cũng được áp dụng cho các loại thuốc Phần D có trong danh sách thuốc cần phải xin phép trước hoặc phải thực hiện liệu pháp bước. Ví dụ về các mức độ thay đổi trong việc chăm sóc gồm có: người có bảo hiểm của chương trình được xuất viện về nhà; người có bảo hiểm của chương trình không còn ở tại cơ sở điều dưỡng theo Medicare Phần A và cần chuyển về danh sách thuốc phần D; người có bảo hiểm của chương trình không còn ở tại cơ sở chăm sóc lâu dài và trở về cộng đồng; và, người có bảo hiểm của chương trình là người xuất viện từ bệnh viện tâm thần có phác đồ thuốc có tính cá nhân cao.

Các nhà thuốc có hợp đồng CCA Health có thể nhập mã đệ trình tiêu chuẩn của ngành tại điểm bán hàng để hủy bỏ các hạn chế về danh mục thuốc. Dịch vụ sau giờ làm việc (MedImpact) của PMB có hợp đồng với CCA Health sẽ cung cấp cho các nhà thuốc tiếp xúc với những đại diện có thể giải quyết các vấn đề trong việc xử lý yêu cầu của nhà thuốc. Việc tiếp xúc này sẽ cho phép nhà thuốc giải quyết được các yêu cầu về cấp thuốc ngay tại điểm bán hàng và bảo đảm người có bảo hiểm của chương trình có thể nhận được thuốc theo cách thức đáng tin cậy.

Để tìm hiểu thêm

Để biết chi tiết hơn về việc CCA Health California đài thọ cho thuốc toa của quý vị, xin xem Chứng từ Bảo hiểm của quý vị và các tài liệu khác của chương trình.

Nếu quý vị có thắc mắc về CCA Health California, xin liên lạc với chúng tôi. Thông tin liên lạc của chúng tôi, cùng với ngày cập nhật cuối cùng của danh mục thuốc, có in tại bìa trước và bìa sau.

Nếu quý vị có các thắc mắc chung về việc bảo hiểm thuốc toa Medicare, xin gọi Medicare theo số 1-800-MEDICARE (1-800-633-4227) 24 giờ mỗi ngày/7 mỗi tuần. Người dùng TTY vui lòng gọi 1-877-486-2048. Hoặc vào http://www.medicare.gov.

Danh mục Thuốc của CCA Health California

Danh mục thuốc bắt đầu từ trang kế tiếp có thông tin về việc đài thọ cho một số loại thuốc được CCA Health California đài thọ. Nếu quý vị có những trở ngại trong việc tìm thuốc của mình trong danh sách, xin mở Bảng mục lục bắt đầu từ trang I-1.

Cột thứ nhất của bảng này là tên thuốc. Các thuốc thương hiệu được viết hoa (ví dụ, ELIQUIS) và các thuốc gốc được viết thường in nghiêng (ví dụ, *simvastatin*).

Thông tin trong cột Yêu cầu/Giới hạn cho quý vị biết CCA Health California có yêu cầu đặc biệt nào về việc đài thọ cho thuốc của quý vị hay không.

Viết tắt	Mô tả	Giải thích
PA	Hạn chế về Xin phép Trước	Quý vị (hoặc bác sĩ của quý vị) bắt buộc phải xin CCA Health California cho phép trước khi quý vị mua thuốc toa của quý vị. Nếu không được chấp thuận trước, CCA Health California có thể sẽ không đài thọ cho thuốc này.
PA BvD	Hạn chế về Xin phép Trước để Xác định của Phần B so với Phần D	Thuốc này có thể đủ tiêu chuẩn để được đài thọ theo Medicare Phần B hoặc Phần D. Quý vị (hoặc bác sĩ của quý vị) cần phải xin CCA Health California cho phép trước để xác định thuốc này sẽ được đài thọ theo Medicare Phần D trước khi quý vị mua thuốc toa của mình. Nếu không được chấp thuận trước, CCA Health California có thể sẽ không đài thọ cho thuốc này.
PA-HRM	Hạn chế về Xin phép Trước đối với Thuốc có Nguy cơ cao	Thuốc này được CMS coi là nguy hiểm tiềm tàng và do đó, là Loại thuốc Rủi ro Cao đối với người thụ hưởng Medicare từ 65 tuổi trở lên. Các hội viên từ 65 tuổi trở lên phải xin CCA Health California cho phép trước khi quý vị mua thuốc toa của quý vị. Nếu không được chấp thuận trước, CCA Health California có thể sẽ không đài thọ cho thuốc này
PA NSO	Hạn chế về Xin phép Trước chỉ đối với Lần bắt đầu Mới	Nếu quý vị là hội viên mới hoặc nếu quy vị chưa dùng loại thuốc này trước đây, quý vị (hoặc bác sĩ của quý vị) phải xin CCA Health California cho phép trước khi quý vị mua thuốc toa của quý vị. Nếu không được chấp thuận trước, CCA Health California có thể sẽ không đài thọ cho thuốc này.
PA NSO-HRM	Hạn chế về Xin phép Trước đối với Thuốc Nguy cơ cao và Chỉ đối với Lần bắt đầu Mới	Thuốc này được CMS coi là nguy hiểm tiềm tàng và do đó, là Loại thuốc Rủi ro Cao đối với người thụ hưởng Medicare từ 65 tuổi trở lên. Các hội viên từ 65 tuổi trở lên phải xin CCA Health California cho phép trước khi quý vị mua thuốc toa của quý vị. Nếu không được chấp thuận trước, CCA Health California có thể sẽ không đài thọ cho thuốc này.
QL	Hạn chế về Giới hạn Số lượng	CCA Health giới hạn số lượng thuốc này được bảo hiểm trên mỗi đơn, hoặc trong khoảng thời gian cụ thể.

Viết tắt	Mô tả	Giải thích
ST	Hạn chế về Trị liệu theo từng Giai đoạn	Trước khi CCA Health California đài thọ cho thuốc này, quý vị phải dùng thử (những) loại thuốc khác để điều cho bệnh trạng của mình. Thuốc này chỉ có thể được đài thọ nếu (những) thuốc khác không có hiệu quả với quý vị.
EX	Thuốc Phần D Không được bảo hiểm	Thông thường, thuốc kê đơn này không được bảo hiểm trong Chương trình Thuốc kê đơn của Medicare. Số tiền quý vị phải thanh toán khi mua thuốc theo đơn này không được tính vào tổng chi phí thuốc của quý vị (có nghĩa là số tiền quý vị thanh toán không giúp quý vị đủ điều kiện hưởng bảo hiểm tai họa). Ngoài ra, nếu quý vị đang nhận trợ cấp đặc biệt cho thuốc kê đơn của mình, quý vị sẽ không được nhận bất kỳ trợ cấp đặc biệt nào để thanh toán cho thuốc này.
LA	Thuốc được Phân phối Giới hạn	Đơn thuốc này có thể chỉ sẵn có ở một số nhà thuốc nhất định. Để biết thông tin chi tiết, vui lòng xem Danh bạ Nhà thuốc hoặc gọi cho Phòng Dịch vụ Hội viên tại số 888-254-9907. Người dùng TTY vui lòng gọi 888-254-9907.
GC	Giai đoạn Không được Bảo hiểm	Chúng tôi cung cấp bảo hiểm cho loại thuốc theo toa này trong giai đoạn không được bảo hiểm. Gói Choice 001, có phạm vi bảo hiểm cho Cấp 1 và 2. Gói Choice 002, có phạm vi bảo hiểm cho Cấp 1 Gói Plus 003, không có phạm vi Gap. Xin tham khảo Chứng từ Bảo hiểm để biết thêm về việc bảo hiểm này.
GC*	Thời gian không được bảo hiểm bổ sung	Chúng tôi cung cấp bảo hiểm cho loại thuốc theo toa này trong giai đoạn không được bảo hiểm. Gói Choice 001, có phạm vi bảo hiểm cho Cấp 1 và 2. Gói Plus 003, không có phạm vi Gap. Xin tham khảo Chứng từ Bảo hiểm để biết thêm về việc bảo hiểm này.
NEDS	Lượng cấp Theo Ngày Không Kéo dài	Quý vị có thể nhận được nhiều hơn lượng thuốc 1 tháng của hầu hết thuốc trong danh mục thuốc qua đặt hàng qua thư hoặc bán lẻ theo mức chia sẻ chi phí được giảm bớt. Thuốc <u>không</u> có cho lượng thuốc theo ngày gia hạn (lớn hơn lượng thuốc 1 tháng) qua quyền lợi đặt hàng qua thư hoặc nhà thuốc bán lẻ được ghi "NEDS" trong cột Yêu cầu/Giới hạn của danh mục thuốc.
HI	Thuốc Truyền tại Nhà thuốc	Thuốc theo toa này có thể được bao trả theo quyền lợi y tế của chúng tôi. Để biết thêm thông tin, gọi
TUỔI	Giới hạn Tuổi tác	Thuốc theo toa này sẽ chỉ được cung cấp cho các nhóm tuổi cụ thể.
CB	Quyền lợi Tối đa	Thuốc này có mức quyền lợi tối đa.

Thông thường, thuốc kê đơn này không được bảo hiểm trong Chương trình Thuốc kê đơn của Medicare. Số tiền quý vị phải thanh toán khi mua thuốc theo đơn này không được tính vào tổng chi phí thuốc của quý vị (có nghĩa là số tiền quý vị thanh toán không giúp quý vị đủ điều kiện hưởng bảo hiểm tai họa). Ngoài ra, nếu quý vị đang nhận trợ cấp đặc biệt cho thuốc kê đơn của mình, quý vị sẽ không được nhận bất kỳ trợ cấp đặc biệt nào để thanh toán cho thuốc này.

Tên thuốc	Bậc Thuốc	Yêu cầu/Giới hạn
viên uống sildenafil 100 mg (Viagra)	2	Giới hạn Số lượng (tối đa 6 viên cứ 30 ngày)
viên uống sildenafil 50 mg (Viagra)	2	Giới hạn Số lượng (tối đa 6 viên cứ 30 ngày)
viên uống sildenafil 25 mg (Viagra)	2	Giới hạn Số lượng (tối đa 6 viên cứ 30 ngày)

Tiền đồng trả/Đồng bảo hiểm đối với các hội viên của Choice (HMO), Plan 001 tại Quận San Joaquin:

Bậc	Mô tả	Tiền đồng trả/Đồng bảo hiểm	
		với lượng cấp 30 ngày	với lượng cấp 90 ngày
Bậc 1	Thuốc gốc được Ưu tiên	$0	$0
Bậc 2	Thuốc gốc	$7	$14
Bậc 3	Thuốc Chính hiệu được Ưu tiên	$45	$90
Bậc 4	Thuốc Không được Ưu tiên	$100	$200
Bậc 5	Bậc Đặc trị	33%	Không áp dụng

Tiền đồng trả/Đồng bảo hiểm cho các hội viên Choice (HMO), Plan 002 tại Quận Santa Clara:

Bậc	Mô tả	Tiền đồng trả/Đồng bảo hiểm	
		với lượng cấp 30 ngày	với lượng cấp 90 ngày
Bậc 1	Thuốc gốc được Ưu tiên	$0	$0
Bậc 2	Thuốc gốc	$7	$14
Bậc 3	Thuốc Chính hiệu được Ưu tiên	$45	$90
Bậc 4	Thuốc Không được Ưu tiên	$100	$200
Bậc 5	Bậc Đặc trị	33%	Không áp dụng

Tiền đồng trả/Đồng bảo hiểm cho các hội viên Plus (HMO), Plan 003 tại Quận San Joaquin và Quận Santa Clara:

Bậc	Mô tả	Tiền đồng trả/Đồng bảo hiểm	
		với lượng cấp 30 ngày	với lượng cấp 90 ngày
Bậc 1	Thuốc gốc được Ưu tiên	$0	$0
Bậc 2	Thuốc gốc	25%	25%
Bậc 3	Thuốc Chính hiệu được Ưu tiên	25%	25%
Bậc 4	Thuốc Không được Ưu tiên	25%	25%
Bậc 5	Bậc Đặc trị	25%	Không áp dụng

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Drug Name		Drug Tier	Requirements/Limits
Analgesics			
Analgesics, Miscellaneous			
acetaminophen-codeine oral solution 120-12 mg/5 ml		1	GC; NEDS; QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg		2	GC; NEDS; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg		2	GC; NEDS; QL (180 per 30 days)
buprenorphine hcl injection solution 0.3 mg/ml	(Buprenex)	2	GC
buprenorphine hcl injection syringe 0.3 mg/ml		2	GC
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	(Esgic)	2	GC; QL (180 per 30 days)
butalbital-aspirin-caffeine oral capsule 50-325-40 mg		4	QL (180 per 30 days)
butalbital-aspirin-caffeine oral tablet 50-325-40 mg		2	GC; QL (180 per 30 days)
codeine sulfate oral tablet 30 mg, 60 mg		2	GC; NEDS; QL (180 per 30 days)
endocet oral tablet 10-325 mg	(oxycodone-acetaminophen)	2	GC; NEDS; QL (180 per 30 days)
endocet oral tablet 2.5-325 mg, 5-325 mg	(oxycodone-acetaminophen)	2	GC; NEDS; QL (360 per 30 days)
endocet oral tablet 7.5-325 mg	(oxycodone-acetaminophen)	2	GC; NEDS; QL (240 per 30 days)
fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg	(Actiq)	5	PA; NEDS; QL (120 per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	(Actiq)	3	PA; NEDS; QL (120 per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr		3	NEDS; QL (10 per 30 days)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr		2	GC; NEDS; QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml		4	NEDS; QL (2700 per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg	2	GC; NEDS; QL (180 per 30 days)
hydrocodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	2	GC; NEDS; QL (240 per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	2	GC; NEDS; QL (150 per 30 days)
hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml	2	GC
hydromorphone oral liquid 1 mg/ml (Dilaudid)	2	GC; NEDS; QL (1200 per 30 days)
hydromorphone oral tablet 2 mg, 4 mg, 8 mg (Dilaudid)	2	GC; NEDS; QL (180 per 30 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 300 MCG/SPRAY, 400 MCG/SPRAY	5	PA; NEDS; QL (30 per 30 days)
methadone injection solution 10 mg/ml	2	GC; QL (120 per 30 days)
methadone oral solution 10 mg/5 ml	2	GC; NEDS; QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	2	GC; NEDS; QL (1200 per 30 days)
methadone oral tablet 10 mg	2	GC; NEDS; QL (120 per 30 days)
methadone oral tablet 5 mg	2	GC; NEDS; QL (180 per 30 days)
methadose oral tablet,soluble 40 mg (methadone)	2	GC; NEDS; QL (30 per 30 days)
morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)	2	PA; GC; NEDS; QL (180 per 30 days)
morphine oral solution 10 mg/5 ml	2	GC; NEDS; QL (700 per 30 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	2	GC; NEDS; QL (300 per 30 days)
MORPHINE ORAL TABLET 15 MG	4	NEDS; QL (180 per 30 days)
MORPHINE ORAL TABLET 30 MG	4	NEDS; QL (120 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
morphine oral tablet extended release 100 mg, 200 mg, 60 mg	(MS Contin)	2	GC; NEDS; QL (60 per 30 days)
morphine oral tablet extended release 15 mg, 30 mg	(MS Contin)	2	GC; NEDS; QL (90 per 30 days)
oxycodone oral solution 5 mg/5 ml		4	NEDS; QL (1300 per 30 days)
oxycodone oral tablet 10 mg, 5 mg		2	GC; NEDS; QL (180 per 30 days)
oxycodone oral tablet 15 mg, 30 mg	(Roxicodone)	2	GC; NEDS; QL (120 per 30 days)
oxycodone oral tablet 20 mg		2	GC; NEDS; QL (120 per 30 days)
oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	(OxyContin)	3	NEDS; QL (60 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg	(Endocet)	2	GC; NEDS; QL (180 per 30 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	(Endocet)	2	GC; NEDS; QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 7.5-325 mg	(Endocet)	2	GC; NEDS; QL (240 per 30 days)
oxycodone-aspirin oral tablet 4.8355-325 mg		2	GC; NEDS; 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, 80 MG	(oxycodone)	3	NEDS; QL (60 per 30 days)
tramadol oral tablet 50 mg		1	GC; NEDS; QL (240 per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg	(Ultracet)	2	GC; NEDS; QL (300 per 30 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 9 MG		3	NEDS; QL (60 per 30 days)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 27 MG		3	NEDS; QL (120 per 30 days)

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

Drug Name		Drug Tier	Requirements/Limits
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 36 MG		3	NEDS; QL (240 per 30 days)
Nonsteroidal Anti-Inflammatory Agents			
celecoxib oral capsule 100 mg, 200 mg, 50 mg	(Celebrex)	2	GC; QL (60 per 30 days)
diclofenac epolamine transdermal patch 12 hour 1.3 %	(Flector)	4	PA; QL (60 per 30 days)
diclofenac potassium oral tablet 50 mg	(Cataflam)	2	GC; QL (120 per 30 days)
diclofenac sodium oral tablet extended release 24 hr 100 mg		2	GC; QL (60 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 25 mg		2	GC; QL (150 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 50 mg		2	GC; QL (120 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 75 mg		2	GC; QL (60 per 30 days)
diclofenac sodium topical drops 1.5 %		2	GC; QL (300 per 30 days)
diclofenac sodium topical gel 1 %	(Arthritis Pain (diclofenac))	2	GC; QL (1000 per 30 days)
diclofenac sodium topical gel 3 %		4	PA; QL (100 per 28 days)
diclofenac sodium topical solution in metered-dose pump 20 mg/gram lactuation(2 %)	(Pennsaid)	5	PA; NEDS; QL (224 per 28 days)
etodolac oral capsule 200 mg, 300 mg		4	
etodolac oral tablet 400 mg	(Lodine)	4	
etodolac oral tablet 500 mg		4	
flurbiprofen oral tablet 100 mg		2	GC
ibu oral tablet 400 mg, 600 mg, 800 mg	(ibuprofen)	1	GC
ibuprofen oral suspension 100 mg/5 ml	(Children's Advil)	2	GC
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	(IBU)	1	GC

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

Drug Name		Drug Tier	Requirements/Limits
indomethacin oral capsule 25 mg		1	GC; QL (240 per 30 days)
indomethacin oral capsule 50 mg		1	GC; QL (120 per 30 days)
ketorolac oral tablet 10 mg		2	GC; QL (20 per 30 days)
mefenamic acid oral capsule 250 mg		4	
meloxicam oral tablet 15 mg, 7.5 mg		1	GC
nabumetone oral tablet 500 mg, 750 mg	(Relafen)	2	GC
naproxen oral tablet 250 mg, 375 mg		1	GC
naproxen oral tablet 500 mg	(Naprosyn)	1	GC
naproxen oral tablet,delayed release (dr/ec) 375 mg, 500 mg	(EC-Naprosyn)	2	GC
sulindac oral tablet 150 mg, 200 mg		2	GC
Anesthetics			
Local Anesthetics			
glydo mucous membrane jelly in applicator 2 %	(lidocaine hcl)	2	GC; QL (30 per 30 days)
lidocaine (pf) injection solution 15 mg/ml (1.5 %), 20 mg/ml (2 %), 5 mg/ml (0.5 %)	(Xylocaine-MPF)	1	GC
lidocaine (pf) injection solution 40 mg/ml (4 %)		1	GC
lidocaine hcl 1% 20 mg/2 ml vl sdv, p/f 10 mg/ml (1 %)	(Xylocaine-MPF)	1	GC
lidocaine hcl injection solution 10 mg/ml (1 %), 20 mg/ml (2 %), 5 mg/ml (0.5 %)	(Xylocaine)	1	GC
lidocaine hcl mucous membrane jelly 2 %		2	GC; QL (30 per 30 days)
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)		2	PA; GC
lidocaine topical adhesive patch,medicated 5 %	(Lidoderm)	2	PA; GC; QL (90 per 30 days)
lidocaine topical ointment 5 %		4	PA; QL (90 per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
lidocaine viscous mucous membrane solution 2 % (lidocaine hcl)	2	GC
lidocaine-prilocaine topical cream 2.5-2.5 %	4	PA; QL (30 per 30 days)
ZTLIDO TOPICAL ADHESIVE PATCH,MEDICATED 1.8 %	3	PA; QL (90 per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents		
Anti-Addiction/Substance Abuse Treatment Agents		
acamprosate oral tablet,delayed release (dr/ec) 333 mg	3	
buprenorphine hcl sublingual tablet 2 mg, 8 mg	2	GC; QL (90 per 30 days)
buprenorphine-naloxone sublingual film 12-3 mg (Suboxone)	4	QL (60 per 30 days)
buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg (Suboxone)	4	QL (90 per 30 days)
buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg	2	GC; QL (90 per 30 days)
bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg	2	GC
CHANTIX CONTINUING MONTH BOX ORAL TABLET 1 MG (varenicline)	3	QL (336 per 365 days)
disulfiram oral tablet 250 mg, 500 mg	2	GC
KLOXXADO NASAL SPRAY,NON-AEROSOL 8 MG/ACTUATION	3	QL (4 per 30 days)
LUCEMYRA ORAL TABLET 0.18 MG	5	NEDS; QL (228 per 14 days)
naloxone injection solution 0.4 mg/ml	1	GC
naloxone injection syringe 0.4 mg/ml, 1 mg/ml	2	GC
naloxone nasal spray,non-aerosol 4 mg/actuation (Narcan)	2	GC; QL (4 per 30 days)
naltrexone oral tablet 50 mg	2	GC

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

Drug Name		Drug Tier	Requirements/Limits
NARCAN NASAL SPRAY,NON-AEROSOL 4 MG/ACTUATION	(naloxone)	3	QL (4 per 30 days)
NICOTROL INHALATION CARTRIDGE 10 MG		4	QL (1008 per 90 days)
SUBLOCADE SUBCUTANEOUS SOLUTION, EXTENDED REL SYRINGE 100 MG/0.5 ML		5	NEDS; QL (0.5 per 30 days)
SUBLOCADE SUBCUTANEOUS SOLUTION, EXTENDED REL SYRINGE 300 MG/1.5 ML		5	NEDS; QL (1.5 per 30 days)
varenicline oral tablet 0.5 mg		2	GC; QL (336 per 365 days)
varenicline oral tablet 1 mg	(Chantix Continuing Month Box)	2	GC; QL (336 per 365 days)
varenicline oral tablets,dose pack 0.5 mg (11)- 1 mg (42)	(Chantix Starting Month Box)	2	GC
Antianxiety Agents			
Benzodiazepines			
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	(Xanax)	1	GC; NEDS; QL (120 per 30 days)
alprazolam oral tablet 2 mg	(Xanax)	1	GC; NEDS; QL (150 per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg		1	GC; NEDS; QL (120 per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	(Klonopin)	1	GC; QL (90 per 30 days)
clonazepam oral tablet 2 mg	(Klonopin)	1	GC; QL (300 per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg		4	QL (90 per 30 days)
clonazepam oral tablet,disintegrating 2 mg		4	QL (300 per 30 days)
clorazepate dipotassium oral tablet 15 mg, 3.75 mg		2	GC; QL (180 per 30 days)

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

Drug Name		Drug Tier	Requirements/Limits
clorazepate dipotassium oral tablet 7.5 mg	(Tranxene T-Tab)	2	GC; QL (180 per 30 days)
diazepam 25 mg/5 ml oral conc 5 mg/ml	(Diazepam Intensol)	4	QL (1200 per 30 days)
diazepam injection solution 5 mg/ml		2	GC; QL (10 per 28 days)
diazepam injection syringe 5 mg/ml		3	QL (10 per 28 days)
diazepam intensol oral concentrate 5 mg/ml	(diazepam)	4	QL (1200 per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)		4	QL (1200 per 30 days)
diazepam oral tablet 10 mg, 2 mg, 5 mg	(Valium)	1	GC; QL (120 per 30 days)
lorazepam injection solution 2 mg/ml, 4 mg/ml	(Ativan)	1	GC; QL (2 per 30 days)
lorazepam injection syringe 2 mg/ml, 4 mg/ml		1	GC; QL (2 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	(Ativan)	1	GC; NEDS; QL (90 per 30 days)
lorazepam oral tablet 2 mg	(Ativan)	1	GC; NEDS; QL (150 per 30 days)
temazepam oral capsule 15 mg, 30 mg	(Restoril)	1	GC; NEDS; QL (30 per 30 days)
Antibacterials			
Aminoglycosides			
gentamicin injection solution 20 mg/2 ml, 40 mg/ml		2	GC
gentamicin sulfate (ped) (pf) injection solution 20 mg/2 ml		2	GC
gentamicin sulfate (pf) intravenous solution 100 mg/10 ml, 60 mg/6 ml, 80 mg/8 ml		2	GC
neomycin oral tablet 500 mg		2	GC
streptomycin intramuscular recon soln 1 gram		5	NEDS
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG		5	NEDS; QL (224 per 28 days)

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

Drug Name		Drug Tier	Requirements/Limits
tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml	(Tobi)	5	PA BvD; NEDS
tobramycin inhalation solution for nebulization 300 mg/4 ml	(Bethkis)	5	PA BvD; NEDS
tobramycin sulfate injection solution 40 mg/ml		4	
Antibacterials, Miscellaneous			
chloramphenicol sod succinate intravenous recon soln 1 gram		2	GC
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	(Cleocin HCl)	1	GC
clindamycin in 5 % dextrose intravenous piggyback 300 mg/50 ml		2	GC
clindamycin phosphate injection solution 150 (mg/ml) (6 ml)		2	GC
clindamycin phosphate injection solution 150 mg/ml	(Cleocin)	2	GC
clindamycin phosphate intravenous solution 600 mg/4 ml		2	GC
colistin (colistimethate na) injection recon soln 150 mg	(Coly-Mycin M Parenteral)	5	NEDS
daptomycin intravenous recon soln 500 mg	(Cubicin RF)	5	NEDS
FIRVANQ ORAL RECON SOLN 25 MG/ML		4	
linezolid 600 mg/300 ml-0.9% nacl 600 mg/300 ml		3	
linezolid in dextrose 5% intravenous piggyback 600 mg/300 ml	(Zyvox)	3	
linezolid oral suspension for reconstitution 100 mg/5 ml	(Zyvox)	5	NEDS
linezolid oral tablet 600 mg	(Zyvox)	2	GC
methenamine hippurate oral tablet 1 gram	(Hiprex)	2	GC
metronidazole in nacl (iso-os) intravenous piggyback 500 mg/100 ml	(Metro I.V.)	2	GC

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

Drug Name		Drug Tier	Requirements/Limits
metronidazole oral tablet 250 mg, 500 mg		1	GC
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	(Macrodantin)	2	GC; QL (120 per 30 days)
nitrofurantoin macrocrystal oral capsule 25 mg	(Macrodantin)	4	QL (120 per 30 days)
nitrofurantoin monohyd/m-cryst oral capsule 100 mg	(Macrobid)	2	GC; QL (60 per 30 days)
polymyxin b sulfate injection recon soln 500,000 unit		2	GC
SYNERCID INTRAVENOUS RECON SOLN 500 MG		5	NEDS
trimethoprim oral tablet 100 mg		1	GC
vancomycin intravenous recon soln 1,000 mg, 10 gram, 5 gram, 500 mg, 750 mg		2	GC
vancomycin oral capsule 125 mg	(Vancocin)	4	QL (56 per 14 days)
vancomycin oral capsule 250 mg	(Vancocin)	4	QL (112 per 14 days)
XIFAXAN ORAL TABLET 200 MG		5	PA; NEDS; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG		5	PA; NEDS; QL (90 per 30 days)
Cephalosporins			
cefaclor oral capsule 250 mg, 500 mg		2	GC
cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml		4	
cefadroxil oral capsule 500 mg		2	GC
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml		2	GC
cefazolin in dextrose (iso-os) intravenous piggyback 2 gram/50 ml		2	GC
cefazolin injection recon soln 1 gram, 10 gram, 500 mg		2	GC
cefdinir oral capsule 300 mg		2	GC

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Drug Name	Drug Tier	Requirements/Limits
cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	4	
cefepime injection recon soln 1 gram, 2 gram	3	
cefixime oral capsule 400 mg (Suprax)	4	
cefotaxime injection recon soln 1 gram	2	GC
cefoxitin 1 gm piggyback bag 1 gram/50 ml	4	
cefoxitin intravenous recon soln 1 gram	4	
cefoxitin intravenous recon soln 10 gram, 2 gram	4	
cefpodoxime oral suspension for reconstitution 100 mg/5 ml, 50 mg/5 ml	4	
cefpodoxime oral tablet 100 mg, 200 mg	2	GC
cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	2	GC
cefprozil oral tablet 250 mg, 500 mg	2	GC
ceftazidime injection recon soln 1 gram, 2 gram, 6 gram (Tazicef)	2	GC
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	2	GC
cefuroxime axetil oral tablet 250 mg, 500 mg	2	GC
cefuroxime sodium injection recon soln 750 mg	2	GC
cefuroxime sodium intravenous recon soln 1.5 gram, 7.5 gram	2	GC
cephalexin oral capsule 250 mg, 500 mg	1	GC
cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	2	GC

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Drug Name		Drug Tier	Requirements/Limits
TEFLARO INTRAVENOUS RECON SOLN 400 MG, 600 MG		5	NEDS
Macrolides			
azithromycin intravenous recon soln 500 mg	(Zithromax)	2	GC
azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml	(Zithromax)	4	
azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)		1	GC
azithromycin oral tablet 250 mg, 500 mg	(Zithromax)	1	GC
azithromycin oral tablet 600 mg		2	GC
clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml		4	
clarithromycin oral tablet 250 mg, 500 mg		2	GC
DIFICID ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML		5	NEDS; QL (136 per 10 days)
DIFICID ORAL TABLET 200 MG		5	NEDS; QL (20 per 10 days)
erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml	(E.E.S. Granules)	4	
erythromycin ethylsuccinate oral suspension for reconstitution 400 mg/5 ml	(EryPed 400)	4	
erythromycin oral tablet 250 mg, 500 mg		4	
Miscellaneous B-Lactam Antibiotics			
aztreonam injection recon soln 1 gram, 2 gram	(Azactam)	3	
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML		5	PA; LA; NEDS
ertapenem injection recon soln 1 gram	(Invanz)	4	

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Drug Name	Drug Tier	Requirements/Limits
imipenem-cilastatin intravenous recon soln 250 mg	3	
imipenem-cilastatin intravenous recon soln 500 mg (Primaxin IV)	3	
meropenem intravenous recon soln 1 gram	4	
meropenem intravenous recon soln 500 mg	4	
meropenem-0.9% nacl 500 mg/50 500 mg/50 ml	4	
Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	GC
amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml	1	GC
amoxicillin oral tablet 500 mg, 875 mg	1	GC
amoxicillin oral tablet,chewable 125 mg, 250 mg	2	GC
amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 400-57 mg/5 ml	4	
amoxicillin-pot clavulanate oral suspension for reconstitution 600-42.9 mg/5 ml (Augmentin ES-600)	4	
amoxicillin-pot clavulanate oral tablet 500-125 mg (Augmentin)	1	GC
amoxicillin-pot clavulanate oral tablet 875-125 mg	1	GC
amoxicillin-pot clavulanate oral tablet,chewable 200-28.5 mg, 400-57 mg	4	
ampicillin oral capsule 250 mg, 500 mg	2	GC
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg, 2 gram, 250 mg, 500 mg	3	

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Drug Name	Drug Tier	Requirements/Limits
ampicillin-sulbactam injection recon soln 1.5 gram, 15 gram, 3 gram (Unasyn)	3	
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML, 600,000 UNIT/ML	4	
dicloxacillin oral capsule 250 mg, 500 mg	2	GC
nafcillin 1 gm/ 50 ml inj 1 gram/50 ml	2	GC
nafcillin 2 gm/ 100 ml inj 2 gram/100 ml	2	GC
nafcillin injection recon soln 1 gram, 2 gram	2	GC
nafcillin injection recon soln 10 gram	5	NEDS
penicillin g potassium injection recon soln 20 million unit (Pfizerpen-G)	4	
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml, 600,000 unit/ml	2	GC
penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml	2	GC
penicillin v potassium oral tablet 250 mg, 500 mg	1	GC
pfizerpen-g injection recon soln 20 million unit (penicillin g potassium)	4	
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram	3	
piperacillin-tazobactam intravenous recon soln 40.5 gram	4	
Quinolones		
BAXDELA ORAL TABLET 450 MG	5	PA; NEDS; QL (28 per 14 days)
ciprofloxacin hcl oral tablet 250 mg, 500 mg (Cipro)	1	GC
ciprofloxacin hcl oral tablet 750 mg	1	GC

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Drug Name		Drug Tier	Requirements/Limits
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml, 400 mg/200 ml		2	GC
ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml, 500 mg/5 ml	(Cipro)	4	
levofloxacin in d5w intravenous piggyback 250 mg/50 ml, 500 mg/100 ml, 750 mg/150 ml		2	GC
levofloxacin intravenous solution 25 mg/ml		4	
levofloxacin oral solution 250 mg/10 ml		4	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg		1	GC
moxifloxacin oral tablet 400 mg		4	
Sulfonamides			
sulfadiazine oral tablet 500 mg		3	
sulfamethoxazole-trimethoprim intravenous solution 400-80 mg/5 ml		4	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml	(Sulfatrim)	4	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg	(Bactrim)	1	GC
sulfamethoxazole-trimethoprim oral tablet 800-160 mg	(Bactrim DS)	1	GC
Tetracyclines			
doxy-100 intravenous recon soln 100 mg	(doxycycline hyclate)	3	
doxycycline hyclate intravenous recon soln 100 mg	(Doxy-100)	2	GC
doxycycline hyclate oral capsule 100 mg, 50 mg	(Morgidox)	2	GC
doxycycline hyclate oral tablet 100 mg	(LymePak)	2	GC
doxycycline hyclate oral tablet 20 mg		2	GC
doxycycline monohydrate oral capsule 100 mg	(Mondoxyne NL)	2	GC; QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
doxycycline monohydrate oral capsule 50 mg	(Monodox)	2	GC; QL (60 per 30 days)
doxycycline monohydrate oral suspension for reconstitution 25 mg/5 ml	(Vibramycin (mono))	2	GC
doxycycline monohydrate oral tablet 100 mg	(Avidoxy)	2	GC; QL (60 per 30 days)
doxycycline monohydrate oral tablet 50 mg		2	GC; QL (60 per 30 days)
minocycline oral capsule 100 mg, 50 mg, 75 mg		2	GC
mondoxyne nl oral capsule 100 mg	(doxycycline monohydrate)	2	GC; QL (60 per 30 days)
tetracycline oral capsule 250 mg, 500 mg		4	
tigecycline intravenous recon soln 50 mg	(Tygacil)	5	NEDS
Anticancer Agents			
Anticancer Agents			
abiraterone oral tablet 250 mg, 500 mg	(Zytiga)	5	PA NSO; NEDS; QL (120 per 30 days)
ABRAXANE INTRAVENOUS SUSPENSION FOR RECONSTITUTION 100 MG	(paclitaxel protein-bound)	5	PA BvD; NEDS
ADCETRIS INTRAVENOUS RECON SOLN 50 MG		5	PA NSO; NEDS
adriamycin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml	(doxorubicin)	2	PA BvD; GC
adrucil intravenous solution 2.5 gram/50 ml	(fluorouracil)	2	PA BvD; GC
ALECENSA ORAL CAPSULE 150 MG		5	PA NSO; NEDS; QL (240 per 30 days)
ALIMTA INTRAVENOUS RECON SOLN 100 MG, 500 MG	(pemetrexed disodium)	5	NEDS
ALIQOPA INTRAVENOUS RECON SOLN 60 MG		5	PA NSO; NEDS; QL (3 per 28 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG		5	PA NSO; NEDS; QL (30 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
ALUNBRIG ORAL TABLET 30 MG		5	PA NSO; NEDS; QL (120 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK 90 MG (7)- 180 MG (23)		5	PA NSO; NEDS
alymsys intravenous solution 25 mg/ml		5	PA NSO; NEDS
anastrozole oral tablet 1 mg	(Arimidex)	1	GC
arsenic trioxide intravenous solution 1 mg/ml		5	NEDS
arsenic trioxide intravenous solution 2 mg/ml	(Trisenox)	5	NEDS
ASPARLAS INTRAVENOUS SOLUTION 750 UNIT/ML		5	PA NSO; NEDS
AVASTIN INTRAVENOUS SOLUTION 25 MG/ML		5	PA NSO; NEDS
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG		5	PA NSO; NEDS; QL (30 per 30 days)
azacitidine injection recon soln 100 mg	(Vidaza)	5	NEDS
BALVERSA ORAL TABLET 3 MG		5	PA NSO; NEDS; QL (84 per 28 days)
BALVERSA ORAL TABLET 4 MG		5	PA NSO; NEDS; QL (56 per 28 days)
BALVERSA ORAL TABLET 5 MG		5	PA NSO; NEDS; QL (28 per 28 days)
BAVENCIO INTRAVENOUS SOLUTION 20 MG/ML		5	PA NSO; NEDS
BELEODAQ INTRAVENOUS RECON SOLN 500 MG		5	PA NSO; NEDS
BENDEKA INTRAVENOUS SOLUTION 25 MG/ML	(bendamustine)	5	PA NSO; NEDS
BESPONSA INTRAVENOUS RECON SOLN 0.9 MG (0.25 MG/ML INITIAL)		5	PA NSO; NEDS
bexarotene oral capsule 75 mg	(Targretin)	5	PA NSO; NEDS
bexarotene topical gel 1 %	(Targretin)	5	PA NSO; NEDS
bicalutamide oral tablet 50 mg	(Casodex)	2	GC

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Drug Name	Drug Tier	Requirements/Limits
BLENREP INTRAVENOUS RECON SOLN 100 MG	5	PA NSO; NEDS
bleomycin injection recon soln 15 unit, 30 unit	2	GC
BLINCYTO INTRAVENOUS KIT 35 MCG	5	PA NSO; NEDS
bortezomib injection recon soln 1 mg	4	PA NSO
bortezomib injection recon soln 2.5 mg	5	PA NSO; NEDS
BORTEZOMIB INTRAVENOUS RECON SOLN 3.5 MG	5	PA NSO; NEDS
BOSULIF ORAL TABLET 100 MG	5	PA NSO; NEDS; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PA NSO; NEDS; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5	PA NSO; NEDS; QL (180 per 30 days)
BRUKINSA ORAL CAPSULE 80 MG	5	PA NSO; NEDS; QL (120 per 30 days)
CABOMETYX ORAL TABLET 20 MG, 60 MG	5	PA NSO; NEDS; QL (30 per 30 days)
CABOMETYX ORAL TABLET 40 MG	5	PA NSO; NEDS; QL (60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET 100 MG	5	PA NSO; NEDS; QL (60 per 30 days)
CALQUENCE ORAL CAPSULE 100 MG	5	PA NSO; NEDS; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG (vandetanib)	5	PA NSO; NEDS; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG (vandetanib)	5	PA NSO; NEDS; QL (30 per 30 days)
clofarabine intravenous solution 1 mg/ml (Clolar)	5	NEDS
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)	5	PA NSO; NEDS; QL (112 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA NSO; NEDS; QL (56 per 28 days)
COTELLIC ORAL TABLET 20 MG	5	PA NSO; LA; NEDS; QL (63 per 28 days)
cyclophosphamide intravenous recon soln 1 gram, 2 gram, 500 mg	5	PA BvD; NEDS
cyclophosphamide intravenous solution 200 mg/ml	5	PA BvD; NEDS
CYCLOPHOSPHAMIDE ORAL CAPSULE 25 MG, 50 MG	4	PA BvD; ST
cyclophosphamide oral tablet 25 mg, 50 mg	3	PA BvD; ST
CYRAMZA INTRAVENOUS SOLUTION 10 MG/ML	5	PA NSO; NEDS
DANYELZA INTRAVENOUS SOLUTION 4 MG/ML	5	PA NSO; NEDS; QL (120 per 28 days)
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1,800 MG-30,000 UNIT/15 ML	5	PA NSO; NEDS
DARZALEX INTRAVENOUS SOLUTION 20 MG/ML	5	PA NSO; LA; NEDS
DAURISMO ORAL TABLET 100 MG	5	PA NSO; NEDS; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	5	PA NSO; NEDS; QL (60 per 30 days)
decitabine intravenous recon soln 50 mg (Dacogen)	5	NEDS
doxorubicin intravenous solution 10 mg/5 ml, 2 mg/ml, 20 mg/10 ml, 50 mg/25 ml	2	PA BvD; GC
doxorubicin, peg-liposomal intravenous suspension 2 mg/ml (Doxil)	5	PA BvD; NEDS
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	4	
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	4	

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Drug Name	Drug Tier	Requirements/Limits
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	4	
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	4	
EMCYT ORAL CAPSULE 140 MG	5	NEDS
EMPLICITI INTRAVENOUS RECON SOLN 300 MG, 400 MG	5	PA NSO; NEDS
ENHERTU INTRAVENOUS RECON SOLN 100 MG	5	PA NSO; NEDS
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, 200 MG/100 ML	5	PA NSO; NEDS
ERIVEDGE ORAL CAPSULE 150 MG	5	PA NSO; NEDS; QL (30 per 30 days)
ERLEADA ORAL TABLET 60 MG	5	PA NSO; NEDS; QL (120 per 30 days)
erlotinib oral tablet 100 mg, 25 mg (Tarceva)	5	PA NSO; NEDS; QL (60 per 30 days)
erlotinib oral tablet 150 mg (Tarceva)	5	PA NSO; NEDS; QL (90 per 30 days)
ETOPOPHOS INTRAVENOUS RECON SOLN 100 MG	4	
etoposide intravenous solution 20 mg/ml (Toposar)	2	GC
everolimus (antineoplastic) oral tablet 10 mg (Afinitor)	5	PA NSO; NEDS; QL (56 per 28 days)
everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg, 7.5 mg (Afinitor)	5	PA NSO; NEDS; QL (28 per 28 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg (Afinitor Disperz)	5	PA NSO; NEDS; QL (112 per 28 days)
exemestane oral tablet 25 mg (Aromasin)	4	
EXKIVITY ORAL CAPSULE 40 MG	5	PA NSO; NEDS; QL (120 per 30 days)
FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG	5	PA NSO; NEDS

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Drug Name		Drug Tier	Requirements/Limits
floxuridine injection recon soln 0.5 gram		2	PA BvD; GC
fluorouracil intravenous solution 1 gram/20 ml, 5 gram/100 ml, 500 mg/10 ml		2	PA BvD; GC
flutamide oral capsule 125 mg	(Eulexin)	3	
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG		5	PA NSO; NEDS; QL (21 per 28 days)
fulvestrant intramuscular syringe 250 mg/5 ml	(Faslodex)	5	NEDS
GAVRETO ORAL CAPSULE 100 MG		5	PA NSO; NEDS; QL (120 per 30 days)
GAZYVA INTRAVENOUS SOLUTION 1,000 MG/40 ML		5	PA NSO; NEDS
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG		5	PA NSO; NEDS; QL (30 per 30 days)
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION 600 MG-10,000 UNIT/5 ML		5	PA NSO; NEDS; QL (5 per 21 days)
HERCEPTIN INTRAVENOUS RECON SOLN 150 MG		5	PA NSO; NEDS
HERZUMA INTRAVENOUS RECON SOLN 150 MG, 420 MG		5	PA NSO; NEDS
hydroxyurea oral capsule 500 mg	(Hydrea)	2	GC
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG		5	PA NSO; NEDS; QL (21 per 28 days)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG		5	PA NSO; NEDS; QL (21 per 28 days)
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG		5	PA NSO; NEDS; QL (30 per 30 days)
IDHIFA ORAL TABLET 100 MG, 50 MG		5	PA NSO; NEDS; QL (30 per 30 days)
ifosfamide intravenous recon soln 1 gram	(Ifex)	2	GC
ifosfamide intravenous solution 1 gram/20 ml, 3 gram/60 ml		2	GC
imatinib oral tablet 100 mg	(Gleevec)	3	PA NSO; QL (180 per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
imatinib oral tablet 400 mg (Gleevec)	3	PA NSO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA NSO; NEDS; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA NSO; NEDS; QL (28 per 28 days)
IMBRUVICA ORAL SUSPENSION 70 MG/ML	5	PA NSO; NEDS; QL (240 per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	5	PA NSO; NEDS; QL (28 per 28 days)
IMFINZI INTRAVENOUS SOLUTION 50 MG/ML	5	PA NSO; NEDS
IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML	4	PA NSO; QL (4 per 365 days)
IMLYGIC INJECTION SUSPENSION 10EXP8 (100 MILLION) PFU/ML	5	PA NSO; NEDS; QL (8 per 28 days)
INLYTA ORAL TABLET 1 MG	5	PA NSO; NEDS; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	5	PA NSO; NEDS; QL (120 per 30 days)
INQOVI ORAL TABLET 35-100 MG	5	PA NSO; NEDS; QL (5 per 28 days)
INREBIC ORAL CAPSULE 100 MG	5	PA NSO; NEDS; QL (120 per 30 days)
IRESSA ORAL TABLET 250 MG	5	PA NSO; NEDS; QL (60 per 30 days)
IXEMPRA INTRAVENOUS RECON SOLN 15 MG, 45 MG	5	NEDS
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA NSO; NEDS; QL (60 per 30 days)
JEMPERLI INTRAVENOUS SOLUTION 50 MG/ML	5	PA NSO; NEDS
KANJINTI INTRAVENOUS RECON SOLN 150 MG, 420 MG	5	PA NSO; NEDS
KEYTRUDA INTRAVENOUS SOLUTION 25 MG/ML	5	PA NSO; NEDS; QL (8 per 21 days)

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Drug Name	Drug Tier	Requirements/Limits
KIMMTRAK INTRAVENOUS SOLUTION 100 MCG/0.5 ML	5	PA NSO; NEDS; QL (2 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	5	PA NSO; NEDS; QL (49 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	5	PA NSO; NEDS; QL (70 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	5	PA NSO; NEDS; QL (91 per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA NSO; NEDS; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PA NSO; NEDS; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PA NSO; NEDS; QL (63 per 28 days)
KOSELUGO ORAL CAPSULE 10 MG	5	PA NSO; NEDS; QL (300 per 30 days)
KOSELUGO ORAL CAPSULE 25 MG	5	PA NSO; NEDS; QL (120 per 30 days)
KYPROLIS INTRAVENOUS RECON SOLN 10 MG, 30 MG, 60 MG	5	PA NSO; NEDS
lapatinib oral tablet 250 mg (Tykerb)	5	PA NSO; NEDS
lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg (Revlimid)	5	PA NSO; NEDS; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)	5	PA NSO; NEDS
letrozole oral tablet 2.5 mg (Femara)	1	GC
LEUKERAN ORAL TABLET 2 MG	5	NEDS
leuprolide subcutaneous kit 1 mg/0.2 ml	5	NEDS

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Drug Name	Drug Tier	Requirements/Limits
LIBTAYO INTRAVENOUS SOLUTION 50 MG/ML	5	PA NSO; NEDS; QL (7 per 21 days)
LONSURF ORAL TABLET 15-6.14 MG	5	PA NSO; NEDS; QL (100 per 28 days)
LONSURF ORAL TABLET 20-8.19 MG	5	PA NSO; NEDS; QL (80 per 28 days)
LORBRENA ORAL TABLET 100 MG	5	PA NSO; NEDS; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA NSO; NEDS; QL (90 per 30 days)
LUMAKRAS ORAL TABLET 120 MG	5	PA NSO; NEDS; QL (240 per 30 days)
LUMOXITI INTRAVENOUS RECON SOLN 1 MG	5	PA NSO; NEDS
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	5	NEDS
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	5	NEDS
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG	5	NEDS
LYNPARZA ORAL TABLET 100 MG, 150 MG	5	PA NSO; NEDS; QL (120 per 30 days)
LYSODREN ORAL TABLET 500 MG	5	NEDS
MARGENZA INTRAVENOUS SOLUTION 25 MG/ML	5	PA NSO; NEDS
MATULANE ORAL CAPSULE 50 MG	5	NEDS
megestrol oral tablet 20 mg, 40 mg	2	GC
MEKINIST ORAL TABLET 0.5 MG	5	PA NSO; NEDS; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PA NSO; NEDS; QL (30 per 30 days)
MEKTOVI ORAL TABLET 15 MG	5	PA NSO; NEDS; QL (180 per 30 days)
mercaptopurine oral tablet 50 mg	2	GC

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

Drug Name	Drug Tier	Requirements/Limits
methotrexate sodium (pf) injection recon soln 1 gram	2	GC
methotrexate sodium (pf) injection solution 25 mg/ml	2	GC
methotrexate sodium injection solution 25 mg/ml	2	GC
methotrexate sodium oral tablet 2.5 mg	2	PA BvD; ST; GC
mitoxantrone intravenous concentrate 2 mg/ml	2	GC
MONJUVI INTRAVENOUS RECON SOLN 200 MG	5	PA NSO; NEDS
MVASI INTRAVENOUS SOLUTION 25 MG/ML	5	PA NSO; NEDS
MYLOTARG INTRAVENOUS RECON SOLN 4.5 MG (1 MG/ML INITIAL CONC)	5	PA NSO; NEDS
NERLYNX ORAL TABLET 40 MG	5	PA NSO; NEDS; QL (180 per 30 days)
nilutamide oral tablet 150 mg (Nilandron)	5	NEDS
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA NSO; NEDS; QL (3 per 28 days)
NUBEQA ORAL TABLET 300 MG	5	PA NSO; NEDS; QL (120 per 30 days)
ODOMZO ORAL CAPSULE 200 MG	5	PA NSO; LA; NEDS
OGIVRI INTRAVENOUS RECON SOLN 150 MG, 420 MG	5	PA NSO; NEDS
ONCASPAR INJECTION SOLUTION 750 UNIT/ML	5	PA NSO; NEDS
ONIVYDE INTRAVENOUS DISPERSION 4.3 MG/ML	5	NEDS
ONTRUZANT INTRAVENOUS RECON SOLN 150 MG, 420 MG	5	PA NSO; NEDS
ONUREG ORAL TABLET 200 MG, 300 MG	5	PA NSO; NEDS; QL (14 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 120 MG/12 ML, 240 MG/24 ML, 40 MG/4 ML	5	PA NSO; NEDS
OPDUALAG INTRAVENOUS SOLUTION 240-80 MG/20 ML	5	PA NSO; NEDS
paclitaxel protein-bound intravenous suspension for reconstitution 100 mg (Abraxane)	5	PA BvD; NEDS
PADCEV INTRAVENOUS RECON SOLN 20 MG, 30 MG	5	PA NSO; NEDS
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	5	PA NSO; NEDS; QL (30 per 30 days)
pemetrexed disodium intravenous recon soln 750 mg	5	NEDS
pemetrexed disodium intravenous solution 25 mg/ml	5	NEDS
pemetrexed intravenous recon soln 1 gram, 100 mg, 500 mg	5	NEDS
PEPAXTO INTRAVENOUS RECON SOLN 20 MG	5	PA NSO; NEDS; QL (2 per 28 days)
PHESGO SUBCUTANEOUS SOLUTION 1,200 MG-600MG-30000 UNIT/15ML	5	PA NSO; NEDS; QL (15 per 21 days)
PHESGO SUBCUTANEOUS SOLUTION 600 MG-600 MG-20000 UNIT/10ML	5	PA NSO; NEDS; QL (10 per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA NSO; NEDS; QL (28 per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	5	PA NSO; NEDS; QL (56 per 28 days)
POLIVY INTRAVENOUS RECON SOLN 140 MG, 30 MG	5	PA NSO; NEDS
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA NSO; NEDS; QL (21 per 28 days)
PORTRAZZA INTRAVENOUS SOLUTION 800 MG/50 ML (16 MG/ML)	5	PA NSO; NEDS; QL (100 per 21 days)

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Drug Name	Drug Tier	Requirements/Limits
PROLEUKIN INTRAVENOUS RECON SOLN 22 MILLION UNIT	5	NEDS
PURIXAN ORAL SUSPENSION 20 MG/ML	5	NEDS
QINLOCK ORAL TABLET 50 MG	5	PA NSO; NEDS; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	5	PA NSO; NEDS; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5	PA NSO; NEDS; QL (120 per 30 days)
REVLIMID ORAL CAPSULE (lenalidomide) 2.5 MG, 20 MG	5	PA NSO; LA; NEDS; QL (28 per 28 days)
RIABNI INTRAVENOUS SOLUTION 10 MG/ML	5	PA NSO; NEDS
RITUXAN HYCELA SUBCUTANEOUS SOLUTION 1400 MG/11.7 ML (120 MG/ML), 1600 MG/13.4 ML (120 MG/ML)	5	PA NSO; NEDS
RITUXAN INTRAVENOUS CONCENTRATE 10 MG/ML	5	PA NSO; NEDS
ROZLYTREK ORAL CAPSULE 100 MG	5	PA NSO; NEDS; QL (180 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5	PA NSO; NEDS; QL (90 per 30 days)
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA NSO; NEDS; QL (120 per 30 days)
RUXIENCE INTRAVENOUS SOLUTION 10 MG/ML	5	PA NSO; NEDS
RYBREVANT INTRAVENOUS SOLUTION 50 MG/ML	5	PA NSO; NEDS
RYDAPT ORAL CAPSULE 25 MG	5	PA NSO; NEDS; QL (224 per 28 days)
SARCLISA INTRAVENOUS SOLUTION 20 MG/ML	5	PA NSO; NEDS
SCEMBLIX ORAL TABLET 20 MG, 40 MG	5	PA NSO; NEDS
SOLTAMOX ORAL SOLUTION 20 MG/10 ML	5	NEDS

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Drug Name	Drug Tier	Requirements/Limits
sorafenib oral tablet 200 mg (Nexavar)	5	PA NSO; NEDS; QL (120 per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG	5	PA NSO; NEDS; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG	5	PA NSO; NEDS; QL (90 per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA NSO; NEDS; QL (84 per 28 days)
sunitinib oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg (Sutent)	5	PA NSO; NEDS; QL (30 per 30 days)
SYLVANT INTRAVENOUS RECON SOLN 100 MG, 400 MG	5	PA NSO; NEDS
SYNRIBO SUBCUTANEOUS RECON SOLN 3.5 MG	5	PA NSO; NEDS
TABLOID ORAL TABLET 40 MG (thioguanine)	4	
TABRECTA ORAL TABLET 150 MG, 200 MG	5	PA NSO; NEDS; QL (120 per 30 days)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	5	PA NSO; NEDS; QL (120 per 30 days)
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA NSO; LA; NEDS; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG	5	PA NSO; NEDS; QL (90 per 30 days)
TALZENNA ORAL CAPSULE 0.5 MG, 0.75 MG, 1 MG	5	PA NSO; NEDS; QL (30 per 30 days)
tamoxifen oral tablet 10 mg, 20 mg	2	GC
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PA NSO; NEDS; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	5	PA NSO; NEDS; QL (120 per 30 days)
TAZVERIK ORAL TABLET 200 MG	5	PA NSO; NEDS; QL (240 per 30 days)
TECENTRIQ INTRAVENOUS SOLUTION 1,200 MG/20 ML (60 MG/ML), 840 MG/14 ML (60 MG/ML)	5	PA NSO; NEDS

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Drug Name	Drug Tier	Requirements/Limits
TEMODAR INTRAVENOUS RECON SOLN 100 MG	5	PA NSO; NEDS
TEPMETKO ORAL TABLET 225 MG	5	PA NSO; NEDS; QL (60 per 30 days)
thiotepa injection recon soln 100 mg, 15 mg (Tepadina)	5	NEDS
TIBSOVO ORAL TABLET 250 MG	5	PA NSO; NEDS; QL (60 per 30 days)
TICE BCG INTRAVESICAL SUSPENSION FOR RECONSTITUTION 50 MG	4	
TIVDAK INTRAVENOUS RECON SOLN 40 MG	5	PA NSO; NEDS; QL (5 per 21 days)
toposar intravenous solution 20 mg/ml (etoposide)	2	GC
toremifene oral tablet 60 mg (Fareston)	5	NEDS
TRAZIMERA INTRAVENOUS RECON SOLN 150 MG, 420 MG	5	PA NSO; NEDS
TREANDA INTRAVENOUS RECON SOLN 100 MG, 25 MG	5	PA NSO; NEDS
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG	5	NEDS; QL (1 per 84 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG	5	NEDS; QL (1 per 168 days)
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 3.75 MG	4	QL (1 per 28 days)
tretinoin (antineoplastic) oral capsule 10 mg	5	NEDS
TRODELVY INTRAVENOUS RECON SOLN 180 MG	5	PA NSO; NEDS

Drug Name	Drug Tier	Requirements/Limits
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1), 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2), 75 MG/DAY (25 MG X 3)	5	PA NSO; NEDS
TRUXIMA INTRAVENOUS SOLUTION 10 MG/ML	5	PA NSO; NEDS
TUKYSA ORAL TABLET 150 MG	5	PA NSO; NEDS; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	5	PA NSO; NEDS; QL (300 per 30 days)
TURALIO ORAL CAPSULE 200 MG	5	PA NSO; NEDS; QL (120 per 30 days)
UNITUXIN INTRAVENOUS SOLUTION 3.5 MG/ML	5	PA NSO; NEDS
valrubicin intravesical solution 40 mg/ml (Valstar)	5	NEDS
VELCADE INJECTION RECON SOLN 3.5 MG (bortezomib)	5	PA NSO; NEDS
VENCLEXTA ORAL TABLET 10 MG	3	PA NSO; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	5	PA NSO; LA; NEDS; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	3	PA NSO; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG	5	PA NSO; LA; NEDS
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA NSO; NEDS; QL (56 per 28 days)
vinorelbine intravenous solution 10 mg/ml, 50 mg/5 ml (Navelbine)	2	GC
VITRAKVI ORAL CAPSULE 100 MG	5	PA NSO; NEDS; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PA NSO; NEDS; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA NSO; NEDS; QL (300 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA NSO; NEDS; QL (30 per 30 days)
VONJO ORAL CAPSULE 100 MG	5	PA NSO; NEDS; QL (120 per 30 days)
VOTRIENT ORAL TABLET 200 MG	5	PA NSO; NEDS; QL (120 per 30 days)
VYXEOS INTRAVENOUS RECON SOLN 44-100 MG	5	PA BvD; NEDS
WELIREG ORAL TABLET 40 MG	5	PA NSO; NEDS; QL (90 per 30 days)
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA NSO; NEDS; QL (120 per 30 days)
XATMEP ORAL SOLUTION 2.5 MG/ML	4	PA BvD; ST
XOSPATA ORAL TABLET 40 MG	5	PA NSO; NEDS; QL (90 per 30 days)
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5)	5	PA NSO; NEDS; QL (20 per 28 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (20 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	5	PA NSO; NEDS; QL (8 per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	5	PA NSO; NEDS; QL (4 per 28 days)
XPOVIO ORAL TABLET 40MG TWICE WEEK (80 MG/WEEK), 80 MG/WEEK (20 MG X 4)	5	PA NSO; NEDS; QL (16 per 28 days)
XPOVIO ORAL TABLET 60 MG/WEEK (20 MG X 3)	5	PA NSO; NEDS; QL (12 per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	5	PA NSO; NEDS; QL (24 per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	5	PA NSO; NEDS; QL (32 per 28 days)
XTANDI ORAL CAPSULE 40 MG	5	PA NSO; NEDS; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA NSO; NEDS; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
XTANDI ORAL TABLET 80 MG	5	PA NSO; NEDS; QL (60 per 30 days)
YERVOY INTRAVENOUS SOLUTION 200 MG/40 ML (5 MG/ML), 50 MG/10 ML (5 MG/ML)	5	PA NSO; NEDS
YONDELIS INTRAVENOUS RECON SOLN 1 MG	5	PA NSO; NEDS
YONSA ORAL TABLET 125 MG	5	PA NSO; NEDS; QL (120 per 30 days)
ZEJULA ORAL CAPSULE 100 MG	5	PA NSO; NEDS; QL (90 per 30 days)
ZELBORAF ORAL TABLET 240 MG	5	PA NSO; NEDS; QL (240 per 30 days)
ZEPZELCA INTRAVENOUS RECON SOLN 4 MG	5	PA NSO; NEDS
ZIRABEV INTRAVENOUS SOLUTION 25 MG/ML	5	PA NSO; NEDS
ZOLADEX SUBCUTANEOUS IMPLANT 10.8 MG	4	QL (1 per 84 days)
ZOLADEX SUBCUTANEOUS IMPLANT 3.6 MG	4	QL (1 per 28 days)
ZOLINZA ORAL CAPSULE 100 MG	5	NEDS
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA NSO; NEDS; QL (60 per 30 days)
ZYKADIA ORAL TABLET 150 MG	5	PA NSO; NEDS; QL (84 per 28 days)
ZYNLONTA INTRAVENOUS RECON SOLN 10 MG	5	PA NSO; NEDS
Anticonvulsants		
Anticonvulsants		
APTIOM ORAL TABLET 200 MG, 400 MG	5	ST; NEDS; QL (30 per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	5	ST; NEDS; QL (60 per 30 days)
BRIVIACT INTRAVENOUS SOLUTION 50 MG/5 ML	3	QL (80 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
BRIVIACT ORAL SOLUTION 10 MG/ML		3	QL (600 per 30 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG		3	QL (60 per 30 days)
carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg	(Carbatrol)	4	
carbamazepine oral suspension 100 mg/5 ml	(Tegretol)	4	
carbamazepine oral tablet 200 mg	(Epitol)	2	GC
carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg	(Tegretol XR)	4	
carbamazepine oral tablet,chewable 100 mg		2	GC
CELONTIN ORAL CAPSULE 300 MG		4	
clobazam oral suspension 2.5 mg/ml	(Onfi)	4	QL (480 per 30 days)
clobazam oral tablet 10 mg, 20 mg	(Onfi)	4	QL (60 per 30 days)
DIACOMIT ORAL CAPSULE 250 MG		5	PA NSO; NEDS; QL (360 per 30 days)
DIACOMIT ORAL CAPSULE 500 MG		5	PA NSO; NEDS; QL (180 per 30 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG		5	PA NSO; NEDS; QL (360 per 30 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG		5	PA NSO; NEDS; QL (180 per 30 days)
diazepam rectal kit 12.5-15-17.5-20 mg, 5-7.5-10 mg	(Diastat AcuDial)	4	
diazepam rectal kit 2.5 mg	(Diastat)	4	
divalproex oral capsule, delayed rel sprinkle 125 mg	(Depakote Sprinkles)	2	GC
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	(Depakote ER)	2	GC
divalproex oral tablet,delayed release (dr/ec) 125 mg, 250 mg, 500 mg	(Depakote)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
EPIDIOLEX ORAL SOLUTION 100 MG/ML		5	PA NSO; NEDS
epitol oral tablet 200 mg	(carbamazepine)	2	GC
EPRONTIA ORAL SOLUTION 25 MG/ML		4	QL (480 per 30 days)
ethosuximide oral capsule 250 mg	(Zarontin)	3	
ethosuximide oral solution 250 mg/5 ml	(Zarontin)	2	GC
felbamate oral suspension 600 mg/5 ml	(Felbatol)	4	
felbamate oral tablet 400 mg, 600 mg	(Felbatol)	4	
FINTEPLA ORAL SOLUTION 2.2 MG/ML		5	PA NSO; NEDS
fosphenytoin injection solution 100 mg pe/2 ml, 500 mg pe/10 ml	(Cerebyx)	2	GC
FYCOMPA ORAL SUSPENSION 0.5 MG/ML		5	ST; NEDS; QL (720 per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG		5	ST; NEDS; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG		4	ST; QL (30 per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG		5	ST; NEDS; QL (60 per 30 days)
gabapentin oral capsule 100 mg, 300 mg	(Neurontin)	1	GC; QL (360 per 30 days)
gabapentin oral capsule 400 mg	(Neurontin)	1	GC; QL (270 per 30 days)
gabapentin oral solution 250 mg/5 ml	(Neurontin)	4	QL (2160 per 30 days)
gabapentin oral tablet 600 mg	(Neurontin)	2	GC; QL (180 per 30 days)
gabapentin oral tablet 800 mg	(Neurontin)	2	GC; QL (120 per 30 days)
lacosamide intravenous solution 200 mg/20 ml	(Vimpat)	2	GC; QL (200 per 5 days)
lacosamide oral solution 10 mg/ml	(Vimpat)	2	GC; QL (1200 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	(Vimpat)	2	GC; QL (60 per 30 days)
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	(Subvenite)	1	GC
lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg	(Lamictal)	2	GC
levetiracetam intravenous solution 500 mg/5 ml	(Keppra)	2	GC
levetiracetam oral solution 100 mg/ml	(Keppra)	2	GC
levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg	(Keppra)	2	GC
levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg	(Keppra XR)	2	GC
NAYZILAM NASAL SPRAY,NON-AEROSOL 5 MG/SPRAY (0.1 ML)		4	QL (10 per 30 days)
oxcarbazepine oral suspension 300 mg/5 ml (60 mg/ml)	(Trileptal)	4	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	(Trileptal)	2	GC
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG		4	ST
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG		5	ST; NEDS
phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)		4	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg		2	GC
phenytoin oral suspension 125 mg/5 ml	(Dilantin-125)	2	GC
phenytoin oral tablet,chewable 50 mg	(Dilantin Infatabs)	2	GC
phenytoin sodium extended oral capsule 100 mg	(Dilantin Extended)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
phenytoin sodium extended oral capsule 200 mg, 300 mg	(Phenytek)	2	GC
phenytoin sodium intravenous solution 50 mg/ml		2	GC
phenytoin sodium intravenous syringe 50 mg/ml		2	GC
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	(Lyrica)	2	GC; QL (90 per 30 days)
pregabalin oral capsule 225 mg, 300 mg	(Lyrica)	2	GC; QL (60 per 30 days)
pregabalin oral solution 20 mg/ml	(Lyrica)	4	QL (900 per 30 days)
primidone oral tablet 250 mg, 50 mg	(Mysoline)	2	GC
rufinamide oral suspension 40 mg/ml	(Banzel)	5	ST; NEDS
rufinamide oral tablet 200 mg, 400 mg	(Banzel)	5	ST; NEDS
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG		4	ST; QL (60 per 30 days)
SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG, 750 MG		4	ST; QL (120 per 30 days)
subvenite oral tablet 100 mg, 150 mg, 200 mg, 25 mg	(lamotrigine)	1	GC
SYMPAZAN ORAL FILM 10 MG, 20 MG		5	PA NSO; NEDS; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG		4	PA NSO; QL (60 per 30 days)
tiagabine oral tablet 12 mg, 16 mg, 2 mg, 4 mg	(Gabitril)	4	
topiramate oral capsule, sprinkle 15 mg, 25 mg	(Topamax)	2	GC
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	(Topamax)	1	GC
valproate sodium intravenous solution 500 mg/5 ml (100 mg/ml)		2	GC
valproic acid (as sodium salt) oral solution 250 mg/5 ml		2	GC
valproic acid oral capsule 250 mg		2	GC

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Drug Name		Drug Tier	Requirements/Limits
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML)		4	
vigabatrin oral powder in packet 500 mg	(Vigadrone)	5	PA NSO; NEDS; QL (180 per 30 days)
vigabatrin oral tablet 500 mg	(Sabril)	5	PA NSO; NEDS; QL (180 per 30 days)
vigadrone oral powder in packet 500 mg	(vigabatrin)	5	PA NSO; NEDS; QL (180 per 30 days)
VIMPAT INTRAVENOUS SOLUTION 200 MG/20 ML	(lacosamide)	3	QL (200 per 5 days)
XCOPRI MAINTENANCE PACK ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)		4	ST; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG, 50 MG		4	ST; QL (30 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG		4	ST; QL (60 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14), 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)		4	ST
ZONISADE ORAL SUSPENSION 100 MG/5 ML		4	
zonisamide oral capsule 100 mg, 25 mg	(Zonegran)	2	GC
zonisamide oral capsule 50 mg		2	GC
ZTALMY ORAL SUSPENSION 50 MG/ML		5	PA NSO; NEDS; QL (1080 per 30 days)
Antidementia Agents			
Antidementia Agents			
donepezil oral tablet 10 mg, 5 mg	(Aricept)	1	GC; QL (30 per 30 days)

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

Drug Name		Drug Tier	Requirements/Limits
donepezil oral tablet,disintegrating 10 mg, 5 mg		2	GC; QL (30 per 30 days)
ergoloid oral tablet 1 mg		4	
galantamine oral capsule,ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg	(Razadyne ER)	2	GC; QL (30 per 30 days)
galantamine oral solution 4 mg/ml		4	QL (200 per 30 days)
galantamine oral tablet 12 mg, 4 mg, 8 mg		2	GC; QL (60 per 30 days)
memantine oral capsule,sprinkle,er 24hr 14 mg, 21 mg, 28 mg, 7 mg	(Namenda XR)	4	ST; QL (30 per 30 days)
memantine oral solution 2 mg/ml		4	QL (300 per 30 days)
memantine oral tablet 10 mg, 5 mg	(Namenda)	2	GC; QL (60 per 30 days)
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7/14/21/28 MG-10 MG		3	ST
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG		3	ST; QL (30 per 30 days)
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg		2	GC; QL (60 per 30 days)
rivastigmine transdermal patch 24 hour 13.3 mg/24 hour, 4.6 mg/24 hour, 9.5 mg/24 hour	(Exelon Patch)	4	QL (30 per 30 days)
Antidepressants			
Antidepressants			
amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg		2	GC
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg		4	
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC 45-105 MG		5	ST; NEDS
bupropion hcl oral tablet 100 mg, 75 mg		2	GC
bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg	(Wellbutrin XL)	2	GC

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

Drug Name		Drug Tier	Requirements/Limits
bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg	(Wellbutrin SR)	2	GC
citalopram oral solution 10 mg/5 ml		4	QL (600 per 30 days)
citalopram oral tablet 10 mg	(Celexa)	1	GC; QL (120 per 30 days)
citalopram oral tablet 20 mg, 40 mg	(Celexa)	1	GC; QL (30 per 30 days)
clomipramine oral capsule 25 mg, 50 mg, 75 mg	(Anafranil)	4	
desipramine oral tablet 10 mg, 25 mg	(Norpramin)	4	
desipramine oral tablet 100 mg, 150 mg, 50 mg, 75 mg		4	
desvenlafaxine succinate oral tablet extended release 24 hr 100 mg, 25 mg, 50 mg	(Pristiq)	4	QL (30 per 30 days)
doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg		2	GC
doxepin oral concentrate 10 mg/ml		1	GC
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG		4	ST; QL (60 per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG		4	ST; QL (30 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	(Cymbalta)	2	GC; QL (60 per 30 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR		5	ST; NEDS; QL (30 per 30 days)
escitalopram oxalate oral solution 5 mg/5 ml		4	
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	(Lexapro)	1	GC
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)		4	ST

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Drug Name		Drug Tier	Requirements/Limits
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG		4	ST; QL (30 per 30 days)
fluoxetine oral capsule 10 mg, 20 mg, 40 mg	(Prozac)	1	GC
fluoxetine oral solution 20 mg/5 ml (4 mg/ml)		4	
fluvoxamine oral tablet 100 mg, 25 mg, 50 mg		2	GC
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg		2	GC
maprotiline oral tablet 25 mg, 50 mg, 75 mg		2	GC
MARPLAN ORAL TABLET 10 MG		4	
mirtazapine oral tablet 15 mg, 30 mg	(Remeron)	2	GC
mirtazapine oral tablet 45 mg, 7.5 mg		2	GC
mirtazapine oral tablet,disintegrating 15 mg, 30 mg, 45 mg	(Remeron SolTab)	2	GC
nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg		4	
nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg	(Pamelor)	1	GC
nortriptyline oral solution 10 mg/5 ml		4	
paroxetine hcl oral suspension 10 mg/5 ml	(Paxil)	4	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	(Paxil)	1	GC
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg		2	GC
phenelzine oral tablet 15 mg	(Nardil)	2	GC
protriptyline oral tablet 10 mg, 5 mg		4	
sertraline oral concentrate 20 mg/ml	(Zoloft)	2	GC

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Drug Name	Drug Tier	Requirements/Limits
sertraline oral tablet 100 mg, 25 mg, 50 mg (Zoloft)	1	GC
SPRAVATO NASAL SPRAY,NON-AEROSOL 28 MG	4	PA NSO
SPRAVATO NASAL SPRAY,NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)	5	PA NSO; NEDS
tranylcypromine oral tablet 10 mg (Parnate)	4	
trazodone oral tablet 100 mg, 150 mg, 50 mg	1	GC
trazodone oral tablet 300 mg	4	
trimipramine oral capsule 100 mg, 25 mg, 50 mg	4	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	3	QL (30 per 30 days)
venlafaxine besylate oral tablet extended release 24hr 112.5 mg	4	QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg (Effexor XR)	2	GC; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 37.5 mg, 75 mg (Effexor XR)	2	GC; QL (90 per 30 days)
venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	2	GC
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	3	
vilazodone oral tablet 10 mg, 20 mg, 40 mg (Viibryd)	2	GC; QL (30 per 30 days)
ZULRESSO INTRAVENOUS SOLUTION 5 MG/ML	5	NEDS
Antidiabetic Agents		
Antidiabetic Agents, Miscellaneous		
acarbose oral tablet 100 mg, 25 mg, 50 mg (Precose)	2	GC; QL (90 per 30 days)
FARXIGA ORAL TABLET 10 MG, 5 MG	3	QL (30 per 30 days)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG	3	QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (30 per 30 days)
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG	3	QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	QL (30 per 30 days)
KORLYM ORAL TABLET 300 MG	5	PA; NEDS; QL (112 per 28 days)
metformin oral tablet 1,000 mg	1	GC; QL (75 per 30 days)
metformin oral tablet 500 mg	1	GC; QL (150 per 30 days)
metformin oral tablet 850 mg	1	GC; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	GC; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	GC; QL (60 per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	3	QL (1.5 per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	QL (3 per 28 days)
pioglitazone oral tablet 15 mg, 30 mg, 45 mg (Actos)	1	GC; QL (30 per 30 days)
repaglinide oral tablet 0.5 mg, 1 mg	1	GC; QL (120 per 30 days)
repaglinide oral tablet 2 mg	1	GC; QL (240 per 30 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG	3	QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR 2,700 MCG/2.7 ML	5	PA; NEDS; QL (10.8 per 28 days)
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR 1,500 MCG/1.5 ML	5	PA; NEDS; QL (10.8 per 28 days)
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG	3	QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	QL (60 per 30 days)
TRADJENTA ORAL TABLET 5 MG	3	QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	3	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	3	QL (60 per 30 days)
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML	3	QL (2 per 28 days)
VICTOZA SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	3	QL (9 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	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	3	QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
Insulins		
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (30 per 28 days)
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (3 ML)	3	QL (30 per 28 days)
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	QL (40 per 28 days)
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML	3	QL (40 per 28 days)
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML)	3	QL (24 per 28 days)
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine)	3	QL (30 per 28 days)
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glargine)	3	QL (40 per 28 days)
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30)	3	QL (40 per 28 days)
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	3	QL (30 per 28 days)
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	3	QL (30 per 28 days)
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	QL (40 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)		3	QL (30 per 28 days)
NOVOLIN R REGULAR U-100 INSULN INJECTION SOLUTION 100 UNIT/ML		3	QL (40 per 28 days)
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	(insulin aspart u-100)	2	GC; QL (30 per 28 days)
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	(insulin asp prt-insulin aspart)	2	GC; QL (40 per 28 days)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	(insulin asp prt-insulin aspart)	2	GC; QL (30 per 28 days)
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	(insulin aspart u-100)	2	GC; QL (30 per 28 days)
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML	(insulin aspart u-100)	2	GC; QL (40 per 28 days)
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML		3	QL (30 per 30 days)
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML)		3	QL (18 per 28 days)
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)		3	QL (13.5 per 28 days)
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML)		3	QL (15 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
Sulfonylureas			
glimepiride oral tablet 1 mg, 2 mg	(Amaryl)	1	GC; QL (30 per 30 days)
glimepiride oral tablet 4 mg	(Amaryl)	1	GC; QL (60 per 30 days)
glipizide oral tablet 10 mg		1	GC; QL (120 per 30 days)
glipizide oral tablet 5 mg		1	GC; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	(Glucotrol XL)	1	GC; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg, 5 mg	(Glucotrol XL)	1	GC; QL (30 per 30 days)
glipizide-metformin oral tablet 2.5-250 mg		1	GC; QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg		1	GC; QL (120 per 30 days)
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	(Glynase)	1	GC
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg		1	GC
glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg		1	GC
Antifungals			
Antifungals			
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML		4	PA BvD
AMBISOME INTRAVENOUS SUSPENSION FOR RECONSTITUTION 50 MG	(amphotericin b liposome)	5	PA BvD; NEDS
amphotericin b injection recon soln 50 mg		2	PA BvD; GC
amphotericin b liposome intravenous suspension for reconstitution 50 mg	(AmBisome)	5	PA BvD; NEDS
caspofungin intravenous recon soln 50 mg	(Cancidas)	5	NEDS
caspofungin intravenous recon soln 70 mg	(Cancidas)	3	

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Drug Name		Drug Tier	Requirements/Limits
ciclopirox topical cream 0.77 %	(Ciclodan)	2	GC; QL (180 per 30 days)
ciclopirox topical solution 8 %	(Ciclodan)	2	GC; QL (19.8 per 30 days)
clotrimazole mucous membrane troche 10 mg		2	GC
clotrimazole topical cream 1 %	(Antifungal (clotrimazole))	2	GC
clotrimazole topical solution 1 %		2	GC
clotrimazole-betamethasone topical cream 1-0.05 %		2	GC; QL (90 per 30 days)
econazole topical cream 1 %		4	QL (170 per 30 days)
fluconazole in nacl (iso-osm) intravenous piggyback 100 mg/50 ml, 200 mg/100 ml, 400 mg/200 ml		2	GC
fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml	(Diflucan)	4	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	(Diflucan)	2	GC
flucytosine oral capsule 250 mg, 500 mg	(Ancobon)	5	NEDS
griseofulvin microsize oral suspension 125 mg/5 ml		4	
griseofulvin microsize oral tablet 500 mg		4	
itraconazole oral capsule 100 mg	(Sporanox)	2	GC
ketoconazole oral tablet 200 mg		2	GC
ketoconazole topical cream 2 %		2	GC; QL (180 per 30 days)
ketoconazole topical shampoo 2 %		2	GC; QL (360 per 30 days)
miconazole-3 vaginal suppository 200 mg		2	GC
NOXAFIL ORAL SUSPENSION 200 MG/5 ML (40 MG/ML)	(posaconazole)	5	PA; NEDS
nyamyc topical powder 100,000 unit/gram	(nystatin)	2	GC; QL (60 per 30 days)
nystatin oral suspension 100,000 unit/ml		2	GC; QL (900 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
nystatin oral tablet 500,000 unit		2	GC
nystatin topical cream 100,000 unit/gram		2	GC; QL (60 per 30 days)
nystatin topical ointment 100,000 unit/gram		2	GC; QL (60 per 30 days)
nystatin topical powder 100,000 unit/gram	(Nyamyc)	2	GC; QL (60 per 30 days)
nystop topical powder 100,000 unit/gram	(nystatin)	2	GC; QL (60 per 30 days)
posaconazole oral tablet,delayed release (dr/ec) 100 mg	(Noxafil)	5	PA; NEDS
terbinafine hcl oral tablet 250 mg		1	GC
voriconazole intravenous recon soln 200 mg	(Vfend IV)	5	PA BvD; NEDS
voriconazole oral suspension for reconstitution 200 mg/5 ml (40 mg/ml)	(Vfend)	5	PA; NEDS
voriconazole oral tablet 200 mg, 50 mg	(Vfend)	3	
Antigout Agents			
Antigout Agents, Other			
allopurinol oral tablet 100 mg	(Zyloprim)	1	GC
allopurinol oral tablet 300 mg		1	GC
colchicine oral tablet 0.6 mg	(Colcrys)	4	PA; QL (120 per 30 days)
febuxostat oral tablet 40 mg, 80 mg	(Uloric)	4	ST; QL (30 per 30 days)
MITIGARE ORAL CAPSULE 0.6 MG	(colchicine)	2	GC; QL (60 per 30 days)
probenecid oral tablet 500 mg		2	GC
probenecid-colchicine oral tablet 500-0.5 mg		2	GC
Antihistamines			
Antihistamines			
cyproheptadine oral syrup 2 mg/5 ml		2	GC
diphenhydramine hcl injection solution 50 mg/ml		2	GC
diphenhydramine hcl injection syringe 50 mg/ml		4	

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Drug Name		Drug Tier	Requirements/Limits
diphenhydramine hcl oral elixir 12.5 mg/5 ml	(Diphen)	2	GC
hydroxyzine hcl intramuscular solution 25 mg/ml, 50 mg/ml		2	GC
hydroxyzine hcl oral solution 10 mg/5 ml		2	GC
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg		1	GC
levocetirizine oral tablet 5 mg	(24HR Allergy Relief)	1	GC
promethazine oral syrup 6.25 mg/5 ml		2	GC
Anti-Infectives (Skin And Mucous Membrane)			
Anti-Infectives (Skin And Mucous Membrane)			
clindamycin phosphate vaginal cream 2 %	(Cleocin)	2	GC
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	(Vandazole)	2	GC
terconazole vaginal cream 0.4 %, 0.8 %		2	GC
terconazole vaginal suppository 80 mg		4	
Antimigraine Agents			
Antimigraine Agents			
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML, 70 MG/ML		3	PA; QL (1 per 30 days)
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 225 MG/1.5 ML		3	PA; QL (1.5 per 30 days)
AJOVY SYRINGE SUBCUTANEOUS SYRINGE 225 MG/1.5 ML		3	PA; QL (1.5 per 30 days)
dihydroergotamine injection solution 1 mg/ml		3	QL (24 per 28 days)
dihydroergotamine nasal spray,non-aerosol 0.5 mg/pump act. (4 mg/ml)	(Migranal)	5	NEDS; QL (8 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
EMGALITY PEN SUBCUTANEOUS PEN INJECTOR 120 MG/ML		3	PA; QL (2 per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML		3	PA; QL (2 per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)		3	PA; QL (3 per 30 days)
NURTEC ODT ORAL TABLET,DISINTEGRATING 75 MG		3	PA; QL (18 per 30 days)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG		3	PA; QL (30 per 30 days)
rizatriptan oral tablet 10 mg	(Maxalt)	2	GC; QL (12 per 30 days)
rizatriptan oral tablet 5 mg		2	GC; QL (12 per 30 days)
rizatriptan oral tablet,disintegrating 10 mg	(Maxalt-MLT)	2	GC; QL (12 per 30 days)
rizatriptan oral tablet,disintegrating 5 mg		2	GC; QL (12 per 30 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation	(Imitrex)	4	QL (12 per 30 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	(Imitrex)	4	QL (18 per 30 days)
sumatriptan succinate oral tablet 100 mg	(Imitrex)	2	GC; QL (9 per 30 days)
sumatriptan succinate oral tablet 25 mg, 50 mg	(Imitrex)	2	GC; QL (18 per 30 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml	(Imitrex STATdose Refill)	4	QL (4 per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml	(Imitrex STATdose Pen)	4	QL (4 per 28 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5 ml	(Imitrex)	4	QL (4 per 28 days)
sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml		4	QL (4 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
UBRELVY ORAL TABLET 100 MG, 50 MG	3	PA; QL (16 per 30 days)
Antimycobacterials		
Antimycobacterials		
dapsone oral tablet 100 mg, 25 mg	2	GC
ethambutol oral tablet 100 mg	2	GC
ethambutol oral tablet 400 mg (Myambutol)	2	GC
isoniazid oral solution 50 mg/5 ml	2	GC
isoniazid oral tablet 100 mg, 300 mg	1	GC
PRETOMANID ORAL TABLET 200 MG	4	QL (30 per 30 days)
PRIFTIN ORAL TABLET 150 MG	4	
pyrazinamide oral tablet 500 mg	3	
rifabutin oral capsule 150 mg (Mycobutin)	4	
rifampin intravenous recon soln 600 mg (Rifadin)	4	
rifampin oral capsule 150 mg, 300 mg	2	GC
SIRTURO ORAL TABLET 100 MG, 20 MG	5	PA; NEDS
TRECATOR ORAL TABLET 250 MG	4	
Antinausea Agents		
Antinausea Agents		
AKYNZEO (FOSNETUPITANT) INTRAVENOUS RECON SOLN 235-0.25 MG	4	
AKYNZEO (FOSNETUPITANT) INTRAVENOUS SOLUTION 235 MG-0.25 MG /20 ML	4	
AKYNZEO (NETUPITANT) ORAL CAPSULE 300-0.5 MG	4	PA BvD
aprepitant oral capsule 125 mg	4	PA BvD; QL (2 per 28 days)
aprepitant oral capsule 40 mg	4	PA BvD; QL (1 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
aprepitant oral capsule 80 mg	(Emend)	4	PA BvD; QL (4 per 28 days)
aprepitant oral capsule,dose pack 125 mg (1)- 80 mg (2)	(Emend)	4	PA BvD; QL (6 per 28 days)
compro rectal suppository 25 mg	(prochlorperazine)	4	
dimenhydrinate injection solution 50 mg/ml		2	GC
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	(Marinol)	4	PA; QL (60 per 30 days)
droperidol injection solution 2.5 mg/ml		2	GC
EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ ML FINAL CONC.)		4	PA BvD; QL (6 per 28 days)
fosaprepitant intravenous recon soln 150 mg	(Emend (fosaprepitant))	4	QL (2 per 28 days)
granisetron (pf) intravenous solution 1 mg/ml (1 ml), 100 mcg/ml		2	GC
granisetron hcl intravenous solution 1 mg/ml		2	GC
granisetron hcl oral tablet 1 mg		4	PA BvD
meclizine oral tablet 12.5 mg		2	GC
meclizine oral tablet 25 mg	(Dramamine (meclizine))	2	GC
ondansetron hcl (pf) injection solution 4 mg/2 ml		1	GC
ondansetron hcl (pf) injection syringe 4 mg/2 ml		1	GC
ondansetron hcl intravenous solution 2 mg/ml		2	GC
ondansetron hcl oral tablet 4 mg, 8 mg		2	PA BvD; GC
ondansetron oral tablet,disintegrating 4 mg, 8 mg		2	PA BvD; GC
prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml), 5 mg/ml		2	GC

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

Drug Name		Drug Tier	Requirements/Limits
prochlorperazine maleate oral tablet 10 mg, 5 mg	(Compazine)	2	GC
prochlorperazine rectal suppository 25 mg	(Compro)	4	
promethazine injection solution 25 mg/ml, 50 mg/ml	(Phenergan)	4	
promethazine oral tablet 12.5 mg, 25 mg, 50 mg		1	GC
promethazine rectal suppository 50 mg	(Promethegan)	4	
promethegan rectal suppository 12.5 mg, 25 mg	(promethazine)	4	
scopolamine base transdermal patch 3 day 1 mg over 3 days	(Transderm-Scop)	2	GC; QL (10 per 30 days)
Antiparasite Agents			
Antiparasite Agents			
albendazole oral tablet 200 mg		5	NEDS
atovaquone oral suspension 750 mg/5 ml	(Mepron)	3	
atovaquone-proguanil oral tablet 250-100 mg	(Malarone)	2	GC
atovaquone-proguanil oral tablet 62.5-25 mg	(Malarone Pediatric)	2	GC
chloroquine phosphate oral tablet 250 mg		4	QL (50 per 30 days)
chloroquine phosphate oral tablet 500 mg		4	QL (25 per 30 days)
COARTEM ORAL TABLET 20-120 MG		4	
hydroxychloroquine oral tablet 200 mg	(Plaquenil)	2	GC; QL (90 per 30 days)
IMPAVIDO ORAL CAPSULE 50 MG		5	PA; NEDS; QL (84 per 28 days)
ivermectin oral tablet 3 mg	(Stromectol)	2	GC
KRINTAFEL ORAL TABLET 150 MG		4	
mefloquine oral tablet 250 mg		2	GC
nitazoxanide oral tablet 500 mg	(Alinia)	5	NEDS

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Drug Name		Drug Tier	Requirements/Limits
paromomycin oral capsule 250 mg	(Humatin)	4	
pentamidine inhalation recon soln 300 mg	(Nebupent)	3	PA BvD
pentamidine injection recon soln 300 mg	(Pentam)	4	
PRIMAQUINE ORAL TABLET 26.3 MG		4	
pyrimethamine oral tablet 25 mg	(Daraprim)	5	PA; NEDS
quinine sulfate oral capsule 324 mg	(Qualaquin)	4	PA; QL (42 per 7 days)
Antiparkinsonian Agents			
Antiparkinsonian Agents			
amantadine hcl oral capsule 100 mg		2	GC
amantadine hcl oral solution 50 mg/5 ml		1	GC
apomorphine subcutaneous cartridge 10 mg/ml	(APOKYN)	5	PA; NEDS; QL (60 per 30 days)
benztropine oral tablet 0.5 mg, 1 mg, 2 mg		2	GC
bromocriptine oral capsule 5 mg	(Parlodel)	4	
bromocriptine oral tablet 2.5 mg	(Parlodel)	2	GC
cabergoline oral tablet 0.5 mg		2	GC
carbidopa-levodopa oral tablet 10-100 mg	(Sinemet)	2	GC
carbidopa-levodopa oral tablet 25-100 mg	(Dhivy)	2	GC
carbidopa-levodopa oral tablet 25-250 mg		2	GC
carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg		2	GC
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg	(Stalevo 50)	4	
carbidopa-levodopa-entacapone oral tablet 18.75-75-200 mg	(Stalevo 75)	4	
carbidopa-levodopa-entacapone oral tablet 25-100-200 mg	(Stalevo 100)	4	
carbidopa-levodopa-entacapone oral tablet 31.25-125-200 mg	(Stalevo 125)	4	

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Drug Name	Drug Tier	Requirements/Limits
carbidopa-levodopa-entacapone oral tablet 37.5-150-200 mg (Stalevo 150)	4	
carbidopa-levodopa-entacapone oral tablet 50-200-200 mg (Stalevo 200)	4	
entacapone oral tablet 200 mg (Comtan)	3	
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE 42 MG	5	PA; NEDS; QL (300 per 30 days)
KYNMOBI SUBLINGUAL FILM 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	5	PA; NEDS; QL (150 per 30 days)
KYNMOBI SUBLINGUAL FILM 10-15-20-25-30 MG	5	PA; NEDS
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR	3	QL (30 per 30 days)
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG	4	ST; QL (30 per 30 days)
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 322 MG/DAY(129 MG X1-193MG X1)	4	ST; QL (60 per 30 days)
pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg (Mirapex)	1	GC
rasagiline oral tablet 0.5 mg, 1 mg (Azilect)	4	
ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	2	GC
selegiline hcl oral capsule 5 mg	2	GC
selegiline hcl oral tablet 5 mg	2	GC
trihexyphenidyl oral elixir 0.4 mg/ml	2	GC
trihexyphenidyl oral tablet 2 mg, 5 mg	1	GC
XADAGO ORAL TABLET 100 MG	4	PA; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
XADAGO ORAL TABLET 50 MG	5	PA; NEDS; QL (30 per 30 days)
Antipsychotic Agents		
Antipsychotic Agents		
aripiprazole oral solution 1 mg/ml	4	QL (900 per 30 days)
aripiprazole oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg (Abilify)	4	QL (30 per 30 days)
aripiprazole oral tablet 2 mg (Abilify)	4	QL (60 per 30 days)
aripiprazole oral tablet,disintegrating 10 mg	4	ST; QL (90 per 30 days)
aripiprazole oral tablet,disintegrating 15 mg	5	ST; NEDS; QL (60 per 30 days)
ARISTADA INITIO INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 675 MG/2.4 ML	5	NEDS; QL (4.8 per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	5	NEDS; QL (3.9 per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	5	NEDS; QL (1.6 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	5	NEDS; QL (2.4 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	5	NEDS; QL (3.2 per 28 days)
asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg (Saphris)	2	GC; QL (60 per 30 days)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	5	ST; NEDS; QL (30 per 30 days)
chlorpromazine injection solution 25 mg/ml	2	GC

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Drug Name		Drug Tier	Requirements/Limits
chlorpromazine oral concentrate 100 mg/ml, 30 mg/ml		4	
chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg		4	
clozapine oral tablet 100 mg	(Clozaril)	2	GC; QL (270 per 30 days)
clozapine oral tablet 200 mg	(Clozaril)	3	QL (135 per 30 days)
clozapine oral tablet 25 mg	(Clozaril)	3	QL (90 per 30 days)
clozapine oral tablet 50 mg	(Clozaril)	2	GC; QL (90 per 30 days)
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg		4	ST; QL (90 per 30 days)
clozapine oral tablet,disintegrating 150 mg		4	ST; QL (180 per 30 days)
clozapine oral tablet,disintegrating 200 mg		5	ST; NEDS; QL (120 per 30 days)
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG		5	ST; NEDS; QL (60 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)- 4MG(2)-6MG(2)		4	ST
fluphenazine decanoate injection solution 25 mg/ml		2	GC
fluphenazine hcl injection solution 2.5 mg/ml		3	
fluphenazine hcl oral concentrate 5 mg/ml		4	
fluphenazine hcl oral elixir 2.5 mg/5 ml		4	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg		4	
haloperidol decanoate intramuscular solution 100 mg/ml	(Haldol Decanoate)	3	
haloperidol decanoate intramuscular solution 100 mg/ml (1 ml)		2	GC
haloperidol decanoate intramuscular solution 50 mg/ml	(Haldol Decanoate)	2	GC

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Drug Name	Drug Tier	Requirements/Limits
haloperidol decanoate intramuscular solution 50 mg/ml(1ml)	3	
haloperidol lactate injection solution 5 mg/ml	2	GC
haloperidol lactate intramuscular syringe 5 mg/ml	2	GC
haloperidol lactate oral concentrate 2 mg/ml	2	GC
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	2	GC
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5	NEDS; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5	NEDS; QL (5 per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	NEDS; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	NEDS; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	NEDS; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	NEDS; QL (0.5 per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5	NEDS; QL (0.88 per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5	NEDS; QL (1.32 per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	NEDS; QL (1.75 per 84 days)

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Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5	NEDS; QL (2.63 per 84 days)
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	3	QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	3	QL (60 per 30 days)
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	2	GC
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	5	PA NSO; NEDS; QL (30 per 30 days)
molindone oral tablet 10 mg	2	GC; QL (240 per 30 days)
molindone oral tablet 25 mg	2	GC; QL (270 per 30 days)
molindone oral tablet 5 mg	2	GC; QL (120 per 30 days)
NUPLAZID ORAL CAPSULE 34 MG	5	PA NSO; NEDS; QL (30 per 30 days)
NUPLAZID ORAL TABLET 10 MG	5	PA NSO; NEDS; QL (30 per 30 days)
olanzapine intramuscular recon soln 10 mg (Zyprexa)	3	QL (30 per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg (Zyprexa)	2	GC; QL (30 per 30 days)
olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg (Zyprexa Zydis)	4	QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg (Invega)	4	QL (30 per 30 days)
paliperidone oral tablet extended release 24hr 6 mg (Invega)	4	QL (60 per 30 days)
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	4	
PERSERIS ABDOMINAL SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 120 MG, 90 MG	5	NEDS; QL (1 per 30 days)
pimozide oral tablet 1 mg, 2 mg	3	

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Drug Name	Drug Tier	Requirements/Limits
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg (Seroquel)	2	GC; QL (90 per 30 days)
quetiapine oral tablet 150 mg	2	GC; QL (30 per 30 days)
quetiapine oral tablet 300 mg, 400 mg (Seroquel)	2	GC; QL (60 per 30 days)
REXULTI ORAL TABLET 0.25 MG	5	ST; NEDS; QL (120 per 30 days)
REXULTI ORAL TABLET 0.5 MG	5	ST; NEDS; QL (60 per 30 days)
REXULTI ORAL TABLET 1 MG, 2 MG, 3 MG, 4 MG	5	ST; NEDS; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	4	QL (2 per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	5	NEDS; QL (2 per 28 days)
risperidone oral solution 1 mg/ml (Risperdal)	2	GC; QL (480 per 30 days)
risperidone oral tablet 0.25 mg	2	GC; QL (60 per 30 days)
risperidone oral tablet 0.5 mg, 1 mg, 2 mg, 3 mg (Risperdal)	2	GC; QL (60 per 30 days)
risperidone oral tablet 4 mg (Risperdal)	2	GC; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	4	QL (60 per 30 days)
risperidone oral tablet,disintegrating 3 mg, 4 mg	4	QL (120 per 30 days)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR	5	ST; NEDS; QL (30 per 30 days)
thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	GC

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Drug Name	Drug Tier	Requirements/Limits
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	4	
trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg	2	GC
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5	ST; NEDS; QL (540 per 30 days)
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	5	ST; NEDS; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE,DOSE PACK 1.5 MG (1)- 3 MG (6)	4	ST
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg (Geodon)	2	GC; QL (60 per 30 days)
ziprasidone mesylate intramuscular recon soln 20 mg/ml (final conc.) (Geodon)	3	QL (6 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 300 MG	5	NEDS; QL (2 per 28 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 405 MG	5	NEDS; QL (1 per 28 days)
Antivirals (Systemic)		
Antiretrovirals		
abacavir oral solution 20 mg/ml (Ziagen)	4	
abacavir oral tablet 300 mg (Ziagen)	2	GC
abacavir-lamivudine oral tablet 600-300 mg (Epzicom)	2	GC
abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg (Trizivir)	5	NEDS

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Drug Name	Drug Tier	Requirements/Limits
APRETUDE (cabotegravir) INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 600 MG/3 ML (200 MG/ML)	5	NEDS; QL (24 per 365 days)
APTIVUS (WITH VITAMIN E) ORAL SOLUTION 100 MG/ML	5	NEDS
APTIVUS ORAL CAPSULE 250 MG	5	NEDS
atazanavir oral capsule 150 mg	3	
atazanavir oral capsule 200 mg, 300 mg (Reyataz)	3	
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG	5	NEDS
CABENUVA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 400 MG/2 ML- 600 MG/2 ML, 600 MG/3 ML- 900 MG/3 ML	5	NEDS
cabotegravir intramuscular suspension,extended release 400 mg/2 ml (200 mg/ml)	5	NEDS; QL (24 per 365 days)
cabotegravir intramuscular suspension,extended release 600 mg/3 ml (200 mg/ml) (Apretude)	5	NEDS; QL (24 per 365 days)
CIMDUO ORAL TABLET 300-300 MG	5	NEDS
COMPLERA ORAL TABLET 200-25-300 MG	5	NEDS
CRIXIVAN ORAL CAPSULE 200 MG	4	
DELSTRIGO ORAL TABLET 100-300-300 MG	5	NEDS
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	5	NEDS
didanosine oral capsule,delayed release(dr/ec) 250 mg, 400 mg	3	
DOVATO ORAL TABLET 50-300 MG	5	NEDS

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Drug Name		Drug Tier	Requirements/Limits
EDURANT ORAL TABLET 25 MG		5	NEDS
efavirenz oral capsule 200 mg	(Sustiva)	3	
efavirenz oral capsule 50 mg	(Sustiva)	2	GC
efavirenz oral tablet 600 mg		3	
efavirenz-emtricitabin-tenofov oral tablet 600-200-300 mg	(Atripla)	5	NEDS
efavirenz-lamivu-tenofov disop oral tablet 400-300-300 mg	(Symfi Lo)	5	NEDS
efavirenz-lamivu-tenofov disop oral tablet 600-300-300 mg	(Symfi)	5	NEDS
emtricitabine oral capsule 200 mg	(Emtriva)	3	
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg, 200-300 mg	(Truvada)	5	NEDS
EMTRIVA ORAL SOLUTION 10 MG/ML		4	
EPIVIR HBV ORAL SOLUTION 25 MG/5 ML (5 MG/ML)		4	
etravirine oral tablet 100 mg, 200 mg	(Intelence)	5	NEDS
EVOTAZ ORAL TABLET 300-150 MG		5	NEDS
fosamprenavir oral tablet 700 mg	(Lexiva)	3	
FUZEON SUBCUTANEOUS RECON SOLN 90 MG		5	NEDS
GENVOYA ORAL TABLET 150-150-200-10 MG		5	NEDS
INTELENCE ORAL TABLET 25 MG		4	
INVIRASE ORAL TABLET 500 MG		5	NEDS
ISENTRESS HD ORAL TABLET 600 MG		5	NEDS
ISENTRESS ORAL POWDER IN PACKET 100 MG		4	
ISENTRESS ORAL TABLET 400 MG		5	NEDS

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Drug Name		Drug Tier	Requirements/Limits
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG		4	
JULUCA ORAL TABLET 50-25 MG		5	NEDS
lamivudine oral solution 10 mg/ml	(Epivir)	4	
lamivudine oral tablet 100 mg	(Epivir HBV)	4	
lamivudine oral tablet 150 mg, 300 mg	(Epivir)	2	GC
lamivudine-zidovudine oral tablet 150-300 mg	(Combivir)	2	GC
LEXIVA ORAL SUSPENSION 50 MG/ML		4	
lopinavir-ritonavir oral solution 400-100 mg/5 ml	(Kaletra)	2	GC; QL (480 per 30 days)
lopinavir-ritonavir oral tablet 100-25 mg	(Kaletra)	3	QL (300 per 30 days)
lopinavir-ritonavir oral tablet 200-50 mg	(Kaletra)	5	NEDS; QL (120 per 30 days)
maraviroc oral tablet 150 mg, 300 mg	(Selzentry)	5	NEDS
nevirapine oral suspension 50 mg/5 ml		4	
nevirapine oral tablet 200 mg		2	GC
nevirapine oral tablet extended release 24 hr 100 mg, 400 mg		4	
NORVIR ORAL POWDER IN PACKET 100 MG		4	
NORVIR ORAL SOLUTION 80 MG/ML		4	
ODEFSEY ORAL TABLET 200-25-25 MG		5	NEDS
PIFELTRO ORAL TABLET 100 MG		5	NEDS
PREZCOBIX ORAL TABLET 800-150 MG-MG		5	NEDS
PREZISTA ORAL SUSPENSION 100 MG/ML		5	NEDS

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Drug Name	Drug Tier	Requirements/Limits
PREZISTA ORAL TABLET 150 MG, 600 MG, 800 MG	5	NEDS
PREZISTA ORAL TABLET 75 MG	4	
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML	4	
REYATAZ ORAL POWDER IN PACKET 50 MG	5	NEDS
rilpivirine intramuscular suspension,extended release 600 mg/2 ml (300 mg/ml), 900 mg/3 ml (300 mg/ml)	5	NEDS
ritonavir oral tablet 100 mg (Norvir)	2	GC
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR 600 MG	5	NEDS
SELZENTRY ORAL SOLUTION 20 MG/ML	4	
SELZENTRY ORAL TABLET 25 MG	3	
SELZENTRY ORAL TABLET 75 MG	5	NEDS
stavudine oral capsule 15 mg, 20 mg, 30 mg, 40 mg	2	GC
STRIBILD ORAL TABLET 150-150-200-300 MG	5	NEDS
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	NEDS
TEMIXYS ORAL TABLET 300-300 MG	5	NEDS
tenofovir disoproxil fumarate oral tablet 300 mg (Viread)	2	GC
TIVICAY ORAL TABLET 10 MG	4	
TIVICAY ORAL TABLET 25 MG, 50 MG	5	NEDS
TIVICAY PD ORAL TABLET FOR SUSPENSION 5 MG	4	

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Drug Name		Drug Tier	Requirements/Limits
TRIUMEQ ORAL TABLET 600-50-300 MG		5	NEDS
TRIUMEQ PD ORAL TABLET FOR SUSPENSION 60-5-30 MG		5	NEDS
TRIZIVIR ORAL TABLET 300-150-300 MG	(abacavir-lamivudine-zidovudine)	5	NEDS
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33 ML (150 MG/ML)		5	NEDS
VEMLIDY ORAL TABLET 25 MG		5	NEDS; QL (30 per 30 days)
VIRACEPT ORAL TABLET 250 MG, 625 MG		5	NEDS
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM)		5	NEDS
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG		5	NEDS
VOCABRIA ORAL TABLET 30 MG		4	
zidovudine oral capsule 100 mg	(Retrovir)	2	GC
zidovudine oral syrup 10 mg/ml	(Retrovir)	2	GC
zidovudine oral tablet 300 mg		2	GC
Antivirals, Miscellaneous			
foscarnet intravenous solution 24 mg/ml	(Foscavir)	4	PA BvD
oseltamivir oral capsule 30 mg	(Tamiflu)	2	GC; QL (84 per 180 days)
oseltamivir oral capsule 45 mg	(Tamiflu)	2	GC; QL (48 per 180 days)
oseltamivir oral capsule 75 mg	(Tamiflu)	2	GC; QL (42 per 180 days)
oseltamivir oral suspension for reconstitution 6 mg/ml	(Tamiflu)	2	GC; QL (540 per 180 days)
PAXLOVID (EUA) ORAL TABLETS,DOSE PACK 150-100 MG		4	QL (20 per 5 days)
PAXLOVID (EUA) ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG		4	QL (30 per 5 days)

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Drug Name		Drug Tier	Requirements/Limits
PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML		5	PA; NEDS; QL (336 per 28 days)
PREVYMIS INTRAVENOUS SOLUTION 480 MG/24 ML		5	PA; NEDS; QL (672 per 28 days)
PREVYMIS ORAL TABLET 240 MG, 480 MG		5	PA; NEDS; QL (28 per 28 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION		4	QL (60 per 180 days)
rimantadine oral tablet 100 mg	(Flumadine)	3	
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5 ML		5	PA; NEDS
XOFLUZA ORAL TABLET 20 MG, 40 MG		4	QL (4 per 180 days)
XOFLUZA ORAL TABLET 80 MG		4	QL (2 per 180 days)
Hcv Antivirals			
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG		5	PA; NEDS; QL (28 per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG		5	PA; NEDS; QL (56 per 28 days)
EPCLUSA ORAL TABLET 200-50 MG		5	PA; NEDS; QL (28 per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	(sofosbuvir-velpatasvir)	5	PA; NEDS; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG		5	PA; NEDS; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG		5	PA; NEDS; QL (56 per 28 days)
HARVONI ORAL TABLET 45-200 MG		5	PA; NEDS; QL (28 per 28 days)
HARVONI ORAL TABLET 90-400 MG	(ledipasvir-sofosbuvir)	5	PA; NEDS; QL (28 per 28 days)
VOSEVI ORAL TABLET 400-100-100 MG		5	PA; NEDS; QL (28 per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
Interferons		
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML), 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	5	PA NSO; NEDS
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML, 6 MILLION UNIT/ML	5	PA NSO; NEDS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	NEDS
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5	NEDS
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML	5	NEDS
Nucleosides And Nucleotides		
acyclovir oral capsule 200 mg	2	GC
acyclovir oral suspension 200 mg/5 ml (Zovirax)	4	
acyclovir oral tablet 400 mg, 800 mg	2	GC
acyclovir sodium intravenous recon soln 1,000 mg, 500 mg	2	PA BvD; GC
acyclovir sodium intravenous solution 50 mg/ml	3	PA BvD
adefovir oral tablet 10 mg (Hepsera)	3	
entecavir oral tablet 0.5 mg, 1 mg (Baraclude)	2	GC
famciclovir oral tablet 125 mg, 250 mg, 500 mg	2	GC
ganciclovir sodium intravenous recon soln 500 mg	5	PA BvD; NEDS
ganciclovir sodium intravenous solution 50 mg/ml	5	PA BvD; NEDS
lagevrio (eua) oral capsule 200 mg	4	QL (40 per 5 days)
ribavirin inhalation recon soln 6 gram (Virazole)	5	PA BvD; NEDS
ribavirin oral capsule 200 mg	2	GC
ribavirin oral tablet 200 mg	2	GC

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Drug Name		Drug Tier	Requirements/Limits
valacyclovir oral tablet 1 gram, 500 mg	(Valtrex)	4	
valganciclovir oral tablet 450 mg	(Valcyte)	2	GC
VEKLURY INTRAVENOUS RECON SOLN 100 MG	(remdesivir)	5	PA BvD; NEDS
Blood Products/Modifiers/Volume Expanders			
Anticoagulants			
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 5 MG (74 TABS)		3	
ELIQUIS ORAL TABLET 2.5 MG		3	QL (60 per 30 days)
ELIQUIS ORAL TABLET 5 MG		3	QL (74 per 30 days)
enoxaparin subcutaneous solution 300 mg/3 ml	(Lovenox)	2	GC; QL (30 per 30 days)
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	(Lovenox)	3	QL (60 per 30 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	(Lovenox)	3	QL (48 per 30 days)
enoxaparin subcutaneous syringe 30 mg/0.3 ml	(Lovenox)	3	QL (18 per 30 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	(Lovenox)	3	QL (24 per 30 days)
enoxaparin subcutaneous syringe 60 mg/0.6 ml	(Lovenox)	3	QL (36 per 30 days)
fondaparinux subcutaneous syringe 10 mg/0.8 ml	(Arixtra)	5	NEDS; QL (24 per 30 days)
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	(Arixtra)	3	QL (15 per 30 days)
fondaparinux subcutaneous syringe 5 mg/0.4 ml	(Arixtra)	5	NEDS; QL (12 per 30 days)
fondaparinux subcutaneous syringe 7.5 mg/0.6 ml	(Arixtra)	5	NEDS; QL (18 per 30 days)
heparin (porcine) injection cartridge 5,000 unit/ml (1 ml)		2	GC

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Drug Name	Drug Tier	Requirements/Limits
heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml	2	GC
heparin (porcine) injection syringe 5,000 unit/ml	2	GC
heparin, porcine (pf) injection solution 1,000 unit/ml	2	GC
heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml	2	GC
jantoven oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg (warfarin)	1	GC
warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg (Jantoven)	1	GC
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9)	3	
XARELTO ORAL SUSPENSION FOR RECONSTITUTION 1 MG/ML	3	QL (600 per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	3	QL (60 per 30 days)
Blood Formation Modifiers		
CINRYZE INTRAVENOUS RECON SOLN 500 UNIT (5 ML)	5	PA; NEDS; QL (20 per 30 days)
DOPTELET (10 TAB PACK) ORAL TABLET 20 MG	5	PA; NEDS; QL (60 per 30 days)
DOPTELET (15 TAB PACK) ORAL TABLET 20 MG	5	PA; NEDS; QL (60 per 30 days)
DOPTELET (30 TAB PACK) ORAL TABLET 20 MG	5	PA; NEDS; QL (60 per 30 days)
FULPHILA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NEDS
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT	5	PA; NEDS; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements/Limits
HAEGARDA SUBCUTANEOUS RECON SOLN 3,000 UNIT	5	PA; NEDS; QL (20 per 30 days)
LEUKINE INJECTION RECON SOLN 250 MCG	5	NEDS
MOZOBIL SUBCUTANEOUS SOLUTION 24 MG/1.2 ML (20 MG/ML)	5	NEDS
MULPLETA ORAL TABLET 3 MG	5	PA; NEDS; QL (7 per 7 days)
NEULASTA ONPRO SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML	5	PA; NEDS
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NEDS
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	5	PA; NEDS
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; NEDS
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NEDS
ORLADEYO ORAL CAPSULE 110 MG, 150 MG	5	PA; NEDS; QL (30 per 30 days)
PROMACTA ORAL POWDER IN PACKET 12.5 MG	5	PA; NEDS; QL (90 per 30 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	5	PA; NEDS; QL (180 per 30 days)
PROMACTA ORAL TABLET 12.5 MG	5	PA; NEDS; QL (90 per 30 days)
PROMACTA ORAL TABLET 25 MG	5	PA; NEDS; QL (30 per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	5	PA; NEDS; QL (60 per 30 days)
RELEUKO INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	5	PA; NEDS

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Drug Name	Drug Tier	Requirements/Limits
RELEUKO SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; NEDS
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; QL (12 per 28 days)
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	3	PA; QL (4 per 28 days)
UDENYCA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NEDS
ZARXIO INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; NEDS
Hematologic Agents, Miscellaneous		
ADAKVEO INTRAVENOUS SOLUTION 10 MG/ML	5	PA; NEDS
anagrelide oral capsule 0.5 mg (Agrylin)	2	GC
anagrelide oral capsule 1 mg	2	GC
CABLIVI INJECTION KIT 11 MG	5	PA; NEDS; QL (30 per 30 days)
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	4	
GIVLAARI SUBCUTANEOUS SOLUTION 189 MG/ML	5	PA; NEDS
protamine intravenous solution 10 mg/ml	2	GC
SIKLOS ORAL TABLET 1,000 MG, 100 MG	4	PA
TAVALISSE ORAL TABLET 100 MG, 150 MG	5	PA; NEDS; QL (60 per 30 days)
tranexamic acid intravenous solution 1,000 mg/10 ml (100 mg/ml) (Cyklokapron)	2	GC
tranexamic acid oral tablet 650 mg (Lysteda)	2	GC
Platelet-Aggregation Inhibitors		
aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg	4	QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
BRILINTA ORAL TABLET 60 MG, 90 MG	3	
cilostazol oral tablet 100 mg, 50 mg	2	GC
clopidogrel oral tablet 75 mg (Plavix)	1	GC
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	2	GC
pentoxifylline oral tablet extended release 400 mg	2	GC
prasugrel oral tablet 10 mg, 5 mg (Effient)	4	QL (30 per 30 days)
Caloric Agents		
Caloric Agents		
AMINOSYN II 15 % INTRAVENOUS PARENTERAL SOLUTION 15 %	4	PA BvD
AMINOSYN-PF 7 % (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 7 %	4	PA BvD
CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION 5 %	4	PA BvD
CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %	4	PA BvD
CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %	4	PA BvD
CLINIMIX 5%-D20W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 5 %	4	PA BvD
CLINIMIX 6%-D5W (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 6-5 %	4	PA BvD
CLINIMIX 8%-D10W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 8-10 %	4	PA BvD

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Drug Name	Drug Tier	Requirements/Limits
CLINIMIX 8%-D14W(SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 8-14 %	4	PA BvD
CLINIMIX E 2.75%/D5W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 2.75 %	4	PA BvD
CLINIMIX E 4.25%/D10W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %	4	PA BvD
CLINIMIX E 4.25%/D5W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %	4	PA BvD
CLINIMIX E 5%/D15W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 5 %	4	PA BvD
CLINIMIX E 5%/D20W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 5 %	4	PA BvD
CLINIMIX E 8%-D10W SULFITEFREE INTRAVENOUS PARENTERAL SOLUTION 8-10 %	4	PA BvD
CLINIMIX E 8%-D14W SULFITEFREE INTRAVENOUS PARENTERAL SOLUTION 8-14 %	4	PA BvD
dextrose 10 % in water (d10w) intravenous parenteral solution 10 %	2	PA BvD; GC
dextrose 5 % in water (d5w) intravenous parenteral solution	2	GC
HEPATAMINE 8% INTRAVENOUS PARENTERAL SOLUTION 8 %	4	PA BvD
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	PA BvD

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Drug Name	Drug Tier	Requirements/Limits
NEPHRAMINE 5.4 % INTRAVENOUS PARENTERAL SOLUTION 5.4 %	4	PA BvD
NUTRILIPID INTRAVENOUS EMULSION 20 %	4	PA BvD
PROCALAMINE 3% INTRAVENOUS PARENTERAL SOLUTION 3 %	4	PA BvD
PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION	4	PA BvD
TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %	4	PA BvD
TROPHAMINE 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %	4	PA BvD
Cardiovascular Agents		
Alpha-Adrenergic Agents		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	GC
clonidine transdermal patch weekly 0.1 mg/24 hr (Catapres-TTS-1)	4	QL (4 per 28 days)
clonidine transdermal patch weekly 0.2 mg/24 hr (Catapres-TTS-2)	4	QL (4 per 28 days)
clonidine transdermal patch weekly 0.3 mg/24 hr (Catapres-TTS-3)	4	QL (8 per 28 days)
doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg (Cardura)	2	GC
droxidopa oral capsule 100 mg, 200 mg, 300 mg (Northera)	5	PA; NEDS; QL (180 per 30 days)
guanfacine oral tablet 1 mg, 2 mg	2	GC
methyldopa oral tablet 250 mg, 500 mg	4	
midodrine oral tablet 10 mg, 2.5 mg, 5 mg	2	GC

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Drug Name		Drug Tier	Requirements/Limits
phenylephrine hcl injection solution 10 mg/ml	(Vazculep)	2	GC
prazosin oral capsule 1 mg, 2 mg, 5 mg	(Minipress)	4	
Angiotensin Ii Receptor Antagonists			
EDARBI ORAL TABLET 40 MG, 80 MG		3	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG		3	
ENTRESTO ORAL TABLET 24-26 MG		3	QL (180 per 30 days)
ENTRESTO ORAL TABLET 49-51 MG, 97-103 MG		3	QL (60 per 30 days)
irbesartan oral tablet 150 mg, 300 mg, 75 mg	(Avapro)	1	GC
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	(Avalide)	1	GC
losartan oral tablet 100 mg, 25 mg, 50 mg	(Cozaar)	1	GC
losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	(Hyzaar)	1	GC
olmesartan oral tablet 20 mg, 40 mg, 5 mg	(Benicar)	1	GC
olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	(Benicar HCT)	1	GC
telmisartan oral tablet 20 mg, 40 mg, 80 mg	(Micardis)	1	GC
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	(Diovan)	1	GC
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	(Diovan HCT)	1	GC
Angiotensin-Converting Enzyme Inhibitors			
benazepril oral tablet 10 mg, 20 mg, 40 mg	(Lotensin)	1	GC
benazepril oral tablet 5 mg		1	GC

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Drug Name		Drug Tier	Requirements/Limits
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	(Lotensin HCT)	1	GC
benazepril-hydrochlorothiazide oral tablet 5-6.25 mg		1	GC
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg		2	GC
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	(Vasotec)	1	GC
enalaprilat intravenous solution 1.25 mg/ml		2	GC
enalapril-hydrochlorothiazide oral tablet 10-25 mg	(Vaseretic)	1	GC
enalapril-hydrochlorothiazide oral tablet 5-12.5 mg		1	GC
fosinopril oral tablet 10 mg, 20 mg, 40 mg		1	GC
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	(Zestril)	1	GC
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	(Zestoretic)	1	GC
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg		1	GC
quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg	(Accupril)	1	GC
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	(Accuretic)	1	GC
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	(Altace)	1	GC
trandolapril oral tablet 1 mg, 2 mg, 4 mg		1	GC
Antiarrhythmic Agents			
amiodarone oral tablet 200 mg	(Pacerone)	1	GC
amiodarone oral tablet 400 mg	(Pacerone)	4	
disopyramide phosphate oral capsule 100 mg, 150 mg	(Norpace)	3	

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

Drug Name		Drug Tier	Requirements/Limits
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	(Tikosyn)	4	
flecainide oral tablet 100 mg, 150 mg, 50 mg		2	GC
lidocaine (pf) injection solution 10 mg/ml (1 %)	(Xylocaine-MPF)	1	GC
lidocaine (pf) intravenous syringe 100 mg/5 ml (2 %), 50 mg/5 ml (1 %)		1	GC
mexiletine oral capsule 150 mg, 200 mg, 250 mg		2	GC
MULTAQ ORAL TABLET 400 MG		3	
pacerone oral tablet 200 mg	(amiodarone)	1	GC
pacerone oral tablet 400 mg	(amiodarone)	4	
procainamide injection solution 100 mg/ml, 500 mg/ml		2	GC
procainamide intravenous syringe 100 mg/ml		2	GC
propafenone oral tablet 150 mg, 225 mg, 300 mg		2	GC
quinidine sulfate oral tablet 200 mg		1	GC
quinidine sulfate oral tablet 300 mg		2	GC
Beta-Adrenergic Blocking Agents			
acebutolol oral capsule 200 mg, 400 mg		2	GC
atenolol oral tablet 100 mg, 25 mg, 50 mg	(Tenormin)	1	GC
atenolol-chlorthalidone oral tablet 100-25 mg	(Tenoretic 100)	2	GC
atenolol-chlorthalidone oral tablet 50-25 mg	(Tenoretic 50)	2	GC
betaxolol oral tablet 10 mg, 20 mg		2	GC
bisoprolol fumarate oral tablet 10 mg, 5 mg		2	GC
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	(Ziac)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	(Coreg)	1	GC
labetalol intravenous solution 5 mg/ml		2	GC
labetalol intravenous syringe 20 mg/4 ml (5 mg/ml)		2	GC
labetalol oral tablet 100 mg, 200 mg, 300 mg		2	GC
metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg	(Toprol XL)	1	GC
metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg		2	GC
metoprolol tartrate intravenous solution 5 mg/5 ml		2	GC
metoprolol tartrate oral tablet 100 mg, 50 mg	(Lopressor)	1	GC
metoprolol tartrate oral tablet 25 mg		1	GC
nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	(Bystolic)	2	GC
propranolol intravenous solution 1 mg/ml		2	GC
propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg	(Inderal LA)	4	
propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)		2	GC
propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg		2	GC
propranolol-hydrochlorothiazid oral tablet 40-25 mg, 80-25 mg		2	GC
sorine oral tablet 120 mg, 160 mg, 240 mg, 80 mg	(sotalol)	2	GC
sotalol af oral tablet 120 mg, 160 mg, 80 mg	(sotalol)	2	GC
sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg	(Sorine)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
timolol maleate oral tablet 10 mg, 20 mg, 5 mg		4	
Calcium-Channel Blocking Agents			
cartia xt oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	(diltiazem hcl)	2	GC
diltiazem hcl intravenous solution 5 mg/ml		2	GC
diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg		4	
diltiazem hcl oral capsule,extended release 24 hr 420 mg	(Tiadylt ER)	2	GC
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	(Cartia XT)	2	GC
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg	(Cardizem)	2	GC
diltiazem hcl oral tablet 90 mg		2	GC
dilt-xr oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 mg	(diltiazem hcl)	2	GC
taztia xt oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	(diltiazem hcl)	2	GC
tiadylt er oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	(diltiazem hcl)	2	GC
verapamil intravenous syringe 2.5 mg/ml		2	GC
verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg	(Verelan PM)	4	
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg	(Verelan)	2	GC
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	(Verelan)	4	
verapamil oral tablet 120 mg, 40 mg, 80 mg		1	GC
verapamil oral tablet extended release 120 mg, 180 mg, 240 mg	(Calan SR)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
Cardiovascular Agents, Miscellaneous			
CORLANOR ORAL SOLUTION 5 MG/5 ML		3	QL (600 per 30 days)
CORLANOR ORAL TABLET 5 MG, 7.5 MG		3	QL (60 per 30 days)
digitek oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	(digoxin)	2	GC
digox oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	(digoxin)	2	GC
digoxin 250 mcg tablet 250 mcg (0.25 mg)	(Digitek)	2	GC
digoxin injection syringe 250 mcg/ml (0.25 mg/ml)		2	GC
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	(Digitek)	2	GC
epinephrine injection auto-injector 0.15 mg/0.3 ml	(EpiPen Jr)	2	GC; QL (4 per 30 days)
epinephrine injection auto-injector 0.3 mg/0.3 ml	(Auvi-Q)	2	GC; QL (4 per 30 days)
epinephrine injection solution 1 mg/ml	(Adrenalin)	1	GC
hydralazine injection solution 20 mg/ml		2	GC
hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg		2	GC
icatibant subcutaneous syringe 30 mg/3 ml	(Sajazir)	5	PA; NEDS; QL (18 per 30 days)
metyrosine oral capsule 250 mg	(Demser)	5	NEDS
ranolazine oral tablet extended release 12 hr 1,000 mg	(Ranexa)	4	QL (60 per 30 days)
ranolazine oral tablet extended release 12 hr 500 mg	(Ranexa)	4	QL (120 per 30 days)
sajazir subcutaneous syringe 30 mg/3 ml	(icatibant)	5	PA; NEDS; QL (18 per 30 days)
VYNDAMAX ORAL CAPSULE 61 MG		5	PA; NEDS; QL (30 per 30 days)
VYNDAQEL ORAL CAPSULE 20 MG		5	PA; NEDS; QL (120 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
Dihydropyridines		
amlodipine oral tablet 10 mg, 2.5 mg, 5 mg (Norvasc)	1	GC
amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 5-10 mg, 5-20 mg (Lotrel)	1	GC
amlodipine-benazepril oral capsule 2.5-10 mg, 5-40 mg	1	GC
amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg (Exforge)	1	GC
nicardipine oral capsule 20 mg, 30 mg	4	
nifedipine oral capsule 10 mg, 20 mg	4	
nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg (Procardia XL)	2	GC
nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg	2	GC
Diuretics		
amiloride oral tablet 5 mg	2	GC
amiloride-hydrochlorothiazide oral tablet 5-50 mg	2	GC
bumetanide injection solution 0.25 mg/ml	4	
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	2	GC
chlorothiazide sodium intravenous recon soln 500 mg (Diuril IV)	2	GC
chlorthalidone oral tablet 25 mg, 50 mg	2	GC
furosemide injection solution 10 mg/ml	2	GC
furosemide injection syringe 10 mg/ml	1	GC
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	2	GC
furosemide oral tablet 20 mg, 40 mg, 80 mg (Lasix)	1	GC

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

Drug Name		Drug Tier	Requirements/Limits
hydrochlorothiazide oral capsule 12.5 mg		1	GC
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg		1	GC
indapamide oral tablet 1.25 mg, 2.5 mg		1	GC
JYNARQUE ORAL TABLET 15 MG, 30 MG		5	PA; NEDS; QL (120 per 30 days)
JYNARQUE ORAL TABLETS, SEQUENTIAL 15 MG (AM)/ 15 MG (PM), 30 MG (AM)/ 15 MG (PM), 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM)		5	PA; NEDS; QL (56 per 28 days)
metolazone oral tablet 10 mg, 2.5 mg, 5 mg		2	GC
spironolactone oral tablet 100 mg, 25 mg, 50 mg	(Aldactone)	1	GC
torsemide oral tablet 10 mg, 100 mg, 5 mg		2	GC
torsemide oral tablet 20 mg	(Soaanz)	2	GC
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg		1	GC
triamterene-hydrochlorothiazid oral tablet 37.5-25 mg	(Maxzide-25mg)	1	GC
triamterene-hydrochlorothiazid oral tablet 75-50 mg	(Maxzide)	1	GC
Dyslipidemics			
atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	(Lipitor)	1	GC; QL (30 per 30 days)
cholestyramine (with sugar) oral powder in packet 4 gram	(Questran)	2	GC
cholestyramine light oral powder in packet 4 gram	(cholestyramine-aspartame)	2	GC
colesevelam oral powder in packet 3.75 gram	(WelChol)	3	
colesevelam oral tablet 625 mg	(WelChol)	2	GC
colestipol oral packet 5 gram	(Colestid)	3	
colestipol oral tablet 1 gram	(Colestid)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
ezetimibe oral tablet 10 mg	(Zetia)	2	GC; QL (30 per 30 days)
fenofibrate micronized oral capsule 134 mg, 200 mg, 67 mg		4	
fenofibrate nanocrystallized oral tablet 145 mg, 48 mg	(Tricor)	2	GC
fenofibrate nanocrystallized oral tablet 160 mg		2	GC
fenofibrate oral tablet 160 mg, 54 mg		2	GC
gemfibrozil oral tablet 600 mg	(Lopid)	1	GC
JUXTAPID ORAL CAPSULE 10 MG, 30 MG, 40 MG, 60 MG		5	PA; NEDS; QL (30 per 30 days)
JUXTAPID ORAL CAPSULE 20 MG		5	PA; NEDS; QL (90 per 30 days)
JUXTAPID ORAL CAPSULE 5 MG		5	PA; NEDS; QL (45 per 30 days)
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG		3	QL (30 per 30 days)
lovastatin oral tablet 10 mg, 20 mg, 40 mg		1	GC
NEXLETOL ORAL TABLET 180 MG		3	QL (30 per 30 days)
NEXLIZET ORAL TABLET 180-10 MG		3	QL (30 per 30 days)
niacin oral tablet 500 mg	(Niacor)	4	
niacin oral tablet extended release 24 hr 1,000 mg	(Niaspan Extended-Release)	4	
niacin oral tablet extended release 24 hr 500 mg		2	GC
niacin oral tablet extended release 24 hr 750 mg		4	
omega-3 acid ethyl esters oral capsule 1 gram	(Lovaza)	2	GC; QL (120 per 30 days)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML		3	QL (2 per 28 days)
pravastatin oral tablet 10 mg, 80 mg		1	GC

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Drug Name		Drug Tier	Requirements/Limits
pravastatin oral tablet 20 mg, 40 mg		1	GC; QL (30 per 30 days)
prevalite oral powder in packet 4 gram	(cholestyramine-aspartame)	2	GC
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML		3	QL (7 per 28 days)
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML		3	QL (6 per 28 days)
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML		3	QL (6 per 28 days)
rosuvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg	(Crestor)	1	GC; QL (30 per 30 days)
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	(Zocor)	1	GC; QL (30 per 30 days)
simvastatin oral tablet 5 mg		1	GC; QL (30 per 30 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	(icosapent ethyl)	2	GC; QL (240 per 30 days)
VASCEPA ORAL CAPSULE 1 GRAM	(icosapent ethyl)	2	GC; QL (120 per 30 days)
Renin-Angiotensin-Aldosterone System Inhibitors			
aliskiren oral tablet 150 mg, 300 mg	(Tekturna)	4	
eplerenone oral tablet 25 mg, 50 mg	(Inspra)	4	
KERENDIA ORAL TABLET 10 MG, 20 MG		3	PA; QL (30 per 30 days)
Vasodilators			
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg		2	GC
isosorbide dinitrate oral tablet 5 mg	(Isordil Titradose)	2	GC
isosorbide mononitrate oral tablet 10 mg, 20 mg		2	GC
isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg		1	GC

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Drug Name		Drug Tier	Requirements/Limits
isosorbide-hydralazine oral tablet 20-37.5 mg	(BiDil)	2	GC
minitran transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	(nitroglycerin)	2	GC
minoxidil oral tablet 10 mg, 2.5 mg		2	GC
nitroglycerin intravenous solution 50 mg/10 ml (5 mg/ml)		2	GC
nitroglycerin sublingual tablet 0.3 mg, 0.4 mg, 0.6 mg	(Nitrostat)	2	GC
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr	(Nitro-Dur)	2	GC
Central Nervous System Agents			
Central Nervous System Agents			
atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg	(Strattera)	3	QL (60 per 30 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	(Strattera)	3	QL (30 per 30 days)
AUBAGIO ORAL TABLET 14 MG, 7 MG		5	PA; NEDS; QL (30 per 30 days)
AUSTEDO ORAL TABLET 12 MG, 9 MG		5	PA; NEDS; QL (120 per 30 days)
AUSTEDO ORAL TABLET 6 MG		5	PA; NEDS; QL (60 per 30 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML		5	PA; NEDS; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML		5	PA; NEDS; QL (1 per 28 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG		5	PA; NEDS; QL (15 per 30 days)
caffeine citrate intravenous solution 60 mg/3 ml (20 mg/ml)	(Cafcit)	2	PA BvD; GC
caffeine citrate oral solution 60 mg/3 ml (20 mg/ml)		2	GC
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	(glatiramer)	5	PA; NEDS; QL (30 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	(glatiramer)	5	PA; NEDS; QL (12 per 28 days)
dalfampridine oral tablet extended release 12 hr 10 mg	(Ampyra)	2	PA; GC; QL (60 per 30 days)
dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg	(Focalin)	2	GC; QL (60 per 30 days)
dextroamphetamine sulfate oral tablet 10 mg	(Zenzedi)	4	QL (180 per 30 days)
dextroamphetamine sulfate oral tablet 15 mg, 5 mg	(Zenzedi)	4	QL (90 per 30 days)
dextroamphetamine sulfate oral tablet 20 mg, 30 mg	(Zenzedi)	4	QL (60 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 5 mg	(Adderall XR)	4	QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr 20 mg, 25 mg, 30 mg	(Adderall XR)	4	QL (60 per 30 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	(Adderall)	2	GC; QL (60 per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	(Tecfidera)	5	PA; NEDS; QL (14 per 7 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	(Tecfidera)	5	PA; NEDS
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	(Tecfidera)	5	PA; NEDS; QL (60 per 30 days)
flumazenil intravenous solution 0.1 mg/ml		2	GC
GILENYA ORAL CAPSULE 0.25 MG		5	PA; NEDS; QL (30 per 30 days)
GILENYA ORAL CAPSULE 0.5 MG	(fingolimod)	5	PA; NEDS; QL (30 per 30 days)
glatiramer subcutaneous syringe 20 mg/ml	(Copaxone)	5	PA; NEDS; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	(Copaxone)	5	PA; NEDS; QL (12 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
glatopa subcutaneous syringe 20 mg/ml (glatiramer)	5	PA; NEDS; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml (glatiramer)	5	PA; NEDS; QL (12 per 28 days)
guanfacine oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg, 4 mg (Intuniv ER)	2	GC; QL (30 per 30 days)
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR 20 MG/0.4 ML	5	PA; NEDS; QL (1.2 per 28 days)
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	GC
lithium carbonate oral tablet 300 mg	2	GC
lithium carbonate oral tablet extended release 300 mg (Lithobid)	2	GC
lithium carbonate oral tablet extended release 450 mg	2	GC
MAVENCLAD (10 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAVENCLAD (4 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAVENCLAD (5 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAVENCLAD (6 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAVENCLAD (7 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAVENCLAD (8 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAVENCLAD (9 TABLET PACK) ORAL TABLET 10 MG	5	PA; NEDS
MAYZENT ORAL TABLET 0.25 MG	5	PA; NEDS; QL (112 per 28 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	5	PA; NEDS; QL (30 per 30 days)
MAYZENT STARTER(FOR 1MG MAINT) ORAL TABLETS,DOSE PACK 0.25 MG (7 TABS)	4	PA

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Drug Name	Drug Tier	Requirements/Limits
MAYZENT STARTER(FOR 2MG MAINT) ORAL TABLETS,DOSE PACK 0.25 MG (12 TABS)	5	PA; NEDS
methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 40 mg, 50 mg, 60 mg	4	QL (30 per 30 days)
methylphenidate hcl oral capsule, er biphasic 30-70 30 mg	4	QL (60 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg, 20 mg, 40 mg (Ritalin LA)	4	QL (30 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg (Ritalin LA)	4	QL (60 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	4	QL (30 per 30 days)
methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml (Methylin)	2	GC; QL (900 per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg (Ritalin)	2	GC; QL (90 per 30 days)
OCREVUS INTRAVENOUS SOLUTION 30 MG/ML	5	PA; NEDS; QL (20 per 180 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	5	PA; NEDS; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA; NEDS
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	5	PA; NEDS; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA; NEDS
RADICAVA INTRAVENOUS SOLUTION 30 MG/100 ML	5	PA; NEDS; QL (2800 per 28 days)
riluzole oral tablet 50 mg (Rilutek)	2	GC; QL (60 per 30 days)
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG	3	QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42)		3	
TASCENSO ODT ORAL TABLET,DISINTEGRATING 0.25 MG		5	PA; NEDS; QL (30 per 30 days)
tetrabenazine oral tablet 12.5 mg, 25 mg	(Xenazine)	5	PA; NEDS; QL (112 per 28 days)
VUMERITY ORAL CAPSULE,DELAYED RELEASE(DR/EC) 231 MG		5	PA; NEDS; QL (120 per 30 days)
Contraceptives			
Contraceptives			
afirmelle oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
altavera (28) oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
alyacen 1/35 (28) oral tablet 1-35 mg-mcg	(norethindrone-ethin estradiol)	2	GC
alyacen 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg		2	GC
amethia oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	(l norgest/e.estradiol-e.estrad)	2	GC; QL (91 per 84 days)
apri oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
aranelle (28) oral tablet 0.5/1/0.5-35 mg-mcg		2	GC
ashlyna oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	(l norgest/e.estradiol-e.estrad)	2	GC; QL (91 per 84 days)
aubra eq oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
aurovela 1.5/30 (21) oral tablet 1.5-30 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
aurovela 1/20 (21) oral tablet 1-20 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
aurovela 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
aurovela fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	2	GC
aurovela fe 1-20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	1	GC
aviane oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
ayuna oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
azurette (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC
balziva (28) oral tablet 0.4-35 mg-mcg		2	GC
bekyree (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC
blisovi 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC
blisovi fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	2	GC
blisovi fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	1	GC
briellyn oral tablet 0.4-35 mg-mcg		2	GC
camila oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
caziant (28) oral tablet 0.1/.125/.15-25 mg-mcg		2	GC
chateal eq (28) oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
cryselle (28) oral tablet 0.3-30 mg-mcg	(norgestrel-ethinyl estradiol)	2	GC
cyclafem 1/35 (28) oral tablet 1-35 mg-mcg	(norethindrone-ethin estradiol)	2	GC
cyclafem 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg		2	GC
cyred eq oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
dasetta 1/35 (28) oral tablet 1-35 mg-mcg	(norethindrone-ethin estradiol)	2	GC
dasetta 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg		2	GC

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Drug Name		Drug Tier	Requirements/Limits
daysee oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	(l norgest/e.estradiol-e.estrad)	2	GC; QL (91 per 84 days)
deblitane oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(Azurette (28))	2	GC
desogestrel-ethinyl estradiol oral tablet 0.15-0.03 mg	(Apri)	2	GC
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg	(Jasmiel (28))	2	GC
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	(Syeda)	2	GC
elinest oral tablet 0.3-30 mg-mcg	(norgestrel-ethinyl estradiol)	2	GC
ELLA ORAL TABLET 30 MG		4	QL (6 per 365 days)
eluryng vaginal ring 0.12-0.015 mg/24 hr	(etonogestrel-ethinyl estradiol)	4	QL (1 per 28 days)
emoquette oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
enpresse oral tablet 50-30 (6)/75-40 (5)/125-30(10)	(levonorg-eth estrad triphasic)	2	GC
enskyce oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
errin oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
estarylla oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	2	GC
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg	(Kelnor 1/35 (28))	2	GC
ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg	(Kelnor 1-50 (28))	2	GC
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr	(EluRyng)	4	QL (1 per 28 days)
falmina (28) oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
femynor oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
hailey 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC
hailey fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	2	GC
hailey fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	2	GC
hailey oral tablet 1.5-30 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
heather oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
iclevia oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	(levonorgestrel-ethinyl estrad)	2	GC; QL (91 per 84 days)
incassia oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	(levonorgestrel-ethinyl estrad)	2	GC; QL (91 per 84 days)
isibloom oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
jaimiess oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	(l norgest/e.estradiol-e.estrad)	2	GC; QL (91 per 84 days)
jasmiel (28) oral tablet 3-0.02 mg	(drospirenone-ethinyl estradiol)	2	GC
jencycla oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
juleber oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
junel 1.5/30 (21) oral tablet 1.5-30 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
junel 1/20 (21) oral tablet 1-20 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
junel fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	2	GC
junel fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	1	GC
junel fe 24 oral tablet 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC
kalliga oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
kariva (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC
kelnor 1/35 (28) oral tablet 1-35 mg-mcg	(ethynodiol diac-eth estradiol)	2	GC
kelnor 1-50 (28) oral tablet 1-50 mg-mcg	(ethynodiol diac-eth estradiol)	2	GC
kurvelo (28) oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	(LoJaimiess)	2	GC; QL (91 per 84 days)
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	(Amethia)	2	GC; QL (91 per 84 days)
larin 1.5/30 (21) oral tablet 1.5-30 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
larin 1/20 (21) oral tablet 1-20 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
larin 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC
larin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	2	GC
larin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	1	GC
larissia oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
lessina oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
levonest (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	(levonorg-eth estrad triphasic)	2	GC
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	(Afirmelle)	2	GC
levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg	(Altavera (28))	2	GC
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	(Iclevia)	2	GC; QL (91 per 84 days)

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Drug Name		Drug Tier	Requirements/Limits
levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)	(Enpresse)	2	GC
levora-28 oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
lillow (28) oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
lojaimiess oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7)	(l norgest/e.estradiol-e.estrad)	2	GC; QL (91 per 84 days)
loryna (28) oral tablet 3-0.02 mg	(drospirenone-ethinyl estradiol)	2	GC
low-ogestrel (28) oral tablet 0.3-30 mg-mcg	(norgestrel-ethinyl estradiol)	2	GC
lo-zumandimine (28) oral tablet 3-0.02 mg	(drospirenone-ethinyl estradiol)	2	GC
lutera (28) oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
lyleq oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
lyza oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
marlissa (28) oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
merzee oral capsule 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC
microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	1	GC
mili oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	1	GC
mono-linyah oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	2	GC
necon 0.5/35 (28) oral tablet 0.5-35 mg-mcg		2	GC
nikki (28) oral tablet 3-0.02 mg	(drospirenone-ethinyl estradiol)	2	GC
norethindrone (contraceptive) oral tablet 0.35 mg	(Camila)	1	GC

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

Drug Name		Drug Tier	Requirements/Limits
norethindrone ac-eth estradiol oral tablet 1.5-30 mg-mcg	(Aurovela 1.5/30 (21))	2	GC
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	(Aurovela 1/20 (21))	2	GC
norethindrone-e.estradiol-iron oral capsule 1 mg-20 mcg (24)/75 mg (4)	(Merzee)	2	GC
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	(Aurovela Fe 1-20 (28))	1	GC
norethindrone-e.estradiol-iron oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	(Aurovela Fe 1.5/30 (28))	2	GC
norethindrone-e.estradiol-iron oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	(Tri-Legest Fe)	2	GC
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg	(Tri-Lo-Estarylla)	2	GC
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(Tri-Estarylla)	2	GC
norgestimate-ethinyl estradiol oral tablet 0.25-35 mg-mcg	(Femynor)	2	GC
norlyda oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
nortrel 0.5/35 (28) oral tablet 0.5-35 mg-mcg		2	GC
nortrel 1/35 (21) oral tablet 1-35 mg-mcg (21)		2	GC
nortrel 1/35 (28) oral tablet 1-35 mg-mcg	(norethindrone-ethin estradiol)	2	GC
nortrel 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg		2	GC
nylia 1/35 (28) oral tablet 1-35 mg-mcg	(norethindrone-ethin estradiol)	2	GC
nylia 7/7/7 (28) oral tablet 0.5/0.75/1 mg- 35 mcg		2	GC
nymyo oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
orsythia oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
philith oral tablet 0.4-35 mg-mcg		2	GC
pimtrea (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC
pirmella oral tablet 0.5/0.75/1 mg-35 mcg		2	GC
pirmella oral tablet 1-35 mg-mcg	(norethindrone-ethin estradiol)	2	GC
portia 28 oral tablet 0.15-0.03 mg	(levonorgestrel-ethinyl estrad)	2	GC
previfem oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	1	GC
reclipsen (28) oral tablet 0.15-0.03 mg	(desogestrel-ethinyl estradiol)	2	GC
setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	(levonorgestrel-ethinyl estrad)	2	GC; QL (91 per 84 days)
sharobel oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
simliya (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC
simpesse oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)	(l norgest/e.estradiol-e.estrad)	2	GC; QL (91 per 84 days)
sprintec (28) oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	2	GC
sronyx oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
syeda oral tablet 3-0.03 mg	(drospirenone-ethinyl estradiol)	2	GC
tarina 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	(norethindrone-e.estradiol-iron)	2	GC
tarina fe 1-20 eq (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	(norethindrone-e.estradiol-iron)	1	GC
tri femynor oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	2	GC
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
tri-legest fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	(norethindrone-e.estradiol-iron)	2	GC
tri-linyah oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	2	GC
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	(norgestimate-ethinyl estradiol)	1	GC
tri-lo-marzia oral tablet 0.18/0.215/0.25 mg-25 mcg	(norgestimate-ethinyl estradiol)	1	GC
tri-lo-mili oral tablet 0.18/0.215/0.25 mg-25 mcg	(norgestimate-ethinyl estradiol)	1	GC
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	(norgestimate-ethinyl estradiol)	2	GC
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	2	GC
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	2	GC
tri-previfem (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	1	GC
tri-sprintec (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	2	GC
trivora (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	(levonorg-eth estrad triphasic)	2	GC
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	(norgestimate-ethinyl estradiol)	1	GC
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	(norgestimate-ethinyl estradiol)	2	GC
tulana oral tablet 0.35 mg	(norethindrone (contraceptive))	1	GC
tyblume oral tablet,chewable 0.1 mg- 20 mcg		2	GC
velivet triphasic regimen (28) oral tablet 0.1/.125/.15-25 mg-mcg		2	GC
vestura (28) oral tablet 3-0.02 mg	(drospirenone-ethinyl estradiol)	2	GC
vienva oral tablet 0.1-20 mg-mcg	(levonorgestrel-ethinyl estrad)	2	GC
viorele (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
volnea (28) oral tablet 0.15-0.02 mgx21 /0.01 mg x 5	(desog-e.estradiol/e.estradiol)	2	GC
vyfemla (28) oral tablet 0.4-35 mg-mcg		2	GC
vylibra oral tablet 0.25-35 mg-mcg	(norgestimate-ethinyl estradiol)	2	GC
wera (28) oral tablet 0.5-35 mg-mcg		2	GC
xulane transdermal patch weekly 150-35 mcg/24 hr		4	QL (3 per 28 days)
zafemy transdermal patch weekly 150-35 mcg/24 hr		4	QL (3 per 28 days)
zarah oral tablet 3-0.03 mg	(drospirenone-ethinyl estradiol)	2	GC
zovia 1-35 (28) oral tablet 1-35 mg-mcg	(ethynodiol diac-eth estradiol)	2	GC
zumandimine (28) oral tablet 3-0.03 mg	(drospirenone-ethinyl estradiol)	2	GC
Dental And Oral Agents			
Dental And Oral Agents			
chlorhexidine gluconate mucous membrane mouthwash 0.12 %	(Paroex Oral Rinse)	1	GC
denta 5000 plus dental cream 1.1 %	(fluoride (sodium))	1	GC
dentagel dental gel 1.1 %	(fluoride (sodium))	1	GC
fluoride (sodium) dental solution 0.2 %	(PreviDent)	1	GC
oralone dental paste 0.1 %	(triamcinolone acetonide)	2	GC
paroex oral rinse mucous membrane mouthwash 0.12 %	(chlorhexidine gluconate)	1	GC
periogard mucous membrane mouthwash 0.12 %	(chlorhexidine gluconate)	1	GC
pilocarpine hcl oral tablet 5 mg, 7.5 mg	(Salagen (pilocarpine))	2	GC
sf 5000 plus dental cream 1.1 %	(fluoride (sodium))	1	GC
sodium fluoride-pot nitrate dental paste 1.1-5 %	(Fluoridex Sensitivity Relief)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
triamcinolone acetonide dental paste 0.1 %	(Oralone)	2	GC
Dermatological Agents			
Dermatological Agents, Other			
accutane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	(isotretinoin)	2	GC
acitretin oral capsule 10 mg, 17.5 mg, 25 mg		2	GC
acyclovir topical ointment 5 %	(Zovirax)	4	QL (30 per 30 days)
ALCOHOL 70% SWABS	(Alcohol Pads)	1	GC
ALCOHOL PADS TOPICAL PADS, MEDICATED	(alcohol swabs)	1	GC
ALCOHOL PREP SWABS TOPICAL PADS, MEDICATED	(alcohol swabs)	1	GC
ammonium lactate topical cream 12 %		2	GC
ammonium lactate topical lotion 12 %	(Skin Treatment)	2	GC
BD SINGLE USE SWAB	(alcohol swabs)	1	GC
calcipotriene scalp solution 0.005 %		4	QL (120 per 30 days)
calcipotriene topical cream 0.005 %	(Dovonex)	4	QL (120 per 30 days)
CARETOUCH ALCOHOL 70% PREP PAD	(alcohol swabs)	1	GC
CURITY ALCOHOL PREPS 2 PLY,MEDIUM	(alcohol swabs)	1	GC
DROPSAFE ALCOHOL 70% PREP PADS	(alcohol swabs)	1	GC
EASY COMFORT ALCOHOL 70% PAD	(alcohol swabs)	1	GC
EASY TOUCH ALCOHOL 70% PADS GAMMA-STERILIZED	(alcohol swabs)	1	GC
fluorouracil topical cream 0.5 %	(Carac)	5	NEDS
fluorouracil topical cream 5 %	(Efudex)	2	GC
fluorouracil topical solution 2 %, 5 %		2	GC
HEB INCONTROL ALCOHOL 70% PADS	(alcohol swabs)	1	GC

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Drug Name		Drug Tier	Requirements/Limits
imiquimod topical cream in packet 5 %		2	GC; QL (24 per 30 days)
IV ANTISEPTIC WIPES	(alcohol swabs)	1	GC
KENDALL ALCOHOL 70% PREP PAD	(alcohol swabs)	1	GC
KLISYRI TOPICAL OINTMENT IN PACKET 1 %		3	QL (5 per 5 days)
methoxsalen oral capsule,liqd-filled,rapid rel 10 mg		5	NEDS
PANRETIN TOPICAL GEL 0.1 %		5	NEDS; QL (180 per 30 days)
podofilox topical solution 0.5 %		2	GC
PRO COMFORT ALCOHOL 70% PADS	(alcohol swabs)	1	GC
PURE COMFORT ALCOHOL 70% PADS	(alcohol swabs)	1	GC
RA ISOPROPYL ALCOHOL 70% WIPES	(alcohol swabs)	1	GC
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM		4	QL (180 per 30 days)
SURE COMFORT ALCOHOL PREP PADS	(alcohol swabs)	1	GC
SURE-PREP ALCOHOL PREP PADS	(alcohol swabs)	1	GC
TRUE COMFORT ALCOHOL 70% PADS	(alcohol swabs)	1	GC
TRUE COMFORT PRO ALCOHOL PADS	(alcohol swabs)	1	GC
ULTILET ALCOHOL STERL SWAB	(alcohol swabs)	1	GC
VALCHLOR TOPICAL GEL 0.016 %		5	NEDS
WEBCOL ALCOHOL PREPS 20'S,LARGE	(alcohol swabs)	1	GC
zenatane oral capsule 10 mg, 20 mg, 30 mg, 40 mg	(isotretinoin)	2	GC
Dermatological Antibacterials			
clindamycin phosphate topical solution 1 %	(Cleocin T)	2	GC; QL (180 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
clindamycin phosphate topical swab 1 %	(Clindacin ETZ)	2	GC
ery pads topical swab 2 %	(erythromycin with ethanol)	2	GC
erythromycin with ethanol topical gel 2 %	(Erygel)	4	QL (180 per 30 days)
erythromycin with ethanol topical solution 2 %		2	GC; QL (180 per 30 days)
gentamicin topical cream 0.1 %		2	GC; QL (120 per 30 days)
gentamicin topical ointment 0.1 %		2	GC; QL (120 per 30 days)
metronidazole topical cream 0.75 %	(Rosadan)	4	
metronidazole topical gel 0.75 %	(Rosadan)	2	GC
metronidazole topical gel 1 %	(Metrogel)	4	
metronidazole topical lotion 0.75 %	(MetroLotion)	4	
mupirocin topical ointment 2 %	(Centany)	1	GC; QL (220 per 30 days)
neomycin-polymyxin b gu irrigation solution 40 mg-200,000 unit/ml		2	GC
rosadan topical cream 0.75 %	(metronidazole)	4	
selenium sulfide topical lotion 2.5 %		2	GC
silver sulfadiazine topical cream 1 %	(SSD)	2	GC
ssd topical cream 1 %	(silver sulfadiazine)	4	
sulfacetamide sodium (acne) topical suspension 10 %	(Klaron)	4	
Dermatological Anti-Inflammatory Agents			
ala-cort topical cream 1 %	(hydrocortisone)	1	GC
alclometasone topical cream 0.05 %		2	GC
alclometasone topical ointment 0.05 %		2	GC
betamethasone dipropionate topical cream 0.05 %		2	GC
betamethasone dipropionate topical lotion 0.05 %		2	GC
betamethasone dipropionate topical ointment 0.05 %		2	GC

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Drug Name		Drug Tier	Requirements/Limits
betamethasone valerate topical cream 0.1 %		2	GC
betamethasone valerate topical lotion 0.1 %		2	GC
betamethasone valerate topical ointment 0.1 %		2	GC
betamethasone, augmented topical cream 0.05 %		2	GC
betamethasone, augmented topical gel 0.05 %		2	GC
betamethasone, augmented topical lotion 0.05 %		3	
betamethasone, augmented topical ointment 0.05 %	(Diprolene (augmented))	2	GC
clobetasol scalp solution 0.05 %		2	GC
clobetasol topical cream 0.05 %		2	GC
clobetasol-emollient topical cream 0.05 %		2	GC
desoximetasone topical cream 0.25 %	(Topicort)	2	GC; QL (120 per 30 days)
EUCRISA TOPICAL OINTMENT 2 %		3	
fluocinolone topical cream 0.01 %		2	GC
fluocinolone topical cream 0.025 %	(Synalar)	2	GC
fluocinolone topical ointment 0.025 %	(Synalar)	2	GC
fluocinonide topical cream 0.05 %		2	GC
fluocinonide topical solution 0.05 %		2	GC
fluocinonide-e topical cream 0.05 %	(fluocinonide-emollient)	4	
fluticasone propionate topical cream 0.05 %		2	GC
fluticasone propionate topical ointment 0.005 %		2	GC
halobetasol propionate topical cream 0.05 %		2	GC
halobetasol propionate topical ointment 0.05 %		2	GC

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Drug Name		Drug Tier	Requirements/Limits
hydrocortisone 2.5% cream 2.5 %		1	GC
hydrocortisone topical cream 1 %	(Ala-Cort)	1	GC
hydrocortisone topical cream with perineal applicator 2.5 %	(Procto-Med HC)	1	GC
hydrocortisone topical lotion 2.5 %		2	GC
hydrocortisone topical ointment 1 %	(Anti-Itch (HC))	1	GC
hydrocortisone topical ointment 2.5 %		1	GC
mometasone topical cream 0.1 %		2	GC
mometasone topical ointment 0.1 %		2	GC
mometasone topical solution 0.1 %		2	GC
pimecrolimus topical cream 1 %	(Elidel)	4	QL (100 per 30 days)
prednicarbate topical ointment 0.1 %		2	GC
procto-med hc topical cream with perineal applicator 2.5 %	(hydrocortisone)	2	GC
proctosol hc topical cream with perineal applicator 2.5 %	(hydrocortisone)	2	GC
proctozone-hc topical cream with perineal applicator 2.5 %	(hydrocortisone)	2	GC
tacrolimus topical ointment 0.03 %, 0.1 %	(Protopic)	4	QL (100 per 30 days)
triamcinolone acetonide topical cream 0.025 %		1	GC
triamcinolone acetonide topical cream 0.1 %, 0.5 %	(Triderm)	1	GC
triamcinolone acetonide topical lotion 0.025 %, 0.1 %		2	GC
triamcinolone acetonide topical ointment 0.025 %		1	GC
triamcinolone acetonide topical ointment 0.1 %, 0.5 %		2	GC
Dermatological Retinoids			
adapalene topical cream 0.1 %	(Differin)	4	
adapalene topical gel 0.1 %	(Differin)	2	GC
ALTRENO TOPICAL LOTION 0.05 %		4	PA
tazarotene topical cream 0.1 %	(Tazorac)	4	

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Drug Name		Drug Tier	Requirements/Limits
TAZORAC TOPICAL CREAM 0.05 %		4	
tretinoin topical cream 0.025 %	(Avita)	4	PA
tretinoin topical cream 0.05 %, 0.1 %	(Retin-A)	4	PA
tretinoin topical gel 0.01 %	(Retin-A)	4	PA
tretinoin topical gel 0.025 %	(Avita)	4	PA
tretinoin topical gel 0.05 %	(Atralin)	4	PA
Scabicides And Pediculicides			
malathion topical lotion 0.5 %	(Ovide)	4	
permethrin topical cream 5 %	(Elimite)	2	GC
Devices			
Devices			
1ST TIER UNIFINE PENTP 5MM 31G 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
1ST TIER UNIFINE PNTIP 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
1ST TIER UNIFINE PNTIP 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
1ST TIER UNIFINE PNTIP 8MM 31G STRL,SINGLE-USE,SHRT 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
1ST TIER UNIFINE PNTP 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
1ST TIER UNIFINE PNTP 31GX3/16 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
1ST TIER UNIFINE PNTP 32GX5/32 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ABOUTTIME PEN NEEDLE 30G X 8MM 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
ABOUTTIME PEN NEEDLE 31G X 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
ABOUTTIME PEN NEEDLE 31G X 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
ABOUTTIME PEN NEEDLE 32G X 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
ADVOCATE INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS SYR 0.3 ML 29GX1/2 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS SYR 0.5 ML 29GX1/2 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS SYR 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ADVOCATE INS SYR 1 ML 30GX5/16 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ADVOCATE PEN NDL 12.7MM 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
ADVOCATE PEN NEEDLE 4MM 33G 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ADVOCATE PEN NEEDLES 5MM 31G 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
ADVOCATE PEN NEEDLES 8MM 31G 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
ASSURE ID DUO-SHIELD 30GX3/16" 30 GAUGE X 3/16"		2	GC
ASSURE ID DUO-SHIELD 30GX5/16" 30 GAUGE X 5/16"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"		2	GC
ASSURE ID PEN NEEDLE 30GX3/16" 30 GAUGE X 3/16"		2	GC
ASSURE ID PEN NEEDLE 30GX5/16" 30 GAUGE X 5/16"		2	GC
ASSURE ID PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic, safety)	2	GC
ASSURE ID SYR 0.5 ML 29GX1/2" (RX) 0.5 ML 29 GAUGE X 1/2"		2	GC
ASSURE ID SYR 0.5 ML 31GX15/64" 0.5 ML 31 GAUGE X 15/64"		2	GC
ASSURE ID SYR 1 ML 31GX15/64" 1 ML 31 GAUGE X 15/64"		2	GC
BD AUTOSHIELD DUO NDL 5MMX30G 30 GAUGE X 3/16"		2	GC
BD ECLIPSE 30GX1/2" SYRINGE 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
BD INS SYR 0.3 ML 8MMX31G(1/2) 0.3 ML 31 GAUGE X 5/16"		2	GC
BD INS SYRINGE 1/2 ML 6MMX31G (ONLY FOR 500 UNIT/ML INSULIN) 1/2 ML 31 GAUGE X 15/64"		2	GC
BD INS SYRN UF 1 ML 12.7MMX30G NOT FOR RETAIL SALE 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
BD INSULIN SYR 1 ML 25GX1" 1 ML 25 X 1"		2	GC
BD INSULIN SYR 1 ML 25GX5/8" 1 ML 25 GAUGE X 5/8"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
BD INSULIN SYR 1 ML 26GX1/2" 1 ML 26 X 1/2"		2	GC
BD INSULIN SYR 1 ML 27GX5/8" MICRO-FINE 1 ML 27 GAUGE X 5/8"		2	GC
BD INSULIN SYR 1 ML 28GX1/2" (OTC) 1 ML 28 GAUGE X 1/2"	(Comfort EZ Insulin Syringe)	2	GC
BD INSULIN SYRINGE 1 ML W/O NEEDLE 1 ML	(insulin syringe needleless)	2	GC
BD LUER-LOK SYRINGE 1 ML 1 ML	(BD Insulin Syringe Slip Tip)	2	GC
BD NANO 2 GEN PEN NDL 32GX4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
BD SAFETGLD INS 0.3 ML 29G 13MM 0.3 ML 29 GAUGE X 1/2"		2	GC
BD SAFETGLD INS 0.5 ML 13MMX29G 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
BD SAFETYGLD INS 0.3 ML 31G 8MM 0.3 ML 31 GAUGE X 5/16"		2	GC
BD SAFETYGLD INS 0.5 ML 30G 8MM 0.5 ML 30 GAUGE X 5/16"		2	GC
BD SAFETYGLD INS 1 ML 29G 13MM 1 ML 29 GAUGE X 1/2"		2	GC
BD SAFETYGLID INS 1 ML 6MMX31G 1 ML 31 GAUGE X 15/64"		2	GC
BD SAFETYGLIDE NEEDLE NEEDLE 27 X 5/8 "		2	GC
BD SAFETYGLIDE SYRINGE 27GX5/8 1 ML 27 GAUGE X 5/8"		2	GC
BD SAFTYGLD INS 0.3 ML 6MMX31G 0.3 ML 31 GAUGE X 15/64"		2	GC
BD SAFTYGLD INS 0.5 ML 29G 13MM 0.5 ML 29 GAUGE X 1/2"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
BD SAFTYGLD INS 0.5 ML 6MMX31G 0.5 ML 31 GAUGE X 15/64"		2	GC
BD UF MICRO PEN NEEDLE 6MMX32G 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
BD UF MINI PEN NEEDLE 5MMX31G 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
BD UF NANO PEN NEEDLE 4MMX32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
BD UF ORIG PEN NDL 12.7MMX29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
BD UF SHORT PEN NEEDLE 8MMX31G 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
BD VEO INS 0.3 ML 6MMX31G (1/2) 0.3 ML 31 GAUGE X 15/64"		2	GC
BD VEO INS SYRING 1 ML 6MMX31G 1 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
BD VEO INS SYRN 0.3 ML 6MMX31G 0.3 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
BD VEO INS SYRN 0.5 ML 6MMX31G 1/2 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
BORDERED GAUZE 2"X2" 2 X 2 "	(gauze bandage)	1	GC
CAREFINE PEN NEEDLE 12.7MM 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
CAREFINE PEN NEEDLE 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
CAREFINE PEN NEEDLE 5MM 32G 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
CAREFINE PEN NEEDLE 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
CAREFINE PEN NEEDLE 8MM 30G 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
CAREFINE PEN NEEDLES 6MM 32G 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
CAREFINE PEN NEEDLES 8MM 31G 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
CAREONE SYR 0.3 ML 31GX5/16" SHORT, HRI 0.3 ML 31 GAUGE X 5/16"	(Advocate Syringes)	2	GC
CARETOUCH PEN NEEDLE 29G 12MM 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
CARETOUCH PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
CARETOUCH PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
CARETOUCH PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
CARETOUCH PEN NEEDLE 32GX3/16" 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
CARETOUCH PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
CARETOUCH SYR 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
CARETOUCH SYR 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
CARETOUCH SYR 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
CARETOUCH SYR 1 ML 28GX5/16" 1 ML 28 X 5/16"		2	GC
CARETOUCH SYR 1 ML 29GX5/16" 1 ML 29 GAUGE X 5/16		2	GC
CARETOUCH SYR 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
CARETOUCH SYR 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
CLICKFINE 31G X 5/16" NEEDLES 8MM, UNIVERSAL 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
CLICKFINE PEN NEEDLE 32GX5/32" 32GX4MM, STERILE 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
CLICKFINE UNIVERSAL 31G X 1/4" 6MM, STORE BRAND 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
COMFORT EZ INS 0.3 ML 30GX1/2" 0.3 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ INS 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
COMFORT EZ INSULIN SYR 0.3 ML 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ INSULIN SYR 0.5 ML 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ PEN NEEDLE 12MM 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 4MM 32G SINGLE USE, MICRO 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 4MM 33G 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 5MM 31G MINI 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 5MM 32G SINGLE USE,MINI,HRI 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 5MM 33G 33 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
COMFORT EZ PEN NEEDLES 6MM 32G 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 6MM 33G 33 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 8MM 31G SHORT 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 8MM 32G 32 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
COMFORT EZ PEN NEEDLES 8MM 33G 33 GAUGE X 5/16"		2	GC
COMFORT EZ SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 0.5 ML 28GX1/2" 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
COMFORT EZ SYR 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
COMFORT POINT PEN NDL 31GX1/3" 31 GAUGE X 1/3"		2	GC
COMFORT POINT PEN NDL 31GX1/6" 31 GAUGE X 1/6"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
COMFORT TOUCH PEN NDL 31G 4MM 31 GAUGE X 5/32"		2	GC
COMFORT TOUCH PEN NDL 31G 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 31G 6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 31G 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 32G 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 32G 5MM 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 32G 6MM 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 32G 8MM 32 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 33G 6MM 33 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 33GX4MM 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
COMFORT TOUCH PEN NDL 33GX5MM 33 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
CURAD GAUZE PADS 2" X 2" 2 X 2 "	(gauze bandage)	1	GC
CURITY GAUZE SPONGES (12 PLY)-200/BAG 2 X 2 "		1	GC
CURITY GUAZE PADS 1'S(12 PLY) 2 X 2 "	(gauze bandage)	1	GC
DERMACEA 2"X2" GAUZE 12 PLY, USP TYPE VII 2 X 2 "	(gauze bandage)	1	GC
DERMACEA GAUZE 2"X2" SPONGE 8 PLY 2 X 2 "		1	GC
DERMACEA NON-WOVEN 2"X2" SPNGE 2 X 2 "		1	GC
DROPLET 0.5 ML 29GX12.5MM(1/2) 0.5 ML 29 GAUGE X 1/2"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
DROPLET 0.5 ML 30GX12.5MM(1/2) 0.5 ML 30 GAUGE X 1/2"		2	GC
DROPLET INS 0.3 ML 29GX12.5MM 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
DROPLET INS 0.3 ML 30GX12.5MM 0.3 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
DROPLET INS 0.5 ML 30GX6MM(1/2) 0.5ML 30 GAUGE X 15/64"		2	GC
DROPLET INS 0.5 ML 30GX8MM(1/2) 0.5 ML 30 GAUGE X 5/16"		2	GC
DROPLET INS 0.5 ML 31GX6MM(1/2) 0.5 ML 31 GAUGE X 15/64"		2	GC
DROPLET INS 0.5 ML 31GX8MM(1/2) 0.5 ML 31 GAUGE X 5/16"		2	GC
DROPLET INS SYR 0.3 ML 30GX6MM 0.3 ML 30 GAUGE X 15/64"		2	GC
DROPLET INS SYR 0.3 ML 30GX8MM 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
DROPLET INS SYR 0.3 ML 31GX6MM 0.3 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
DROPLET INS SYR 0.3 ML 31GX8MM 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
DROPLET INS SYR 1 ML 29GX12.5MM 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
DROPLET INS SYR 1 ML 30GX12.5MM 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
DROPLET INS SYR 1 ML 30GX6MM 1 ML 30 GAUGE X 15/64"		2	GC
DROPLET INS SYR 1 ML 30GX8MM 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
DROPLET INS SYR 1 ML 31GX6MM 1 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
DROPLET INS SYR 1 ML 31GX8MM 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
DROPLET MICRON 34G X 9/64" 34 GAUGE X 9/64"		2	GC
DROPLET PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 29GX3/8" 29 GAUGE X 3/8"		2	GC
DROPLET PEN NEEDLE 30GX5/16" 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 32GX3/16" 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 32GX5/16" 32 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
DROPLET PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
DROPSAFE PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"		2	GC
DROPSAFE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic, safety)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
DROPSAFE PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"		2	GC
DRUG MART ULTRA COMFORT SYR 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
EASY COMFORT 0.3 ML SYRINGE 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
EASY COMFORT 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
EASY COMFORT 0.5 ML 32GX5/16" 1/2 ML 32 GAUGE X 5/16"		2	GC
EASY COMFORT 0.5 ML SYRINGE 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
EASY COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
EASY COMFORT 1 ML 32GX5/16" 1 ML 32 GAUGE X 5/16"		2	GC
EASY COMFORT INSULIN 1 ML SYR 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
EASY COMFORT PEN NDL 31GX1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
EASY COMFORT PEN NDL 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
EASY COMFORT PEN NDL 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
EASY COMFORT PEN NDL 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
EASY COMFORT PEN NDL 33G 4MM 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
EASY COMFORT PEN NDL 33G 5MM 33 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
EASY COMFORT PEN NDL 33G 6MM 33 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
EASY COMFORT SYR 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY GLIDE INS 0.3 ML 31GX6MM 0.3 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
EASY GLIDE INS 0.5 ML 31GX6MM 1/2 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
EASY GLIDE INS 1 ML 31GX6MM 1 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
EASY GLIDE PEN NEEDLE 4MM 33G 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
EASY TOUCH 0.3 ML SYR 30GX1/2" 0.3 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY TOUCH 0.5 ML SYR 27GX1/2" 1/2 ML 27 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY TOUCH 0.5 ML SYR 29GX1/2" 0.5 ML 29 GAUGE X 1/2"		2	GC
EASY TOUCH 0.5 ML SYR 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY TOUCH 0.5 ML SYR 30GX5/16 0.5 ML 30 GAUGE X 5/16"		2	GC
EASY TOUCH 1 ML SYR 27GX1/2" 1 ML 27 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC

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Drug Name	Drug Tier	Requirements/Limits
EASY TOUCH 1 ML SYR 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	GC
EASY TOUCH 1 ML SYR 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	GC
EASY TOUCH FLIPLOK 1 ML 27GX0.5 1 ML 27 GAUGE X 1/2"	2	GC
EASY TOUCH INSULIN 1 ML 29GX1/2 1 ML 29 GAUGE X 1/2"	2	GC
EASY TOUCH INSULIN 1 ML 30GX1/2 1 ML 30 GAUGE X 1/2"	2	GC
EASY TOUCH INSULIN SYR 0.3 ML 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (insulin syringe-needle u-100)	2	GC
EASY TOUCH INSULIN SYR 0.5 ML 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (insulin syringe-needle u-100)	2	GC
EASY TOUCH INSULIN SYR 1 ML 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (insulin syringe-needle u-100)	2	GC
EASY TOUCH INSULIN SYR 1 ML RETRACTABLE 1 ML 30 GAUGE X 1/2" (insulin syringe-needle u-100)	2	GC
EASY TOUCH INSULN 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	2	GC
EASY TOUCH INSULN 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	2	GC
EASY TOUCH INSULN 1 ML 30GX5/16 1 ML 30 GAUGE X 5/16"	2	GC
EASY TOUCH INSULN 1 ML 30GX5/16 1 ML 30 GAUGE X 5/16"	2	GC
EASY TOUCH INSULN 1 ML 31GX5/16 1 ML 31 GAUGE X 5/16"	2	GC

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Drug Name		Drug Tier	Requirements/Limits
EASY TOUCH INSULN 1 ML 31GX5/16 1 ML 31 GAUGE X 5/16"		2	GC
EASY TOUCH LUER LOK INSUL 1 ML 1 ML	(insulin syringe needleless)	2	GC
EASY TOUCH PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 30GX5/16 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 31GX3/16 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 31GX5/16 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 32GX3/16 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
EASY TOUCH PEN NEEDLE 32GX5/32 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
EASY TOUCH SAF PEN NDL 29G 5MM 29 GAUGE X 3/16"		2	GC
EASY TOUCH SAF PEN NDL 29G 8MM 29 GAUGE X 5/16"		2	GC
EASY TOUCH SAF PEN NDL 30G 5MM 30 GAUGE X 3/16"		2	GC
EASY TOUCH SAF PEN NDL 30G 8MM 30 GAUGE X 5/16"		2	GC
EASY TOUCH SYR 0.5 ML 28G 12.7MM 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY TOUCH SYR 0.5 ML 29G 12.7MM 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY TOUCH SYR 1 ML 27G 16MM 1 ML 27 GAUGE X 5/8"		2	GC
EASY TOUCH SYR 1 ML 28G 12.7MM 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
EASY TOUCH SYR 1 ML 29G 12.7MM 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
EASY TOUCH UNI-SLIP SYR 1 ML 1 ML	(insulin syringe needleless)	2	GC
EASYTOUCH SAF PEN NDL 30G 6MM 30 GAUGE X 1/4"		2	GC
EQL INSULIN 0.3 ML SYRINGE SHORT NEEDLE 0.3 ML 30	(Ultra Comfort Insulin Syringe)	2	GC
EQL INSULIN 0.5 ML SYRINGE SHORT NEEDLE 1/2 ML 30 GAUGE	(Lite Touch Insulin Syringe)	2	GC
EQL INSULIN 1 ML SYRINGE SHORT NEEDLE 1 ML 30 GAUGE X 7/16"	(Lite Touch Insulin Syringe)	2	GC
EXEL INSULIN SYRINGE 27G-1 ML 1 ML 27 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
FIFTY50 INS 0.5 ML 31GX5/16" SHORT NEEDLE 0.5 ML 31 GAUGE X 5/16"	(Advocate Syringes)	2	GC
FIFTY50 INS SYR 1 ML 31GX5/16" SHORT NEEDLE 1 ML 31 GAUGE X 5/16	(Advocate Syringes)	2	GC
FIFTY50 PEN 31G X 3/16" NEEDLE (OTC) 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
FP INSULIN 1 ML SYRINGE 1 ML 28 GAUGE	(Lite Touch Insulin Syringe)	2	GC
FREESTYLE PREC 0.5 ML 30GX5/16 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
FREESTYLE PREC 0.5 ML 31GX5/16 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
FREESTYLE PREC 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
FREESTYLE PREC 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	(gauze bandage)	1	GC
GNP ULT C 0.3 ML 29GX1/2" (1/2) 1/2 UNIT 0.3 ML 29 GAUGE X 1/2"		2	GC
GNP ULTRA COMFORT 0.5 ML SYR 1/2 ML 29 , 1/2 ML 30 GAUGE	(insulin syringe-needle u-100)	2	GC
GNP ULTRA COMFORT 1 ML SYRINGE 1 ML 28 GAUGE, 1 ML 30 GAUGE X 7/16"	(insulin syringe-needle u-100)	2	GC
GNP ULTRA COMFORT 1 ML SYRINGE 1 ML 29 GAUGE		2	GC
GNP ULTRA COMFORT 3/10 ML SYR 0.3 ML 30	(insulin syringe-needle u-100)	2	GC
HEALTHWISE INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
HEALTHWISE INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
HEALTHWISE INS 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
HEALTHWISE INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
HEALTHWISE INS 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
HEALTHWISE INS 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
HEALTHWISE PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
HEALTHWISE PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
HEALTHWISE PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
HEALTHY ACCENTS PENTIP 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
HEALTHY ACCENTS PENTIP 5MM 31G 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
HEALTHY ACCENTS PENTIP 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
HEALTHY ACCENTS PENTIP 8MM 31G 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
HEALTHY ACCENTS PENTP 12MM 29G 29 GAUGE X 1/2"		2	GC
INCONTROL PEN NEEDLE 12MM 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
INCONTROL PEN NEEDLE 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
INCONTROL PEN NEEDLE 5MM 31G 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
INCONTROL PEN NEEDLE 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
INCONTROL PEN NEEDLE 8MM 31G 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
INPEN (FOR HUMALOG) BLUE SUBCUTANEOUS INSULIN PEN		3	
INPEN (NOVOLOG OR FIASP) BLUE SUBCUTANEOUS INSULIN PEN		3	
INSULIN SYR 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(Advocate Syringes)	2	GC
INSULIN SYR 0.3 ML 31GX1/4(1/2) 0.3 ML 31 GAUGE X 1/4"	(UltiCare Insuln Syr(half unit))	2	GC
INSULIN SYRIN 0.3 ML 30GX1/2" SHORT NEEDLE 0.3 ML 30 GAUGE X 1/2"	(Comfort EZ Insulin Syringe)	2	GC
INSULIN SYRIN 0.5 ML 28GX1/2" 1/2 ML 28 GAUGE X 1/2"	(Comfort EZ Insulin Syringe)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
INSULIN SYRIN 0.5 ML 29GX1/2" (OTC) 0.5 ML 29 GAUGE X 1/2"	(Advocate Syringes)	2	GC
INSULIN SYRIN 0.5 ML 30GX1/2" SHORT NEEDLE (OTC) 0.5 ML 30 GAUGE X 1/2"	(Comfort EZ Insulin Syringe)	2	GC
INSULIN SYRIN 0.5 ML 30GX5/16" SHORT NEEDLE (OTC) 0.5 ML 30 GAUGE X 5/16"	(Advocate Syringes)	2	GC
INSULIN SYRING 0.5 ML 27GX1/2" 1/2 ML 27 GAUGE X 1/2"	(Easy Touch Insulin Syringe)	2	GC
INSULIN SYRINGE 0.3 ML 0.3 ML 29 GAUGE	(insulin syringe-needle u-100)	2	GC
INSULIN SYRINGE 0.3 ML 31GX1/4 0.3 ML 31 GAUGE X 1/4"	(Sure Comfort Insulin Syringe)	2	GC
INSULIN SYRINGE 0.5 ML 1/2 ML 29	(insulin syringe-needle u-100)	2	GC
INSULIN SYRINGE 0.5 ML 31GX1/4 1/2 ML 31 GAUGE X 1/4"	(Sure Comfort Insulin Syringe)	2	GC
INSULIN SYRINGE 1 ML 1 ML 29 GAUGE		2	GC
INSULIN SYRINGE 1 ML 30GX1/2" (RX) 1 ML 30 GAUGE X 1/2"	(BD Eclipse Luer-Lok)	2	GC
INSULIN SYRINGE 1 ML 30GX5/16" SHORT NEEDLE (OTC) 1 ML 30 GAUGE X 5/16	(Advocate Syringes)	2	GC
INSULIN SYRINGE 1 ML 31GX1/4" 1 ML 31 GAUGE X 1/4"	(Sure Comfort Insulin Syringe)	2	GC
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE	(Ultilet Insulin Syringe)	2	GC
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 1 ML 29 GAUGE X 1/2"	(Advocate Syringes)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 1/2 ML 28 GAUGE	(Lite Touch Insulin Syringe)	2	GC
INSUPEN 30G ULTRAFIN NEEDLE 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
INSUPEN 31G ULTRAFIN NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
INSUPEN 32G 6MM PEN NEEDLE 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
INSUPEN 32G 8MM PEN NEEDLE 32 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
INSUPEN PEN NEEDLE 29GX12MM 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
INSUPEN PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
INSUPEN PEN NEEDLE 32GX4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
INSUPEN PEN NEEDLE 33GX4MM 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
LISCO SPONGES 100/BAG 2 X 2 "		1	GC
LITE TOUCH 31GX1/4" PEN NEEDLE 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
LITE TOUCH INSULIN 0.5 ML SYR 1/2 ML 28 GAUGE, 1/2 ML 29 , 1/2 ML 30 GAUGE	(insulin syringe-needle u-100)	2	GC
LITE TOUCH INSULIN 1 ML SYR 1 ML 28 GAUGE, 1 ML 30 GAUGE X 7/16"	(insulin syringe-needle u-100)	2	GC
LITE TOUCH INSULIN 1 ML SYR 1 ML 29 GAUGE		2	GC
LITE TOUCH INSULIN SYR 1 ML 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
LITE TOUCH PEN NEEDLE 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
LITE TOUCH PEN NEEDLE 31G 31 GAUGE X 3/16", 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
LITETOUCH INS 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
LITETOUCH INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
LITETOUCH INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
LITETOUCH INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
LITETOUCH SYR 0.5 ML 28GX1/2" 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
LITETOUCH SYR 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
LITETOUCH SYR 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
LITETOUCH SYRIN 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
LITETOUCH SYRIN 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
LITETOUCH SYRIN 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
MAGELLAN INSUL SYRINGE 0.3 ML 0.3 ML 30 X 5/16"		2	GC
MAGELLAN INSUL SYRINGE 0.5 ML 0.5 ML 30 GAUGE X 5/16"		2	GC
MAGELLAN INSULIN SYR 0.3 ML 0.3 ML 29 X 1/2"		2	GC
MAGELLAN INSULIN SYR 0.5 ML 0.5 ML 29 GAUGE X 1/2"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
MAGELLAN INSULIN SYRINGE 1 ML 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16"		2	GC
MAXICOMFORT II PEN NDL 31GX6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
MAXICOMFORT INS 0.5 ML 27GX1/2" 1/2 ML 27 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MAXI-COMFORT INS 0.5 ML 28G 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MAXICOMFORT INS 1 ML 27GX1/2" 1 ML 27 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MAXI-COMFORT INS 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MAXICOMFORT PEN NDL 29G X 5MM 29 GAUGE X 3/16"		2	GC
MAXICOMFORT PEN NDL 29G X 8MM 29 GAUGE X 5/16"		2	GC
MICRODOT PEN NEEDLE 31GX6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
MICRODOT PEN NEEDLE 32GX4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
MICRODOT PEN NEEDLE 33GX4MM 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
MINI PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	(1st Tier Unifine Pentips)	2	GC
MINI PEN NEEDLE 32G 5MM 32 GAUGE X 3/16"	(CareFine Pen Needle)	2	GC
MINI PEN NEEDLE 32G 6MM 32 GAUGE X 1/4"	(BD Ultra-Fine Micro Pen Needle)	2	GC
MINI PEN NEEDLE 32G 8MM 32 GAUGE X 5/16"	(Comfort EZ Pen Needles)	2	GC
MINI PEN NEEDLE 33G 4MM 33 GAUGE X 5/32"	(Advocate Pen Needle)	2	GC
MINI PEN NEEDLE 33G 5MM 33 GAUGE X 3/16"	(Comfort EZ Pen Needles)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
MINI PEN NEEDLE 33G 6MM 33 GAUGE X 1/4"	(Comfort EZ Pen Needles)	2	GC
MINI ULTRA-THIN II PEN NDL 31G STERILE 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
MONOJECT 0.5 ML SYRN 28GX1/2" 1/2 ML 28 GAUGE	(insulin syringe-needle u-100)	2	GC
MONOJECT 1 ML SYRN 27X1/2" 1 ML 27 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT 1 ML SYRN 28GX1/2" (OTC) 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSUL SYR U100 (OTC) 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSUL SYR U100 .5ML,29GX1/2" (OTC) 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSUL SYR U100 0.5 ML CONVERTS TO 29G (OTC) 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSUL SYR U100 1 ML 1 ML 25 GAUGE X 5/8"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSUL SYR U100 1 ML 3'S, 29GX1/2" (OTC) 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSUL SYR U100 1 ML W/O NEEDLE (OTC) 1 ML	(insulin syringes (disposable))	2	GC
MONOJECT INSULIN SYR 0.3 ML (OTC) 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSULIN SYR 0.3 ML 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSULIN SYR 0.5 ML (OTC) 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSULIN SYR 0.5 ML 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSULIN SYR 1 ML 3'S (OTC) 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
MONOJECT INSULIN SYR U-100 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
MONOJECT INSULIN SYR U-100 29 GAUGE X 1/2"		2	GC
MONOJECT SYRINGE 0.3 ML 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
MONOJECT SYRINGE 0.5 ML 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
MONOJECT SYRINGE 1 ML 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
NOVOFINE 30 NEEDLE		2	GC
NOVOFINE 32G NEEDLES 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
NOVOFINE PLUS PEN NDL 32GX1/6" 32 GAUGE X 1/6"		2	GC
NOVOTWIST NEEDLE 32G 5MM 32 GAUGE X 1/5"		2	GC
OMNIPOD 5 G6 INTRO KIT (GEN 5) SUBCUTANEOUS CARTRIDGE		3	QL (1 per 365 days)
OMNIPOD 5 G6 PODS (GEN 5) SUBCUTANEOUS CARTRIDGE		3	
OMNIPOD CLASSIC PDM KIT(GEN 3)		3	QL (1 per 365 days)
OMNIPOD CLASSIC PODS (GEN 3) SUBCUTANEOUS CARTRIDGE		3	
OMNIPOD DASH INTRO KIT (GEN 4) SUBCUTANEOUS CARTRIDGE		3	QL (1 per 365 days)
OMNIPOD DASH PDM KIT (GEN 4)		3	QL (1 per 365 days)
OMNIPOD DASH PODS (GEN 4) SUBCUTANEOUS CARTRIDGE		3	
PC UNIFINE PENTIPS 8MM NEEDLE SHORT 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
PEN NEEDLE 30G X 5/16" 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
PEN NEEDLE 30G X 8MM 30 GAUGE X 5/16"	(AboutTime Pen Needle)	2	GC
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	(1st Tier Unifine Pentips Plus)	2	GC
PEN NEEDLES 12MM 29G 29GX12MM,STRL 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
PEN NEEDLES 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
PEN NEEDLES 6MM 31G 31GX6MM, STRL 31 GAUGE X 1/4"	(1st Tier Unifine Pentips)	2	GC
PEN NEEDLES 8MM 31G 31GX8MM,STRL,SHORT (OTC) 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
PENTIPS PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
PENTIPS PEN NEEDLE 31GX3/16" MINI, 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
PENTIPS PEN NEEDLE 31GX5/16" SHORT, 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
PENTIPS PEN NEEDLE 32G 6MM 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
PENTIPS PEN NEEDLE 32GX5/32" 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
PENTIPS PEN NEEDLE 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
PIP PEN NEEDLE 31G X 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
PIP PEN NEEDLE 32G X 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
PREVENT PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"		2	GC
PREVENT PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
PRO COMFORT 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
PRO COMFORT 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
PRO COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
PRO COMFORT 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
PRO COMFORT 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
PRO COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
PRO COMFORT PEN NDL 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
PRO COMFORT PEN NDL 32G X 1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
PRO COMFORT PEN NDL 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
PRO COMFORT PEN NDL 5MM 32G 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
PRODIGY INS SYR 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
PRODIGY SYRNG 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
PRODIGY SYRNGE 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
PURE COMFORT PEN NDL 32G 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
PURE COMFORT PEN NDL 32G 5MM 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
PURE COMFORT PEN NDL 32G 6MM 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
PURE COMFORT PEN NDL 32G 8MM 32 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
RELI ON 31G X 1/4" NEEDLES 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
RELION INS SYR 0.3 ML 31GX6MM 0.3 ML 31 GAUGE X 15/64"	(BD Veo Insulin Syringe UF)	2	GC
RELION INS SYR 0.5 ML 31GX6MM 1/2 ML 31 GAUGE X 15/64"	(BD Veo Insulin Syringe UF)	2	GC
RELION INS SYR 1 ML 31GX15/64" 1 ML 31 GAUGE X 15/64"	(BD Veo Insulin Syringe UF)	2	GC
RELI-ON INSULIN 0.5 ML SYR 1/2 ML 29	(Lite Touch Insulin Syringe)	2	GC
RELI-ON INSULIN 1 ML SYR 1 ML 29 GAUGE X 7/16"		2	GC
RELION MINI PEN 31G X 1/4" NDL 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
RELION PEN NEEDLE 31G 6MM 31 GAUGE X 15/64"		2	GC
RELION PEN NEEDLES 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
SAFESNAP INS SYR UNITS-100 0.3 ML 30GX5/16",10X10 0.3 ML 30 GAUGE X 5/16"		2	GC
SAFESNAP INS SYR UNITS-100 0.5 ML 29GX1/2",10X10 0.5 ML 29 GAUGE X 1/2"		2	GC
SAFESNAP INS SYR UNITS-100 0.5 ML 30GX5/16",10X10 0.5 ML 30 GAUGE X 5/16"		2	GC
SAFESNAP INS SYR UNITS-100 1 ML 28GX1/2",10X10 1 ML 28 GAUGE X 1/2"		2	GC
SAFESNAP INS SYR UNITS-100 1 ML 29GX1/2",10X10 1 ML 29 GAUGE X 1/2"		2	GC
SAFETY PEN NEEDLE 31G 4MM 31 GAUGE X 5/32"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
SAFETY PEN NEEDLE 5MM X 31G 31 GAUGE X 3/16"	(pen needle, diabetic, safety)	2	GC
SECURESAFE PEN NDL 30GX5/16" OUTER 30 GAUGE X 5/16"		2	GC
SKY SAFETY PEN NEEDLE 30G 5MM 30 GAUGE X 3/16"		2	GC
SM STERILE PADS 2" X 2" 2"X2", STERILE 2 X 2 "	(gauze bandage)	1	GC
SM ULT CFT 0.3 ML 31GX5/16(1/2) 0.3 ML 31 GAUGE X 5/16"		2	GC
SURE CMFT SFTY PEN NDL 31G 6MM 31 GAUGE X 1/4"		2	GC
SURE CMFT SFTY PEN NDL 32G 4MM 32 GAUGE X 5/32"		2	GC
NEEDLES, INSULIN DISP., SAFETY	(insulin syringe-needle u-100)	2	GC
SURE COMFORT 0.5 ML SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
SURE COMFORT 1 ML SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
SURE COMFORT 3/10 ML SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
SURE COMFORT 3/10 ML SYRINGE INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
SURE COMFORT 30G PEN NEEDLE 30 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
SURE COMFORT 31G PEN NEEDLE 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
SURE COMFORT INS 0.3 ML 31GX1/4 0.3 ML 31 GAUGE X 1/4"	(insulin syringe-needle u-100)	2	GC
SURE COMFORT INS 0.5 ML 31GX1/4 1/2 ML 31 GAUGE X 1/4"	(insulin syringe-needle u-100)	2	GC
SURE COMFORT INS 1 ML 31GX1/4" 1 ML 31 GAUGE X 1/4"	(insulin syringe-needle u-100)	2	GC
SURE COMFORT PEN NDL 29GX1/2" 12.7MM 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
SURE COMFORT PEN NDL 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
SURE COMFORT PEN NDL 32GX1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
SURE COMFORT PEN NDL 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
SURE-FINE PEN NEEDLES 12.7MM 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
SURE-FINE PEN NEEDLES 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
SURE-FINE PEN NEEDLES 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
SURE-JECT INSU SYR U100 0.3 ML 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
SURE-JECT INSU SYR U100 0.5 ML 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
SURE-JECT INSU SYR U100 1 ML 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
SURE-JECT INSUL SYR U100 1 ML 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
SURE-JECT INSULIN SYRINGE 1 ML 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
TECHLITE 0.3 ML 29GX12MM (1/2) 0.3 ML 29 GAUGE X 1/2"		2	GC
TECHLITE 0.3 ML 30GX12MM (1/2) 0.3 ML 30 GAUGE X 1/2"		2	GC
TECHLITE 0.3 ML 30GX8MM (1/2) 0.3 ML 30 GAUGE X 5/16"		2	GC
TECHLITE 0.3 ML 31GX6MM (1/2) 0.3 ML 31 GAUGE X 15/64"		2	GC
TECHLITE 0.3 ML 31GX8MM (1/2) 0.3 ML 31 GAUGE X 5/16"		2	GC
TECHLITE 0.5 ML 29GX12MM (1/2) 0.5 ML 29 GAUGE X 1/2"		2	GC
TECHLITE 0.5 ML 30GX12MM (1/2) 0.5 ML 30 GAUGE X 1/2"		2	GC
TECHLITE 0.5 ML 30GX8MM (1/2) 0.5 ML 30 GAUGE X 5/16"		2	GC
TECHLITE 0.5 ML 31GX6MM (1/2) 0.5 ML 31 GAUGE X 15/64"		2	GC
TECHLITE 0.5 ML 31GX8MM (1/2) 0.5 ML 31 GAUGE X 5/16"		2	GC
TECHLITE INS SYR 1 ML 29GX12MM 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TECHLITE INS SYR 1 ML 30GX12MM 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TECHLITE INS SYR 1 ML 30GX8MM 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TECHLITE INS SYR 1 ML 31GX6MM 1 ML 31 GAUGE X 15/64"	(insulin syringe-needle u-100)	2	GC
TECHLITE INS SYR 1 ML 31GX8MM 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TECHLITE PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
TECHLITE PEN NEEDLE 29GX3/8" 29 GAUGE X 3/8"		2	GC

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

Drug Name		Drug Tier	Requirements/Limits
TECHLITE PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TECHLITE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
TECHLITE PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
TECHLITE PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TECHLITE PEN NEEDLE 32GX5/16" 32 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
TECHLITE PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
TERUMO INS SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	(Advocate Syringes)	2	GC
TERUMO INS SYRINGE U100-1 ML 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TERUMO INS SYRINGE U100-1 ML 1 ML 30 GAUGE X 3/8"	(Thinpro Insulin Syringe)	2	GC
TERUMO INS SYRINGE U100-1/2 ML 1/2 ML 30 X 3/8"	(insulin syringe-needle u-100)	2	GC
TERUMO INS SYRINGE U100-1/3 ML 0.3 ML 30 X 3/8"	(insulin syringe-needle u-100)	2	GC
TERUMO INS SYRNG U100-1/2 ML 0.5 ML 29 GAUGE X 1/2", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
THINPRO INS SYRIN U100-0.3 ML 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 X 3/8"	(insulin syringe-needle u-100)	2	GC
THINPRO INS SYRIN U100-0.3 ML 0.3 ML 31 X 3/8"		2	GC
THINPRO INS SYRIN U100-0.5 ML 0.5 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8"	(insulin syringe-needle u-100)	2	GC
THINPRO INS SYRIN U100-0.5 ML 0.5 ML 31 X 3/8"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
THINPRO INS SYRIN U100-1 ML 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 3/8"	(insulin syringe-needle u-100)	2	GC
THINPRO INS SYRIN U100-1 ML 1 ML 31 X 3/8"		2	GC
TOPCARE CLICKFINE 31G X 1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TOPCARE CLICKFINE 31G X 5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
TOPCARE ULTRA COMFORT SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TRUE CMFRT PRO 0.5 ML 30G 5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
TRUE CMFRT PRO 0.5 ML 31G 5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
TRUE CMFRT PRO 0.5 ML 32G 5/16" 1/2 ML 32 GAUGE X 5/16"		2	GC
TRUE COMFORT 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
TRUE COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TRUE COMFORT PEN NDL 31G 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 31GX5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 31GX6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 32G 5MM 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
TRUE COMFORT PEN NDL 32G 6MM 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 32GX4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 33G 4MM 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 33G 5MM 33 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
TRUE COMFORT PEN NDL 33G 6MM 33 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TRUE COMFORT PRO 1 ML 30G 1/2" 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUE COMFORT PRO 1 ML 30G 5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TRUE COMFORT PRO 1 ML 31G 5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TRUE COMFORT PRO 1 ML 32G 5/16" 1 ML 32 GAUGE X 5/16"		2	GC
TRUE COMFRT PRO 0.5 ML 30G 1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS PEN NEEDLE 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
TRUEPLUS PEN NEEDLE 31G X 1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
TRUEPLUS PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
TRUEPLUS PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
TRUEPLUS PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
TRUEPLUS SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
TRUEPLUS SYR 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 0.5 ML 28GX1/2" 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 1 ML 28GX1/2" 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 1 ML 29GX1/2" 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 1 ML 30GX5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
TRUEPLUS SYR 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULT CFT 0.3 ML 30GX5/16" (1/2) 1/2 UNIT 0.3 ML 30 GAUGE X 5/16"		2	GC
ULTICAR INS 0.3 ML 31GX1/4(1/2) 0.3 ML 31 GAUGE X 1/4"	(insulin syr/ndl u100 half mark)	2	GC
ULTICARE INS 0.3 ML 31GX1/4" 0.3 ML 31 GAUGE X 1/4"	(insulin syringe-needle u-100)	2	GC
ULTICARE INS 0.5 ML 31GX1/4" 1/2 ML 31 GAUGE X 1/4"	(insulin syringe-needle u-100)	2	GC
ULTICARE INS 1 ML 31GX1/4" 1 ML 31 GAUGE X 1/4"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
ULTICARE INS SYR 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTICARE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
ULTICARE PEN NEEDLE 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
ULTICARE PEN NEEDLE 8MM 31G 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
ULTICARE PEN NEEDLES 12MM 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
ULTICARE PEN NEEDLES 4MM 32G MICRO, 32GX4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ULTICARE PEN NEEDLES 6MM 32G 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
ULTICARE SAFE PEN NDL 5MM 30G 30 GAUGE X 3/16"		2	GC
ULTICARE SAFE PEN NDL 8MM 30G 30 GAUGE X 5/16"		2	GC
ULTICARE SYR 0.3 ML 30GX1/2" 0.3 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTICARE SYR 0.3 ML 31GX5/16" SHORT NDL 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTICARE SYR 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTICARE SYR 0.5 ML 31GX5/16" SHORT NDL 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTICARE SYR 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTIGUARD SAFE 1 ML 30G 12.7MM 1 ML 30 X 1/2"		2	GC
ULTIGUARD SAFE PACK 29G 12.7MM 29 GAUGE X 1/2"		2	GC

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Drug Name		Drug Tier	Requirements/Limits
ULTIGUARD SAFE PACK 32G 4MM 32 GAUGE X 5/32"		2	GC
ULTIGUARD SAFE0.3 ML 30G 12.7MM 0.3 ML 30 X 1/2"		2	GC
ULTIGUARD SAFE0.5 ML 30G 12.7MM 1/2 ML 30 X 1/2"		2	GC
ULTIGUARD SAFEPACK 1 ML 31G 8MM 1 ML 31 X 5/16"		2	GC
ULTIGUARD SAFEPACK 31G 5MM 31 GAUGE X 3/16"		2	GC
ULTIGUARD SAFEPACK 31G 6MM 31 GAUGE X 1/4"		2	GC
ULTIGUARD SAFEPACK 31G 8MM 31 GAUGE X 5/16"		2	GC
ULTIGUARD SAFEPACK 32G 6MM 32 GAUGE X 1/4"		2	GC
ULTIGUARD SAFEPK 0.3 ML 31G 8MM 0.3 ML 31 X 5/16"		2	GC
ULTIGUARD SAFEPK 0.5 ML 31G 8MM 1/2 ML 31 X 5/16"		2	GC
ULTILET INSULIN SYRINGE 0.3 ML 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTILET INSULIN SYRINGE 0.5 ML 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTILET INSULIN SYRINGE 1 ML 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTILET PEN NEEDLE 29 GAUGE		2	GC
ULTILET PEN NEEDLE 4MM 32G 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ULTRA COMFORT 0.3 ML SYRINGE 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
ULTRA COMFORT 0.5 ML 28GX1/2" CONVERTS TO 29G 1/2 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA COMFORT 0.5 ML 29GX1/2" 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA COMFORT 0.5 ML SYRINGE 1/2 ML 28 GAUGE	(insulin syringe-needle u-100)	2	GC
ULTRA COMFORT 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTRA COMFORT 1 ML SYRINGE 1 ML 28 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA FLO 0.3 ML 30G 1/2" (1/2) 0.3 ML 30 GAUGE X 1/2"		2	GC
ULTRA FLO 0.3 ML 30G 5/16"(1/2) 0.3 ML 30 GAUGE X 5/16"		2	GC
ULTRA FLO 0.3 ML 31G 5/16"(1/2) 0.3 ML 31 GAUGE X 5/16"		2	GC
ULTRA FLO PEN NEEDLE 31G 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
ULTRA FLO PEN NEEDLE 31G 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
ULTRA FLO PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ULTRA FLO PEN NEEDLE 33G 4MM 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ULTRA FLO PEN NEEDLES 12MM 29G 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
ULTRA FLO SYR 0.3 ML 29GX1/2" 0.3 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA FLO SYR 0.3 ML 30G 5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRA FLO SYR 0.3 ML 31G 5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
ULTRA FLO SYR 0.5 ML 29G 1/2" 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA THIN PEN NDL 32G X 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ULTRACARE INS 0.3 ML 30GX5/16" 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 0.3 ML 31GX5/16" 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 0.5 ML 30GX1/2" 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 0.5 ML 30GX5/16" 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 0.5 ML 31GX5/16" 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 1 ML 30G X 5/16" 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 1 ML 30GX1/2" 1 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRACARE INS 1 ML 31G X 5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTRACARE PEN NEEDLE 31GX1/4" 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
ULTRACARE PEN NEEDLE 31GX3/16" 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
ULTRACARE PEN NEEDLE 31GX5/16" 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
ULTRACARE PEN NEEDLE 32GX1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
ULTRACARE PEN NEEDLE 32GX3/16" 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
ULTRACARE PEN NEEDLE 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
ULTRACARE PEN NEEDLE 33GX5/32" 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
ULTRA-THIN II 1 ML 31GX5/16" 1 ML 31 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS 0.3 ML 30G 0.3 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS 0.3 ML 31G 0.3 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS 0.5 ML 29G 0.5 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS 0.5 ML 30G 0.5 ML 30 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS 0.5 ML 31G 0.5 ML 31 GAUGE X 5/16"	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS SYR 1 ML 29G 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II INS SYR 1 ML 30G 1 ML 30 GAUGE X 5/16	(insulin syringe-needle u-100)	2	GC
ULTRA-THIN II PEN NDL 29GX1/2" 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
ULTRA-THIN II PEN NDL 31GX5/16 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
UNIFINE PEN NEEDLE 32G 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS 12MM 29G 29GX12MM, STRL 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS 31GX3/16" 31GX5MM,STRL,MINI 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS 32GX1/4" 32 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS 32GX5/32" 32GX4MM, STRL, NANO 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS 33GX5/32" 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS 6MM 31G 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
UNIFINE PENTIPS MAX 30GX3/16" 30 GAUGE X 3/16"		2	GC
UNIFINE PENTIPS NEEDLES 29G 29 GAUGE		2	GC
UNIFINE PENTIPS PLUS 29GX1/2" 12MM 29 GAUGE X 1/2"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS PLUS 30GX3/16" 30 GAUGE X 3/16"		2	GC
UNIFINE PENTIPS PLUS 31GX1/4" ULTRA SHORT, 6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS PLUS 31GX3/16" MINI 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS PLUS 31GX5/16" SHORT 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS PLUS 32GX5/32" 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
UNIFINE PENTIPS PLUS 33GX5/32" 33 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
UNIFINE SAFECONTROL 30GX3/16" 30 GAUGE X 3/16"		2	GC
UNIFINE SAFECONTROL 30GX5/16" 30 GAUGE X 5/16"		2	GC
UNIFINE SAFECONTROL 32G 4MM 32 GAUGE X 5/32"		2	GC
UNIFINE ULTRA PEN NDL 31G 5MM 31 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
UNIFINE ULTRA PEN NDL 31G 6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
UNIFINE ULTRA PEN NDL 31G 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
UNIFINE ULTRA PEN NDL 32G 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
VANISHPOINT 0.5 ML 30GX1/2" SY OUTER 0.5 ML 30 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC

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

Drug Name		Drug Tier	Requirements/Limits
VANISHPOINT INS 1 ML 30GX3/16" 1 ML 30 GAUGE X 3/16"		2	GC
VANISHPOINT U-100 29X1/2 SYR 1 ML 29 GAUGE X 1/2"	(insulin syringe-needle u-100)	2	GC
VERIFINE PEN NEEDLE 31G X 6MM 31 GAUGE X 1/4"	(pen needle, diabetic)	2	GC
VERIFINE PEN NEEDLE 31G X 8MM 31 GAUGE X 5/16"	(pen needle, diabetic)	2	GC
VERIFINE PEN NEEDLE 32G X 4MM 32 GAUGE X 5/32"	(pen needle, diabetic)	2	GC
VERIFINE PEN NEEDLE 32G X 5MM 32 GAUGE X 3/16"	(pen needle, diabetic)	2	GC
VERSALON ALL PURPOSE SPONGE 25'S,N-STERILE,3PLY 2 X 2 "		1	GC
V-GO 20 DEVICE		3	
V-GO 30 DEVICE		3	
V-GO 40 DEVICE		3	
Enzyme Replacement/Modifiers			
Enzyme Replacement/Modifiers			
ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5 ML		5	NEDS
CERDELGA ORAL CAPSULE 84 MG		5	PA; NEDS
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT		5	NEDS
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 - 120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT		3	
ELAPRASE INTRAVENOUS SOLUTION 6 MG/3 ML		5	NEDS
ELITEK INTRAVENOUS RECON SOLN 1.5 MG, 7.5 MG		5	NEDS

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Drug Name	Drug Tier	Requirements/Limits
FABRAZYME INTRAVENOUS RECON SOLN 35 MG, 5 MG	5	PA; NEDS
GALAFOLD ORAL CAPSULE 123 MG	5	PA; NEDS; QL (14 per 28 days)
javygtor oral tablet,soluble 100 mg (sapropterin)	5	NEDS
KANUMA INTRAVENOUS SOLUTION 2 MG/ML	5	PA; NEDS
KRYSTEXXA INTRAVENOUS SOLUTION 8 MG/ML	5	PA BvD; NEDS
MEPSEVII INTRAVENOUS SOLUTION 2 MG/ML	5	PA; NEDS
miglustat oral capsule 100 mg (Zavesca)	5	PA; NEDS; QL (90 per 30 days)
NAGLAZYME INTRAVENOUS SOLUTION 5 MG/5 ML	5	NEDS
nitisinone oral capsule 10 mg, 2 mg, 5 mg (Orfadin)	5	PA; NEDS
NITYR ORAL TABLET 10 MG, 2 MG, 5 MG	5	PA; NEDS
ORFADIN ORAL CAPSULE 20 MG	5	PA; NEDS
ORFADIN ORAL SUSPENSION 4 MG/ML	5	PA; NEDS
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML	5	PA; NEDS
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA BvD; NEDS
REVCOVI INTRAMUSCULAR SOLUTION 2.4 MG/1.5 ML (1.6 MG/ML)	5	PA; NEDS
sapropterin oral tablet,soluble 100 mg (Javygtor)	5	NEDS
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML	5	PA; LA; NEDS

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Drug Name	Drug Tier	Requirements/Limits
VIMIZIM INTRAVENOUS SOLUTION 5 MG/5 ML (1 MG/ML)	5	PA; NEDS
VPRIV INTRAVENOUS RECON SOLN 400 UNIT	5	NEDS
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	3	
Eye, Ear, Nose, Throat Agents		
Eye, Ear, Nose, Throat Agents, Miscellaneous		
apraclonidine ophthalmic (eye) drops 0.5 %	2	GC
atropine ophthalmic (eye) drops 1 % (Isopto Atropine)	4	
azelastine nasal aerosol,spray 137 mcg (0.1 %)	2	GC; QL (30 per 25 days)
azelastine ophthalmic (eye) drops 0.05 %	2	GC
cromolyn ophthalmic (eye) drops 4 %	2	GC
cyclopentolate ophthalmic (eye) drops 0.5 %, 1 %, 2 % (Cyclogyl)	2	GC
CYSTARAN OPHTHALMIC (EYE) DROPS 0.44 %	5	PA; NEDS; QL (60 per 28 days)
epinastine ophthalmic (eye) drops 0.05 %	2	GC
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	2	GC; QL (30 per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	2	GC; QL (15 per 10 days)
levofloxacin ophthalmic (eye) drops 1.5 %	4	

Drug Name		Drug Tier	Requirements/Limits
olopatadine ophthalmic (eye) drops 0.1 %	(Eye Allergy Itch-Redness Rlf)	2	GC
olopatadine ophthalmic (eye) drops 0.2 %	(Clear Eyes Once Daily Allergy)	4	
proparacaine ophthalmic (eye) drops 0.5 %	(Alcaine)	2	GC
TEPEZZA INTRAVENOUS RECON SOLN 500 MG		5	PA; NEDS
Eye, Ear, Nose, Throat Anti-Infectives Agents			
acetic acid otic (ear) solution 2 %		2	GC
bacitracin ophthalmic (eye) ointment 500 unit/gram		4	
bacitracin-polymyxin b ophthalmic (eye) ointment 500-10,000 unit/gram	(Polycin)	2	GC
bleph-10 ophthalmic (eye) drops 10 %	(sulfacetamide sodium)	2	GC
ciprofloxacin hcl ophthalmic (eye) drops 0.3 %	(Ciloxan)	2	GC
ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %	(Ciprodex)	3	QL (7.5 per 7 days)
erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)		2	GC; QL (3.5 per 4 days)
gentak ophthalmic (eye) ointment 0.3 % (3 mg/gram)	(gentamicin)	2	GC
gentamicin ophthalmic (eye) drops 0.3 %		1	GC
levofloxacin ophthalmic (eye) drops 0.5 %		4	
moxifloxacin ophthalmic (eye) drops 0.5 %	(Vigamox)	2	GC
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 %		4	
neomycin-bacitracin-poly-hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%	(Neo-Polycin HC)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
neomycin-bacitracin-polymyxin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g	(Neo-Polycin)	2	GC
neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %	(Maxitrol)	2	GC
neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %	(Maxitrol)	2	GC
neomycin-polymyxin-gramicidin ophthalmic (eye) drops 1.75 mg-10,000 unit-0.025mg/ml		2	GC
neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml		4	
neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%		2	GC
neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%		2	GC
neo-polycin hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%	(neomycin-bacitracin-poly-hc)	2	GC
neo-polycin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g	(neomycin-bacitracin-polymyxin)	2	GC
ofloxacin ophthalmic (eye) drops 0.3 %	(Ocuflox)	2	GC
ofloxacin otic (ear) drops 0.3 %		2	GC
polycin ophthalmic (eye) ointment 500-10,000 unit/gram	(bacitracin-polymyxin b)	2	GC
polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit-1 mg/ml	(Polytrim)	1	GC
sulfacetamide sodium ophthalmic (eye) drops 10 %		2	GC
sulfacetamide sodium ophthalmic (eye) ointment 10 %		2	GC

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Drug Name		Drug Tier	Requirements/Limits
sulfacetamide-prednisolone ophthalmic (eye) drops 10 %-0.23 % (0.25 %)		2	GC
tobramycin ophthalmic (eye) drops 0.3 %	(Tobrex)	2	GC
tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %	(TobraDex)	2	GC
trifluridine ophthalmic (eye) drops 1 %		3	
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 %		4	
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.5 %		3	
Eye, Ear, Nose, Throat Anti-Inflammatory Agents			
ALREX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.2 %		3	ST
BROMSITE OPHTHALMIC (EYE) DROPS 0.075 %		3	
cyclosporine ophthalmic (eye) dropperette 0.05 %	(Restasis)	2	GC; QL (60 per 30 days)
dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %		2	GC
diclofenac sodium ophthalmic (eye) drops 0.1 %		2	GC
difluprednate ophthalmic (eye) drops 0.05 %	(Durezol)	3	
EYSUVIS OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 %		3	QL (8.3 per 14 days)
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)		2	GC; QL (50 per 25 days)
fluorometholone ophthalmic (eye) drops,suspension 0.1 %	(FML Liquifilm)	4	
flurbiprofen sodium ophthalmic (eye) drops 0.03 %		2	GC
fluticasone propionate nasal spray,suspension 50 mcg/actuation	(24 Hour Allergy Relief)	1	GC; QL (16 per 30 days)

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Drug Name	Drug Tier	Requirements/Limits
ILEVRO OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3 %	3	
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION 1 %	3	
ketorolac ophthalmic (eye) drops 0.5 % (Acular)	2	GC; QL (10 per 25 days)
LOTEMAX OPHTHALMIC (EYE) OINTMENT 0.5 %	3	
LOTEMAX SM OPHTHALMIC (EYE) DROPS,GEL 0.38 %	3	
loteprednol etabonate ophthalmic (eye) drops,gel 0.5 % (Lotemax)	4	
mometasone nasal spray,non-aerosol 50 mcg/actuation	4	QL (34 per 30 days)
prednisolone acetate ophthalmic (eye) drops,suspension 1 % (Pred Forte)	4	
prednisolone sodium phosphate ophthalmic (eye) drops 1 %	2	GC
PROLENSA OPHTHALMIC (EYE) DROPS 0.07 %	3	
RESTASIS MULTIDOSE OPHTHALMIC (EYE) DROPS 0.05 %	3	QL (60 per 30 days)
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 % (cyclosporine)	2	GC; QL (60 per 30 days)
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION	3	ST; QL (32 per 30 days)
XIIDRA OPHTHALMIC (EYE) DROPPERETTE 5 %	3	QL (60 per 30 days)
Gastrointestinal Agents		
Antiulcer Agents And Acid Suppressants		
cimetidine hcl oral solution 300 mg/5 ml	2	GC
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg (Nexium)	2	GC; QL (30 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg	(Nexium)	2	GC; QL (60 per 30 days)
esomeprazole magnesium oral granules dr for susp in packet 10 mg, 20 mg	(Nexium Packet)	3	ST; QL (30 per 30 days)
esomeprazole magnesium oral granules dr for susp in packet 40 mg	(Nexium Packet)	3	ST; QL (60 per 30 days)
esomeprazole sodium intravenous recon soln 20 mg		2	GC
esomeprazole sodium intravenous recon soln 40 mg	(Nexium IV)	2	GC
famotidine (pf) intravenous solution 20 mg/2 ml		1	GC
famotidine (pf)-nacl (iso-os) intravenous piggyback 20 mg/50 ml		2	GC
famotidine intravenous solution 10 mg/ml		2	GC
famotidine oral tablet 20 mg	(Acid Controller)	1	GC
famotidine oral tablet 40 mg	(Pepcid)	1	GC
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	(Prevacid 24Hr)	4	QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	(Prevacid)	4	QL (60 per 30 days)
misoprostol oral tablet 100 mcg, 200 mcg	(Cytotec)	2	GC
nizatidine oral capsule 150 mg, 300 mg		2	GC
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg		1	GC
omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram, 40-1.1 mg-gram	(Zegerid)	4	ST; QL (30 per 30 days)
pantoprazole intravenous recon soln 40 mg	(Protonix)	2	GC
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	(Protonix)	1	GC; QL (30 per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	(Protonix)	1	GC; QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
rabeprazole oral tablet,delayed release (dr/ec) 20 mg	(AcipHex)	2	GC; QL (30 per 30 days)
sucralfate oral tablet 1 gram	(Carafate)	2	GC
Gastrointestinal Agents, Other			
carglumic acid oral tablet, dispersible 200 mg	(Carbaglu)	5	NEDS
constulose oral solution 10 gram/15 ml	(lactulose)	2	GC
cromolyn oral concentrate 100 mg/5 ml	(Gastrocrom)	4	
dicyclomine oral capsule 10 mg		2	GC
dicyclomine oral solution 10 mg/5 ml		4	
dicyclomine oral tablet 20 mg		2	GC
diphenoxylate-atropine oral tablet 2.5-0.025 mg	(Lomotil)	4	
enulose oral solution 10 gram/15 ml	(lactulose)	2	GC
GATTEX 30-VIAL SUBCUTANEOUS KIT 5 MG		5	PA; NEDS
generlac oral solution 10 gram/15 ml	(lactulose)	2	GC
glycopyrrolate oral tablet 1 mg	(Robinul)	2	GC
glycopyrrolate oral tablet 2 mg	(Robinul Forte)	2	GC
kionex (with sorbitol) oral suspension 15-19.3 gram/60 ml		2	GC
lactulose oral solution 10 gram/15 ml	(Constulose)	2	GC
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG		3	QL (30 per 30 days)
LOKELMA ORAL POWDER IN PACKET 10 GRAM		3	QL (34 per 30 days)
LOKELMA ORAL POWDER IN PACKET 5 GRAM		3	QL (30 per 30 days)
loperamide oral capsule 2 mg	(Anti-Diarrheal (loperamide))	2	GC
lubiprostone oral capsule 24 mcg, 8 mcg	(Amitiza)	3	QL (60 per 30 days)
methscopolamine oral tablet 2.5 mg, 5 mg		4	

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Drug Name		Drug Tier	Requirements/Limits
metoclopramide hcl injection solution 5 mg/ml		2	GC
metoclopramide hcl injection syringe 5 mg/ml		2	GC
metoclopramide hcl oral solution 5 mg/5 ml		2	GC
metoclopramide hcl oral tablet 10 mg, 5 mg	(Reglan)	1	GC
MOVANTIK ORAL TABLET 12.5 MG, 25 MG		3	QL (30 per 30 days)
OCALIVA ORAL TABLET 10 MG, 5 MG		5	PA; NEDS; QL (30 per 30 days)
RAVICTI ORAL LIQUID 1.1 GRAM/ML		5	PA; NEDS
sodium phenylbutyrate oral tablet 500 mg	(Buphenyl)	5	NEDS
sodium polystyrene (sorb free) oral suspension 15 gram/60 ml		2	GC
sodium polystyrene sulfonate oral powder		2	GC
sps (with sorbitol) oral suspension 15-20 gram/60 ml		2	GC
ursodiol oral capsule 300 mg		2	GC
ursodiol oral tablet 250 mg	(URSO 250)	2	GC
ursodiol oral tablet 500 mg	(URSO Forte)	2	GC
XERMELO ORAL TABLET 250 MG		5	PA; NEDS; QL (90 per 30 days)
Laxatives			
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM -12 GRAM/160 ML		3	
gavilyte-c oral recon soln 240-22.72-6.72 -5.84 gram	(peg 3350-electrolytes)	2	GC
gavilyte-g oral recon soln 236-22.74-6.74 -5.86 gram	(peg 3350-electrolytes)	2	GC
gavilyte-n oral recon soln 420 gram	(peg-electrolyte soln)	2	GC
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	(GaviLyte-G)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
peg-electrolyte soln oral recon soln 420 gram		2	GC
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram	(Suprep Bowel Prep Kit)	3	
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM	(sodium,potassium,mag sulfates)	3	
SUTAB ORAL TABLET 1.479-0.188- 0.225 GRAM		3	
trilyte with flavor packets oral recon soln 420 gram	(peg-electrolyte soln)	2	GC
Phosphate Binders			
calcium acetate(phosphat bind) oral capsule 667 mg		2	GC
calcium acetate(phosphat bind) oral tablet 667 mg		2	GC
PHOSLYRA ORAL SOLUTION 667 MG (169 MG CALCIUM)/5 ML		4	
sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram	(Renvela)	5	NEDS
sevelamer carbonate oral tablet 800 mg	(Renvela)	4	
sevelamer hcl oral tablet 400 mg		3	
VELPHORO ORAL TABLET,CHEWABLE 500 MG		3	
Genitourinary Agents			
Antispasmodics, Urinary			
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg		2	GC
fesoterodine oral tablet extended release 24 hr 4 mg, 8 mg	(Toviaz)	2	GC
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG, 50 MG		3	
oxybutynin chloride oral syrup 5 mg/5 ml		2	GC
oxybutynin chloride oral tablet 5 mg		2	GC

Drug Name		Drug Tier	Requirements/Limits
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	(Ditropan XL)	2	GC
oxybutynin chloride oral tablet extended release 24hr 15 mg		2	GC
tolterodine oral capsule,extended release 24hr 2 mg, 4 mg	(Detrol LA)	2	GC
tolterodine oral tablet 1 mg, 2 mg	(Detrol)	2	GC
trospium oral tablet 20 mg		4	
Genitourinary Agents, Miscellaneous			
alfuzosin oral tablet extended release 24 hr 10 mg	(Uroxatral)	1	GC; QL (30 per 30 days)
dutasteride oral capsule 0.5 mg	(Avodart)	2	GC
finasteride oral tablet 5 mg	(Proscar)	1	GC
tamsulosin oral capsule 0.4 mg	(Flomax)	1	GC
terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg		1	GC
THIOLA EC ORAL TABLET,DELAYED RELEASE (DR/EC) 100 MG, 300 MG		5	PA; NEDS
tiopronin oral tablet 100 mg	(Thiola)	5	NEDS
Heavy Metal Antagonists			
Heavy Metal Antagonists			
clovique oral capsule 250 mg	(trientine)	5	PA; NEDS; QL (240 per 30 days)
deferasirox oral granules in packet 180 mg, 360 mg, 90 mg	(Jadenu Sprinkle)	5	PA; NEDS
deferasirox oral tablet 180 mg, 360 mg	(Jadenu)	5	PA; NEDS
deferasirox oral tablet 90 mg	(Jadenu)	3	PA
deferasirox oral tablet, dispersible 125 mg	(Exjade)	2	PA; GC
deferasirox oral tablet, dispersible 250 mg, 500 mg	(Exjade)	5	PA; NEDS
deferiprone oral tablet 1,000 mg, 500 mg	(Ferriprox)	5	PA; NEDS
deferoxamine injection recon soln 2 gram		2	PA; GC

Drug Name		Drug Tier	Requirements/Limits
deferoxamine injection recon soln 500 mg	(Desferal)	2	PA; GC
FERRIPROX 1,000 MG TAB(2X/DAY) 1,000 MG	(deferiprone)	5	PA; NEDS
FERRIPROX ORAL SOLUTION 100 MG/ML		5	PA; NEDS
FERRIPROX ORAL TABLET 1,000 MG	(deferiprone)	5	PA; NEDS
penicillamine oral capsule 250 mg	(Cuprimine)	5	PA; NEDS
penicillamine oral tablet 250 mg	(Depen Titratabs)	5	PA; NEDS
trientine oral capsule 250 mg	(Syprine)	5	PA; NEDS; QL (240 per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying			
Androgens			
ANADROL-50 ORAL TABLET 50 MG		5	PA; NEDS
danazol oral capsule 100 mg, 200 mg, 50 mg		3	
oxandrolone oral tablet 10 mg	(Oxandrin)	2	GC
oxandrolone oral tablet 2.5 mg	(Oxandrin)	4	
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	(Depo-Testosterone)	2	PA; GC
testosterone cypionate intramuscular oil 200 mg/ml (1 ml)		2	PA; GC
testosterone enanthate intramuscular oil 200 mg/ml		2	PA; GC; QL (5 per 28 days)
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	(Vogelxo)	3	PA; QL (300 per 30 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	(AndroGel)	2	PA; GC; QL (150 per 30 days)
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	(AndroGel)	4	PA; QL (300 per 30 days)

Drug Name		Drug Tier	Requirements/Limits
testosterone transdermal solution in metered pump w/app 30 mg/actuation (1.5 ml)		4	PA; QL (180 per 30 days)
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML		3	PA; QL (2 per 28 days)
Estrogens And Antiestrogens			
amabelz oral tablet 0.5-0.1 mg, 1-0.5 mg	(estradiol-norethindrone acet)	2	GC
dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	(estradiol)	2	GC; QL (8 per 28 days)
DUAVEE ORAL TABLET 0.45-20 MG		3	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	(Estrace)	1	GC
estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	(Dotti)	2	GC; QL (8 per 28 days)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	(Climara)	2	GC; QL (4 per 28 days)
estradiol vaginal cream 0.01 % (0.1 mg/gram)	(Estrace)	2	GC
estradiol vaginal tablet 10 mcg	(Yuvafem)	2	GC; QL (18 per 28 days)
estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml	(Delestrogen)	2	GC
estradiol-norethindrone acet oral tablet 0.5-0.1 mg	(Amabelz)	2	GC
FEMRING VAGINAL RING 0.05 MG/24 HR, 0.1 MG/24 HR		4	QL (1 per 84 days)
fyavolv oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	(norethindrone ac-eth estradiol)	2	GC
jinteli oral tablet 1-5 mg-mcg	(norethindrone ac-eth estradiol)	2	GC

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Drug Name		Drug Tier	Requirements/Limits
lyllana transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	(estradiol)	2	GC; QL (8 per 28 days)
mimvey oral tablet 1-0.5 mg	(estradiol-norethindrone acet)	2	GC
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	(Fyavolv)	2	GC
PREMARIN INJECTION RECON SOLN 25 MG		3	
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.9 MG		3	
PREMARIN ORAL TABLET 0.625 MG, 1.25 MG	(conjugated estrogens)	3	
PREMARIN VAGINAL CREAM 0.625 MG/GRAM		3	
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14)		3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG		3	
raloxifene oral tablet 60 mg	(Evista)	2	GC
yuvafem vaginal tablet 10 mcg	(estradiol)	2	GC; QL (18 per 28 days)
Glucocorticoids/Mineralocorticoids			
a-hydrocort injection recon soln 100 mg		2	GC
betamethasone acet,sod phos injection suspension 6 mg/ml	(Celestone Soluspan)	2	GC
dexamethasone 0.5 mg/5 ml liq 0.5 mg/5 ml		2	GC
dexamethasone oral elixir 0.5 mg/5 ml		2	GC
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg		2	GC
dexamethasone sodium phos (pf) injection solution 10 mg/ml		1	GC

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Drug Name	Drug Tier	Requirements/Limits
dexamethasone sodium phos (pf) injection syringe 10 mg/ml	1	GC
dexamethasone sodium phosphate injection solution 10 mg/ml, 4 mg/ml	1	GC
dexamethasone sodium phosphate injection syringe 4 mg/ml	1	GC
EMFLAZA ORAL SUSPENSION 22.75 MG/ML	5	PA; NEDS; QL (91 per 28 days)
EMFLAZA ORAL TABLET 18 MG	5	PA; NEDS; QL (30 per 30 days)
EMFLAZA ORAL TABLET 30 MG, 36 MG, 6 MG	5	PA; NEDS; QL (60 per 30 days)
fludrocortisone oral tablet 0.1 mg	2	GC
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg (Cortef)	2	GC
methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml (Depo-Medrol)	2	GC
methylprednisolone oral tablet 16 mg, 4 mg, 8 mg (Medrol)	2	GC
methylprednisolone oral tablet 32 mg	2	GC
methylprednisolone oral tablets,dose pack 4 mg (Medrol (Pak))	2	GC
methylprednisolone sodium succ injection recon soln 125 mg, 40 mg	2	GC
methylprednisolone sodium succ intravenous recon soln 1,000 mg (Solu-Medrol)	2	GC
prednisolone 15 mg/5 ml soln d/f 15 mg/5 ml (3 mg/ml)	2	PA BvD; GC
prednisolone oral solution 15 mg/5 ml	2	PA BvD; GC
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml)	3	PA BvD
prednisolone sodium phosphate oral solution 5 mg base/5 ml (6.7 mg/5 ml) (Pediapred)	3	PA BvD
prednisone oral solution 5 mg/5 ml	3	PA BvD
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	PA BvD; GC

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Drug Name	Drug Tier	Requirements/Limits
prednisone oral tablets,dose pack 10 mg, 10 mg (48 pack), 5 mg, 5 mg (48 pack)	2	GC
SOLU-CORTEF ACT-O-VIAL (PF) INJECTION RECON SOLN 100 MG/2 ML	4	
triamcinolone acetonide injection suspension 40 mg/ml (Kenalog)	2	GC
Pituitary		
ACTHAR INJECTION GEL 80 UNIT/ML	5	PA; NEDS; QL (35 per 28 days)
BYNFEZIA SUBCUTANEOUS PEN INJECTOR 2,500 MCG/ML	5	NEDS
CORTROPHIN GEL INJECTION GEL 80 UNIT/ML	5	PA; NEDS; QL (35 per 28 days)
desmopressin injection solution 4 mcg/ml (DDAVP)	4	
desmopressin nasal spray with pump 10 mcg/spray (0.1 ml)	4	
desmopressin oral tablet 0.1 mg, 0.2 mg (DDAVP)	2	GC
EGRIFTA SV SUBCUTANEOUS RECON SOLN 2 MG	5	PA; NEDS; QL (30 per 30 days)
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML	5	NEDS
lanreotide subcutaneous syringe 120 mg/0.5 ml (Somatuline Depot)	5	PA NSO; NEDS; QL (0.5 per 28 days)
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	5	NEDS
LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG, 7.5 MG	5	NEDS
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	5	NEDS
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	5	NEDS

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Drug Name	Drug Tier	Requirements/Limits
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	5	PA; NEDS
octreotide acetate injection solution 1,000 mcg/ml, 200 mcg/ml	3	
octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml (Sandostatin)	3	
octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)	3	
ORGOVYX ORAL TABLET 120 MG	5	PA NSO; NEDS
ORILISSA ORAL TABLET 150 MG	5	PA; NEDS; QL (28 per 28 days)
ORILISSA ORAL TABLET 200 MG	5	PA; NEDS; QL (56 per 28 days)
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 10 MG, 20 MG, 30 MG	5	NEDS
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	5	PA; NEDS
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML), 0.9 MG/ML (1 ML)	5	PA; NEDS; QL (60 per 30 days)
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML (lanreotide)	5	PA NSO; NEDS; QL (0.5 per 28 days)
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 60 MG/0.2 ML	5	PA NSO; NEDS; QL (0.2 per 28 days)
SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 90 MG/0.3 ML	5	PA NSO; NEDS; QL (0.3 per 28 days)

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Drug Name		Drug Tier	Requirements/Limits
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG		5	PA; NEDS
SUPPRELIN LA IMPLANT KIT 50 MG (65 MCG/DAY)		5	NEDS; QL (1 per 360 days)
SYNAREL NASAL SPRAY,NON-AEROSOL 2 MG/ML		5	NEDS
TRIPTODUR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 22.5 MG		5	NEDS; QL (1 per 168 days)
ZORBTIVE SUBCUTANEOUS RECON SOLN 8.8 MG		5	PA; NEDS
Progestins			
hydroxyprogesterone cap(ppres) intramuscular oil 250 mg/ml	(Makena)	5	NEDS
medroxyprogesterone intramuscular suspension 150 mg/ml	(Depo-Provera)	2	GC; QL (1 per 84 days)
medroxyprogesterone intramuscular syringe 150 mg/ml	(Depo-Provera)	2	GC; QL (1 per 84 days)
medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg	(Provera)	1	GC
megestrol oral suspension 400 mg/10 ml (40 mg/ml)		2	GC
norethindrone acetate oral tablet 5 mg	(Aygestin)	2	GC
progesterone intramuscular oil 50 mg/ml		2	GC
progesterone micronized oral capsule 100 mg, 200 mg	(Prometrium)	2	GC
Thyroid And Antithyroid Agents			
levothyroxine oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg	(Euthyrox)	1	GC
levothyroxine oral tablet 300 mcg	(Levo-T)	1	GC
liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg	(Cytomel)	2	GC

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Drug Name	Drug Tier	Requirements/Limits
methimazole oral tablet 10 mg, 5 mg	1	GC
propylthiouracil oral tablet 50 mg	2	GC
Immunological Agents		
Immunological Agents		
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG	5	NEDS
azathioprine oral tablet 50 mg (Imuran)	2	PA BvD; GC
azathioprine sodium injection recon soln 100 mg	2	PA BvD; GC
BENLYSTA INTRAVENOUS RECON SOLN 120 MG, 400 MG	5	PA; NEDS
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR 200 MG/ML	5	PA; NEDS; QL (8 per 28 days)
BENLYSTA SUBCUTANEOUS SYRINGE 200 MG/ML	5	PA; NEDS; QL (8 per 28 days)
BESREMI SUBCUTANEOUS SYRINGE 500 MCG/ML	5	PA NSO; NEDS; QL (2 per 28 days)
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; NEDS
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML	5	PA; NEDS
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; NEDS
cyclosporine intravenous solution 250 mg/5 ml (Sandimmune)	2	PA BvD; GC
cyclosporine modified oral capsule 100 mg, 25 mg (Gengraf)	2	PA BvD; GC
cyclosporine modified oral capsule 50 mg	2	PA BvD; GC
cyclosporine modified oral solution 100 mg/ml (Gengraf)	3	PA BvD
cyclosporine oral capsule 100 mg, 25 mg (Sandimmune)	3	PA BvD
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML	5	PA; NEDS

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Drug Name	Drug Tier	Requirements/Limits
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML	5	PA; NEDS
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML)	5	PA; NEDS
ENBREL SUBCUTANEOUS RECON SOLN 25 MG (1 ML)	5	PA; NEDS
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	5	PA; NEDS
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)	5	PA; NEDS
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML)	5	PA; NEDS
everolimus (immunosuppressive) oral tablet 0.25 mg (Zortress)	4	PA BvD
everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg (Zortress)	5	PA BvD; NEDS
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %, 5 %	5	PA BvD; NEDS
GAMIFANT INTRAVENOUS SOLUTION 5 MG/ML	5	PA; NEDS
GAMMAGARD LIQUID INJECTION SOLUTION 10 %	5	PA BvD; NEDS
GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN 10 GRAM, 5 GRAM	5	PA BvD; NEDS
GAMMAPLEX (WITH SORBITOL) INTRAVENOUS SOLUTION 5 %	5	PA BvD; NEDS
GAMMAPLEX INTRAVENOUS SOLUTION 10 %, 10 % (100 ML), 10 % (200 ML)	5	PA BvD; NEDS
gengraf oral capsule 100 mg, 25 mg (cyclosporine modified)	2	PA BvD; GC
gengraf oral solution 100 mg/ml (cyclosporine modified)	3	PA BvD

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Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NEDS
HUMIRA PEN PSOR-UVEITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NEDS
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NEDS
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; NEDS
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; NEDS
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; NEDS
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; NEDS
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; NEDS
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML	5	PA; NEDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML	5	PA; NEDS
HYQVIA SUBCUTANEOUS SOLUTION 10 GRAM /100 ML (10 %), 2.5 GRAM /25 ML (10 %), 20 GRAM /200 ML (10 %), 30 GRAM /300 ML (10 %), 5 GRAM /50 ML (10 %)	5	PA BvD; NEDS

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Drug Name		Drug Tier	Requirements/Limits
ILARIS (PF) SUBCUTANEOUS SOLUTION 150 MG/ML		5	PA; NEDS
leflunomide oral tablet 10 mg, 20 mg	(Arava)	2	GC
mycophenolate mofetil (hcl) intravenous recon soln 500 mg	(CellCept Intravenous)	2	PA BvD; GC
mycophenolate mofetil oral capsule 250 mg	(CellCept)	2	PA BvD; GC
mycophenolate mofetil oral suspension for reconstitution 200 mg/ml	(CellCept)	5	PA BvD; NEDS
mycophenolate mofetil oral tablet 500 mg	(CellCept)	2	PA BvD; GC
NULOJIX INTRAVENOUS RECON SOLN 250 MG		5	PA BvD; NEDS
OCTAGAM INTRAVENOUS SOLUTION 10 %, 5 %		5	PA BvD; NEDS
PRIVIGEN INTRAVENOUS SOLUTION 10 %		5	PA BvD; NEDS
PROGRAF INTRAVENOUS SOLUTION 5 MG/ML		4	PA BvD
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG		4	PA BvD; ST
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML		3	
REZUROCK ORAL TABLET 200 MG		5	PA NSO; NEDS
RIDAURA ORAL CAPSULE 3 MG		5	NEDS
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG		5	PA; NEDS
sirolimus oral solution 1 mg/ml	(Rapamune)	5	PA BvD; NEDS
sirolimus oral tablet 0.5 mg, 1 mg	(Rapamune)	4	PA BvD
sirolimus oral tablet 2 mg	(Rapamune)	5	PA BvD; NEDS

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Drug Name	Drug Tier	Requirements/Limits
SKYRIZI INTRAVENOUS SOLUTION 60 MG/ML	5	PA; NEDS
SKYRIZI SUBCUTANEOUS PEN INJECTOR 150 MG/ML	5	PA; NEDS
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.83 ML	5	PA; NEDS
SKYRIZI SUBCUTANEOUS SYRINGE KIT 150MG/1.66ML(75 MG/0.83 ML X2)	5	PA; NEDS
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	5	PA; NEDS
STELARA INTRAVENOUS SOLUTION 130 MG/26 ML	5	PA; NEDS
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML	5	PA; NEDS
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML	5	PA; NEDS
tacrolimus oral capsule 0.5 mg, 1 mg (Prograf)	2	PA BvD; GC
tacrolimus oral capsule 5 mg (Prograf)	3	PA BvD
TREMFYA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	5	PA; NEDS
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML	5	PA; NEDS
TYSABRI INTRAVENOUS SOLUTION 300 MG/15 ML	5	PA; LA; NEDS
XELJANZ ORAL SOLUTION 1 MG/ML	5	PA; NEDS
XELJANZ ORAL TABLET 10 MG, 5 MG	5	PA; NEDS
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG, 22 MG	5	PA; NEDS

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Drug Name	Drug Tier	Requirements/Limits
Vaccines		
ACTHIB (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	3	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	3	
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	3	
BCG VACCINE, LIVE (PF) PERCUTANEOUS SUSPENSION FOR RECONSTITUTION 50 MG	3	
BEXSERO INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML	3	
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML	3	
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	3	
DAPTACEL (DTAP PEDIATRIC) (PF) INTRAMUSCULAR SUSPENSION 15-10-5 LF-MCG-LF/0.5ML	3	
DENGVAXIA (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP4.5-6 CCID50/0.5 ML	3	QL (3 per 365 days)
ENGERIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML	3	PA BvD

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Drug Name	Drug Tier	Requirements/Limits
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	3	PA BvD
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	3	PA BvD
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML	3	QL (1.5 per 365 days)
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML	3	QL (1.5 per 365 days)
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	3	
HIBERIX (PF) INTRAMUSCULAR RECON SOLN 10 MCG/0.5 ML	3	
IMOVAX RABIES VACCINE (PF) INTRAMUSCULAR RECON SOLN 2.5 UNIT	3	PA BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION 25-58-10 LF-MCG-LF/0.5ML	3	
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE 25-58-10 LF-MCG-LF/0.5ML	3	
IPOL INJECTION SUSPENSION 40-8-32 UNIT/0.5 ML	3	
IXIARO (PF) INTRAMUSCULAR SYRINGE 6 MCG/0.5 ML	3	
KINRIX (PF) INTRAMUSCULAR SUSPENSION 25 LF-58 MCG-10 LF/0.5 ML	3	

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Drug Name	Drug Tier	Requirements/Limits
KINRIX (PF) INTRAMUSCULAR SYRINGE 25 LF-58 MCG-10 LF/0.5 ML	3	
MENACTRA (PF) INTRAMUSCULAR SOLUTION 4 MCG/0.5 ML	3	
MENQUADFI (PF) INTRAMUSCULAR SOLUTION 10 MCG/0.5 ML	3	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	3	
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML	3	
PEDIARIX (PF) INTRAMUSCULAR SYRINGE 10 MCG-25LF-25 MCG-10LF/0.5 ML	3	
PEDVAX HIB (PF) INTRAMUSCULAR SOLUTION 7.5 MCG/0.5 ML	3	
PENTACEL (PF) INTRAMUSCULAR KIT 15 LF UNIT-20 MCG-5 LF/0.5 ML, 15LF-48MCG-62DU -10 MCG/0.5ML	3	
PREHEVBRIO (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML	3	PA BvD
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML	3	
PROQUAD (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3-4.3-3- 3.99 TCID50/0.5	3	

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Drug Name	Drug Tier	Requirements/Limits
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML, 15 LF-48 MCG-5 LF UNIT/0.5ML (58 UNT/ML)	3	
QUADRACEL (PF) INTRAMUSCULAR SYRINGE 15 LF-48 MCG- 5 LF UNIT/0.5ML	3	
RABAVERT (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 2.5 UNIT	3	PA BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5 ML	3	PA BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	3	PA BvD
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION 10EXP6 CCID50/ML	3	
ROTATEQ VACCINE ORAL SOLUTION 2 ML	3	
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG/0.5 ML	3	QL (2 per 365 days)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF UNIT/0.5 ML (tetanus-diphtheria toxoids-td)	3	
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML	3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML	3	

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Drug Name	Drug Tier	Requirements/Limits
TETANUS,DIPHTHERIA TOX PED(PF) INTRAMUSCULAR SUSPENSION 5-25 LF UNIT/0.5 ML	3	
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	3	QL (0.75 per 365 days)
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	3	QL (1.5 per 365 days)
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML	3	
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML	3	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	3	
TYPHIM VI INTRAMUSCULAR SYRINGE 25 MCG/0.5 ML (typhoid vi polysacch vaccine)	3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 50 UNIT/ML	3	
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML, 50 UNIT/ML	3	
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML	3	QL (2 per 365 days)
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML, 10 EXP4.74 UNIT/0.5 ML(2.5 ML IN 1 VIAL)	3	

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Drug Name		Drug Tier	Requirements/Limits
Inflammatory Bowel Disease Agents			
Inflammatory Bowel Disease Agents			
alosetron oral tablet 0.5 mg	(Lotronex)	3	
alosetron oral tablet 1 mg	(Lotronex)	5	NEDS
balsalazide oral capsule 750 mg	(Colazal)	2	GC
budesonide oral capsule,delayed,extend.release 3 mg		4	
DIPENTUM ORAL CAPSULE 250 MG		5	ST; NEDS
hydrocortisone rectal enema 100 mg/60 ml	(Cortenema)	4	
mesalamine oral capsule (with del rel tablets) 400 mg	(Delzicol)	4	
mesalamine oral capsule,extended release 24hr 0.375 gram	(Apriso)	4	
mesalamine oral tablet,delayed release (dr/ec) 1.2 gram	(Lialda)	4	
mesalamine oral tablet,delayed release (dr/ec) 800 mg	(Asacol HD)	4	
mesalamine rectal suppository 1,000 mg	(Canasa)	3	
sulfasalazine oral tablet 500 mg	(Azulfidine)	2	GC
sulfasalazine oral tablet,delayed release (dr/ec) 500 mg	(Azulfidine EN-tabs)	4	
UCERIS RECTAL FOAM 2 MG/ACTUATION		3	
Metabolic Bone Disease Agents			
Metabolic Bone Disease Agents			
alendronate oral tablet 10 mg, 5 mg		1	GC; QL (30 per 30 days)
alendronate oral tablet 35 mg		1	GC; QL (4 per 28 days)
alendronate oral tablet 70 mg	(Fosamax)	1	GC; QL (4 per 28 days)
calcitonin (salmon) nasal spray,non-aerosol 200 unit/actuation		2	GC; QL (3.7 per 28 days)
calcitriol intravenous solution 1 mcg/ml		2	GC

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Drug Name		Drug Tier	Requirements/Limits
calcitriol oral capsule 0.25 mcg, 0.5 mcg	(Rocaltrol)	2	GC
calcitriol oral solution 1 mcg/ml	(Rocaltrol)	4	
cinacalcet oral tablet 30 mg	(Sensipar)	3	QL (60 per 30 days)
cinacalcet oral tablet 60 mg	(Sensipar)	5	NEDS; QL (60 per 30 days)
cinacalcet oral tablet 90 mg	(Sensipar)	5	NEDS; QL (120 per 30 days)
EVENITY SUBCUTANEOUS SYRINGE 105 MG/1.17 ML, 210MG/2.34ML (105MG/1.17MLX2)		5	PA; NEDS; QL (2.34 per 30 days)
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (600MCG/2.4ML)		3	PA; QL (2.4 per 28 days)
ibandronate intravenous solution 3 mg/3 ml		4	QL (3 per 84 days)
ibandronate intravenous syringe 3 mg/3 ml		4	QL (3 per 84 days)
ibandronate oral tablet 150 mg	(Boniva)	2	GC; QL (1 per 28 days)
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG/DOSE, 25 MCG/DOSE, 50 MCG/DOSE, 75 MCG/DOSE		5	PA; NEDS; QL (2 per 28 days)
paricalcitol oral capsule 1 mcg, 2 mcg	(Zemplar)	4	
paricalcitol oral capsule 4 mcg		4	
PROLIA SUBCUTANEOUS SYRINGE 60 MG/ML		3	QL (1 per 180 days)
RAYALDEE ORAL CAPSULE,EXTENDED RELEASE 24 HR 30 MCG		3	QL (60 per 30 days)
risedronate oral tablet 150 mg	(Actonel)	4	QL (1 per 28 days)
risedronate oral tablet 30 mg, 5 mg		4	QL (30 per 30 days)
risedronate oral tablet 35 mg	(Actonel)	4	QL (4 per 28 days)
risedronate oral tablet 35 mg (12 pack), 35 mg (4 pack)		4	QL (4 per 28 days)
risedronate oral tablet,delayed release (dr/ec) 35 mg	(Atelvia)	4	QL (4 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML)	3	PA; QL (1.56 per 30 days)
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7 ML (70 MG/ML)	5	PA; NEDS
zoledronic acid intravenous recon soln 4 mg	4	
zoledronic acid intravenous solution 4 mg/5 ml	4	
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml (Reclast)	4	QL (100 per 300 days)
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML	5	PA; NEDS
betaine oral powder 1 gram/scoop (Cystadane)	5	NEDS
buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	2	GC
diazoxide oral suspension 50 mg/ml (Proglycem)	2	GC
ELMIRON ORAL CAPSULE 100 MG	4	QL (90 per 30 days)
ENDARI ORAL POWDER IN PACKET 5 GRAM	5	PA; NEDS; QL (180 per 30 days)
EVRYSDI ORAL RECON SOLN 0.75 MG/ML	5	PA; NEDS
EXONDYS-51 INTRAVENOUS SOLUTION 50 MG/ML	5	PA; LA; NEDS
fomepizole intravenous solution 1 gram/ml	5	NEDS
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML	3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML	3	

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Drug Name		Drug Tier	Requirements/Limits
GVOKE SUBCUTANEOUS SOLUTION 1 MG/0.2 ML		3	
hydroxyzine pamoate oral capsule 100 mg		2	GC
hydroxyzine pamoate oral capsule 25 mg, 50 mg	(Vistaril)	1	GC
KEVEYIS ORAL TABLET 50 MG		5	PA; NEDS; QL (120 per 30 days)
leucovorin calcium injection recon soln 100 mg, 200 mg, 350 mg, 50 mg, 500 mg		3	
leucovorin calcium injection solution 10 mg/ml		3	
leucovorin calcium oral tablet 10 mg, 15 mg, 5 mg		2	GC
leucovorin calcium oral tablet 25 mg		3	
levocarnitine (with sugar) oral solution 100 mg/ml	(Carnitor)	2	GC
levocarnitine oral tablet 330 mg	(Carnitor)	4	
levoleucovorin calcium intravenous recon soln 50 mg	(Fusilev)	5	NEDS
mesna intravenous solution 100 mg/ml	(Mesnex)	2	GC
MESNEX ORAL TABLET 400 MG		5	NEDS
OXLUMO SUBCUTANEOUS SOLUTION 94.5 MG/0.5 ML		5	PA; NEDS
pyridostigmine bromide oral syrup 60 mg/5 ml	(Mestinon)	4	
pyridostigmine bromide oral tablet 30 mg		4	
pyridostigmine bromide oral tablet 60 mg	(Mestinon)	2	GC
RECTIV RECTAL OINTMENT 0.4 % (W/W)		4	QL (30 per 30 days)
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2 ML (150 MG/ML)		5	PA; NEDS; QL (4 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)	5	PA; NEDS; QL (4 per 28 days)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG	5	PA NSO; NEDS; QL (60 per 30 days)
TOTECT INTRAVENOUS RECON SOLN 500 MG	5	NEDS
TYBOST ORAL TABLET 150 MG	4	QL (30 per 30 days)
VISTOGARD ORAL GRANULES IN PACKET 10 GRAM	5	NEDS; QL (24 per 14 days)
XURIDEN ORAL GRANULES IN PACKET 2 GRAM	5	PA; NEDS; QL (120 per 30 days)
ZEGALOGUE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 0.6 MG/0.6 ML	3	
ZEGALOGUE SYRINGE SUBCUTANEOUS SYRINGE 0.6 MG/0.6 ML	3	
Ophthalmic Agents		
Antiglaucoma Agents		
acetazolamide oral capsule, extended release 500 mg	2	GC
acetazolamide oral tablet 125 mg, 250 mg	2	GC
acetazolamide sodium injection recon soln 500 mg	2	GC
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	3	
AZOPT OPHTHALMIC (EYE) DROPS,SUSPENSION 1 % (brinzolamide)	2	GC
brimonidine ophthalmic (eye) drops 0.2 %	1	GC
brimonidine-timolol ophthalmic (eye) drops 0.2-0.5 % (Combigan)	3	

Drug Name		Drug Tier	Requirements/Limits
carteolol ophthalmic (eye) drops 1 %		2	GC
COMBIGAN OPHTHALMIC (EYE) DROPS 0.2-0.5 %	(brimonidine-timolol)	3	
dorzolamide ophthalmic (eye) drops 2 %	(Trusopt)	2	GC
dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml	(Cosopt)	2	GC
latanoprost ophthalmic (eye) drops 0.005 %	(Xalatan)	1	GC; QL (2.5 per 25 days)
levobunolol ophthalmic (eye) drops 0.5 %		1	GC
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %		3	QL (2.5 per 25 days)
metipranolol ophthalmic (eye) drops 0.3 %		2	GC
pilocarpine hcl ophthalmic (eye) drops 1 %, 4 %		2	GC
pilocarpine hcl ophthalmic (eye) drops 2 %	(Isopto Carpine)	2	GC
RHOPRESSA OPHTHALMIC (EYE) DROPS 0.02 %		3	QL (2.5 per 25 days)
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 %		3	QL (2.5 per 25 days)
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION 1-0.2 %		3	
timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %	(Timoptic)	1	GC
timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %	(Timoptic-XE)	4	
travoprost ophthalmic (eye) drops 0.004 %	(Travatan Z)	4	QL (2.5 per 25 days)
Replacement Preparations			
Replacement Preparations			
calcium chloride intravenous syringe 100 mg/ml (10 %)		2	GC
d5 % and 0.9 % sodium chloride intravenous parenteral solution		4	

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Drug Name	Drug Tier	Requirements/Limits
d5 %-0.45 % sodium chloride intravenous parenteral solution	4	
ISOLYTE S IV SOLUTION-EXCEL SINGLE USE	4	
ISOLYTE S PH 7.4 INTRAVENOUS PARENTERAL SOLUTION	4	
ISOLYTE-P IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION 5 %	4	
klor-con m10 oral tablet,er particles/crystals 10 meq (potassium chloride)	2	GC
klor-con m15 oral tablet,er particles/crystals 15 meq (potassium chloride)	2	GC
klor-con m20 oral tablet,er particles/crystals 20 meq (potassium chloride)	2	GC
magnesium sulfate in d5w intravenous piggyback 1 gram/100 ml	2	GC
magnesium sulfate in water intravenous parenteral solution 20 gram/500 ml (4 %), 40 gram/1,000 ml (4 %)	2	PA BvD; GC
magnesium sulfate in water intravenous piggyback 2 gram/50 ml (4 %), 4 gram/100 ml (4 %), 4 gram/50 ml (8 %)	2	PA BvD; GC
magnesium sulfate injection syringe 4 meq/ml	2	PA BvD; GC
NORMOSOL-M IN 5 % DEXTROSE INTRAVENOUS PARENTERAL SOLUTION	4	
PLASMA-LYTE 148 INTRAVENOUS PARENTERAL SOLUTION	4	
PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION	4	
potassium chloride intravenous solution 2 meq/ml	1	PA BvD; GC

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Drug Name		Drug Tier	Requirements/Limits
potassium chloride intravenous solution 2 meq/ml (20 ml)		2	PA BvD; GC
potassium chloride oral capsule, extended release 10 meq, 8 meq		2	GC
potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml		4	
potassium chloride oral tablet extended release 10 meq, 20 meq	(K-Tab)	2	GC
potassium chloride oral tablet extended release 8 meq	(Klor-Con 8)	2	GC
potassium chloride oral tablet,er particles/crystals 10 meq	(Klor-Con M10)	2	GC
potassium chloride oral tablet,er particles/crystals 15 meq	(Klor-Con M15)	2	GC
potassium chloride oral tablet,er particles/crystals 20 meq	(Klor-Con M20)	2	GC
potassium chloride-0.45 % nacl intravenous parenteral solution 20 meq/l		2	GC
potassium citrate oral tablet extended release 10 meq (1,080 mg)	(Urocit-K 10)	2	GC
potassium citrate oral tablet extended release 15 meq	(Urocit-K 15)	2	GC
potassium citrate oral tablet extended release 5 meq (540 mg)	(Urocit-K 5)	2	GC
sodium chloride 0.45 % intravenous parenteral solution 0.45 %		2	GC
sodium chloride 0.9 % injection solution		2	GC
sodium chloride 0.9 % intravenous parenteral solution		2	GC
sodium chloride 0.9% solution mini-bag, single use		2	GC

Drug Name		Drug Tier	Requirements/Limits
Respiratory Tract Agents			
Anti-Inflammatories, Inhaled Corticosteroids			
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	(fluticasone propion-salmeterol)	2	GC; QL (60 per 30 days)
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION		3	QL (12 per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION		3	QL (30 per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE	(fluticasone furoate-vilanterol)	3	QL (60 per 30 days)
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml	(Pulmicort)	3	PA BvD; QL (120 per 30 days)
budesonide inhalation suspension for nebulization 1 mg/2 ml	(Pulmicort)	3	PA BvD; QL (60 per 30 days)
FLOVENT 100 MCG DISKUS 100 MCG/ACTUATION		3	QL (60 per 30 days)
FLOVENT 250 MCG DISKUS 250 MCG/ACTUATION		3	QL (120 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION		3	QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION		3	QL (120 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	(fluticasone propionate)	3	QL (12 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	(fluticasone propionate)	3	QL (24 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	(fluticasone propionate)	3	QL (21.2 per 30 days)
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION	(budesonide-formoterol)	3	QL (30.6 per 30 days)
Antileukotrienes			
montelukast oral tablet 10 mg	(Singulair)	1	GC
montelukast oral tablet,chewable 4 mg, 5 mg	(Singulair)	1	GC
zafirlukast oral tablet 10 mg, 20 mg	(Accolate)	4	
Bronchodilators			
albuterol 5 mg/ml solution 5 mg/ml		2	PA BvD; GC; QL (120 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	(Proventil HFA)	2	GC; QL (17 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)		2	GC; QL (13.4 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)		2	GC; QL (36 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	PA BvD; GC; QL (360 per 30 days)
albuterol sulfate inhalation solution for nebulization 2.5 mg/0.5 ml		2	PA BvD; GC; QL (120 per 30 days)
albuterol sulfate oral syrup 2 mg/5 ml		2	GC
albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg		2	GC

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Drug Name	Drug Tier	Requirements/Limits
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION	3	QL (60 per 30 days)
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION	4	QL (25.8 per 28 days)
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-9-4.8 MCG/ACTUATION	3	QL (10.7 per 30 days)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	3	QL (8 per 30 days)
ipratropium bromide inhalation solution 0.02 %	2	PA BvD; GC; QL (312.5 per 30 days)
ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml	2	PA BvD; GC; QL (540 per 30 days)
metaproterenol oral syrup 10 mg/5 ml	1	GC
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE	3	QL (60 per 30 days)
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION	3	QL (4 per 30 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG	3	QL (30 per 30 days)
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION	3	QL (4 per 30 days)
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION	3	QL (4 per 28 days)
terbutaline oral tablet 2.5 mg, 5 mg	4	

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Drug Name	Drug Tier	Requirements/Limits
terbutaline subcutaneous solution 1 mg/ml	5	NEDS
theophylline oral solution 80 mg/15 ml	4	
theophylline oral tablet extended release 12 hr 300 mg, 450 mg	4	
theophylline oral tablet extended release 24 hr 400 mg, 600 mg	2	GC
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG, 200-62.5-25 MCG	3	QL (60 per 30 days)
Respiratory Tract Agents, Other		
acetylcysteine intravenous solution 200 mg/ml (20 %) (Acetadote)	2	GC
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)	2	PA BvD; GC
BRONCHITOL INHALATION CAPSULE, W/INHALATION DEVICE 40 MG	5	NEDS; QL (560 per 28 days)
CINQAIR INTRAVENOUS SOLUTION 10 MG/ML	5	PA; NEDS
cromolyn inhalation solution for nebulization 20 mg/2 ml	2	PA BvD; GC
DALIRESP ORAL TABLET 250 MCG (roflumilast)	3	QL (28 per 28 days)
DALIRESP ORAL TABLET 500 MCG (roflumilast)	3	QL (30 per 30 days)
ESBRIET ORAL CAPSULE 267 MG	5	PA; NEDS; QL (270 per 30 days)
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR 30 MG/ML	5	PA; NEDS; QL (1 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	5	PA; NEDS; QL (1 per 28 days)
KALYDECO ORAL GRANULES IN PACKET 25 MG, 50 MG, 75 MG	5	PA; NEDS; QL (56 per 28 days)

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Drug Name	Drug Tier	Requirements/Limits
KALYDECO ORAL TABLET 150 MG	5	PA; NEDS; QL (56 per 28 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML	5	PA; LA; NEDS; QL (3 per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN 100 MG	5	PA; LA; NEDS; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	5	PA; LA; NEDS; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	5	PA; LA; NEDS; QL (0.4 per 28 days)
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA; NEDS; QL (60 per 30 days)
ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG, 75-94 MG	5	PA; NEDS; QL (56 per 28 days)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; NEDS; QL (120 per 30 days)
pirfenidone oral tablet 267 mg (Esbriet)	5	PA; NEDS; QL (270 per 30 days)
pirfenidone oral tablet 534 mg	5	PA; NEDS; QL (90 per 30 days)
pirfenidone oral tablet 801 mg (Esbriet)	5	PA; NEDS; QL (90 per 30 days)
PROLASTIN C 1,000 MG/20 ML VL PRICE/ONE MG,SUV 1,000 MG (+/-)/20 ML	5	PA BvD; NEDS
PROLASTIN-C INTRAVENOUS RECON SOLN 1,000 MG	5	PA BvD; NEDS
roflumilast oral tablet 500 mcg (Daliresp)	2	GC; QL (30 per 30 days)
SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N)	5	PA; NEDS; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N)	5	PA; NEDS; QL (84 per 28 days)
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	5	PA; NEDS

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Drug Name		Drug Tier	Requirements/Limits
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML		5	PA; NEDS
Skeletal Muscle Relaxants			
Skeletal Muscle Relaxants			
baclofen oral tablet 10 mg, 20 mg, 5 mg		2	GC
chlorzoxazone oral tablet 250 mg		5	NEDS; QL (120 per 30 days)
chlorzoxazone oral tablet 500 mg		2	GC
cyclobenzaprine oral tablet 10 mg, 5 mg		1	GC
dantrolene oral capsule 100 mg, 50 mg		2	GC
dantrolene oral capsule 25 mg	(Dantrium)	2	GC
methocarbamol oral tablet 500 mg, 750 mg		2	GC
revonto intravenous recon soln 20 mg	(dantrolene)	2	GC
tizanidine oral tablet 2 mg		2	GC
tizanidine oral tablet 4 mg	(Zanaflex)	2	GC
Sleep Disorder Agents			
Sleep Disorder Agents			
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	(Nuvigil)	2	PA; GC; QL (30 per 30 days)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG		3	QL (30 per 30 days)
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	(Lunesta)	4	QL (30 per 30 days)
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML		5	PA; NEDS; QL (150 per 30 days)
HETLIOZ ORAL CAPSULE 20 MG		5	PA; NEDS; QL (30 per 30 days)
modafinil oral tablet 100 mg	(Provigil)	2	PA; GC; QL (30 per 30 days)
modafinil oral tablet 200 mg	(Provigil)	2	PA; GC; QL (60 per 30 days)

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Drug Name		Drug Tier	Requirements/Limits
SUNOSI ORAL TABLET 150 MG, 75 MG		4	PA; QL (30 per 30 days)
XYREM ORAL SOLUTION 500 MG/ML		5	PA; LA; NEDS; QL (540 per 30 days)
zaleplon oral capsule 10 mg, 5 mg		4	QL (30 per 30 days)
zolpidem oral tablet 10 mg, 5 mg	(Ambien)	1	GC; QL (30 per 30 days)
Vasodilating Agents			
Vasodilating Agents			
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG		5	PA; NEDS; QL (90 per 30 days)
alyq oral tablet 20 mg	(tadalafil (pulm. hypertension))	3	PA; QL (60 per 30 days)
ambrisentan oral tablet 10 mg, 5 mg	(Letairis)	5	PA; NEDS; QL (30 per 30 days)
epoprostenol (glycine) intravenous recon soln 0.5 mg, 1.5 mg	(Flolan)	5	PA; NEDS
OPSUMIT ORAL TABLET 10 MG		5	PA; NEDS; QL (30 per 30 days)
sildenafil (pulm.hypertension) intravenous solution 10 mg/12.5 ml	(Revatio)	5	PA; NEDS; QL (37.5 per 1 day)
sildenafil (pulm.hypertension) oral tablet 20 mg	(Revatio)	2	PA; GC; QL (90 per 30 days)
sildenafil oral tablet 100 mg, 25 mg, 50 mg	(Viagra)	2	GC; EX; CB (6 EA per 30 days)
tadalafil (pulm. hypertension) oral tablet 20 mg	(Alyq)	3	PA; QL (60 per 30 days)
TRACLEER ORAL TABLET 125 MG, 62.5 MG	(bosentan)	5	PA; LA; NEDS; QL (60 per 30 days)
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG		5	PA; NEDS; QL (112 per 28 days)
treprostinil sodium injection solution 1 mg/ml, 10 mg/ml, 2.5 mg/ml, 5 mg/ml	(Remodulin)	5	PA; NEDS
TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML)		5	PA; NEDS

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Drug Name	Drug Tier	Requirements/Limits
UPTRAVI INTRAVENOUS RECON SOLN 1,800 MCG	5	PA; NEDS; QL (60 per 30 days)
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	5	PA; NEDS; QL (60 per 30 days)
UPTRAVI ORAL TABLET 200 MCG	5	PA; NEDS; QL (240 per 30 days)
UPTRAVI ORAL TABLETS,DOSE PACK 200 MCG (140)- 800 MCG (60)	5	PA; NEDS
Vitamins And Minerals		
Vitamins And Minerals		
bal-care dha combo pack 27-1-430 mg	2	GC
bal-care dha essential pack 27 mg iron-1 mg -374 mg	2	GC
calcium pnv oral capsule 28-1-250 mg	2	GC
c-nate dha softgel 28 mg iron-1 mg - 200 mg	2	GC
completenate tablet chew 29 mg iron- 1 mg	2	GC
dothelle dha oral capsule 35-1-200 mg	2	GC
extra-virt plus dha oral capsule 29 mg iron-1.25 mg-55 mg	2	GC
folivane-ob capsule 85-1 mg	2	GC
hemenatal ob + dha oral combo pack 28 mg iron-6 mg iron-1 mg	2	GC
kosher prenatal plus iron tab 30 mg iron- 1 mg	2	GC
marnatal-f capsule 60 mg iron-1 mg	2	GC
m-natal plus tablet 27 mg iron- 1 mg (pnv,calcium 72-iron-folic acid)	2	GC
mynatal advance oral tablet 90-1-50 mg	2	GC
mynatal capsule 65 mg iron- 1 mg	2	GC
mynatal oral tablet 90-1-50 mg	2	GC

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

Drug Name	Drug Tier	Requirements/Limits
mynatal plus captab 65 mg iron- 1 mg	2	GC
mynatal-z captab 65 mg iron- 1 mg	2	GC
mynate 90 plus oral tablet extended release 90 mg iron-1 mg	2	GC
newgen tablet 32-1,000 mg-mcg	2	GC
niva-plus tablet 27 mg iron- 1 mg	2	GC
obstetrix dha oral combo pack,tablet and cap,dr 29 mg iron-1 mg -50 mg	2	GC
o-cal prenatal tablet 15 mg iron-1,000 mcg	2	GC
pnv 29-1 tablet (rx) 29 mg iron- 1 mg	2	GC
pnv-dha + docusate oral capsule 27-1.25-55-300 mg	2	GC
pnv-ferrous fumarate-docu-fa oral tablet 29 mg iron- 1 mg-25 mg	2	GC
pnv-omega softgel 28-1-300 mg	2	GC
pnv-vp-u oral capsule 106.5-1 mg	2	GC
pr natal 400 combo pack 29-1-400 mg	2	GC
pr natal 400 ec combo pack 29-1-400 mg	2	GC
pr natal 430 combo pack 29 mg iron-1 mg -430 mg	2	GC
pr natal 430 ec combo pack 29-1-430 mg	2	GC
prena1 true combo pack 30 mg iron-1.4 mg-300 mg	2	GC
prenaissance oral capsule 29-1.25-55-325 mg	2	GC
prenaissance plus oral capsule 28-1-50-250 mg	2	GC
prenatabs fa tablet 29-1 mg	2	GC
prenatal 19 (with docusate) oral tablet 29 mg iron- 1 mg-25 mg	2	GC
prenatal 19 chewable tablet 29 mg iron- 1 mg	2	GC

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

Drug Name		Drug Tier	Requirements/Limits
prenatal low iron tablet (rx) 27 mg iron- 1 mg		2	GC
prenatal plus iron tablet (rx) 29 mg iron- 1 mg	(pnv,calcium 72-iron,carb-folic)	2	GC
prenatal plus tablet (rx) 27 mg iron- 1 mg	(pnv,calcium 72-iron-folic acid)	2	GC
prenatal vitamin plus low iron oral tablet 27 mg iron- 1 mg	(pnv,calcium 72-iron-folic acid)	2	GC
prenatal-u capsule 106.5-1 mg		2	GC
preplus ca-fe 27 mg-fa 1 mg tb (rx) 27 mg iron- 1 mg	(pnv,calcium 72-iron-folic acid)	2	GC
pretab 29 mg-1 mg tablet (rx) 29-1 mg		2	GC
purefe ob plus capsule 106 mg iron- 1 mg		2	GC
purefe plus capsule 106 mg iron- 1 mg		2	GC
r-natal ob softgel 20 mg iron- 1 mg-320 mg		2	GC
select-ob chewable caplet 29 mg iron- 1 mg		2	GC
select-ob chewable caplet 29 mg iron- 1 mg		2	GC
se-natal 19 chewable tablet 29 mg iron- 1 mg		2	GC
taron-c dha capsule 35-1-200 mg		2	GC
taron-prex prenatal-dha oral capsule 30 mg iron-1.2 mg-55 mg-265 mg		2	GC
triveen-duo dha combo pack 29-1-400 mg		2	GC
triveen-prx rnf oral capsule 26-1.2-55-300 mg		2	GC
vena-bal dha oral combo pack,tablet and cap,dr 27-1-430 mg		2	GC
vinate care chewable tablet 40 mg iron- 1 mg		2	GC
vinate gt oral tablet 90-1-50 mg		2	GC
vinate ii oral tablet 29 mg iron- 1 mg		2	GC
vinate ultra oral tablet 90-1-50 mg		2	GC

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Drug Name	Drug Tier	Requirements/Limits
virt-c dha softgel (rx) 35-1-200 mg	2	GC
virt-nate dha softgel 28 mg iron-1 mg -200 mg	2	GC
virt-pn dha softgel (rx) 27 mg iron-1 mg -300 mg	2	GC
virt-pn oral tablet 27-1 mg	2	GC
virt-pn plus softgel (rx) 28-1-300 mg	2	GC
vitafol gummies 3.33 mg iron- 0.33 mg	2	GC
vitafol nano tablet 18 mg iron- 1 mg	2	GC
vitafol-ob+dha combo pack 65-1-250 mg	2	GC
viva dha oral capsule 28 mg iron-1 mg -200 mg	2	GC
vol-nate oral tablet 28 mg iron- 1 mg	2	GC
vp-ch plus oral capsule 29 mg iron-1 mg -50 mg-265 mg	2	GC
vp-ch-pnv oral capsule 30 mg iron-1 mg -50 mg-260 mg	2	GC
vp-pnv-dha softgel (rx) 28 mg iron-1 mg-200 mg	2	GC
zatean-pn dha capsule 27 mg iron-1 mg -300 mg	2	GC
zatean-pn plus softgel 28-1-300 mg	2	GC
zingiber tablet 1.2 mg-40 mg- 124.1 mg-100 mg	2	GC

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

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This formulary was updated on 12/01/2022. For more recent information or other questions, please contact CCA Health California Member Service at 1-866-333-3530 or, for TTY users, 711, 8 a.m. to 8 p.m., seven days a week from October 1 through March 31 and 8 a.m. to 8 p.m. Monday to Friday from April 1 through September 30, or visit www.ccahealthca.org.

Este formulario se actualizó el 12/01/2022. Para obtener información más reciente o si tiene cualquier otra pregunta, comuníquese con el Servicio para los miembros de CCA Health California al 1-866-333-3530. Los usuarios de TTY deben llamar al 711. Desde el 1.º de octubre hasta el 31 de marzo, el horario de atención es de 8:00 a. m. a 8:00 p. m., los siete días de la semana; y desde el 1.º de abril hasta el 30 de septiembre, el horario de atención es de 8:00 a. m. a 8:00 p. m., de lunes a viernes. También puede visitar www.ccahealthca.org.

本處方藥一覽表更新於 2022 年 12 月 01 日。如需最新資訊或有其他問題，請聯絡 CCA Health California 會員服務部，電話：1-866-333-3530，聽障人士可致電 711。10 月 1 日至 3 月 31 日期間，辦公時間為每週七天，上午 8 點至晚上 8 點；4 月 1 日至 9 月 30 日期間，辦公時間為週一至週五，上午 8 點至晚上 8 點，或者瀏覽 www.ccahealthca.org。

이 처방집은 2022 년 12월 01일에 업데이트되었습니다. 더욱 최근의 정보를 원하시거나 기타 궁금한 사항이 있으시면 CCA Health California 가입자 서비스부에 1-866-333-3530번으로, TTY사용자는 711번으로 10월 1일부터 3월 31일까지는 주 7일 오전 8시-오후 8시 중에 그리고 4월 1일부터 9월 30일까지는 월요일-금요일 오전 8시-오후 8시 중에 전화해 주십시오. 또는 www.ccahealthca.org을 언제든 방문하실 수 있습니다.

Danh mục thuốc này được cập nhật vào ngày 12/01/2022. Để biết thông tin gần đây hoặc có thắc mắc gì khác, xin vui lòng gọi cho CCA Health California theo số 1-866-333-3530 hoặc, với người dùng TTY, 711, 8 giờ sáng đến 8 giờ tối., bảy ngày mỗi tuần từ ngày 1 tháng 10 đến ngày 31 tháng 3 và từ 8 giờ sáng đến 8 giờ tối, Thứ Hai đến Thứ Sáu, từ ngày 1 tháng 4 đến ngày 30 tháng 9, hoặc truy cập www.ccahealthca.org.

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