

SHARP Health Plan

2023 Formulary

List of covered prescription drugs

Employer-sponsored plans from Sharp Health Plan

This drug list applies to all Large Group HMO and Large Group POS products, and the following Small Group HMO products: Bronze HDHP NG 1, CalChoice Bronze HDHP NG 3, CalChoice Bronze HMO NG 2, CalChoice Gold HMO NG 2, CalChoice Gold HMO NG 3, CalChoice Gold HMO NG 5, CalChoice Platinum HMO NG 1, CalChoice Platinum HMO NG 2, CalChoice Platinum HMO NG 3, CalChoice Silver HMO NG 1, CalChoice Silver HMO NG 2, CalChoice Silver HMO NG 3, Gold HMO NG 1, Gold HMO NG 2, Gold HMO NG 3, Gold HMO NG 4, Gold HMO NG 5, Gold HMO NG 6, Gold HMO NG 7, HDHP NG 1 L, HDHP NG 2 L, HDHP NG 3 L, HDHP NG 4 L, HDHP NG 5 L, HMO GF 1, HMO GF 2, HMO GF 3, HMO GF 4, HMO GF 5, HMO GF 6, HMO GF 7, HMO NG 10 L, HMO NG 11 L, HMO NG 12 L, HMO NG 13 L, HMO NG 14 L, HMO NG 15 L, HMO NG 16 L, HMO NG 17 L, HMO NG 18 L, HMO NG 19 L, HMO NG 20 L, HMO NG 21 L, HMO NG 22 L, HMO NG 23 L, HMO NG 24 L, HMO NG 25 L, HMO NG 26 L, HMO NG 27 L, HMO NG 28 L, HMO NG 29 L, HMO NG 30 L, HMO NG 31 L, HMO NG 32 L, HMO NG 33 L, HMO NG 34 L, HMO NG 35 L, HMO NG 36 L, HMO NG 37 L, HMO NG 38 L, HMO NG 39 L, HMO NG 40 L, HMO NG 41 L, HMO NG 42 L, HMO NG 43 L, HMO NG 44 L, HMO NG 5 L, HMO NG 6 L, HMO NG 7 L, HMO NG 8 L, HMO NG 9 L, Platinum HMO NG 1, Platinum HMO NG 2, Platinum HMO NG 3, Platinum HMO NG 4, Platinum HMO NG 7, Platinum HMO NG 8, POS NG 3 L, Sharp HealthCare HMO NG 1 L (Premium), Silver HMO NG 1, Silver HMO NG 2, Sharp HealthCare HMO NG 2 L (Basic), HMO GF 1 L, HMO GF 3 L, HMO GF 4 L, HMO GF 6 L, HMO GF 14 L, HMO GF 15 L, POS NG 3 L, POS NG 9 L, POS NG 10 L, POS NG 11 L, POS NG 12 L, POS NG 13 L, POS NG 14 L, POS NG 15 L, POS NG 16 L, POS NG 17 L, POS NG 18 L, POS NG 19 L, POS NG 20 L, HDHP POS 21 L, HDHP POS 22 L, HDHP POS 23 L, Platinum POS NG 1, Gold POS NG 1, Silver POS NG 1, Custom Employer Groups

An electronic version of this Prescription Drug List is available on the Sharp Health Plan website, by visiting sharphealthplan.com/search-drug-list. You can find specific cost sharing information in your plan's coverage documents by logging in to your Sharp Connect account on our website by visiting sharphealthplan.com/login. This document is subject to change and all previous versions are no longer in effect. Last updated 12/01/2023.

Table of Contents

Introduction	iii
Definitions	iv
How often does the Formulary change?	v
Will I be notified of a Formulary change?	vi
How do I locate a Prescription Drug on the Formulary?	vi
How do I know if the drug listed on the Formulary is a Brand or Generic Drug?	vii
What is a Drug Tier?	vii
Are There Any Coverage Requirements or Limits?	viii
What Is Prior Authorization?	ix
What is PA**?	ix
What Is Quantity Limit?	x
What Is Step Therapy?	x
What Is MO?	xi
What Is a Specialty Drug?	xi
What Is an Oral Anti-Cancer Drug?	xi
What if a Drug Is Not Listed on the Formulary? What is a Formulary Exception?	xi
Where Can I Fill My Prescription Drug?	xi
What Is Therapeutic Interchange?	xii
What Is Generic Substitution?	xii
You Have the Right to Appeal	xii
Appeals Due to Denial of Coverage for a Nonformulary Drug	xiii
All Other Appeals	xiii
Questions	xiii
Exclusions and Limitations to the Outpatient Prescription Drug Benefit	xiii
Nondiscrimination Notice	xv
Language Assistance Services	xviii
List of Prescription Drugs	1-144
Index	145-210
Step Therapy Criteria	211

Introduction

December 2023

This document contains a list of the federal Food and Drug Administration (FDA) approved drugs covered for Sharp Health Plan Members under the pharmacy outpatient prescription drug benefit, and is also known as the Formulary. The outpatient prescription drug benefit covers outpatient drugs provided to Members through a network retail, specialty or mail order pharmacy. Drugs covered under the pharmacy benefit are generally oral or topical medications, unless otherwise listed on the Formulary. The presence of a drug on the Formulary does not guarantee that it will be prescribed by your Prescribing Provider for a particular medical condition. Refer to the end of this Introduction for information about drug benefit exclusions for the outpatient prescription drug benefit.

If you have questions regarding your outpatient prescription drug benefit, please call our Customer Service department at 1-855-298-4252.

A Medical Benefit drug is a drug that is physician administered or is self-injectable. Medical Benefit drugs are covered under the Medical Benefit. Refer to the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook for specific information about the Cost Shares, exclusions and limitations for these drugs covered under your Medical Benefit:

1. Medically Necessary formulas and special food products prescribed by a Plan Physician to treat phenylketonuria (PKU), provided that these formulas and special foods exceed the cost of a normal diet.
2. Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office and self-injectable drugs covered under the medical benefit.
3. FDA-approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by, or under direct supervision of a physician.
4. Immunization or immunological agents, including, but not limited to: biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under the outpatient prescription drug benefit.
6. Items that are approved by the FDA as a medical device. Please refer to the Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning for information about medical devices covered by Sharp Health Plan.

Definitions

Defined terms are capitalized throughout this Formulary and have the meaning set forth below throughout this Formulary and in the Glossary section of your Member Handbook.

“Appeal” is a written or oral request, by or on behalf of a Member, to re-evaluate a specific determination made by Sharp Health Plan or any of its delegated entities (e.g., Plan Providers).

“Brand-Name Drug” is a drug that is marketed under a proprietary, trademark-protected name. The Brand Name Drug shall be listed in all CAPITAL letters.

“Coinsurance” is a percentage of the cost of a Covered Benefit (for example, 20%) that an Enrollee pays after the Enrollee has paid the Deductible, if a Deductible applies to the Covered Benefit, such as the prescription drug benefit.

“Copayment” is a fixed dollar amount (for example, \$20) that an Enrollee pays for a Covered Benefit after the Enrollee has paid the Deductible, if a Deductible applies to the Covered Benefit, such as the prescription drug benefit.

“Deductible” is the amount an Enrollee pays for certain Covered Benefits before Sharp Health Plan begins payment for all or part of the cost of the Covered Benefit under the terms of the policy.

“Drug Tier” is a group of Prescription Drugs that corresponds to a specified cost sharing tier in Sharp Health Plan’s Prescription Drug coverage. The tier in which a Prescription Drug is placed determines the Enrollee’s portion of the cost for the drug.

“Enrollee” is a person enrolled in Sharp Health Plan who is entitled to receive services from the Plan. All references to Enrollees in this Formulary template shall also include Subscribers as defined in this section below. An Enrollee is also referred to as a Member.

“Exception Request” is a request for coverage of a Prescription Drug. If an Enrollee, his or her designee, or prescribing health care provider submits an Exception Request for coverage of a Prescription Drug, Sharp Health Plan must cover the Prescription Drug when the drug is determined to be Medically Necessary to treat the Enrollee’s condition. Drugs and supplies that fall within one of the outpatient prescription drug benefit exclusions described in the Member Handbook are not eligible for an Exception Request.

“Exigent Circumstances” are when an Enrollee is suffering from a health condition that may seriously jeopardize the Enrollee’s life, health, or ability to regain maximum function, or when an Enrollee is undergoing a current course of treatment using a Nonformulary Drug.

“Formulary” is the complete list of drugs preferred for use and eligible for coverage under a Sharp Health Plan product, and includes all drugs covered under the outpatient prescription drug benefit of the Sharp Health Plan product. Formulary is also known as a Prescription Drug list,

“Generic Drug” is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A Generic Drug is listed in bold and italicized

lowercase letters.

"Grievance" is a written or oral expression of dissatisfaction regarding Sharp Health Plan, a provider and/or a pharmacy, including quality of care concerns.

"Nonformulary Drug" is a Prescription Drug that is not listed on Sharp Health Plan's Formulary.

"Out-of-Pocket Cost" are Copayments, Coinsurance, and the applicable Deductible, plus all costs for health care services that are not covered by Sharp Health Plan.

"Prescribing Provider" is a health care provider authorized to write a Prescription to treat a medical condition for a Sharp Health Plan Enrollee.

"Prescription" is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

"Prescription Drug" is a drug that is approved by the federal Food and Drug Administration (FDA) that is prescribed by your Prescribing Provider and requires a prescription under applicable law.

"Prior Authorization" is Sharp Health Plan's requirement that the Enrollee or the Enrollee's Prescribing Provider obtain the Sharp Health Plan's Authorization for a Prescription Drug before Sharp Health Plan will cover the drug. Sharp Health Plan shall grant a Prior Authorization when it is Medically Necessary for the Enrollee to obtain the drug.

"Step Therapy" is a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Sharp Health Plan may require the Enrollee to try one or more drugs to treat the Enrollee's medical condition before Sharp Health Plan will cover a particular drug for the condition pursuant to a Step Therapy request. If the Enrollee's Prescribing Provider submits a request for Step Therapy exception, Sharp Health Plan shall make exceptions to Step Therapy when the criteria is met.

"Subscriber" means the person who is responsible for payment to Sharp Health Plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

How often does the Formulary change?

The Sharp Health Plan Formulary is developed to identify safe and effective drugs for Members while maintaining affordable benefits. The Formulary and Drug Coverage Requirements and Limits are updated regularly, based on input from the Pharmacy and Therapeutics (P&T) Committee, which meets quarterly. The Formulary and the Drug Coverage Requirements and Limits are subject to change monthly as new clinical information and new drugs become available. The P&T Committee members are clinical pharmacists and actively practicing physicians of various medical specialties. The P&T Committee frequently consults with other medical experts for input to the Committee.

The P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications
- Relevant utilization experience
- Physician recommendations

Will I be notified of a Formulary change?

Sharp Health Plan will provide sixty (60) days written notice of a Formulary change to negatively affected Members. The notice will include the date the Member will be impacted by the change. Some examples of Formulary changes that will result in a notice to the member include, but are not limited to:

- A drug or dosage form is moved to a higher Drug Tier that results in an increase in cost sharing
- A drug or dosage form is removed from the Formulary
- Drug Coverage Requirements or Limits for a drug are added or changed

Changes to the Formulary that may occur without prior written notice to the Member include:

- A drug is removed from the Formulary because it is removed from the market by either the drug manufacturer or the FDA
- A drug is added to the Formulary
- A drug is moved to a lower Drug Tier
- A Drug Coverage Requirement or Limit is removed from a drug
- A generic drug is added to the Formulary and the Brand Name drug is moved to a higher Drug Tier or removed from the Formulary

The drug formulary can be accessed by current and prospective Members. To view the most current Formulary, please visit sharphealthplan.com/search-drug-list.

How do I locate a Prescription Drug on the Formulary?

Covered Prescription Drugs are listed alphabetically by Generic name and Brand-Name in the alphabetical Index.

Within the Formulary, drugs are listed alphabetically under the column titled "Prescription Drug Name" by its Brand or Generic name under the therapeutic category and class to which it belongs. If a generic for a Brand Name Drug is not available or is not covered, the Generic Drug name will not be listed separately by its generic name.

You can find a Prescription Drug on the formulary by looking for its Generic or Brand-Name alphabetically in the Index, or by looking for it in the Formulary, where it is listed alphabetically under the therapeutic category and class to which it belongs. Sharp Health Plan uses the MediSpan® classification system for therapeutic category and class. MediSpan® maintains the Master Drug Data Base of drug information for professionals in the health sciences. The Master Drug Data Base provides pricing and descriptive drug information on name brand, generic, prescription and OTC medications and herbal products and is updated daily.

How do I know if the drug listed on the Formulary is a Brand or Generic Drug?

Brand-Name Drugs are listed in all CAPITAL LETTERS followed by the generic name in parentheses in (*lowercase bold italics*).

If a Generic equivalent for a Brand-Name Drug is available and is covered, the Generic Drug will be listed separately from the Brand-Name Drug in all *lowercase bold italics*.

When a Generic Drug is marketed under a Brand-Name, the Brand-Name will be listed after the Generic name in parentheses with the first letter of the word capitalized.

Here is how this is listed on the Formulary:

Drug Type	Listing on the Formulary
Brand-Name Drug and Generic-Name	FIBRICOR TAB 35MG (<i>fenofibric acid</i>)
Generic-Name that is covered on the Formulary	<i>fenofibric acid tab 35mg</i>
Generic Drug marketed with a Brand-Name	<i>amiodarone hcl tab 100mg</i> (Pacerone)

Some drugs are commercially available as both a Brand-Name and a Generic-Name. Contracted pharmacies are required to dispense the Generic version of the drug, unless Prior Authorization for the Brand-Name Drug is obtained from Sharp Health Plan.

The Brand-Name listed in this document is for reference only and is not an indication that the Brand-Name Drug is covered by Sharp Health Plan, unless Sharp Health Plan has Authorized the Brand-Name Drug due to medical necessity or specifically noted.

What is a Drug Tier?

Each covered drug is assigned to a Drug Tier. The Drug Tier is a group of drugs that indicates what your Copayment or Coinsurance is for each drug. A Deductible may also apply. For information about your Copayments, Coinsurance and/or Deductible, please consult your benefits information available online by visiting sharphealthplan.com/login and log in to your SharpConnect account. When you create a SharpConnect account, you can easily access your benefit information online 24

hours a day, 7 days a week.

A preferred drug is a drug that the Pharmacy and Therapeutics Committee has determined provides greater value than its alternatives when considering clinical effectiveness, safety and overall value.

The Drug Tier is marked throughout this document by one of the following symbols:

Symbol	Drug Tier	Description
PV	PV	Select drugs covered with no Copayment when recommended for preventive use as indicated under Preventive Care Services, including certain generic and over-the-counter contraceptives for women.
1	Tier 1	Preferred Generic Drugs. These drugs are subject to your Tier 1 Copayment.
2	Tier 2	Preferred Brand-Name Drugs and inhaler spacers. These drugs and inhaler spacers are subject to your Tier 2 Copayment.
3	Tier 3	Non-preferred drugs (may include Brand Name or Generic Drugs). These drugs are subject to your Tier 3 Copayment.

Are There Any Coverage Requirements or Limits?

Some covered Generic and Brand-Name Drugs have coverage requirements or limits on coverage. Symbols are used to identify drugs with a Coverage Requirement or Limit. The following symbols are used in this Formulary:

Symbol	Meaning	Description
PA	Prior Authorization	Requires Prior Authorization by Sharp Health Plan based on specific clinical criteria. See "What is Prior Authorization?" below for additional information.
PA**	Prior Authorization if Step Therapy is not met	Requires Prior Authorization by Sharp Health Plan based on specific clinical criteria, if Step Therapy criteria has not been met.
QL	Quantity Limit	Coverage is limited to a specific quantity per Prescription and/or time period. Prior Authorization is required for other quantities.
ST	Step Therapy	Coverage depends on previous use of another drug. Prior Authorization may be required. See "What Is Step Therapy?" below for additional information.

MO	Mail Order	A maintenance drug that is available for up to a 90-day supply and is eligible to be filled through mail order.
SP	Specialty	A specialty drug that must be filled by a pharmacy in the Sharp Health Plan Specialty Pharmacy network and is limited to a 30-day supply per fill.
OAC	Oral Anti-Cancer	An orally administered anticancer medication. Notwithstanding any Deductible, the total amount of Copayments and Coinsurance does not exceed two hundred fifty dollars (\$250) for an individual Prescription of up to a 30-day supply.

What Is Prior Authorization?

Drugs with a PA symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization. Your Prescribing Provider must request Prior Authorization, or approval for coverage, from Sharp Health Plan by calling our Customer Service department, submitting a fax request, or submitting an electronic Prior Authorization Form. Once all the needed supporting information has been received, the Prior Authorization request will be either approved or denied based on our clinical policies within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances. Exigent Circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a Nonformulary Drug. Sharp Health Plan will provide coverage for the Prescription, including refills, for the duration of the Prescription for non-urgent requests, and for the duration of the exigency for requests based on Exigent Circumstances. If Sharp Health Plan fails to respond to a completed Prior Authorization request within 72 hours of receiving a non-urgent request or within 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted, including refills.

If Sharp Health Plan denies a request for Prior Authorization, the Member, an Authorized Representative, or the Prescribing Provider can file an Appeal or Grievance. Information about this process is described in the section of the Formulary called, "You Have the Right to Appeal."

If Sharp Health Plan approved a Prior Authorization request for your medication and medical condition, Sharp Health Plan will not discontinue or limit coverage if your Prescribing Provider continues to prescribe it for the same medical condition, provided the drug is appropriately prescribed and is safe and effective for treating your medical condition.

What is PA**?

Drugs with a PA** symbol in the Coverage Requirements and Limits column of the Formulary are subject to Prior Authorization based on specific clinical criteria if Step Therapy has not been met. There may be a situation when it is Medically Necessary for you to receive certain drugs without first trying the alternative drug. In these instances, your doctor may request a Prior Authorization by

following the Prior Authorization process described above.

What Is Quantity Limit?

Drugs with a QL symbol in the Coverage Requirements and Limits column of the Formulary are subject to Quantity Limits. Quantity Limits exist when drugs are limited to a determined number of doses based on criteria, including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximum approved dose. A Member's Prescribing Provider may submit a request for a quantity of medication that exceeds the Quantity Limit by following the Prior Authorization request procedure stated above. Medical Necessity for the quantity requested must be provided. Once all of the required supporting information has been received, the Prior Authorization request will be either approved or denied within 72 hours for non-urgent requests or within 24 hours in urgent or Exigent Circumstances.

What Is Step Therapy?

Drugs with a ST symbol in the Coverage Requirements and Limits column of the Formulary are subject to Step Therapy. The Step Therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain drugs. This means that to receive coverage, you may need to first try a proven, cost-effective drug. Remember, treatment decisions are always between you and your doctor. There may be a situation when it is Medically Necessary for you to receive certain drugs without first trying an alternative drug. In these instances, your doctor may request a Step Therapy Exception by following the Prior Authorization process as described above. If Sharp Health Plan fails to respond to a completed Step Therapy Exception request within 72 hours of receiving a non-urgent request or within 24 hours of receiving a request based on Exigent Circumstances, the request is deemed granted, including refills. When a provider determines that the drug required under Step Therapy is inconsistent with good professional practice, the provider should submit their justification and clinical documentation supporting the provider's determination with a Step Therapy Exception Request, and the Plan will approve the Step Therapy Exception Request.

If a request for prior authorization or a step therapy exception is incomplete or relevant information necessary to make a coverage determination is not included, we will notify your provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or relevant information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial.

If you have moved from another insurance plan to Sharp Health Plan and are taking a medication that your previous insurer covered, Sharp Health Plan will not require you to follow Step Therapy in order to obtain the medication. Your doctor may need to submit a request to Sharp Health Plan in order to provide you with continuity of coverage.

What Is MO?

Drugs with a MO symbol in the Coverage Requirements and Limits column of the Formulary are classified as Maintenance Drugs and can be filled for a 90-day supply at a retail location or through Mail Order.

What Is a Specialty Drug?

Drugs with a SP symbol in the Coverage Requirements and Limits column of the Formulary are Specialty drugs. A Specialty drug is a drug that the FDA or the manufacturer states must be distributed through a Specialty pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that the Pharmacy and Therapeutics Committee determines to be a Specialty medication.

What Is an Oral Anti-Cancer Drug?

Drugs with an OAC symbol in the Coverage Requirements and Limits column of the Formulary are Oral Anti-Cancer drugs. Notwithstanding any Deductible, the total amount of Copayments and Coinsurance for these drugs does not exceed two hundred fifty dollars (\$250) for an individual Prescription of up to a 30-day supply.

What if a Drug Is Not Listed on the Formulary? What is a Formulary Exception?

Drugs that are not listed on the Formulary are Nonformulary Drugs and are not covered. There may be times when it is Medically Necessary for you to receive a Nonformulary Drug. In these instances, you, your Authorized Representative or your Prescribing Provider may request a Formulary Exception by following the Prior Authorization Request process described above. Once all of the required supporting information has been received, the Formulary Exception Request will be either approved or denied based on medical necessity within 72 hours for non-urgent requests, or within 24 hours in urgent or Exigent Circumstances. If Sharp Health Plan denies a Formulary Exception Request, the Member, an Authorized Representative, or the Provider can file an Appeal with Sharp Health Plan. Nonformulary Brand-Name Drugs approved for coverage will be subject to the Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Tier 1 Cost Share. When approved, Sharp Health Plan shall provide coverage of the Nonformulary non-urgent request for the duration of the Prescription, including refills. Sharp Health Plan shall provide coverage, including refills, pursuant to a request based on Exigent Circumstances for the duration of the exigency.

Where Can I Fill My Prescription Drug?

To find a pharmacy in our network, use our Pharmacy Locator tool. First, register for an account at www.caremark.com. The Pharmacy Locator tool is available after you log into your account and will allow you to search for a pharmacy that meets your needs. For example, you can search for a

pharmacy close to your home, one that is open 24 hours a day, or one that offers drive-thru service.

Specialty drugs can be filled at CVS Specialty Pharmacy and will be mailed to you. Visit www.CVSspecialty.com to enroll. You can also take your Specialty drug prescription to a CVS retail pharmacy. Your Prescription will be sent to CVS Specialty Pharmacy to be filled. You may return to your local CVS pharmacy to pick up your Prescription.

Mail order medications can be filled at CVS/caremark. You can enroll with CVS/caremark by visiting info.caremark.com/mailservice.

What Is Therapeutic Interchange?

Sharp Health Plan employs therapeutic interchange as part of its prescription drug benefit. Therapeutic interchange is the practice of replacing (with the Prescribing Provider's approval) a Prescription Drug originally prescribed for a patient with a Prescription Drug that is preferred on the Formulary. Using therapeutic interchange may offer advantages, such as value through improved convenience, affordability, improved outcomes or fewer side effects. Two or more drugs may be considered appropriate for therapeutic interchange if they can be expected to produce similar levels of clinical effectiveness and sound medical outcomes in patients. If, during the Prior Authorization process, the requested medication has a preferred Formulary alternative that may be considered appropriate for therapeutic interchange, a request to consider the preferred drug(s) may be conveyed to the Prescribing Provider. The Prescribing Provider may choose to use therapeutic interchange and select a pharmaceutical that does not require Prior Authorization or Step Therapy.

What Is Generic Substitution?

When a Generic Drug is available, the pharmacy is required to switch a Brand-Name Drug to the generic equivalent, unless Sharp Health Plan has authorized the Brand-Name Drug due to medical necessity. If the brand-name drug is Medically Necessary and Prior Authorization is obtained from Sharp Health Plan, you must pay the Cost Share for the corresponding Brand-Name Drug tier. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their Brand-Name equivalents.

In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

You Have the Right to Appeal

If you do not agree with a coverage decision, you, your Authorized Representative or your provider may request an Appeal. You must submit your request within 180 days from the postmark date of the denial notice.

Appeals Due to Denial of Coverage for a Nonformulary Drug

If an exception request for coverage of a Nonformulary drug is denied, you, your Authorized Representative or your provider may request an external Exception Request review. Sharp Health Plan will ensure that a decision is made within 72 hours of receiving the required supporting information in routine circumstances or within 24 hours of receiving the required supporting information in urgent circumstances.

All Other Appeals

If a decision is made to delay, deny or modify coverage of a Formulary Drug, you, your Authorized Representative or your provider may request an Appeal. A decision will be made within 30 days in routine circumstances or 72 hours in urgent circumstances.

For all types of Appeals, the circumstance may be considered urgent if the routine decision-making process might seriously jeopardize your life or health, or when you are experiencing severe pain.

Please refer to your Member Handbook for more information on the Appeal process.

Questions

If you have any questions, please contact Customer Care by calling 1-855-298-4252. If you or somebody who you are helping have questions about Sharp Health Plan, you have the right to obtain assistance and information in your language without any cost to you.

Exclusions and Limitations to the Outpatient Prescription Drug Benefit

The services and supplies listed below are exclusions and limitations to your Outpatient Prescription Drug Benefits and are not covered by Sharp Health Plan:

1. Drugs dispensed by a person or entity other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency Medical Condition or urgent care condition.
2. Drugs prescribed by non-Plan Providers and not authorized by Sharp Health Plan, except when coverage is otherwise required for treatment of an Emergency Medical Condition.
3. Over-the-counter medications or supplies, even if written on Prescription, except as specifically identified as covered in this Formulary. This exclusion does not apply to over-the-counter products that Sharp Health Plan must cover as a "preventive care" benefit under federal law with a Prescription or if the prescription legend drug is

Medically Necessary due to a documented treatment failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.

4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.
5. Drugs that are packaged with over-the-counter medications or other non-prescription items/supplies.
6. Vitamins (other than pediatric or prenatal vitamins listed in this Formulary).
7. Drugs and supplies prescribed solely for the treatment of hair loss, athletic performance, sexual dysfunction, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease. Drugs for treatment of hair loss or sexual dysfunction are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders.)
8. Herbal, nutritional and dietary supplements.
9. Drugs prescribed solely for the purpose of shortening the duration of the common cold.
10. Dental products and medications prescribed for a dental treatment (such as mouthwash to prevent gum disease) are not covered. Drugs prescribed by a dentist to treat a medical condition (such as antibiotics to treat an infection) are covered.
11. Drugs and supplies prescribed in connection with a service or supply that is not a Covered Benefit, unless required to treat a complication that arises as a result of the service or supply.
12. Travel and/or required work-related immunizations.
13. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
14. Drugs obtained outside of the United States, unless they are furnished in connection with Urgent Care Services or Emergency Services.
15. Drugs that are prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity or Mental Health and Substance Use Disorders. Members must be enrolled in a Sharp Health Plan-approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage when prescribed for treatment of morbid obesity.

16. Off-label use of FDA-approved Prescription Drugs, unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer-reviewed journal.
17. Replacement of lost, stolen, or destroyed medications.
18. Compounded medications, unless determined to be Medically Necessary and Prior Authorization is obtained.
19. Brand-Name Drugs when a generic equivalent is available.
20. Any Prescription Drug for which there is an over-the-counter product that has the identical active ingredient and dosage as the Prescription Drug.

The exclusions listed above do not apply to:

1. Coverage of an entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.
2. Drugs listed in this Formulary.
3. Over-the-counter products that are specifically covered and listed as a preventive care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at \$0 Cost Sharing subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary and your Member Handbook under Family Planning and Preventive Care Services.
4. Insulin, glucagon and insulin syringes. These items are covered when Medically Necessary, even if they are available without a Prescription. Please see your Formulary and your Member Handbook under Diabetes Treatment.
5. Items that are approved by the FDA as a medical device. Please see your Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning Services for information about medical devices covered by Sharp Health Plan.

Some drugs are commercially available as both a Brand-Name version and a generic version. It is the policy of Sharp Health Plan that when a generic version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug unless prior Authorization for the Brand-Name Drug is obtained. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://www.hhs.gov/ocr/office/file/index.html).

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: www.dmhc.ca.gov.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն (Armenian):

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռախոսից) 711).

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید (TTY:711) 1-800-359-2002 (TTY:711). باشد می فراهم.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телефон: 711).

日本語 (Japanese):

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

قیر علا (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. تصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ਓਕ਼ਟਾ (Mon Khmer, Cambodian):

ប្រយ័ត្តុ: បើសិនជាអ្ម៌កនិយាយ ភាសាញឺ សេវាចំនួយផ្លូវការភាសា ដោយមិនគិតណូល
គិតអាជមានសំរាប់បំពើអ្នក។ ចូរទូរស័ព្ទ 1-800-359-2002 (TTY:711)⁴

Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

ਹਿੰਦੀ (Hindi):

ਧਿਆਨ ਦੇਂ: ਯदि ਆਪ ਹਿੰਦੀ ਬੋਲਤੇ ਹੋ ਤੋ ਆਪਕੇ ਲਿਏ ਮੁਫਤ ਮੌਜੂਦਾ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਏਂ ਉਪਲਬਧ ਹਨ। 1-800-359-2002 (TTY:711) ਪਰ ਕਾਲ ਕਰੋ।

ਗਾਂਧਾਰੀ (Thai):

ਵੇਖਨ: ਗਾਂਧਾਰੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ 1-800-359-2002 (TTY:711)।

List of Prescription Drugs

ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS	10
AMPHETAMINES	10
ANOREXIANTS NON-AMPHETAMINE.....	14
ANTI-OBESITY AGENTS	14
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS.....	15
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)	15
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS.....	15
STIMULANTS - MISC.	16
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES.....	21
ALLERGENIC EXTRACTS.....	21
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS	21
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS	21
ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION CONDITIONS	21
ANTIRHEUMATIC - ENZYME INHIBITORS	21
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS).....	22
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS.....	23
PYRIMIDINE SYNTHESIS INHIBITORS.....	23
ANALGESICS - NONNARCOTIC.....	23
ANALGESIC COMBINATIONS	23
SALICYLATES.....	24
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN	24
OPIOID AGONISTS	24
OPIOID COMBINATIONS	29
OPIOID PARTIAL AGONISTS.....	32
ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES.....	33
ANDROGENS	33
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS	33
INTRARECTAL STEROIDS	33
RECTAL COMBINATIONS.....	34
RECTAL STEROIDS.....	34
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES	34
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES	34
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS.....	34
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS	34
ANTI-INFECTIVE MISC. - COMBINATIONS	34
ANTIPROTOZOAL AGENTS.....	34
GLYCOPEPTIDES	35
LEPROSTATIC.....	35
LINCOSAMIDES.....	35
MONOBACTAMS	35
OXAZOLIDINONES	35
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS.....	35
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS.....	35

ANTIANGINALS-OTHER	35
NITRATES	35
ANTIANXIETY AGENTS - DRUGS TO TREAT ANXIETY.....	36
ANTIANXIETY AGENTS - MISC.....	36
BENZODIAZEPINES	36
ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS	37
ANTIARRHYTHMICS TYPE I-A.....	37
ANTIARRHYTHMICS TYPE I-B.....	37
ANTIARRHYTHMICS TYPE I-C.....	37
ANTIARRHYTHMICS TYPE III.....	38
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE.....	38
ANTI-INFLAMMATORY AGENTS	38
BRONCHODILATORS - ANTICHOLINERGICS.....	38
LEUKOTRIENE MODULATORS.....	38
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS	38
STEROID INHALANTS	38
SYMPATHOMIMETICS.....	39
XANTHINES	41
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS	41
COUMARIN ANTICOAGULANTS.....	41
DIRECT FACTOR XA INHIBITORS	41
THROMBIN INHIBITORS	42
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES.....	42
AMPA GLUTAMATE RECEPTOR ANTAGONISTS	42
ANTICONVULSANTS - BENZODIAZEPINES	42
ANTICONVULSANTS - MISC.....	42
CARBAMATES.....	45
GABA MODULATORS	45
HYDANTOINS	45
SUCCINIMIDES	45
VALPROIC ACID	46
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION	46
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS).....	46
ANTIDEPRESSANTS - MISC.	46
MONOAMINE OXIDASE INHIBITORS (MAOIS).....	46
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	46
SEROTONIN MODULATORS.....	47
SEROTONIN-NOREpinephrine REUPTAKE INHIBITORS (SNRIS)	47
TRICYCLIC AGENTS.....	48
ANTIDIABETICS - DRUGS TO TREAT DIABETES.....	49
ALPHA-GLUCOSIDASE INHIBITORS	49
ANTIDIABETIC - AMYLIN ANALOGS.....	49
ANTIDIABETIC COMBINATIONS.....	49
BIGUANIDES.....	50
DIABETIC OTHER	51
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS	51

INCRETIN MIMETIC AGENTS	51
INSULIN.....	51
INSULIN SENSITIZING AGENTS	52
MEGLITINIDE ANALOGUES.....	52
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS	52
SULFONYLUREAS	53
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA	53
ANTIPERISTALTIC AGENTS	53
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING	53
ANTIDOTES - CHELATING AGENTS.....	53
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING.....	53
OPIOID ANTAGONISTS.....	53
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING.....	54
5-HT3 RECEPTOR ANTAGONISTS.....	54
ANTIEMETICS - ANTICHOLINERGIC.....	54
ANTIEMETICS - MISCELLANEOUS	54
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS	54
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS.....	54
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS.....	54
IMIDAZOLE-RELATED ANTIFUNGALS	54
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES	55
ANTIHISTAMINES - ETHANOLAMINES	55
ANTIHISTAMINES - NON-SEDATING	55
ANTIHISTAMINES - PHENOTHIAZINES	55
ANTIHISTAMINES - PIPERIDINES.....	55
ANTIHYPERTROPHIC DRUGS - DRUGS TO TREAT HIGH CHOLESTEROL.....	55
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS	55
ANTIHYPERLIPIDEMICS - COMBINATIONS	55
ANTIHYPERLIPIDEMICS - MISC.	56
BILE ACID SEQUESTRANTS	56
FIBRIC ACID DERIVATIVES	56
HMG COA REDUCTASE INHIBITORS	56
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS.....	57
NICOTINIC ACID DERIVATIVES.....	57
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE	58
ACE INHIBITORS	58
AGENTS FOR PHEOCHROMOCYTOMA.....	58
ANGIOTENSIN II RECEPTOR ANTAGONISTS.....	59
ANTIADRENERGIC ANTIHYPERTENSIVES.....	59
ANTIHYPERTENSIVE COMBINATIONS	60
DIRECT RENIN INHIBITORS.....	62
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)	62
VASODILATORS	62
ANTIMALARIALS - DRUGS TO TREAT MALARIA	62
ANTIMALARIAL COMBINATIONS	62
ANTIMALARIALS - DRUGS TO TREAT MALARIA	62
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS	63

ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS.....	63
ANTIMYCOPHARMACEUTICAL AGENTS - DRUGS TO TREAT INFECTIONS	63
ANTI TB COMBINATIONS	63
ANTIMYCOPHARMACEUTICAL AGENTS - DRUGS TO TREAT INFECTIONS	63
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER	63
ALKYLATING AGENTS.....	63
ANTIMETABOLITES	64
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS.....	64
ANTINEOPLASTIC - EGFR INHIBITORS	64
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS.....	65
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	65
ANTINEOPLASTIC - IMMUNOMODULATORS.....	66
ANTINEOPLASTIC COMBINATIONS.....	66
ANTINEOPLASTIC ENZYME INHIBITORS	66
ANTINEOPLASTICS MISC.....	70
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS	70
MITOTIC INHIBITORS	70
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE .	70
ANTIPARKINSON ADJUNCTIVE THERAPY	70
ANTIPARKINSON ANTICHOLINERGICS	70
ANTIPARKINSON COMT INHIBITORS	70
ANTIPARKINSON DOPAMINERGICS	70
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS	72
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES.....	72
ANTIMANIC AGENTS.....	72
ANTIPSYCHOTICS - MISC.....	72
BENZISOXAZOLES	73
BUTYROPHENONES	73
DIBENZAPINES.....	73
DIHYDROINDOLONES	74
PHENOTHIAZINES.....	74
QUINOLINONE DERIVATIVES.....	75
THIOXANTHENES.....	75
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS	75
ANTIRETROVIRALS.....	75
ANTIVIRAL COMBINATIONS	77
CMV AGENTS	78
HEPATITIS AGENTS	78
HERPES AGENTS	78
INFLUENZA AGENTS	79
MISC. ANTIVIRALS	79
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS	79
ALPHA-BETA BLOCKERS	79
BETA BLOCKERS CARDIO-SELECTIVE.....	79
BETA BLOCKERS NON-SELECTIVE	80
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS	80

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS	80
CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS	83
CARDIAC GLYCOSIDES.....	83
CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS	83
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS	83
IMPOTENCE AGENTS	84
PROSTAGLANDIN VASODILATORS.....	84
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS	84
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS	84
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST	84
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR.....	85
SINUS NODE INHIBITORS	85
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC).....	85
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS.....	85
CEPHALOSPORINS - 1ST GENERATION.....	85
CEPHALOSPORINS - 2ND GENERATION	85
CEPHALOSPORINS - 3RD GENERATION.....	85
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL	86
COMBINATION CONTRACEPTIVES - ORAL.....	86
COMBINATION CONTRACEPTIVES - TRANSDERMAL	93
COMBINATION CONTRACEPTIVES - VAGINAL.....	94
EMERGENCY CONTRACEPTIVES	94
PROGESTIN CONTRACEPTIVES - ORAL.....	94
CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE.....	94
GLUCOCORTICOSTEROIDS	94
MINERALOCORTICOIDS	95
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS	95
ANTITUSSIVES	95
COUGH/COLD/ALLERGY COMBINATIONS	96
EXPECTORANTS.....	96
MISC. RESPIRATORY INHALANTS.....	96
MUCOLYTICS	96
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS	96
ACNE PRODUCTS.....	96
ANTI-INFLAMMATORY AGENTS - TOPICAL.....	99
ANTIBIOTICS - TOPICAL.....	99
ANTIFUNGALS - TOPICAL	99
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL	99
ANTIPSORIATICS.....	100
ANTISEBORRHEIC PRODUCTS.....	100
ANTIVIRALS - TOPICAL	100
BURN PRODUCTS	100
CORTICOSTEROIDS - TOPICAL	100
ECZEMA AGENTS.....	102
EMOLLIENTS.....	102

IMMUNOMODULATING AGENTS - TOPICAL	102
IMMUNOSUPPRESSIVE AGENTS - TOPICAL.....	102
KERATOLYTIC/ANTIMITOTIC AGENTS	102
LOCAL ANESTHETICS - TOPICAL.....	102
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL.....	103
ROSACEA AGENTS	103
SCABICIDES & PEDICULICIDES	103
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS	103
DIGESTIVE ENZYMESE.....	103
DIURETICS - DRUGS TO TREAT HEART CONDITIONS	104
CARBONIC ANHYDRASE INHIBITORS	104
DIURETIC COMBINATIONS.....	104
LOOP DIURETICS.....	104
POTASSIUM SPARING DIURETICS.....	104
THIAZIDES AND THIAZIDE-LIKE DIURETICS.....	105
ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES.....	105
BONE DENSITY REGULATORS	105
FERTILITY REGULATORS	105
GNRH/LHRH ANTAGONISTS.....	105
HORMONE RECEPTOR MODULATORS	105
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS.....	105
METABOLIC MODIFIERS.....	106
MINERALOCORTICOID RECEPTOR ANTAGONISTS	106
POSTERIOR PITUITARY HORMONES	106
PROGESTERONE RECEPTOR ANTAGONISTS	107
PROLACTIN INHIBITORS.....	107
VASOPRESSIN RECEPTOR ANTAGONISTS.....	107
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES	107
ESTROGEN COMBINATIONS.....	107
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES	108
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS.....	109
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS	109
GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS	109
GALLSTONE SOLUBILIZING AGENTS.....	109
GASTROINTESTINAL ANTIALLERGY AGENTS.....	109
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS	109
GASTROINTESTINAL STIMULANTS.....	109
INFLAMMATORY BOWEL AGENTS.....	110
INTESTINAL ACIDIFIERS.....	110
IRRITABLE BOWEL SYNDROME (IBS) AGENTS	110
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS	110
PHOSPHATE BINDER AGENTS.....	110
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS	110
ALKALINIZERS	110
CYSTINOSIS AGENTS	111

PROSTATIC HYPERPLASIA AGENTS	111
URINARY ANALGESICS	111
URINARY STONE AGENTS.....	111
GOUT AGENTS - DRUGS TO TREAT GOUT.....	111
GOUT AGENT COMBINATIONS.....	111
GOUT AGENTS - DRUGS TO TREAT GOUT	111
URICOSURICS	111
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS.....	111
HEMATOLOGIC - TYROSINE KINASE INHIBITORS.....	111
HEMATORHEOLOGIC AGENTS.....	111
PLASMA KALLIKREIN INHIBITORS	111
PLATELET AGGREGATION INHIBITORS.....	112
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS.....	112
AGENTS FOR GAUCHER DISEASE	112
AGENTS FOR SICKLE CELL DISEASE	112
FOLIC ACID/FOLATES	112
HEMATOPOIETIC GROWTH FACTORS.....	113
HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS	114
HEMOSTATICS - SYSTEMIC.....	114
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS.....	114
BARBITURATE HYPNOTICS	114
HYPNOTICS - TRICYCLIC AGENTS	114
NON-BARBITURATE HYPNOTICS.....	114
OREXIN RECEPTOR ANTAGONISTS	115
SELECTIVE MELATONIN RECEPTOR AGONISTS.....	115
LAXATIVES - DRUGS TO TREAT CONSTIPATION.....	115
LAXATIVE COMBINATIONS.....	115
LAXATIVES - MISCELLANEOUS.....	115
MACROLIDES - DRUGS TO TREAT INFECTIONS	115
AZITHROMYCIN	115
CLARITHROMYCIN	115
ERYTHRUMYCINS	116
FIDAXOMICIN	116
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING	116
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL.....	116
PARENTERAL THERAPY SUPPLIES	116
RESPIRATORY THERAPY SUPPLIES	117
MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES.....	119
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	119
SEROTONIN AGONISTS	119
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION	120
FLUORIDE.....	120
PHOSPHATE	121
POTASSIUM.....	121
MISCELLANEOUS THERAPEUTIC CLASSES.....	121
CHELATING AGENTS	121

IMMUNOMODULATORS	121
IMMUNOSUPPRESSIVE AGENTS.....	122
POTASSIUM REMOVING AGENTS.....	123
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT	123
ANESTHETICS TOPICAL ORAL	123
ANTI-INFECTIVES - THROAT	123
STEROIDS - MOUTH/THROAT/DENTAL.....	123
THROAT PRODUCTS - MISC.....	123
MULTIVITAMINS - DRUGS FOR NUTRITION.....	124
PRENATAL VITAMINS.....	124
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS	124
CENTRAL MUSCLE RELAXANTS.....	124
DIRECT MUSCLE RELAXANTS.....	124
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE	125
NASAL AGENT COMBINATIONS.....	125
NASAL ANTIALLERGY	125
NASAL ANTICHOLINERGICS.....	125
NASAL STEROIDS	125
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES.....	125
ALS AGENTS	125
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS	125
BETA-BLOCKERS - OPHTHALMIC	125
CYCLOPLEGIC MYDRIATICS	125
MIOTICS.....	126
OPHTHALMIC ADRENERGIC AGENTS.....	126
OPHTHALMIC ANTI-INFECTIVES	126
OPHTHALMIC IMMUNOMODULATORS	127
OPHTHALMIC INTEGRIN ANTAGONISTS	127
OPHTHALMIC STEROIDS	127
OPHTHALMICS - MISC.....	127
PROSTAGLANDINS - OPHTHALMIC.....	128
OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR.....	128
OTIC AGENTS - MISCELLANEOUS.....	128
OTIC ANTI-INFECTIVES	128
OTIC COMBINATIONS	128
OTIC STEROIDS	128
OXYTOCICS - DRUGS FOR PREGNANCY	128
OXYTOCICS - DRUGS FOR PREGNANCY.....	128
PENICILLINS - DRUGS TO TREAT INFECTIONS	128
AMINOPENICILLINS	128
NATURAL PENICILLINS	129
PENICILLIN COMBINATIONS.....	129
PENICILLINASE-RESISTANT PENICILLINS.....	129
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES	129
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES	129
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS	129

AGENTS FOR CHEMICAL DEPENDENCY	129
ANTI-CATAPLECTIC AGENTS.....	129
ANTIDEMENTIA AGENTS.....	130
COMBINATION PSYCHOTHERAPEUTICS.....	130
HYPOTACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS	131
MOVEMENT DISORDER DRUG THERAPY	131
MULTIPLE SCLEROSIS AGENTS	131
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS.....	132
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS.....	132
SMOKING DETERRENTS	132
RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS.....	137
CYSTIC FIBROSIS AGENTS.....	137
PULMONARY FIBROSIS AGENTS	137
SULFONAMIDES - DRUGS TO TREAT INFECTIONS.....	137
SULFONAMIDES - DRUGS TO TREAT INFECTIONS	137
TETRACYCLINES - DRUGS TO TREAT INFECTIONS	137
TETRACYCLINES - DRUGS TO TREAT INFECTIONS	137
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS.....	138
ANTITHYROID AGENTS.....	138
THYROID HORMONES.....	138
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID	140
ANTISPASMODICS	140
H-2 ANTAGONISTS.....	140
MISC. ANTI-ULCER.....	140
PROTON PUMP INHIBITORS.....	140
ULCER DRUGS - PROSTAGLANDINS	141
ULCER THERAPY COMBINATIONS.....	141
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE.....	141
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC).....	141
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS	142
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS.....	142
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS	142
VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS	142
SPERMICIDES	142
VAGINAL ANTI-INFECTIVES	142
VAGINAL CONTRACEPTIVE - PH MODULATORS	142
VAGINAL ESTROGENS	142
VAGINAL PROGESTINS	142
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS	143
ANAPHYLAXIS THERAPY AGENTS.....	143
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS.....	143
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS	143
VITAMINS - DRUGS FOR NUTRITION	143
OIL SOLUBLE VITAMINS	143
Index	144

Sharp Health Plan effective 12/01/2023

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AMPHETAMINES		
<i>amphetamine sulfate tab 5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine sulfate tab 10 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amphetamine-dextroamphetamine cap er 24hr 25 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine cap er 24hr 30 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 7.5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 10 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 12.5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 15 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 20 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 30 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 5 mg	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 10 mg	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Oral Solution 5 mg/5ml) PROCENTRA	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 2.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 5 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 7.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 10 mg</i>	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 10 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 15 mg) ZENZEDI	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>dextroamphetamine sulfate tab 20 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 20 mg) ZENZEDI	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 30 mg) ZENZEDI	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 10 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 20 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 30 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 40 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 50 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 60 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate cap 70 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>lisdexamfetamine dimesylate chew tab 10 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 20 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 30 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 40 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 50 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>lisdexamfetamine dimesylate chew tab 60 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methamphetamine hcl tab 5 mg</i>	1	PA, QL (450 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
ANOREXIANTS NON-AMPHETAMINE		
<i>benzphetamine hcl tab 50 mg</i>	1	PA
<i>diethylpropion hcl tab 25 mg</i>	1	PA
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA
<i>phendimetrazine tartrate tab 35 mg</i>	1	PA
<i>phentermine hcl cap 15 mg</i>	1	PA
<i>phentermine hcl cap 30 mg</i>	1	PA
<i>phentermine hcl cap 37.5 mg</i>	1	PA
<i>phentermine hcl tab 37.5 mg</i>	1	PA
<i>QSYMIA CAP 3.75-23 (phentermine hcl-topiramate)</i>	2	PA
<i>QSYMIA CAP 7.5-46MG (phentermine hcl-topiramate)</i>	2	PA
<i>QSYMIA CAP 11.25-69 (phentermine hcl-topiramate)</i>	2	PA
<i>QSYMIA CAP 15-92MG (phentermine hcl-topiramate)</i>	2	PA
ANTI-OBESITY AGENTS		
<i>orlistat cap 120 mg</i>	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
<i>atomoxetine hcl cap 10 mg (base equiv)</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>atomoxetine hcl cap 100 mg (base equiv)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>clonidine hcl tab er 12hr 0.1 mg</i>	1	MO
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>	1	MO
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>	1	MO
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>	1	MO
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>	1	MO
QELBREE CAP 100MG ER (<i>viloxazine hcl (adhd)</i>)	2	QL (270 caps every 75 days), MO
QELBREE CAP 150MG ER (<i>viloxazine hcl (adhd)</i>)	2	QL (270 caps every 75 days), MO
QELBREE CAP 200MG ER (<i>viloxazine hcl (adhd)</i>)	2	QL (270 caps every 75 days), MO
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG (<i>solriamfetol hcl</i>)	2	PA, MO
SUNOSI TAB 150MG (<i>solriamfetol hcl</i>)	2	PA, MO
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG (<i>pitolisant hcl</i>)	2	SP, PA, QL (2 tabs every 1 day)

MO - Available at mail-order **OAC** - Oral Anti-Cancer **PA** - Prior Authorization **PA**** - Prior Authorization if step therapy is not met **QL** - Quantity Limits **SP** - Specialty **ST** - Step Therapy

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
WAKIX TAB 17.8MG (<i>pitolisant hcl</i>)	2	SP, PA, QL (2 tabs every 1 day)
STIMULANTS - MISC.		
<i>armodafinil tab 50 mg</i>	1	PA, MO
<i>armodafinil tab 150 mg</i>	1	PA, MO
<i>armodafinil tab 200 mg</i>	1	PA, MO
<i>armodafinil tab 250 mg</i>	1	PA, MO
AZSTARYS CAP 26.1-5.2 (<i>serdexmethylphenidate chloride-dexmethylphenidate hcl</i>)	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
AZSTARYS CAP 39.2-7.8 (<i>serdexmethylphenidate chloride-dexmethylphenidate hcl</i>)	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
AZSTARYS CAP 52.3-10. (<i>serdexmethylphenidate chloride-dexmethylphenidate hcl</i>)	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dexamethylphenidate hcl cap er 24 hr 35 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexamethylphenidate hcl cap er 24 hr 40 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexamethylphenidate hcl tab 2.5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dexamethylphenidate hcl tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dexamethylphenidate hcl tab 10 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 10 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 20 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 10 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 10 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 15 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 20 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl cap er 24hr 20 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 30 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 30 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 40 mg (la)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 40 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 50 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 60 mg (la)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 60 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 30 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 40 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 50 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl cap er 60 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 2.5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 10 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl soln 5 mg/5ml	1	PA, QL (5400 mL every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl soln 10 mg/5ml	1	PA, QL (2700 mL every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 10 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 20 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 10 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 20 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl tab er 24hr 18 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 27 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 36 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 54 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 18 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 27 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 36 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 54 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 10 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 15 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 20 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methylphenidate td patch 30 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>modafinil tab 100 mg</i>	1	PA, MO
<i>modafinil tab 200 mg</i>	1	PA, MO

ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES

ALLERGENIC EXTRACTS

GRASTEK SUB 2800BAU (<i>timothy grass pollen allergen extract</i>)	2	PA, MO
ORALAIR SUB 300 IR (<i>grass mixed pollens allergen extract</i>)	2	PA, MO
RAGWITEK SUB (<i>short ragweed pollen allergen extract</i>)	2	PA, MO

AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS

AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS

<i>neomycin sulfate tab 500 mg</i>	1	
<i>tobramycin nebu soln 300 mg/4ml</i>	1	SP, PA, QL (8 mL every 1 day)
<i>tobramycin nebu soln 300 mg/5ml</i>	1	SP, PA, QL (10 mL every 1 day)

ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION

CONDITIONS

ANTIRHEUMATIC - ENZYME INHIBITORS

RINVOQ TAB 15MG ER (<i>upadacitinib</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
RINVOQ TAB 30MG ER (<i>upadacitinib</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Ulcerative Colitis
RINVOQ TAB 45MG ER (<i>upadacitinib</i>)	2	SP, PA, QL (56 tabs every 56 days); Preferred for Ulcerative Colitis
XELJANZ SOL 1MG/ML (<i>tofacitinib citrate</i>)	2	SP, PA, QL (10 mL every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ TAB 5MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ TAB 10MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XELJANZ XR TAB 11MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
XELJANZ XR TAB 22MG (<i>tofacitinib citrate</i>)	2	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis, Ulcerative Colitis
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
<i>celecoxib cap 50 mg</i>	1	MO
<i>celecoxib cap 100 mg</i>	1	MO
<i>celecoxib cap 200 mg</i>	1	MO
<i>celecoxib cap 400 mg</i>	1	MO
<i>diclofenac potassium tab 50 mg</i>	1	MO
<i>diclofenac sodium tab delayed release 25 mg</i>	1	MO
<i>diclofenac sodium tab delayed release 50 mg</i>	1	MO
<i>diclofenac sodium tab delayed release 75 mg</i>	1	MO
<i>diclofenac sodium tab er 24hr 100 mg</i>	1	MO
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i>	1	MO
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i>	1	MO
<i>etodolac cap 200 mg</i>	1	MO
<i>etodolac cap 300 mg</i>	1	MO
<i>etodolac tab 400 mg</i>	1	MO
<i>etodolac tab 500 mg</i>	1	MO
<i>etodolac tab er 24hr 400 mg</i>	1	MO
<i>etodolac tab er 24hr 500 mg</i>	1	MO
<i>etodolac tab er 24hr 600 mg</i>	1	MO
<i>flurbiprofen tab 50 mg</i>	1	MO
<i>flurbiprofen tab 100 mg</i>	1	MO
<i>ibuprofen susp 100 mg/5ml</i>	1	
<i>ibuprofen tab 400 mg</i>	1	MO
(Ibuprofen Tab 400 mg) IBU	1	MO
<i>ibuprofen tab 600 mg</i>	1	MO
(Ibuprofen Tab 600 mg) IBU	1	MO
<i>ibuprofen tab 800 mg</i>	1	MO
(Ibuprofen Tab 800 mg) IBU	1	MO
<i>indomethacin cap 25 mg</i>	1	MO
<i>indomethacin cap 50 mg</i>	1	MO
<i>indomethacin cap er 75 mg</i>	1	MO
<i>indomethacin suppos 50 mg</i>	1	MO
<i>ketorolac tromethamine tab 10 mg</i>	1	
<i>meclofenamate sodium cap 50 mg</i>	1	MO
<i>meclofenamate sodium cap 100 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>mefenamic acid cap 250 mg</i>	1	MO
<i>meloxicam susp 7.5 mg/5ml</i>	1	MO
<i>meloxicam tab 7.5 mg</i>	1	MO
<i>meloxicam tab 15 mg</i>	1	MO
<i>nabumetone tab 500 mg</i>	1	MO
<i>nabumetone tab 750 mg</i>	1	MO
<i>naproxen sodium tab 275 mg</i>	1	MO
<i>naproxen sodium tab 550 mg</i>	1	MO
<i>naproxen tab 250 mg</i>	1	MO
<i>naproxen tab 375 mg</i>	1	MO
<i>naproxen tab 500 mg</i>	1	MO
<i>naproxen tab ec 375 mg</i>	1	MO
(Naproxen Tab Ec 375 mg) EC-NAPROXEN	1	MO
<i>naproxen tab ec 500 mg</i>	1	MO
(Naproxen Tab Ec 500 mg) EC-NAPROXEN	1	MO
<i>oxaprozin tab 600 mg</i>	1	MO
<i>piroxicam cap 10 mg</i>	1	MO
<i>piroxicam cap 20 mg</i>	1	MO
<i>sulindac tab 150 mg</i>	1	MO
<i>sulindac tab 200 mg</i>	1	MO
<i>tolmetin sodium cap 400 mg</i>	1	MO
<i>tolmetin sodium tab 600 mg</i>	1	MO
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20/30 (<i>apremilast</i>)	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 30MG (<i>apremilast</i>)	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
PYRIMIDINE SYNTHESIS INHIBITORS		
<i>leflunomide tab 10 mg</i>	1	MO
<i>leflunomide tab 20 mg</i>	1	MO
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
<i>butalbital-acetaminophen tab 50-325 mg</i>	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen Tab 50-325 mg) TENCON	1	QL (48 tabs every 25 days)
<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg</i>	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg) BAC	1	QL (48 tabs every 25 days)
<i>butalbital-aspirin-caffeine cap 50-325-40 mg</i>	1	QL (48 caps every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SALICYLATES		
(Aspirin Chew Tab 81 mg) ASPIRIN CHILDRENS	PV	QL (100 tabs every 30 days); \$0 copay for members age 12-59 years at risk for preeclampsia, otherwise not covered
aspirin tab delayed release 81 mg	PV	QL (100 tabs every 30 days); \$0 copay for members age 12-59 years at risk for preeclampsia, otherwise not covered
diflunisal tab 500 mg	1	MO
salsalate tab 750 mg	1	MO
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN		
OPIOID AGONISTS		
codeine sulfate tab 30 mg	1	PA, QL (42 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
fentanyl citrate buccal tab 100 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 200 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 400 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 600 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 800 mcg (base equiv)	1	PA
fentanyl citrate lozenge on a handle 200 mcg	1	PA
fentanyl citrate lozenge on a handle 400 mcg	1	PA
fentanyl citrate lozenge on a handle 600 mcg	1	PA
fentanyl citrate lozenge on a handle 800 mcg	1	PA
fentanyl citrate lozenge on a handle 1200 mcg	1	PA
fentanyl citrate lozenge on a handle 1600 mcg	1	PA
fentanyl td patch 72hr 12 mcg/hr	1	ST, QL (10 patches every 25 days); PA**
fentanyl td patch 72hr 25 mcg/hr	1	ST, QL (10 patches every 25 days); PA**
fentanyl td patch 72hr 37.5 mcg/hr	1	ST, QL (10 patches every 25 days); PA**
fentanyl td patch 72hr 50 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 62.5 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 75 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 87.5 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 100 mcg/hr	1	PA; High Strength Requires PA
hydrocodone bitartrate cap er 12hr 10 mg	1	ST, QL (60 caps every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone bitartrate cap er 12hr 15 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 20 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 30 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 40 mg	1	ST, QL (60 caps every 25 days); PA**
hydrocodone bitartrate cap er 12hr 50 mg	1	PA; High Strength Requires PA
hydrocodone bitartrate tab er 24hr deter 20 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 30 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 40 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 60 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 80 mg	1	ST, QL (30 tabs every 25 days); PA**
hydrocodone bitartrate tab er 24hr deter 100 mg	1	PA; High Strength Requires PA
hydrocodone bitartrate tab er 24hr deter 120 mg	1	PA; High Strength Requires PA
hydromorphone hcl liqd 1 mg/ml	1	PA, QL (600 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 2 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 4 mg	1	PA, QL (150 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 8 mg	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab er 24hr 8 mg	1	ST, QL (120 tabs every 25 days); PA**
hydromorphone hcl tab er 24hr 12 mg	1	ST, QL (120 tabs every 25 days); PA**
hydromorphone hcl tab er 24hr 16 mg	1	ST, QL (120 tabs every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydromorphone hcl tab er 24hr 32 mg	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
meperidine hcl oral soln 50 mg/5ml	1	PA, QL (90 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
meperidine hcl tab 50 mg	1	PA, QL (18 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
methadone hcl conc 10 mg/ml	1	QL (30 mL every 25 days); Indicated for opioid addiction
(Methadone Hcl Conc 10 mg/ml) METHADONE HYDROCHLORIDE I	1	PA, QL (30 mL every 25 days); Indicated for opioid addiction
methadone hcl soln 5 mg/5ml	1	ST, QL (450 ml every 25 days); PA**
methadone hcl soln 10 mg/5ml	1	ST, QL (300 mL every 25 days); PA**
methadone hcl tab 5 mg	1	ST, QL (90 tabs every 25 days); PA**
methadone hcl tab 10 mg	1	ST, QL (60 tabs every 25 days); PA**
methadone hcl tab for oral susp 40 mg	1	QL (9 tabs every 25 days); Indicated for opioid addiction
(Methadone Hcl Tab For Oral Susp 40 mg) METHADOSE	1	QL (9 tabs every 25 days); Indicated for opioid addiction
morphine sulfate beads cap er 24hr 30 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 45 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 60 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 75 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 90 mg	1	ST, QL (30 caps every 25 days); PA**
morphine sulfate beads cap er 24hr 120 mg	1	PA; High Strength Requires PA
morphine sulfate cap er 24hr 10 mg	1	ST, QL (60 caps every 25 days); PA**
morphine sulfate cap er 24hr 20 mg	1	ST, QL (60 caps every 25 days); PA**
morphine sulfate cap er 24hr 30 mg	1	ST, QL (60 caps every 25 days); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>morphine sulfate cap er 24hr 50 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 60 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 80 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 100 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate oral soln 10 mg/5ml</i>	1	PA, QL (900 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate oral soln 20 mg/5ml</i>	1	PA, QL (675 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (135 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>morphine sulfate tab er 15 mg</i>	1	ST, QL (90 tabs every 25 days); PA**
<i>morphine sulfate tab er 30 mg</i>	1	ST, QL (90 tabs every 25 days); PA**
<i>morphine sulfate tab er 60 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate tab er 100 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate tab er 200 mg</i>	1	PA; High Strength Requires PA
<i>oxycodone hcl cap 5 mg</i>	1	PA, QL (180 caps every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (90 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>oxycodone hcl soln 5 mg/5ml</i>	1	PA, QL (900 mL every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone hcl tab 5 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 10 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 15 mg	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 20 mg	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab 30 mg	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl tab er 12hr deter 10 mg	1	ST, QL (60 tabs every 25 days); PA**
oxycodone hcl tab er 12hr deter 20 mg	1	ST, QL (60 tabs every 25 days); PA**
oxycodone hcl tab er 12hr deter 40 mg	1	PA; High Strength Requires PA
oxycodone hcl tab er 12hr deter 80 mg	1	PA; High Strength Requires PA
oxymorphone hcl tab 5 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tab 10 mg	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
tramadol hcl oral soln 5 mg/ml	1	PA, QL (1800 mL every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
tramadol hcl tab 50 mg	1	PA, QL (180 tabs every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>tramadol hcl tab er 24hr 100 mg</i>	1	ST, QL (30 tabs every 25 days); PA**; Not available under age 12
<i>tramadol hcl tab er 24hr 200 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
<i>tramadol hcl tab er 24hr 300 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	1	ST, QL (30 tabs every 25 days); PA**; Not available under age 12
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	1	PA; High Strength Requires PA; Not available under age 12
XTAMPZA ER CAP 9MG (<i>oxycodone</i>)	2	ST, QL (60 caps every 25 days); PA**
XTAMPZA ER CAP 13.5MG (<i>oxycodone</i>)	2	ST, QL (60 caps every 25 days); PA**
XTAMPZA ER CAP 18MG (<i>oxycodone</i>)	2	ST, QL (60 caps every 25 days); PA**
XTAMPZA ER CAP 27MG (<i>oxycodone</i>)	2	ST, QL (60 caps every 25 days); PA**
XTAMPZA ER CAP 36MG (<i>oxycodone</i>)	2	PA; High Strength Requires PA
OPIOID COMBINATIONS		
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1	ST, QL (2700 mL every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen w/ codeine tab 300-15 mg</i>	1	ST, QL (400 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen w/ codeine tab 300-30 mg</i>	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>acetaminophen w/ codeine tab 300-60 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	1	ST, QL (300 caps every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
(Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg) TREZIX	1	ST, QL (300 caps every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i>	1	QL (48 caps every 25 days); Not available under age 12
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	1	QL (48 caps every 25 days); Not available under age 12
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	1	QL (48 caps every 25 days); Not available under age 12
(Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg) ASCOMP/CODEINE	1	QL (48 caps every 25 days); Not available under age 12
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 5-300 mg</i>	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 7.5-300 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	1	PA, QL (180 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 10-300 mg</i>	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone-ibuprofen tab 5-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 7.5-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 10-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 2.5-325 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 2.5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 5-325 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 7.5-325 mg	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 7.5-325 mg) ENDOCET	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
oxycodone w/ acetaminophen tab 10-325 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 10-325 mg) ENDOCET	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
tramadol-acetaminophen tab 37.5-325 mg	1	ST, QL (40 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
OPIOID PARTIAL AGONISTS		
BELBUCA MIS 75MCG (buprenorphine hcl)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 150MCG (buprenorphine hcl)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 300MCG (buprenorphine hcl)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 450MCG (buprenorphine hcl)	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 600MCG (buprenorphine hcl)	2	PA; High Strength Requires PA
BELBUCA MIS 750MCG (buprenorphine hcl)	2	PA; High Strength Requires PA
BELBUCA MIS 900MCG (buprenorphine hcl)	2	PA; High Strength Requires PA
buprenorphine hcl sl tab 2 mg (base equiv)	1	
buprenorphine hcl sl tab 8 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	
buprenorphine td patch weekly 5 mcg/hr	1	ST, QL (4 patches every month); PA**
buprenorphine td patch weekly 7.5 mcg/hr	1	ST, QL (4 patches every month); PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>buprenorphine td patch weekly 10 mcg/hr</i>	1	ST, QL (4 patches every month); PA**
<i>buprenorphine td patch weekly 15 mcg/hr</i>	1	PA; High Strength Requires PA
<i>buprenorphine td patch weekly 20 mcg/hr</i>	1	PA; High Strength Requires PA
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	1	
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
ZUBSOLV SUB 0.7-0.18 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 1.4-0.36 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 2.9-0.71 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 5.7-1.4 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 8.6-2.1 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	
ZUBSOLV SUB 11.4-2.9 (<i>buprenorphine hcl-naloxone hcl dihydrate</i>)	2	

ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES

ANDROGENS

<i>danazol cap 50 mg</i>	1	
<i>danazol cap 100 mg</i>	1	
<i>danazol cap 200 mg</i>	1	
<i>methyltestosterone cap 10 mg</i>	1	PA, MO
NATESTO GEL 5.5MG (<i>testosterone</i>)	2	PA, MO
<i>testosterone td gel 10mg/act (2%)</i>	1	PA, MO
<i>testosterone td gel 12.5 mg/act (1%)</i>	1	PA, MO
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	1	PA, MO
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	1	PA, MO
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	1	PA, MO
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	1	PA, MO
<i>testosterone td gel 50 mg/5gm (1%)</i>	1	PA, MO
<i>testosterone td soln 30 mg/act</i>	1	PA, MO

ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS

INTRARECTAL STEROIDS

<i>budesonide rectal foam 2 mg/act</i>	1	
CORTIFOAM AER 90MG (<i>hydrocortisone acetate (intrarectal)</i>)	2	
<i>hydrocortisone enema 100 mg/60ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
RECTAL COMBINATIONS		
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	1	
PROCTOFOAM AER HC 1% (<i>hydrocortisone acetate w/ pramoxine</i>)	2	
RECTAL STEROIDS		
(Hydrocortisone Acetate Suppos 25 mg) ANUCORT-HC	1	
(Hydrocortisone Acetate Suppos 30 mg) HEMMOREX-HC	1	
<i>hydrocortisone perianal cream 1%</i>	1	
<i>hydrocortisone perianal cream 2.5%</i>	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTO-MED HC	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTOSOL HC	1	
(Hydrocortisone Perianal Cream 2.5%) PROCTOZONE-HC	1	
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
<i>albendazole tab 200 mg</i>	1	
EMVERM CHW 100MG (<i>mebendazole</i>)	2	
<i>ivermectin tab 3 mg</i>	1	PA
<i>praziquantel tab 600 mg</i>	1	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
<i>IMPAVIDO CAP 50MG (<i>miltefosine</i>)</i>	3	
<i>metronidazole cap 375 mg</i>	1	
<i>metronidazole tab 250 mg</i>	1	
<i>metronidazole tab 500 mg</i>	1	
<i>pentamidine isethionate for nebulization soln 300 mg</i>	1	
<i>tinidazole tab 250 mg</i>	1	
<i>tinidazole tab 500 mg</i>	1	
<i>trimethoprim tab 100 mg</i>	1	
XIFAXAN TAB 550MG (<i>rifaximin</i>)	2	MO
ANTI-INFECTIVE MISC. - COMBINATIONS		
ANTI-INFECTIVE MISC. - COMBINATIONS		
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
(Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml) SULFATRIM PEDIATRIC	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
ANTIPROTOZOAL AGENTS		
<i>atovaquone susp 750 mg/5ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>nitazoxanide tab 500 mg</i>	1	
GLYCOPEPTIDES		
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	1	
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	1	
<i>vancomycin hcl for oral soln 25 mg/ml (base equivalent)</i>	1	
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	1	
LEPROSTATICs		
<i>dapsone tab 25 mg</i>	1	MO
<i>dapsone tab 100 mg</i>	1	MO
LINCOSAMIDES		
<i>clindamycin hcl cap 75 mg</i>	1	
<i>clindamycin hcl cap 150 mg</i>	1	
<i>clindamycin hcl cap 300 mg</i>	1	
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)</i>	1	
MONOBACTAMS		
<i>CAYSTON INH 75MG (aztreonam lysine)</i>	3	SP, PA
OXAZOLIDINONES		
<i>linezolid for susp 100 mg/5ml</i>	1	
<i>linezolid tab 600 mg</i>	1	
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
<i>methenamine hippurate tab 1 gm</i>	1	
<i>methenamine mandelate tab 0.5 gm</i>	1	
<i>nitrofurantoin macrocrystalline cap 25 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 50 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin susp 25 mg/5ml</i>	1	
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS		
ANTIANGINALS-OTHER		
<i>ranolazine tab er 12hr 500 mg</i>	1	MO
<i>ranolazine tab er 12hr 1000 mg</i>	1	MO
NITRATES		
<i>isosorbide dinitrate tab 5 mg</i>	1	MO
<i>isosorbide dinitrate tab 10 mg</i>	1	MO
<i>isosorbide dinitrate tab 20 mg</i>	1	MO
<i>isosorbide dinitrate tab 30 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>isosorbide mononitrate tab 10 mg</i>	1	MO
<i>isosorbide mononitrate tab 20 mg</i>	1	MO
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	1	MO
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	1	MO
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	1	MO
NITRO-DUR DIS 0.3MG/HR (<i>nitroglycerin</i>)	2	MO
NITRO-DUR DIS 0.8MG/HR (<i>nitroglycerin</i>)	2	MO
<i>nitroglycerin sl tab 0.3 mg</i>	1	MO
<i>nitroglycerin sl tab 0.4 mg</i>	1	MO
<i>nitroglycerin sl tab 0.6 mg</i>	1	MO
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	1	MO
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	1	MO
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	1	MO
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	1	MO
<i>nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)</i>	1	MO

ANTIANXIETY AGENTS - DRUGS TO TREAT ANXIETY

ANTIANXIETY AGENTS - MISC.

<i>buspirone hcl tab 5 mg</i>	1	
<i>buspirone hcl tab 7.5 mg</i>	1	
<i>buspirone hcl tab 10 mg</i>	1	
<i>buspirone hcl tab 15 mg</i>	1	
<i>buspirone hcl tab 30 mg</i>	1	
<i>hydroxyzine hcl syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl tab 10 mg</i>	1	
<i>hydroxyzine hcl tab 25 mg</i>	1	
<i>hydroxyzine hcl tab 50 mg</i>	1	
<i>hydroxyzine pamoate cap 25 mg</i>	1	
<i>hydroxyzine pamoate cap 50 mg</i>	1	
<i>hydroxyzine pamoate cap 100 mg</i>	1	
<i>meprobamate tab 200 mg</i>	1	
<i>meprobamate tab 400 mg</i>	1	

BENZODIAZEPINES

<i>alprazolam orally disintegrating tab 0.5 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam orally disintegrating tab 0.25 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam orally disintegrating tab 1 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam orally disintegrating tab 2 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 0.5 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 0.25 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 1 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab 2 mg</i>	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 0.5 mg</i>	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 0.5 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 1 mg</i>	1	QL (150 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Alprazolam Tab Er 24hr 1 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 2 mg</i>	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 2 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
<i>alprazolam tab er 24hr 3 mg</i>	1	QL (90 tabs every 25 days)
(Alprazolam Tab Er 24hr 3 mg) ALPRAZOLAM XR	1	QL (90 tabs every 25 days)
<i>chlordiazepoxide hcl cap 5 mg</i>	1	QL (360 caps every 25 days)
<i>chlordiazepoxide hcl cap 10 mg</i>	1	QL (360 caps every 25 days)
<i>chlordiazepoxide hcl cap 25 mg</i>	1	QL (360 caps every 25 days)
<i>clorazepate dipotassium tab 3.75 mg</i>	1	QL (180 tabs every 25 days)
<i>clorazepate dipotassium tab 7.5 mg</i>	1	QL (180 tabs every 25 days)
<i>clorazepate dipotassium tab 15 mg</i>	1	QL (180 tabs every 25 days)
<i>diazepam conc 5 mg/ml</i>	1	QL (240 mL every 25 days)
<i>diazepam oral soln 1 mg/ml</i>	1	QL (1200 mL every 25 days)
<i>diazepam tab 2 mg</i>	1	QL (120 tabs every 25 days)
<i>diazepam tab 5 mg</i>	1	QL (120 tabs every 25 days)
<i>diazepam tab 10 mg</i>	1	QL (120 tabs every 25 days)
<i>lorazepam conc 2 mg/ml</i>	1	QL (150 mL every 25 days)
<i>lorazepam tab 0.5 mg</i>	1	QL (150 tabs every 25 days)
<i>lorazepam tab 1 mg</i>	1	QL (150 tabs every 25 days)
<i>lorazepam tab 2 mg</i>	1	QL (150 tabs every 25 days)
<i>oxazepam cap 10 mg</i>	1	QL (120 caps every 25 days)
<i>oxazepam cap 15 mg</i>	1	QL (120 caps every 25 days)
<i>oxazepam cap 30 mg</i>	1	QL (120 caps every 25 days)

ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS

ANTIARRHYTHMICS TYPE I-A

<i>disopyramide phosphate cap 100 mg</i>	1	MO
<i>disopyramide phosphate cap 150 mg</i>	1	MO
NORPACE CAP 100MG CR (<i>disopyramide phosphate</i>)	2	MO
NORPACE CAP 150MG CR (<i>disopyramide phosphate</i>)	2	MO
<i>quinidine gluconate tab er 324 mg</i>	1	MO

ANTIARRHYTHMICS TYPE I-B

<i>mexiletine hcl cap 150 mg</i>	1	MO
<i>mexiletine hcl cap 200 mg</i>	1	MO
<i>mexiletine hcl cap 250 mg</i>	1	MO

ANTIARRHYTHMICS TYPE I-C

<i>flecainide acetate tab 50 mg</i>	1	MO
<i>flecainide acetate tab 100 mg</i>	1	MO
<i>flecainide acetate tab 150 mg</i>	1	MO
<i>propafenone hcl cap er 12hr 225 mg</i>	1	MO
<i>propafenone hcl cap er 12hr 325 mg</i>	1	MO
<i>propafenone hcl cap er 12hr 425 mg</i>	1	MO
<i>propafenone hcl tab 150 mg</i>	1	MO
<i>propafenone hcl tab 225 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>propafenone hcl tab 300 mg</i>	1	MO
ANTIARRHYTHMICS TYPE III		
<i>amiodarone hcl tab 100 mg</i>	1	MO
(Amiodarone Hcl Tab 100 mg) PACERONE	1	MO
<i>amiodarone hcl tab 200 mg</i>	1	MO
(Amiodarone Hcl Tab 200 mg) PACERONE	1	MO
<i>amiodarone hcl tab 400 mg</i>	1	MO
(Amiodarone Hcl Tab 400 mg) PACERONE	1	MO
<i>dofetilide cap 125 mcg (0.125 mg)</i>	1	SP, PA
<i>dofetilide cap 250 mcg (0.25 mg)</i>	1	SP, PA
<i>dofetilide cap 500 mcg (0.5 mg)</i>	1	SP, PA
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
ANTI-INFLAMMATORY AGENTS		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (720 mL every 75 days), MO
BRONCHODILATORS - ANTICHOLINERGICS		
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (938 mL every 75 days), MO
<i>SPIRIVA AER 1.25MCG (tiotropium bromide monohydrate)</i>	2	QL (3 inhalers every 75 days), MO
<i>SPIRIVA CAP HANDIHLR (tiotropium bromide monohydrate)</i>	2	QL (90 caps every 75 days), MO
<i>SPIRIVA SPR 2.5MCG (tiotropium bromide monohydrate)</i>	2	QL (3 inhalers every 75 days), MO
<i>tiotropium bromide monohydrate inhal cap 18 mcg (base equiv)</i>	1	QL (90 caps every 75 days), MO
<i>YUPELRI SOL (reverfenacin)</i>	2	QL (270 mL every 75 days), MO
LEUKOTRIENE MODULATORS		
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	MO
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	1	MO
<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	1	MO
<i>montelukast sodium tab 10 mg (base equiv)</i>	1	MO
<i>zafirlukast tab 10 mg</i>	1	MO
<i>zafirlukast tab 20 mg</i>	1	MO
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
<i>roflumilast tab 250 mcg</i>	1	MO
<i>roflumilast tab 500 mcg</i>	1	MO
STEROID INHALANTS		
<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (360 mL every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>budesonide inhalation susp 0.25 mg/2ml</i>	1	QL (540 mL every 75 days), MO
<i>budesonide inhalation susp 1 mg/2ml</i>	1	QL (180 mL every 75 days), MO
FLOVENT HFA AER 44MCG (<i>fluticasone propionate hfa</i>)	3	QL (6 inhalers every 75 days), MO
FLOVENT HFA AER 110MCG (<i>fluticasone propionate hfa</i>)	3	QL (6 inhalers every 75 days), MO
FLOVENT HFA AER 220MCG (<i>fluticasone propionate hfa</i>)	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aer 110 mcg/act (125 valve)</i>	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aer 220 mcg/act (250 valve)</i>	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aero 44 mcg/act (50 valve)</i>	3	QL (6 inhalers every 75 days), MO
PULMICORT INH 90MCG (<i>budesonide (inhalation)</i>)	2	QL (9 inhalers every 75 days), MO
PULMICORT INH 180MCG (<i>budesonide (inhalation)</i>)	2	QL (6 inhalers every 75 days), MO
SYMPATHOMIMETICS		
ADVAIR DISKU AER 100/50 (<i>fluticasone-salmeterol</i>)	1	QL (180 inhalations every 75 days), MO
ADVAIR DISKU AER 250/50 (<i>fluticasone-salmeterol</i>)	1	QL (180 inhalations every 75 days), MO
ADVAIR DISKU AER 500/50 (<i>fluticasone-salmeterol</i>)	1	QL (180 inhalations every 75 days), MO
ADVAIR HFA AER 45/21 (<i>fluticasone-salmeterol</i>)	2	QL (3 inhalers every 75 days), MO
ADVAIR HFA AER 115/21 (<i>fluticasone-salmeterol</i>)	2	QL (3 inhalers every 75 days), MO
ADVAIR HFA AER 230/21 (<i>fluticasone-salmeterol</i>)	2	QL (3 inhalers every 75 days), MO
AIRSUPRA AER 90-80MCG (<i>albuterol-budesonide</i>)	2	QL (9 inhalers every 75 days)
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	1	QL (6 inhalers every 75 days), MO
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (180 mL every 75 days), MO
<i>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (1125 mL every 75 days), MO
<i>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</i>	1	QL (1125 mL every 75 days), MO
<i>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (1125 mL every 75 days), MO
<i>albuterol sulfate syrup 2 mg/5ml</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>albuterol sulfate tab 2 mg</i>	1	MO
<i>albuterol sulfate tab 4 mg</i>	1	MO
ANORO ELLIPT AER 62.5-25 (<i>umeclidinium-vilanterol</i>)	2	QL (180 blisters every 75 days), MO
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	1	QL (360 mL every 75 days), MO
BREO ELLIPTA INH 50-25MCG (<i>fluticasone furoate-vilanterol</i>)	2	QL (3 inhalers every 75 days), MO
BREO ELLIPTA INH 100-25 (<i>fluticasone furoate-vilanterol</i>)	2	QL (180 blisters every 75 days), MO
BREO ELLIPTA INH 200-25 (<i>fluticasone furoate-vilanterol</i>)	2	QL (180 blisters every 75 days), MO
BREZTRI AERO AER SPHERE (<i>budesonide-glycopyrrolate-formoterol fumarate</i>)	2	QL (3 inhalers every 75 days), MO
<i>fluticasone furoate-vilanterol aero powd ba 100-25 mcg/act</i>	1	PA, QL (180 blisters every 75 days), MO
<i>fluticasone furoate-vilanterol aero powd ba 200-25 mcg/act</i>	1	PA, QL (180 blisters every 75 days), MO
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (360 mL every 75 days), MO
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	1	QL (1620 mL every 75 days), MO
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	1	QL (900 mL every 75 days), MO
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (900 mL every 75 days), MO
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (900 mL every 75 days), MO
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	1	QL (270 mL every 75 days), MO
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	1	QL (6 inhalers every 75 days), MO
SEREVENT DIS AER 50MCG (<i>salmeterol xinafoate</i>)	2	QL (180 inhalations every 75 days), MO
STIOLTO AER 2.5-2.5 (<i>tiotropium bromide-olodaterol hcl</i>)	2	QL (3 inhalers every 75 days), MO
STRIVERDI AER 2.5MCG (<i>olodaterol hcl</i>)	2	QL (3 inhalers every 75 days), MO
SYMBICORT AER 80-4.5 (<i>budesonide-formoterol fumarate dihydrate</i>)	2	QL (9 inhalers every 75 days), MO
SYMBICORT AER 160-4.5 (<i>budesonide-formoterol fumarate dihydrate</i>)	2	QL (9 inhalers every 75 days), MO
<i>terbutaline sulfate tab 2.5 mg</i>	1	MO
<i>terbutaline sulfate tab 5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TRELEGY AER 100MCG (<i>fluticasone-umeclidinium-vilanterol</i>)	2	QL (3 inhalers every 75 days), MO
TRELEGY AER 200MCG (<i>fluticasone-umeclidinium-vilanterol</i>)	2	QL (3 inhalers every 75 days), MO
XANTHINES		
<i>theophylline elixir 80 mg/15ml</i>	1	MO
(Theophylline Elixir 80 mg/15ml) ELIXOPHYLLIN	1	MO
<i>theophylline soln 80 mg/15ml</i>	1	MO
<i>theophylline tab er 12hr 300 mg</i>	1	MO
<i>theophylline tab er 12hr 450 mg</i>	1	MO
<i>theophylline tab er 24hr 400 mg</i>	1	MO
<i>theophylline tab er 24hr 600 mg</i>	1	MO
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS		
COUMARIN ANTICOAGULANTS		
<i>warfarin sodium tab 1 mg</i>	1	MO
(Warfarin Sodium Tab 1 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 2 mg</i>	1	MO
(Warfarin Sodium Tab 2 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 2.5 mg</i>	1	MO
(Warfarin Sodium Tab 2.5 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 3 mg</i>	1	MO
(Warfarin Sodium Tab 3 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 4 mg</i>	1	MO
(Warfarin Sodium Tab 4 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 5 mg</i>	1	MO
(Warfarin Sodium Tab 5 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 6 mg</i>	1	MO
(Warfarin Sodium Tab 6 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 7.5 mg</i>	1	MO
(Warfarin Sodium Tab 7.5 mg) JANTOVEN	1	MO
<i>warfarin sodium tab 10 mg</i>	1	MO
(Warfarin Sodium Tab 10 mg) JANTOVEN	1	MO
DIRECT FACTOR XA INHIBITORS		
<i>ELIQUIS ST P TAB 5MG (apixaban)</i>	2	
<i>ELIQUIS TAB 2.5MG (apixaban)</i>	2	MO
<i>ELIQUIS TAB 5MG (apixaban)</i>	2	MO
<i>XARELTO STAR TAB 15/20MG (rivaroxaban)</i>	2	
<i>XARELTO SUS 1MG/ML (rivaroxaban)</i>	2	MO
<i>XARELTO TAB 2.5MG (rivaroxaban)</i>	2	MO
<i>XARELTO TAB 10MG (rivaroxaban)</i>	2	MO
<i>XARELTO TAB 15MG (rivaroxaban)</i>	2	MO
<i>XARELTO TAB 20MG (rivaroxaban)</i>	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
THROMBIN INHIBITORS		
<i>dabigatran etexilate mesylate cap 75 mg (etexilate base eq)</i>	1	MO
<i>dabigatran etexilate mesylate cap 150 mg (etexilate base eq)</i>	1	MO
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
<i>FYCOMPA SUS 0.5MG/ML (perampanel)</i>	2	MO
<i>FYCOMPA TAB 2MG (perampanel)</i>	2	MO
<i>FYCOMPA TAB 4MG (perampanel)</i>	2	MO
<i>FYCOMPA TAB 6MG (perampanel)</i>	2	MO
<i>FYCOMPA TAB 8MG (perampanel)</i>	2	MO
<i>FYCOMPA TAB 10MG (perampanel)</i>	2	MO
<i>FYCOMPA TAB 12MG (perampanel)</i>	2	MO
ANTICONVULSANTS - BENZODIAZEPINES		
<i>clobazam suspension 2.5 mg/ml</i>	1	MO
<i>clobazam tab 10 mg</i>	1	MO
<i>clobazam tab 20 mg</i>	1	MO
<i>clonazepam orally disintegrating tab 0.5 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 0.25 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 0.125 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 1 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam orally disintegrating tab 2 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam tab 0.5 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam tab 1 mg</i>	1	QL (300 tabs every 25 days)
<i>clonazepam tab 2 mg</i>	1	QL (300 tabs every 25 days)
<i>diazepam rectal gel delivery system 2.5 mg</i>	1	
<i>diazepam rectal gel delivery system 10 mg</i>	1	
<i>diazepam rectal gel delivery system 20 mg</i>	1	
<i>NAYZILAM SPR 5MG (midazolam (anticonvulsant))</i>	2	
<i>VALTOCO SPR 5MG (diazepam (anticonvulsant))</i>	2	
<i>VALTOCO SPR 10MG (diazepam (anticonvulsant))</i>	2	
<i>VALTOCO SPR 15MG (diazepam (anticonvulsant))</i>	2	
<i>VALTOCO SPR 20MG (diazepam (anticonvulsant))</i>	2	
ANTICONVULSANTS - MISC.		
<i>APTIOM TAB 200MG (eslicarbazepine acetate)</i>	2	MO
<i>APTIOM TAB 400MG (eslicarbazepine acetate)</i>	2	MO
<i>APTIOM TAB 600MG (eslicarbazepine acetate)</i>	2	MO
<i>APTIOM TAB 800MG (eslicarbazepine acetate)</i>	2	MO
<i>carbamazepine cap er 12hr 100 mg</i>	1	MO
<i>carbamazepine cap er 12hr 200 mg</i>	1	MO
<i>carbamazepine cap er 12hr 300 mg</i>	1	MO
<i>carbamazepine chew tab 100 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>carbamazepine susp 100 mg/5ml</i>	1	MO
<i>carbamazepine tab 200 mg</i>	1	MO
(Carbamazepine Tab 200 mg) EPITOL	1	MO
<i>carbamazepine tab er 12hr 100 mg</i>	1	MO
<i>carbamazepine tab er 12hr 200 mg</i>	1	MO
<i>carbamazepine tab er 12hr 400 mg</i>	1	MO
<i>gabapentin cap 100 mg</i>	1	MO
<i>gabapentin cap 300 mg</i>	1	MO
<i>gabapentin cap 400 mg</i>	1	MO
<i>gabapentin oral soln 250 mg/5ml</i>	1	MO
<i>gabapentin tab 600 mg</i>	1	MO
<i>gabapentin tab 800 mg</i>	1	MO
<i>lacosamide oral solution 10 mg/ml</i>	1	MO
<i>lacosamide tab 50 mg</i>	1	MO
<i>lacosamide tab 100 mg</i>	1	MO
<i>lacosamide tab 150 mg</i>	1	MO
<i>lacosamide tab 200 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 25 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 50 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 100 mg</i>	1	MO
<i>lamotrigine orally disintegrating tab 200 mg</i>	1	MO
<i>lamotrigine tab 25 mg</i>	1	MO
(Lamotrigine Tab 25 mg) SUBVENITE	1	MO
<i>lamotrigine tab 25 mg (42) & 100 mg (7) starter kit</i>	1	
(Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit) SUBVENITE STARTER KIT/ORA	1	
<i>lamotrigine tab 35 x 25 mg starter kit</i>	1	
(Lamotrigine Tab 35 X 25 mg Starter Kit) SUBVENITE STARTER KIT/BLU	1	
<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit</i>	1	
(Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit) SUBVENITE STARTER KIT/GRE	1	
<i>lamotrigine tab 100 mg</i>	1	MO
(Lamotrigine Tab 100 mg) SUBVENITE	1	MO
<i>lamotrigine tab 150 mg</i>	1	MO
(Lamotrigine Tab 150 mg) SUBVENITE	1	MO
<i>lamotrigine tab 200 mg</i>	1	MO
(Lamotrigine Tab 200 mg) SUBVENITE	1	MO
<i>lamotrigine tab chewable dispersible 5 mg</i>	1	MO
<i>lamotrigine tab chewable dispersible 25 mg</i>	1	MO
<i>lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit</i>	1	
<i>lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit</i>	1	
<i>lamotrigine tab er 24hr 25 mg</i>	1	MO
<i>lamotrigine tab er 24hr 50 mg</i>	1	MO
<i>lamotrigine tab er 24hr 100 mg</i>	1	MO
<i>lamotrigine tab er 24hr 200 mg</i>	1	MO
<i>lamotrigine tab er 24hr 250 mg</i>	1	MO
<i>lamotrigine tab er 24hr 300 mg</i>	1	MO
<i>levetiracetam oral soln 100 mg/ml</i>	1	MO
<i>levetiracetam tab 250 mg</i>	1	MO
<i>levetiracetam tab 500 mg</i>	1	MO
(Levetiracetam Tab 500 mg) ROWEPR	1	MO
<i>levetiracetam tab 750 mg</i>	1	MO
<i>levetiracetam tab 1000 mg</i>	1	MO
<i>levetiracetam tab er 24hr 500 mg</i>	1	MO
<i>levetiracetam tab er 24hr 750 mg</i>	1	MO
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i>	1	MO
<i>oxcarbazepine tab 150 mg</i>	1	MO
<i>oxcarbazepine tab 300 mg</i>	1	MO
<i>oxcarbazepine tab 600 mg</i>	1	MO
OXTELLAR XR TAB 150MG (<i>oxcarbazepine</i>)	2	MO
OXTELLAR XR TAB 300MG (<i>oxcarbazepine</i>)	2	MO
OXTELLAR XR TAB 600MG (<i>oxcarbazepine</i>)	2	MO
<i>pregabalin cap 25 mg</i>	1	MO
<i>pregabalin cap 50 mg</i>	1	MO
<i>pregabalin cap 75 mg</i>	1	MO
<i>pregabalin cap 100 mg</i>	1	MO
<i>pregabalin cap 150 mg</i>	1	MO
<i>pregabalin cap 200 mg</i>	1	MO
<i>pregabalin cap 225 mg</i>	1	MO
<i>pregabalin cap 300 mg</i>	1	MO
<i>pregabalin soln 20 mg/ml</i>	1	MO
<i>primidone tab 50 mg</i>	1	MO
<i>primidone tab 250 mg</i>	1	MO
<i>rufinamide susp 40 mg/ml</i>	1	MO
<i>rufinamide tab 200 mg</i>	1	MO
<i>rufinamide tab 400 mg</i>	1	MO
<i>topiramate cap er 24hr 25 mg</i>	1	MO
<i>topiramate cap er 24hr 50 mg</i>	1	MO
<i>topiramate cap er 24hr 100 mg</i>	1	MO
<i>topiramate cap er 24hr 200 mg</i>	1	MO
<i>topiramate sprinkle cap 15 mg</i>	1	MO
<i>topiramate sprinkle cap 25 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>topiramate tab 25 mg</i>	1	MO
<i>topiramate tab 50 mg</i>	1	MO
<i>topiramate tab 100 mg</i>	1	MO
<i>topiramate tab 200 mg</i>	1	MO
TROKENDI XR CAP 25MG (<i>topiramate</i>)	2	MO
TROKENDI XR CAP 50MG (<i>topiramate</i>)	2	MO
TROKENDI XR CAP 100MG (<i>topiramate</i>)	2	MO
TROKENDI XR CAP 200MG (<i>topiramate</i>)	2	MO
<i>zonisamide cap 25 mg</i>	1	MO
<i>zonisamide cap 50 mg</i>	1	MO
<i>zonisamide cap 100 mg</i>	1	MO
CARBAMATES		
<i>felbamate susp 600 mg/5ml</i>	1	MO
<i>felbamate tab 400 mg</i>	1	MO
<i>felbamate tab 600 mg</i>	1	MO
XCOPRI PAK 12.5-25 (<i>cenobamate</i>)	2	PA
XCOPRI PAK 50-100MG (<i>cenobamate</i>)	2	PA
XCOPRI PAK 100-150 (<i>cenobamate</i>)	2	PA, MO
XCOPRI PAK 150-200 (<i>cenobamate</i>)	2	PA
XCOPRI PAK 150-200 (<i>cenobamate</i>)	2	PA, MO
XCOPRI TAB 50MG (<i>cenobamate</i>)	2	PA, MO
XCOPRI TAB 100MG (<i>cenobamate</i>)	2	PA, MO
XCOPRI TAB 150MG (<i>cenobamate</i>)	2	PA, MO
XCOPRI TAB 200MG (<i>cenobamate</i>)	2	PA, MO
GABA MODULATORS		
<i>tiagabine hcl tab 2 mg</i>	1	MO
<i>tiagabine hcl tab 4 mg</i>	1	MO
<i>tiagabine hcl tab 12 mg</i>	1	MO
<i>tiagabine hcl tab 16 mg</i>	1	MO
<i>vigabatrin powd pack 500 mg</i>	1	SP, PA, QL (6 packets every 1 day)
(Vigabatrin Powd Pack 500 mg) VIGADRONE	1	SP, PA, QL (6 packets every 1 day)
<i>vigabatrin tab 500 mg</i>	1	SP, PA, QL (6 tabs every 1 day)
HYDANTOINS		
<i>phenytoin chew tab 50 mg</i>	1	MO
<i>phenytoin sodium extended cap 100 mg</i>	1	MO
<i>phenytoin sodium extended cap 200 mg</i>	1	MO
<i>phenytoin sodium extended cap 300 mg</i>	1	MO
<i>phenytoin susp 125 mg/5ml</i>	1	MO
SUCCINIMIDES		
<i>ethosuximide cap 250 mg</i>	1	MO
<i>ethosuximide soln 250 mg/5ml</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>methylsuximide cap 300 mg</i>	1	MO
VALPROIC ACID		
<i>divalproex sodium cap delayed release sprinkle 125 mg</i>	1	MO
<i>divalproex sodium tab delayed release 125 mg</i>	1	MO
<i>divalproex sodium tab delayed release 250 mg</i>	1	MO
<i>divalproex sodium tab delayed release 500 mg</i>	1	MO
<i>divalproex sodium tab er 24 hr 250 mg</i>	1	MO
<i>divalproex sodium tab er 24 hr 500 mg</i>	1	MO
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	1	MO
<i>valproic acid cap 250 mg</i>	1	MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
<i>mirtazapine orally disintegrating tab 15 mg</i>	1	MO
<i>mirtazapine orally disintegrating tab 30 mg</i>	1	MO
<i>mirtazapine orally disintegrating tab 45 mg</i>	1	MO
<i>mirtazapine tab 7.5 mg</i>	1	MO
<i>mirtazapine tab 15 mg</i>	1	MO
<i>mirtazapine tab 30 mg</i>	1	MO
<i>mirtazapine tab 45 mg</i>	1	MO
ANTIDEPRESSANTS - MISC.		
<i>bupropion hcl tab 75 mg</i>	1	MO
<i>bupropion hcl tab 100 mg</i>	1	MO
<i>bupropion hcl tab er 12hr 100 mg</i>	1	MO
<i>bupropion hcl tab er 12hr 150 mg</i>	1	MO
<i>bupropion hcl tab er 12hr 200 mg</i>	1	MO
<i>bupropion hcl tab er 24hr 150 mg</i>	1	MO
<i>bupropion hcl tab er 24hr 300 mg</i>	1	MO
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
<i>phenelzine sulfate tab 15 mg</i>	1	MO
<i>tranylcypromine sulfate tab 10 mg</i>	1	MO
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	1	MO
<i>citalopram hydrobromide tab 10 mg (base equiv)</i>	1	MO
<i>citalopram hydrobromide tab 20 mg (base equiv)</i>	1	MO
<i>citalopram hydrobromide tab 40 mg (base equiv)</i>	1	MO
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	1	MO
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	1	MO
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	1	MO
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	1	MO
<i>fluoxetine hcl cap 10 mg</i>	1	MO
<i>fluoxetine hcl cap 20 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>fluoxetine hcl cap 40 mg</i>	1	MO
<i>fluoxetine hcl cap delayed release 90 mg</i>	1	MO
<i>fluoxetine hcl solution 20 mg/5ml</i>	1	MO
<i>fluoxetine hcl tab 10 mg</i>	1	MO
<i>fluoxetine hcl tab 20 mg</i>	1	MO
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	1	MO
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	1	MO
<i>fluvoxamine maleate tab 25 mg</i>	1	MO
<i>fluvoxamine maleate tab 50 mg</i>	1	MO
<i>fluvoxamine maleate tab 100 mg</i>	1	MO
<i>paroxetine hcl oral susp 10 mg/5ml (base equiv)</i>	1	MO
<i>paroxetine hcl tab 10 mg</i>	1	MO
<i>paroxetine hcl tab 20 mg</i>	1	MO
<i>paroxetine hcl tab 30 mg</i>	1	MO
<i>paroxetine hcl tab 40 mg</i>	1	MO
<i>paroxetine hcl tab er 24hr 12.5 mg</i>	1	MO
<i>paroxetine hcl tab er 24hr 25 mg</i>	1	MO
<i>paroxetine hcl tab er 24hr 37.5 mg</i>	1	MO
<i>sertraline hcl oral concentrate for solution 20 mg/ml</i>	1	MO
<i>sertraline hcl tab 25 mg</i>	1	MO
<i>sertraline hcl tab 50 mg</i>	1	MO
<i>sertraline hcl tab 100 mg</i>	1	MO
SEROTONIN MODULATORS		
<i>nefazodone hcl tab 50 mg</i>	1	MO
<i>nefazodone hcl tab 100 mg</i>	1	MO
<i>nefazodone hcl tab 150 mg</i>	1	MO
<i>nefazodone hcl tab 200 mg</i>	1	MO
<i>nefazodone hcl tab 250 mg</i>	1	MO
<i>trazodone hcl tab 50 mg</i>	1	MO
<i>trazodone hcl tab 100 mg</i>	1	MO
<i>trazodone hcl tab 150 mg</i>	1	MO
<i>trazodone hcl tab 300 mg</i>	1	MO
<i>TRINTELLIX TAB 5MG (vortioxetine hbr)</i>	2	ST, MO; PA**
<i>TRINTELLIX TAB 10MG (vortioxetine hbr)</i>	2	ST, MO; PA**
<i>TRINTELLIX TAB 20MG (vortioxetine hbr)</i>	2	ST, MO; PA**
<i>vilazodone hcl tab 10 mg</i>	1	MO
<i>vilazodone hcl tab 20 mg</i>	1	MO
<i>vilazodone hcl tab 40 mg</i>	1	MO
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	1	MO
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 20 mg (base eq)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</i>	1	MO
<i>duloxetine hcl enteric coated pellets cap 60 mg (base eq)</i>	1	MO
<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	1	MO
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	1	MO
TRICYCLIC AGENTS		
<i>amitriptyline hcl tab 10 mg</i>	1	MO
<i>amitriptyline hcl tab 25 mg</i>	1	MO
<i>amitriptyline hcl tab 50 mg</i>	1	MO
<i>amitriptyline hcl tab 75 mg</i>	1	MO
<i>amitriptyline hcl tab 100 mg</i>	1	MO
<i>amitriptyline hcl tab 150 mg</i>	1	MO
<i>amoxapine tab 25 mg</i>	1	MO
<i>amoxapine tab 50 mg</i>	1	MO
<i>amoxapine tab 100 mg</i>	1	MO
<i>amoxapine tab 150 mg</i>	1	MO
<i>clomipramine hcl cap 25 mg</i>	1	MO
<i>clomipramine hcl cap 50 mg</i>	1	MO
<i>clomipramine hcl cap 75 mg</i>	1	MO
<i>desipramine hcl tab 10 mg</i>	1	MO
<i>desipramine hcl tab 25 mg</i>	1	MO
<i>desipramine hcl tab 50 mg</i>	1	MO
<i>desipramine hcl tab 75 mg</i>	1	MO
<i>desipramine hcl tab 100 mg</i>	1	MO
<i>desipramine hcl tab 150 mg</i>	1	MO
<i>doxepin hcl cap 10 mg</i>	1	MO
<i>doxepin hcl cap 25 mg</i>	1	MO
<i>doxepin hcl cap 50 mg</i>	1	MO
<i>doxepin hcl cap 75 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>doxepin hcl cap 100 mg</i>	1	MO
<i>doxepin hcl cap 150 mg</i>	1	MO
<i>doxepin hcl conc 10 mg/ml</i>	1	MO
<i>imipramine hcl tab 10 mg</i>	1	MO
<i>imipramine hcl tab 25 mg</i>	1	MO
<i>imipramine hcl tab 50 mg</i>	1	MO
<i>imipramine pamoate cap 75 mg</i>	1	MO
<i>imipramine pamoate cap 100 mg</i>	1	MO
<i>imipramine pamoate cap 125 mg</i>	1	MO
<i>imipramine pamoate cap 150 mg</i>	1	MO
<i>nortriptyline hcl cap 10 mg</i>	1	MO
<i>nortriptyline hcl cap 25 mg</i>	1	MO
<i>nortriptyline hcl cap 50 mg</i>	1	MO
<i>nortriptyline hcl cap 75 mg</i>	1	MO
<i>nortriptyline hcl soln 10 mg/5ml</i>	1	MO
<i>protriptyline hcl tab 5 mg</i>	1	MO
<i>protriptyline hcl tab 10 mg</i>	1	MO
<i>trimipramine maleate cap 25 mg</i>	1	MO
<i>trimipramine maleate cap 50 mg</i>	1	MO
<i>trimipramine maleate cap 100 mg</i>	1	MO

ANTIDIABETICS - DRUGS TO TREAT DIABETES

ALPHA-GLUCOSIDASE INHIBITORS

<i>acarbose tab 25 mg</i>	1	MO
<i>acarbose tab 50 mg</i>	1	MO
<i>acarbose tab 100 mg</i>	1	MO
<i>miglitol tab 25 mg</i>	1	MO
<i>miglitol tab 50 mg</i>	1	MO
<i>miglitol tab 100 mg</i>	1	MO

ANTIDIABETIC - AMYLIN ANALOGS

<i>SYMLINPEN 60 INJ 1000MCG (pramlintide acetate)</i>	2	MO
<i>SYMLNPEN 120 INJ 1000MCG (pramlintide acetate)</i>	2	MO

ANTIDIABETIC COMBINATIONS

<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	MO
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	MO
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	MO
<i>glyburide-metformin tab 1.25-250 mg</i>	1	MO
<i>glyburide-metformin tab 2.5-500 mg</i>	1	MO
<i>glyburide-metformin tab 5-500 mg</i>	1	MO
<i>GLYXAMBI TAB 10-5 MG (empagliflozin-linagliptin)</i>	2	MO
<i>GLYXAMBI TAB 25-5 MG (empagliflozin-linagliptin)</i>	2	MO
<i>JANUMET TAB 50-500MG (sitagliptin-metformin hcl)</i>	2	MO
<i>JANUMET TAB 50-1000 (sitagliptin-metformin hcl)</i>	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
JANUMET XR TAB 50-500MG (<i>sitagliptin-metformin hcl</i>)	2	MO
JANUMET XR TAB 50-1000 (<i>sitagliptin-metformin hcl</i>)	2	MO
JANUMET XR TAB 100-1000 (<i>sitagliptin-metformin hcl</i>)	2	MO
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>	1	MO
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	1	MO
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	1	MO
<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	1	MO
<i>saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg</i>	1	MO
<i>saxagliptin-metformin hcl tab er 24hr 5-500 mg</i>	1	MO
<i>saxagliptin-metformin hcl tab er 24hr 5-1000 mg</i>	1	MO
SOLIQUA INJ 100/33 (<i>insulin glargine-lixisenatide</i>)	2	PA, MO
SYNJARDY TAB (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY TAB 5-500MG (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY TAB 5-1000MG (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY TAB 12.5-500 (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB 5-1000MG (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB 10-1000 (<i>empagliflozin-metformin hcl</i>)	2	MO
SYNJARDY XR TAB 25-1000 (<i>empagliflozin-metformin hcl</i>)	2	MO
TRIJARDY XR TAB (<i>empagliflozin-linagliptin-metformin</i>)	2	MO
XIGDUO XR TAB 2.5-1000 (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 5-500MG (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 5-1000MG (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 10-500MG (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XIGDUO XR TAB 10-1000 (<i>dapagliflozin propanediol-metformin hcl</i>)	2	MO
XULTOPHY INJ 100/3.6 (<i>insulin degludec-liraglutide</i>)	2	PA, MO
BIGUANIDES		
<i>metformin hcl oral soln 500 mg/5ml</i>	1	MO
<i>metformin hcl tab 500 mg</i>	1	MO
<i>metformin hcl tab 850 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>metformin hcl tab 1000 mg</i>	1	MO
<i>metformin hcl tab er 24hr 500 mg</i>	1	MO
<i>metformin hcl tab er 24hr 750 mg</i>	1	MO
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE (<i>glucagon</i>)	2	
BAQSIMI TWO POW 3MG/DOSE (<i>glucagon</i>)	2	
<i>diazoxide susp 50 mg/ml</i>	1	MO
<i>glucagon (rdna) for inj kit 1 mg</i>	1	
GVOKE HYPO 1 INJ 1MG/.2ML (<i>glucagon</i>)	2	
GVOKE HYPO 1 INJ .5/.1ML (<i>glucagon</i>)	2	
GVOKE HYPO 2 INJ 1MG/.2ML (<i>glucagon</i>)	2	
GVOKE HYPO 2 INJ .5/.1ML (<i>glucagon</i>)	2	
GVOKE KIT SOL 1MG/0.2M (<i>glucagon</i>)	2	
GVOKE PFS INJ (<i>glucagon</i>)	2	
ZEGALOGUE INJ 0.6/0.6 (<i>dasiglucagon hcl</i>)	2	
Dipeptidyl Peptidase-4 (DPP-4) Inhibitors		
JANUVIA TAB 25MG (<i>sitagliptin phosphate</i>)	2	MO
JANUVIA TAB 50MG (<i>sitagliptin phosphate</i>)	2	MO
JANUVIA TAB 100MG (<i>sitagliptin phosphate</i>)	2	MO
<i>saxagliptin hcl tab 2.5 mg (base equiv)</i>	1	MO
<i>saxagliptin hcl tab 5 mg (base equiv)</i>	1	MO
INCRETIN MIMETIC AGENTS		
MOUNJARO INJ 2.5/0.5 (<i>tirzepatide</i>)	2	PA
MOUNJARO INJ 5MG/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 7.5/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 10MG/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 12.5/0.5 (<i>tirzepatide</i>)	2	PA, MO
MOUNJARO INJ 15MG/0.5 (<i>tirzepatide</i>)	2	PA, MO
OZEMPIC INJ 2MG/3ML (<i>semaglutide</i>)	2	PA, MO
OZEMPIC INJ 4MG/3ML (<i>semaglutide</i>)	2	PA, MO
OZEMPIC INJ 8MG/3ML (<i>semaglutide</i>)	2	PA, MO
RYBELSUS TAB 3MG (<i>semaglutide</i>)	2	PA, MO
RYBELSUS TAB 7MG (<i>semaglutide</i>)	2	PA, MO
RYBELSUS TAB 14MG (<i>semaglutide</i>)	2	PA, MO
TRULICITY INJ 0.75/0.5 (<i>dulaglutide</i>)	2	PA, MO
TRULICITY INJ 1.5/0.5 (<i>dulaglutide</i>)	2	PA, MO
TRULICITY INJ 3/0.5 (<i>dulaglutide</i>)	2	PA, MO
TRULICITY INJ 4.5/0.5 (<i>dulaglutide</i>)	2	PA, MO
VICTOZA INJ 18MG/3ML (<i>liraglutide</i>)	2	PA, MO
INSULIN		
BASAGLAR INJ 100UNIT (<i>insulin glargine</i>)	2	MO
FIASP FLEX INJ TOUCH (<i>insulin aspart (with niacinamide)</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FIASP INJ 100/ML (<i>insulin aspart (with niacinamide)</i>)	2	MO
FIASP PENFIL INJ U-100 (<i>insulin aspart (with niacinamide)</i>)	2	MO
HUMULIN R INJ U-500 (<i>insulin regular (human)</i>)	2	MO
LEVEMIR INJ (<i>insulin detemir</i>)	2	MO
LEVEMIR INJ FLEXPEN (<i>insulin detemir</i>)	2	MO
NOVOLIN INJ 70/30 (<i>insulin nph isophane & reg (human)</i>)	2	MO; RELION not covered
NOVOLIN INJ 70/30 FP (<i>insulin nph isophane & reg (human)</i>)	2	MO; RELION not covered
NOVOLIN N INJ 100 UNIT (<i>insulin nph (human) (isophane)</i>)	2	MO; RELION not covered
NOVOLIN N INJ U-100 (<i>insulin nph (human) (isophane)</i>)	2	MO; RELION not covered
NOVOLIN R INJ 100 UNIT (<i>insulin regular (human)</i>)	2	MO; RELION not covered
NOVOLIN R INJ U-100 (<i>insulin regular (human)</i>)	2	MO; RELION not covered
NOVOLOG INJ 100/ML (<i>insulin aspart</i>)	2	MO; RELION not covered
NOVOLOG INJ FLEXPEN (<i>insulin aspart</i>)	2	MO; RELION not covered
NOVOLOG INJ PENFILL (<i>insulin aspart</i>)	2	MO; RELION not covered
NOVOLOG MIX INJ 70/30 (<i>insulin aspart protamine & aspart (human)</i>)	2	MO; RELION not covered
NOVOLOG MIX INJ FLEXPEN (<i>insulin aspart protamine & aspart (human)</i>)	2	MO; RELION not covered
TOUJEO MAX INJ 300IU/ML (<i>insulin glargine</i>)	2	MO
TOUJEO SOLO INJ 300IU/ML (<i>insulin glargine</i>)	2	MO
TRESIBA FLEX INJ 100UNIT (<i>insulin degludec</i>)	2	MO
TRESIBA FLEX INJ 200UNIT (<i>insulin degludec</i>)	2	MO
TRESIBA INJ 100UNIT (<i>insulin degludec</i>)	2	MO
INSULIN SENSITIZING AGENTS		
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	1	MO
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	1	MO
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	MO
MEGLITINIDE ANALOGUES		
<i>nateglinide tab 60 mg</i>	1	MO
<i>nateglinide tab 120 mg</i>	1	MO
<i>repaglinide tab 0.5 mg</i>	1	MO
<i>repaglinide tab 1 mg</i>	1	MO
<i>repaglinide tab 2 mg</i>	1	MO
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
<i>FARXIGA TAB 5MG (dapagliflozin propanediol)</i>	2	MO
<i>FARXIGA TAB 10MG (dapagliflozin propanediol)</i>	2	MO
<i>JARDIANCE TAB 10MG (empagliflozin)</i>	2	MO
<i>JARDIANCE TAB 25MG (empagliflozin)</i>	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SULFONYLUREAS		
<i>glimepiride tab 1 mg</i>	1	MO
<i>glimepiride tab 2 mg</i>	1	MO
<i>glimepiride tab 4 mg</i>	1	MO
<i>glipizide tab 5 mg</i>	1	MO
<i>glipizide tab 10 mg</i>	1	MO
<i>glipizide tab er 24hr 2.5 mg</i>	1	MO
(Glipizide Tab Er 24hr 2.5 mg) GLIPIZIDE XL	1	MO
<i>glipizide tab er 24hr 5 mg</i>	1	MO
(Glipizide Tab Er 24hr 5 mg) GLIPIZIDE XL	1	MO
<i>glipizide tab er 24hr 10 mg</i>	1	MO
(Glipizide Tab Er 24hr 10 mg) GLIPIZIDE XL	1	MO
<i>glyburide micronized tab 1.5 mg</i>	1	MO
<i>glyburide micronized tab 3 mg</i>	1	MO
<i>glyburide micronized tab 6 mg</i>	1	MO
<i>glyburide tab 1.25 mg</i>	1	MO
<i>glyburide tab 2.5 mg</i>	1	MO
<i>glyburide tab 5 mg</i>	1	MO
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA		
ANTIPERISTALTIC AGENTS		
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
<i>loperamide hcl cap 2 mg</i>	1	
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
ANTIDOTES - CHELATING AGENTS		
<i>deferasirox granules packet 90 mg</i>	1	SP, PA
<i>deferasirox granules packet 180 mg</i>	1	SP, PA
<i>deferasirox granules packet 360 mg</i>	1	SP, PA
<i>deferasirox tab 90 mg</i>	1	SP, PA
<i>deferasirox tab 180 mg</i>	1	SP, PA
<i>deferasirox tab 360 mg</i>	1	SP, PA
<i>deferasirox tab for oral susp 125 mg</i>	1	SP, PA
<i>deferasirox tab for oral susp 250 mg</i>	1	SP, PA
<i>deferasirox tab for oral susp 500 mg</i>	1	SP, PA
<i>deferiprone tab 500 mg</i>	1	SP, PA
<i>deferiprone tab 1000 mg</i>	1	SP, PA
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
<i>VISTOGARD PAK 10GM (uridine triacetate (emergency treatment))</i>	2	QL (20 packets every 5 days)
OPIOID ANTAGONISTS		
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	1	QL (4 sprays every 25 days)
<i>naltrexone hcl tab 50 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
5-HT3 RECEPTOR ANTAGONISTS		
<i>granisetron hcl tab 1 mg</i>	1	QL (12 tabs every 21 days)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	1	QL (200 mL every 21 days)
<i>ondansetron hcl tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 24 mg</i>	1	QL (2 tabs every 21 days)
<i>ondansetron orally disintegrating tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron orally disintegrating tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>SANCUSO DIS 3.1MG (granisetron)</i>	2	QL (2 patches every 21 days)
ANTIEMETICS - ANTICHOLINERGIC		
<i>meclizine hcl tab 12.5 mg</i>	1	
<i>meclizine hcl tab 25 mg</i>	1	
<i>meclizine hcl tab 50 mg</i>	1	
<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
<i>trimethobenzamide hcl cap 300 mg</i>	1	
ANTIEMETICS - MISCELLANEOUS		
<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i>	1	
<i>dronabinol cap 2.5 mg</i>	1	QL (60 caps every 25 days)
<i>dronabinol cap 5 mg</i>	1	QL (60 caps every 25 days)
<i>dronabinol cap 10 mg</i>	1	QL (60 caps every 25 days)
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
<i>aprepitant capsule 40 mg</i>	1	QL (3 caps every 180 days)
<i>aprepitant capsule 80 mg</i>	1	QL (4 caps every 21 days)
<i>aprepitant capsule 125 mg</i>	1	QL (2 caps every 21 days)
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	1	QL (6 caps every 21 days)
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
<i>flucytosine cap 250 mg</i>	1	
<i>griseofulvin microsize susp 125 mg/5ml</i>	1	
<i>griseofulvin microsize tab 500 mg</i>	1	
<i>griseofulvin ultramicrosize tab 125 mg</i>	1	
<i>griseofulvin ultramicrosize tab 250 mg</i>	1	
<i>nystatin tab 500000 unit</i>	1	
<i>terbinafine hcl tab 250 mg</i>	1	PA
IMIDAZOLE-RELATED ANTIFUNGALS		
<i>fluconazole for susp 10 mg/ml</i>	1	
<i>fluconazole for susp 40 mg/ml</i>	1	
<i>fluconazole tab 50 mg</i>	1	
<i>fluconazole tab 100 mg</i>	1	
<i>fluconazole tab 150 mg</i>	1	
<i>fluconazole tab 200 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>itraconazole cap 100 mg</i>	1	PA
<i>itraconazole oral soln 10 mg/ml</i>	1	PA
<i>ketoconazole tab 200 mg</i>	1	
<i>posaconazole susp 40 mg/ml</i>	1	MO
<i>voriconazole for susp 40 mg/ml</i>	1	
<i>voriconazole tab 50 mg</i>	1	
<i>voriconazole tab 200 mg</i>	1	

ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES

ANTIHISTAMINES - ETHANOLAMINES

<i>carbinoxamine maleate soln 4 mg/5ml</i>	1
<i>carbinoxamine maleate tab 4 mg</i>	1
<i>clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)</i>	1
<i>clemastine fumarate tab 2.68 mg</i>	1

ANTIHISTAMINES - NON-SEDATING

<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>	1
<i>desloratadine tab 5 mg</i>	1
<i>desloratadine tab orally disintegrating 2.5 mg</i>	1
<i>desloratadine tab orally disintegrating 5 mg</i>	1
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	1
<i>levocetirizine dihydrochloride tab 5 mg</i>	1
<i>loratadine tab 10 mg</i>	1

ANTIHISTAMINES - PHENOTHIAZINES

<i>promethazine hcl suppos 12.5 mg</i>	1
(Promethazine Hcl Suppos 12.5 mg) PROMETHEGAN	1
<i>promethazine hcl suppos 25 mg</i>	1
(Promethazine Hcl Suppos 25 mg) PROMETHEGAN	1
(Promethazine Hcl Suppos 50 mg) PROMETHEGAN	1
<i>promethazine hcl syrup 6.25 mg/5ml</i>	1
<i>promethazine hcl tab 12.5 mg</i>	1
<i>promethazine hcl tab 25 mg</i>	1
<i>promethazine hcl tab 50 mg</i>	1

ANTIHISTAMINES - PIPERIDINES

<i>ciproheptadine hcl syrup 2 mg/5ml</i>	1
<i>ciproheptadine hcl tab 4 mg</i>	1

ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL

ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS

NEXLETOL TAB 180MG (<i>bempedoic acid</i>)	2	MO
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ANTIHYPERLIPIDEMICS - COMBINATIONS

<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	MO
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	MO
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	MO
NEXLIZET TAB 180/10MG (<i>bempedoic acid-ezetimibe</i>)	2	MO
ANTIHYPERLIPIDEMICS - MISC.		
<i>omega-3-acid ethyl esters cap 1 gm</i>	1	MO
VASCEPA CAP 0.5GM (<i>icosapent ethyl</i>)	1	MO
VASCEPA CAP 1GM (<i>icosapent ethyl</i>)	1	MO
BILE ACID SEQUESTRANTS		
<i>cholestyramine light powder 4 gm/dose</i>	1	MO
(Cholestyramine Light Powder 4 gm/dose) PREVALITE	1	MO
<i>cholestyramine light powder packets 4 gm</i>	1	MO
(Cholestyramine Light Powder Packets 4 gm)	1	MO
PREVALITE		
<i>cholestyramine powder 4 gm/dose</i>	1	MO
<i>cholestyramine powder packets 4 gm</i>	1	MO
<i>colesevelam hcl packet for susp 3.75 gm</i>	1	MO
<i>colesevelam hcl tab 625 mg</i>	1	MO
<i>colestipol hcl granule packets 5 gm</i>	1	MO
<i>colestipol hcl granules 5 gm</i>	1	MO
<i>colestipol hcl tab 1 gm</i>	1	MO
FIBRIC ACID DERIVATIVES		
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	1	MO
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	1	MO
<i>fenofibrate cap 150 mg</i>	1	MO
<i>fenofibrate micronized cap 43 mg</i>	1	MO
<i>fenofibrate micronized cap 67 mg</i>	1	MO
<i>fenofibrate micronized cap 134 mg</i>	1	MO
<i>fenofibrate micronized cap 200 mg</i>	1	MO
<i>fenofibrate tab 48 mg</i>	1	MO
<i>fenofibrate tab 54 mg</i>	1	MO
<i>fenofibrate tab 145 mg</i>	1	MO
<i>fenofibrate tab 160 mg</i>	1	MO
<i>fenofibric acid tab 35 mg</i>	1	MO
<i>fenofibric acid tab 105 mg</i>	1	MO
<i>gemfibrozil tab 600 mg</i>	1	MO
HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	1	MO
<i>fluvastatin sodium cap 20 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>fluvastatin sodium cap 40 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>fluvastatin sodium tab er 24 hr 80 mg (base equivalent)</i>	1	MO; \$0 copay for members age 40 through 75
<i>lovastatin tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>lovastatin tab 20 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>lovastatin tab 40 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pitavastatin calcium tab 1 mg</i>	1	MO
<i>pitavastatin calcium tab 2 mg</i>	1	MO
<i>pitavastatin calcium tab 4 mg</i>	1	MO
<i>pravastatin sodium tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 20 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 40 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pravastatin sodium tab 80 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 5 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 20 mg</i>	1	MO
<i>rosuvastatin calcium tab 40 mg</i>	1	MO
<i>simvastatin tab 5 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 10 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 20 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 40 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>simvastatin tab 80 mg</i>	1	MO
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
<i>ezetimibe tab 10 mg</i>	1	MO
NICOTINIC ACID DERIVATIVES		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	1	MO
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	1	MO
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE		
ACE INHIBITORS		
<i>benazepril hcl tab 5 mg</i>	1	MO
<i>benazepril hcl tab 10 mg</i>	1	MO
<i>benazepril hcl tab 20 mg</i>	1	MO
<i>benazepril hcl tab 40 mg</i>	1	MO
<i>captopril tab 12.5 mg</i>	1	MO
<i>captopril tab 25 mg</i>	1	MO
<i>captopril tab 50 mg</i>	1	MO
<i>captopril tab 100 mg</i>	1	MO
<i>enalapril maleate oral soln 1 mg/ml</i>	1	MO
<i>enalapril maleate tab 2.5 mg</i>	1	MO
<i>enalapril maleate tab 5 mg</i>	1	MO
<i>enalapril maleate tab 10 mg</i>	1	MO
<i>enalapril maleate tab 20 mg</i>	1	MO
<i>fosinopril sodium tab 10 mg</i>	1	MO
<i>fosinopril sodium tab 20 mg</i>	1	MO
<i>fosinopril sodium tab 40 mg</i>	1	MO
<i>lisinopril tab 2.5 mg</i>	1	MO
<i>lisinopril tab 5 mg</i>	1	MO
<i>lisinopril tab 10 mg</i>	1	MO
<i>lisinopril tab 20 mg</i>	1	MO
<i>lisinopril tab 30 mg</i>	1	MO
<i>lisinopril tab 40 mg</i>	1	MO
<i>moexipril hcl tab 7.5 mg</i>	1	MO
<i>moexipril hcl tab 15 mg</i>	1	MO
<i>perindopril erbumine tab 2 mg</i>	1	MO
<i>perindopril erbumine tab 4 mg</i>	1	MO
<i>perindopril erbumine tab 8 mg</i>	1	MO
<i>quinapril hcl tab 5 mg</i>	1	MO
<i>quinapril hcl tab 10 mg</i>	1	MO
<i>quinapril hcl tab 20 mg</i>	1	MO
<i>quinapril hcl tab 40 mg</i>	1	MO
<i>ramipril cap 1.25 mg</i>	1	MO
<i>ramipril cap 2.5 mg</i>	1	MO
<i>ramipril cap 5 mg</i>	1	MO
<i>ramipril cap 10 mg</i>	1	MO
<i>trandolapril tab 1 mg</i>	1	MO
<i>trandolapril tab 2 mg</i>	1	MO
<i>trandolapril tab 4 mg</i>	1	MO
AGENTS FOR PHEOCHROMOCYTOMA		
<i>metyrosine cap 250 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil tab 4 mg</i>	1	MO
<i>candesartan cilexetil tab 8 mg</i>	1	MO
<i>candesartan cilexetil tab 16 mg</i>	1	MO
<i>candesartan cilexetil tab 32 mg</i>	1	MO
<i>irbesartan tab 75 mg</i>	1	MO
<i>irbesartan tab 150 mg</i>	1	MO
<i>irbesartan tab 300 mg</i>	1	MO
<i>losartan potassium tab 25 mg</i>	1	MO
<i>losartan potassium tab 50 mg</i>	1	MO
<i>losartan potassium tab 100 mg</i>	1	MO
<i>olmesartan medoxomil tab 5 mg</i>	1	MO
<i>olmesartan medoxomil tab 20 mg</i>	1	MO
<i>olmesartan medoxomil tab 40 mg</i>	1	MO
<i>telmisartan tab 20 mg</i>	1	MO
<i>telmisartan tab 40 mg</i>	1	MO
<i>telmisartan tab 80 mg</i>	1	MO
<i>valsartan tab 40 mg</i>	1	MO
<i>valsartan tab 80 mg</i>	1	MO
<i>valsartan tab 160 mg</i>	1	MO
<i>valsartan tab 320 mg</i>	1	MO
ANTIADRENERGIC ANTIHYPERTENSIVES		
<i>clonidine hcl tab 0.1 mg</i>	1	MO
<i>clonidine hcl tab 0.2 mg</i>	1	MO
<i>clonidine hcl tab 0.3 mg</i>	1	MO
<i>clonidine hcl tab er 24hr 0.17 mg (base equivalent)</i>	1	MO
<i>clonidine td patch weekly 0.1 mg/24hr</i>	1	MO
<i>clonidine td patch weekly 0.2 mg/24hr</i>	1	MO
<i>clonidine td patch weekly 0.3 mg/24hr</i>	1	MO
<i>doxazosin mesylate tab 1 mg</i>	1	MO
<i>doxazosin mesylate tab 2 mg</i>	1	MO
<i>doxazosin mesylate tab 4 mg</i>	1	MO
<i>doxazosin mesylate tab 8 mg</i>	1	MO
<i>guanfacine hcl tab 1 mg</i>	1	MO
<i>guanfacine hcl tab 2 mg</i>	1	MO
<i>prazosin hcl cap 1 mg</i>	1	MO
<i>prazosin hcl cap 2 mg</i>	1	MO
<i>prazosin hcl cap 5 mg</i>	1	MO
<i>terazosin hcl cap 1 mg (base equivalent)</i>	1	MO
<i>terazosin hcl cap 2 mg (base equivalent)</i>	1	MO
<i>terazosin hcl cap 5 mg (base equivalent)</i>	1	MO
<i>terazosin hcl cap 10 mg (base equivalent)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIHYPERTENSIVE COMBINATIONS		
ACCURETIC TAB 10-12.5 (<i>quinapril-hydrochlorothiazide</i>)	3	MO
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	MO
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	MO
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	MO
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i>	1	MO
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	1	MO
<i>atenolol & chlorthalidone tab 50-25 mg</i>	1	MO
<i>atenolol & chlorthalidone tab 100-25 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 5-6.25 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	1	MO
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	1	MO
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	1	MO
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	1	MO
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	1	MO
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	1	MO
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	1	MO
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	MO
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	MO
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	MO
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	MO
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	MO
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	MO
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	MO
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	MO
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	1	MO
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	1	MO
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	1	MO
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	MO
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	MO
<i>olmesartanamlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	MO
<i>olmesartanamlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	MO
<i>olmesartanamlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	MO
<i>olmesartanamlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	MO
<i>olmesartanamlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	MO
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	1	MO
<i>telmisartan-amlodipine tab 40-5 mg</i>	1	MO
<i>telmisartan-amlodipine tab 40-10 mg</i>	1	MO
<i>telmisartan-amlodipine tab 80-5 mg</i>	1	MO
<i>telmisartan-amlodipine tab 80-10 mg</i>	1	MO
<i>telmisartan-hydrochlorothiazide tab 40-12.5 mg</i>	1	MO
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	MO
<i>telmisartan-hydrochlorothiazide tab 80-25 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	1	MO
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	MO
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	MO
DIRECT RENIN INHIBITORS		
<i>aliskiren fumarate tab 150 mg (base equivalent)</i>	1	MO
<i>aliskiren fumarate tab 300 mg (base equivalent)</i>	1	MO
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
<i>eplerenone tab 25 mg</i>	1	MO
<i>eplerenone tab 50 mg</i>	1	MO
VASODILATORS		
<i>hydralazine hcl tab 10 mg</i>	1	MO
<i>hydralazine hcl tab 25 mg</i>	1	MO
<i>hydralazine hcl tab 50 mg</i>	1	MO
<i>hydralazine hcl tab 100 mg</i>	1	MO
<i>minoxidil tab 2.5 mg</i>	1	MO
<i>minoxidil tab 10 mg</i>	1	MO
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
ANTIMALARIAL COMBINATIONS		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
<i>COARTEM TAB 20-120MG (artemether-lumefantrine)</i>	3	
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
<i>chloroquine phosphate tab 250 mg</i>	1	MO
<i>chloroquine phosphate tab 500 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	MO
<i>mefloquine hcl tab 250 mg</i>	1	MO
<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	1	
<i>pyrimethamine tab 25 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>quinine sulfate cap 324 mg</i>	1	
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
GUANIDINE TAB 125MG	3	PA
<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	1	
<i>pyridostigmine bromide tab 60 mg</i>	1	
<i>pyridostigmine bromide tab er 180 mg</i>	1	
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
ANTI TB COMBINATIONS		
RIFATER TAB (<i>isoniazid-rifampin w/ pyrazinamide</i>)	3	
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
<i>cycloserine cap 250 mg</i>	1	
<i>ethambutol hcl tab 100 mg</i>	1	
<i>ethambutol hcl tab 400 mg</i>	1	
<i>isoniazid syrup 50 mg/5ml</i>	1	MO
<i>isoniazid tab 100 mg</i>	1	MO
<i>isoniazid tab 300 mg</i>	1	MO
PASER GRA 4GM (<i>aminosalicylic acid</i>)	3	
<i>pyrazinamide tab 500 mg</i>	1	
<i>rifabutin cap 150 mg</i>	1	
<i>rifampin cap 150 mg</i>	1	
<i>rifampin cap 300 mg</i>	1	
SIRTURO TAB 20MG (<i>bedaquiline fumarate</i>)	3	
SIRTURO TAB 100MG (<i>bedaquiline fumarate</i>)	3	
TRECATOR TAB 250MG (<i>ethionamide</i>)	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
<i>cyclophosphamide cap 25 mg</i>	1	OAC
<i>cyclophosphamide cap 50 mg</i>	1	OAC
GLEOSTINE CAP 10MG (<i>lomustine</i>)	3	SP; OAC
GLEOSTINE CAP 40MG (<i>lomustine</i>)	3	SP; OAC
GLEOSTINE CAP 100MG (<i>lomustine</i>)	3	SP; OAC
LEUKERAN TAB 2MG (<i>chlorambucil</i>)	2	OAC
<i>melphalan tab 2 mg</i>	1	OAC
MYLERAN TAB 2MG (<i>busulfan</i>)	2	OAC
<i>temozolomide cap 5 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 20 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 100 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 140 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 180 mg</i>	1	SP, PA; OAC
<i>temozolomide cap 250 mg</i>	1	SP, PA; OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIMETABOLITES		
<i>capecitabine tab 150 mg</i>	1	SP, PA; OAC
<i>capecitabine tab 500 mg</i>	1	SP, PA; OAC
<i>mercaptopurine tab 50 mg</i>	1	OAC
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	1	OAC
TABLOID TAB 40MG (<i>thioguanine</i>)	2	OAC
TREXALL TAB 5MG (<i>methotrexate sodium</i>)	2	OAC
TREXALL TAB 7.5MG (<i>methotrexate sodium</i>)	2	OAC
TREXALL TAB 10MG (<i>methotrexate sodium</i>)	2	OAC
TREXALL TAB 15MG (<i>methotrexate sodium</i>)	2	OAC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG (<i>axitinib</i>)	2	SP, PA, QL (8 tabs every 1 day); OAC
INLYTA TAB 5MG (<i>axitinib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
LENVIMA CAP 4MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 8 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 10 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 12MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 14 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 18 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 20 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 24 MG (<i>lenvatinib mesylate</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
ANTINEOPLASTIC - EGFR INHIBITORS		
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
<i>erlotinib hcl tab 100 mg (base equivalent)</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>erlotinib hcl tab 150 mg (base equivalent)</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>gefitinib tab 250 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
IRESSA TAB 250MG (<i>gefitinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
TAGRISSO TAB 40MG (<i>osimertinib mesylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TAGRISSO TAB 80MG (<i>osimertinib mesylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP 150MG (<i>vismodegib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
ODOMZO CAP 200MG (<i>sonidegib phosphate</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
<i>abiraterone acetate tab 250 mg</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
<i>abiraterone acetate tab 500 mg</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
<i>anastrozole tab 1 mg</i>	PV	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>bicalutamide tab 50 mg</i>	1	OAC
EMCYT CAP 140MG (<i>estramustine phosphate sodium</i>)	2	OAC
ERLEADA TAB 60MG (<i>apalutamide</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
ERLEADA TAB 240MG (<i>apalutamide</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
<i>exemestane tab 25 mg</i>	PV	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>letrozole tab 2.5 mg</i>	1	MO; OAC
LYSODREN TAB 500MG (<i>mitotane</i>)	2	OAC
<i>megestrol acetate susp 40 mg/ml</i>	1	OAC
<i>megestrol acetate tab 20 mg</i>	1	OAC
<i>megestrol acetate tab 40 mg</i>	1	OAC
<i>nilutamide tab 150 mg</i>	1	OAC
NUBEQA TAB 300MG (<i>darolutamide</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
<i>tamoxifen citrate tab 10 mg (base equivalent)</i>	1	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>tamoxifen citrate tab 20 mg (base equivalent)</i>	1	MO; OAC, \$0 copay ages 35 and older for the primary prevention of breast cancer
<i>toremifene citrate tab 60 mg (base equivalent)</i>	1	MO; OAC
XTANDI CAP 40MG (<i>enzalutamide</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
XTANDI TAB 40MG (<i>enzalutamide</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XTANDI TAB 80MG (<i>enzalutamide</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
YONSA TAB 125MG (<i>abiraterone acetate micronized</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP 1MG (<i>pomalidomide</i>)	3	SP, PA; OAC
POMALYST CAP 2MG (<i>pomalidomide</i>)	3	SP, PA; OAC
POMALYST CAP 3MG (<i>pomalidomide</i>)	3	SP, PA; OAC
POMALYST CAP 4MG (<i>pomalidomide</i>)	3	SP, PA; OAC
ANTINEOPLASTIC COMBINATIONS		
KISQALI 200 PAK FEMARA (<i>ribociclib succinate-letrazole</i>)	2	SP, PA, QL (49 packs every 28 days); OAC
KISQALI 400 PAK FEMARA (<i>ribociclib succinate-letrazole</i>)	2	SP, PA, QL (70 packs every 28 days); OAC
KISQALI 600 PAK FEMARA (<i>ribociclib succinate-letrazole</i>)	2	SP, PA, QL (91 packs every 28 days); OAC
LONSURF TAB 15-6.14 (<i>trifluridine-tipiracil</i>)	2	SP, PA, QL (100 tabs every 28 days); OAC
LONSURF TAB 20-8.19 (<i>trifluridine-tipiracil</i>)	2	SP, PA, QL (80 tabs every 28 days); OAC
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP 150MG (<i>alectinib hcl</i>)	2	SP, PA, QL (8 caps every 1 day); OAC
ALUNBRIG PAK (<i>brigatinib</i>)	2	PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 30MG (<i>brigatinib</i>)	2	PA, QL (4 tabs every 1 day); OAC
ALUNBRIG TAB 90MG (<i>brigatinib</i>)	2	PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 180MG (<i>brigatinib</i>)	2	PA, QL (1 tab every 1 day); OAC
BOSULIF TAB 100MG (<i>bosutinib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
BOSULIF TAB 400MG (<i>bosutinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
BOSULIF TAB 500MG (<i>bosutinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
BRAFTOVI CAP 75MG (<i>encorafenib</i>)	2	SP, PA, QL (6 caps every 1 day); OAC
BRUKINSA CAP 80MG (<i>zanubrutinib</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
CABOMETYX TAB 20MG (<i>cabozantinib s-malate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 40MG (<i>cabozantinib s-malate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CABOMETYX TAB 60MG (<i>cabozantinib s-malate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
CALQUENCE TAB 100MG (<i>acalabrutinib maleate</i>)	2	PA, QL (2 tabs every 1 day); OAC
COPIKTRA CAP 15MG (<i>duvelisib</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
COPIKTRA CAP 25MG (<i>duvelisib</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
COTELLIC TAB 20MG (<i>cobimetinib fumarate</i>)	2	SP, PA, QL (63 tabs every 28 days); OAC
<i>everolimus tab 2.5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 7.5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 10 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab for oral susp 2 mg</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
<i>everolimus tab for oral susp 3 mg</i>	1	SP, PA, QL (3 tabs every 1 day); OAC
<i>everolimus tab for oral susp 5 mg</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
GAVRETO CAP 100MG (<i>pralsetinib</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
IBRANCE CAP 75MG (<i>palbociclib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE CAP 100MG (<i>palbociclib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE CAP 125MG (<i>palbociclib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
IBRANCE TAB 75MG (<i>palbociclib</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
IBRANCE TAB 100MG (<i>palbociclib</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
IBRANCE TAB 125MG (<i>palbociclib</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	1	SP, PA, QL (2 tabs every 1 day); OAC
IMBRUVICA CAP 70MG (<i>ibrutinib</i>)	2	PA, QL (1 cap every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMBRUVICA CAP 140MG (<i>ibrutinib</i>)	2	PA, QL (3 caps every 1 day); OAC
IMBRUVICA SUS 70MG/ML (<i>ibrutinib</i>)	2	PA, QL (6 mL every 1 day); OAC
IMBRUVICA TAB 140MG (<i>ibrutinib</i>)	2	PA, QL (1 tab every 1 day); OAC
IMBRUVICA TAB 280MG (<i>ibrutinib</i>)	2	PA, QL (1 tab every 1 day); OAC
IMBRUVICA TAB 420MG (<i>ibrutinib</i>)	2	PA, QL (1 tab every 1 day); OAC
KISQALI TAB 200DOSE (<i>ribociclib succinate</i>)	2	SP, PA, QL (21 tabs every 28 days); OAC
KISQALI TAB 400DOSE (<i>ribociclib succinate</i>)	2	SP, PA, QL (42 tabs every 28 days); OAC
KISQALI TAB 600DOSE (<i>ribociclib succinate</i>)	2	SP, PA, QL (63 tabs every 28 days); OAC
KOSELUGO CAP 10MG (<i>selumetinib sulfate</i>)	2	PA, QL (8 caps every 1 day); OAC
KOSELUGO CAP 25MG (<i>selumetinib sulfate</i>)	2	PA, QL (4 caps every 1 day); OAC
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	1	SP, PA, QL (6 tabs every 1 day); OAC
LYNPARZA TAB 100MG (<i>olaparib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
LYNPARZA TAB 150MG (<i>olaparib</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
MEKTOVI TAB 15MG (<i>binimetinib</i>)	2	SP, PA, QL (6 tabs every 1 day); OAC
NEXAVAR TAB 200MG (<i>sorafenib tosylate</i>)	2	SP, PA, QL (4 tabs every 1 day); OAC
NINLARO CAP 2.3MG (<i>ixazomib citrate</i>)	2	SP, PA, QL (6 caps every 28 days); OAC
NINLARO CAP 3MG (<i>ixazomib citrate</i>)	2	SP, PA, QL (6 caps every 28 days); OAC
NINLARO CAP 4MG (<i>ixazomib citrate</i>)	2	SP, PA, QL (6 caps every 28 days); OAC
<i>pazopanib hcl tab 200 mg (base equiv)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
RETEVMO CAP 40MG (<i>selpercatinib</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
RETEVMO CAP 80MG (<i>selpercatinib</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
ROZLYTREK CAP 100MG (<i>entrectinib</i>)	2	SP, PA, QL (1 cap every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ROZLYTREK CAP 200MG (<i>entrectinib</i>)	2	SP, PA, QL (3 caps every 1 day); OAC
RYDAPT CAP 25MG (<i>midostaurin</i>)	2	SP, PA, QL (8 caps every 1 day); OAC
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
SPRYCEL TAB 20MG (<i>dasatinib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
SPRYCEL TAB 50MG (<i>dasatinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
SPRYCEL TAB 70MG (<i>dasatinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
SPRYCEL TAB 80MG (<i>dasatinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
SPRYCEL TAB 100MG (<i>dasatinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
SPRYCEL TAB 140MG (<i>dasatinib</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
STIVARGA TAB 40MG (<i>regorafenib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>sunitinib malate cap 25 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>sunitinib malate cap 50 mg (base equivalent)</i>	1	SP, PA, QL (1 cap every 1 day); OAC
VITRAKVI CAP 25MG (<i>larotrectinib sulfate</i>)	2	SP, PA, QL (6 caps every 1 day); OAC
VITRAKVI CAP 100MG (<i>larotrectinib sulfate</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
VITRAKVI SOL 20MG/ML (<i>larotrectinib sulfate</i>)	2	SP, PA, QL (10 mL every 1 day); OAC
XOSPATA TAB 40MG (<i>gilteritinib fumarate</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
ZEJULA TAB 100MG (<i>niraparib tosylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 200MG (<i>niraparib tosylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 300MG (<i>niraparib tosylate</i>)	2	SP, PA, QL (1 tab every 1 day); OAC
ZELBORAF TAB 240MG (<i>vemurafenib</i>)	2	SP, PA, QL (8 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZOLINZA CAP 100MG (<i>vorinostat</i>)	2	SP, PA, QL (4 caps every 1 day); OAC
ZYDELIG TAB 100MG (<i>idelalisib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
ZYDELIG TAB 150MG (<i>idelalisib</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC
ZYKADIA TAB 150MG (<i>ceritinib</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC
ANTINEOPLASTICS MISC.		
<i>bexarotene cap 75 mg</i>	1	SP, PA; OAC
<i>hydroxyurea cap 500 mg</i>	1	OAC
MATULANE CAP 50MG (<i>procarbazine hcl</i>)	2	OAC
<i>tretinoiin cap 10 mg</i>	1	OAC
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
<i>leucovorin calcium tab 5 mg</i>	1	OAC
<i>leucovorin calcium tab 10 mg</i>	1	OAC
<i>leucovorin calcium tab 15 mg</i>	1	OAC
<i>leucovorin calcium tab 25 mg</i>	1	OAC
MITOTIC INHIBITORS		
<i>etoposide cap 50 mg</i>	1	OAC
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
ANTIPARKINSON ADJUNCTIVE THERAPY		
<i>carbidopa tab 25 mg</i>	1	MO
ANTIPARKINSON ANTICHOLINERGICS		
<i>benztropine mesylate tab 0.5 mg</i>	1	MO
<i>benztropine mesylate tab 1 mg</i>	1	MO
<i>benztropine mesylate tab 2 mg</i>	1	MO
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i>	1	MO
<i>trihexyphenidyl hcl tab 2 mg</i>	1	MO
<i>trihexyphenidyl hcl tab 5 mg</i>	1	MO
ANTIPARKINSON COMT INHIBITORS		
<i>entacapone tab 200 mg</i>	1	MO
<i>tolcapone tab 100 mg</i>	1	MO
ANTIPARKINSON DOPAMINERGICS		
<i>amantadine hcl cap 100 mg</i>	1	MO
<i>amantadine hcl soln 50 mg/5ml</i>	1	MO
<i>amantadine hcl tab 100 mg</i>	1	MO
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	1	MO
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	1	MO
<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	1	MO
<i>carbidopa & levodopa orally disintegrating tab 25-250 mg</i>	1	MO
<i>carbidopa & levodopa tab 10-100 mg</i>	1	MO
<i>carbidopa & levodopa tab 25-100 mg</i>	1	MO
<i>carbidopa & levodopa tab 25-250 mg</i>	1	MO
<i>carbidopa & levodopa tab er 25-100 mg</i>	1	MO
<i>carbidopa & levodopa tab er 50-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	1	MO
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	1	MO
DHIVY TAB 25-100MG (<i>carbidopa-levodopa</i>)	3	MO
INBRIJA CAP 42MG (<i>levodopa</i>)	2	PA, QL (10 caps every 1 day), MO
NEUPRO DIS 1MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 2MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 3MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 4MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 6MG/24HR (<i>rotigotine</i>)	2	MO
NEUPRO DIS 8MG/24HR (<i>rotigotine</i>)	2	MO
<i>pramipexole dihydrochloride tab 0.5 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 0.25 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 0.75 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 0.125 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 1 mg</i>	1	MO
<i>pramipexole dihydrochloride tab 1.5 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 0.75 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 0.375 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 1.5 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 2.25 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 3 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 3.75 mg</i>	1	MO
<i>pramipexole dihydrochloride tab er 24hr 4.5 mg</i>	1	MO
<i>ropinirole hydrochloride tab 0.5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>ropinirole hydrochloride tab 0.25 mg</i>	1	MO
<i>ropinirole hydrochloride tab 1 mg</i>	1	MO
<i>ropinirole hydrochloride tab 2 mg</i>	1	MO
<i>ropinirole hydrochloride tab 3 mg</i>	1	MO
<i>ropinirole hydrochloride tab 4 mg</i>	1	MO
<i>ropinirole hydrochloride tab 5 mg</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	1	MO
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	1	MO
RYTARY CAP 95MG (<i>carbidopa-levodopa</i>)	2	MO
RYTARY CAP 145MG (<i>carbidopa-levodopa</i>)	2	MO
RYTARY CAP 195MG (<i>carbidopa-levodopa</i>)	2	MO
RYTARY CAP 245MG (<i>carbidopa-levodopa</i>)	2	MO
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	1	MO
<i>rasagiline mesylate tab 1 mg (base equiv)</i>	1	MO
<i>selegiline hcl cap 5 mg</i>	1	MO
<i>selegiline hcl tab 5 mg</i>	1	MO
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES		
ANTIMANIC AGENTS		
<i>lithium carbonate cap 150 mg</i>	1	MO
<i>lithium carbonate cap 300 mg</i>	1	MO
<i>lithium carbonate cap 600 mg</i>	1	MO
<i>lithium carbonate tab 300 mg</i>	1	MO
<i>lithium carbonate tab er 300 mg</i>	1	MO
<i>lithium carbonate tab er 450 mg</i>	1	MO
ANTIPSYCHOTICS - MISC.		
<i>lurasidone hcl tab 20 mg</i>	1	MO
<i>lurasidone hcl tab 40 mg</i>	1	MO
<i>lurasidone hcl tab 60 mg</i>	1	MO
<i>lurasidone hcl tab 80 mg</i>	1	MO
<i>lurasidone hcl tab 120 mg</i>	1	MO
VRAYLAR CAP 1.5-3MG (<i>cariprazine hcl</i>)	2	ST; PA**
VRAYLAR CAP 1.5MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
VRAYLAR CAP 3MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
VRAYLAR CAP 4.5MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VRAYLAR CAP 6MG (<i>cariprazine hcl</i>)	2	ST, MO; PA**
<i>ziprasidone hcl cap 20 mg</i>	1	MO
<i>ziprasidone hcl cap 40 mg</i>	1	MO
<i>ziprasidone hcl cap 60 mg</i>	1	MO
<i>ziprasidone hcl cap 80 mg</i>	1	MO
BENZISOXAZOLES		
<i>paliperidone tab er 24hr 1.5 mg</i>	1	MO
<i>paliperidone tab er 24hr 3 mg</i>	1	MO
<i>paliperidone tab er 24hr 6 mg</i>	1	MO
<i>paliperidone tab er 24hr 9 mg</i>	1	MO
<i>risperidone orally disintegrating tab 0.5 mg</i>	1	MO
<i>risperidone orally disintegrating tab 0.25 mg</i>	1	MO
<i>risperidone orally disintegrating tab 1 mg</i>	1	MO
<i>risperidone orally disintegrating tab 2 mg</i>	1	MO
<i>risperidone orally disintegrating tab 3 mg</i>	1	MO
<i>risperidone orally disintegrating tab 4 mg</i>	1	MO
<i>risperidone soln 1 mg/ml</i>	1	MO
<i>risperidone tab 0.5 mg</i>	1	MO
<i>risperidone tab 0.25 mg</i>	1	MO
<i>risperidone tab 1 mg</i>	1	MO
<i>risperidone tab 2 mg</i>	1	MO
<i>risperidone tab 3 mg</i>	1	MO
<i>risperidone tab 4 mg</i>	1	MO
BUTYROPHENONES		
<i>haloperidol lactate oral conc 2 mg/ml</i>	1	MO
<i>haloperidol tab 0.5 mg</i>	1	MO
<i>haloperidol tab 1 mg</i>	1	MO
<i>haloperidol tab 2 mg</i>	1	MO
<i>haloperidol tab 5 mg</i>	1	MO
<i>haloperidol tab 10 mg</i>	1	MO
<i>haloperidol tab 20 mg</i>	1	MO
DIBENZAPINES		
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	1	MO
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	1	MO
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	1	MO
<i>clozapine orally disintegrating tab 12.5 mg</i>	1	
<i>clozapine orally disintegrating tab 25 mg</i>	1	
<i>clozapine orally disintegrating tab 100 mg</i>	1	
<i>clozapine orally disintegrating tab 150 mg</i>	1	
<i>clozapine orally disintegrating tab 200 mg</i>	1	
<i>clozapine tab 25 mg</i>	1	
<i>clozapine tab 50 mg</i>	1	
<i>clozapine tab 100 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>clozapine tab 200 mg</i>	1	
<i>loxapine succinate cap 5 mg</i>	1	MO
<i>loxapine succinate cap 10 mg</i>	1	MO
<i>loxapine succinate cap 25 mg</i>	1	MO
<i>loxapine succinate cap 50 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 5 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 10 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 15 mg</i>	1	MO
<i>olanzapine orally disintegrating tab 20 mg</i>	1	MO
<i>olanzapine tab 2.5 mg</i>	1	MO
<i>olanzapine tab 5 mg</i>	1	MO
<i>olanzapine tab 7.5 mg</i>	1	MO
<i>olanzapine tab 10 mg</i>	1	MO
<i>olanzapine tab 15 mg</i>	1	MO
<i>olanzapine tab 20 mg</i>	1	MO
<i>quetiapine fumarate tab 25 mg</i>	1	MO
<i>quetiapine fumarate tab 50 mg</i>	1	MO
<i>quetiapine fumarate tab 100 mg</i>	1	MO
<i>quetiapine fumarate tab 150 mg</i>	1	MO
<i>quetiapine fumarate tab 200 mg</i>	1	MO
<i>quetiapine fumarate tab 300 mg</i>	1	MO
<i>quetiapine fumarate tab 400 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 50 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 150 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 200 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 300 mg</i>	1	MO
<i>quetiapine fumarate tab er 24hr 400 mg</i>	1	MO
DIHYDROINDOLONES		
<i>molindone hcl tab 5 mg</i>	1	MO
<i>molindone hcl tab 10 mg</i>	1	MO
<i>molindone hcl tab 25 mg</i>	1	MO
PHENOTHIAZINES		
<i>chlorpromazine hcl tab 10 mg</i>	1	MO
<i>chlorpromazine hcl tab 25 mg</i>	1	MO
<i>chlorpromazine hcl tab 50 mg</i>	1	MO
<i>chlorpromazine hcl tab 100 mg</i>	1	MO
<i>chlorpromazine hcl tab 200 mg</i>	1	MO
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	1	MO
<i>fluphenazine hcl oral conc 5 mg/ml</i>	1	MO
<i>fluphenazine hcl tab 1 mg</i>	1	MO
<i>fluphenazine hcl tab 2.5 mg</i>	1	MO
<i>fluphenazine hcl tab 5 mg</i>	1	MO
<i>fluphenazine hcl tab 10 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>perphenazine tab 2 mg</i>	1	MO
<i>perphenazine tab 4 mg</i>	1	MO
<i>perphenazine tab 8 mg</i>	1	MO
<i>perphenazine tab 16 mg</i>	1	MO
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	1	MO
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	1	MO
<i>prochlorperazine suppos 25 mg</i>	1	
(Prochlorperazine Suppos 25 mg) COMPRO	1	
<i>thioridazine hcl tab 10 mg</i>	1	MO
<i>thioridazine hcl tab 25 mg</i>	1	MO
<i>thioridazine hcl tab 50 mg</i>	1	MO
<i>thioridazine hcl tab 100 mg</i>	1	MO
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	1	MO
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	1	MO
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	1	MO
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	MO
QUINOLINONE DERIVATIVES		
<i>aripiprazole oral solution 1 mg/ml</i>	1	MO
<i>aripiprazole orally disintegrating tab 10 mg</i>	1	MO
<i>aripiprazole orally disintegrating tab 15 mg</i>	1	MO
<i>aripiprazole tab 2 mg</i>	1	MO
<i>aripiprazole tab 5 mg</i>	1	MO
<i>aripiprazole tab 10 mg</i>	1	MO
<i>aripiprazole tab 15 mg</i>	1	MO
<i>aripiprazole tab 20 mg</i>	1	MO
<i>aripiprazole tab 30 mg</i>	1	MO
THIOXANTHENES		
<i>thiothixene cap 1 mg</i>	1	MO
<i>thiothixene cap 2 mg</i>	1	MO
<i>thiothixene cap 5 mg</i>	1	MO
<i>thiothixene cap 10 mg</i>	1	MO
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIRETROVIRALS		
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	1	SP, QL (30 mL every 1 day)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	1	SP, QL (2 tabs every 1 day)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	1	SP, QL (1 cap every 1 day)
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	1	SP, QL (2 caps every 1 day)
<i>atazanavir sulfate cap 300 mg (base equiv)</i>	1	SP, QL (1 cap every 1 day)
<i>BIKTARVY TAB (bictegravir-emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day); (30-120-15 mg)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BIKTARVY TAB (<i>bictegravir-emtricitabine-tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day); (50-200-25 mg)
CIMDUO TAB 300-300 (<i>lamivudine-tenofovir disoproxil fumarate</i>)	2	SP, QL (1 tab every 1 day)
CRIVAN CAP 200MG (<i>indinavir sulfate</i>)	3	SP, PA
CRIVAN CAP 400MG (<i>indinavir sulfate</i>)	3	SP, PA
<i>darunavir tab 600 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>darunavir tab 800 mg</i>	1	SP, QL (1 tab every 1 day)
DESCOVY TAB 120-15MG (<i>emtricitabine-tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day)
DESCOVY TAB 200/25MG (<i>emtricitabine-tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day); \$0 copay for PrEP
DOVATO TAB 50-300MG (<i>dolutegravir sodium-lamivudine</i>)	2	SP, QL (1 tab every 1 day)
EDURANT TAB 25MG (<i>rilpivirine hcl</i>)	2	SP, QL (2 tabs every 1 day)
<i>efavirenz tab 600 mg</i>	1	SP, QL (1 tab every 1 day)
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine caps 200 mg</i>	1	SP, QL (1 cap every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	SP, QL (1 tab every 1 day)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	1	SP, QL (1 tab every 1 day); \$0 copay for PrEP
EMTRIVA CAP 200MG (<i>emtricitabine</i>)	2	SP, QL (1 cap every 1 day)
EMTRIVA SOL 10MG/ML (<i>emtricitabine</i>)	2	SP, QL (680 mL every 28 days)
<i>etravirine tab 100 mg</i>	1	SP, QL (4 tabs every 1 day)
<i>etravirine tab 200 mg</i>	1	SP, QL (2 tabs every 1 day)
EVOTAZ TAB 300-150 (<i>atazanavir sulfate-cobicistat</i>)	2	SP, QL (1 tab every 1 day)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	1	SP, QL (4 tabs every 1 day)
GENVOYA TAB (<i>elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide</i>)	2	SP, QL (1 tab every 1 day)
INTELENCE TAB 25MG (<i>etravirine</i>)	2	SP, QL (4 tabs every 1 day)
INTELENCE TAB 100MG (<i>etravirine</i>)	2	SP, QL (4 tabs every 1 day)
INTELENCE TAB 200MG (<i>etravirine</i>)	2	SP, QL (2 tabs every 1 day)
ISENTRESS CHW 25MG (<i>raltegravir potassium</i>)	2	SP, QL (6 tabs every 1 day)
ISENTRESS CHW 100MG (<i>raltegravir potassium</i>)	2	SP, QL (6 tabs every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ISENTRESS HD TAB 600MG (<i>raltegravir potassium</i>)	2	SP, QL (2 tabs every 1 day)
ISENTRESS POW 100MG (<i>raltegravir potassium</i>)	2	SP, QL (2 packets every 1 day)
ISENTRESS TAB 400MG (<i>raltegravir potassium</i>)	2	SP, QL (4 tabs every 1 day)
<i>lamivudine oral soln 10 mg/ml</i>	1	SP, QL (32 mL every 1 day)
<i>lamivudine tab 150 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>lamivudine tab 300 mg</i>	1	SP, QL (1 tab every 1 day)
<i>lamivudine-zidovudine tab 150-300 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	1	SP, QL (16 mL every 1 day)
<i>lopinavir-ritonavir tab 100-25 mg</i>	1	SP, QL (10 tabs every 1 day)
<i>lopinavir-ritonavir tab 200-50 mg</i>	1	SP, QL (4 tabs every 1 day)
<i>maraviroc tab 150 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>maraviroc tab 300 mg</i>	1	SP, QL (4 tabs every 1 day)
<i>nevirapine susp 50 mg/5ml</i>	1	SP, QL (40 mL every 1 day)
<i>nevirapine tab 200 mg</i>	1	SP, QL (2 tabs every 1 day)
<i>nevirapine tab er 24hr 400 mg</i>	1	SP, QL (1 tab every 1 day)
NORVIR POW 100MG (<i>ritonavir</i>)	2	SP, QL (12 packets every 1 day)
NORVIR TAB 100MG (<i>ritonavir</i>)	2	SP, QL (12 tabs every 1 day)
ODEFSEY TAB (<i>emtricitabine-rilpivirine-tenofovir alafenamide fumarate</i>)	2	SP, QL (1 tab every 1 day)
PREZCOBIX TAB 800-150 (<i>darunavir-cobicistat</i>)	2	SP, QL (1 tab every 1 day)
PREZISTA SUS 100MG/ML (<i>darunavir</i>)	2	SP, QL (400 mL every 30 days)
PREZISTA TAB 75MG (<i>darunavir</i>)	2	SP, QL (10 tabs every 1 day)
PREZISTA TAB 150MG (<i>darunavir</i>)	2	SP, QL (6 tabs every 1 day)
PREZISTA TAB 600MG (<i>darunavir</i>)	2	SP, QL (2 tabs every 1 day)
PREZISTA TAB 800MG (<i>darunavir</i>)	2	SP, QL (1 tab every 1 day)
<i>ritonavir tab 100 mg</i>	1	SP, QL (12 tabs every 1 day)
SYMTUZA TAB (<i>darunavir-cobicistat-emtricitabine-tenofovir alafenamide</i>)	2	SP, QL (1 tab every 1 day)
<i>tenofovir disoproxil fumarate tab 300 mg</i>	1	SP, QL (1 tab every 1 day)
TIVICAY PD TAB 5MG (<i>dolutegravir sodium</i>)	2	SP, QL (12 tabs every 1 day)
TIVICAY TAB 10MG (<i>dolutegravir sodium</i>)	2	SP, QL (8 tabs every 1 day)
TIVICAY TAB 25MG (<i>dolutegravir sodium</i>)	2	SP, QL (2 tabs every 1 day)
TIVICAY TAB 50MG (<i>dolutegravir sodium</i>)	2	SP, QL (2 tabs every 1 day)
TRIUMEQ PD TAB (<i>abacavir-dolutegravir-lamivudine</i>)	2	SP, QL (6 tabs every 1 day)
TRIUMEQ TAB (<i>abacavir-dolutegravir-lamivudine</i>)	2	SP, QL (1 tab every 1 day)
<i>zidovudine cap 100 mg</i>	1	SP, QL (6 caps every 1 day)
<i>zidovudine syrup 10 mg/ml</i>	1	SP, QL (64 mL every 1 day)
<i>zidovudine tab 300 mg</i>	1	SP, QL (2 tabs every 1 day)
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 300-100 (<i>nirmatrelvir-ritonavir</i>)	PV	QL (1 carton every 90 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CMV AGENTS		
<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i>	1	QL (1000 mL every 30 days), MO
<i>valganciclovir hcl tab 450 mg (base equivalent)</i>	1	QL (4 tabs every 1 day), MO
HEPATITIS AGENTS		
<i>adefovir dipivoxil tab 10 mg</i>	1	SP
<i>entecavir tab 0.5 mg</i>	1	SP, QL (1 tab every 1 day)
<i>entecavir tab 1 mg</i>	1	SP, QL (1 tab every 1 day)
<i>EPCLUSA PAK 150-37.5 (sofosbuvir-velpatasvir)</i>	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
<i>EPCLUSA PAK 200-50MG (sofosbuvir-velpatasvir)</i>	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
<i>EPCLUSA TAB 200-50MG (sofosbuvir-velpatasvir)</i>	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
<i>EPCLUSA TAB 400-100 (sofosbuvir-velpatasvir)</i>	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
<i>HARVONI PAK (ledipasvir-sofosbuvir)</i>	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
<i>HARVONI PAK 45-200MG (ledipasvir-sofosbuvir)</i>	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
<i>HARVONI TAB 45-200MG (ledipasvir-sofosbuvir)</i>	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6
<i>HARVONI TAB 90-400MG (ledipasvir-sofosbuvir)</i>	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6
<i>lamivudine tab 100 mg (hbv)</i>	1	SP
<i>ribavirin cap 200 mg</i>	1	SP, PA
<i>ribavirin tab 200 mg</i>	1	SP, PA
<i>VOSEVI TAB (sofosbuvir-velpatasvir-voxilaprevir)</i>	2	SP, PA, QL (1 tab every 1 day); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).
HERPES AGENTS		
<i>acyclovir cap 200 mg</i>	1	
<i>acyclovir susp 200 mg/5ml</i>	1	
<i>acyclovir tab 400 mg</i>	1	
<i>acyclovir tab 800 mg</i>	1	
<i>famciclovir tab 125 mg</i>	1	
<i>famciclovir tab 250 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>famciclovir tab 500 mg</i>	1	
<i>valacyclovir hcl tab 1 gm</i>	1	
<i>valacyclovir hcl tab 500 mg</i>	1	
INFLUENZA AGENTS		
<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	1	
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	1	
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	1	
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	1	
<i>RELENZA MIS DISKHALE (zanamivir)</i>	2	
<i>rimantadine hydrochloride tab 100 mg</i>	1	
MISC. ANTIVIRALS		
LAGEVRIA CAP 200MG (<i>molnupiravir</i>)	PV	QL (40 caps every 90 days)
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
ALPHA-BETA BLOCKERS		
<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	MO
<i>carvedilol phosphate cap er 24hr 20 mg</i>	1	MO
<i>carvedilol phosphate cap er 24hr 40 mg</i>	1	MO
<i>carvedilol phosphate cap er 24hr 80 mg</i>	1	MO
<i>carvedilol tab 3.125 mg</i>	1	MO
<i>carvedilol tab 6.25 mg</i>	1	MO
<i>carvedilol tab 12.5 mg</i>	1	MO
<i>carvedilol tab 25 mg</i>	1	MO
<i>labetalol hcl tab 100 mg</i>	1	MO
<i>labetalol hcl tab 200 mg</i>	1	MO
<i>labetalol hcl tab 300 mg</i>	1	MO
BETA BLOCKERS CARDIO-SELECTIVE		
<i>acebutolol hcl cap 200 mg</i>	1	MO
<i>acebutolol hcl cap 400 mg</i>	1	MO
<i>atenolol tab 25 mg</i>	1	MO
<i>atenolol tab 50 mg</i>	1	MO
<i>atenolol tab 100 mg</i>	1	MO
<i>betaxolol hcl tab 10 mg</i>	1	MO
<i>betaxolol hcl tab 20 mg</i>	1	MO
<i>bisoprolol fumarate tab 5 mg</i>	1	MO
<i>bisoprolol fumarate tab 10 mg</i>	1	MO
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	1	MO
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	1	MO
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	1	MO
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>metoprolol tartrate tab 25 mg</i>	1	MO
<i>metoprolol tartrate tab 37.5 mg</i>	1	MO
<i>metoprolol tartrate tab 50 mg</i>	1	MO
<i>metoprolol tartrate tab 75 mg</i>	1	MO
<i>metoprolol tartrate tab 100 mg</i>	1	MO
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	1	MO
<i>nebivolol hcl tab 5 mg (base equivalent)</i>	1	MO
<i>nebivolol hcl tab 10 mg (base equivalent)</i>	1	MO
<i>nebivolol hcl tab 20 mg (base equivalent)</i>	1	MO
BETA BLOCKERS NON-SELECTIVE		
<i>nadolol tab 20 mg</i>	1	MO
<i>nadolol tab 40 mg</i>	1	MO
<i>nadolol tab 80 mg</i>	1	MO
<i>pindolol tab 5 mg</i>	1	MO
<i>pindolol tab 10 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 60 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 80 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 120 mg</i>	1	MO
<i>propranolol hcl cap er 24hr 160 mg</i>	1	MO
<i>propranolol hcl oral soln 20 mg/5ml</i>	1	MO
<i>propranolol hcl oral soln 40 mg/5ml</i>	1	MO
<i>propranolol hcl tab 10 mg</i>	1	MO
<i>propranolol hcl tab 20 mg</i>	1	MO
<i>propranolol hcl tab 40 mg</i>	1	MO
<i>propranolol hcl tab 60 mg</i>	1	MO
<i>propranolol hcl tab 80 mg</i>	1	MO
<i>sotalol hcl (afib/afl) tab 80 mg</i>	1	MO
<i>sotalol hcl (afib/afl) tab 120 mg</i>	1	MO
<i>sotalol hcl (afib/afl) tab 160 mg</i>	1	MO
<i>sotalol hcl tab 80 mg</i>	1	MO
<i>sotalol hcl tab 120 mg</i>	1	MO
<i>sotalol hcl tab 160 mg</i>	1	MO
<i>sotalol hcl tab 240 mg</i>	1	MO
<i>timolol maleate tab 5 mg</i>	1	MO
<i>timolol maleate tab 10 mg</i>	1	MO
<i>timolol maleate tab 20 mg</i>	1	MO

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS

<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	1	MO
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>amlodipine besylate tab 10 mg (base equivalent)</i>	1	MO
<i>diltiazem hcl cap er 12hr 60 mg</i>	1	MO
<i>diltiazem hcl cap er 12hr 90 mg</i>	1	MO
<i>diltiazem hcl cap er 12hr 120 mg</i>	1	MO
<i>diltiazem hcl cap er 24hr 120 mg</i>	1	MO
(Diltiazem Hcl Cap Er 24hr 120 mg) DILT-XR	1	MO
<i>diltiazem hcl cap er 24hr 180 mg</i>	1	MO
(Diltiazem Hcl Cap Er 24hr 180 mg) DILT-XR	1	MO
<i>diltiazem hcl cap er 24hr 240 mg</i>	1	MO
(Diltiazem Hcl Cap Er 24hr 240 mg) DILT-XR	1	MO
<i>diltiazem hcl coated beads cap er 24hr 120 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 180 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	1	MO
(Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg) CARTIA XT	1	MO
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg) TAZTIA XT	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg) TAZTIA XT	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg) TAZTIA XT	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg) TAZTIA XT	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg) TAZTIA XT	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg) TIADYLT ER	1	MO
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i>	1	MO
(Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg) TIADYLT ER	1	MO
<i>diltiazem hcl tab 30 mg</i>	1	MO
<i>diltiazem hcl tab 60 mg</i>	1	MO
<i>diltiazem hcl tab 90 mg</i>	1	MO
<i>diltiazem hcl tab 120 mg</i>	1	MO
<i>felodipine tab er 24hr 2.5 mg</i>	1	MO
<i>felodipine tab er 24hr 5 mg</i>	1	MO
<i>felodipine tab er 24hr 10 mg</i>	1	MO
<i>isradipine cap 2.5 mg</i>	1	MO
<i>isradipine cap 5 mg</i>	1	MO
<i>levamlodipine maleate tab 2.5 mg</i>	1	MO
<i>levamlodipine maleate tab 5 mg</i>	1	MO
<i>nicardipine hcl cap 20 mg</i>	1	MO
<i>nicardipine hcl cap 30 mg</i>	1	MO
<i>nifedipine cap 10 mg</i>	1	MO
<i>nifedipine cap 20 mg</i>	1	MO
<i>nifedipine tab er 24hr 30 mg</i>	1	MO
<i>nifedipine tab er 24hr 60 mg</i>	1	MO
<i>nifedipine tab er 24hr 90 mg</i>	1	MO
<i>nifedipine tab er 24hr osmotic release 30 mg</i>	1	MO
<i>nifedipine tab er 24hr osmotic release 60 mg</i>	1	MO
<i>nifedipine tab er 24hr osmotic release 90 mg</i>	1	MO
<i>nimodipine cap 30 mg</i>	1	
<i>nisoldipine tab er 24hr 8.5 mg</i>	1	MO
<i>nisoldipine tab er 24hr 17 mg</i>	1	MO
<i>nisoldipine tab er 24hr 20 mg</i>	1	MO
<i>nisoldipine tab er 24hr 25.5 mg</i>	1	MO
<i>nisoldipine tab er 24hr 30 mg</i>	1	MO
<i>nisoldipine tab er 24hr 34 mg</i>	1	MO
<i>nisoldipine tab er 24hr 40 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 100 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 120 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 180 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>verapamil hcl cap er 24hr 200 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 240 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 300 mg</i>	1	MO
<i>verapamil hcl cap er 24hr 360 mg</i>	1	MO
<i>verapamil hcl tab 40 mg</i>	1	MO
<i>verapamil hcl tab 80 mg</i>	1	MO
<i>verapamil hcl tab 120 mg</i>	1	MO
<i>verapamil hcl tab er 120 mg</i>	1	MO
<i>verapamil hcl tab er 180 mg</i>	1	MO
<i>verapamil hcl tab er 240 mg</i>	1	MO

CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS

CARDIAC GLYCOSIDES

<i>digoxin oral soln 0.05 mg/ml</i>	1	MO
<i>digoxin tab 62.5 mcg (0.0625 mg)</i>	1	MO
<i>digoxin tab 125 mcg (0.125 mg)</i>	1	MO
<i>digoxin tab 250 mcg (0.25 mg)</i>	1	MO

CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	1	MO
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	1	MO
<i>ENTRESTO TAB 24-26MG (sacubitril-valsartan)</i>	2	PA, MO
<i>ENTRESTO TAB 49-51MG (sacubitril-valsartan)</i>	2	PA, MO
<i>ENTRESTO TAB 97-103MG (sacubitril-valsartan)</i>	2	PA, MO
<i>isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMPOTENCE AGENTS		
<i>sildenafil citrate tab 25 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>sildenafil citrate tab 50 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>sildenafil citrate tab 100 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>tadalafil tab 2.5 mg</i>	1	PA, QL (1 tab every 1 day), MO
<i>tadalafil tab 5 mg</i>	1	PA, QL (1 tab every 1 day), MO
<i>tadalafil tab 10 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>tadalafil tab 20 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardenafil hcl orally disintegrating tab 10 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardenafil hcl tab 2.5 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardenafil hcl tab 5 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardenafil hcl tab 10 mg</i>	1	PA, QL (8 tabs every 21 days)
<i>vardenafil hcl tab 20 mg</i>	1	PA, QL (8 tabs every 21 days)
PROSTAGLANDIN VASODILATORS		
<i>ORENITRAM TAB 0.25MG (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB 0.125MG (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB 1MG (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB 2.5MG (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB 5MG (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB MONTH 1 (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB MONTH 2 (<i>treprostинil diolamine</i>)</i>	2	SP, PA
<i>ORENITRAM TAB MONTH 3 (<i>treprostинil diolamine</i>)</i>	2	SP, PA
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
<i>ambrisentan tab 5 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>ambrisentan tab 10 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>bosentan tab 62.5 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>bosentan tab 125 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>OPSUMIT TAB 10MG (<i>macitentan</i>)</i>	2	SP, PA, QL (1 tab every 1 day)
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
<i>sildenafil citrate for suspension 10 mg/ml</i>	1	SP, PA, QL (224 mL every 30 days)
<i>sildenafil citrate tab 20 mg</i>	1	SP, PA, QL (12 tabs every 1 day)
<i>tadalafil tab 20 mg (pah)</i>	1	SP, PA, QL (2 tabs every 1 day)
(Tadalafil Tab 20 mg (Pah)) ALYQ	1	SP, PA, QL (2 tabs every 1 day)
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
<i>UPTRAVI PACK TAB 200/800 (<i>selexipag</i>)</i>	2	SP, PA, QL (1 pack every 28 days)
<i>UPTRAVI TAB 200MCG (<i>selexipag</i>)</i>	2	SP, PA, QL (5 tabs every 1 day)
<i>UPTRAVI TAB 400MCG (<i>selexipag</i>)</i>	2	SP, PA, QL (2 tabs every 1 day)
<i>UPTRAVI TAB 600MCG (<i>selexipag</i>)</i>	2	SP, PA, QL (2 tabs every 1 day)
<i>UPTRAVI TAB 800MCG (<i>selexipag</i>)</i>	2	SP, PA, QL (2 tabs every 1 day)
<i>UPTRAVI TAB 1000MCG (<i>selexipag</i>)</i>	2	SP, PA, QL (2 tabs every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
UPTRAVI TAB 1200MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1400MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1600MCG (<i>selexipag</i>)	2	SP, PA, QL (2 tabs every 1 day)
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1.5MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2.5MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2MG (<i>riociguat</i>)	2	SP, PA, QL (3 tabs every 1 day)
SINUS NODE INHIBITORS		
CORLANOR TAB 5MG (<i>ivabradine hcl</i>)	2	MO
CORLANOR TAB 7.5MG (<i>ivabradine hcl</i>)	2	MO
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG (<i>vericiguat</i>)	2	MO
VERQUVO TAB 5MG (<i>vericiguat</i>)	2	MO
VERQUVO TAB 10MG (<i>vericiguat</i>)	2	MO
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
CEPHALOSPORINS - 1ST GENERATION		
<i>cefadroxil cap 500 mg</i>	1	
<i>cefadroxil for susp 250 mg/5ml</i>	1	
<i>cefadroxil for susp 500 mg/5ml</i>	1	
<i>cefadroxil tab 1 gm</i>	1	
<i>cephalexin cap 250 mg</i>	1	
<i>cephalexin cap 500 mg</i>	1	
<i>cephalexin cap 750 mg</i>	1	
<i>cephalexin for susp 125 mg/5ml</i>	1	
<i>cephalexin for susp 250 mg/5ml</i>	1	
<i>cephalexin tab 250 mg</i>	1	
<i>cephalexin tab 500 mg</i>	1	
CEPHALOSPORINS - 2ND GENERATION		
<i>cefaclor cap 250 mg</i>	1	
<i>cefaclor cap 500 mg</i>	1	
<i>cefaclor for susp 250 mg/5ml</i>	1	
<i>ceftazidime for susp 125 mg/5ml</i>	1	
<i>ceftazidime for susp 250 mg/5ml</i>	1	
<i>ceftazidime tab 250 mg</i>	1	
<i>ceftazidime tab 500 mg</i>	1	
<i>cefuroxime axetil tab 250 mg</i>	1	
<i>cefuroxime axetil tab 500 mg</i>	1	
CEPHALOSPORINS - 3RD GENERATION		
<i>cefdinir cap 300 mg</i>	1	
<i>cefdinir for susp 125 mg/5ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>cefdinir for susp 250 mg/5ml</i>	1	
<i>cefixime cap 400 mg</i>	1	
<i>cefixime for susp 100 mg/5ml</i>	1	
<i>cefixime for susp 200 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	1	
<i>cefpodoxime proxetil tab 100 mg</i>	1	
<i>cefpodoxime proxetil tab 200 mg</i>	1	

CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL

COMBINATION CONTRACEPTIVES - ORAL

<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) AZURETTE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) KARIVA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) PIMTREA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) SIMLIYA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VIORELE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VOLNEA	PV	MO
(Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) VELIVET	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) APRI	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) CYRED EQ	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) ENSKYCE	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) ISIBLOOM	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) JULEBER	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) KALLIGA	PV	MO
(Desogestrel & Ethynodiol-Diol Tab 0.15 mg-30 mcg) RECLIPSEN	PV	MO
<i>drospirenone-ethynodiol-diol tab 0.02-0.03 mg</i>	PV	MO
<i>drospirenone-ethynodiol-diol tab 0.03-0.04 mg</i>	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg) TYDEMY	PV	MO
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) JASMIEL	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LO-ZUMANDIMINE	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) LORYNA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) NIKKI	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg) VESTURA	PV	MO
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) OCELLA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) SYEDA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) ZUMANDIMINE	PV	MO
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) KELNOR 1/35	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) ZOVIA 1/35	PV	MO
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) KELNOR 1/50	PV	MO
FALESSA KIT (<i>levonorgestrel-ethinyl estradiol & folic acid</i>)	PV	MO
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg</i>	PV	MO
(Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg & eth Est 0.01 mg) RIVELSA	PV	MO
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	PV	MO
(Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)) CAMRESE LO	PV	MO
(Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)) LOJAIMIESS	PV	MO
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) AMETHIA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) ASHLYNA	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) CAMRESE	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) DAYSEE	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) JAIMIESS	PV	MO
(Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)) SIMPESSE	PV	MO
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) ICLEVIA	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) INTROVALE	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) JOLESSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg) SETLAKIN	PV	MO
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AFIRMELLE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AUBRA EQ	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AVIANE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) DELYLA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) FALMINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LESSINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LUTERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) SRONYX	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) VIENVA	PV	MO
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ALTAVERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) AYUNA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CHATEAL EQ	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KURVELO	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) LEVORA 0.15/30-28	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) MARLISSA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) PORTIA-28	PV	MO
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) ENPRESSE-28	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) LEVONEST	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) TRIVORA-28	PV	MO
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) AMETHYST	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) DOLISHALE	PV	MO
<i>levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)</i>	PV	MO
(Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) JOYEAUX	PV	MO
LO LOESTRIN TAB 1-10-10 (<i>norethindrone acetate-ethinyl estradiol-fe fum (biphasic)</i>)	PV	MO
NATAZIA TAB (<i>estradiol valerate-dienogest</i>)	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) BALZIVA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) BRIELLYN	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) PHILITH	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg) VYFEMLA	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NECON 0.5/35-28	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) NORTREL 0.5/35 (28)	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg) WERA	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg ALYACEN 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg DASETTA 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NORTREL 1/35	PV	MO
(Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg) NYLIA 1/35	PV	MO
<i>norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg) WYMZYA FE	PV	MO
<i>norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg</i>	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) KAITLIB FE	PV	MO
(Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) LAYOLIS FE	PV	MO
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1- 35 mg-mcg</i>	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1- 35 mg-Mcg) TILIA FE	PV	MO
(Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1- 35 mg-Mcg) TRI-LEGEST FE	PV	MO
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) AUROVELA 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) JUNEL 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) LARIN 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) LOESTRIN 1/20-21	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) MICROGESTIN 1/20	PV	MO
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) AUROVELA 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) HAILEY 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) JUNEL 1.5/30	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LARIN 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) LOESTRIN 1.5/30-21	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) MICROGESTIN 1.5/30	PV	MO
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) AUROVELA FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) BLISOVI FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) HAILEY FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) JUNEL FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) LARIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) LOESTRIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) MICROGESTIN FE 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg) TARINA FE 1/20 EQ	PV	MO
<i>norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) AUROVELA FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) BLISOVI FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) HAILEY FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) JUNEL FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) LARIN FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) LOESTRIN FE 1.5/30	PV	MO
(Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg) MICROGESTIN FE 1.5/30	PV	MO
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) CHARLOTTE 24 FE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) FINZALA	PV	MO
(Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) MIBELAS 24 FE	PV	MO
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i>	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) GEMMILY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) MERZEE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)) TAYSOFY	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) AUROVELA 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) BLISOVI 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) HAILEY 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) JUNEL FE 24	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) LARIN 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) MICROGESTIN 24 FE	PV	MO
(Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)) TARINA 24 FE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) ALYACEN 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) DASETTA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NORTREL 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg) NYLIA 7/7/7	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) ARANELLE	PV	MO
(Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg) LEENA	PV	MO
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) ESTARYLLA	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MILI	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) MONO-LINYAH	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) NYMYO	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) SPRINTEC 28	PV	MO
(Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg) VYLIBRA	PV	MO
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-ESTARYLLA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-MARZIA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-MILI	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-LO-SPRINTEC	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg) TRI-VYLIBRA LO	PV	MO
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-ESTARYLLA	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-LINYAH	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-MILI	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-NYMYO	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-SPRINTEC	PV	MO
(Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg) TRI-VYLIBRA	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) CRYSELLE-28	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) ELINEST	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg) LOW-OGESTREL	PV	MO
(Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg) OGESTREL	PV	MO
<i>COMBINATION CONTRACEPTIVES - TRANSDERMAL</i>		
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) XULANE	PV	MO
(Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) ZAFEMY	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS (<i>segesterone acetate-ethinyl estradiol</i>)	PV	QL (1 ring every 300 days), MO; Quantity max 1 per fill; Quantity max 1 per 300 days
NUVARING MIS (<i>etonogestrel-ethinyl estradiol</i>)	1	MO
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG (<i>ulipristal acetate</i>)	PV	
PROGESTIN CONTRACEPTIVES - ORAL		
<i>norethindrone tab 0.35 mg</i>	PV	MO
(Norethindrone Tab 0.35 mg) CAMILA	PV	MO
(Norethindrone Tab 0.35 mg) DEBLITANE	PV	MO
(Norethindrone Tab 0.35 mg) ERRIN	PV	MO
(Norethindrone Tab 0.35 mg) HEATHER	PV	MO
(Norethindrone Tab 0.35 mg) INCASSIA	PV	MO
(Norethindrone Tab 0.35 mg) JENCYCLA	PV	MO
(Norethindrone Tab 0.35 mg) LYLEQ	PV	MO
(Norethindrone Tab 0.35 mg) LYZA	PV	MO
(Norethindrone Tab 0.35 mg) NORA-BE	PV	MO
(Norethindrone Tab 0.35 mg) NORLYROC	PV	MO
(Norethindrone Tab 0.35 mg) SHAROBEL	PV	MO
CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
GLUCOCORTICOSTEROIDS		
<i>budesonide delayed release particles cap 3 mg</i>	1	
<i>dexamethasone elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone soln 0.5 mg/5ml</i>	1	
<i>dexamethasone tab 0.5 mg</i>	1	
<i>dexamethasone tab 0.75 mg</i>	1	
<i>dexamethasone tab 1 mg</i>	1	
<i>dexamethasone tab 1.5 mg</i>	1	
<i>dexamethasone tab 2 mg</i>	1	
<i>dexamethasone tab 4 mg</i>	1	
<i>dexamethasone tab 6 mg</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	1	
(Dexamethasone Tab Therapy Pack 1.5 mg (21))	1	
HIDEX 6-DAY		
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
EMFLAZA SUS 22.75/ML (<i>deflazacort</i>)	3	PA
EMFLAZA TAB 6MG (<i>deflazacort</i>)	3	PA
EMFLAZA TAB 18MG (<i>deflazacort</i>)	3	PA
EMFLAZA TAB 30MG (<i>deflazacort</i>)	3	PA
EMFLAZA TAB 36MG (<i>deflazacort</i>)	3	PA
<i>hydrocortisone tab 5 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>hydrocortisone tab 10 mg</i>	1	
<i>hydrocortisone tab 20 mg</i>	1	
<i>MEDROL TAB 2MG (methylprednisolone)</i>	3	
<i>methylprednisolone tab 4 mg</i>	1	
<i>methylprednisolone tab 8 mg</i>	1	
<i>methylprednisolone tab 16 mg</i>	1	
<i>methylprednisolone tab 32 mg</i>	1	
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	1	
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	1	
<i>prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)</i>	1	
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	1	
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	1	
<i>prednisolone soln 15 mg/5ml</i>	1	
<i>prednisolone tab 5 mg</i>	1	
<i>prednisone oral soln 5 mg/5ml</i>	1	
<i>prednisone tab 1 mg</i>	1	
<i>prednisone tab 2.5 mg</i>	1	
<i>prednisone tab 5 mg</i>	1	
<i>prednisone tab 10 mg</i>	1	
<i>prednisone tab 20 mg</i>	1	
<i>prednisone tab 50 mg</i>	1	
<i>prednisone tab therapy pack 5 mg (21)</i>	1	
<i>prednisone tab therapy pack 5 mg (48)</i>	1	
<i>prednisone tab therapy pack 10 mg (21)</i>	1	
<i>prednisone tab therapy pack 10 mg (48)</i>	1	
MINERALOCORTICOIDS		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	MO
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS		
ANTITUSSIVES		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	1	Not available under age 6

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Hydrocodone Bitart-Homatropine Methylbromide Soln 5-1.5 mg/5ml) HYDROMET	1	Not available under age 6
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	1	Not available under age 6
COUGH/COLD/ALLERGY COMBINATIONS		
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	Not available under age 12
(Promethazine & Phenylephrine Syrup 6.25-5 mg/5ml) PROMETHAZINE VC	1	
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	1	Not available under age 12
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	1	
(Promethazine-Phenylephrine-Codeine Syrup 6.25-5-10 mg/5ml) PROMETHAZINE VC/CODEINE	1	Not available under age 12
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
(Pseudoephed-Bromphen-Dm Syrup 30-2-10 mg/5ml) BROMFED DM	1	
EXPECTORANTS		
<i>potassium iodide oral soln 1 gm/ml</i>	1	
MISC. RESPIRATORY INHALANTS		
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
(Sodium Chloride Soln Nebu 3%) NEBUSAL	1	
<i>sodium chloride soln nebu 7%</i>	1	
(Sodium Chloride Soln Nebu 7%) PULMOSAL	1	
<i>sodium chloride soln nebu 10%</i>	1	
MUCOLYTICS		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS		
ACNE PRODUCTS		
<i>adapalene cream 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>adapalene gel 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>adapalene gel 0.3%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	1	
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	1	
AKLIEF CRE 0.005% (<i>trifarotene</i>)	2	PA
ARAZLO LOT 0.045% (<i>tazarotene (acne)</i>)	2	PA
(Benzoyl Peroxide Foam 5.3%) BENZEPRO	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>benzoyl peroxide foam 9.8%</i>	1	
<i>benzoyl peroxide gel 8%</i>	1	
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	1	
<i>benzoyl peroxide-hydrocortisone lotion 5-0.5%</i>	1	
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	1	
(Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%) NEUAC	1	
<i>clindamycin phosphate foam 1%</i>	1	
(Clindamycin Phosphate Foam 1%) CLINDACIN	1	
<i>clindamycin phosphate gel 1%</i>	1	
<i>clindamycin phosphate lotion 1%</i>	1	
<i>clindamycin phosphate soln 1%</i>	1	
<i>clindamycin phosphate swab 1%</i>	1	
(Clindamycin Phosphate Swab 1%) CLINDACIN ETZ PLEGETS	1	
(Clindamycin Phosphate Swab 1%) CLINDACIN-P	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i>	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%</i>	1	
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>dapsone gel 5%</i>	1	
<i>dapsone gel 7.5%</i>	1	
EPIDUO FORTE GEL 0.3-2.5% (<i>adapalene-benzoyl peroxide</i>)	2	
EPIDUO GEL 0.1-2.5% (<i>adapalene-benzoyl peroxide</i>)	2	
<i>erythromycin gel 2%</i>	1	
(Erythromycin Pads 2%) ERY	1	
<i>erythromycin soln 2%</i>	1	
<i>isotretinoin cap 10 mg</i>	1	PA
(Isotretinoin Cap 10 mg) ACCUTANE	1	PA
(Isotretinoin Cap 10 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 10 mg) CLARAVIS	1	PA
(Isotretinoin Cap 10 mg) ZENATANE	1	PA
<i>isotretinoin cap 20 mg</i>	1	PA
(Isotretinoin Cap 20 mg) ACCUTANE	1	PA
(Isotretinoin Cap 20 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 20 mg) CLARAVIS	1	PA
(Isotretinoin Cap 20 mg) ZENATANE	1	PA
<i>isotretinoin cap 25 mg</i>	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>isotretinoin cap 30 mg</i>	1	PA
(Isotretinoin Cap 30 mg) ACCUTANE	1	PA
(Isotretinoin Cap 30 mg) CLARAVIS	1	PA
(Isotretinoin Cap 30 mg) ZENATANE	1	PA
<i>isotretinoin cap 35 mg</i>	1	PA
<i>isotretinoin cap 40 mg</i>	1	PA
(Isotretinoin Cap 40 mg) ACCUTANE	1	PA
(Isotretinoin Cap 40 mg) AMNESTEEM	1	PA
(Isotretinoin Cap 40 mg) CLARAVIS	1	PA
(Isotretinoin Cap 40 mg) ZENATANE	1	PA
<i>sulfacetamide sodium lotion 10% (acne)</i>	1	
<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4%</i>	1	
(Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%) SULFAMEZ WASH	1	
<i>tretinoin cream 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin cream 0.05%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin cream 0.025%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin gel 0.01%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin gel 0.05%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin gel 0.025%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin microsphere gel 0.1%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin microsphere gel 0.04%</i>	1	PA; PA Required for age greater than or equal to age 35
<i>tretinoin microsphere gel 0.08%</i>	1	PA; PA Required for age greater than or equal to age 35
TWYNEO CRE 0.1-3% (<i>tretinoin-benzoyl peroxide</i>)	2	PA; PA Required for age greater than or equal to age 35
WINLEVI CRE 1% (<i>clascoterone</i>)	2	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTI-INFLAMMATORY AGENTS - TOPICAL		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium gel 1% (1.16% diethylamine equiv)</i>	1	PA
<i>diclofenac sodium soln 1.5%</i>	1	
ANTIBIOTICS - TOPICAL		
<i>gentamicin sulfate cream 0.1%</i>	1	
<i>gentamicin sulfate oint 0.1%</i>	1	
<i>mupirocin oint 2%</i>	1	
ANTIFUNGALS - TOPICAL		
<i>ciclopirox gel 0.77%</i>	1	
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1	
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1	
<i>ciclopirox shampoo 1%</i>	1	
<i>ciclopirox solution 8%</i>	1	PA
(Ciclopirox Solution 8%) CICLODAN	1	PA
<i>clotrimazole cream 1%</i>	1	
<i>clotrimazole soln 1%</i>	1	
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1	
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1	
<i>econazole nitrate cream 1%</i>	1	
(Iodoquinol-Hydrocortisone In Aloe Vehicle Cream 1-1.9%) IODOQUIMEZ-HC	1	
<i>ketoconazole cream 2%</i>	1	
<i>ketoconazole shampoo 2%</i>	1	
<i>naftifine hcl cream 1%</i>	1	
<i>naftifine hcl cream 2%</i>	1	
<i>naftifine hcl gel 2%</i>	1	
NAFTIN GEL 1% (<i>naftifine hcl</i>)	2	
NAFTIN GEL 2% (<i>naftifine hcl</i>)	2	
<i>nystatin cream 100000 unit/gm</i>	1	
<i>nystatin oint 100000 unit/gm</i>	1	
<i>nystatin topical powder 100000 unit/gm</i>	1	
(Nystatin Topical Powder 100000 unit/gm) NYAMYC	1	
(Nystatin Topical Powder 100000 unit/gm) NYSTOP	1	
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	1	
<i>oxiconazole nitrate cream 1%</i>	1	
<i>sulconazole nitrate cream 1%</i>	1	
<i>sulconazole nitrate solution 1%</i>	1	
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
<i>bexarotene gel 1%</i>	1	SP, PA
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	
<i>fluorouracil cream 5%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
ANTIPSORIATICS		
<i>acitretin cap 10 mg</i>	1	PA
<i>acitretin cap 17.5 mg</i>	1	PA
<i>acitretin cap 25 mg</i>	1	PA
<i>calcipotriene oint 0.005%</i>	1	
(Calcipotriene Oint 0.005%) CALCITRENE	1	
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	1	
<i>methoxsalen rapid cap 10 mg</i>	1	
<i>tazarotene cream 0.1%</i>	1	PA
<i>tazarotene gel 0.1%</i>	1	PA
<i>tazarotene gel 0.05%</i>	1	PA
ZORYVE CRE 0.3% (<i>roflumilast (topical)</i>)	2	
ANTISEBORRHEIC PRODUCTS		
<i>selenium sulfide lotion 2.5%</i>	1	
ANTIVIRALS - TOPICAL		
<i>acyclovir oint 5%</i>	1	
<i>penciclovir cream 1%</i>	1	
BURN PRODUCTS		
<i>mafénide acetate packet for topical soln 5% (50 gm)</i>	1	
<i>silver sulfadiazine cream 1%</i>	1	
(Silver Sulfadiazine Cream 1%) SSD	1	
CORTICOSTEROIDS - TOPICAL		
<i>alclometasone dipropionate cream 0.05%</i>	1	
<i>alclometasone dipropionate oint 0.05%</i>	1	
<i>amcinonide lotion 0.1%</i>	1	
<i>amcinonide oint 0.1%</i>	1	
<i>betamethasone dipropionate augmented cream 0.05%</i>	1	
<i>betamethasone dipropionate augmented gel 0.05%</i>	1	
<i>betamethasone dipropionate augmented lotion 0.05%</i>	1	
<i>betamethasone dipropionate augmented oint 0.05%</i>	1	
<i>betamethasone dipropionate cream 0.05%</i>	1	
<i>betamethasone dipropionate lotion 0.05%</i>	1	
<i>betamethasone valerate aerosol foam 0.12%</i>	1	
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	1	
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	1	
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	1	
BRYHALI LOT 0.01% (<i>halobetasol propionate</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CAPEX SHA 0.01% (<i>fluocinolone acetonide</i>)	2	
<i>clobetasol propionate cream 0.05%</i>	1	
<i>clobetasol propionate emollient base cream 0.05%</i>	1	
<i>clobetasol propionate foam 0.05%</i>	1	
<i>clobetasol propionate gel 0.05%</i>	1	
<i>clobetasol propionate lotion 0.05%</i>	1	
<i>clobetasol propionate oint 0.05%</i>	1	
<i>clobetasol propionate shampoo 0.05%</i>	1	
(Clobetasol Propionate Shampoo 0.05%) CLODAN	1	
<i>clobetasol propionate soln 0.05%</i>	1	
<i>desonide cream 0.05%</i>	1	
<i>desonide lotion 0.05%</i>	1	
<i>desonide oint 0.05%</i>	1	
<i>desoximetasone cream 0.05%</i>	1	
<i>desoximetasone cream 0.25%</i>	1	
<i>desoximetasone gel 0.05%</i>	1	
<i>desoximetasone oint 0.25%</i>	1	
<i>desoximetasone spray 0.25%</i>	1	
ENSTILAR AER (<i>calcipotriene-betamethasone dipropionate</i>)	2	
<i>fluocinolone acetonide cream 0.01%</i>	1	
<i>fluocinolone acetonide cream 0.025%</i>	1	
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	1	
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	1	
<i>fluocinolone acetonide oint 0.025%</i>	1	
<i>fluocinolone acetonide soln 0.01%</i>	1	
<i>fluocinonide cream 0.05%</i>	1	
<i>fluocinonide emulsified base cream 0.05%</i>	1	
<i>fluocinonide gel 0.05%</i>	1	
<i>fluocinonide oint 0.05%</i>	1	
<i>fluocinonide soln 0.05%</i>	1	
<i>fluticasone propionate cream 0.05%</i>	1	
<i>fluticasone propionate lotion 0.05%</i>	1	
<i>fluticasone propionate oint 0.005%</i>	1	
<i>halobetasol propionate cream 0.05%</i>	1	
<i>halobetasol propionate oint 0.05%</i>	1	
<i>hydrocortisone butyrate cream 0.1%</i>	1	
<i>hydrocortisone butyrate oint 0.1%</i>	1	
<i>hydrocortisone butyrate soln 0.1%</i>	1	
<i>hydrocortisone cream 1%</i>	1	
(Hydrocortisone Cream 1%) ALA-CORT	1	
<i>hydrocortisone cream 2.5%</i>	1	
<i>hydrocortisone lotion 2.5%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>hydrocortisone oint 1%</i>	1	
<i>hydrocortisone oint 2.5%</i>	1	
<i>hydrocortisone valerate cream 0.2%</i>	1	
<i>hydrocortisone valerate oint 0.2%</i>	1	
<i>lidocaine-hydrocortisone acetate cream 1-1%</i>	1	
<i>mometasone furoate cream 0.1%</i>	1	
<i>mometasone furoate oint 0.1%</i>	1	
<i>mometasone furoate solution 0.1% (lotion)</i>	1	
TEXACORT SOL 2.5% (<i>hydrocortisone (topical)</i>)	2	
<i>triamcinolone acetonide cream 0.1%</i>	1	
<i>triamcinolone acetonide cream 0.5%</i>	1	
(Triamcinolone Acetonide Cream 0.5%) TRIDERM	1	
<i>triamcinolone acetonide cream 0.025%</i>	1	
<i>triamcinolone acetonide lotion 0.1%</i>	1	
<i>triamcinolone acetonide lotion 0.025%</i>	1	
<i>triamcinolone acetonide oint 0.1%</i>	1	
<i>triamcinolone acetonide oint 0.5%</i>	1	
<i>triamcinolone acetonide oint 0.025%</i>	1	
ECZEMA AGENTS		
CIBINQO TAB 50MG (<i>abrocitinib</i>)	2	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 100MG (<i>abrocitinib</i>)	2	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 200MG (<i>abrocitinib</i>)	2	SP, PA, QL (1 tab every 1 day)
EMOLLIENTS		
<i>lactic acid (ammonium lactate) cream 12%</i>	1	
<i>lactic acid (ammonium lactate) lotion 12%</i>	1	
IMMUNOMODULATING AGENTS - TOPICAL		
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	
ZYCLARA CRE 3.75% (<i>imiquimod</i>)	2	
ZYCLARA PUMP CRE 2.5% (<i>imiquimod</i>)	2	
ZYCLARA PUMP CRE 3.75% (<i>imiquimod</i>)	2	
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
<i>pimecrolimus cream 1%</i>	1	PA
<i>tacrolimus oint 0.1%</i>	1	PA
<i>tacrolimus oint 0.03%</i>	1	PA
KERATOLYTIC/ANTIMITOTIC AGENTS		
CONDYLOX GEL 0.5% (<i>podofilox</i>)	2	
<i>podofilox soln 0.5%</i>	1	
LOCAL ANESTHETICS - TOPICAL		
<i>ethyl chloride aerosol spray</i>	1	
(Lidocaine HCl Cream 3%) LIDOPIN	1	
(Lidocaine HCl Gel 2%) 7T LIDO GEL	1	QL (30 gm every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>lidocaine hcl lotion 3%</i>	1	
<i>lidocaine hcl soln 4%</i>	1	QL (50 mL every 25 days)
<i>lidocaine oint 5%</i>	1	QL (50 gm every 25 days)
<i>lidocaine patch 5%</i>	1	PA
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 25 days)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2% (<i>crisaborole</i>)	2	
ROSACEA AGENTS		
<i>azelaic acid gel 15%</i>	1	
<i>brimonidine tartrate gel 0.33% (base equivalent)</i>	1	
FINACEA AER 15% (<i>azelaic acid</i>)	2	
<i>metronidazole cream 0.75%</i>	1	
<i>metronidazole gel 0.75%</i>	1	
<i>metronidazole gel 1%</i>	1	
<i>metronidazole lotion 0.75%</i>	1	
ORACEA CAP 40MG (<i>doxycycline (rosacea)</i>)	1	
RHOFADE CRE 1% (<i>oxymetazoline hcl (topical)</i>)	2	
SOOLANTRA CRE 1% (<i>ivermectin (rosacea)</i>)	1	
SCABICIDES & PEDICULICIDES		
(Crotamiton Lotion 10%) CROTAN	1	
<i>malathion lotion 0.5%</i>	1	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
DIGESTIVE ENZYMES		
CREON CAP 3000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 6000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 12000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 24000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
CREON CAP 36000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
VIOKACE TAB 10440 (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
VIOKACE TAB 20880 (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 3000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 5000UNIT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZENPEP CAP 10000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 15000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 20000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 25000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO
ZENPEP CAP 40000UNT (<i>pancrelipase (lipase-protease-amylase)</i>)	2	MO

DIURETICS - DRUGS TO TREAT HEART CONDITIONS

CARBONIC ANHYDRASE INHIBITORS

<i>acetazolamide cap er 12hr 500 mg</i>	1	MO
<i>acetazolamide tab 125 mg</i>	1	MO
<i>acetazolamide tab 250 mg</i>	1	MO
<i>dichlorphenamide tab 50 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
<i>methazolamide tab 25 mg</i>	1	MO
<i>methazolamide tab 50 mg</i>	1	MO

DIURETIC COMBINATIONS

<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	MO
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	1	MO
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	MO
<i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	1	MO
<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	1	MO

LOOP DIURETICS

<i>bumetanide tab 0.5 mg</i>	1	MO
<i>bumetanide tab 1 mg</i>	1	MO
<i>bumetanide tab 2 mg</i>	1	MO
<i>ethacrynic acid tab 25 mg</i>	1	MO
<i>furosemide oral soln 8 mg/ml</i>	1	MO
<i>furosemide oral soln 10 mg/ml</i>	1	MO
<i>furosemide tab 20 mg</i>	1	MO
<i>furosemide tab 40 mg</i>	1	MO
<i>furosemide tab 80 mg</i>	1	MO
<i>torsemide tab 5 mg</i>	1	MO
<i>torsemide tab 10 mg</i>	1	MO
<i>torsemide tab 20 mg</i>	1	MO
<i>torsemide tab 100 mg</i>	1	MO

POTASSIUM SPARING DIURETICS

<i>amiloride hcl tab 5 mg</i>	1	MO
<i>spironolactone susp 25 mg/5ml</i>	1	MO
<i>spironolactone tab 25 mg</i>	1	MO
<i>spironolactone tab 50 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>spironolactone tab 100 mg</i>	1	MO
<i>triامترنے cap 50 mg</i>	1	MO
<i>triامترنے cap 100 mg</i>	1	MO
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
<i>chlorthalidone tab 25 mg</i>	1	MO
<i>chlorthalidone tab 50 mg</i>	1	MO
<i>hydrochlorothiazide cap 12.5 mg</i>	1	MO
<i>hydrochlorothiazide tab 12.5 mg</i>	1	MO
<i>hydrochlorothiazide tab 25 mg</i>	1	MO
<i>hydrochlorothiazide tab 50 mg</i>	1	MO
<i>indapamide tab 1.25 mg</i>	1	MO
<i>indapamide tab 2.5 mg</i>	1	MO
<i>metolazone tab 2.5 mg</i>	1	MO
<i>metolazone tab 5 mg</i>	1	MO
<i>metolazone tab 10 mg</i>	1	MO
ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES		
BONE DENSITY REGULATORS		
<i>alendronate sodium oral soln 70 mg/75ml</i>	1	MO
<i>alendronate sodium tab 5 mg</i>	1	MO
<i>alendronate sodium tab 10 mg</i>	1	MO
<i>alendronate sodium tab 35 mg</i>	1	MO
<i>alendronate sodium tab 70 mg</i>	1	MO
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	1	MO
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1	MO
<i>risedronate sodium tab 5 mg</i>	1	MO
<i>risedronate sodium tab 30 mg</i>	1	
<i>risedronate sodium tab 35 mg</i>	1	MO
<i>risedronate sodium tab 150 mg</i>	1	MO
<i>risedronate sodium tab delayed release 35 mg</i>	1	MO
FERTILITY REGULATORS		
<i>clomiphene citrate tab 50 mg</i>	1	Only covered if member has supplemental benefit. Limit 3 fills per lifetime.
GNRH/LHRH ANTAGONISTS		
<i>ORILISSA TAB 150MG (elagolix sodium)</i>	2	
<i>ORILISSA TAB 200MG (elagolix sodium)</i>	2	
HORMONE RECEPTOR MODULATORS		
<i>raloxifene hcl tab 60 mg</i>	1	MO; \$0 copay ages 35 and older for the primary prevention of breast cancer
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
<i>SYNAREL SOL 2MG/ML (nafarelin acetate)</i>	3	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
METABOLIC MODIFIERS		
<i>betaine powder for oral solution</i>	1	SP, PA
<i>calcitriol cap 0.5 mcg</i>	1	MO
<i>calcitriol cap 0.25 mcg</i>	1	MO
<i>calcitriol oral soln 1 mcg/ml</i>	1	MO
<i>carglumic acid soluble tab 200 mg</i>	1	SP, PA
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	1	SP, PA, QL (4 tabs every 1 day)
<i>doxercalciferol cap 0.5 mcg</i>	1	MO
<i>doxercalciferol cap 1 mcg</i>	1	MO
<i>doxercalciferol cap 2.5 mcg</i>	1	MO
<i>levocarnitine oral soln 1 gm/10ml (10%)</i>	1	MO
<i>levocarnitine tab 330 mg</i>	1	MO
<i>nitisinone cap 2 mg</i>	1	SP, PA
<i>nitisinone cap 5 mg</i>	1	SP, PA
<i>nitisinone cap 10 mg</i>	1	SP, PA
<i>nitisinone cap 20 mg</i>	1	SP, PA
ORFADIN CAP 2MG (<i>nitisinone</i>)	2	SP, PA
ORFADIN CAP 5MG (<i>nitisinone</i>)	2	SP, PA
ORFADIN CAP 10MG (<i>nitisinone</i>)	2	SP, PA
ORFADIN CAP 20MG (<i>nitisinone</i>)	2	SP, PA
ORFADIN SUS 4MG/ML (<i>nitisinone</i>)	2	PA, MO
<i>paricalcitol cap 1 mcg</i>	1	MO
<i>paricalcitol cap 2 mcg</i>	1	MO
<i>paricalcitol cap 4 mcg</i>	1	MO
<i>sapropterin dihydrochloride powder packet 100 mg</i>	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 100 mg)	1	SP, PA
JAVYGTOR		
<i>sapropterin dihydrochloride powder packet 500 mg</i>	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 500 mg)	1	SP, PA
JAVYGTOR		
<i>sapropterin dihydrochloride tab 100 mg</i>	1	SP, PA
(Sapropterin Dihydrochloride Tab 100 mg) JAVYGTOR	1	SP, PA
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i>	1	SP, PA, QL (26.6 gm every 1 day)
<i>sodium phenylbutyrate tab 500 mg</i>	1	SP, PA, QL (40 tabs every 1 day)
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG (<i>finerenone</i>)	2	PA, MO
KERENDIA TAB 20MG (<i>finerenone</i>)	2	PA, MO
POSTERIOR PITUITARY HORMONES		
<i>desmopressin acetate nasal spray soln 0.01%</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	1	MO
<i>desmopressin acetate tab 0.1 mg</i>	1	MO
<i>desmopressin acetate tab 0.2 mg</i>	1	MO
PROGESTERONE RECEPTOR ANTAGONISTS		
<i>mifepristone tab 200 mg</i>	1	
PROLACTIN INHIBITORS		
<i>cabergoline tab 0.5 mg</i>	1	
VASOPRESSIN RECEPTOR ANTAGONISTS		
<i>tolvaptan tab 15 mg</i>	1	SP, PA
<i>tolvaptan tab 30 mg</i>	1	SP, PA
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
ESTROGEN COMBINATIONS		
<i>CLIMARA PRO DIS WEEKLY (estradiol-levonorgestrel)</i>	2	MO
<i>COMBIPATCH DIS (estradiol & norethindrone acetate)</i>	2	MO
<i>DUAVEE TAB 0.45-20 (conjugated estrogens-bazedoxifene)</i>	2	MO
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	MO
(Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg) AMABELZ	1	MO
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	1	MO
(Estradiol & Norethindrone Acetate Tab 1-0.5 mg) AMABELZ	1	MO
(Estradiol & Norethindrone Acetate Tab 1-0.5 mg) MIMVEY	1	MO
<i>MYFEMBREE TAB (relugolix-estradiol-norethindrone acetate)</i>	2	
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg) FYAVOLV	1	MO
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg) FYAVOLV	1	MO
(Norethindrone Acetate-Ethyln Estradiol Tab 1 mg-5 mcg) JINTELI	1	MO
<i>ORIAHNN CAP (elagolix sodium-estradiol-norethindrone acetate)</i>	2	
<i>PREMPHASE TAB (conjugated estrogens-medroxyprogesterone acetate)</i>	2	MO
<i>PREMPRO TAB (conjugated estrogens-medroxyprogesterone acetate)</i>	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PREMPRO TAB 0.3-1.5 (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
PREMPRO TAB 0.45-1.5 (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
PREMPRO TAB 0.625-5 (<i>conjugated estrogens-medroxyprogesterone acetate</i>)	2	MO
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
DIVIGEL GEL 0.5MG (<i>estradiol</i>)	2	MO
DIVIGEL GEL 0.25MG (<i>estradiol</i>)	2	MO
DIVIGEL GEL 0.75MG (<i>estradiol</i>)	2	MO
DIVIGEL GEL 1.25MG (<i>estradiol</i>)	2	MO
DIVIGEL GEL 1MG/GM (<i>estradiol</i>)	2	MO
<i>estradiol tab 0.5 mg</i>	1	MO
<i>estradiol tab 1 mg</i>	1	MO
<i>estradiol tab 2 mg</i>	1	MO
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	1	MO
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i>	1	MO
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i>	1	MO
<i>estradiol td gel 1 mg/gm (0.1%)</i>	1	MO
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i>	1	MO
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.1 mg/24hr) DOTTI	1	MO
(Estradiol Td Patch Twice Weekly 0.1 mg/24hr)	1	MO
LYLLANA		
<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.05 mg/24hr)	1	MO
DOTTI		
(Estradiol Td Patch Twice Weekly 0.05 mg/24hr)	1	MO
LYLLANA		
<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.025 mg/24hr)	1	MO
DOTTI		
(Estradiol Td Patch Twice Weekly 0.025 mg/24hr)	1	MO
LYLLANA		
<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.075 mg/24hr)	1	MO
DOTTI		
(Estradiol Td Patch Twice Weekly 0.075 mg/24hr)	1	MO
LYLLANA		
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	1	MO
(Estradiol Td Patch Twice Weekly 0.0375 mg/24hr)	1	MO
DOTTI		
(Estradiol Td Patch Twice Weekly 0.0375 mg/24hr)	1	MO
LYLLANA		

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>estradiol td patch weekly 0.1 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.05 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.06 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.025 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.075 mg/24hr</i>	1	MO
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	1	MO
EVAMIST SPR 1.53MG (<i>estradiol</i>)	2	MO

FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS

FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS

<i>CIPRO (5%) SUS 250MG/5 (<i>ciprofloxacin</i>)</i>	3
<i>CIPRO (10%) SUS 500MG/5 (<i>ciprofloxacin</i>)</i>	3
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	1
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	1
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	1
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	1
<i>levofloxacin oral soln 25 mg/ml</i>	1
<i>levofloxacin tab 250 mg</i>	1
<i>levofloxacin tab 500 mg</i>	1
<i>levofloxacin tab 750 mg</i>	1
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1
<i>ofloxacin tab 300 mg</i>	1
<i>ofloxacin tab 400 mg</i>	1

GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL

DISORDERS

GALLSTONE SOLUBILIZING AGENTS

<i>ursodiol cap 300 mg</i>	1	MO
<i>ursodiol tab 250 mg</i>	1	MO
<i>ursodiol tab 500 mg</i>	1	MO

GASTROINTESTINAL ANTIALLERGY AGENTS

<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	MO
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GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS

<i>lubiprostone cap 8 mcg</i>	1	PA, MO
<i>lubiprostone cap 24 mcg</i>	1	PA, MO

GASTROINTESTINAL STIMULANTS

<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	1
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	1
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	1
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	1

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
INFLAMMATORY BOWEL AGENTS		
<i>balsalazide disodium cap 750 mg</i>	1	
<i>mesalamine cap dr 400 mg</i>	1	MO
<i>mesalamine cap er 24hr 0.375 gm</i>	1	MO
<i>mesalamine enema 4 gm</i>	1	
<i>mesalamine suppos 1000 mg</i>	1	
<i>mesalamine tab delayed release 1.2 gm</i>	1	MO
<i>mesalamine tab delayed release 800 mg</i>	1	
<i>sulfasalazine tab 500 mg</i>	1	MO
<i>sulfasalazine tab delayed release 500 mg</i>	1	MO
INTESTINAL ACIDIFIERS		
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	1	MO
(Lactulose (Encephalopathy) Solution 10 gm/15ml)	1	MO
ENULOSE		
(Lactulose (Encephalopathy) Solution 10 gm/15ml)	1	MO
GENERLAC		
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
<i>alosetron hcl tab 0.5 mg (base equiv)</i>	1	PA, MO
<i>alosetron hcl tab 1 mg (base equiv)</i>	1	PA, MO
LINZESS CAP 72MCG (<i>linaclootide</i>)	2	PA, MO
LINZESS CAP 145MCG (<i>linaclootide</i>)	2	PA, MO
LINZESS CAP 290MCG (<i>linaclootide</i>)	2	PA, MO
VIBERZI TAB 75MG (<i>eluxadoline</i>)	2	PA, MO
VIBERZI TAB 100MG (<i>eluxadoline</i>)	2	PA, MO
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
SYMPROIC TAB 0.2MG (<i>naldemedine tosylate</i>)	2	
PHOSPHATE BINDER AGENTS		
AURYXIA TAB 210MG (<i>ferric citrate</i>)	2	MO
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	MO
<i>calcium acetate (phosphate binder) tab 667 mg</i>	1	MO
<i>sevelamer carbonate packet 0.8 gm</i>	1	MO
<i>sevelamer carbonate packet 2.4 gm</i>	1	MO
<i>sevelamer carbonate tab 800 mg</i>	1	MO
<i>sevelamer hcl tab 400 mg</i>	1	MO
<i>sevelamer hcl tab 800 mg</i>	1	MO
VELPHORO CHW 500MG (<i>sucroferric oxyhydroxide</i>)	2	MO
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
ALKALINIZERS		
(Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg) CYTRA K CRYSTALS	1	

MO - Available at mail-order OAC - Oral Anti-Cancer PA - Prior Authorization PA** - Prior Authorization if step therapy is not met QL - Quantity Limits SP - Specialty ST - Step Therapy

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>potassium citrate tab er 5 meq (540 mg)</i>	1	
<i>potassium citrate tab er 10 meq (1080 mg)</i>	1	
<i>potassium citrate tab er 15 meq (1620 mg)</i>	1	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG (<i>cysteamine bitartrate</i>)	2	SP, PA
CYSTAGON CAP 150MG (<i>cysteamine bitartrate</i>)	2	SP, PA
PROSTATIC HYPERPLASIA AGENTS		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	1	MO
<i>dutasteride cap 0.5 mg</i>	1	MO
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	1	MO
<i>finasteride tab 5 mg</i>	1	MO
<i>silodosin cap 4 mg</i>	1	MO
<i>silodosin cap 8 mg</i>	1	MO
<i>tamsulosin hcl cap 0.4 mg</i>	1	MO
URINARY ANALGESICS		
(Phenazopyridine Hcl Tab 200 mg) PHENAZO	1	
URINARY STONE AGENTS		
<i>tiopronin tab 100 mg</i>	1	SP, PA
GOUT AGENTS - DRUGS TO TREAT GOUT		
GOUT AGENT COMBINATIONS		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	MO
GOUT AGENTS - DRUGS TO TREAT GOUT		
<i>allopurinol tab 100 mg</i>	1	MO
<i>allopurinol tab 300 mg</i>	1	MO
<i>colchicine cap 0.6 mg</i>	1	
<i>colchicine tab 0.6 mg</i>	1	
<i>febuxostat tab 40 mg</i>	1	MO
<i>febuxostat tab 80 mg</i>	1	MO
<i>MITIGARE CAP 0.6MG (colchicine)</i>	1	
URICOSURICS		
<i>probenecid tab 500 mg</i>	1	MO
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS		
HEMATOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB 100MG (<i>fostamatinib disodium</i>)	2	PA, QL (2 tabs every 1 day), MO
TAVALISSE TAB 150MG (<i>fostamatinib disodium</i>)	2	PA, QL (2 tabs every 1 day), MO
HEMATORHEOLOGIC AGENTS		
<i>pentoxifylline tab er 400 mg</i>	1	MO
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO CAP 110MG (<i>berotralstat hcl</i>)	2	PA, QL (1 cap every 1 day), MO
ORLADEYO CAP 150MG (<i>berotralstat hcl</i>)	2	PA, QL (1 cap every 1 day), MO

MO - Available at mail-order **OAC** - Oral Anti-Cancer **PA** - Prior Authorization **PA**** - Prior Authorization if step therapy is not met **QL** - Quantity Limits **SP** - Specialty **ST** - Step Therapy

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PLATELET AGGREGATION INHIBITORS		
<i>anagrelide hcl cap 0.5 mg</i>	1	MO
<i>anagrelide hcl cap 1 mg</i>	1	MO
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	1	MO
BRILINTA TAB 60MG (<i>ticagrelor</i>)	2	MO
BRILINTA TAB 90MG (<i>ticagrelor</i>)	2	MO
<i>cilostazol tab 50 mg</i>	1	MO
<i>cilostazol tab 100 mg</i>	1	MO
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	1	MO
<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	1	
<i>dipyridamole tab 25 mg</i>	1	MO
<i>dipyridamole tab 50 mg</i>	1	MO
<i>dipyridamole tab 75 mg</i>	1	MO
<i>prasugrel hcl tab 5 mg (base equiv)</i>	1	MO
<i>prasugrel hcl tab 10 mg (base equiv)</i>	1	MO
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG (<i>eliglustat tartrate</i>)	2	SP, PA, QL (2 caps every 1 day)
<i>miglustat cap 100 mg</i>	1	SP, PA, QL (3 caps every 1 day)
(Miglustat Cap 100 mg) YARGESA	1	SP, PA, QL (3 caps every 1 day)
AGENTS FOR SICKLE CELL DISEASE		
SIKLOS TAB 100MG (<i>hydroxyurea (sickle cell disease)</i>)	2	
SIKLOS TAB 1000MG (<i>hydroxyurea (sickle cell disease)</i>)	2	
FOLIC ACID/FOLATES		
<i>folic acid cap 0.8 mg</i>	PV	QL (100 caps every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Cap 0.8 mg) FA-8	PV	QL (100 caps every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
<i>folic acid tab 1 mg</i>	1	MO
<i>folic acid tab 400 mcg</i>	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 400 mcg) FOLATE	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 400 mcg) GNP FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 400 mcg) HM FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Folic Acid Tab 400 mcg) PX FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 400 mcg) RA FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 400 mcg) SM FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 400 mcg) YL FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for ages 55 and under, otherwise not covered
<i>folic acid tab 800 mcg</i>	PV	QL (100 tabs every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 800 mcg) CVS FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 800 mcg) FA-8	PV	QL (100 tabs every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 800 mcg) KP FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 800 mcg) QC FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered
(Folic Acid Tab 800 mcg) RA FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for ages 55 and under, otherwise not covered

HEMATOPOIETIC GROWTH FACTORS

DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC; 1 carton of 1 blister card (10 tabs)
DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA, QL (2 tabs every 1 day); OAC; 1 carton of 2 blister card (15 tabs)
DOPTELET TAB 20MG (<i>avatrombopag maleate</i>)	2	SP, PA, QL (3 tabs every 1 day); OAC; 1 carton of 1 blister card (15 tabs)
PROMACTA PAK 25MG (<i>eltrombopag olamine</i>)	2	SP, PA, QL (6 packets every 1 day)
PROMACTA POW 12.5MG (<i>eltrombopag olamine</i>)	2	SP, PA, QL (4 packets every 1 day)
PROMACTA TAB 12.5MG (<i>eltrombopag olamine</i>)	2	SP, PA, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PROMACTA TAB 25MG (<i>eltrombopag olamine</i>)	2	SP, PA, QL (1 tab every 1 day)
PROMACTA TAB 50MG (<i>eltrombopag olamine</i>)	2	SP, PA, QL (2 tabs every 1 day)
PROMACTA TAB 75MG (<i>eltrombopag olamine</i>)	2	SP, PA, QL (2 tabs every 1 day)

HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS

HEMOSTATICS - SYSTEMIC

<i>aminocaproic acid oral soln 0.25 gm/ml</i>	1
<i>aminocaproic acid tab 500 mg</i>	1
<i>aminocaproic acid tab 1000 mg</i>	1
<i>tranexamic acid tab 650 mg</i>	1

HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS

BARBITURATE HYPNOTICS

<i>phenobarbital elixir 20 mg/5ml</i>	1	MO
<i>phenobarbital tab 15 mg</i>	1	MO
<i>phenobarbital tab 16.2 mg</i>	1	MO
<i>phenobarbital tab 30 mg</i>	1	MO
<i>phenobarbital tab 32.4 mg</i>	1	MO
<i>phenobarbital tab 60 mg</i>	1	MO
<i>phenobarbital tab 64.8 mg</i>	1	MO
<i>phenobarbital tab 97.2 mg</i>	1	MO
<i>phenobarbital tab 100 mg</i>	1	MO

HYPNOTICS - TRICYCLIC AGENTS

<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1

NON-BARBITURATE HYPNOTICS

<i>estazolam tab 1 mg</i>	1	QL (15 tabs every 25 days)
<i>estazolam tab 2 mg</i>	1	QL (15 tabs every 25 days)
<i>eszopiclone tab 1 mg</i>	1	QL (15 tabs every 25 days)
<i>eszopiclone tab 2 mg</i>	1	QL (15 tabs every 25 days)
<i>eszopiclone tab 3 mg</i>	1	QL (15 tabs every 25 days)
<i>flurazepam hcl cap 15 mg</i>	1	QL (15 caps every 25 days)
<i>flurazepam hcl cap 30 mg</i>	1	QL (15 caps every 25 days)
<i>midazolam hcl syrup 2 mg/ml (base equivalent)</i>	1	
<i>temazepam cap 7.5 mg</i>	1	QL (15 caps every 25 days)
<i>temazepam cap 15 mg</i>	1	QL (15 caps every 25 days)
<i>temazepam cap 22.5 mg</i>	1	QL (15 caps every 25 days)
<i>temazepam cap 30 mg</i>	1	QL (15 caps every 25 days)
<i>triazolam tab 0.25 mg</i>	1	QL (10 tabs every 25 days)
<i>triazolam tab 0.125 mg</i>	1	QL (10 tabs every 25 days)
<i>zaleplon cap 5 mg</i>	1	QL (15 caps every 25 days)
<i>zaleplon cap 10 mg</i>	1	QL (15 caps every 25 days)
<i>zolpidem tartrate tab 5 mg</i>	1	QL (15 tabs every 25 days)
<i>zolpidem tartrate tab 10 mg</i>	1	QL (15 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>zolpidem tartrate tab er 6.25 mg</i>	1	QL (15 tabs every 25 days)
<i>zolpidem tartrate tab er 12.5 mg</i>	1	QL (15 tabs every 25 days)
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB 5MG (<i>suvorexant</i>)	2	PA
BELSOMRA TAB 10MG (<i>suvorexant</i>)	2	PA
BELSOMRA TAB 15MG (<i>suvorexant</i>)	2	PA
BELSOMRA TAB 20MG (<i>suvorexant</i>)	2	PA
DAYVIGO TAB 5MG (<i>lemborexant</i>)	2	ST
DAYVIGO TAB 10MG (<i>lemborexant</i>)	2	ST
QUVIVIQ TAB 25MG (<i>daridorexant hcl</i>)	2	ST
QUVIVIQ TAB 50MG (<i>daridorexant hcl</i>)	2	ST
SELECTIVE MELATONIN RECEPTOR AGONISTS		
<i>ramelteon tab 8 mg</i>	1	QL (15 tabs every 25 days)
<i>tasimelteon capsule 20 mg</i>	1	SP, PA, QL (1 cap every 1 day)
LAXATIVES - DRUGS TO TREAT CONSTIPATION		
LAXATIVE COMBINATIONS		
CLENPIQ SOL (<i>sodium picosulfate-magnesium oxide-anhydrous citric acid</i>)	PV	\$0 copay for members age 45 through 74
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm) GAVILYTE-G	1	
(Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm) GAVILYTE-C	1	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	1	
PREPOPIK PAK (<i>sodium picosulfate-magnesium oxide-anhydrous citric acid</i>)	PV	\$0 copay for members age 45 through 74
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	PV	\$0 copay for members age 45 through 74
LAXATIVES - MISCELLANEOUS		
<i>lactulose solution 10 gm/15ml</i>	1	MO
(Lactulose Solution 10 gm/15ml) CONSTULOSE	1	MO
MACROLIDES - DRUGS TO TREAT INFECTIONS		
AZITHROMYCIN		
<i>azithromycin for susp 100 mg/5ml</i>	1	
<i>azithromycin for susp 200 mg/5ml</i>	1	
<i>azithromycin powd pack for susp 1 gm</i>	1	
<i>azithromycin tab 250 mg</i>	1	
<i>azithromycin tab 500 mg</i>	1	
<i>azithromycin tab 600 mg</i>	1	
CLARITHROMYCIN		
<i>clarithromycin for susp 125 mg/5ml</i>	1	
<i>clarithromycin for susp 250 mg/5ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>clarithromycin tab 250 mg</i>	1	
<i>clarithromycin tab 500 mg</i>	1	
<i>clarithromycin tab er 24hr 500 mg</i>	1	
ERYTHROMYCINS		
<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate tab 400 mg</i>	1	
(Erythromycin Ethylsuccinate Tab 400 mg) E.E.S. 400	1	
(Erythromycin Stearate Tab 250 mg) ERYTHROCIN STEARATE	1	
<i>erythromycin tab 250 mg</i>	1	
<i>erythromycin tab 500 mg</i>	1	
<i>erythromycin tab delayed release 250 mg</i>	1	
(Erythromycin Tab Delayed Release 250 mg) ERY-TAB	1	
<i>erythromycin tab delayed release 333 mg</i>	1	
(Erythromycin Tab Delayed Release 333 mg) ERY-TAB	1	
<i>erythromycin tab delayed release 500 mg</i>	1	
(Erythromycin Tab Delayed Release 500 mg) ERY-TAB	1	
<i>erythromycin w/ delayed release particles cap 250 mg</i>	1	
FIDAXOMICIN		
DIFICID SUS (<i>fidaxomicin</i>)	2	
DIFICID TAB 200MG (<i>fidaxomicin</i>)	2	
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING		
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
FC2 FEMALE MIS CONDOM (<i>condoms - female</i>)	PV	QL (36 condoms every 75 days)
FC FEMALE MIS CONDOM (<i>condoms - female</i>)	PV	QL (36 condoms every 75 days)
MALE MIS CONDOM (<i>condoms latex lubricated - male</i>)	PV	QL (36 condoms every 75 days)
PARENTERAL THERAPY SUPPLIES		
BD INSULIN PEN NEEDLES - OTC (<i>insulin pen needle</i>)	2	
BD INSULIN SYRINGE - OTC (<i>insulin syringe/needle u-100</i>)	2	
BD INSULIN SYRINGE - OTC (<i>insulin syringes (disposable)</i>)	2	
BD INSULIN SYRINGE - RX (<i>insulin syringe/needle u-100</i>)	2	
BD INSULIN SYRINGE - RX (<i>insulin syringe/needle u-500</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS FLOW-VU (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR PLS MIS LRG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR PLS MIS MED MASK (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR PLS MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
AERCHMBR Z- MIS STAT PLS (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS CHAMBER (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS FLOSIGNA (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS MV (<i>spacer/aerosol-holding chambers</i>)	2	
AEROCHAMBER MIS PLUS (<i>spacer/aerosol-holding chambers</i>)	2	
AEROVENT MIS PLUS (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHE EASE MIS LG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHE EASE MIS MED MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHE EASE MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHERITE MIS (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHERITE MIS LG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHERITE MIS MED MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHERITE MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHERITE MIS SPACER (<i>spacer/aerosol-holding chambers</i>)	2	
BREATHERITE MIS W/MASK (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS CHAMBER (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS LG MASK (<i>spacer/aerosol-holding chambers</i>)	2	
COMPACT SPAC MIS MD MASK (<i>spacer/aerosol-holding chambers</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
COMPACT SPAC MIS SM MASK (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS MASK LG (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS MASK MED (<i>spacer/aerosol-holding chambers</i>)	2	
EASIVENT MIS MASK SM (<i>spacer/aerosol-holding chambers</i>)	2	
FLEXICHAMBER MIS (<i>spacer/aerosol-holding chambers</i>)	2	
FLEXICHAMBER MIS MASK LRG (<i>spacer/aerosol-holding chamber supplies - masks</i>)	2	
FLEXICHAMBER MIS MASK SM (<i>spacer/aerosol-holding chamber supplies - masks</i>)	2	
HOLD CHAMBER MIS ADLT LG (<i>spacer/aerosol-holding chambers</i>)	2	
HOLD CHAMBER MIS MEDIUM (<i>spacer/aerosol-holding chambers</i>)	2	
HOLD CHAMBER MIS SMALL (<i>spacer/aerosol-holding chambers</i>)	2	
INSPIRACHAMB MIS LARGE (<i>spacer/aerosol-holding chambers</i>)	2	
INSPIRACHAMB MIS MEDIUM (<i>spacer/aerosol-holding chambers</i>)	2	
INSPIRACHAMB MIS MOUTHPC (<i>spacer/aerosol-holding chambers</i>)	2	
INSPIRACHAMB MIS SMALL (<i>spacer/aerosol-holding chambers</i>)	2	
INSPIREASE MIS DD SYST (<i>spacer/aerosol-holding chambers</i>)	2	
LITEAIRE MIS (<i>spacer/aerosol-holding chambers</i>)	2	
MICROCHAMBER MIS (<i>spacer/aerosol-holding chambers</i>)	2	
MICROSPACER MIS (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS ADV LRG (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS ADV MED (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS ADV SM (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS DIA LG (<i>spacer/aerosol-holding chambers</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPTICHAMBER MIS DIA MD (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS DIA SM (<i>spacer/aerosol-holding chambers</i>)	2	
OPTICHAMBER MIS DIAMOND (<i>spacer/aerosol-holding chambers</i>)	2	
OPTIHALER MIS (<i>spacer/aerosol-holding chambers</i>)	2	
POCKET CHAMB MIS (<i>spacer/aerosol-holding chambers</i>)	2	
POCKET SPACE MIS (<i>spacer/aerosol-holding chambers</i>)	2	
PROCHAMBER MIS VHC (<i>spacer/aerosol-holding chambers</i>)	2	
RITEFLO MIS (<i>spacer/aerosol-holding chambers</i>)	2	
VORTEX VALVE MIS CHAMBER (<i>spacer/aerosol-holding chambers</i>)	2	
WATCHHALER MIS (<i>spacer/aerosol-holding chambers</i>)	2	

MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES

CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG

NURTEC TAB 75MG ODT (<i>rimegepant sulfate</i>)	2	
QULIPTA TAB 10MG (<i>atogepant</i>)	2	MO
QULIPTA TAB 30MG (<i>atogepant</i>)	2	MO
QULIPTA TAB 60MG (<i>atogepant</i>)	2	MO
UBRELVY TAB 50MG (<i>ubrogepant</i>)	2	
UBRELVY TAB 100MG (<i>ubrogepant</i>)	2	

SEROTONIN AGONISTS

<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 tabs every 25 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 tabs every 25 days)
<i>eletriptan hydrobromide tab 20 mg (base equivalent)</i>	1	QL (12 tabs every 25 days)
<i>eletriptan hydrobromide tab 40 mg (base equivalent)</i>	1	QL (12 tabs every 25 days)
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i>	1	QL (18 tabs every 25 days)
<i>naratriptan hcl tab 1 mg (base equiv)</i>	1	QL (12 tabs every 25 days)
<i>naratriptan hcl tab 2.5 mg (base equiv)</i>	1	QL (12 tabs every 25 days)
ONZETRA XSAI MIS 11MG (<i>sumatriptan succinate</i>)	2	ST, QL (16 nosepieces (8 pouches) every 25 days); PA**
REYVOW TAB 50MG (<i>lasmiditan succinate</i>)	3	
REYVOW TAB 100MG (<i>lasmiditan succinate</i>)	3	
<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i>	1	QL (18 tabs every 25 days)
<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq)</i>	1	QL (18 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	1	QL (18 tabs every 25 days)
<i>rizatriptan benzoate tab 10 mg (base equivalent)</i>	1	QL (18 tabs every 25 days)
<i>sumatriptan nasal spray 5 mg/act</i>	1	QL (24 sprays (4 boxes) every 25 days)
<i>sumatriptan nasal spray 20 mg/act</i>	1	QL (12 sprays (2 boxes) every 25 days)
<i>sumatriptan succinate inj 6 mg/0.5ml</i>	1	QL (12 injections every 25 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml</i>	1	QL (18 injections every 25 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml</i>	1	QL (12 injections every 25 days)
<i>sumatriptan succinate solution cartridge 4 mg/0.5ml</i>	1	QL (18 injections every 25 days)
<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	1	QL (12 injections every 25 days)
<i>sumatriptan succinate tab 25 mg</i>	1	QL (12 tabs every 25 days)
<i>sumatriptan succinate tab 50 mg</i>	1	QL (12 tabs every 25 days)
<i>sumatriptan succinate tab 100 mg</i>	1	QL (12 tabs every 25 days)
ZEMBRACE SYM INJ 3/0.5ML (<i>sumatriptan succinate</i>)	2	ST, QL (24 injections every 25 days); PA**
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	1	QL (12 bottles every 25 days)
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	1	QL (12 tabs every 25 days)
<i>zolmitriptan orally disintegrating tab 5 mg</i>	1	QL (12 tabs every 25 days)
<i>zolmitriptan tab 2.5 mg</i>	1	QL (12 tabs every 25 days)
<i>zolmitriptan tab 5 mg</i>	1	QL (12 tabs every 25 days)

MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION

FLUORIDE

FLUORABON DRO (<i>sodium fluoride</i>)	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)</i>	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)</i>	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride chew tab 1 mg f (from 2.2 mg naf)</i>	1	MO
<i>sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)</i>	PV	MO; \$0 applies for ages 5 and under
(Sodium Fluoride Soln 0.25 mg/drop F (From 0.55 mg/drop Naf)) FLURA-DROPS	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride tab 0.5 mg f (from 1.1 mg naf)</i>	PV	MO; \$0 applies for ages 5 and under
<i>sodium fluoride tab 1 mg f (from 2.2 mg naf)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
PHOSPHATE		
(Potassium Phosphate Monobasic Tab 500 mg) PHOSPHO-TRIN K500	1	MO
POTASSIUM		
(Potassium Bicarbonate Effer Tab 25 meq) EFFER-K	1	MO
(Potassium Bicarbonate Effer Tab 25 meq) K-PRIME	1	MO
(Potassium Bicarbonate Effer Tab 25 meq) KLOR-CON/EF	1	MO
<i>potassium chloride cap er 8 meq</i>	1	MO
<i>potassium chloride cap er 10 meq</i>	1	MO
<i>potassium chloride microencapsulated crys er tab 10 meq</i>	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 10 meq) KLOR-CON M10	1	MO
<i>potassium chloride microencapsulated crys er tab 15 meq</i>	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 15 meq) KLOR-CON M15	1	MO
<i>potassium chloride microencapsulated crys er tab 20 meq</i>	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 20 meq) KLOR-CON M20	1	MO
<i>potassium chloride oral soln 10% (20 meq/15ml)</i>	1	MO
<i>potassium chloride oral soln 20% (40 meq/15ml)</i>	1	MO
<i>potassium chloride powder packet 20 meq</i>	1	MO
(Potassium Chloride Powder Packet 20 meq) KLOR-CON	1	MO
<i>potassium chloride tab er 8 meq (600 mg)</i>	1	MO
(Potassium Chloride Tab Er 8 meq (600 mg)) KLOR-CON 8	1	MO
<i>potassium chloride tab er 10 meq</i>	1	MO
(Potassium Chloride Tab Er 10 meq) KLOR-CON 10	1	MO
<i>potassium chloride tab er 20 meq (1500 mg)</i>	1	MO
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
<i>penicillamine cap 250 mg</i>	1	SP
<i>penicillamine tab 250 mg</i>	1	SP
<i>trientine hcl cap 250 mg</i>	1	SP
IMMUNOMODULATORS		
<i>lenalidomide cap 5 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>lenalidomide cap 10 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>lenalidomide cap 15 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<i>lenalidomide cap 20 mg</i>	1	SP, PA, QL (42 caps every 28 days); OAC
<i>lenalidomide cap 25 mg</i>	1	SP, PA, QL (42 caps every 28 days); OAC
<i>lenalidomide caps 2.5 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 2.5MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 5MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 10MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 15MG (<i>lenalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
REVLIMID CAP 20MG (<i>lenalidomide</i>)	2	SP, PA, QL (42 caps every 28 days); OAC
REVLIMID CAP 25MG (<i>lenalidomide</i>)	2	SP, PA, QL (42 caps every 28 days); OAC
THALOMID CAP 50MG (<i>thalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
THALOMID CAP 100MG (<i>thalidomide</i>)	2	SP, PA, QL (1 cap every 1 day); OAC
THALOMID CAP 150MG (<i>thalidomide</i>)	2	SP, PA, QL (2 caps every 1 day); OAC
THALOMID CAP 200MG (<i>thalidomide</i>)	2	SP, PA, QL (2 caps every 1 day); OAC

IMMUNOSUPPRESSIVE AGENTS

<i>azathioprine tab 50 mg</i>	1	MO
<i>azathioprine tab 75 mg</i>	1	MO
(Azathioprine Tab 75 mg) AZASAN	1	MO
<i>azathioprine tab 100 mg</i>	1	MO
(Azathioprine Tab 100 mg) AZASAN	1	MO
<i>cyclosporine cap 25 mg</i>	1	SP
<i>cyclosporine cap 100 mg</i>	1	SP
<i>cyclosporine modified cap 25 mg</i>	1	SP
(Cyclosporine Modified Cap 25 mg) GENGRAF	1	SP
<i>cyclosporine modified cap 50 mg</i>	1	SP
<i>cyclosporine modified cap 100 mg</i>	1	SP
(Cyclosporine Modified Cap 100 mg) GENGRAF	1	SP
<i>cyclosporine modified oral soln 100 mg/ml</i>	1	SP
(Cyclosporine Modified Oral Soln 100 mg/ml) GENGRAF	1	SP

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>everolimus tab 0.5 mg</i>	1	SP
<i>everolimus tab 0.25 mg</i>	1	SP
<i>everolimus tab 0.75 mg</i>	1	SP
<i>everolimus tab 1 mg</i>	1	SP
<i>mycophenolate mofetil cap 250 mg</i>	1	SP
<i>mycophenolate mofetil for oral susp 200 mg/ml</i>	1	SP
<i>mycophenolate mofetil tab 500 mg</i>	1	SP
<i>mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)</i>	1	SP
<i>mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)</i>	1	SP
<i>sirolimus oral soln 1 mg/ml</i>	1	SP
<i>sirolimus tab 0.5 mg</i>	1	SP
<i>sirolimus tab 1 mg</i>	1	SP
<i>sirolimus tab 2 mg</i>	1	SP
<i>tacrolimus cap 0.5 mg</i>	1	SP
<i>tacrolimus cap 1 mg</i>	1	SP
<i>tacrolimus cap 5 mg</i>	1	SP

POTASSIUM REMOVING AGENTS

(Sodium Polystyrene Sulfonate Oral Susp 15 gm/60ml) SPS	1	
<i>sodium polystyrene sulfonate powder</i>	1	
VELTASSA POW 8.4GM (<i>patiromer sorbitex calcium</i>)	2	MO
VELTASSA POW 16.8GM (<i>patiromer sorbitex calcium</i>)	2	MO
VELTASSA POW 25.2GM (<i>patiromer sorbitex calcium</i>)	2	MO

MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT

ANESTHETICS TOPICAL ORAL

<i>lidocaine hcl viscous soln 2%</i>	1	
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ANTI-INFECTIVES - THROAT

<i>clotrimazole troche 10 mg</i>	1	
<i>nystatin susp 100000 unit/ml</i>	1	

STEROIDS - MOUTH/THROAT/DENTAL

<i>triamcinolone acetonide dental paste 0.1%</i>	1	
(Triamcinolone Acetonide Dental Paste 0.1%) KOURZEQ	1	
(Triamcinolone Acetonide Dental Paste 0.1%) ORALONE DENTAL PASTE	1	

THROAT PRODUCTS - MISC.

<i>cevimeline hcl cap 30 mg</i>	1	MO
<i>pilocarpine hcl tab 5 mg</i>	1	MO
<i>pilocarpine hcl tab 7.5 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MULTIVITAMINS - DRUGS FOR NUTRITION		
PRENATAL VITAMINS		
(Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg) PNV-DHA	1	
(Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg) INATAL GT	1	
(Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg) PNV-SELECT	1	
(Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg) PRENATAL 19	1	
(Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg) TRINATE	1	
(Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg) ELITE-OB	1	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
CENTRAL MUSCLE RELAXANTS		
<i>baclofen oral soln 5 mg/5ml</i>	1	
<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 20 mg</i>	1	
<i>carisoprodol tab 350 mg</i>	1	PA
<i>chlorzoxazone tab 500 mg</i>	1	
<i>cyclobenzaprine hcl tab 5 mg</i>	1	
<i>cyclobenzaprine hcl tab 10 mg</i>	1	
<i>LYVISPAN GRA 5MG (<i>baclofen</i>)</i>	2	
<i>LYVISPAN GRA 10MG (<i>baclofen</i>)</i>	2	
<i>LYVISPAN GRA 20MG (<i>baclofen</i>)</i>	2	
<i>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
<i>tizanidine hcl cap 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 4 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 6 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	1	
DIRECT MUSCLE RELAXANTS		
<i>dantrolene sodium cap 25 mg</i>	1	
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
NASAL AGENT COMBINATIONS		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 bottle every 25 days)
NASAL ANTIALLERGY		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	QL (2 bottles every 25 days)
<i>azelastine hcl nasal spray 0.15% (205.5 mcg/spray)</i>	1	QL (2 bottles every 25 days)
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 bottle every 25 days)
NASAL ANTICHOLINERGICS		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	MO
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	MO
NASAL STEROIDS		
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	1	QL (3 bottles every 25 days)
<i>fluticasone propionate nasal susp 50 mcg/act</i>	1	QL (1 bottle every 25 days)
<i>mometasone furoate nasal susp 50 mcg/act</i>	1	QL (34 gm every 25 days)
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES		
ALS AGENTS		
<i>riluzole tab 50 mg</i>	1	MO
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS		
BETA-BLOCKERS - OPHTHALMIC		
<i>betaxolol hcl ophth soln 0.5%</i>	1	MO
<i>BETOPTIC-S SUS 0.25% OP (betaxolol hcl (ophth))</i>	2	MO
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	1	MO
<i>carteolol hcl ophth soln 1%</i>	1	MO
<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	1	MO
<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	1	MO
<i>levobunolol hcl ophth soln 0.5%</i>	1	MO
<i>timolol maleate ophth gel forming soln 0.5%</i>	1	MO
<i>timolol maleate ophth gel forming soln 0.25%</i>	1	MO
<i>timolol maleate ophth soln 0.5%</i>	1	MO
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	1	MO
<i>timolol maleate ophth soln 0.25%</i>	1	MO
<i>timolol maleate preservative free ophth soln 0.5%</i>	1	MO
<i>timolol maleate preservative free ophth soln 0.25%</i>	1	MO
CYCLOPLEGIC MYDRIATICS		
<i>atropine sulfate ophth soln 1%</i>	1	MO
<i>cyclopentolate hcl ophth soln 1%</i>	1	MO
<i>phenylephrine hcl ophth soln 2.5%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Phenylephrine Hcl Ophth Soln 2.5%) ALTAFRIN	1	
<i>phenylephrine hcl ophth soln 10%</i>	1	
(Phenylephrine Hcl Ophth Soln 10%) ALTAFRIN	1	
<i>tropicamide ophth soln 0.5%</i>	1	MO
<i>tropicamide ophth soln 1%</i>	1	MO
MIOTICS		
<i>pilocarpine hcl ophth soln 1%</i>	1	MO
<i>pilocarpine hcl ophth soln 2%</i>	1	MO
<i>pilocarpine hcl ophth soln 4%</i>	1	MO
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1% (<i>brimonidine tartrate</i>)	2	MO
ALPHAGAN P SOL 0.15% (<i>brimonidine tartrate</i>)	2	MO
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	
<i>brimonidine tartrate ophth soln 0.1%</i>	1	MO
<i>brimonidine tartrate ophth soln 0.2%</i>	1	MO
<i>brimonidine tartrate ophth soln 0.15%</i>	1	MO
SIMBRINZA SUS 1-0.2% (<i>brinzolamide-brimonidine tartrate</i>)	2	MO
OPHTHALMIC ANTI-INFECTIVES		
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
(Bacitracin-Polymyxin B Ophth Oint) POLYCIN	1	
BESIVANCE SUS 0.6% (<i>besifloxacin hcl</i>)	2	
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	1	
<i>erythromycin ophth oint 5 mg/gm</i>	1	
<i>gatifloxacin ophth soln 0.5%</i>	1	
<i>gentamicin sulfate ophth soln 0.3%</i>	1	
<i>levofloxacin ophth soln 1.5%</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-1000ount op oin</i>	1	
(Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-1000ount Op Oin) NEO-POLYCIN	1	
<i>neomycin-polomyx-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	1	
<i>ofloxacin ophth soln 0.3%</i>	1	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	
<i>sulfacetamide sodium ophth oint 10%</i>	1	
<i>sulfacetamide sodium ophth soln 10%</i>	1	
<i>tobramycin ophth soln 0.3%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TOBREX OIN 0.3% OP (<i>tobramycin (ophth)</i>)	3	
<i>trifluridine ophth soln 1%</i>	1	
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS EMU 0.05% OP (<i>cyclosporine (ophth)</i>)	1	MO
RESTASIS MUL EMU 0.05% OP (<i>cyclosporine (ophth)</i>)	2	MO
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5% (<i>lifitegrast</i>)	2	MO
OPHTHALMIC STEROIDS		
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
(Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint 1%)	1	
NEO-POLYCIN HC		
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	1	
<i>difluprednate ophth emulsion 0.05%</i>	1	
<i>fluorometholone ophth susp 0.1%</i>	1	
<i>loteprednol etabonate ophth gel 0.5%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	1	
<i>neomycin-polymyxin-hc ophth susp</i>	1	
PRED SOD PHO SOL 1% OP	3	
<i>prednisolone acetate ophth susp 1%</i>	1	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
TOBRADEX OIN 0.3-0.1% (<i>tobramycin-dexamethasone</i>)	2	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
OPHTHALMICS - MISC.		
<i>azelastine hcl ophth soln 0.05%</i>	1	
<i>bepotastine besilate ophth soln 1.5%</i>	1	
<i>brinzolamide ophth susp 1%</i>	1	MO
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
<i>cromolyn sodium ophth soln 4%</i>	1	
<i>diclofenac sodium ophth soln 0.1%</i>	1	
<i>dorzolamide hcl ophth soln 2%</i>	1	MO
<i>epinastine hcl ophth soln 0.05%</i>	1	
<i>flurbiprofen sodium ophth soln 0.03%</i>	1	
ILEVRO DRO 0.3% OP (<i>nepafenac</i>)	2	
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
<i>olopatadine hcl ophth soln 0.1% (base equivalent)</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>olopatadine hcl ophth soln 0.2% (base equivalent)</i>	1	
<i>PROLENSA SOL 0.07% (bromfenac sodium (ophth))</i>	2	
PROSTAGLANDINS - OPHTHALMIC		
<i>bimatoprost ophth soln 0.03%</i>	1	MO
<i>latanoprost ophth soln 0.005%</i>	1	MO
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	MO
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	MO
OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR		
OTIC AGENTS - MISCELLANEOUS		
<i>acetic acid otic soln 2%</i>	1	
OTIC ANTI-INFECTIVES		
<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	1	
<i>ofloxacin otic soln 0.3%</i>	1	
OTIC COMBINATIONS		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	1	
<i>neomycin-polymyxin-hc otic soln 1%</i>	1	
<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	1	
OTIC STEROIDS		
<i>fluocinolone acetonide (otic) oil 0.01%</i>	1	
(Fluocinolone Acetonide (Otic) Oil 0.01%) FLAC	1	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	1	
OXYTOCICS - DRUGS FOR PREGNANCY		
OXYTOCICS - DRUGS FOR PREGNANCY		
<i>methylergonovine maleate tab 0.2 mg</i>	1	
(Methylergonovine Maleate Tab 0.2 mg)	1	
METHERGINE		
PENICILLINS - DRUGS TO TREAT INFECTIONS		
AMINOPENICILLINS		
<i>amoxicillin (trihydrate) cap 250 mg</i>	1	
<i>amoxicillin (trihydrate) cap 500 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	1	
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) tab 500 mg</i>	1	
<i>amoxicillin (trihydrate) tab 875 mg</i>	1	
<i>ampicillin cap 500 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NATURAL PENICILLINS		
<i>penicillin v potassium for soln 125 mg/5ml</i>	1	
<i>penicillin v potassium for soln 250 mg/5ml</i>	1	
<i>penicillin v potassium tab 250 mg</i>	1	
<i>penicillin v potassium tab 500 mg</i>	1	
PENICILLIN COMBINATIONS		
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
AUGMENTIN SUS 125/5ML (<i>amoxicillin & pot clavulanate</i>)	3	
PENICILLINASE-RESISTANT PENICILLINS		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
<i>medroxyprogesterone acetate tab 2.5 mg</i>	1	MO
<i>medroxyprogesterone acetate tab 5 mg</i>	1	MO
<i>medroxyprogesterone acetate tab 10 mg</i>	1	MO
<i>megestrol acetate susp 625 mg/5ml</i>	1	MO
<i>norethindrone acetate tab 5 mg</i>	1	MO
<i>progesterone cap 100 mg</i>	1	MO
<i>progesterone cap 200 mg</i>	1	MO
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AGENTS FOR CHEMICAL DEPENDENCY		
<i>acamprosate calcium tab delayed release 333 mg</i>	1	MO
<i>disulfiram tab 250 mg</i>	1	MO
<i>disulfiram tab 500 mg</i>	1	MO
ANTI-CATAPLECTIC AGENTS		
<i>XYWAV SOL 0.5GM/ML (<i>calcium, magnesium, potassium, & sodium oxybates</i>)</i>	2	PA, QL (18 mL every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDEMENTIA AGENTS		
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	1	MO
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	1	MO
<i>donepezil hydrochloride tab 5 mg</i>	1	MO
<i>donepezil hydrochloride tab 10 mg</i>	1	MO
<i>donepezil hydrochloride tab 23 mg</i>	1	MO
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	1	MO
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	1	MO
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	1	MO
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	1	MO
<i>galantamine hydrobromide tab 4 mg</i>	1	MO
<i>galantamine hydrobromide tab 8 mg</i>	1	MO
<i>galantamine hydrobromide tab 12 mg</i>	1	MO
<i>memantine hcl cap er 24hr 7 mg</i>	1	MO
<i>memantine hcl cap er 24hr 14 mg</i>	1	MO
<i>memantine hcl cap er 24hr 21 mg</i>	1	MO
<i>memantine hcl cap er 24hr 28 mg</i>	1	MO
<i>memantine hcl oral solution 2 mg/ml</i>	1	MO
<i>memantine hcl tab 5 mg</i>	1	MO
<i>memantine hcl tab 10 mg</i>	1	MO
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	1	
<i>NAMZARIC CAP (memantine hcl-donepezil hcl)</i>	2	
<i>NAMZARIC CAP 7-10MG (memantine hcl-donepezil hcl)</i>	2	MO
<i>NAMZARIC CAP 14-10MG (memantine hcl-donepezil hcl)</i>	2	MO
<i>NAMZARIC CAP 21-10MG (memantine hcl-donepezil hcl)</i>	2	MO
<i>NAMZARIC CAP 28-10MG (memantine hcl-donepezil hcl)</i>	2	MO
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	1	MO
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	1	MO
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	1	MO
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	1	MO
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	1	MO
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	1	MO
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	1	MO
COMBINATION PSYCHOTHERAPEUTICS		
<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	1	MO
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	1	MO
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 2-10 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 2-25 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 4-10 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 4-25 mg</i>	1	MO
<i>perphenazine-amitriptyline tab 4-50 mg</i>	1	MO
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB 100MG (<i>flibanserin</i>)	3	PA, MO
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB 6MG (<i>deutetetrabenazine</i>)	2	SP, PA, QL (2 tabs every 1 day)
AUSTEDO TAB 9MG (<i>deutetetrabenazine</i>)	2	SP, PA, QL (4 tabs every 1 day)
AUSTEDO TAB 12MG (<i>deutetetrabenazine</i>)	2	SP, PA, QL (4 tabs every 1 day)
AUSTEDO XR TAB 6MG (<i>deutetetrabenazine</i>)	2	SP, PA, QL (3 tabs every 1 day)
AUSTEDO XR TAB 12MG (<i>deutetetrabenazine</i>)	2	SP, PA, QL (4 tabs every 1 day)
AUSTEDO XR TAB 24MG (<i>deutetetrabenazine</i>)	2	SP, PA, QL (2 tabs every 1 day)
AUSTEDO XR TAB TITR KIT (<i>deutetetrabenazine</i>)	2	SP, PA, QL (42 tabs every 28 days)
INGREZZA CAP 40-80MG (<i>valbenazine tosylate</i>)	2	SP, PA
INGREZZA CAP 40MG (<i>valbenazine tosylate</i>)	2	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 60MG (<i>valbenazine tosylate</i>)	2	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 80MG (<i>valbenazine tosylate</i>)	2	SP, PA, QL (1 cap every 1 day)
<i>tetrabenazine tab 12.5 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
<i>tetrabenazine tab 25 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
MULTIPLE SCLEROSIS AGENTS		
<i>dalfampridine tab er 12hr 10 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1	SP, PA, QL (14 caps every 28 days)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1	SP, PA, QL (2 caps every 1 day)
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i>	1	SP, PA, QL (60 caps every 30 days)
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	1	SP, PA, QL (1 cap every 1 day)
<i>MAYZENT PAK STARTER (siponimod fumarate)</i>	2	SP, PA, QL (12 tablet starter pack)
<i>MAYZENT PAK STARTER (siponimod fumarate)</i>	2	SP, PA, QL (7 tabs every 4 days)
<i>MAYZENT TAB 0.25MG (siponimod fumarate)</i>	2	SP, PA, QL (12 tabs every 5 days)
<i>MAYZENT TAB 1MG (siponimod fumarate)</i>	2	SP, PA, QL (1 tab every 1 day)
<i>MAYZENT TAB 2MG (siponimod fumarate)</i>	2	SP, PA, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>teriflunomide tab 7 mg</i>	1	SP, PA, QL (1 tab every 1 day)
<i>teriflunomide tab 14 mg</i>	1	SP, PA, QL (1 tab every 1 day)
VUMERITY CAP 231MG (<i>diroximel fumarate</i>)	2	SP, PA, QL (4 caps every 1 day)
ZEPOSIA 7DAY CAP STR PACK (<i>ozanimod hcl</i>)	2	SP, PA, QL (7 caps every 7 days); Preferred for Ulcerative Colitis
ZEPOSIA CAP .92MG (<i>ozanimod hcl</i>)	2	SP, PA, QL (1 cap every 1 day); Preferred for Ulcerative Colitis
ZEPOSIA CAP STR KIT (<i>ozanimod hcl</i>)	2	SP, PA, QL (28 caps every 28 days); Preferred for Ulcerative Colitis

POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS

GRALISE TAB 300MG (<i> gabapentin (once-daily) </i>)	2	MO
GRALISE TAB 450MG (<i> gabapentin (once-daily) </i>)	2	MO
GRALISE TAB 600MG (<i> gabapentin (once-daily) </i>)	2	MO
GRALISE TAB 750MG (<i> gabapentin (once-daily) </i>)	2	MO
GRALISE TAB 900MG (<i> gabapentin (once-daily) </i>)	2	MO
<i>pregabalin tab er 24hr 82.5 mg</i>	1	MO
<i>pregabalin tab er 24hr 165 mg</i>	1	MO
<i>pregabalin tab er 24hr 330 mg</i>	1	MO

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS

<i>ergoloid mesylates tab 1 mg</i>	1	MO
<i>pimozide tab 1 mg</i>	1	MO
<i>pimozide tab 2 mg</i>	1	MO

SMOKING DETERRENTS

<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 2 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) CVS NICOTINE POLACRILEX S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Gum 2 mg) KLS QUIT2	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) NICORELIEF	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) PX STOP SMOKING AID	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) RA NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 2 mg) THRIVE	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 4 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GNP NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GOODSENSE NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) KLS QUIT4	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) PX STOP SMOKING AID	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE GUM	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Gum 4 mg) RA NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) CVS NICOTINE LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) EQL NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GNP NICOTINE MINI LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) GOODSENSE NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) KLS QUIT2	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) NICOTINE MINI LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) PX STOP SMOKING AID	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) RA MINI NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) RA NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 2 mg) SM NICOTINE	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) CVS NICOTINE LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) CVS NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) EQ NICOTINE LOZENGES	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Polacrilex Lozenge 4 mg) EQ NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) EQL NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GNP NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GNP NICOTINE POLACRILEX M	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GOODSENSE NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) GOODSENSE NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) HM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) KLS QUIT4	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) NICOTINE MINI LOZENGE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) PX STOP SMOKING AID	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) RA MINI NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) RA NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Lozenge 4 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 7 mg/24hr</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) EQ NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) EQ NICOTINE STEP 3	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) GNP NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) HM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) NICOTINE STEP 3	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Td Patch 24hr 7 mg/24hr) RA NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 7 mg/24hr) TGT NICOTINE STEP THREE	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 14 mg/24hr</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) EQ NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) GNP NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) HM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) NICOTINE STEP 2	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 14 mg/24hr) TGT NICOTINE STEP TWO	PV	\$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 21 mg/24hr</i>	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) CVS NICOTINE TRANSDERMAL	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) EQ NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) HM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) NICOTINE STEP 1	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) RA NICOTINE	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) RA NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year
(Nicotine Td Patch 24hr 21 mg/24hr) SM NICOTINE TRANSDERMAL S	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Nicotine Td Patch 24hr 21 mg/24hr) TGT NICOTINE STEP ONE	PV	\$0 limited to 2 treatment cycles/year
NICOTROL INH (<i>nicotine</i>)	PV	\$0 limited to 2 treatment cycles/year
NICOTROL NS SPR 10MG/ML (<i>nicotine</i>)	PV	\$0 limited to 2 treatment cycles/year
<i>varenicline tartrate tab 0.5 mg (base equiv)</i>	PV	\$0 limited to 2 treatment cycles/year
<i>varenicline tartrate tab 1 mg (base equiv)</i>	PV	\$0 limited to 2 treatment cycles/year
<i>varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack</i>	PV	\$0 limited to 2 treatment cycles/year

RESPIRATORY AGENTS - MISC. - DRUGS FOR THE LUNGS

CYSTIC FIBROSIS AGENTS

KALYDECO PAK 25MG (<i>ivacaftor</i>)	3	PA, MO
KALYDECO PAK 50MG (<i>ivacaftor</i>)	3	PA, MO
KALYDECO PAK 75MG (<i>ivacaftor</i>)	3	PA, MO
KALYDECO TAB 150MG (<i>ivacaftor</i>)	3	PA, MO

PULMONARY FIBROSIS AGENTS

OFEV CAP 100MG (<i>nintedanib esylate</i>)	2	SP, PA, QL (2 caps every 1 day)
OFEV CAP 150MG (<i>nintedanib esylate</i>)	2	SP, PA, QL (2 caps every 1 day)
<i>pirfenidone cap 267 mg</i>	1	SP, PA, QL (9 caps every 1 day)
<i>pirfenidone tab 267 mg</i>	1	SP, PA, QL (9 tabs every 1 day)
<i>pirfenidone tab 801 mg</i>	1	SP, PA, QL (3 tabs every 1 day)

SULFONAMIDES - DRUGS TO TREAT INFECTIONS

SULFONAMIDES - DRUGS TO TREAT INFECTIONS

<i>sulfadiazine tab 500 mg</i>	1
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TETRACYCLINES - DRUGS TO TREAT INFECTIONS

TETRACYCLINES - DRUGS TO TREAT INFECTIONS

<i>demeclacycline hcl tab 150 mg</i>	1
<i>demeclacycline hcl tab 300 mg</i>	1
<i>doxycycline hyclate cap 50 mg</i>	1
<i>doxycycline hyclate cap 100 mg</i>	1
<i>doxycycline hyclate tab 100 mg</i>	1
<i>doxycycline monohydrate cap 50 mg</i>	1
<i>doxycycline monohydrate cap 100 mg</i>	1
(Doxycycline Monohydrate Cap 100 mg)	1
MONDOXYNE NL	
<i>doxycycline monohydrate for susp 25 mg/5ml</i>	1
<i>doxycycline monohydrate tab 50 mg</i>	1
<i>doxycycline monohydrate tab 75 mg</i>	1
<i>doxycycline monohydrate tab 100 mg</i>	1
(Doxycycline Monohydrate Tab 100 mg) AVIDOXY	1

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>doxycycline monohydrate tab 150 mg</i>	1	
<i>minocycline hcl cap 50 mg</i>	1	
<i>minocycline hcl cap 75 mg</i>	1	
<i>minocycline hcl cap 100 mg</i>	1	
<i>minocycline hcl tab 50 mg</i>	1	
<i>minocycline hcl tab 75 mg</i>	1	
<i>minocycline hcl tab 100 mg</i>	1	
<i>tetracycline hcl cap 250 mg</i>	1	
<i>tetracycline hcl cap 500 mg</i>	1	

THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS

ANTITHYROID AGENTS

<i>methimazole tab 5 mg</i>	1	MO
<i>methimazole tab 10 mg</i>	1	MO
<i>propylthiouracil tab 50 mg</i>	1	MO

THYROID HORMONES

<i>levothyroxine sodium tab 25 mcg</i>	1	MO
(Levothyroxine Sodium Tab 25 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 25 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 50 mcg</i>	1	MO
(Levothyroxine Sodium Tab 50 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 50 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 75 mcg</i>	1	MO
(Levothyroxine Sodium Tab 75 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 75 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 88 mcg</i>	1	MO
(Levothyroxine Sodium Tab 88 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 88 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 100 mcg</i>	1	MO
(Levothyroxine Sodium Tab 100 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 100 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 112 mcg</i>	1	MO
(Levothyroxine Sodium Tab 112 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 112 mcg) LEVO-T	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levothyroxine Sodium Tab 112 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 112 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 125 mcg</i>	1	MO
(Levothyroxine Sodium Tab 125 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 125 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 137 mcg</i>	1	MO
(Levothyroxine Sodium Tab 137 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 137 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 150 mcg</i>	1	MO
(Levothyroxine Sodium Tab 150 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 150 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 150 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 150 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 175 mcg</i>	1	MO
(Levothyroxine Sodium Tab 175 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 175 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 175 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 175 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 200 mcg</i>	1	MO
(Levothyroxine Sodium Tab 200 mcg) EUTHYROX	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 200 mcg) UNITHROID	1	MO
<i>levothyroxine sodium tab 300 mcg</i>	1	MO
(Levothyroxine Sodium Tab 300 mcg) LEVO-T	1	MO
(Levothyroxine Sodium Tab 300 mcg) UNITHROID	1	MO
<i>liothyronine sodium tab 5 mcg</i>	1	MO
<i>liothyronine sodium tab 25 mcg</i>	1	MO
<i>liothyronine sodium tab 50 mcg</i>	1	MO
SYNTHROID TAB 25MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 50MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 75MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 88MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 100MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 112MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 125MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 137MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 150MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 175MCG (<i>levothyroxine sodium</i>)	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SYNTHROID TAB 200MCG (<i>levothyroxine sodium</i>)	2	MO
SYNTHROID TAB 300MCG (<i>levothyroxine sodium</i>)	2	MO

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID

ANTISPASMODICS

<i>chlor diazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	1	
<i>dicyclomine hcl cap 10 mg</i>	1	
<i>dicyclomine hcl oral soln 10 mg/5ml</i>	1	
<i>dicyclomine hcl tab 20 mg</i>	1	
<i>glycopyrrolate oral soln 1 mg/5ml</i>	1	MO
<i>glycopyrrolate tab 1 mg</i>	1	
<i>glycopyrrolate tab 2 mg</i>	1	
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	1	MO
(Hyoscyamine Sulfate Elixir 0.125 mg/5ml) HYOSYNE	1	MO
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	1	MO
(Hyoscyamine Sulfate SI Tab 0.125 mg) OSCIMIN	1	MO
<i>hyoscyamine sulfate soln 0.125 mg/ml</i>	1	MO
(Hyoscyamine Sulfate Soln 0.125 mg/ml) HYOSYNE	1	MO
<i>hyoscyamine sulfate tab 0.125 mg</i>	1	MO
(Hyoscyamine Sulfate Tab 0.125 mg) OSCIMIN	1	MO
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	1	MO
(Hyoscyamine Sulfate Tab Disint 0.125 mg) NULEV	1	MO
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	

H-2 ANTAGONISTS

<i>cimetidine tab 200 mg</i>	1	
<i>cimetidine tab 300 mg</i>	1	MO
<i>cimetidine tab 400 mg</i>	1	MO
<i>cimetidine tab 800 mg</i>	1	MO
<i>famotidine for susp 40 mg/5ml</i>	1	MO
<i>famotidine tab 20 mg</i>	1	MO
<i>famotidine tab 40 mg</i>	1	MO
<i>nizatidine cap 150 mg</i>	1	MO
<i>nizatidine cap 300 mg</i>	1	MO

MISC. ANTI-ULCER

<i>sucralfate tab 1 gm</i>	1	MO
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PROTON PUMP INHIBITORS

<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	1	QL (90 caps every year), MO
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	1	QL (90 caps every year), MO
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	1	QL (90 packets every year), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	1	QL (90 packets every year), MO
<i>lansoprazole cap delayed release 15 mg</i>	1	QL (90 caps every year), MO
<i>lansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year), MO
<i>omeprazole cap delayed release 10 mg</i>	1	QL (90 caps every year), MO
<i>omeprazole cap delayed release 20 mg</i>	1	QL (90 caps every year), MO
<i>omeprazole cap delayed release 40 mg</i>	1	QL (90 caps every year), MO
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	1	QL (90 tabs every year), MO
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 tabs every year), MO
<i>rabeprazole sodium ec tab 20 mg</i>	1	QL (90 tabs every year), MO

ULCER DRUGS - PROSTAGLANDINS

<i>misoprostol tab 100 mcg</i>	1	MO
<i>misoprostol tab 200 mcg</i>	1	MO

ULCER THERAPY COMBINATIONS

<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 &500 &30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
<i>PYLERA CAP (bismuth subcitrate potassium-metronidazole-tetracycline)</i>	2	
<i>TALICIA CAP (amoxicillin-rifabutin-omeprazole)</i>	2	

URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)

<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	1	MO
<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	1	MO
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	1	MO
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	1	MO
<i>oxybutynin chloride solution 5 mg/5ml</i>	1	MO
<i>oxybutynin chloride tab 5 mg</i>	1	MO
<i>oxybutynin chloride tab er 24hr 5 mg</i>	1	MO
<i>oxybutynin chloride tab er 24hr 10 mg</i>	1	MO
<i>oxybutynin chloride tab er 24hr 15 mg</i>	1	MO
<i>solifenacin succinate tab 5 mg</i>	1	MO
<i>solifenacin succinate tab 10 mg</i>	1	MO
<i>tolterodine tartrate cap er 24hr 2 mg</i>	1	MO
<i>tolterodine tartrate cap er 24hr 4 mg</i>	1	MO
<i>tolterodine tartrate tab 1 mg</i>	1	MO
<i>tolterodine tartrate tab 2 mg</i>	1	MO
<i>trospium chloride cap er 24hr 60 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>trospium chloride tab 20 mg</i>	1	MO
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB 75MG (<i>vibegron</i>)	2	MO
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
<i>bethanechol chloride tab 5 mg</i>	1	
<i>bethanechol chloride tab 10 mg</i>	1	
<i>bethanechol chloride tab 25 mg</i>	1	
<i>bethanechol chloride tab 50 mg</i>	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
<i>flavoxate hcl tab 100 mg</i>	1	MO
VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS		
SPERMICIDES		
ENCARE SUP 100MG (<i>nonoxynol-9</i>)	PV	
GYNOL II GEL 3% (<i>nonoxynol-9</i>)	PV	
SHUR-SEAL GEL 2% (<i>nonoxynol-9</i>)	PV	
TODAY SPONGE MIS (<i>nonoxynol-9</i>)	PV	
VCF VAGINAL AER CONTRACP (<i>nonoxynol-9</i>)	PV	
VCF VAGINAL GEL CONTRACE (<i>nonoxynol-9</i>)	PV	
VCF VAGINAL MIS CONTRACP (<i>nonoxynol-9</i>)	PV	
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate vaginal cream 2%</i>	1	
<i>metronidazole vaginal gel 0.75%</i>	1	
(Miconazole Nitrate Vaginal Suppos 200 mg)	1	
MICONAZOLE 3		
<i>terconazole vaginal cream 0.4%</i>	1	
<i>terconazole vaginal cream 0.8%</i>	1	
<i>terconazole vaginal suppos 80 mg</i>	1	
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXXI GEL (<i>lactic acid-citric acid-potassium bitartrate</i>)	PV	
VAGINAL ESTROGENS		
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	MO
IMVEXXY MAIN SUP 4MCG (<i>estradiol vaginal</i>)	2	MO
IMVEXXY MAIN SUP 10MCG (<i>estradiol vaginal</i>)	2	MO
IMVEXXY STRT SUP 4MCG (<i>estradiol vaginal</i>)	2	MO
IMVEXXY STRT SUP 10MCG (<i>estradiol vaginal</i>)	2	MO
VAGIFEM TAB 10MCG (<i>estradiol vaginal</i>)	1	MO
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG (<i>progesterone (vaginal)</i>)	2	
CRINONE GEL 8% VAG (<i>progesterone (vaginal)</i>)	2	PA
ENDOMETRIN SUP 100MG (<i>progesterone (vaginal)</i>)	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS

ANAPHYLAXIS THERAPY AGENTS

AUVI-Q INJ 0.1MG (<i>epinephrine (anaphylaxis)</i>)	2
AUVI-Q INJ 0.3MG (<i>epinephrine (anaphylaxis)</i>)	2
AUVI-Q INJ 0.15MG (<i>epinephrine (anaphylaxis)</i>)	2
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1
<i>epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)</i>	1
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1
EPIPEN 2-PAK INJ 0.3MG (<i>epinephrine (anaphylaxis)</i>)	2
EPIPEN-JR INJ 0.15MG (<i>epinephrine (anaphylaxis)</i>)	2

NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS

<i>droxidopa cap 100 mg</i>	1	SP, PA, QL (3 caps every 1 day)
<i>droxidopa cap 200 mg</i>	1	SP, PA, QL (6 caps every 1 day)
<i>droxidopa cap 300 mg</i>	1	SP, PA, QL (6 caps every 1 day)

VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS

<i>midodrine hcl tab 2.5 mg</i>	1	
<i>midodrine hcl tab 5 mg</i>	1	
<i>midodrine hcl tab 10 mg</i>	1	

VITAMINS - DRUGS FOR NUTRITION

OIL SOLUBLE VITAMINS

<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	1	MO
<i>phytonadione tab 5 mg</i>	1	

Index

7	
7T LIDO GEL	
see Lidocaine Hcl Gel 2%	103
A	
<i>abacavir sulfate soln 20 mg/ml (base equiv) ..</i>	76
<i>abacavir sulfate tab 300 mg (base equiv)</i>	76
<i>abacavir sulfate-lamivudine tab 600-300 mg .</i>	76
<i>abacavir-dolutegravir-lamivudine</i>	
see TRIUMEQ PD TAB	78
see TRIUMEQ TAB	78
<i>abiraterone acetate micronized</i>	
see YONSA TAB 125MG	67
<i>abiraterone acetate tab 250 mg</i>	66
<i>abiraterone acetate tab 500 mg</i>	66
<i>abrocitinib</i>	
see CIBINQO TAB 100MG	103
see CIBINQO TAB 200MG	103
see CIBINQO TAB 50MG	103
<i>acalabrutinib maleate</i>	
see CALQUENCE TAB 100MG	68
<i>acamprosate calcium tab delayed release 333 mg</i>	130
<i>acarbose tab 100 mg</i>	50
<i>acarbose tab 25 mg</i>	50
<i>acarbose tab 50 mg</i>	50
ACCURETIC TAB 10-12.5	61
ACUTANE	
see Isotretinoin Cap 10 mg	98
see Isotretinoin Cap 20 mg	98
see Isotretinoin Cap 30 mg	99
see Isotretinoin Cap 40 mg	99
<i>acebutolol hcl cap 200 mg</i>	80
<i>acebutolol hcl cap 400 mg</i>	80
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	30
<i>acetaminophen w/ codeine tab 300-15 mg</i>	30
<i>acetaminophen w/ codeine tab 300-30 mg</i>	30
<i>acetaminophen w/ codeine tab 300-60 mg</i>	30
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	31
Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg	31
<i>acetazolamide cap er 12hr 500 mg</i>	105
<i>acetazolamide tab 125 mg</i>	105
<i>acetazolamide tab 250 mg</i>	105
<i>acetic acid otic soln 2%.....</i>	129
<i>acetylcysteine inhal soln 10%</i>	97
<i>acetylcysteine inhal soln 20%</i>	97
<i>acitretin cap 10 mg</i>	101
<i>acitretin cap 17.5 mg</i>	101
<i>acitretin cap 25 mg</i>	101
<i>acyclovir cap 200 mg</i>	79
<i>acyclovir oint 5%</i>	101
<i>acyclovir susp 200 mg/5ml</i>	79
<i>acyclovir tab 400 mg</i>	79
<i>acyclovir tab 800 mg</i>	79
<i>adapalene cream 0.1%.....</i>	97
<i>adapalene gel 0.1%.....</i>	97
<i>adapalene gel 0.3%.....</i>	97
<i>adapalene-benzoyl peroxide</i>	
see EPIDUO FORTE GEL 0.3-2.5%.....	98
see EPIDUO GEL 0.1-2.5%.....	98
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	97
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	97
ADDYI TAB 100MG.....	132
<i>adefovir dipivoxil tab 10 mg</i>	79
ADEMPAS TAB 0.5MG	86
ADEMPAS TAB 1.5MG	86
ADEMPAS TAB 1MG	86
ADEMPAS TAB 2.5MG	86
ADEMPAS TAB 2MG	86
ADVAIR DISKU AER 100/50.....	40
ADVAIR DISKU AER 250/50.....	40
ADVAIR DISKU AER 500/50.....	40
ADVAIR HFA AER 115/21.....	40
ADVAIR HFA AER 230/21.....	40
ADVAIR HFA AER 45/21.....	40
AERCHMBR PLS MIS FLOW-VU	118
AERCHMBR PLS MIS LRG MASK	118
AERCHMBR PLS MIS MED MASK.....	118
AERCHMBR PLS MIS SM MASK	118
AERCHMBR Z- MIS STAT PLS.....	118
AEROCHAMBER MIS CHAMBER	118
AEROCHAMBER MIS FOSIGNA	118
AEROCHAMBER MIS MV	118
AEROCHAMBER MIS PLUS	118
AEROVENT MIS PLUS	118
AFIRMELLE	

see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	89
AIRSUPRA AER 90-80MCG	40
AKLIEF CRE 0.005%.....	97
ALA-CORT see Hydrocortisone Cream 1%.....	102
albendazole tab 200 mg	35
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	40
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)	40
albuterol sulfate soln nebu 0.5% (5 mg/ml)	40
albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)	40
albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)	40
albuterol sulfate syrup 2 mg/5ml	40
albuterol sulfate tab 2 mg	41
albuterol sulfate tab 4 mg	41
albuterol-budesonide see AIRSUPRA AER 90-80MCG	40
alclometasone dipropionate cream 0.05%	101
alclometasone dipropionate oint 0.05%	101
ALECENSA CAP 150MG.....	67
alectinib hcl see ALECENSA CAP 150MG	67
alendronate sodium oral soln 70 mg/75ml ...	106
alendronate sodium tab 10 mg	106
alendronate sodium tab 35 mg	106
alendronate sodium tab 5 mg	106
alendronate sodium tab 70 mg	106
alfuzosin hcl tab er 24hr 10 mg	112
aliskiren fumarate tab 150 mg (base equivalent)	63
aliskiren fumarate tab 300 mg (base equivalent)	63
allopurinol tab 100 mg	112
allopurinol tab 300 mg	112
almotriptan malate tab 12.5 mg	120
almotriptan malate tab 6.25 mg	120
alosetron hcl tab 0.5 mg (base equiv)	111
alosetron hcl tab 1 mg (base equiv)	111
ALPHAGAN P SOL 0.1%.....	127
ALPHAGAN P SOL 0.15%.....	127
alprazolam orally disintegrating tab 0.25 mg .	37
alprazolam orally disintegrating tab 0.5 mg	37
alprazolam orally disintegrating tab 1 mg	37
alprazolam orally disintegrating tab 2 mg	37
alprazolam tab 0.25 mg	37
alprazolam tab 0.5 mg	37
alprazolam tab 1 mg	37
alprazolam tab 2 mg	37
alprazolam tab er 24hr 0.5 mg	37
Alprazolam Tab Er 24hr 0.5 mg	37
alprazolam tab er 24hr 1 mg	37
Alprazolam Tab Er 24hr 1 mg	38
alprazolam tab er 24hr 2 mg	38
Alprazolam Tab Er 24hr 2 mg	38
alprazolam tab er 24hr 3 mg	38
Alprazolam Tab Er 24hr 3 mg	38
ALPRAZOLAM XR see Alprazolam Tab Er 24hr 0.5 mg.....	37
see Alprazolam Tab Er 24hr 1 mg	38
see Alprazolam Tab Er 24hr 2 mg	38
see Alprazolam Tab Er 24hr 3 mg	38
ALTAFRIN see Phenylephrine Hcl Ophth Soln 10%	127
see Phenylephrine Hcl Ophth Soln 2.5%	127
ALTAVERA see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	89
ALUNBRIG PAK	67
ALUNBRIG TAB 180MG	67
ALUNBRIG TAB 30MG	67
ALUNBRIG TAB 90MG	67
ALYACEN 1/35 see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg	91
ALYACEN 7/7/7 see Norethindrone-Eth Estradiol Tab 0.5- 35/0.75-35/1-35 mg-Mcg	93
ALYQ see Tadalafil Tab 20 mg (Pah)	85
AMABELZ see Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg.....	108
see Estradiol & Norethindrone Acetate Tab 1- 0.5 mg.....	108
amantadine hcl cap 100 mg	71
amantadine hcl soln 50 mg/5ml	71
amantadine hcl tab 100 mg	71
ambrisentan tab 10 mg	85
ambrisentan tab 5 mg	85
amcinonide lotion 0.1%	101

<i>amcinonide oint 0.1%</i>	101
AMETHIA	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7).....	88
AMETHYST	
see Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg	90
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	105
<i>amiloride hcl tab 5 mg</i>	105
<i>aminocaproic acid oral soln 0.25 gm/ml</i>	115
<i>aminocaproic acid tab 1000 mg</i>	115
<i>aminocaproic acid tab 500 mg</i>	115
<i>aminosalicylic acid</i>	
see PASER GRA 4GM	64
<i>amiodarone hcl tab 100 mg</i>	39
Amiodarone Hcl Tab 100 mg	39
<i>amiodarone hcl tab 200 mg</i>	39
Amiodarone Hcl Tab 200 mg	39
<i>amiodarone hcl tab 400 mg</i>	39
Amiodarone Hcl Tab 400 mg	39
<i>amitriptyline hcl tab 10 mg</i>	49
<i>amitriptyline hcl tab 100 mg</i>	49
<i>amitriptyline hcl tab 150 mg</i>	49
<i>amitriptyline hcl tab 25 mg</i>	49
<i>amitriptyline hcl tab 50 mg</i>	49
<i>amitriptyline hcl tab 75 mg</i>	49
<i>amlodipine besylate tab 10 mg (base equivalent)</i>	82
<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	81
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	81
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	84
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	84
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	61
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	61
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	61
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	61
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	61
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	61
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	61
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	61
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	61
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	61
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	61
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	61
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	61
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	61
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i>	61
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i>	61
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	61
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i>	61
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i>	61
AMNESTEEM	
see Isotretinoin Cap 10 mg.....	98
see Isotretinoin Cap 20 mg.....	98
see Isotretinoin Cap 40 mg.....	99
<i>amoxapine tab 100 mg</i>	49

<i>amoxapine tab 150 mg</i>	49
<i>amoxapine tab 25 mg</i>	49
<i>amoxapine tab 50 mg</i>	49
<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	142
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	130
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	130
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	130
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	130
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	130
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	130
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	130
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	130
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	130
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	130
<i>amoxicillin & pot clavulanate</i> see AUGMENTIN SUS 125/5ML.....	130
<i>amoxicillin (trihydrate) cap 250 mg</i>	129
<i>amoxicillin (trihydrate) cap 500 mg</i>	129
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	129
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	129
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	129
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	129
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	129
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	129
<i>amoxicillin (trihydrate) tab 500 mg</i>	129
<i>amoxicillin (trihydrate) tab 875 mg</i>	129
<i>amoxicillin-rifabutin-omeprazole</i> see TALICIA CAP.....	142
<i>amphetamine sulfate tab 10 mg</i>	11
<i>amphetamine sulfate tab 5 mg</i>	11
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg</i>	11
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg</i>	11
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg</i>	11
<i>amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg</i>	11
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	11
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	11
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	11
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	12
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	12
<i>amphetamine-dextroamphetamine tab 10 mg</i>	12
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	12
<i>amphetamine-dextroamphetamine tab 15 mg</i>	12
<i>amphetamine-dextroamphetamine tab 20 mg</i>	12
<i>amphetamine-dextroamphetamine tab 30 mg</i>	12
<i>amphetamine-dextroamphetamine tab 5 mg</i>	12
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	12
<i>ampicillin cap 500 mg</i>	129
<i>anagrelide hcl cap 0.5 mg</i>	113
<i>anagrelide hcl cap 1 mg</i>	113
<i>anastrozole tab 1 mg</i>	66
<i>ANNOVERA MIS</i>	95
<i>ANORO ELLIPT AER 62.5-25</i>	41
<i>ANUCORT-HC</i> see Hydrocortisone Acetate Suppos 25 mg	35
<i>apalutamide</i> see ERLEADA TAB 240MG.....	66
see ERLEADA TAB 60MG	66
<i>apixaban</i> see ELIQUIS ST P TAB 5MG	42
see ELIQUIS TAB 2.5MG	42
see ELIQUIS TAB 5MG	42
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	127
<i>apremilast</i> see OTEZLA TAB 10/20/30.....	24
see OTEZLA TAB 30MG.....	24
<i>aprepitant capsule 125 mg</i>	55
<i>aprepitant capsule 40 mg</i>	55

aprepitant capsule 80 mg	55
aprepitant capsule therapy pack 80 & 125 mg	55
APRI	
see Desogestrel & Ethinyl Estradiol Tab 0.15	
mg-30 mcg	87
APTIOM TAB 200MG	43
APTIOM TAB 400MG	43
APTIOM TAB 600MG	43
APTIOM TAB 800MG	43
ARANELLE	
see Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg	93
ARAZLO LOT 0.045%	97
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	41
ariPIPRAZOLE oral solution 1 mg/ml	76
ariPIPRAZOLE orally disintegrating tab 10 mg	76
ariPIPRAZOLE orally disintegrating tab 15 mg	76
ariPIPRAZOLE tab 10 mg	76
ariPIPRAZOLE tab 15 mg	76
ariPIPRAZOLE tab 2 mg	76
ariPIPRAZOLE tab 20 mg	76
ariPIPRAZOLE tab 30 mg	76
ariPIPRAZOLE tab 5 mg	76
armodafinil tab 150 mg	17
armodafinil tab 200 mg	17
armodafinil tab 250 mg	17
armodafinil tab 50 mg	17
artemether-lumefantrine	
see COARTEM TAB 20-120MG	63
ASCOMP/CODEINE	
see Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg	31
asenapine maleate sl tab 10 mg (base equiv)	74
asenapine maleate sl tab 2.5 mg (base equiv)	74
asenapine maleate sl tab 5 mg (base equiv)	74
ASHLYNA	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	89
Aspirin Chew Tab 81 mg	25
ASPIRIN CHILDRENS	
see Aspirin Chew Tab 81 mg	25
aspirin tab delayed release 81 mg	25
aspirin-dipyridamole cap er 12hr 25-200 mg	113
atazanavir sulfate cap 150 mg (base equiv)	76
atazanavir sulfate cap 200 mg (base equiv)	76
atazanavir sulfate cap 300 mg (base equiv)	76

atazanavir sulfate-cobicistat	
see EVOTAZ TAB 300-150	77
atenolol & chlorthalidone tab 100-25 mg	61
atenolol & chlorthalidone tab 50-25 mg	61
atenolol tab 100 mg	80
atenolol tab 25 mg	80
atenolol tab 50 mg	80
atogepant	
see QULIPTA TAB 10MG	120
see QULIPTA TAB 30MG	120
see QULIPTA TAB 60MG	120
atomoxetine hcl cap 10 mg (base equiv)	16
atomoxetine hcl cap 100 mg (base equiv)	16
atomoxetine hcl cap 18 mg (base equiv)	16
atomoxetine hcl cap 25 mg (base equiv)	16
atomoxetine hcl cap 40 mg (base equiv)	16
atomoxetine hcl cap 60 mg (base equiv)	16
atomoxetine hcl cap 80 mg (base equiv)	16
atorvastatin calcium tab 10 mg (base equivalent)	57
atorvastatin calcium tab 20 mg (base equivalent)	57
atorvastatin calcium tab 40 mg (base equivalent)	57
atorvastatin calcium tab 80 mg (base equivalent)	58
atovaquone susp 750 mg/5ml	35
atovaquone-proguanil hcl tab 250-100 mg	63
atovaquone-proguanil hcl tab 62.5-25 mg	63
atropine sulfate ophth soln 1%	126
AUBRA EQ	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	89
AUGMENTIN SUS 125/5ML	130
AUROVELA 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg	91
AUROVELA 1/20	
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg	91
AUROVELA 24 FE	
see Norethindrone Ace-Eth Estradiol-Fe Tab 1 mg-20 mcg (24)	93
AUROVELA FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg	92
AUROVELA FE 1/20	

see Norethindrone Ace & Ethinyl Estradiol-Fe	116
Tab 1 mg-20 mcg	92
AURYXIA TAB 210MG	111
AUSTEDO TAB 12MG.....	132
AUSTEDO TAB 6MG.....	132
AUSTEDO TAB 9MG.....	132
AUSTEDO XR TAB 12MG.....	132
AUSTEDO XR TAB 24MG.....	132
AUSTEDO XR TAB 6MG.....	132
AUSTEDO XR TAB TITR KIT	132
AUVI-Q INJ 0.15MG.....	144
AUVI-Q INJ 0.1MG.....	144
AUVI-Q INJ 0.3MG.....	144
avatrombopag maleate	
see DOPTELET TAB 20MG	114
AVIANE	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
mg-20 mcg	89
AVIDOXY	
see Doxycycline Monohydrate Tab 100 mg	138
axitinib	
see INLYTA TAB 1MG.....	65
see INLYTA TAB 5MG.....	65
AYUNA	
see Levonorgestrel & Ethinyl Estradiol Tab	
0.15 mg-30 mcg.....	89
AZASAN	
see Azathioprine Tab 100 mg.....	123
see Azathioprine Tab 75 mg	123
azathioprine tab 100 mg	123
Azathioprine Tab 100 mg	123
azathioprine tab 50 mg	123
azathioprine tab 75 mg	123
Azathioprine Tab 75 mg	123
azelaic acid	
see FINACEA AER 15%	104
azelaic acid gel 15%	104
azelastine hcl nasal spray 0.1% (137 mcg/spray)	
.....	126
azelastine hcl nasal spray 0.15% (205.5 mcg/spray)	126
azithromycin for susp 100 mg/5ml	116
azithromycin for susp 200 mg/5ml	116
azithromycin powd pack for susp 1 gm	116
azithromycin tab 250 mg	116
azithromycin tab 500 mg	116
azithromycin tab 600 mg	116
AZSTARYS CAP 26.1-5.2.....	17
AZSTARYS CAP 39.2-7.8.....	17
AZSTARYS CAP 52.3-10.....	17
aztreonam lysine	
see CAYSTON INH 75MG	36
AZURETTE	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
0.02/0.01 mg(21/5)	87
B	
BAC	
see Butalbital-Acetaminophen-Caffeine Tab	
50-325-40 mg.....	24
bacitracin ophth oint 500 unit/gm	127
bacitracin-polymyxin b ophth oint	127
Bacitracin-Polymyxin B Ophth Oint.....	127
bacitracin-polymyxin-neomycin-hc ophth oint	
1%	128
Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint	
1%	128
baclofen	
see LYVISPAH GRA 10MG	125
see LYVISPAH GRA 20MG	125
see LYVISPAH GRA 5MG	125
baclofen oral soln 5 mg/5ml	125
baclofen tab 10 mg	125
baclofen tab 20 mg	125
baclofen tab 5 mg	125
balsalazide disodium cap 750 mg	111
BALZIVA	
see Norethindrone & Ethinyl Estradiol Tab 0.4	
mg-35 mcg	90
BAQSIMI ONE POW 3MG/DOSE	52
BAQSIMI TWO POW 3MG/DOSE	52
BASAGLAR INJ 100UNIT	52
BD INSULIN PEN NEEDLES - OTC	117
BD INSULIN SYRINGE - OTC	117
BD INSULIN SYRINGE - RX.....	117
bedaquiline fumarate	
see SIRTURO TAB 100MG	64
see SIRTURO TAB 20MG	64
BELBUCA MIS 150MCG	33
BELBUCA MIS 300MCG	33
BELBUCA MIS 450MCG	33
BELBUCA MIS 600MCG	33

BELBUCA MIS 750MCG.....	33	<i>betamethasone dipropionate augmented cream 0.05%</i>	101
BELBUCA MIS 75MCG.....	33	<i>betamethasone dipropionate augmented gel 0.05%</i>	101
BELBUCA MIS 900MCG.....	33	<i>betamethasone dipropionate augmented lotion 0.05%</i>	101
BELSOMRA TAB 10MG	116	<i>betamethasone dipropionate augmented oint 0.05%</i>	101
BELSOMRA TAB 15MG	116	<i>betamethasone dipropionate cream 0.05%...101</i>	
BELSOMRA TAB 20MG	116	<i>betamethasone dipropionate lotion 0.05% ...101</i>	
BELSOMRA TAB 5MG	116	<i>betamethasone valerate aerosol foam 0.12%</i>	101
bempedoic acid		<i>betamethasone valerate cream 0.1% (base equivalent)</i>	101
see NEXLETOL TAB 180MG	56	<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	101
bempedoic acid-ezetimibe		<i>betamethasone valerate oint 0.1% (base equivalent)</i>	101
see NEXLIZET TAB 180/10MG	57	<i>betaxolol hcl (ophth)</i>	
benazepril & hydrochlorothiazide tab 10-12.5 mg		see BETOPTIC-S SUS 0.25% OP	126
mg	61	<i>betaxolol hcl ophth soln 0.5%</i>	126
benazepril & hydrochlorothiazide tab 20-12.5 mg		<i>betaxolol hcl tab 10 mg</i>	80
mg	61	<i>betaxolol hcl tab 20 mg</i>	80
benazepril & hydrochlorothiazide tab 20-25 mg		<i>bethanechol chloride tab 10 mg</i>	143
.....	61	<i>bethanechol chloride tab 25 mg</i>	143
benazepril & hydrochlorothiazide tab 5-6.25 mg		<i>bethanechol chloride tab 5 mg</i>	143
.....	61	<i>bethanechol chloride tab 50 mg</i>	143
benazepril hcl tab 10 mg	59	<i>BETOPTIC-S SUS 0.25% OP</i>	126
benazepril hcl tab 20 mg	59	<i>bexarotene cap 75 mg</i>	71
benazepril hcl tab 40 mg	59	<i>bexarotene gel 1%</i>	100
benazepril hcl tab 5 mg	59	<i>bicalutamide tab 50 mg</i>	66
BENZEPRO		<i>bictegravir-emtricitabine-tenofovir alafenamide fumarate</i>	
see Benzoyl Peroxide Foam 5.3%.....	97	see BIKTARVY TAB.....	76, 77
benzonatate cap 100 mg	96	<i>BIKTARVY TAB</i>	76, 77
benzonatate cap 150 mg	96	<i>bimatoprost ophth soln 0.03%</i>	129
benzonatate cap 200 mg	96	binimetinib	
Benzoyl Peroxide Foam 5.3%.....	97	see MEKTOVI TAB 15MG	69
benzoyl peroxide foam 9.8%	98	bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg	142
benzoyl peroxide gel 8%	98	bismuth subcitrate potassium-metronidazole-tetracycline	
benzoyl peroxide-erythromycin gel 5-3%	98	see PYLERA CAP	142
benzoyl peroxide-hydrocortisone lotion 5-0.5%		bisoprolol & hydrochlorothiazide tab 10-6.25 mg	61
.....	98	bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	61
benzphetamine hcl tab 50 mg	15		
benztropine mesylate tab 0.5 mg	71		
benztropine mesylate tab 1 mg	71		
benztropine mesylate tab 2 mg	71		
bepotastine besilate ophth soln 1.5%	128		
berotralstat hcl			
see ORLADEYO CAP 110MG	112		
see ORLADEYO CAP 150MG	112		
besifloxacin hcl			
see BESIVANCE SUS 0.6%.....	127		
BESIVANCE SUS 0.6%	127		
betaine powder for oral solution	107		

bisoprolol & hydrochlorothiazide tab 5-6.25 mg	.....	61
bisoprolol fumarate tab 10 mg	.....	80
bisoprolol fumarate tab 5 mg	.....	80
BLISOVI 24 FE		
see Norethindrone Ace-Ethinyl Estradiol-Fe		
Tab 1 mg-20 mcg (24)		93
BLISOVI FE 1.5/30		
see Norethindrone Ace & Ethinyl Estradiol-Fe		
Tab 1.5 mg-30 mcg		92
BLISOVI FE 1/20		
see Norethindrone Ace & Ethinyl Estradiol-Fe		
Tab 1 mg-20 mcg		92
bosentan tab 125 mg	.....	85
bosentan tab 62.5 mg	.....	85
BOSULIF TAB 100MG	.....	67
BOSULIF TAB 400MG	.....	67
BOSULIF TAB 500MG	.....	67
bosutinib		
see BOSULIF TAB 100MG		67
see BOSULIF TAB 400MG		67
see BOSULIF TAB 500MG		67
BRAFTOVI CAP 75MG	.....	67
BREATHE EASE MIS LG MASK	.....	118
BREATHE EASE MIS MED MASK	.....	118
BREATHE EASE MIS SM MASK	.....	118
BREATHERITE MIS	.....	118
BREATHERITE MIS LG MASK	.....	118
BREATHERITE MIS MED MASK	.....	118
BREATHERITE MIS SM MASK	.....	118
BREATHERITE MIS SPACER	.....	118
BREATHERITE MIS W/MASK	.....	118
BREO ELLIPTA INH 100-25	.....	41
BREO ELLIPTA INH 200-25	.....	41
BREO ELLIPTA INH 50-25MCG	.....	41
BREZTRI AERO AER SPHERE	.....	41
BRIELLYN		
see Norethindrone & Ethinyl Estradiol Tab 0.4		
mg-35 mcg		90
brigatinib		
see ALUNBRIG PAK		67
see ALUNBRIG TAB 180MG		67
see ALUNBRIG TAB 30MG		67
see ALUNBRIG TAB 90MG		67
BRILINTA TAB 60MG	.....	113
BRILINTA TAB 90MG	.....	113
brimonidine tartrate		
see ALPHAGAN P SOL 0.1%.....		127
see ALPHAGAN P SOL 0.15%.....		127
brimonidine tartrate gel 0.33% (base equivalent)	.....	104
brimonidine tartrate ophth soln 0.1%	.....	127
brimonidine tartrate ophth soln 0.15%	.....	127
brimonidine tartrate ophth soln 0.2%	.....	127
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	.....	126
brinzolamide ophth susp 1%	.....	128
brinzolamide-brimonidine tartrate		
see SIMBRINZA SUS 1-0.2%		127
BROMFED DM		
see Pseudoephed-Bromphen-Dm Syrup 30-2-10 mg/5ml		97
bromfenac sodium (ophth)		
see PROLENSA SOL 0.07%		129
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	.....	128
bromocriptine mesylate cap 5 mg (base equivalent)	.....	71
bromocriptine mesylate tab 2.5 mg (base equivalent)	.....	71
BRUKINSA CAP 80MG	.....	67
BRYHALI LOT 0.01%	.....	101
budesonide (inhalation)		
see PULMICORT INH 180MCG		40
see PULMICORT INH 90MCG		40
budesonide delayed release particles cap 3 mg	.....	95
budesonide inhalation susp 0.25 mg/2ml	.....	40
budesonide inhalation susp 0.5 mg/2ml	.....	39
budesonide inhalation susp 1 mg/2ml	.....	40
budesonide rectal foam 2 mg/act	.....	34
budesonide-formoterol fumarate dihydrate		
see SYMBICORT AER 160-4.5		41
see SYMBICORT AER 80-4.5		41
budesonide-glycopyrrolate-formoterol fumarate		
see BREZTRI AERO AER SPHERE		41
bumetanide tab 0.5 mg	.....	105
bumetanide tab 1 mg	.....	105
bumetanide tab 2 mg	.....	105
buprenorphine hcl		
see BELBUCA MIS 150MCG.....		33
see BELBUCA MIS 300MCG.....		33
see BELBUCA MIS 450MCG.....		33
see BELBUCA MIS 600MCG.....		33

see BELBUCA MIS 750MCG	33
see BELBUCA MIS 75MCG	33
see BELBUCA MIS 900MCG	33
buprenorphine hcl sl tab 2 mg (base equiv)	33
buprenorphine hcl sl tab 8 mg (base equiv)	33
buprenorphine hcl-naloxone hcl dihydrate	
see ZUBSOLV SUB 0.7-0.18	34
see ZUBSOLV SUB 1.4-0.36	34
see ZUBSOLV SUB 11.4-2.9	34
see ZUBSOLV SUB 2.9-0.71	34
see ZUBSOLV SUB 5.7-1.4	34
see ZUBSOLV SUB 8.6-2.1	34
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	33
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	33
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	33
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	33
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	33
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	33
buprenorphine td patch weekly 10 mcg/hr	34
buprenorphine td patch weekly 15 mcg/hr	34
buprenorphine td patch weekly 20 mcg/hr	34
buprenorphine td patch weekly 5 mcg/hr	33
buprenorphine td patch weekly 7.5 mcg/hr	33
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	133
bupropion hcl tab 100 mg	47
bupropion hcl tab 75 mg	47
bupropion hcl tab er 12hr 100 mg	47
bupropion hcl tab er 12hr 150 mg	47
bupropion hcl tab er 12hr 200 mg	47
bupropion hcl tab er 24hr 150 mg	47
bupropion hcl tab er 24hr 300 mg	47
buspirone hcl tab 10 mg	37
buspirone hcl tab 15 mg	37
buspirone hcl tab 30 mg	37
buspirone hcl tab 5 mg	37
buspirone hcl tab 7.5 mg	37
busulfan	
see MYLERAN TAB 2MG	64
butalbital-acetaminophen tab 50-325 mg	24
Butalbital-Acetaminophen Tab 50-325 mg.....	24
butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg	31
butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg	31
butalbital-acetaminophen-caffeine tab 50-325-40 mg	24
Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg	24
butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg	31
Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg	31
butalbital-aspirin-caffeine cap 50-325-40 mg	24
butorphanol tartrate nasal soln 10 mg/ml	34
C	
cabergoline tab 0.5 mg	108
CABOMETYX TAB 20MG	67
CABOMETYX TAB 40MG	67
CABOMETYX TAB 60MG	68
cabozantinib s-malate	
see CABOMETYX TAB 20MG	67
see CABOMETYX TAB 40MG	67
see CABOMETYX TAB 60MG	68
calcipotriene oint 0.005%	101
Calcipotriene Oint 0.005%.....	101
calcipotriene soln 0.005% (50 mcg/ml)	101
calcipotriene-betamethasone dipropionate	
see ENSTILAR AER	102
calcitonin (salmon) nasal soln 200 unit/act	106
CALCITRENE	
see Calcipotriene Oint 0.005%.....	101
calcitriol cap 0.25 mcg	107
calcitriol cap 0.5 mcg	107
calcitriol oral soln 1 mcg/ml	107
calcium acetate (phosphate binder) cap 667 mg (169 mg ca)	111
calcium acetate (phosphate binder) tab 667 mg	111
calcium, magnesium, potassium, & sodium oxybates	
see XYWAV SOL 0.5GM/ML	130
CALQUENCE TAB 100MG.....	68
CAMILA	
see Norethindrone Tab 0.35 mg	95
CAMRESE	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	89

CAMRESE LO	
see Levonorg-Eth Est Tab 0.1-0.02mg(84) &	
Eth Est Tab 0.01mg(7).....	88
candesartan cilexetil tab 16 mg	60
candesartan cilexetil tab 32 mg	60
candesartan cilexetil tab 4 mg	60
candesartan cilexetil tab 8 mg	60
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	61
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	61
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	62
capecitabine tab 150 mg	65
capecitabine tab 500 mg	65
CAPEX SHA 0.01%	102
captopril & hydrochlorothiazide tab 25-15 mg 62	
captopril & hydrochlorothiazide tab 25-25 mg 62	
captopril & hydrochlorothiazide tab 50-15 mg 62	
captopril & hydrochlorothiazide tab 50-25 mg 62	
captopril tab 100 mg	59
captopril tab 12.5 mg	59
captopril tab 25 mg	59
captopril tab 50 mg	59
carbamazepine cap er 12hr 100 mg	43
carbamazepine cap er 12hr 200 mg	43
carbamazepine cap er 12hr 300 mg	43
carbamazepine chew tab 100 mg	43
carbamazepine susp 100 mg/5ml	44
carbamazepine tab 200 mg	44
Carbamazepine Tab 200 mg	44
carbamazepine tab er 12hr 100 mg	44
carbamazepine tab er 12hr 200 mg	44
carbamazepine tab er 12hr 400 mg	44
carbidopa & levodopa orally disintegrating tab 10-100 mg	71
carbidopa & levodopa orally disintegrating tab 25-100 mg	72
carbidopa & levodopa orally disintegrating tab 25-250 mg	72
carbidopa & levodopa tab 10-100 mg	72
carbidopa & levodopa tab 25-100 mg	72
carbidopa & levodopa tab 25-250 mg	72
carbidopa & levodopa tab er 25-100 mg	72
carbidopa & levodopa tab er 50-200 mg	72
carbidopa tab 25 mg	71
carbidopa-levodopa	
see DHIVY TAB 25-100MG	72
see RYTARY CAP 145MG.....	73
see RYTARY CAP 195MG.....	73
see RYTARY CAP 245MG.....	73
see RYTARY CAP 95MG.....	73
carbidopa-levodopa-entacapone tabs 12.5-50- 200 mg	72
carbidopa-levodopa-entacapone tabs 18.75-75- 200 mg	72
carbidopa-levodopa-entacapone tabs 25-100- 200 mg	72
carbidopa-levodopa-entacapone tabs 31.25- 125-200 mg	72
carbidopa-levodopa-entacapone tabs 37.5-150- 200 mg	72
carbidopa-levodopa-entacapone tabs 50-200- 200 mg	72
carbinoxamine maleate soln 4 mg/5ml	56
carbinoxamine maleate tab 4 mg	56
carglumic acid soluble tab 200 mg	107
cariprazine hcl	
see VRAYLAR CAP 1.5-3MG	73
see VRAYLAR CAP 1.5MG	73
see VRAYLAR CAP 3MG	73
see VRAYLAR CAP 4.5MG	73
see VRAYLAR CAP 6MG	74
carisoprodol tab 350 mg	125
carteolol hcl ophth soln 1%	126
CARTIA XT	
see Diltiazem Hcl Coated Beads Cap Er 24hr	
120 mg.....	82
see Diltiazem Hcl Coated Beads Cap Er 24hr	
180 mg.....	82
see Diltiazem Hcl Coated Beads Cap Er 24hr	
240 mg.....	82
see Diltiazem Hcl Coated Beads Cap Er 24hr	
300 mg.....	82
carvedilol phosphate cap er 24hr 10 mg	80
carvedilol phosphate cap er 24hr 20 mg	80
carvedilol phosphate cap er 24hr 40 mg	80
carvedilol phosphate cap er 24hr 80 mg	80
carvedilol tab 12.5 mg	80
carvedilol tab 25 mg	80
carvedilol tab 3.125 mg	80
carvedilol tab 6.25 mg	80
CAYSTON INH 75MG	36
cefaclor cap 250 mg	86

<i>cefaclor cap 500 mg</i>	86
<i>cefaclor for susp 250 mg/5ml</i>	86
<i>cefadroxil cap 500 mg</i>	86
<i>cefadroxil for susp 250 mg/5ml</i>	86
<i>cefadroxil for susp 500 mg/5ml</i>	86
<i>cefadroxil tab 1 gm</i>	86
<i>cefdinir cap 300 mg</i>	86
<i>cefdinir for susp 125 mg/5ml</i>	86
<i>cefdinir for susp 250 mg/5ml</i>	87
<i>cefixime cap 400 mg</i>	87
<i>cefixime for susp 100 mg/5ml</i>	87
<i>cefixime for susp 200 mg/5ml</i>	87
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	87
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	87
<i>cefpodoxime proxetil tab 100 mg</i>	87
<i>cefpodoxime proxetil tab 200 mg</i>	87
<i>ceprozil for susp 125 mg/5ml</i>	86
<i>ceprozil for susp 250 mg/5ml</i>	86
<i>ceprozil tab 250 mg</i>	86
<i>ceprozil tab 500 mg</i>	86
<i>cefuroxime axetil tab 250 mg</i>	86
<i>cefuroxime axetil tab 500 mg</i>	86
<i>celecoxib cap 100 mg</i>	23
<i>celecoxib cap 200 mg</i>	23
<i>celecoxib cap 400 mg</i>	23
<i>celecoxib cap 50 mg</i>	23
cenobamate	
see XCOPRI PAK 100-150	46
see XCOPRI PAK 12.5-25	46
see XCOPRI PAK 150-200	46
see XCOPRI PAK 50-100MG	46
see XCOPRI TAB 100MG	46
see XCOPRI TAB 150MG	46
see XCOPRI TAB 200MG	46
see XCOPRI TAB 50MG	46
cephalexin cap 250 mg	86
cephalexin cap 500 mg	86
cephalexin cap 750 mg	86
cephalexin for susp 125 mg/5ml	86
cephalexin for susp 250 mg/5ml	86
cephalexin tab 250 mg	86
cephalexin tab 500 mg	86
CERDELGA CAP 84MG	113
ceritinib	
see ZYKADIA TAB 150MG.....	71
cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)	56
cevimeline hcl cap 30 mg	124

CHARLOTTE 24 FE	
see Norethindrone Ace-Eth Estradiol-Fe Chew	
Tab 1 mg-20 mcg (24).....	92
CHATEAL EQ	
see Levonorgestrel & Ethynodiol-Diethylstilbestrol Tab	
0.15 mg-30 mcg	90
chlorambucil	
see LEUKERAN TAB 2MG	64
chlordiazepoxide hcl cap 10 mg	38
chlordiazepoxide hcl cap 25 mg	38
chlordiazepoxide hcl cap 5 mg	38
chlordiazepoxide hcl-clidinium bromide cap 5-	
2.5 mg	141
chlordiazepoxide-amitriptyline tab 10-25 mg	131
chlordiazepoxide-amitriptyline tab 5-12.5 mg	
.....	131
chloroquine phosphate tab 250 mg	63
chloroquine phosphate tab 500 mg	63
chlorpromazine hcl tab 10 mg	75
chlorpromazine hcl tab 100 mg	75
chlorpromazine hcl tab 200 mg	75
chlorpromazine hcl tab 25 mg	75
chlorpromazine hcl tab 50 mg	75
chlorthalidone tab 25 mg	106
chlorthalidone tab 50 mg	106
chlorzoxazone tab 500 mg	125
cholestyramine light powder 4 gm/dose	57
Cholestyramine Light Powder 4 gm/dose	57
cholestyramine light powder packets 4 gm	57
Cholestyramine Light Powder Packets 4 gm	57
cholestyramine powder 4 gm/dose	57
cholestyramine powder packets 4 gm	57
choline fenofibrate cap dr 135 mg (fenofibric acid equiv)	57
choline fenofibrate cap dr 45 mg (fenofibric acid equiv)	57
CIBINQO TAB 100MG	103
CIBINQO TAB 200MG	103
CIBINQO TAB 50MG	103
CICLODAN	
see Ciclopirox Solution 8%.....	100
ciclopirox gel 0.77%	100
ciclopirox olamine cream 0.77% (base equiv)	100
ciclopirox olamine susp 0.77% (base equiv)	100
ciclopirox shampoo 1%	100
ciclopirox solution 8%	100
Ciclopirox Solution 8%	100

cilostazol tab 100 mg	113	clemastine fumarate tab 2.68 mg	56
cilostazol tab 50 mg	113	CLENPIQ SOL	116
CIMDUO TAB 300-300	77	CLIMARA PRO DIS WEEKLY	108
cimetidine tab 200 mg	141	CLINDACIN	
cimetidine tab 300 mg	141	see Clindamycin Phosphate Foam 1%	98
cimetidine tab 400 mg	141	CLINDACIN ETZ PLEDGETS	
cimetidine tab 800 mg	141	see Clindamycin Phosphate Swab 1%	98
cinacalcet hcl tab 30 mg (base equiv)	107	CLINDACIN-P	
cinacalcet hcl tab 60 mg (base equiv)	107	see Clindamycin Phosphate Swab 1%	98
cinacalcet hcl tab 90 mg (base equiv)	107	clindamycin hcl cap 150 mg	36
CIPRO (10%) SUS 500MG/5	110	clindamycin hcl cap 300 mg	36
CIPRO (5%) SUS 250MG/5	110	clindamycin hcl cap 75 mg	36
ciprofloxacin		clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	36
see CIPRO (10%) SUS 500MG/5	110	clindamycin phosphate foam 1%	98
see CIPRO (5%) SUS 250MG/5	110	Clindamycin Phosphate Foam 1%.....	98
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	127	clindamycin phosphate gel 1%	98
ciprofloxacin hcl otic soln 0.2% (base equivalent)	129	clindamycin phosphate lotion 1%	98
ciprofloxacin hcl tab 100 mg (base equiv)	110	clindamycin phosphate soln 1%	98
ciprofloxacin hcl tab 250 mg (base equiv)	110	clindamycin phosphate swab 1%	98
ciprofloxacin hcl tab 500 mg (base equiv)	110	Clindamycin Phosphate Swab 1%	98
ciprofloxacin hcl tab 750 mg (base equiv)	110	clindamycin phosphate vaginal cream 2%	143
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	129	clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	98
citalopram hydrobromide oral soln 10 mg/5ml	47	clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%	98
citalopram hydrobromide tab 10 mg (base equiv)	47	clindamycin phosphate-benzoyl peroxide gel 1-5%	98
citalopram hydrobromide tab 20 mg (base equiv)	47	clindamycin phosphate-tretinoin gel 1.2-0.025%	98
citalopram hydrobromide tab 40 mg (base equiv)	47	clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	98
CLARAVIS		Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%	98
see Isotretinoin Cap 10 mg	98	clobazam suspension 2.5 mg/ml	43
see Isotretinoin Cap 20 mg	98	clobazam tab 10 mg	43
see Isotretinoin Cap 30 mg	99	clobazam tab 20 mg	43
see Isotretinoin Cap 40 mg	99	clobetasol propionate cream 0.05%	102
clarithromycin for susp 125 mg/5ml	116	clobetasol propionate emollient base cream 0.05%	102
clarithromycin for susp 250 mg/5ml	116	clobetasol propionate foam 0.05%	102
clarithromycin tab 250 mg	117	clobetasol propionate gel 0.05%	102
clarithromycin tab 500 mg	117	clobetasol propionate lotion 0.05%	102
clarithromycin tab er 24hr 500 mg	117	clobetasol propionate oint 0.05%	102
clascoterone		clobetasol propionate shampoo 0.05%	102
see WINLEVI CRE 1%	99	Clobetasol Propionate Shampoo 0.05%.....	102
clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)	56	clobetasol propionate soln 0.05%	102

CLODAN	
see Clobetasol Propionate Shampoo 0.05%	102
clomiphene citrate tab 50 mg	106
clomipramine hcl cap 25 mg	49
clomipramine hcl cap 50 mg	49
clomipramine hcl cap 75 mg	49
clonazepam orally disintegrating tab 0.125 mg	
.....	43
clonazepam orally disintegrating tab 0.25 mg	43
clonazepam orally disintegrating tab 0.5 mg	.43
clonazepam orally disintegrating tab 1 mg	43
clonazepam orally disintegrating tab 2 mg	43
clonazepam tab 0.5 mg	43
clonazepam tab 1 mg	43
clonazepam tab 2 mg	43
clonidine hcl tab 0.1 mg	60
clonidine hcl tab 0.2 mg	60
clonidine hcl tab 0.3 mg	60
clonidine hcl tab er 12hr 0.1 mg	16
clonidine hcl tab er 24hr 0.17 mg (base equivalent)	60
clonidine td patch weekly 0.1 mg/24hr	60
clonidine td patch weekly 0.2 mg/24hr	60
clonidine td patch weekly 0.3 mg/24hr	60
clopidogrel bisulfate tab 300 mg (base equiv)	
.....	113
clopidogrel bisulfate tab 75 mg (base equiv)	113
clorazepate dipotassium tab 15 mg	38
clorazepate dipotassium tab 3.75 mg	38
clorazepate dipotassium tab 7.5 mg	38
clotrimazole cream 1%	100
clotrimazole soln 1%	100
clotrimazole troche 10 mg	124
clotrimazole w/ betamethasone cream 1-0.05%	
.....	100
clotrimazole w/ betamethasone lotion 1-0.05%	
.....	100
clozapine orally disintegrating tab 100 mg	74
clozapine orally disintegrating tab 12.5 mg	74
clozapine orally disintegrating tab 150 mg	74
clozapine orally disintegrating tab 200 mg	74
clozapine orally disintegrating tab 25 mg	74
clozapine tab 100 mg	74
clozapine tab 200 mg	75
clozapine tab 25 mg	74
clozapine tab 50 mg	74
COARTEM TAB 20-120MG	63
cobimetinib fumarate	
see COTELLIC TAB 20MG	68
codeine sulfate tab 30 mg	25
colchicine	
see MITIGARE CAP 0.6MG	112
colchicine cap 0.6 mg	112
colchicine tab 0.6 mg	112
colchicine w/ probenecid tab 0.5-500 mg	112
colesevelam hcl packet for susp 3.75 gm	57
colesevelam hcl tab 625 mg	57
colestipol hcl granule packets 5 gm	57
colestipol hcl granules 5 gm	57
colestipol hcl tab 1 gm	57
COMBIPATCH DIS	108
COMPACT SPAC MIS CHAMBER	118
COMPACT SPAC MIS LG MASK	118
COMPACT SPAC MIS MD MASK	118
COMPACT SPAC MIS SM MASK	119
COMPRO	
see Prochlorperazine Suppos 25 mg	76
condoms - female	
see FC FEMALE MIS CONDOM	117
see FC2 FEMALE MIS CONDOM	117
condoms latex lubricated - male	
see MALE MIS CONDOM	117
CONDYLOX GEL 0.5%	103
conjugated estrogens-bazedoxifene	
see DUAVEE TAB 0.45-20	108
conjugated estrogens-medroxyprogesterone acetate	
see PREMPHASE TAB.....	108
see PREMPRO TAB	108
see PREMPRO TAB 0.3-1.5.....	109
see PREMPRO TAB 0.45-1.5.....	109
see PREMPRO TAB 0.625-5.....	109
CONSTULOSE	
see Lactulose Solution 10 gm/15ml	116
COPIKTRA CAP 15MG	68
COPIKTRA CAP 25MG	68
CORLANOR TAB 5MG	86
CORLANOR TAB 7.5MG	86
CORTIFOAM AER 90MG	34
COTELLIC TAB 20MG	68
CREON CAP 12000UNT	104
CREON CAP 24000UNT	104
CREON CAP 3000UNIT	104
CREON CAP 36000UNT	104

CREON CAP 6000UNIT.....	104
CRINONE GEL 4% VAG.....	143
CRINONE GEL 8% VAG.....	143
crisaborole	
see EUCRISA OIN 2%	104
CRIXIVAN CAP 200MG.....	77
CRIXIVAN CAP 400MG.....	77
cromolyn sodium ophth soln 4%	128
cromolyn sodium oral conc 100 mg/5ml	110
cromolyn sodium soln nebu 20 mg/2ml	39
Crotamiton Lotion 10%	104
CROTAN	
see Crotamiton Lotion 10%	104
CRYSELLE-28	
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg- 30 mcg	94
CVS FOLIC ACID	
see Folic Acid Tab 800 mcg	114
CVS NICOTINE	
see Nicotine Polacrilex Gum 2 mg.....	133
see Nicotine Polacrilex Gum 4 mg.....	134
CVS NICOTINE GUM	
see Nicotine Polacrilex Gum 4 mg.....	134
CVS NICOTINE LOZENGE	
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	135
CVS NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg.....	133
see Nicotine Polacrilex Gum 4 mg.....	134
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	135
CVS NICOTINE POLACRILEX S	
see Nicotine Polacrilex Gum 2 mg.....	133
CVS NICOTINE TRANSDERMAL	
see Nicotine Td Patch 24hr 14 mg/24hr	137
see Nicotine Td Patch 24hr 21 mg/24hr	137
see Nicotine Td Patch 24hr 7 mg/24hr	136
cyclobenzaprine hcl tab 10 mg	125
cyclobenzaprine hcl tab 5 mg	125
cyclopentolate hcl ophth soln 1%	126
cyclophosphamide cap 25 mg	64
cyclophosphamide cap 50 mg	64
cycloserine cap 250 mg	64
cyclosporine (ophth)	
see RESTASIS EMU 0.05% OP.....	128
see RESTASIS MUL EMU 0.05% OP.....	128
cyclosporine cap 100 mg	123
cyclosporine cap 25 mg	123
cyclosporine modified cap 100 mg	123
Cyclosporine Modified Cap 100 mg	123
cyclosporine modified cap 25 mg	123
Cyclosporine Modified Cap 25 mg	123
cyclosporine modified cap 50 mg	123
cyclosporine modified oral soln 100 mg/ml ...	123
Cyclosporine Modified Oral Soln 100 mg/ml...123	
ciproheptadine hcl syrup 2 mg/5ml	56
ciproheptadine hcl tab 4 mg	56
CYRED EQ	
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	87
CYSTAGON CAP 150MG	112
CYSTAGON CAP 50MG	112
cysteamine bitartrate	
see CYSTAGON CAP 150MG.....	112
see CYSTAGON CAP 50MG	112
CYTRA K CRYSTALS	
see Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg	111
D	
dabigatran etexilate mesylate cap 150 mg (etexilate base eq)	43
dabigatran etexilate mesylate cap 75 mg (etexilate base eq)	43
dalfampridine tab er 12hr 10 mg	132
danazol cap 100 mg	34
danazol cap 200 mg	34
danazol cap 50 mg	34
dantrolene sodium cap 100 mg	125
dantrolene sodium cap 25 mg	125
dantrolene sodium cap 50 mg	125
dapagliflozin propanediol	
see FARXIGA TAB 10MG	53
see FARXIGA TAB 5MG	53
dapagliflozin propanediol-metformin hcl	
see XIGDUO XR TAB 10-1000.....	51
see XIGDUO XR TAB 10-500MG	51
see XIGDUO XR TAB 2.5-1000	51
see XIGDUO XR TAB 5-1000MG	51
see XIGDUO XR TAB 5-500MG	51
dapsone gel 5%	98
dapsone gel 7.5%	98
dapsone tab 100 mg	36
dapsone tab 25 mg	36
daridorexant hcl	

see QUVIVIQ TAB 25MG	116	deferasirox tab 360 mg	54
see QUVIVIQ TAB 50MG	116	deferasirox tab 90 mg	54
darifenacin hydrobromide tab er 24hr 15 mg (base equiv)	142	deferasirox tab for oral susp 125 mg	54
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)	142	deferasirox tab for oral susp 250 mg	54
darolutamide		deferasirox tab for oral susp 500 mg	54
see NUBEQA TAB 300MG	66	deferiprone tab 1000 mg	54
darunavir		deferiprone tab 500 mg	54
see PREZISTA SUS 100MG/ML	78	deflazacort	
see PREZISTA TAB 150MG	78	see EMFLAZA SUS 22.75/ML.....	95
see PREZISTA TAB 600MG	78	see EMFLAZA TAB 18MG.....	95
see PREZISTA TAB 75MG	78	see EMFLAZA TAB 30MG.....	95
see PREZISTA TAB 800MG	78	see EMFLAZA TAB 36MG.....	95
darunavir tab 600 mg	77	see EMFLAZA TAB 6MG.....	95
darunavir tab 800 mg	77	DELYLA	
darunavir-cobicistat		see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
see PREZCOBIX TAB 800-150	78	mg-20 mcg	89
darunavir-cobicistat-emtricitabine-tenofovir alafenamide		demeclocycline hcl tab 150 mg	138
see SYMTUZA TAB	78	demeclocycline hcl tab 300 mg	138
dasatinib		DESCOVY TAB 120-15MG	77
see SPRYCEL TAB 100MG.....	70	DESCOVY TAB 200/25MG.....	77
see SPRYCEL TAB 140MG.....	70	desipramine hcl tab 10 mg	49
see SPRYCEL TAB 20MG.....	70	desipramine hcl tab 100 mg	49
see SPRYCEL TAB 50MG.....	70	desipramine hcl tab 150 mg	49
see SPRYCEL TAB 70MG.....	70	desipramine hcl tab 25 mg	49
see SPRYCEL TAB 80MG.....	70	desipramine hcl tab 50 mg	49
DASETTA 1/35		desipramine hcl tab 75 mg	49
see Norethindrone & Ethinyl Estradiol Tab 1		desloratadine tab 5 mg	56
mg-35 mcg	91	desloratadine tab orally disintegrating 2.5 mg	56
DASETTA 7/7/7		desloratadine tab orally disintegrating 5 mg	56
see Norethindrone-Eth Estradiol Tab 0.5-		desmopressin acetate nasal spray soln 0.01%	
35/0.75-35/1-35 mg-Mcg	93	.....	107
dasiglucagon hcl		desmopressin acetate nasal spray soln 0.01%	
see ZEGALOGUE INJ 0.6/0.6.....	52	(refrigerated)	108
DAYSEE		desmopressin acetate tab 0.1 mg	108
see Levonorg-Eth Est Tab 0.15-0.03mg(84) &		desmopressin acetate tab 0.2 mg	108
Eth Est Tab 0.01mg(7).....	89	desogest-eth estrad & eth estrad tab 0.15- 0.02/0.01 mg(21/5)	87
DAYVIGO TAB 10MG	116	Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
DAYVIGO TAB 5MG	116	0.02/0.01 mg(21/5)	87
DEBLITANE		Desogest-Ethin Est Tab 0.1-0.025/0.125-	
see Norethindrone Tab 0.35 mg	95	0.025/0.15-0.025mg-Mg	87
deferasirox granules packet 180 mg	54	Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30	
deferasirox granules packet 360 mg	54	mcg	87
deferasirox granules packet 90 mg	54	desonide cream 0.05%	102
deferasirox tab 180 mg	54	desonide lotion 0.05%	102
		desonide oint 0.05%	102

<i>desoximetasone cream 0.05%</i>	102
<i>desoximetasone cream 0.25%</i>	102
<i>desoximetasone gel 0.05%</i>	102
<i>desoximetasone oint 0.25%</i>	102
<i>desoximetasone spray 0.25%</i>	102
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	49
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	48
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	48
deutetabenazine	
see AUSTEDO TAB 12MG	132
see AUSTEDO TAB 6MG	132
see AUSTEDO TAB 9MG	132
see AUSTEDO XR TAB 12MG	132
see AUSTEDO XR TAB 24MG	132
see AUSTEDO XR TAB 6MG	132
see AUSTEDO XR TAB TITR KIT	132
<i>dexamethasone elixir 0.5 mg/5ml</i>	95
dexamethasone sodium phosphate ophth soln	
<i>0.1%</i>	128
<i>dexamethasone soln 0.5 mg/5ml</i>	95
<i>dexamethasone tab 0.5 mg</i>	95
<i>dexamethasone tab 0.75 mg</i>	95
<i>dexamethasone tab 1 mg</i>	95
<i>dexamethasone tab 1.5 mg</i>	95
<i>dexamethasone tab 2 mg</i>	95
<i>dexamethasone tab 4 mg</i>	95
<i>dexamethasone tab 6 mg</i>	95
<i>dexamethasone tab therapy pack 1.5 mg (21)</i> 95	
Dexamethasone Tab Therapy Pack 1.5 mg (21) 95	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i> 95	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i> 95	
<i>dexamethylphenidate hcl cap er 24 hr 10 mg</i> ... 17	
<i>dexamethylphenidate hcl cap er 24 hr 15 mg</i> ... 17	
<i>dexamethylphenidate hcl cap er 24 hr 20 mg</i> ... 17	
<i>dexamethylphenidate hcl cap er 24 hr 25 mg</i> ... 17	
<i>dexamethylphenidate hcl cap er 24 hr 30 mg</i> ... 17	
<i>dexamethylphenidate hcl cap er 24 hr 35 mg</i> ... 18	
<i>dexamethylphenidate hcl cap er 24 hr 40 mg</i> ... 18	
<i>dexamethylphenidate hcl cap er 24 hr 5 mg</i> 17	
<i>dexamethylphenidate hcl tab 10 mg</i>	18
<i>dexamethylphenidate hcl tab 2.5 mg</i>	18
<i>dexamethylphenidate hcl tab 5 mg</i>	18
<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	12
dextroamphetamine sulfate cap er 24hr 15 mg	
.....	13
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i> .12	
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	13
Dextroamphetamine Sulfate Oral Solution 5 mg/5ml.....	13
dextroamphetamine sulfate tab 10 mg	13
Dextroamphetamine Sulfate Tab 10 mg	13
dextroamphetamine sulfate tab 15 mg	13
Dextroamphetamine Sulfate Tab 15 mg	13
Dextroamphetamine Sulfate Tab 2.5 mg	13
dextroamphetamine sulfate tab 20 mg	14
Dextroamphetamine Sulfate Tab 20 mg	14
dextroamphetamine sulfate tab 30 mg	14
Dextroamphetamine Sulfate Tab 30 mg	14
dextroamphetamine sulfate tab 5 mg	13
Dextroamphetamine Sulfate Tab 5 mg	13
Dextroamphetamine Sulfate Tab 7.5 mg	13
DHIVY TAB 25-100MG.....	72
diazepam (anticonvulsant)	
see VALTOCO SPR 10MG	43
see VALTOCO SPR 15MG	43
see VALTOCO SPR 20MG	43
see VALTOCO SPR 5MG	43
<i>diazepam conc 5 mg/ml</i>	38
<i>diazepam oral soln 1 mg/ml</i>	38
<i>diazepam rectal gel delivery system 10 mg</i> ....43	
<i>diazepam rectal gel delivery system 2.5 mg</i> ....43	
<i>diazepam rectal gel delivery system 20 mg</i> ....43	
<i>diazepam tab 10 mg</i>	38
<i>diazepam tab 2 mg</i>	38
<i>diazepam tab 5 mg</i>	38
<i>diazoxide susp 50 mg/ml</i>	52
<i>dichlorphenamide tab 50 mg</i>	105
<i>diclofenac epolamine patch 1.3%</i>	100
<i>diclofenac potassium tab 50 mg</i>	23
<i>diclofenac sodium (actinic keratoses) gel 3%.</i> 100	
<i>diclofenac sodium gel 1% (1.16% diethylamine equiv)</i>	100
<i>diclofenac sodium ophth soln 0.1%</i>	128
<i>diclofenac sodium soln 1.5%</i>	100
<i>diclofenac sodium tab delayed release 25 mg</i> .23	
<i>diclofenac sodium tab delayed release 50 mg</i> .23	
<i>diclofenac sodium tab delayed release 75 mg</i> .23	
<i>diclofenac sodium tab er 24hr 100 mg</i>	23

diclofenac w/ misoprostol tab delayed release	
50-0.2 mg	23
diclofenac w/ misoprostol tab delayed release	
75-0.2 mg	23
dicloxacillin sodium cap 250 mg	130
dicloxacillin sodium cap 500 mg	130
dicyclomine hcl cap 10 mg	141
dicyclomine hcl oral soln 10 mg/5ml	141
dicyclomine hcl tab 20 mg	141
diethylpropion hcl tab 25 mg	15
diethylpropion hcl tab er 24hr 75 mg	15
DIFICID SUS.....	117
DIFICID TAB 200MG	117
diflunisal tab 500 mg	25
difluprednate ophth emulsion 0.05%	128
digoxin oral soln 0.05 mg/ml	84
digoxin tab 125 mcg (0.125 mg)	84
digoxin tab 250 mcg (0.25 mg)	84
digoxin tab 62.5 mcg (0.0625 mg)	84
diltiazem hcl cap er 12hr 120 mg	82
diltiazem hcl cap er 12hr 60 mg	82
diltiazem hcl cap er 12hr 90 mg	82
diltiazem hcl cap er 24hr 120 mg	82
Diltiazem Hcl Cap Er 24hr 120 mg	82
diltiazem hcl cap er 24hr 180 mg	82
Diltiazem Hcl Cap Er 24hr 180 mg	82
diltiazem hcl cap er 24hr 240 mg	82
Diltiazem Hcl Cap Er 24hr 240 mg	82
diltiazem hcl coated beads cap er 24hr 120 mg	
.....	82
Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg	
.....	82
diltiazem hcl coated beads cap er 24hr 180 mg	
.....	82
Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg	
.....	82
diltiazem hcl coated beads cap er 24hr 240 mg	
.....	82
Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg	
.....	82
diltiazem hcl coated beads cap er 24hr 300 mg	
.....	82
Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg	
.....	82
diltiazem hcl coated beads cap er 24hr 360 mg	
.....	82
diltiazem hcl extended release beads cap er	
24hr 120 mg	82
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 120 mg	82
diltiazem hcl extended release beads cap er	
24hr 180 mg	82
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 180 mg	82
diltiazem hcl extended release beads cap er	
24hr 240 mg	82
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 240 mg	82
diltiazem hcl extended release beads cap er	
24hr 300 mg	82
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 300 mg	82, 83
diltiazem hcl extended release beads cap er	
24hr 360 mg	83
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 360 mg	83
diltiazem hcl extended release beads cap er	
24hr 420 mg	83
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 420 mg	83
diltiazem hcl tab 120 mg	83
diltiazem hcl tab 30 mg	83
diltiazem hcl tab 60 mg	83
diltiazem hcl tab 90 mg	83
DILT-XR	
see Diltiazem Hcl Cap Er 24hr 120 mg.....	82
see Diltiazem Hcl Cap Er 24hr 180 mg.....	82
see Diltiazem Hcl Cap Er 24hr 240 mg.....	82
dimethyl fumarate capsule delayed release 120 mg	132
dimethyl fumarate capsule delayed release 240 mg	132
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	132
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	
.....	54
diphenoxylate w/ atropine tab 2.5-0.025 mg ..	54
dipyridamole tab 25 mg	113
dipyridamole tab 50 mg	113
dipyridamole tab 75 mg	113
diroximel fumarate	
see VUMERITY CAP 231MG	133
disopyramide phosphate	

see NORPACE CAP 100MG CR.....	38
see NORPACE CAP 150MG CR.....	38
disopyramide phosphate cap 100 mg	38
disopyramide phosphate cap 150 mg	38
disulfiram tab 250 mg	130
disulfiram tab 500 mg	130
divalproex sodium cap delayed release sprinkle 125 mg	47
divalproex sodium tab delayed release 125 mg	47
divalproex sodium tab delayed release 250 mg	47
divalproex sodium tab delayed release 500 mg	47
divalproex sodium tab er 24 hr 250 mg	47
divalproex sodium tab er 24 hr 500 mg	47
DIVIGEL GEL 0.25MG.....	109
DIVIGEL GEL 0.5MG.....	109
DIVIGEL GEL 0.75MG.....	109
DIVIGEL GEL 1.25MG.....	109
DIVIGEL GEL 1MG/GM	109
dofetilide cap 125 mcg (0.125 mg).....	39
dofetilide cap 250 mcg (0.25 mg).....	39
dofetilide cap 500 mcg (0.5 mg)	39
DOLISHALE	
see Levonorgestrel-Ethinyl Estradiol	
(Continuous) Tab 90-20 mcg	90
dolutegravir sodium	
see TIVICAY PD TAB 5MG.....	78
see TIVICAY TAB 10MG.....	78
see TIVICAY TAB 25MG.....	78
see TIVICAY TAB 50MG.....	78
dolutegravir sodium-lamivudine	
see DOVATO TAB 50-300MG	77
donepezil hydrochloride orally disintegrating tab 10 mg	131
donepezil hydrochloride orally disintegrating tab 5 mg	131
donepezil hydrochloride tab 10 mg	131
donepezil hydrochloride tab 23 mg	131
donepezil hydrochloride tab 5 mg	131
DOPTELET TAB 20MG.....	114
dorzolamide hcl ophth soln 2%.....	128
dorzolamide hcl-timolol maleate ophth soln 2- 0.5%	126
dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%	126

DOTTI

see Estradiol Td Patch Twice Weekly 0.025 mg/24hr.....	109
see Estradiol Td Patch Twice Weekly 0.0375 mg/24hr.....	109
see Estradiol Td Patch Twice Weekly 0.05 mg/24hr.....	109
see Estradiol Td Patch Twice Weekly 0.075 mg/24hr.....	109
see Estradiol Td Patch Twice Weekly 0.1 mg/24hr.....	109
DOVATO TAB 50-300MG	77
doxazosin mesylate tab 1 mg	60
doxazosin mesylate tab 2 mg	60
doxazosin mesylate tab 4 mg	60
doxazosin mesylate tab 8 mg	60
doxepin hcl (sleep) tab 3 mg (base equiv).....	115
doxepin hcl (sleep) tab 6 mg (base equiv).....	115
doxepin hcl cap 10 mg	49
doxepin hcl cap 100 mg	50
doxepin hcl cap 150 mg	50
doxepin hcl cap 25 mg	49
doxepin hcl cap 50 mg	49
doxepin hcl cap 75 mg	49
doxepin hcl conc 10 mg/ml	50
doxercalciferol cap 0.5 mcg	107
doxercalciferol cap 1 mcg	107
doxercalciferol cap 2.5 mcg	107
doxycycline (rosacea)	
see ORACEA CAP 40MG.....	104
doxycycline hyclate cap 100 mg	138
doxycycline hyclate cap 50 mg	138
doxycycline hyclate tab 100 mg	138
doxycycline monohydrate cap 100 mg	138
Doxycycline Monohydrate Cap 100 mg	138
doxycycline monohydrate cap 50 mg	138
doxycycline monohydrate for susp 25 mg/5ml	138
doxycycline monohydrate tab 100 mg	138
Doxycycline Monohydrate Tab 100 mg	138
doxycycline monohydrate tab 150 mg	139
doxycycline monohydrate tab 50 mg	138
doxycycline monohydrate tab 75 mg	138
doxylamine-pyridoxine tab delayed release 10- 10 mg	55
dronabinol cap 10 mg	55
dronabinol cap 2.5 mg	55

dronabinol cap 5 mg	55
drospirenone-ethinyl estradiol tab 3-0.02 mg .	88
Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg .	88
drospirenone-ethinyl estradiol tab 3-0.03 mg .	88
Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg .	88
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	87
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	87
Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg	88
droxidopa cap 100 mg	144
droxidopa cap 200 mg	144
droxidopa cap 300 mg	144
DUAVEE TAB 0.45-20.....	108
dulaglutide	
see TRULICITY INJ 0.75/0.5	52
see TRULICITY INJ 1.5/0.5	52
see TRULICITY INJ 3/0.5	52
see TRULICITY INJ 4.5/0.5	52
duloxetine hcl enteric coated pellets cap 20 mg (base eq)	49
duloxetine hcl enteric coated pellets cap 30 mg (base eq)	49
duloxetine hcl enteric coated pellets cap 40 mg (base eq)	49
duloxetine hcl enteric coated pellets cap 60 mg (base eq)	49
dutasteride cap 0.5 mg	112
dutasteride-tamsulosin hcl cap 0.5-0.4 mg ...	112
duvelisib	
see COPIKTRA CAP 15MG	68
see COPIKTRA CAP 25MG	68
E	
E.E.S. 400	
see Erythromycin Ethylsuccinate Tab 400 mg	117
EASIVENT MIS	119
EASIVENT MIS MASK LG	119
EASIVENT MIS MASK MED	119
EASIVENT MIS MASK SM	119
EC-NAPROXEN	
see Naproxen Tab Ec 375 mg.....	24
see Naproxen Tab Ec 500 mg.....	24
econazole nitrate cream 1%	100
EDURANT TAB 25MG	77
efavirenz tab 600 mg	77
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg	77
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg	77
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg	77
EFFER-K	
see Potassium Bicarbonate Effer Tab 25 meq	122
elagolix sodium	
see ORILISSA TAB 150MG	106
see ORILISSA TAB 200MG	106
elagolix sodium-estradiol-norethindrone acetate	
see ORIAHNN CAP	108
eletriptan hydrobromide tab 20 mg (base equivalent)	120
eletriptan hydrobromide tab 40 mg (base equivalent)	120
eliglustat tartrate	
see CERDELGA CAP 84MG	113
ELINEST	
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg	94
ELIQUIS ST P TAB 5MG	42
ELIQUIS TAB 2.5MG	42
ELIQUIS TAB 5MG	42
ELITE-OB	
see Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg	125
ELIXOPHYLLIN	
see Theophylline Elixir 80 mg/15ml	42
ELLA TAB 30MG	95
eltrombopag olamine	
see PROMACTA PAK 25MG	114
see PROMACTA POW 12.5MG	114
see PROMACTA TAB 12.5MG	114
see PROMACTA TAB 25MG	115
see PROMACTA TAB 50MG	115
see PROMACTA TAB 75MG	115
eluxadoline	
see VIBERZI TAB 100MG.....	111
see VIBERZI TAB 75MG.....	111
elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide	
see GENVOYA TAB	77
EMCYT CAP 140MG	66

EMFLAZA SUS 22.75/ML.....	95	<i>enalapril maleate oral soln 1 mg/ml</i>	59
EMFLAZA TAB 18MG	95	<i>enalapril maleate tab 10 mg</i>	59
EMFLAZA TAB 30MG	95	<i>enalapril maleate tab 2.5 mg</i>	59
EMFLAZA TAB 36MG	95	<i>enalapril maleate tab 20 mg</i>	59
EMFLAZA TAB 6MG	95	<i>enalapril maleate tab 5 mg</i>	59
empagliflozin		ENCARE SUP 100MG	143
see JARDIANCE TAB 10MG	53	encorafenib	
see JARDIANCE TAB 25MG	53	see BRAFTOVI CAP 75MG.....	67
empagliflozin-linagliptin		ENDOCET	
see GLYXAMBI TAB 10-5 MG.....	50	see Oxycodone W/ Acetaminophen Tab 10-	
see GLYXAMBI TAB 25-5 MG.....	50	325 mg.....	33
empagliflozin-linagliptin-metformin		see Oxycodone W/ Acetaminophen Tab 2.5-	
see TRIJARDY XR TAB.....	51	325 mg.....	32
empagliflozin-metformin hcl		see Oxycodone W/ Acetaminophen Tab 5-325	
see SYNJARDY TAB	51	mg	32
see SYNJARDY TAB 12.5-500.....	51	see Oxycodone W/ Acetaminophen Tab 7.5-	
see SYNJARDY TAB 5-1000MG	51	325 mg.....	32
see SYNJARDY TAB 5-500MG	51	ENDOMETRIN SUP 100MG	143
see SYNJARDY XR TAB	51	ENPRESSE-28	
see SYNJARDY XR TAB 10-1000	51	see Levonorgestrel-Eth Estra Tab 0.05-	
see SYNJARDY XR TAB 25-1000	51	30/0.075-40/0.125-30mg-Mcg	90
see SYNJARDY XR TAB 5-1000MG	51	ENSKYCE	
emtricitabine		see Desogestrel & Ethynodiol-Diol Tab 0.15	
see EMTRIVA CAP 200MG	77	mg-30 mcg	87
see EMTRIVA SOL 10MG/ML	77	ENSTILAR AER	102
emtricitabine caps 200 mg	77	entacapone tab 200 mg	71
emtricitabine-rilpivirine-tenofovir alafenamide fumarate		entecavir tab 0.5 mg	79
see ODEFSEY TAB	78	entecavir tab 1 mg	79
emtricitabine-tenofovir alafenamide fumarate		entrectinib	
see DESCovy TAB 120-15MG	77	see ROZLYTREK CAP 100MG	69
see DESCovy TAB 200/25MG	77	see ROZLYTREK CAP 200MG	70
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg	77	ENTRESTO TAB 24-26MG	84
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg	77	ENTRESTO TAB 49-51MG	84
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg	77	ENTRESTO TAB 97-103MG	84
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg	77	ENULOSE	
EMTRIVA CAP 200MG	77	see Lactulose (Encephalopathy) Solution 10	
EMTRIVA SOL 10MG/ML	77	gm/15ml	111
EMVERM CHW 100MG.....	35	enzalutamide	
enalapril maleate & hydrochlorothiazide tab 10-25 mg	62	see XTANDI CAP 40MG.....	66
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	62	see XTANDI TAB 40MG.....	66
		see XTANDI TAB 80MG.....	67
		EPCLUSA PAK 150-37.5	79
		EPCLUSA PAK 200-50MG	79
		EPCLUSA TAB 200-50MG	79
		EPCLUSA TAB 400-100	79
		EPIDUO FORTE GEL 0.3-2.5%	98
		EPIDUO GEL 0.1-2.5%	98

epinastine hcl ophth soln 0.05%	128
epinephrine (anaphylaxis)	
see AUVI-Q INJ 0.15MG	144
see AUVI-Q INJ 0.1MG	144
see AUVI-Q INJ 0.3MG	144
see EPIPEN 2-PAK INJ 0.3MG	144
see EPIPEN-JR INJ 0.15MG	144
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)	144
epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)	144
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)	144
EPIPEN 2-PAK INJ 0.3MG	144
EPIPEN-JR INJ 0.15MG.....	144
EPITOL	
see Carbamazepine Tab 200 mg	44
eplerenone tab 25 mg	63
eplerenone tab 50 mg	63
EQ NICOTINE	
see Nicotine Td Patch 24hr 14 mg/24hr	137
see Nicotine Td Patch 24hr 21 mg/24hr	137
see Nicotine Td Patch 24hr 7 mg/24hr	136
EQ NICOTINE LOZENGES	
see Nicotine Polacrilex Lozenge 4 mg	135
EQ NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg.....	133
see Nicotine Polacrilex Gum 4 mg.....	134
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	136
EQ NICOTINE STEP 3	
see Nicotine Td Patch 24hr 7 mg/24hr	136
EQL NICOTINE POLACRILEX	
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	136
ergocalciferol cap 1.25 mg (50000 unit)	144
ergoloid mesylates tab 1 mg	133
ERIVEDGE CAP 150MG	66
ERLEADA TAB 240MG	66
ERLEADA TAB 60MG	66
erlotinib hcl tab 100 mg (base equivalent)	65
erlotinib hcl tab 150 mg (base equivalent)	65
erlotinib hcl tab 25 mg (base equivalent)	65
ERRIN	
see Norethindrone Tab 0.35 mg	95
ERY	
see Erythromycin Pads 2%.....	98

ERY-TAB	
see Erythromycin Tab Delayed Release 250 mg	117
see Erythromycin Tab Delayed Release 333 mg	117
see Erythromycin Tab Delayed Release 500 mg	117
ERYTHROCIN STEARATE	
see Erythromycin Stearate Tab 250 mg.....	117
erythromycin ethylsuccinate for susp 200 mg/5ml	117
erythromycin ethylsuccinate for susp 400 mg/5ml	117
erythromycin ethylsuccinate tab 400 mg	117
Erythromycin Ethylsuccinate Tab 400 mg	117
erythromycin gel 2%	98
erythromycin ophth oint 5 mg/gm	127
Erythromycin Pads 2%	98
erythromycin soln 2%	98
Erythromycin Stearate Tab 250 mg	117
erythromycin tab 250 mg	117
erythromycin tab 500 mg	117
erythromycin tab delayed release 250 mg	117
Erythromycin Tab Delayed Release 250 mg	117
erythromycin tab delayed release 333 mg	117
Erythromycin Tab Delayed Release 333 mg	117
erythromycin tab delayed release 500 mg	117
Erythromycin Tab Delayed Release 500 mg	117
erythromycin w/ delayed release particles cap 250 mg	117
escitalopram oxalate soln 5 mg/5ml (base equiv)	47
escitalopram oxalate tab 10 mg (base equiv)	47
escitalopram oxalate tab 20 mg (base equiv)	47
escitalopram oxalate tab 5 mg (base equiv)	47
eslicarbazepine acetate	
see APTIOM TAB 200MG	43
see APTIOM TAB 400MG	43
see APTIOM TAB 600MG	43
see APTIOM TAB 800MG	43
esomeprazole magnesium cap delayed release 20 mg (base eq)	141
esomeprazole magnesium cap delayed release 40 mg (base eq)	141
esomeprazole magnesium for delayed release susp packet 10 mg	141

esomeprazole magnesium for delayed release	
susp packet 20 mg	142
esomeprazole magnesium for delayed release	
susp packet 40 mg	142
ESTARYLLA	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	93
estazolam tab 1 mg	115
estazolam tab 2 mg	115
estradiol	
see DIVIGEL GEL 0.25MG	109
see DIVIGEL GEL 0.5MG	109
see DIVIGEL GEL 0.75MG	109
see DIVIGEL GEL 1.25MG	109
see DIVIGEL GEL 1MG/GM	109
see EVAMIST SPR 1.53MG	110
estradiol & norethindrone acetate	
see COMBIPATCH DIS	108
estradiol & norethindrone acetate tab 0.5-0.1 mg	
mg	108
Estradiol & Norethindrone Acetate Tab 0.5-0.1	
mg	108
estradiol & norethindrone acetate tab 1-0.5 mg	
.....	108
Estradiol & Norethindrone Acetate Tab 1-0.5 mg	
.....	108
estradiol tab 0.5 mg	109
estradiol tab 1 mg	109
estradiol tab 2 mg	109
estradiol td gel 0.25 mg/0.25gm (0.1%)	109
estradiol td gel 0.5 mg/0.5gm (0.1%)	109
estradiol td gel 0.75 mg/0.75gm (0.1%)	109
estradiol td gel 1 mg/gm (0.1%)	109
estradiol td gel 1.25 mg/1.25gm (0.1%)	109
estradiol td patch twice weekly 0.025 mg/24hr	
.....	109
Estradiol Td Patch Twice Weekly 0.025 mg/24hr	
.....	109
estradiol td patch twice weekly 0.0375 mg/24hr	
.....	109
Estradiol Td Patch Twice Weekly 0.0375 mg/24hr	
.....	109
estradiol td patch twice weekly 0.05 mg/24hr	
.....	109
Estradiol Td Patch Twice Weekly 0.05 mg/24hr	
.....	109
estradiol td patch twice weekly 0.075 mg/24hr	
.....	109
Estradiol Td Patch Twice Weekly 0.075 mg/24hr	
.....	109
estradiol td patch twice weekly 0.1 mg/24hr	109
Estradiol Td Patch Twice Weekly 0.1 mg/24hr	
.....	109
estradiol td patch weekly 0.025 mg/24hr	110
estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)	110
estradiol td patch weekly 0.05 mg/24hr	110
estradiol td patch weekly 0.06 mg/24hr	110
estradiol td patch weekly 0.075 mg/24hr	110
estradiol td patch weekly 0.1 mg/24hr	110
estradiol vaginal	
see IMVEXXY MAIN SUP 10MCG	143
see IMVEXXY MAIN SUP 4MCG	143
see IMVEXXY STRT SUP 10MCG	143
see IMVEXXY STRT SUP 4MCG	143
see VAGIFEM TAB 10MCG	143
estradiol vaginal cream 0.1 mg/gm	143
estradiol valerate-dienogest	
see NATAZIA TAB	90
estradiol-levonorgestrel	
see CLIMARA PRO DIS WEEKLY	108
estramustine phosphate sodium	
see EMCYT CAP 140MG	66
eszopiclone tab 1 mg	115
eszopiclone tab 2 mg	115
eszopiclone tab 3 mg	115
ethacrynic acid tab 25 mg	105
ethambutol hcl tab 100 mg	64
ethambutol hcl tab 400 mg	64
ethionamide	
see TRECATOR TAB 250MG	64
ethosuximide cap 250 mg	46
ethosuximide soln 250 mg/5ml	46
ethyl chloride aerosol spray	103
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	88
Ethynodiol Diacetate & Ethinyl Estradiol Tab 1	
mg-35 mcg	88
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	88
Ethynodiol Diacetate & Ethinyl Estradiol Tab 1	
mg-50 mcg	88
etodolac cap 200 mg	23
etodolac cap 300 mg	23

<i>etodolac tab 400 mg</i>	23
<i>etodolac tab 500 mg</i>	23
<i>etodolac tab er 24hr 400 mg</i>	23
<i>etodolac tab er 24hr 500 mg</i>	23
<i>etodolac tab er 24hr 600 mg</i>	23
<i>etonogestrel-ethynodiol estradiol</i>	
see NUVARING MIS	95
<i>etoposide cap 50 mg</i>	71
<i>etravirine</i>	
see INTELENCE TAB 100MG	77
see INTELENCE TAB 200MG	77
see INTELENCE TAB 25MG	77
<i>etravirine tab 100 mg</i>	77
<i>etravirine tab 200 mg</i>	77
EUCRISA OIN 2%	104
<i>EUTHYROX</i>	
see Levothyroxine Sodium Tab 100 mcg	139
see Levothyroxine Sodium Tab 112 mcg	139
see Levothyroxine Sodium Tab 125 mcg	140
see Levothyroxine Sodium Tab 137 mcg	140
see Levothyroxine Sodium Tab 150 mcg	140
see Levothyroxine Sodium Tab 175 mcg	140
see Levothyroxine Sodium Tab 200 mcg	140
see Levothyroxine Sodium Tab 25 mcg	139
see Levothyroxine Sodium Tab 50 mcg	139
see Levothyroxine Sodium Tab 75 mcg	139
see Levothyroxine Sodium Tab 88 mcg	139
EVAMIST SPR 1.53MG	110
<i>everolimus tab 0.25 mg</i>	124
<i>everolimus tab 0.5 mg</i>	124
<i>everolimus tab 0.75 mg</i>	124
<i>everolimus tab 1 mg</i>	124
<i>everolimus tab 10 mg</i>	68
<i>everolimus tab 2.5 mg</i>	68
<i>everolimus tab 5 mg</i>	68
<i>everolimus tab 7.5 mg</i>	68
<i>everolimus tab for oral susp 2 mg</i>	68
<i>everolimus tab for oral susp 3 mg</i>	68
<i>everolimus tab for oral susp 5 mg</i>	68
EVOTAZ TAB 300-150	77
<i>exemestane tab 25 mg</i>	66
<i>ezetimibe tab 10 mg</i>	58
<i>ezetimibe-simvastatin tab 10-10 mg</i>	56
<i>ezetimibe-simvastatin tab 10-20 mg</i>	56
<i>ezetimibe-simvastatin tab 10-40 mg</i>	57
<i>ezetimibe-simvastatin tab 10-80 mg</i>	57

F

FA-8

see Folic Acid Cap 0.8 mg	113
see Folic Acid Tab 800 mcg.....	114
<i>FALESSA KIT</i>	88
<i>FALMINA</i>	
see Levonorgestrel & Ethynodiol Estradiol Tab 0.1	
mg-20 mcg	89
<i>famciclovir tab 125 mg</i>	79
<i>famciclovir tab 250 mg</i>	79
<i>famciclovir tab 500 mg</i>	80
<i>famotidine for susp 40 mg/5ml</i>	141
<i>famotidine tab 20 mg</i>	141
<i>famotidine tab 40 mg</i>	141
<i>FARXIGA TAB 10MG</i>	53
<i>FARXIGA TAB 5MG</i>	53
<i>FC FEMALE MIS CONDOM</i>	117
<i>FC2 FEMALE MIS CONDOM</i>	117
<i>febuxostat tab 40 mg</i>	112
<i>febuxostat tab 80 mg</i>	112
<i>felbamate susp 600 mg/5ml</i>	46
<i>felbamate tab 400 mg</i>	46
<i>felbamate tab 600 mg</i>	46
<i>felodipine tab er 24hr 10 mg</i>	83
<i>felodipine tab er 24hr 2.5 mg</i>	83
<i>felodipine tab er 24hr 5 mg</i>	83
<i>fenofibrate cap 150 mg</i>	57
<i>fenofibrate micronized cap 134 mg</i>	57
<i>fenofibrate micronized cap 200 mg</i>	57
<i>fenofibrate micronized cap 43 mg</i>	57
<i>fenofibrate micronized cap 67 mg</i>	57
<i>fenofibrate tab 145 mg</i>	57
<i>fenofibrate tab 160 mg</i>	57
<i>fenofibrate tab 48 mg</i>	57
<i>fenofibrate tab 54 mg</i>	57
<i>fenofibric acid tab 105 mg</i>	57
<i>fenofibric acid tab 35 mg</i>	57
<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	
.....	25
<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	
.....	25
<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	
.....	25
<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	
.....	25
<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	
.....	25

<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	25	FLOVENT HFA AER 110MCG	40
<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	25	FLOVENT HFA AER 220MCG	40
<i>fentanyl citrate lozenge on a handle 200 mcg</i>	25	FLOVENT HFA AER 44MCG	40
<i>fentanyl citrate lozenge on a handle 400 mcg</i>	25	<i>fluconazole for susp 10 mg/ml</i>	55
<i>fentanyl citrate lozenge on a handle 600 mcg</i>	25	<i>fluconazole for susp 40 mg/ml</i>	55
<i>fentanyl citrate lozenge on a handle 800 mcg</i>	25	<i>fluconazole tab 100 mg</i>	55
<i>fentanyl td patch 72hr 100 mcg/hr</i>	25	<i>fluconazole tab 150 mg</i>	55
<i>fentanyl td patch 72hr 12 mcg/hr</i>	25	<i>fluconazole tab 200 mg</i>	55
<i>fentanyl td patch 72hr 25 mcg/hr</i>	25	<i>fluconazole tab 50 mg</i>	55
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	25	<i>flucytosine cap 250 mg</i>	55
<i>fentanyl td patch 72hr 50 mcg/hr</i>	25	<i>fludrocortisone acetate tab 0.1 mg</i>	96
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	25	<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	126
<i>fentanyl td patch 72hr 75 mcg/hr</i>	25	<i>fluocinolone acetonide</i>	
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	25	see CAPEX SHA 0.01%	102
<i>ferric citrate</i>		<i>fluocinolone acetonide (otic) oil 0.01%</i>	129
see AURYXIA TAB 210MG	111	Fluocinolone Acetonide (Otic) Oil 0.01%.....	129
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	142	<i>fluocinolone acetonide cream 0.01%</i>	102
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	142	<i>fluocinolone acetonide cream 0.025%</i>	102
FIASP FLEX INJ TOUCH.....	52	<i>fluocinolone acetonide oil 0.01% (body oil)</i> ...	102
FIASP INJ 100/ML.....	53	<i>fluocinolone acetonide oil 0.01% (scalp oil)</i> ...	102
FIASP PENFIL INJ U-100	53	<i>fluocinolone acetonide oint 0.025%</i>	102
<i>fidaxomicin</i>		<i>fluocinolone acetonide soln 0.01%</i>	102
see DIFICID SUS.....	117	<i>fluocinonide cream 0.05%</i>	102
see DIFICID TAB 200MG	117	<i>fluocinonide emulsified base cream 0.05%</i>	102
FINACEA AER 15%	104	<i>fluocinonide gel 0.05%</i>	102
<i>finasteride tab 5 mg</i>	112	<i>fluocinonide oint 0.05%</i>	102
<i>finerenone</i>		<i>fluocinonide soln 0.05%</i>	102
see KERENDIA TAB 10MG	107	FLUORABON DRO	121
see KERENDIA TAB 20MG	107	<i>fluorometholone ophth susp 0.1%</i>	128
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	132	<i>fluorouracil cream 5%</i>	100
FINZALA		<i>fluorouracil soln 2%</i>	101
see Norethindrone Ace-Eth Estradiol-Fe Chew		<i>fluorouracil soln 5%</i>	101
Tab 1 mg-20 mcg (24)	93	<i>fluoxetine hcl cap 10 mg</i>	47
FLAC		<i>fluoxetine hcl cap 20 mg</i>	47
see Fluocinolone Acetonide (Otic) Oil 0.01%		<i>fluoxetine hcl cap 40 mg</i>	48
.....	129	<i>fluoxetine hcl cap delayed release 90 mg</i>	48
<i>flavoxate hcl tab 100 mg</i>	143	<i>fluoxetine hcl solution 20 mg/5ml</i>	48
<i>flecainide acetate tab 100 mg</i>	38	<i>fluoxetine hcl tab 10 mg</i>	48
<i>flecainide acetate tab 150 mg</i>	38	<i>fluoxetine hcl tab 20 mg</i>	48
<i>flecainide acetate tab 50 mg</i>	38	<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	75
FLEXICHAMBER MIS	119	<i>fluphenazine hcl oral conc 5 mg/ml</i>	75
FLEXICHAMBER MIS MASK LRG	119	<i>fluphenazine hcl tab 1 mg</i>	75
FLEXICHAMBER MIS MASK SM	119	<i>fluphenazine hcl tab 10 mg</i>	75
<i>flibanserin</i>		<i>fluphenazine hcl tab 2.5 mg</i>	75
see ADDYI TAB 100MG	132	<i>fluphenazine hcl tab 5 mg</i>	75
FLURA-DROPS			

see Sodium Fluoride Soln 0.25 mg/drop F (From 0.55 mg/drop Naf).....	121
flurazepam hcl cap 15 mg.....	115
flurazepam hcl cap 30 mg.....	115
flurbiprofen sodium ophth soln 0.03%	128
flurbiprofen tab 100 mg	23
flurbiprofen tab 50 mg	23
fluticasone furoate-vilanterol	
see BREO ELLIPTA INH 100-25	41
see BREO ELLIPTA INH 200-25	41
see BREO ELLIPTA INH 50-25MCG	41
fluticasone furoate-vilanterol aero powd ba 100-25 mcg/act	41
fluticasone furoate-vilanterol aero powd ba 200-25 mcg/act	41
fluticasone propionate cream 0.05%	102
fluticasone propionate hfa	
see FLOVENT HFA AER 110MCG.....	40
see FLOVENT HFA AER 220MCG.....	40
see FLOVENT HFA AER 44MCG	40
fluticasone propionate hfa inhal aer 110 mcg/act (125 valve)	40
fluticasone propionate hfa inhal aer 220 mcg/act (250 valve)	40
fluticasone propionate hfa inhal aero 44 mcg/act (50 valve)	40
fluticasone propionate lotion 0.05%	102
fluticasone propionate nasal susp 50 mcg/act	
.....	126
fluticasone propionate oint 0.005%	102
fluticasone-salmeterol	
see ADVAIR DISKU AER 100/50	40
see ADVAIR DISKU AER 250/50	40
see ADVAIR DISKU AER 500/50	40
see ADVAIR HFA AER 115/21	40
see ADVAIR HFA AER 230/21	40
see ADVAIR HFA AER 45/21	40
fluticasone-umeclidinium-vilanterol	
see TRELEGY AER 100MCG	42
see TRELEGY AER 200MCG	42
fluvastatin sodium cap 20 mg (base equivalent)	
.....	58
fluvastatin sodium cap 40 mg (base equivalent)	
.....	58
fluvastatin sodium tab er 24 hr 80 mg (base equivalent)	58
fluvoxamine maleate cap er 24hr 100 mg.....	48
fluvoxamine maleate cap er 24hr 150 mg	48
fluvoxamine maleate tab 100 mg	48
fluvoxamine maleate tab 25 mg	48
fluvoxamine maleate tab 50 mg	48
FOLATE	
see Folic Acid Tab 400 mcg.....	113
folic acid cap 0.8 mg	113
Folic Acid Cap 0.8 mg	113
folic acid tab 1 mg	113
folic acid tab 400 mcg	113
Folic Acid Tab 400 mcg.....	113, 114
folic acid tab 800 mcg	114
Folic Acid Tab 800 mcg.....	114
formoterol fumarate soln nebu 20 mcg/2ml ...	41
fosamprenavir calcium tab 700 mg (base equiv)	
.....	77
fosfomycin tromethamine powd pack 3 gm (base equivalent)	36
fosinopril sodium & hydrochlorothiazide tab 10- 12.5 mg	62
fosinopril sodium & hydrochlorothiazide tab 20- 12.5 mg	62
fosinopril sodium tab 10 mg	59
fosinopril sodium tab 20 mg	59
fosinopril sodium tab 40 mg	59
fostamatinib disodium	
see TAVALISSE TAB 100MG	112
see TAVALISSE TAB 150MG	112
frovatriptan succinate tab 2.5 mg (base equivalent)	120
furosemide oral soln 10 mg/ml	105
furosemide oral soln 8 mg/ml	105
furosemide tab 20 mg	105
furosemide tab 40 mg	105
furosemide tab 80 mg	105
FYAVOLV	
see Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg	108
see Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg	108
FYCOMPA SUS 0.5MG/ML.....	43
FYCOMPA TAB 10MG	43
FYCOMPA TAB 12MG	43
FYCOMPA TAB 2MG	43
FYCOMPA TAB 4MG	43
FYCOMPA TAB 6MG	43
FYCOMPA TAB 8MG	43

G***gabapentin (once-daily)***

- see GRALISE TAB 300MG 133
see GRALISE TAB 450MG 133
see GRALISE TAB 600MG 133
see GRALISE TAB 750MG 133
see GRALISE TAB 900MG 133

gabapentin cap 100 mg 44

gabapentin cap 300 mg 44

gabapentin cap 400 mg 44

gabapentin oral soln 250 mg/5ml 44

gabapentin tab 600 mg 44

gabapentin tab 800 mg 44

galantamine hydrobromide cap er 24hr 16 mg 131

galantamine hydrobromide cap er 24hr 24 mg 131

galantamine hydrobromide cap er 24hr 8 mg 131

galantamine hydrobromide oral soln 4 mg/ml 131

galantamine hydrobromide tab 12 mg 131

galantamine hydrobromide tab 4 mg 131

galantamine hydrobromide tab 8 mg 131

gatifloxacin ophth soln 0.5% 127

GAVILYTE-C

- see Peg 3350-Kcl-Na Bicarb-NaCl-Na Sulfate
For Soln 240 gm 116

GAVILYTE-G

- see Peg 3350-Kcl-Na Bicarb-NaCl-Na Sulfate
For Soln 236 gm 116

GAVRETO CAP 100MG 68

gefitinib

- see IRESSA TAB 250MG 65

gefitinib tab 250 mg 65

gemfibrozil tab 600 mg 57

GEMMILY

- see Norethindrone Ace-Ethinyl Estradiol-Fe
Cap 1 mg-20 mcg (24) 93

GEMTESA TAB 75MG 143

GENERLAC

- see Lactulose (Encephalopathy) Solution 10
gm/15ml 111

GENGRAF

- see Cyclosporine Modified Cap 100 mg 123
see Cyclosporine Modified Cap 25 mg 123

see Cyclosporine Modified Oral Soln 100

mg/ml 123

gentamicin sulfate cream 0.1% 100

gentamicin sulfate oint 0.1% 100

gentamicin sulfate ophth soln 0.3% 127

GENVOYA TAB 77

gilteritinib fumarate

see XOSPATA TAB 40MG 70

GLEOSTINE CAP 100MG 64

GLEOSTINE CAP 10MG 64

GLEOSTINE CAP 40MG 64

glimepiride tab 1 mg 54

glimepiride tab 2 mg 54

glimepiride tab 4 mg 54

glipizide tab 10 mg 54

glipizide tab 5 mg 54

glipizide tab er 24hr 10 mg 54

Glipizide Tab Er 24hr 10 mg 54

glipizide tab er 24hr 2.5 mg 54

Glipizide Tab Er 24hr 2.5 mg 54

glipizide tab er 24hr 5 mg 54

Glipizide Tab Er 24hr 5 mg 54

GLIPIZIDE XL

see Glipizide Tab Er 24hr 10 mg 54

see Glipizide Tab Er 24hr 2.5 mg 54

see Glipizide Tab Er 24hr 5 mg 54

glipizide-metformin hcl tab 2.5-250 mg 50

glipizide-metformin hcl tab 2.5-500 mg 50

glipizide-metformin hcl tab 5-500 mg 50

glucagon

see BAQSIMI ONE POW 3MG/DOSE 52

see BAQSIMI TWO POW 3MG/DOSE 52

see GVOKE HYPO 1 INJ .5/.1ML 52

see GVOKE HYPO 1 INJ 1MG/.2ML 52

see GVOKE HYPO 2 INJ .5/.1ML 52

see GVOKE HYPO 2 INJ 1MG/.2ML 52

see GVOKE KIT SOL 1MG/0.2M 52

see GVOKE PFS INJ 52

glucagon (rdna) for inj kit 1 mg 52

glyburide micronized tab 1.5 mg 54

glyburide micronized tab 3 mg 54

glyburide micronized tab 6 mg 54

glyburide tab 1.25 mg 54

glyburide tab 2.5 mg 54

glyburide tab 5 mg 54

glyburide-metformin tab 1.25-250 mg 50

glyburide-metformin tab 2.5-500 mg 50

glyburide-metformin tab 5-500 mg	50
glycopyrrolate oral soln 1 mg/5ml	141
glycopyrrolate tab 1 mg	141
glycopyrrolate tab 2 mg	141
GLYXAMBI TAB 10-5 MG	50
GLYXAMBI TAB 25-5 MG	50
GNP FOLIC ACID	
see Folic Acid Tab 400 mcg	113
GNP NICOTINE GUM	
see Nicotine Polacrilex Gum 4 mg	134
GNP NICOTINE MINI LOZENGE	
see Nicotine Polacrilex Lozenge 2 mg	135
GNP NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	133
see Nicotine Polacrilex Gum 4 mg	134
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	136
GNP NICOTINE POLACRILEX M	
see Nicotine Polacrilex Lozenge 4 mg	136
GNP NICOTINE TRANSDERMAL	
see Nicotine Td Patch 24hr 14 mg/24hr	137
see Nicotine Td Patch 24hr 7 mg/24hr	136
GOODSENSE NICOTINE	
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	136
GOODSENSE NICOTINE GUM	
see Nicotine Polacrilex Gum 4 mg	134
GOODSENSE NICOTINE POLACR	
see Nicotine Polacrilex Gum 2 mg	133
see Nicotine Polacrilex Gum 4 mg	134
see Nicotine Polacrilex Lozenge 4 mg	136
GRALISE TAB 300MG	133
GRALISE TAB 450MG	133
GRALISE TAB 600MG	133
GRALISE TAB 750MG	133
GRALISE TAB 900MG	133
granisetron	
see SANCUSO DIS 3.1MG	55
granisetron hcl tab 1 mg	55
grass mixed pollens allergen extract	
see ORALAIR SUB 300 IR	22
GRASTEK SUB 2800BAU	22
griseofulvin microsize susp 125 mg/5ml	55
griseofulvin microsize tab 500 mg	55
griseofulvin ultramicrosize tab 125 mg	55
griseofulvin ultramicrosize tab 250 mg	55
guanfacine hcl tab 1 mg	60
guanfacine hcl tab 2 mg	60
guanfacine hcl tab er 24hr 1 mg (base equiv)	16
guanfacine hcl tab er 24hr 2 mg (base equiv)	16
guanfacine hcl tab er 24hr 3 mg (base equiv)	16
guanfacine hcl tab er 24hr 4 mg (base equiv)	16
GUANIDINE TAB 125MG	64
GVOKE HYPO 1 INJ .5/.1ML	52
GVOKE HYPO 1 INJ 1MG/.2ML	52
GVOKE HYPO 2 INJ .5/.1ML	52
GVOKE KIT SOL 1MG/0.2M	52
GVOKE PFS INJ	52
GYNOL II GEL 3%	143
H	
HAILEY 1.5/30	
see Norethindrone Ace & Ethynodiol-Diol Tab 1.5 mg-30 mcg	91
HAILEY 24 FE	
see Norethindrone Ace-Ethinodiol-Fe Tab 1 mg-20 mcg (24)	93
HAILEY FE 1.5/30	
see Norethindrone Ace & Ethynodiol-Fe Tab 1.5 mg-30 mcg	92
HAILEY FE 1/20	
see Norethindrone Ace & Ethynodiol-Fe Tab 1 mg-20 mcg	92
halobetasol propionate	
see BRYHALI LOT 0.01%	101
halobetasol propionate cream 0.05%	102
halobetasol propionate oint 0.05%	102
haloperidol lactate oral conc 2 mg/ml	74
haloperidol tab 0.5 mg	74
haloperidol tab 1 mg	74
haloperidol tab 10 mg	74
haloperidol tab 2 mg	74
haloperidol tab 20 mg	74
haloperidol tab 5 mg	74
HARVONI PAK	79
HARVONI PAK 45-200MG	79
HARVONI TAB 45-200MG	79
HARVONI TAB 90-400MG	79
HEATHER	
see Norethindrone Tab 0.35 mg	95
HEMMOREX-HC	
see Hydrocortisone Acetate Suppos 30 mg	35
HIDEX 6-DAY	

see Dexamethasone Tab Therapy Pack 1.5 mg (21)	95
HM FOLIC ACID	
see Folic Acid Tab 400 mcg	113
HM NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg.....	133
see Nicotine Polacrilex Gum 4 mg.....	134
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	136
HM NICOTINE TRANSDERMALS	
see Nicotine Td Patch 24hr 14 mg/24hr	137
see Nicotine Td Patch 24hr 21 mg/24hr	137
see Nicotine Td Patch 24hr 7 mg/24hr	136
HOLD CHAMBER MIS ADLT LG	119
HOLD CHAMBER MIS MEDIUM	119
HOLD CHAMBER MIS SMALL	119
HUMULIN R INJ U-500	53
hydralazine hcl tab 10 mg	63
hydralazine hcl tab 100 mg	63
hydralazine hcl tab 25 mg	63
hydralazine hcl tab 50 mg	63
hydrochlorothiazide cap 12.5 mg	106
hydrochlorothiazide tab 12.5 mg	106
hydrochlorothiazide tab 25 mg	106
hydrochlorothiazide tab 50 mg	106
hydrocod polst-chlorphen polst er susp 10-8 mg/5ml	97
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	96
Hydrocodone Bitart-Homatropine Methylbrom Soln 5-1.5 mg/5ml.....	97
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	97
hydrocodone bitartrate cap er 12hr 10 mg	25
hydrocodone bitartrate cap er 12hr 15 mg	26
hydrocodone bitartrate cap er 12hr 20 mg	26
hydrocodone bitartrate cap er 12hr 30 mg	26
hydrocodone bitartrate cap er 12hr 40 mg	26
hydrocodone bitartrate cap er 12hr 50 mg	26
hydrocodone bitartrate tab er 24hr deter 100 mg	26
hydrocodone bitartrate tab er 24hr deter 120 mg	26
hydrocodone bitartrate tab er 24hr deter 20 mg	26
hydrocodone bitartrate tab er 24hr deter 30 mg	26

hydrocodone bitartrate tab er 24hr deter 40 mg	26
hydrocodone bitartrate tab er 24hr deter 60 mg	26
hydrocodone bitartrate tab er 24hr deter 80 mg	26
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	31
hydrocodone-acetaminophen tab 10-300 mg	31
hydrocodone-acetaminophen tab 10-325 mg	31
hydrocodone-acetaminophen tab 5-300 mg	31
hydrocodone-acetaminophen tab 5-325 mg	31
hydrocodone-acetaminophen tab 7.5-300 mg	31
hydrocodone-acetaminophen tab 7.5-325 mg	31
hydrocodone-ibuprofen tab 10-200 mg	32
hydrocodone-ibuprofen tab 5-200 mg	32
hydrocodone-ibuprofen tab 7.5-200 mg	32
hydrocortisone (topical)	
see TEXACORT SOL 2.5%	103
hydrocortisone acetate (intrarectal)	
see CORTIFOAM AER 90MG	34
Hydrocortisone Acetate Suppos 25 mg	35
Hydrocortisone Acetate Suppos 30 mg	35
hydrocortisone acetate w/ pramoxine	
see PROCTOFOAM AER HC 1%.....	35
hydrocortisone acetate w/ pramoxine perianal cream 1%	35
hydrocortisone butyrate cream 0.1%	102
hydrocortisone butyrate oint 0.1%	102
hydrocortisone butyrate soln 0.1%	102
hydrocortisone cream 1%	102
Hydrocortisone Cream 1%	102
hydrocortisone cream 2.5%	102
hydrocortisone enema 100 mg/60ml	34
hydrocortisone lotion 2.5%	102
hydrocortisone oint 1%	103
hydrocortisone oint 2.5%	103
hydrocortisone perianal cream 1%	35
hydrocortisone perianal cream 2.5%	35
Hydrocortisone Perianal Cream 2.5%	35
hydrocortisone tab 10 mg	96
hydrocortisone tab 20 mg	96
hydrocortisone tab 5 mg	95
hydrocortisone valerate cream 0.2%	103
hydrocortisone valerate oint 0.2%	103
hydrocortisone w/ acetic acid otic soln 1-2%	129

HYDROMET

see Hydrocodone Bitart-Homatropine	68
Methylbrom Soln 5-1.5 mg/5ml	97
hydromorphone hcl liqd 1 mg/ml	26
hydromorphone hcl tab 2 mg	26
hydromorphone hcl tab 4 mg	26
hydromorphone hcl tab 8 mg	26
hydromorphone hcl tab er 24hr 12 mg	26
hydromorphone hcl tab er 24hr 16 mg	26
hydromorphone hcl tab er 24hr 32 mg	27
hydromorphone hcl tab er 24hr 8 mg	26
hydroxychloroquine sulfate tab 200 mg	63
hydroxyurea (sickle cell disease)	
see SIKLOS TAB 1000MG	113
see SIKLOS TAB 100MG	113
hydroxyurea cap 500 mg	71
hydroxyzine hcl syrup 10 mg/5ml	37
hydroxyzine hcl tab 10 mg	37
hydroxyzine hcl tab 25 mg	37
hydroxyzine hcl tab 50 mg	37
hydroxyzine pamoate cap 100 mg	37
hydroxyzine pamoate cap 25 mg	37
hydroxyzine pamoate cap 50 mg	37
hyoscyamine sulfate elixir 0.125 mg/5ml	141
Hyoscyamine Sulfate Elixir 0.125 mg/5ml	141
hyoscyamine sulfate sl tab 0.125 mg	141
Hyoscyamine Sulfate SI Tab 0.125 mg.....	141
hyoscyamine sulfate soln 0.125 mg/ml	141
Hyoscyamine Sulfate Soln 0.125 mg/ml.....	141
hyoscyamine sulfate tab 0.125 mg	141
Hyoscyamine Sulfate Tab 0.125 mg	141
hyoscyamine sulfate tab disint 0.125 mg	141
Hyoscyamine Sulfate Tab Disint 0.125 mg.....	141
HYOSYNE	
see Hyoscyamine Sulfate Elixir 0.125 mg/5ml	
.....	141
see Hyoscyamine Sulfate Soln 0.125 mg/ml	141
I	
ibandronate sodium tab 150 mg (base equivalent)	106
IBRANCE CAP 100MG	68
IBRANCE CAP 125MG	68
IBRANCE CAP 75MG	68
IBRANCE TAB 100MG	68
IBRANCE TAB 125MG	68
IBRANCE TAB 75MG	68
ibrutinib	
see IMBRUVICA CAP 140MG.....	69
see IMBRUVICA CAP 70MG	68
see IMBRUVICA SUS 70MG/ML	69
see IMBRUVICA TAB 140MG.....	69
see IMBRUVICA TAB 280MG.....	69
see IMBRUVICA TAB 420MG.....	69
IBU	
see Ibuprofen Tab 400 mg.....	23
see Ibuprofen Tab 600 mg.....	23
see Ibuprofen Tab 800 mg.....	23
ibuprofen susp 100 mg/5ml	23
ibuprofen tab 400 mg	23
Ibuprofen Tab 400 mg.....	23
ibuprofen tab 600 mg	23
Ibuprofen Tab 600 mg.....	23
ibuprofen tab 800 mg	23
Ibuprofen Tab 800 mg.....	23
ICLEVIA	
see Levonorgestrel & Ethynodiol (91-Day)	
Tab 0.15-0.03 mg	89
icosapent ethyl	
see VASCEPA CAP 0.5GM	57
see VASCEPA CAP 1GM	57
idelalisib	
see ZYDELIG TAB 100MG.....	71
see ZYDELIG TAB 150MG.....	71
ILEVRO DRO 0.3% OP	128
imatinib mesylate tab 100 mg (base equivalent)	
.....	68
imatinib mesylate tab 400 mg (base equivalent)	
.....	68
IMBRUVICA CAP 140MG	69
IMBRUVICA CAP 70MG	68
IMBRUVICA SUS 70MG/ML	69
IMBRUVICA TAB 140MG	69
IMBRUVICA TAB 280MG	69
IMBRUVICA TAB 420MG	69
imipramine hcl tab 10 mg	50
imipramine hcl tab 25 mg	50
imipramine hcl tab 50 mg	50
imipramine pamoate cap 100 mg	50
imipramine pamoate cap 125 mg	50
imipramine pamoate cap 150 mg	50
imipramine pamoate cap 75 mg	50
imiquimod	
see ZYCLARA CRE 3.75%	103
see ZYCLARA PUMP CRE 2.5%.....	103
see ZYCLARA PUMP CRE 3.75%.....	103

<i>imiquimod cream 3.75%</i>	103	see TRESIBA INJ 100UNIT	53
<i>imiquimod cream 5%</i>	103	<i>insulin degludec-liraglutide</i>	
IMPAVIDO CAP 50MG	35	see XULTOPHY INJ 100/3.6	51
IMVEXXY MAIN SUP 10MCG	143	<i>insulin detemir</i>	
IMVEXXY MAIN SUP 4MCG	143	see LEVEMIR INJ	53
IMVEXXY STRT SUP 10MCG	143	see LEVEMIR INJ FLEXPEN	53
IMVEXXY STRT SUP 4MCG	143	<i>insulin glargine</i>	
INATAL GT		see BASAGLAR INJ 100UNIT	52
see Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab		see TOUJEON MAX INJ 300IU/ML	53
90-1 mg	125	see TOUJEON SOLO INJ 300IU/ML	53
INBRIJA CAP 42MG	72	<i>insulin glargin-lixisenatide</i>	
INCASSIA		see SOLIQUA INJ 100/33	51
see Norethindrone Tab 0.35 mg	95	<i>insulin nph (human) (isophane)</i>	
<i>indapamide tab 1.25 mg</i>	106	see NOVOLIN N INJ 100 UNIT	53
<i>indapamide tab 2.5 mg</i>	106	see NOVOLIN N INJ U-100	53
<i>indinavir sulfate</i>		<i>insulin nph isophane & reg (human)</i>	
see CRIXIVAN CAP 200MG	77	see NOVOLIN INJ 70/30	53
see CRIXIVAN CAP 400MG	77	see NOVOLIN INJ 70/30 FP	53
<i>indomethacin cap 25 mg</i>	23	<i>insulin pen needle</i>	
<i>indomethacin cap 50 mg</i>	23	see BD INSULIN PEN NEEDLES - OTC	117
<i>indomethacin cap er 75 mg</i>	23	<i>insulin regular (human)</i>	
<i>indomethacin suppos 50 mg</i>	23	see HUMULIN R INJ U-500	53
INGREZZA CAP 40-80MG	132	see NOVOLIN R INJ 100 UNIT	53
INGREZZA CAP 40MG	132	see NOVOLIN R INJ U-100	53
INGREZZA CAP 60MG	132	<i>insulin syringe/needle u-100</i>	
INGREZZA CAP 80MG	132	see BD INSULIN SYRINGE - OTC	117
INLYTA TAB 1MG	65	see BD INSULIN SYRINGE - RX	117
INLYTA TAB 5MG	65	<i>insulin syringe/needle u-500</i>	
INSPIRACHAMB MIS LARGE	119	see BD INSULIN SYRINGE - RX	117
INSPIRACHAMB MIS MEDIUM	119	<i>insulin syringes (disposable)</i>	
INSPIRACHAMB MIS MOUTHPC	119	see BD INSULIN SYRINGE - OTC	117
INSPIRACHAMB MIS SMALL	119	INTELENCE TAB 100MG	77
INSPIREASE MIS DD SYST	119	INTELENCE TAB 200MG	77
<i>insulin aspart</i>		INTELENCE TAB 25MG	77
see NOVOLOG INJ 100/ML	53	INTROVALE	
see NOVOLOG INJ FLEXPEN	53	see Levonorgestrel & Ethynodiol (91-Day)	
see NOVOLOG INJ PENFILL	53	Tab 0.15-0.03 mg	89
<i>insulin aspart (with niacinamide)</i>		IODOQUIMEZ-HC	
see FIASP FLEX INJ TOUCH	52	see Iodoquinol-Hydrocortisone In Aloe Vehicle	
see FIASP INJ 100/ML	53	Cream 1-1.9%	100
see FIASP PENFIL INJ U-100	53	Iodoquinol-Hydrocortisone In Aloe Vehicle	
<i>insulin aspart protamine & aspart (human)</i>		Cream 1-1.9%	100
see NOVOLOG MIX INJ 70/30	53	<i>ipratropium bromide inhal soln 0.02%</i>	39
see NOVOLOG MIX INJ FLEXPEN	53	<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	126
<i>insulin degludec</i>		<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	126
see TRESIBA FLEX INJ 100UNIT	53		
see TRESIBA FLEX INJ 200UNIT	53		

<i>ipratropium-albuterol nebu soln 0.5-2.5(3)</i>	
mg/3ml	41
<i>irbesartan tab 150 mg</i>	60
<i>irbesartan tab 300 mg</i>	60
<i>irbesartan tab 75 mg</i>	60
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	62
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	62
IRESSA TAB 250MG	65
ISENTRESS CHW 100MG.....	77
ISENTRESS CHW 25MG.....	77
ISENTRESS HD TAB 600MG.....	78
ISENTRESS POW 100MG.....	78
ISENTRESS TAB 400MG	78
ISIBLOOM	
see Desogestrel & Ethynodiol-Diol Tab 0.15	
mg-30 mcg	87
<i>isoniazid syrup 50 mg/5ml</i>	64
<i>isoniazid tab 100 mg</i>	64
<i>isoniazid tab 300 mg</i>	64
<i>isoniazid-rifampin w/ pyrazinamide</i>	
see RIFATER TAB	64
<i>isosorbide dinitrate tab 10 mg</i>	36
<i>isosorbide dinitrate tab 20 mg</i>	36
<i>isosorbide dinitrate tab 30 mg</i>	36
<i>isosorbide dinitrate tab 5 mg</i>	36
<i>isosorbide dinitrate-hydralazine hcl tab 20-37.5</i>	
mg	84
<i>isosorbide mononitrate tab 10 mg</i>	37
<i>isosorbide mononitrate tab 20 mg</i>	37
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	37
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	37
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	37
<i>isotretinoin cap 10 mg</i>	98
Isotretinoin Cap 10 mg.....	98
<i>isotretinoin cap 20 mg</i>	98
Isotretinoin Cap 20 mg.....	98
<i>isotretinoin cap 25 mg</i>	98
<i>isotretinoin cap 30 mg</i>	99
Isotretinoin Cap 30 mg.....	99
<i>isotretinoin cap 35 mg</i>	99
<i>isotretinoin cap 40 mg</i>	99
Isotretinoin Cap 40 mg.....	99
<i>isradipine cap 2.5 mg</i>	83
<i>isradipine cap 5 mg</i>	83
<i>itraconazole cap 100 mg</i>	56

<i>itraconazole oral soln 10 mg/ml</i>	56
<i>ivabradine hcl</i>	
see CORLANOR TAB 5MG	86
see CORLANOR TAB 7.5MG	86
<i>ivacaftor</i>	
see KALYDECO PAK 25MG	138
see KALYDECO PAK 50MG	138
see KALYDECO PAK 75MG	138
see KALYDECO TAB 150MG	138
<i>ivermectin (rosacea)</i>	
see SOOLANTRA CRE 1%	104
<i>ivermectin tab 3 mg</i>	35
<i>ixazomib citrate</i>	
see NINLARO CAP 2.3MG	69
see NINLARO CAP 3MG	69
see NINLARO CAP 4MG	69
J	
JAIMIESS	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) &	
Eth Est Tab 0.01mg(7)	89
JANTOVEN	
see Warfarin Sodium Tab 1 mg.....	42
see Warfarin Sodium Tab 10 mg.....	42
see Warfarin Sodium Tab 2 mg.....	42
see Warfarin Sodium Tab 2.5 mg.....	42
see Warfarin Sodium Tab 3 mg.....	42
see Warfarin Sodium Tab 4 mg.....	42
see Warfarin Sodium Tab 5 mg.....	42
see Warfarin Sodium Tab 6 mg.....	42
see Warfarin Sodium Tab 7.5 mg.....	42
JANUMET TAB 50-1000	50
JANUMET TAB 50-500MG	50
JANUMET XR TAB 100-1000	51
JANUMET XR TAB 50-1000	51
JANUMET XR TAB 50-500MG	51
JANUVIA TAB 100MG	52
JANUVIA TAB 25MG	52
JANUVIA TAB 50MG	52
JARDIANCE TAB 10MG	53
JARDIANCE TAB 25MG	53
JASMIEL	
see Drospirenone-Ethinodiol-Diol Tab 3-0.02	
mg	88
JAVYGTOR	
see Sapropterin Dihydrochloride Powder	
Packet 100 mg.....	107

see Sapropterin Dihydrochloride Powder	
Packet 500 mg	107
see Sapropterin Dihydrochloride Tab 100 mg	
.....	107
JENCYCLA	
see Norethindrone Tab 0.35 mg	95
JINTELI	
see Norethindrone Acetate-Ethinyl Estradiol	
Tab 1 mg-5 mcg.....	108
JOLESSA	
see Levonorgestrel & Ethinyl Estradiol (91-Day)	
Tab 0.15-0.03 mg.....	89
JOYEAUX	
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1	
mg-20 mcg (21)	90
JULEBER	
see Desogestrel & Ethinyl Estradiol Tab 0.15	
mg-30 mcg	87
JUNEL 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab	
1.5 mg-30 mcg.....	91
JUNEL 1/20	
see Norethindrone Ace & Ethinyl Estradiol Tab	
1 mg-20 mcg	91
JUNEL FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1.5 mg-30 mcg	92
JUNEL FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg	92
JUNEL FE 24	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24)	93
K	
KAITLIB FE	
see Norethindrone & Ethinyl Estradiol-Fe	
Chew Tab 0.8 mg-25 mcg.....	91
KALLIGA	
see Desogestrel & Ethinyl Estradiol Tab 0.15	
mg-30 mcg	87
KALYDECO PAK 25MG	138
KALYDECO PAK 50MG	138
KALYDECO PAK 75MG	138
KALYDECO TAB 150MG	138
KARIVA	
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
0.02/0.01 mg(21/5)	87
KELNOR 1/35	
see Ethynodiol Diacetate & Ethinyl Estradiol	
Tab 1 mg-35 mcg.....	88
KELNOR 1/50	
see Ethynodiol Diacetate & Ethinyl Estradiol	
Tab 1 mg-50 mcg.....	88
KERENDIA TAB 10MG	107
KERENDIA TAB 20MG	107
<i>ketoconazole cream 2%</i>	100
<i>ketoconazole shampoo 2%</i>	100
<i>ketoconazole tab 200 mg</i>	56
<i>ketorolac tromethamine ophth soln 0.4%</i>	128
<i>ketorolac tromethamine ophth soln 0.5%</i>	128
<i>ketorolac tromethamine tab 10 mg</i>	23
KISQALI 200 PAK FEMARA	67
KISQALI 400 PAK FEMARA	67
KISQALI 600 PAK FEMARA	67
KISQALI TAB 200DOSE	69
KISQALI TAB 400DOSE	69
KISQALI TAB 600DOSE	69
KLOR-CON	
see Potassium Chloride Powder Packet 20 meq	
.....	122
KLOR-CON 10	
see Potassium Chloride Tab Er 10 meq	122
KLOR-CON 8	
see Potassium Chloride Tab Er 8 meq (600 mg)	
.....	122
KLOR-CON M10	
see Potassium Chloride Microencapsulated	
Crys Er Tab 10 meq.....	122
KLOR-CON M15	
see Potassium Chloride Microencapsulated	
Crys Er Tab 15 meq.....	122
KLOR-CON M20	
see Potassium Chloride Microencapsulated	
Crys Er Tab 20 meq.....	122
KLOR-CON/EF	
see Potassium Bicarbonate Effer Tab 25 meq	
.....	122
KLS QUIT2	
see Nicotine Polacrilex Gum 2 mg	134
see Nicotine Polacrilex Lozenge 2 mg	135
KLS QUIT4	
see Nicotine Polacrilex Gum 4 mg	134
see Nicotine Polacrilex Lozenge 4 mg	136
KOSELUGO CAP 10MG	69

KOSELUGO CAP 25MG.....	69	<i>lamotrigine tab 200 mg</i>	44
KOURZEQ see Triamcinolone Acetonide Dental Paste 0.1%.....	124	Lamotrigine Tab 200 mg	44
KP FOLIC ACID see Folic Acid Tab 800 mcg	114	<i>lamotrigine tab 25 mg</i>	44
K-PRIME see Potassium Bicarbonate Effer Tab 25 meq	122	Lamotrigine Tab 25 mg	44
KURVELO see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg.....	90	<i>lamotrigine tab 25 mg (42) & 100 mg (7) starter kit</i>	44
L		Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit.....	44
<i>labetalol hcl tab 100 mg</i>	80	<i>lamotrigine tab 35 x 25 mg starter kit</i>	44
<i>labetalol hcl tab 200 mg</i>	80	Lamotrigine Tab 35 X 25 mg Starter Kit	44
<i>labetalol hcl tab 300 mg</i>	80	<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit</i>	44
<i>lacosamide oral solution 10 mg/ml</i>	44	Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit	44
<i>lacosamide tab 100 mg</i>	44	<i>lamotrigine tab chewable dispersible 25 mg</i>	44
<i>lacosamide tab 150 mg</i>	44	<i>lamotrigine tab chewable dispersible 5 mg</i>	44
<i>lacosamide tab 200 mg</i>	44	<i>lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit</i>	44
<i>lacosamide tab 50 mg</i>	44	<i>lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit</i>	44
<i>lactic acid (ammonium lactate) cream 12%</i> ..	103	<i>lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit</i>	45
<i>lactic acid (ammonium lactate) lotion 12%</i> ...	103	<i>lamotrigine tab er 24hr 100 mg</i>	45
<i>lactic acid-citric acid-potassium bitartrate</i> see PHEXXI GEL	143	<i>lamotrigine tab er 24hr 200 mg</i>	45
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	111	<i>lamotrigine tab er 24hr 25 mg</i>	45
Lactulose (Encephalopathy) Solution 10 gm/15ml	111	<i>lamotrigine tab er 24hr 250 mg</i>	45
<i>lactulose solution 10 gm/15ml</i>	116	<i>lamotrigine tab er 24hr 300 mg</i>	45
Lactulose Solution 10 gm/15ml	116	<i>lamotrigine tab er 24hr 50 mg</i>	45
LAGEVRIA CAP 200MG	80	<i>lansoprazole cap delayed release 15 mg</i>	142
<i>lamivudine oral soln 10 mg/ml</i>	78	<i>lansoprazole cap delayed release 30 mg</i>	142
<i>lamivudine tab 100 mg (hbv)</i>	79	<i>lapatinib ditosylate tab 250 mg (base equiv)</i> ..	69
<i>lamivudine tab 150 mg</i>	78	LARIN 1.5/30 see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg	92
<i>lamivudine tab 300 mg</i>	78	LARIN 1/20 see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg	91
<i>lamivudine-tenofovir disoproxil fumarate</i> see CIMDUO TAB 300-300	77	LARIN 24 FE see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24).....	93
<i>lamivudine-zidovudine tab 150-300 mg</i>	78	LARIN FE 1.5/30 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg	92
<i>lamotrigine orally disintegrating tab 100 mg</i> .	44	LARIN FE 1/20 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg	92
<i>lamotrigine orally disintegrating tab 200 mg</i> .	44	<i>larotrectinib sulfate</i>	
<i>lamotrigine orally disintegrating tab 25 mg</i> ...	44		
<i>lamotrigine orally disintegrating tab 50 mg</i> ...	44		
<i>lamotrigine tab 100 mg</i>	44		
Lamotrigine Tab 100 mg.....	44		
<i>lamotrigine tab 150 mg</i>	44		
Lamotrigine Tab 150 mg.....	44		

see VITRAKVI CAP 100MG	70	LENVIMA CAP 14 MG	65
see VITRAKVI CAP 25MG	70	LENVIMA CAP 18 MG	65
see VITRAKVI SOL 20MG/ML	70	LENVIMA CAP 20 MG	65
lasmiditan succinate		LENVIMA CAP 24 MG	65
see REYVOW TAB 100MG	120	LENVIMA CAP 4MG	65
see REYVOW TAB 50MG	120	LENVIMA CAP 8 MG	65
latanoprost ophth soln 0.005%	129	LESSINA	
LAYOLIS FE		see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
see Norethindrone & Ethinyl Estradiol-Fe		mg-20 mcg	89
Chew Tab 0.8 mg-25 mcg.....	91	letrozole tab 2.5 mg	66
ledipasvir-sofosbuvir		leucovorin calcium tab 10 mg	71
see HARVONI PAK	79	leucovorin calcium tab 15 mg	71
see HARVONI PAK 45-200MG	79	leucovorin calcium tab 25 mg	71
see HARVONI TAB 45-200MG	79	leucovorin calcium tab 5 mg	71
see HARVONI TAB 90-400MG	79	LEUKERAN TAB 2MG	64
LEENA		levalbuterol hcl soln nebu 0.31 mg/3ml (base	
see Norethindrone-Eth Estradiol Tab 0.5-35/1-		equiv)	41
35/0.5-35 mg-Mcg	93	levalbuterol hcl soln nebu 0.63 mg/3ml (base	
leflunomide tab 10 mg	24	equiv)	41
leflunomide tab 20 mg	24	levalbuterol hcl soln nebu 1.25 mg/3ml (base	
lemborexant		equiv)	41
see DAYVIGO TAB 10MG	116	levalbuterol hcl soln nebu conc 1.25 mg/0.5ml	
see DAYVIGO TAB 5MG	116	(base equiv)	41
lenalidomide		levalbuterol tartrate inhal aerosol 45 mcg/act	
see REVLIMID CAP 10MG.....	123	(base equiv)	41
see REVLIMID CAP 15MG.....	123	levamlodipine maleate tab 2.5 mg	83
see REVLIMID CAP 2.5MG.....	123	levamlodipine maleate tab 5 mg	83
see REVLIMID CAP 20MG.....	123	LEVEMIR INJ	53
see REVLIMID CAP 25MG.....	123	LEVEMIR INJ FLEXPEN	53
see REVLIMID CAP 5MG	123	levetiracetam oral soln 100 mg/ml	45
lenalidomide cap 10 mg	122	levetiracetam tab 1000 mg	45
lenalidomide cap 15 mg	123	levetiracetam tab 250 mg	45
lenalidomide cap 20 mg	123	levetiracetam tab 500 mg	45
lenalidomide cap 25 mg	123	Levetiracetam Tab 500 mg	45
lenalidomide cap 5 mg	122	levetiracetam tab 750 mg	45
lenalidomide caps 2.5 mg	123	levetiracetam tab er 24hr 500 mg	45
lenvatinib mesylate		levetiracetam tab er 24hr 750 mg	45
see LENVIMA CAP 10 MG	65	levobunolol hcl ophth soln 0.5%	126
see LENVIMA CAP 12MG	65	levocarnitine oral soln 1 gm/10ml (10%)	107
see LENVIMA CAP 14 MG	65	levocarnitine tab 330 mg	107
see LENVIMA CAP 18 MG	65	levocetirizine dihydrochloride soln 2.5 mg/5ml	
see LENVIMA CAP 20 MG	65	(0.5 mg/ml)	56
see LENVIMA CAP 24 MG	65	levocetirizine dihydrochloride tab 5 mg	56
see LENVIMA CAP 4MG	65	levodopa	
see LENVIMA CAP 8 MG	65	see INBRIJA CAP 42MG.....	72
LENVIMA CAP 10 MG	65	levofloxacin ophth soln 1.5%	127
LENVIMA CAP 12MG	65	levofloxacin oral soln 25 mg/ml	110

<i>levofloxacin tab 250 mg</i>	110
<i>levofloxacin tab 500 mg</i>	110
<i>levofloxacin tab 750 mg</i>	110
LEVONEST	
see Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg	90
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg</i>	88
Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg ð Est 0.01 mg	88
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	89
Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg	89
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	89
Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	89
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	89
Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	89, 90
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	90
Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg	90
<i>levonorgestrel-ethinyl estradiol & folic acid</i>	
see FALESSA KIT	88
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	90
Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg	90
<i>levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)</i>	90
Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)	90
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	88
Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7)	88
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	88
Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7)	88, 89
LEVORA 0.15/30-28	
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	90

LEVO-T

see Levothyroxine Sodium Tab 100 mcg	139
see Levothyroxine Sodium Tab 112 mcg	139
see Levothyroxine Sodium Tab 125 mcg	140
see Levothyroxine Sodium Tab 137 mcg	140
see Levothyroxine Sodium Tab 150 mcg	140
see Levothyroxine Sodium Tab 175 mcg	140
see Levothyroxine Sodium Tab 200 mcg	140
see Levothyroxine Sodium Tab 25 mcg	139
see Levothyroxine Sodium Tab 300 mcg	140
see Levothyroxine Sodium Tab 50 mcg	139
see Levothyroxine Sodium Tab 75 mcg	139
see Levothyroxine Sodium Tab 88 mcg	139
<i>levothyroxine sodium</i>	
see SYNTHROID TAB 100MCG	140
see SYNTHROID TAB 112MCG	140
see SYNTHROID TAB 125MCG	140
see SYNTHROID TAB 137MCG	140
see SYNTHROID TAB 150MCG	140
see SYNTHROID TAB 175MCG	140
see SYNTHROID TAB 200MCG	141
see SYNTHROID TAB 25MCG	140
see SYNTHROID TAB 300MCG	141
see SYNTHROID TAB 50MCG	140
see SYNTHROID TAB 75MCG	140
see SYNTHROID TAB 88MCG	140
<i>levothyroxine sodium tab 100 mcg</i>	139
Levothyroxine Sodium Tab 100 mcg	139
<i>levothyroxine sodium tab 112 mcg</i>	139
Levothyroxine Sodium Tab 112 mcg	139, 140
<i>levothyroxine sodium tab 125 mcg</i>	140
Levothyroxine Sodium Tab 125 mcg	140
<i>levothyroxine sodium tab 137 mcg</i>	140
Levothyroxine Sodium Tab 137 mcg	140
<i>levothyroxine sodium tab 150 mcg</i>	140
Levothyroxine Sodium Tab 150 mcg	140
<i>levothyroxine sodium tab 175 mcg</i>	140
Levothyroxine Sodium Tab 175 mcg	140
<i>levothyroxine sodium tab 200 mcg</i>	140
Levothyroxine Sodium Tab 200 mcg	140
<i>levothyroxine sodium tab 25 mcg</i>	139
Levothyroxine Sodium Tab 25 mcg	139
<i>levothyroxine sodium tab 300 mcg</i>	140
Levothyroxine Sodium Tab 300 mcg	140
<i>levothyroxine sodium tab 50 mcg</i>	139
Levothyroxine Sodium Tab 50 mcg	139
<i>levothyroxine sodium tab 75 mcg</i>	139

Levothyroxine Sodium Tab 75 mcg	139
<i>levothyroxine sodium tab 88 mcg</i>	139
Levothyroxine Sodium Tab 88 mcg	139
LEVOXYL	
see Levothyroxine Sodium Tab 100 mcg	139
see Levothyroxine Sodium Tab 112 mcg	140
see Levothyroxine Sodium Tab 125 mcg	140
see Levothyroxine Sodium Tab 137 mcg	140
see Levothyroxine Sodium Tab 150 mcg	140
see Levothyroxine Sodium Tab 175 mcg	140
see Levothyroxine Sodium Tab 200 mcg	140
see Levothyroxine Sodium Tab 25 mcg	139
see Levothyroxine Sodium Tab 50 mcg	139
see Levothyroxine Sodium Tab 75 mcg	139
see Levothyroxine Sodium Tab 88 mcg	139
Lidocaine Hcl Cream 3%	103
Lidocaine Hcl Gel 2%	103
<i>lidocaine hcl lotion 3%</i>	104
<i>lidocaine hcl soln 4%</i>	104
<i>lidocaine hcl viscous soln 2%</i>	124
<i>lidocaine oint 5%</i>	104
<i>lidocaine patch 5%</i>	104
<i>lidocaine-hydrocortisone acetate cream 1-1%</i>	103
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	104
LIDOPIN	
see Lidocaine Hcl Cream 3%	103
<i>lifitegrast</i>	
see XIIDRA DRO 5%	128
<i>linaclotide</i>	
see LINZESS CAP 145MCG.....	111
see LINZESS CAP 290MCG.....	111
see LINZESS CAP 72MCG.....	111
<i>linezolid for susp 100 mg/5ml</i>	36
<i>linezolid tab 600 mg</i>	36
LINZESS CAP 145MCG	111
LINZESS CAP 290MCG	111
LINZESS CAP 72MCG	111
<i>liothyronine sodium tab 25 mcg</i>	140
<i>liothyronine sodium tab 5 mcg</i>	140
<i>liothyronine sodium tab 50 mcg</i>	140
<i>liraglutide</i>	
see VICTOZA INJ 18MG/3ML.....	52
<i>lisdexamfetamine dimesylate cap 10 mg</i>	14
<i>lisdexamfetamine dimesylate cap 20 mg</i>	14
<i>lisdexamfetamine dimesylate cap 30 mg</i>	14
<i>lisdexamfetamine dimesylate cap 40 mg</i>	14
<i>lisdexamfetamine dimesylate cap 50 mg</i>	14
<i>lisdexamfetamine dimesylate cap 60 mg</i>	14
<i>lisdexamfetamine dimesylate cap 70 mg</i>	14
<i>lisdexamfetamine dimesylate chew tab 10 mg</i>	15
<i>lisdexamfetamine dimesylate chew tab 20 mg</i>	15
<i>lisdexamfetamine dimesylate chew tab 30 mg</i>	15
<i>lisdexamfetamine dimesylate chew tab 40 mg</i>	15
<i>lisdexamfetamine dimesylate chew tab 50 mg</i>	15
<i>lisdexamfetamine dimesylate chew tab 60 mg</i>	15
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	62
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	62
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	62
<i>lisinopril tab 10 mg</i>	59
<i>lisinopril tab 2.5 mg</i>	59
<i>lisinopril tab 20 mg</i>	59
<i>lisinopril tab 30 mg</i>	59
<i>lisinopril tab 40 mg</i>	59
<i>lisinopril tab 5 mg</i>	59
LITEAIRE MIS	119
<i>lithium carbonate cap 150 mg</i>	73
<i>lithium carbonate cap 300 mg</i>	73
<i>lithium carbonate cap 600 mg</i>	73
<i>lithium carbonate tab 300 mg</i>	73
<i>lithium carbonate tab er 300 mg</i>	73
<i>lithium carbonate tab er 450 mg</i>	73
LO LOESTRIN TAB 1-10-10	90
LOESTRIN 1.5/30-21	
see Norethindrone Ace & Ethynodiol-Diol Tab	
1.5 mg-30 mcg	92
LOESTRIN 1/20-21	
see Norethindrone Ace & Ethynodiol-Diol Tab	
1 mg-20 mcg	91
LOESTRIN FE 1.5/30	
see Norethindrone Ace & Ethynodiol-Diol-Fe	
Tab 1.5 mg-30 mcg	92
LOESTRIN FE 1/20	
see Norethindrone Ace & Ethynodiol-Diol-Fe	
Tab 1 mg-20 mcg	92
LOJAIMIERS	
see Levonorg-Eth Est Tab 0.1-0.02mg(84) &	
Eth Est Tab 0.01mg(7)	88
<i>lomustine</i>	
see GLEOSTINE CAP 100MG	64
see GLEOSTINE CAP 10MG	64
see GLEOSTINE CAP 40MG	64

LONSURF TAB 15-6.14	67	see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	89
LONSURF TAB 20-8.19	67		
<i>loperamide hcl cap 2 mg</i>	54	LYLEQ	
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	78	see Norethindrone Tab 0.35 mg	95
<i>lopinavir-ritonavir tab 100-25 mg</i>	78	LYLLANA	
<i>lopinavir-ritonavir tab 200-50 mg</i>	78	see Estradiol Td Patch Twice Weekly 0.025 mg/24hr.....	109
<i>loratadine tab 10 mg</i>	56	see Estradiol Td Patch Twice Weekly 0.0375 mg/24hr.....	109
<i>lorazepam conc 2 mg/ml</i>	38	see Estradiol Td Patch Twice Weekly 0.05 mg/24hr.....	109
<i>lorazepam tab 0.5 mg</i>	38	see Estradiol Td Patch Twice Weekly 0.075 mg/24hr.....	109
<i>lorazepam tab 1 mg</i>	38	see Estradiol Td Patch Twice Weekly 0.1 mg/24hr.....	109
<i>lorazepam tab 2 mg</i>	38	LYNPARZA TAB 100MG	69
LORYNA		LYNPARZA TAB 150MG	69
see Drosiprone-Ethinyl Estradiol Tab 3-0.02 mg	88	LYSODREN TAB 500MG	66
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	62	LYVISPAH GRA 10MG	125
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	62	LYVISPAH GRA 20MG	125
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	62	LYVISPAH GRA 5MG.....	125
<i>losartan potassium tab 100 mg</i>	60	LYZA	
<i>losartan potassium tab 25 mg</i>	60	see Norethindrone Tab 0.35 mg	95
<i>losartan potassium tab 50 mg</i>	60	M	
<i>loteprednol etabonate ophth gel 0.5%</i>	128	<i>macitentan</i>	
<i>loteprednol etabonate ophth susp 0.5%</i>	128	see OPSUMIT TAB 10MG.....	85
<i>lovastatin tab 10 mg</i>	58	<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	101
<i>lovastatin tab 20 mg</i>	58	<i>malathion lotion 0.5%</i>	104
<i>lovastatin tab 40 mg</i>	58	MALE MIS CONDOM	117
LOW-OGESTREL		<i>maraviroc tab 150 mg</i>	78
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg- 30 mcg	94	<i>maraviroc tab 300 mg</i>	78
<i>loxapine succinate cap 10 mg</i>	75	MARLISSA	
<i>loxapine succinate cap 25 mg</i>	75	see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	90
<i>loxapine succinate cap 5 mg</i>	75	MATULANE CAP 50MG.....	71
<i>loxapine succinate cap 50 mg</i>	75	MAYZENT PAK STARTER	132
LO-ZUMANDIMINE		MAYZENT TAB 0.25MG	132
see Drosiprone-Ethinyl Estradiol Tab 3-0.02 mg	88	MAYZENT TAB 1MG	132
<i>lubiprostone cap 24 mcg</i>	110	MAYZENT TAB 2MG	132
<i>lubiprostone cap 8 mcg</i>	110	<i>mebendazole</i>	
<i>lurasidone hcl tab 120 mg</i>	73	see EMVERM CHW 100MG.....	35
<i>lurasidone hcl tab 20 mg</i>	73	<i>meclizine hcl tab 12.5 mg</i>	55
<i>lurasidone hcl tab 40 mg</i>	73	<i>meclizine hcl tab 25 mg</i>	55
<i>lurasidone hcl tab 60 mg</i>	73	<i>meclizine hcl tab 50 mg</i>	55
<i>lurasidone hcl tab 80 mg</i>	73	<i>meclofenamate sodium cap 100 mg</i>	23
LUTERA		<i>meclofenamate sodium cap 50 mg</i>	23

MEDROL TAB 2MG	96
<i>medroxyprogesterone acetate tab 10 mg</i>	130
<i>medroxyprogesterone acetate tab 2.5 mg</i>	130
<i>medroxyprogesterone acetate tab 5 mg</i>	130
<i>mefenamic acid cap 250 mg</i>	24
<i>mefloquine hcl tab 250 mg</i>	63
<i>megestrol acetate susp 40 mg/ml</i>	66
<i>megestrol acetate susp 625 mg/5ml</i>	130
<i>megestrol acetate tab 20 mg</i>	66
<i>megestrol acetate tab 40 mg</i>	66
MEKTOVI TAB 15MG	69
<i>meloxicam susp 7.5 mg/5ml</i>	24
<i>meloxicam tab 15 mg</i>	24
<i>meloxicam tab 7.5 mg</i>	24
<i>melphalan tab 2 mg</i>	64
<i>memantine hcl cap er 24hr 14 mg</i>	131
<i>memantine hcl cap er 24hr 21 mg</i>	131
<i>memantine hcl cap er 24hr 28 mg</i>	131
<i>memantine hcl cap er 24hr 7 mg</i>	131
<i>memantine hcl oral solution 2 mg/ml</i>	131
<i>memantine hcl tab 10 mg</i>	131
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	131
<i>memantine hcl tab 5 mg</i>	131
<i>memantine hcl-donepezil hcl</i> see NAMZARIC CAP	131
see NAMZARIC CAP 14-10MG	131
see NAMZARIC CAP 21-10MG	131
see NAMZARIC CAP 28-10MG	131
see NAMZARIC CAP 7-10MG.....	131
<i>meperidine hcl oral soln 50 mg/5ml</i>	27
<i>meperidine hcl tab 50 mg</i>	27
<i>meprobamate tab 200 mg</i>	37
<i>meprobamate tab 400 mg</i>	37
<i>mercaptopurine tab 50 mg</i>	65
MERZEE see Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24).....	93
<i>mesalamine cap dr 400 mg</i>	111
<i>mesalamine cap er 24hr 0.375 gm</i>	111
<i>mesalamine enema 4 gm</i>	111
<i>mesalamine suppos 1000 mg</i>	111
<i>mesalamine tab delayed release 1.2 gm</i>	111
<i>mesalamine tab delayed release 800 mg</i>	111
<i>metaxalone tab 800 mg</i>	125
<i>metformin hcl oral soln 500 mg/5ml</i>	51
<i>metformin hcl tab 1000 mg</i>	52

<i>metformin hcl tab 500 mg</i>	51
<i>metformin hcl tab 850 mg</i>	51
<i>metformin hcl tab er 24hr 500 mg</i>	52
<i>metformin hcl tab er 24hr 750 mg</i>	52
<i>methadone hcl conc 10 mg/ml</i>	27
Methadone Hcl Conc 10 mg/ml.....	27
<i>methadone hcl soln 10 mg/5ml</i>	27
<i>methadone hcl soln 5 mg/5ml</i>	27
<i>methadone hcl tab 10 mg</i>	27
<i>methadone hcl tab 5 mg</i>	27
<i>methadone hcl tab for oral susp 40 mg</i>	27
Methadone Hcl Tab For Oral Susp 40 mg.....	27
METHADONE HYDROCHLORIDE I see Methadone Hcl Conc 10 mg/ml	27
METHADOSE see Methadone Hcl Tab For Oral Susp 40 mg	27
<i>methamphetamine hcl tab 5 mg</i>	15
<i>methazolamide tab 25 mg</i>	105
<i>methazolamide tab 50 mg</i>	105
<i>methenamine hippurate tab 1 gm</i>	36
<i>methenamine mandelate tab 0.5 gm</i>	36
METHERGINE see Methylergonovine Maleate Tab 0.2 mg	129
<i>methimazole tab 10 mg</i>	139
<i>methimazole tab 5 mg</i>	139
<i>methocarbamol tab 500 mg</i>	125
<i>methocarbamol tab 750 mg</i>	125
<i>methotrexate sodium</i> see TREXALL TAB 10MG	65
see TREXALL TAB 15MG	65
see TREXALL TAB 5MG	65
see TREXALL TAB 7.5MG	65
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	65
<i>methoxsalen rapid cap 10 mg</i>	101
<i>methscopolamine bromide tab 2.5 mg</i>	141
<i>methscopolamine bromide tab 5 mg</i>	141
<i>methylsuximide cap 300 mg</i>	47
<i>methylergonovine maleate tab 0.2 mg</i>	129
Methylergonovine Maleate Tab 0.2 mg.....	129
<i>methylphenidate hcl cap er 10 mg (cd)</i>	18
<i>methylphenidate hcl cap er 20 mg (cd)</i>	18
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	18
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	18
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	18
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	18
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	19
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	19

<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i> ...	19
<i>methylphenidate hcl cap er 24hr 40 mg (la)</i> ...	19
<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i> ...	19
<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i> ...	19
<i>methylphenidate hcl cap er 24hr 60 mg (la)</i> ...	19
<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i> ...	19
<i>methylphenidate hcl cap er 30 mg (cd)</i>	19
<i>methylphenidate hcl cap er 40 mg (cd)</i>	19
<i>methylphenidate hcl cap er 50 mg (cd)</i>	19
<i>methylphenidate hcl cap er 60 mg (cd)</i>	20
<i>methylphenidate hcl chew tab 10 mg</i>	20
<i>methylphenidate hcl chew tab 2.5 mg</i>	20
<i>methylphenidate hcl chew tab 5 mg</i>	20
<i>methylphenidate hcl soln 10 mg/5ml</i>	20
<i>methylphenidate hcl soln 5 mg/5ml</i>	20
<i>methylphenidate hcl tab 10 mg</i>	20
<i>methylphenidate hcl tab 20 mg</i>	20
<i>methylphenidate hcl tab 5 mg</i>	20
<i>methylphenidate hcl tab er 10 mg</i>	20
<i>methylphenidate hcl tab er 20 mg</i>	20
<i>methylphenidate hcl tab er 24hr 18 mg</i>	21
<i>methylphenidate hcl tab er 24hr 27 mg</i>	21
<i>methylphenidate hcl tab er 24hr 36 mg</i>	21
<i>methylphenidate hcl tab er 24hr 54 mg</i>	21
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	21
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	21
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	21
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	21
<i>methylphenidate td patch 10 mg/9hr</i>	21
<i>methylphenidate td patch 15 mg/9hr</i>	21
<i>methylphenidate td patch 20 mg/9hr</i>	21
<i>methylphenidate td patch 30 mg/9hr</i>	22
<i>methylprednisolone</i>	
see MEDROL TAB 2MG	96
<i>methylprednisolone tab 16 mg</i>	96
<i>methylprednisolone tab 32 mg</i>	96
<i>methylprednisolone tab 4 mg</i>	96
<i>methylprednisolone tab 8 mg</i>	96
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	96
<i>methyltestosterone cap 10 mg</i>	34
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	110
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	110
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	110
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	110
<i>metolazone tab 10 mg</i>	106
<i>metolazone tab 2.5 mg</i>	106
<i>metolazone tab 5 mg</i>	106
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	62
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	62
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	62
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	80
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	80
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	80
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	80
<i>metoprolol tartrate tab 100 mg</i>	81
<i>metoprolol tartrate tab 25 mg</i>	81
<i>metoprolol tartrate tab 37.5 mg</i>	81
<i>metoprolol tartrate tab 50 mg</i>	81
<i>metoprolol tartrate tab 75 mg</i>	81
<i>metronidazole cap 375 mg</i>	35
<i>metronidazole cream 0.75%</i>	104
<i>metronidazole gel 0.75%</i>	104
<i>metronidazole gel 1%</i>	104
<i>metronidazole lotion 0.75%</i>	104
<i>metronidazole tab 250 mg</i>	35
<i>metronidazole tab 500 mg</i>	35
<i>metronidazole vaginal gel 0.75%</i>	143
<i>metyrosine cap 250 mg</i>	59
<i>mexiletine hcl cap 150 mg</i>	38
<i>mexiletine hcl cap 200 mg</i>	38
<i>mexiletine hcl cap 250 mg</i>	38
<i>MIBELAS 24 FE</i>	
see Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24).....	93
<i>MICONAZOLE 3</i>	
see Miconazole Nitrate Vaginal Suppos 200 mg	143
<i>Miconazole Nitrate Vaginal Suppos 200 mg</i>	143

MICROCHAMBER MIS.....	119
MICROGESTIN 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab	
1.5 mg-30 mcg.....	92
MICROGESTIN 1/20	
see Norethindrone Ace & Ethinyl Estradiol Tab	
1 mg-20 mcg	91
MICROGESTIN 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24)	93
MICROGESTIN FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1.5 mg-30 mcg	92
MICROGESTIN FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg	92
MICROSPACER MIS	119
<i>midazolam (anticonvulsant)</i>	
see NAYZILAM SPR 5MG.....	43
<i>midazolam hcl syrup 2 mg/ml (base equivalent)</i>	
.....	115
<i>midodrine hcl tab 10 mg</i>	144
<i>midodrine hcl tab 2.5 mg</i>	144
<i>midodrine hcl tab 5 mg</i>	144
<i>midostaurin</i>	
see RYDAPT CAP 25MG	70
<i>mifepristone tab 200 mg</i>	108
<i> miglitol tab 100 mg</i>	50
<i> miglitol tab 25 mg</i>	50
<i> miglitol tab 50 mg</i>	50
<i> miglustat cap 100 mg</i>	113
Miglustat Cap 100 mg	113
MILI	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	93
<i> miltefosine</i>	
see IMPAVIDO CAP 50MG	35
MIMVEY	
see Estradiol & Norethindrone Acetate Tab 1-	
0.5 mg.....	108
<i> minocycline hcl cap 100 mg</i>	139
<i> minocycline hcl cap 50 mg</i>	139
<i> minocycline hcl cap 75 mg</i>	139
<i> minocycline hcl tab 100 mg</i>	139
<i> minocycline hcl tab 50 mg</i>	139
<i> minocycline hcl tab 75 mg</i>	139
<i> minoxidil tab 10 mg</i>	63

<i> minoxidil tab 2.5 mg</i>	63
<i> mirtazapine orally disintegrating tab 15 mg</i>	47
<i> mirtazapine orally disintegrating tab 30 mg</i>	47
<i> mirtazapine orally disintegrating tab 45 mg</i>	47
<i> mirtazapine tab 15 mg</i>	47
<i> mirtazapine tab 30 mg</i>	47
<i> mirtazapine tab 45 mg</i>	47
<i> mirtazapine tab 7.5 mg</i>	47
<i> misoprostol tab 100 mcg</i>	142
<i> misoprostol tab 200 mcg</i>	142
MITIGARE CAP 0.6MG.....	112
<i> mitotane</i>	
see LYSODREN TAB 500MG	66
<i> modafinil tab 100 mg</i>	22
<i> modafinil tab 200 mg</i>	22
<i> moexipril hcl tab 15 mg</i>	59
<i> moexipril hcl tab 7.5 mg</i>	59
<i> molindone hcl tab 10 mg</i>	75
<i> molindone hcl tab 25 mg</i>	75
<i> molindone hcl tab 5 mg</i>	75
<i> molnupiravir</i>	
see LAGEVRIO CAP 200MG	80
<i> mometasone furoate cream 0.1%</i>	103
<i> mometasone furoate nasal susp 50 mcg/act.</i>	126
<i> mometasone furoate oint 0.1%</i>	103
<i> mometasone furoate solution 0.1% (lotion)</i>	103
MONDOXYNE NL	
see Doxycycline Monohydrate Cap 100 mg	138
MONO-LINYAH	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg	93
<i> montelukast sodium chew tab 4 mg (base equiv)</i>	
.....	39
<i> montelukast sodium chew tab 5 mg (base equiv)</i>	
.....	39
<i> montelukast sodium oral granules packet 4 mg (base equiv)</i>	
.....	39
<i> montelukast sodium tab 10 mg (base equiv)</i>	39
<i> morphine sulfate beads cap er 24hr 120 mg</i>	27
<i> morphine sulfate beads cap er 24hr 30 mg</i>	27
<i> morphine sulfate beads cap er 24hr 45 mg</i>	27
<i> morphine sulfate beads cap er 24hr 60 mg</i>	27
<i> morphine sulfate beads cap er 24hr 75 mg</i>	27
<i> morphine sulfate beads cap er 24hr 90 mg</i>	27
<i> morphine sulfate cap er 24hr 10 mg</i>	27
<i> morphine sulfate cap er 24hr 100 mg</i>	28
<i> morphine sulfate cap er 24hr 20 mg</i>	27

<i>morphine sulfate cap er 24hr 30 mg</i>	27	<i>see NAFTIN GEL 2%</i>	100
<i>morphine sulfate cap er 24hr 50 mg</i>	28	<i>naftifine hcl cream 1%</i>	100
<i>morphine sulfate cap er 24hr 60 mg</i>	28	<i>naftifine hcl cream 2%</i>	100
<i>morphine sulfate cap er 24hr 80 mg</i>	28	<i>naftifine hcl gel 2%</i>	100
<i>morphine sulfate oral soln 10 mg/5ml</i>	28	NAFTIN GEL 1%	100
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	28	NAFTIN GEL 2%	100
<i>morphine sulfate oral soln 20 mg/5ml</i>	28	<i>naldemedine tosylate</i>	
<i>morphine sulfate tab 15 mg</i>	28	<i>see SYMPROIC TAB 0.2MG</i>	111
<i>morphine sulfate tab 30 mg</i>	28	<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	54
<i>morphine sulfate tab er 100 mg</i>	28	<i>naltrexone hcl tab 50 mg</i>	54
<i>morphine sulfate tab er 15 mg</i>	28	NAMZARIC CAP	131
<i>morphine sulfate tab er 200 mg</i>	28	NAMZARIC CAP 14-10MG	131
<i>morphine sulfate tab er 30 mg</i>	28	NAMZARIC CAP 21-10MG	131
<i>morphine sulfate tab er 60 mg</i>	28	NAMZARIC CAP 28-10MG	131
MOUNJARO INJ 10MG/0.5	52	NAMZARIC CAP 7-10MG	131
MOUNJARO INJ 12.5/0.5	52	<i>naproxen sodium tab 275 mg</i>	24
MOUNJARO INJ 15MG/0.5	52	<i>naproxen sodium tab 550 mg</i>	24
MOUNJARO INJ 2.5/0.5	52	<i>naproxen tab 250 mg</i>	24
MOUNJARO INJ 5MG/0.5	52	<i>naproxen tab 375 mg</i>	24
MOUNJARO INJ 7.5/0.5	52	<i>naproxen tab 500 mg</i>	24
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	127	<i>naproxen tab ec 375 mg</i>	24
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	127	Naproxen Tab Ec 375 mg	24
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	110	<i>naproxen tab ec 500 mg</i>	24
<i>mupirocin oint 2%</i>	100	Naproxen Tab Ec 500 mg	24
<i>mycophenolate mofetil cap 250 mg</i>	124	<i>naratriptan hcl tab 1 mg (base equiv)</i>	120
<i>mycophenolate mofetil for oral susp 200 mg/ml</i>	124	<i>naratriptan hcl tab 2.5 mg (base equiv)</i>	120
<i>mycophenolate mofetil tab 500 mg</i>	124	NATAZIA TAB	90
<i>mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)</i>	124	<i>nateglinide tab 120 mg</i>	53
<i>mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)</i>	124	<i>nateglinide tab 60 mg</i>	53
MYFEMBREE TAB	108	NATESTO GEL 5.5MG	34
MYLERAN TAB 2MG	64	NAYZILAM SPR 5MG	43
N		<i>nebivolol hcl tab 10 mg (base equivalent)</i>	81
<i>nabumetone tab 500 mg</i>	24	<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	81
<i>nabumetone tab 750 mg</i>	24	<i>nebivolol hcl tab 20 mg (base equivalent)</i>	81
<i>adolol tab 20 mg</i>	81	<i>nebivolol hcl tab 5 mg (base equivalent)</i>	81
<i>adolol tab 40 mg</i>	81	NEBUSAL	
<i>adolol tab 80 mg</i>	81	<i>see Sodium Chloride Soln Nebu 3%</i>	97
<i>nafarelin acetate</i>		<i>NECON 0.5/35-28</i>	
<i>see SYNAREL SOL 2MG/ML</i>	106	<i>see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg</i>	90
<i>naftifine hcl</i>		<i>nefazodone hcl tab 100 mg</i>	48
<i>see NAFTIN GEL 1%</i>	100	<i>nefazodone hcl tab 150 mg</i>	48
		<i>nefazodone hcl tab 200 mg</i>	48
		<i>nefazodone hcl tab 250 mg</i>	48
		<i>nefazodone hcl tab 50 mg</i>	48
		<i>neomycin sulfate tab 500 mg</i>	22

neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-1000unt op oin	127
Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-1000unt Op Oin	127
neomycin-polomyx-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	127
neomycin-polymyxin-dexamethasone ophth oint 0.1%	128
neomycin-polymyxin-dexamethasone ophth susp 0.1%	128
neomycin-polymyxin-hc ophth susp	128
neomycin-polymyxin-hc otic soln 1%	129
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	129
NEO-POLYCIN	
see Neomycin-Bacitrac Zn-Polymyx 5(3.5)mg-400unt-1000unt Op Oin	127
NEO-POLYCIN HC	
see Bacitracin-Polymyxin-Neomycin-Hc Ophth Oint 1%	128
nepafenac	
see ILEVRO DRO 0.3% OP	128
NEUAC	
see Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%	98
NEUPRO DIS 1MG/24HR	72
NEUPRO DIS 2MG/24HR	72
NEUPRO DIS 3MG/24HR	72
NEUPRO DIS 4MG/24HR	72
NEUPRO DIS 6MG/24HR	72
NEUPRO DIS 8MG/24HR	72
nevirapine susp 50 mg/5ml	78
nevirapine tab 200 mg	78
nevirapine tab er 24hr 400 mg	78
NEXAVAR TAB 200MG	69
NEXLETOL TAB 180MG	56
NEXLIZET TAB 180/10MG	57
niacin tab er 1000 mg (antihyperlipidemic)	59
niacin tab er 500 mg (antihyperlipidemic)	58
niacin tab er 750 mg (antihyperlipidemic)	58
nicardipine hcl cap 20 mg	83
nicardipine hcl cap 30 mg	83
NICORELIEF	
see Nicotine Polacrilex Gum 2 mg	134
nicotine	
see NICOTROL INH	138
see NICOTROL NS SPR 10MG/ML	138

NICOTINE MINI LOZENGE	
see Nicotine Polacrilex Lozenge 2 mg	135
see Nicotine Polacrilex Lozenge 4 mg	136
nicotine polacrilex gum 2 mg	133
Nicotine Polacrilex Gum 2 mg	133, 134
nicotine polacrilex gum 4 mg	134
Nicotine Polacrilex Gum 4 mg	134, 135
nicotine polacrilex lozenge 2 mg	135
Nicotine Polacrilex Lozenge 2 mg	135
nicotine polacrilex lozenge 4 mg	135
Nicotine Polacrilex Lozenge 4 mg	135, 136
NICOTINE STEP 1	
see Nicotine Td Patch 24hr 21 mg/24hr	137
NICOTINE STEP 2	
see Nicotine Td Patch 24hr 14 mg/24hr	137
NICOTINE STEP 3	
see Nicotine Td Patch 24hr 7 mg/24hr	136
nicotine td patch 24hr 14 mg/24hr	137
Nicotine Td Patch 24hr 14 mg/24hr	137
nicotine td patch 24hr 21 mg/24hr	137
Nicotine Td Patch 24hr 21 mg/24hr	137, 138
nicotine td patch 24hr 7 mg/24hr	136
Nicotine Td Patch 24hr 7 mg/24hr	136, 137
NICOTINE TRANSDERMAL SYST	
see Nicotine Td Patch 24hr 14 mg/24hr	137
see Nicotine Td Patch 24hr 21 mg/24hr	137
see Nicotine Td Patch 24hr 7 mg/24hr	136
NICOTROL INH	138
NICOTROL NS SPR 10MG/ML	138
nifedipine cap 10 mg	83
nifedipine cap 20 mg	83
nifedipine tab er 24hr 30 mg	83
nifedipine tab er 24hr 60 mg	83
nifedipine tab er 24hr 90 mg	83
nifedipine tab er 24hr osmotic release 30 mg	83
nifedipine tab er 24hr osmotic release 60 mg	83
nifedipine tab er 24hr osmotic release 90 mg	83
NIKKI	
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg	88
nilutamide tab 150 mg	66
nimodipine cap 30 mg	83
NINLARO CAP 2.3MG	69
NINLARO CAP 3MG	69
NINLARO CAP 4MG	69
nintedanib esylate	
see OFEV CAP 100MG	138

see OFEV CAP 150MG	138
niraparib tosylate	
see ZEJULA TAB 100MG.....	70
see ZEJULA TAB 200MG.....	70
see ZEJULA TAB 300MG.....	70
nirmatrelvir-ritonavir	
see PAXLOVID TAB 300-100	78
nisoldipine tab er 24hr 17 mg	83
nisoldipine tab er 24hr 20 mg	83
nisoldipine tab er 24hr 25.5 mg	83
nisoldipine tab er 24hr 30 mg	83
nisoldipine tab er 24hr 34 mg	83
nisoldipine tab er 24hr 40 mg	83
nisoldipine tab er 24hr 8.5 mg	83
nitazoxanide tab 500 mg	36
nitisinone	
see ORFADIN CAP 10MG	107
see ORFADIN CAP 20MG	107
see ORFADIN CAP 2MG	107
see ORFADIN CAP 5MG	107
see ORFADIN SUS 4MG/ML	107
nitisinone cap 10 mg	107
nitisinone cap 2 mg	107
nitisinone cap 20 mg	107
nitisinone cap 5 mg	107
NITRO-DUR DIS 0.3MG/HR	37
NITRO-DUR DIS 0.8MG/HR	37
nitrofurantoin macrocrystalline cap 100 mg ...	36
nitrofurantoin macrocrystalline cap 25 mg	36
nitrofurantoin macrocrystalline cap 50 mg	36
nitrofurantoin monohydrate macrocrystalline cap 100 mg	36
nitrofurantoin susp 25 mg/5ml.	36
nitroglycerin	
see NITRO-DUR DIS 0.3MG/HR	37
see NITRO-DUR DIS 0.8MG/HR	37
nitroglycerin sl tab 0.3 mg	37
nitroglycerin sl tab 0.4 mg	37
nitroglycerin sl tab 0.6 mg	37
nitroglycerin td patch 24hr 0.1 mg/hr	37
nitroglycerin td patch 24hr 0.2 mg/hr	37
nitroglycerin td patch 24hr 0.4 mg/hr	37
nitroglycerin td patch 24hr 0.6 mg/hr	37
nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)	37
nizatidine cap 150 mg	141
nizatidine cap 300 mg	141

nonoxynol-9

see ENCARE SUP 100MG	143
see GYNOL II GEL 3%.....	143
see SHUR-SEAL GEL 2%	143
see TODAY SPONGE MIS.....	143
see VCF VAGINAL AER CONTRACP	143
see VCF VAGINAL GEL CONTRACE.....	143
see VCF VAGINAL MIS CONTRACP	143
NORA-BE	
see Norethindrone Tab 0.35 mg	95
Norelgestromin-Ethynodiol Td Pt wk 150-35 mcg/24hr	94
Norethindrone & Ethynodiol Tab 0.4 mg-35 mcg	90
Norethindrone & Ethynodiol Tab 0.5 mg-35 mcg	90
Norethindrone & Ethynodiol Tab 1 mg-35 mcg	91
norethindrone & ethynodiol-fe chew tab 0.4 mg-35 mcg	91
Norethindrone & Ethynodiol-Fe Chew Tab 0.4 mg-35 mcg	91
norethindrone & ethynodiol-fe chew tab 0.8 mg-25 mcg	91
Norethindrone & Ethynodiol-Fe Chew Tab 0.8 mg-25 mcg	91
norethindrone ace & ethynodiol tab 1 mg-20 mcg	91
Norethindrone Ace & Ethynodiol Tab 1 mg-20 mcg	91
norethindrone ace & ethynodiol tab 1.5 mg-30 mcg	91
Norethindrone Ace & Ethynodiol Tab 1.5 mg-30 mcg	91, 92
norethindrone ace & ethynodiol-fe tab 1 mg-20 mcg	92
Norethindrone Ace & Ethynodiol-Fe Tab 1 mg-20 mcg	92
norethindrone ace & ethynodiol-fe tab 1.5 mg-30 mcg	92
Norethindrone Ace & Ethynodiol-Fe Tab 1.5 mg-30 mcg	92
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	92
Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)	92, 93

norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24).....	93
Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24)	93
Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24)	93
norethindrone acetate tab 5 mg.....	130
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg.....	108
Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg	108
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	108
Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg	108
norethindrone acetate-ethinyl estradiol-fe fum (biphasic)	
see LO LOESTRIN TAB 1-10-10	90
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	91
Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg	91
norethindrone tab 0.35 mg.....	95
Norethindrone Tab 0.35 mg	95
Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	93
Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg.....	93
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	93
Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg.....	93, 94
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	94
Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg.....	94
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	94
Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg.....	94
Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg	94
Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg	94
NORLYROC	
see Norethindrone Tab 0.35 mg	95
NORPACE CAP 100MG CR.....	38
NORPACE CAP 150MG CR	38
NORTREL 0.5/35 (28)	
see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg	90
NORTREL 1/35	
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg	91
NORTREL 7/7/7	
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	93
nortriptyline hcl cap 10 mg.....	50
nortriptyline hcl cap 25 mg.....	50
nortriptyline hcl cap 50 mg.....	50
nortriptyline hcl cap 75 mg.....	50
nortriptyline hcl soln 10 mg/5ml	50
NORVIR POW 100MG.....	78
NORVIR TAB 100MG	78
NOVOLIN INJ 70/30.....	53
NOVOLIN INJ 70/30 FP	53
NOVOLIN N INJ 100 UNIT	53
NOVOLIN N INJ U-100	53
NOVOLIN R INJ 100 UNIT.....	53
NOVOLIN R INJ U-100	53
NOVOLOG INJ 100/ML	53
NOVOLOG INJ FLEXPEN.....	53
NOVOLOG INJ PENFILL	53
NOVOLOG MIX INJ 70/30	53
NOVOLOG MIX INJ FLEXPEN.....	53
NUBEQA TAB 300MG	66
NULEV	
see Hyoscyamine Sulfate Tab Disint 0.125 mg	141
NURTEC TAB 75MG ODT	120
NUVARING MIS.....	95
NYAMYC	
see Nystatin Topical Powder 100000 unit/gm	100
NYLIA 1/35	
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg	91
NYLIA 7/7/7	
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg	93
NYMYO	
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg	94
nystatin cream 100000 unit/gm	100

<i>nystatin oint 100000 unit/gm</i>	100
<i>nystatin susp 100000 unit/ml</i>	124
<i>nystatin tab 500000 unit</i>	55
<i>nystatin topical powder 100000 unit/gm</i>	100
Nystatin Topical Powder 100000 unit/gm	100
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	100
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	100
NYSTOP	
see Nystatin Topical Powder 100000 unit/gm	
.....	100
O	
OCELLA	
see Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg	88
ODEFSEY TAB	78
ODOMZO CAP 200MG	66
OFEV CAP 100MG	138
OFEV CAP 150MG	138
<i>ofloxacin ophth soln 0.3%</i>	127
<i>ofloxacin otic soln 0.3%</i>	129
<i>ofloxacin tab 300 mg</i>	110
<i>ofloxacin tab 400 mg</i>	110
OGESTREL	
see Norgestrel & Ethinyl Estradiol Tab 0.5 mg-50 mcg	94
<i>olanzapine orally disintegrating tab 10 mg</i>	75
<i>olanzapine orally disintegrating tab 15 mg</i>	75
<i>olanzapine orally disintegrating tab 20 mg</i>	75
<i>olanzapine orally disintegrating tab 5 mg</i>	75
<i>olanzapine tab 10 mg</i>	75
<i>olanzapine tab 15 mg</i>	75
<i>olanzapine tab 2.5 mg</i>	75
<i>olanzapine tab 20 mg</i>	75
<i>olanzapine tab 5 mg</i>	75
<i>olanzapine tab 7.5 mg</i>	75
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	132
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	132
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	132
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	132
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	132
<i>olaparib</i>	
see LYNPARZA TAB 100MG	69
see LYNPARZA TAB 150MG	69
<i>olmesartan medoxomil tab 20 mg</i>	60
<i>olmesartan medoxomil tab 40 mg</i>	60

<i>olmesartan medoxomil tab 5 mg</i>	60
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	62
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	62
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	62
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	62
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	62
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	62
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	62
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	62
<i>olodaterol hcl</i>	
see STRIVERDI AER 2.5MCG	41
<i>olopatadine hcl nasal soln 0.6%</i>	126
<i>olopatadine hcl ophth soln 0.1% (base equivalent)</i>	128
<i>olopatadine hcl ophth soln 0.2% (base equivalent)</i>	129
<i>omega-3-acid ethyl esters cap 1 gm</i>	57
<i>omeprazole cap delayed release 10 mg</i>	142
<i>omeprazole cap delayed release 20 mg</i>	142
<i>omeprazole cap delayed release 40 mg</i>	142
<i>ondansetron hcl oral soln 4 mg/5ml</i>	55
<i>ondansetron hcl tab 24 mg</i>	55
<i>ondansetron hcl tab 4 mg</i>	55
<i>ondansetron hcl tab 8 mg</i>	55
<i>ondansetron orally disintegrating tab 4 mg</i>	55
<i>ondansetron orally disintegrating tab 8 mg</i>	55
ONZETRA XSAI MIS 11MG	120
OPSUMIT TAB 10MG	85
OPTICHAMBER MIS ADV LRG	119
OPTICHAMBER MIS ADV MED	119
OPTICHAMBER MIS ADV SM	119
OPTICHAMBER MIS DIA LG	119
OPTICHAMBER MIS DIA MD	120
OPTICHAMBER MIS DIA SM	120
OPTICHAMBER MIS DIAMOND	120
OPTIHALER MIS	120
ORACEA CAP 40MG	104
ORALAIR SUB 300 IR	22
ORALONE DENTAL PASTE	

see Triamcinolone Acetonide Dental Paste 0.1%.....	124
ORENITRAM TAB 0.125MG.....	85
ORENITRAM TAB 0.25MG.....	85
ORENITRAM TAB 1MG	85
ORENITRAM TAB 2.5MG	85
ORENITRAM TAB 5MG	85
ORENITRAM TAB MONTH 1.....	85
ORENITRAM TAB MONTH 2.....	85
ORENITRAM TAB MONTH 3.....	85
ORFADIN CAP 10MG	107
ORFADIN CAP 20MG	107
ORFADIN CAP 2MG	107
ORFADIN CAP 5MG	107
ORFADIN SUS 4MG/ML	107
ORIAHNN CAP.....	108
ORILISSA TAB 150MG	106
ORILISSA TAB 200MG	106
ORLADEYO CAP 110MG.....	112
ORLADEYO CAP 150MG.....	112
orlistat cap 120 mg.....	15
orphenadrine citrate tab er 12hr 100 mg.....	125
OSCIMIN	
see Hyoscyamine Sulfate SI Tab 0.125 mg..	141
see Hyoscyamine Sulfate Tab 0.125 mg	141
oseltamivir phosphate cap 30 mg (base equiv).....	80
oseltamivir phosphate cap 45 mg (base equiv).....	80
oseltamivir phosphate cap 75 mg (base equiv).....	80
oseltamivir phosphate for susp 6 mg/ml (base equiv)	80
osimertinib mesylate	
see TAGRISSO TAB 40MG	65
see TAGRISSO TAB 80MG	66
OTEZLA TAB 10/20/30.....	24
OTEZLA TAB 30MG.....	24
oxaprozin tab 600 mg.....	24
oxazepam cap 10 mg.....	38
oxazepam cap 15 mg.....	38
oxazepam cap 30 mg.....	38
oxcarbazepine	
see OXTELLAR XR TAB 150MG	45
see OXTELLAR XR TAB 300MG	45
see OXTELLAR XR TAB 600MG	45
oxcarbazepine susp 300 mg/5ml (60 mg/ml)	45
oxcarbazepine tab 150 mg	45
oxcarbazepine tab 300 mg	45
oxcarbazepine tab 600 mg	45
oxiconazole nitrate cream 1%	100
OXTELLAR XR TAB 150MG	45
OXTELLAR XR TAB 300MG	45
OXTELLAR XR TAB 600MG	45
oxybutynin chloride solution 5 mg/5ml	142
oxybutynin chloride tab 5 mg	142
oxybutynin chloride tab er 24hr 10 mg	142
oxybutynin chloride tab er 24hr 15 mg	142
oxybutynin chloride tab er 24hr 5 mg	142
oxycodone	
see XTAMPZA ER CAP 13.5MG.....	30
see XTAMPZA ER CAP 18MG.....	30
see XTAMPZA ER CAP 27MG.....	30
see XTAMPZA ER CAP 36MG.....	30
see XTAMPZA ER CAP 9MG	30
oxycodone hcl cap 5 mg	28
oxycodone hcl conc 100 mg/5ml (20 mg/ml)	28
oxycodone hcl soln 5 mg/5ml	28
oxycodone hcl tab 10 mg	29
oxycodone hcl tab 15 mg	29
oxycodone hcl tab 20 mg	29
oxycodone hcl tab 30 mg	29
oxycodone hcl tab 5 mg	29
oxycodone hcl tab er 12hr deter 10 mg	29
oxycodone hcl tab er 12hr deter 20 mg	29
oxycodone hcl tab er 12hr deter 40 mg	29
oxycodone hcl tab er 12hr deter 80 mg	29
oxycodone w/ acetaminophen tab 10-325 mg	33
Oxycodone W/ Acetaminophen Tab 10-325 mg	33
oxycodone w/ acetaminophen tab 2.5-325 mg	32
Oxycodone W/ Acetaminophen Tab 2.5-325 mg	32
oxycodone w/ acetaminophen tab 5-325 mg	32
Oxycodone W/ Acetaminophen Tab 5-325 mg	32
oxycodone w/ acetaminophen tab 7.5-325 mg	32
Oxycodone W/ Acetaminophen Tab 7.5-325 mg	32
oxymetazoline hcl (topical)	
see RHOFADE CRE 1%	104
oxymorphone hcl tab 10 mg	29
oxymorphone hcl tab 5 mg	29
ozanimod hcl	
see ZEPOSIA 7DAY CAP STR PACK	133
see ZEPOSIA CAP .92MG	133
see ZEPOSIA CAP STR KIT.....	133

OZEMPIC INJ 2MG/3ML	52	<i>paroxetine hcl tab er 24hr 12.5 mg</i>	48
OZEMPIC INJ 4MG/3ML	52	<i>paroxetine hcl tab er 24hr 25 mg</i>	48
OZEMPIC INJ 8MG/3ML	52	<i>paroxetine hcl tab er 24hr 37.5 mg</i>	48
P		PASER GRA 4GM	64
PACERONE		patiromer sorbitex calcium	
see Amiodarone Hcl Tab 100 mg	39	see VELTASSA POW 16.8GM.....	124
see Amiodarone Hcl Tab 200 mg	39	see VELTASSA POW 25.2GM.....	124
see Amiodarone Hcl Tab 400 mg	39	see VELTASSA POW 8.4GM	124
palbociclib		PAXLOVID TAB 300-100.....	78
see IBRANCE CAP 100MG	68	pazopanib hcl tab 200 mg (base equiv)	69
see IBRANCE CAP 125MG	68	peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	116
see IBRANCE CAP 75MG	68	Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm	116
see IBRANCE TAB 100MG	68	Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm	116
see IBRANCE TAB 125MG	68	peg 3350-kcl-sod bicarb-nacl for soln 420 gm	116
see IBRANCE TAB 75MG	68	penciclovir cream 1%	101
paliperidone tab er 24hr 1.5 mg	74	penicillamine cap 250 mg	122
paliperidone tab er 24hr 3 mg	74	penicillamine tab 250 mg	122
paliperidone tab er 24hr 6 mg	74	penicillin v potassium for soln 125 mg/5ml	130
paliperidone tab er 24hr 9 mg	74	penicillin v potassium for soln 250 mg/5ml	130
pancrelipase (lipase-protease-amylase)		penicillin v potassium tab 250 mg	130
see CREON CAP 12000UNT	104	penicillin v potassium tab 500 mg	130
see CREON CAP 24000UNT	104	pentamidine isethionate for nebulization soln 300 mg	35
see CREON CAP 3000UNIT.....	104	pentazocine w/ naloxone hcl tab 50-0.5 mg	34
see CREON CAP 36000UNT	104	pentoxifylline tab er 400 mg	112
see CREON CAP 6000UNIT.....	104	perampanel	
see VIOKACE TAB 10440	104	see FYCOMPA SUS 0.5MG/ML	43
see VIOKACE TAB 20880	104	see FYCOMPA TAB 10MG	43
see ZENPEP CAP 10000UNT	105	see FYCOMPA TAB 12MG	43
see ZENPEP CAP 15000UNT	105	see FYCOMPA TAB 2MG	43
see ZENPEP CAP 20000UNT	105	see FYCOMPA TAB 4MG	43
see ZENPEP CAP 25000UNT	105	see FYCOMPA TAB 6MG	43
see ZENPEP CAP 3000UNIT	104	see FYCOMPA TAB 8MG	43
see ZENPEP CAP 40000UNT	105	perindopril erbumine tab 2 mg	59
see ZENPEP CAP 5000UNIT	104	perindopril erbumine tab 4 mg	59
pantoprazole sodium ec tab 20 mg (base equiv)	142	perindopril erbumine tab 8 mg	59
pantoprazole sodium ec tab 40 mg (base equiv)	142	permethrin cream 5%	104
paricalcitol cap 1 mcg	107	perphenazine tab 16 mg	76
paricalcitol cap 2 mcg	107	perphenazine tab 2 mg	76
paricalcitol cap 4 mcg	107	perphenazine tab 4 mg	76
paroxetine hcl oral susp 10 mg/5ml (base equiv)	48	perphenazine tab 8 mg	76
paroxetine hcl tab 10 mg	48	perphenazine-amitriptyline tab 2-10 mg	132
paroxetine hcl tab 20 mg	48	perphenazine-amitriptyline tab 2-25 mg	132
paroxetine hcl tab 30 mg	48	perphenazine-amitriptyline tab 4-10 mg	132
paroxetine hcl tab 40 mg	48		

perphenazine-amitriptyline tab 4-25 mg	132	pilocarpine hcl tab 7.5 mg	124
perphenazine-amitriptyline tab 4-50 mg	132	pimecrolimus cream 1%	103
PHENAZO		pimozide tab 1 mg	133
see Phenazopyridine Hcl Tab 200 mg	112	pimozide tab 2 mg	133
Phenazopyridine Hcl Tab 200 mg	112	PIMTREA	
phendimetrazine tartrate tab 35 mg	15	see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
phenelzine sulfate tab 15 mg	47	0.02/0.01 mg(21/5)	87
phenobarbital elixir 20 mg/5ml	115	pindolol tab 10 mg	81
phenobarbital tab 100 mg	115	pindolol tab 5 mg	81
phenobarbital tab 15 mg	115	pioglitazone hcl tab 15 mg (base equiv)	53
phenobarbital tab 16.2 mg	115	pioglitazone hcl tab 30 mg (base equiv)	53
phenobarbital tab 30 mg	115	pioglitazone hcl tab 45 mg (base equiv)	53
phenobarbital tab 32.4 mg	115	pioglitazone hcl-glimepiride tab 30-2 mg	51
phenobarbital tab 60 mg	115	pioglitazone hcl-glimepiride tab 30-4 mg	51
phenobarbital tab 64.8 mg	115	pioglitazone hcl-metformin hcl tab 15-500 mg	51
phenobarbital tab 97.2 mg	115	pioglitazone hcl-metformin hcl tab 15-850 mg	51
phenoxybenzamine hcl cap 10 mg	60	pirfenidone cap 267 mg	138
phentermine hcl cap 15 mg	15	pirfenidone tab 267 mg	138
phentermine hcl cap 30 mg	15	pirfenidone tab 801 mg	138
phentermine hcl cap 37.5 mg	15	piroxicam cap 10 mg	24
phentermine hcl tab 37.5 mg	15	piroxicam cap 20 mg	24
phentermine hcl-topiramate		pitavastatin calcium tab 1 mg	58
see QSYMIA CAP 11.25-69	15	pitavastatin calcium tab 2 mg	58
see QSYMIA CAP 15-92MG	15	pitavastatin calcium tab 4 mg	58
see QSYMIA CAP 3.75-23	15	pitolisant hcl	
see QSYMIA CAP 7.5-46MG	15	see WAKIX TAB 17.8MG	17
phenylephrine hcl ophth soln 10%	127	see WAKIX TAB 4.45MG	16
Phenylephrine Hcl Ophth Soln 10%	127	PNV-DHA	
phenylephrine hcl ophth soln 2.5%	126	see Prenat W/o A W/fefum-Methfol-Fa-Dha	
Phenylephrine Hcl Ophth Soln 2.5%	127	Cap 27-0.6-0.4-300 mg	125
phenytoin chew tab 50 mg	46	PNV-SELECT	
phenytoin sodium extended cap 100 mg	46	see Prenatal Vit W/ Fe Fum-Methylfolate-Fa	
phenytoin sodium extended cap 200 mg	46	Tab 27-0.6-0.4 mg	125
phenytoin sodium extended cap 300 mg	46	POCKET CHAMB MIS	120
phenytoin susp 125 mg/5ml	46	POCKET SPACE MIS	120
PHEXXI GEL	143	podofilox	
PHILITH		see CONDYLOX GEL 0.5%	103
see Norethindrone & Ethinyl Estradiol Tab 0.4		podofilox soln 0.5%	103
mg-35 mcg	90	POLYCIN	
PHOSPHO-TRIN K500		see Bacitracin-Polymyxin B Ophth Oint	127
see Potassium Phosphate Monobasic Tab 500		polymyxin b-trimethoprim ophth soln 10000	
mg	122	unit/ml-0.1%	127
phytonadione tab 5 mg	144	pomalidomide	
pilocarpine hcl ophth soln 1%	127	see POMALYST CAP 1MG	67
pilocarpine hcl ophth soln 2%	127	see POMALYST CAP 2MG	67
pilocarpine hcl ophth soln 4%	127	see POMALYST CAP 3MG	67
pilocarpine hcl tab 5 mg	124	see POMALYST CAP 4MG	67

POMALYST CAP 1MG.....	67
POMALYST CAP 2MG.....	67
POMALYST CAP 3MG.....	67
POMALYST CAP 4MG.....	67
PORTIA-28	
see Levonorgestrel & Ethinyl Estradiol Tab	
0.15 mg-30 mcg.....	90
posaconazole susp 40 mg/ml	56
Potassium Bicarbonate Effer Tab 25 meq	122
potassium chloride cap er 10 meq	122
potassium chloride cap er 8 meq	122
potassium chloride microencapsulated crys er	
tab 10 meq	122
Potassium Chloride Microencapsulated Crys Er	
Tab 10 meq.....	122
potassium chloride microencapsulated crys er	
tab 15 meq	122
Potassium Chloride Microencapsulated Crys Er	
Tab 15 meq.....	122
potassium chloride microencapsulated crys er	
tab 20 meq	122
Potassium Chloride Microencapsulated Crys Er	
Tab 20 meq.....	122
potassium chloride oral soln 10% (20 meq/15ml)	
.....	122
potassium chloride oral soln 20% (40 meq/15ml)	
.....	122
potassium chloride powder packet 20 meq ..	122
Potassium Chloride Powder Packet 20 meq ...	122
potassium chloride tab er 10 meq	122
Potassium Chloride Tab Er 10 meq	122
potassium chloride tab er 20 meq (1500 mg)	122
potassium chloride tab er 8 meq (600 mg)....	122
Potassium Chloride Tab Er 8 meq (600 mg)....	122
Potassium Citrate & Citric Acid Powder Pack	
3300-1002 mg	111
potassium citrate tab er 10 meq (1080 mg) ..	112
potassium citrate tab er 15 meq (1620 mg) ..	112
potassium citrate tab er 5 meq (540 mg).....	112
potassium iodide oral soln 1 gm/ml	97
Potassium Phosphate Monobasic Tab 500 mg	122
pralsetinib	
see GAVRETO CAP 100MG	68
pramipexole dihydrochloride tab 0.125 mg	72
pramipexole dihydrochloride tab 0.25 mg	72
pramipexole dihydrochloride tab 0.5 mg	72
pramipexole dihydrochloride tab 0.75 mg	72
pramipexole dihydrochloride tab 1 mg.....	72
pramipexole dihydrochloride tab 1.5 mg.....	72
pramipexole dihydrochloride tab er 24hr 0.375	
mg	72
pramipexole dihydrochloride tab er 24hr 0.75	
mg	72
pramipexole dihydrochloride tab er 24hr 1.5 mg	
.....	72
pramipexole dihydrochloride tab er 24hr 2.25	
mg	72
pramipexole dihydrochloride tab er 24hr 3 mg	72
pramipexole dihydrochloride tab er 24hr 3.75	
mg	72
pramipexole dihydrochloride tab er 24hr 4.5 mg	
.....	72
pramlintide acetate	
see SYMLINPEN 60 INJ 1000MCG	50
see SYMLNPEN 120 INJ 1000MCG	50
prasugrel hcl tab 10 mg (base equiv).....	113
prasugrel hcl tab 5 mg (base equiv).....	113
pravastatin sodium tab 10 mg	58
pravastatin sodium tab 20 mg	58
pravastatin sodium tab 40 mg	58
pravastatin sodium tab 80 mg	58
praziquantel tab 600 mg	35
prazosin hcl cap 1 mg	60
prazosin hcl cap 2 mg	60
prazosin hcl cap 5 mg	60
PRED SOD PHO SOL 1% OP	128
prednisolone acetate ophth susp 1%	128
prednisolone sod phos orally disintegr tab 10	
mg (base eq)	96
prednisolone sod phos orally disintegr tab 15	
mg (base eq)	96
prednisolone sod phos orally disintegr tab 30	
mg (base eq)	96
prednisolone sod phosph oral soln 6.7 mg/5ml	
(5 mg/5ml base)	96
prednisolone sod phosphate oral soln 15	
mg/5ml (base equiv)	96
prednisolone sodium phosphate oral soln 25	
mg/5ml (base eq)	96
prednisolone soln 15 mg/5ml	96
prednisolone tab 5 mg	96
prednisone oral soln 5 mg/5ml.....	96
prednisone tab 1 mg	96
prednisone tab 10 mg	96

<i>prednisone tab 2.5 mg</i>	96	PREZISTA TAB 150MG	78
<i>prednisone tab 20 mg</i>	96	PREZISTA TAB 600MG	78
<i>prednisone tab 5 mg</i>	96	PREZISTA TAB 75MG	78
<i>prednisone tab 50 mg</i>	96	PREZISTA TAB 800MG	78
<i>prednisone tab therapy pack 10 mg (21)</i>	96	<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	63
<i>prednisone tab therapy pack 10 mg (48)</i>	96	<i>primidone tab 250 mg</i>	45
<i>prednisone tab therapy pack 5 mg (21)</i>	96	<i>primidone tab 50 mg</i>	45
<i>prednisone tab therapy pack 5 mg (48)</i>	96	<i>probenecid tab 500 mg</i>	112
<i>pregabalin cap 100 mg</i>	45	<i>procarbazine hcl</i>	
<i>pregabalin cap 150 mg</i>	45	see MATULANE CAP 50MG.....	71
<i>pregabalin cap 200 mg</i>	45	PROCENTRA	
<i>pregabalin cap 225 mg</i>	45	see Dextroamphetamine Sulfate Oral Solution	
<i>pregabalin cap 25 mg</i>	45	5 mg/5ml	13
<i>pregabalin cap 300 mg</i>	45	PROCHAMBER MIS VHC	120
<i>pregabalin cap 50 mg</i>	45	<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	76
<i>pregabalin cap 75 mg</i>	45	<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	76
<i>pregabalin soln 20 mg/ml</i>	45	<i>prochlorperazine suppos 25 mg</i>	76
<i>pregabalin tab er 24hr 165 mg</i>	133	Prochlorperazine Suppos 25 mg	76
<i>pregabalin tab er 24hr 330 mg</i>	133	PROCTOFOAM AER HC 1%	35
<i>pregabalin tab er 24hr 82.5 mg</i>	133	PROCTO-MED HC	
PREMPHASE TAB	108	see Hydrocortisone Perianal Cream 2.5%	35
PREMPRO TAB	108	PROCTOSOL HC	
PREMPRO TAB 0.3-1.5	109	see Hydrocortisone Perianal Cream 2.5%	35
PREMPRO TAB 0.45-1.5	109	PROCTOZONE-HC	
PREMPRO TAB 0.625-5	109	see Hydrocortisone Perianal Cream 2.5%	35
Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg.....	125	<i>progesterone (vaginal)</i>	
PRENATAL 19		see CRINONE GEL 4% VAG.....	143
see Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg.....	125	see CRINONE GEL 8% VAG.....	143
Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg	125	see ENDOMETRIN SUP 100MG	143
Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg	125	<i>progesterone cap 100 mg</i>	130
Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg	125	<i>progesterone cap 200 mg</i>	130
Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg.....	125	PROLENZA SOL 0.07%	129
Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg	125	PROMACTA PAK 25MG	114
PREPOPIK PAK	116	PROMACTA POW 12.5MG	114
PREVALITE		PROMACTA TAB 12.5MG	114
see Cholestyramine Light Powder 4 gm/dose	57	PROMACTA TAB 25MG	115
see Cholestyramine Light Powder Packets 4 gm	57	PROMACTA TAB 50MG	115
PREZCOBIX TAB 800-150	78	PROMACTA TAB 75MG	115
PREZISTA SUS 100MG/ML	78	Promethazine & Phenylephrine Syrup 6.25-5 mg/5ml.....	97
		<i>promethazine hcl suppos 12.5 mg</i>	56
		Promethazine Hcl Suppos 12.5 mg	56
		<i>promethazine hcl suppos 25 mg</i>	56
		Promethazine Hcl Suppos 25 mg	56

Promethazine Hcl Suppos 50 mg	56	see Sodium Chloride Soln Nebu 7%	97
<i>promethazine hcl syrup 6.25 mg/5ml</i>	56	PX FOLIC ACID	
<i>promethazine hcl tab 12.5 mg</i>	56	see Folic Acid Tab 400 mcg.....	114
<i>promethazine hcl tab 25 mg</i>	56	PX STOP SMOKING AID	
<i>promethazine hcl tab 50 mg</i>	56	see Nicotine Polacrilex Gum 2 mg	134
PROMETHAZINE VC		see Nicotine Polacrilex Gum 4 mg	134
see Promethazine & Phenylephrine Syrup		see Nicotine Polacrilex Lozenge 2 mg	135
6.25-5 mg/5ml.....	97	see Nicotine Polacrilex Lozenge 4 mg	136
PROMETHAZINE VC/CODEINE		PYLERA CAP	142
see Promethazine-Phenylephrine-Codeine		<i>pyrazinamide tab 500 mg</i>	64
Syrup 6.25-5-10 mg/5ml	97	<i>pyridostigmine bromide oral soln 60 mg/5ml</i> ..	64
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	97	<i>pyridostigmine bromide tab 60 mg</i>	64
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	97	<i>pyridostigmine bromide tab er 180 mg</i>	64
Promethazine-Phenylephrine-Codeine Syrup		<i>pyrimethamine tab 25 mg</i>	63
6.25-5-10 mg/5ml	97	Q	
PROMETHEGAN		QC FOLIC ACID	
see Promethazine Hcl Suppos 12.5 mg.....	56	see Folic Acid Tab 800 mcg.....	114
see Promethazine Hcl Suppos 25 mg	56	QELBREE CAP 100MG ER.....	16
see Promethazine Hcl Suppos 50 mg	56	QELBREE CAP 150MG ER.....	16
<i>propafenone hcl cap er 12hr 225 mg</i>	38	QELBREE CAP 200MG ER.....	16
<i>propafenone hcl cap er 12hr 325 mg</i>	38	QSYMIA CAP 11.25-69.....	15
<i>propafenone hcl cap er 12hr 425 mg</i>	38	QSYMIA CAP 15-92MG.....	15
<i>propafenone hcl tab 150 mg</i>	38	QSYMIA CAP 3.75-23.....	15
<i>propafenone hcl tab 225 mg</i>	38	QSYMIA CAP 7.5-46MG.....	15
<i>propafenone hcl tab 300 mg</i>	39	<i>quetiapine fumarate tab 100 mg</i>	75
<i>propranolol hcl cap er 24hr 120 mg</i>	81	<i>quetiapine fumarate tab 150 mg</i>	75
<i>propranolol hcl cap er 24hr 160 mg</i>	81	<i>quetiapine fumarate tab 200 mg</i>	75
<i>propranolol hcl cap er 24hr 60 mg</i>	81	<i>quetiapine fumarate tab 25 mg</i>	75
<i>propranolol hcl cap er 24hr 80 mg</i>	81	<i>quetiapine fumarate tab 300 mg</i>	75
<i>propranolol hcl oral soln 20 mg/5ml</i>	81	<i>quetiapine fumarate tab 400 mg</i>	75
<i>propranolol hcl oral soln 40 mg/5ml</i>	81	<i>quetiapine fumarate tab 50 mg</i>	75
<i>propranolol hcl tab 10 mg</i>	81	<i>quetiapine fumarate tab er 24hr 150 mg</i>	75
<i>propranolol hcl tab 20 mg</i>	81	<i>quetiapine fumarate tab er 24hr 200 mg</i>	75
<i>propranolol hcl tab 40 mg</i>	81	<i>quetiapine fumarate tab er 24hr 300 mg</i>	75
<i>propranolol hcl tab 60 mg</i>	81	<i>quetiapine fumarate tab er 24hr 400 mg</i>	75
<i>propranolol hcl tab 80 mg</i>	81	<i>quetiapine fumarate tab er 24hr 50 mg</i>	75
<i>propylthiouracil tab 50 mg</i>	139	<i>quinapril hcl tab 10 mg</i>	59
<i>protriptyline hcl tab 10 mg</i>	50	<i>quinapril hcl tab 20 mg</i>	59
<i>protriptyline hcl tab 5 mg</i>	50	<i>quinapril hcl tab 40 mg</i>	59
<i>pseudoephed-bromphen-dm syrup 30-2-10</i>		<i>quinapril hcl tab 5 mg</i>	59
<i>mg/5ml</i>	97	<i>quinapril-hydrochlorothiazide</i>	
Pseudoephed-Bromphen-Dm Syrup 30-2-10		see ACCURETIC TAB 10-12.5	61
<i>mg/5ml</i>	97	<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i> ..	62
PULMICORT INH 180MCG	40	<i>quinapril-hydrochlorothiazide tab 20-25 mg</i> ..	63
PULMICORT INH 90MCG	40	<i>quinidine gluconate tab er 324 mg</i>	38
PULMOSAL		<i>quinine sulfate cap 324 mg</i>	64
		QULIPTA TAB 10MG.....	120

QULIPTA TAB 30MG	120	see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	87
QULIPTA TAB 60MG	120	regorafenib	
QUVIVIQ TAB 25MG	116	see STIVARGA TAB 40MG	70
QUVIVIQ TAB 50MG	116	RELENZA MIS DISKHALE	80
R		relugolix-estradiol-norethindrone acetate	
RA FOLIC ACID		see MYFEMBREE TAB	108
see Folic Acid Tab 400 mcg	114	repaglinide tab 0.5 mg	53
see Folic Acid Tab 800 mcg	114	repaglinide tab 1 mg	53
RA MINI NICOTINE		repaglinide tab 2 mg	53
see Nicotine Polacrilex Lozenge 2 mg	135	RESTASIS EMU 0.05% OP	128
see Nicotine Polacrilex Lozenge 4 mg	136	RESTASIS MUL EMU 0.05% OP	128
RA NICOTINE		RETEVMO CAP 40MG	69
see Nicotine Polacrilex Gum 2 mg	134	RETEVMO CAP 80MG	69
see Nicotine Polacrilex Gum 4 mg	134	revefenacin	
see Nicotine Td Patch 24hr 14 mg/24hr	137	see YUPELRI SOL	39
see Nicotine Td Patch 24hr 21 mg/24hr	137	REVLIMID CAP 10MG	123
see Nicotine Td Patch 24hr 7 mg/24hr	136	REVLIMID CAP 15MG	123
RA NICOTINE GUM		REVLIMID CAP 2.5MG	123
see Nicotine Polacrilex Gum 2 mg	134	REVLIMID CAP 20MG	123
see Nicotine Polacrilex Gum 4 mg	134	REVLIMID CAP 25MG	123
RA NICOTINE POLACRILEX		REVLIMID CAP 5MG	123
see Nicotine Polacrilex Gum 2 mg	134	REYVOW TAB 100MG	120
see Nicotine Polacrilex Gum 4 mg	135	REYVOW TAB 50MG	120
see Nicotine Polacrilex Lozenge 2 mg	135	RHOFADE CRE 1%	104
see Nicotine Polacrilex Lozenge 4 mg	136	ribavirin cap 200 mg	79
RA NICOTINE TRANSDERMAL S		ribavirin tab 200 mg	79
see Nicotine Td Patch 24hr 21 mg/24hr	137	ribociclib succinate	
see Nicotine Td Patch 24hr 7 mg/24hr	137	see KISQALI TAB 200DOSE	69
rabeprazole sodium ec tab 20 mg	142	see KISQALI TAB 400DOSE	69
RAGWITEK SUB	22	see KISQALI TAB 600DOSE	69
raloxifene hcl tab 60 mg	106	ribociclib succinate-letrozole	
raltegravir potassium		see KISQALI 200 PAK FEMARA	67
see ISENTRESS CHW 100MG	77	see KISQALI 400 PAK FEMARA	67
see ISENTRESS CHW 25MG	77	see KISQALI 600 PAK FEMARA	67
see ISENTRESS HD TAB 600MG	78	rifabutin cap 150 mg	64
see ISENTRESS POW 100MG	78	rifampin cap 150 mg	64
see ISENTRESS TAB 400MG	78	rifampin cap 300 mg	64
ramelteon tab 8 mg	116	RIFATER TAB	64
ramipril cap 1.25 mg	59	rifaximin	
ramipril cap 10 mg	59	see XIFAXAN TAB 550MG	35
ramipril cap 2.5 mg	59	rilpivirine hcl	
ramipril cap 5 mg	59	see EDURANT TAB 25MG	77
ranolazine tab er 12hr 1000 mg	36	riluzole tab 50 mg	126
ranolazine tab er 12hr 500 mg	36	rimantadine hydrochloride tab 100 mg	80
rasagiline mesylate tab 0.5 mg (base equiv)	73	rimegepant sulfate	
rasagiline mesylate tab 1 mg (base equiv)	73	see NURTEC TAB 75MG ODT	120
RECLIPSEN			

RINVOQ TAB 15MG ER	22
RINVOQ TAB 30MG ER	22
RINVOQ TAB 45MG ER	22
riociguat	
see ADEMPAS TAB 0.5MG	86
see ADEMPAS TAB 1.5MG	86
see ADEMPAS TAB 1MG	86
see ADEMPAS TAB 2.5MG	86
see ADEMPAS TAB 2MG	86
risedronate sodium tab 150 mg	106
risedronate sodium tab 30 mg	106
risedronate sodium tab 35 mg	106
risedronate sodium tab 5 mg	106
risedronate sodium tab delayed release 35 mg	106
risperidone orally disintegrating tab 0.25 mg	74
risperidone orally disintegrating tab 0.5 mg	74
risperidone orally disintegrating tab 1 mg	74
risperidone orally disintegrating tab 2 mg	74
risperidone orally disintegrating tab 3 mg	74
risperidone orally disintegrating tab 4 mg	74
risperidone soln 1 mg/ml	74
risperidone tab 0.25 mg	74
risperidone tab 0.5 mg	74
risperidone tab 1 mg	74
risperidone tab 2 mg	74
risperidone tab 3 mg	74
risperidone tab 4 mg	74
RITEFLO MIS	120
ritonavir	
see NORVIR POW 100MG	78
see NORVIR TAB 100MG	78
ritonavir tab 100 mg	78
rivaroxaban	
see XARELTO STAR TAB 15/20MG	42
see XARELTO SUS 1MG/ML	42
see XARELTO TAB 10MG	42
see XARELTO TAB 15MG	42
see XARELTO TAB 2.5MG	42
see XARELTO TAB 20MG	42
rivastigmine tartrate cap 1.5 mg (base equivalent)	131
rivastigmine tartrate cap 3 mg (base equivalent)	131
rivastigmine tartrate cap 4.5 mg (base equivalent)	131
rivastigmine tartrate cap 6 mg (base equivalent)	131
rivastigmine td patch 24hr 13.3 mg/24hr	131
rivastigmine td patch 24hr 4.6 mg/24hr	131
rivastigmine td patch 24hr 9.5 mg/24hr	131
RIVELSA	
see Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg ð Est 0.01 mg	88
rizatriptan benzoate oral disintegrating tab 10 mg (base eq)	120
rizatriptan benzoate oral disintegrating tab 5 mg (base eq)	120
rizatriptan benzoate tab 10 mg (base equivalent)	121
rizatriptan benzoate tab 5 mg (base equivalent)	121
roflumilast (topical)	
see ZORYVE CRE 0.3%	101
roflumilast tab 250 mcg	39
roflumilast tab 500 mcg	39
ropinirole hydrochloride tab 0.25 mg	73
ropinirole hydrochloride tab 0.5 mg	72
ropinirole hydrochloride tab 1 mg	73
ropinirole hydrochloride tab 2 mg	73
ropinirole hydrochloride tab 3 mg	73
ropinirole hydrochloride tab 4 mg	73
ropinirole hydrochloride tab 5 mg	73
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)	73
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)	73
ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)	73
ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)	73
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)	73
rosuvastatin calcium tab 10 mg	58
rosuvastatin calcium tab 20 mg	58
rosuvastatin calcium tab 40 mg	58
rosuvastatin calcium tab 5 mg	58
rotigotine	
see NEUPRO DIS 1MG/24HR	72
see NEUPRO DIS 2MG/24HR	72
see NEUPRO DIS 3MG/24HR	72
see NEUPRO DIS 4MG/24HR	72
see NEUPRO DIS 6MG/24HR	72

see NEUPRO DIS 8MG/24HR	72
ROWEEPRA	
see Levetiracetam Tab 500 mg	45
ROZLYTREK CAP 100MG	69
ROZLYTREK CAP 200MG	70
rufinamide susp 40 mg/ml	45
rufinamide tab 200 mg	45
rufinamide tab 400 mg	45
RYBELSUS TAB 14MG	52
RYBELSUS TAB 3MG	52
RYBELSUS TAB 7MG	52
RYDAPT CAP 25MG	70
RYTARY CAP 145MG	73
RYTARY CAP 195MG	73
RYTARY CAP 245MG	73
RYTARY CAP 95MG	73
S	
sacubitril-valsartan	
see ENTRESTO TAB 24-26MG.....	84
see ENTRESTO TAB 49-51MG.....	84
see ENTRESTO TAB 97-103MG.....	84
salmeterol xinafoate	
see SEREVENT DIS AER 50MCG	41
salsalate tab 750 mg	25
SANCUSO DIS 3.1MG	55
sapropterin dihydrochloride powder packet 100 mg	107
Sapropterin Dihydrochloride Powder Packet 100 mg	107
sapropterin dihydrochloride powder packet 500 mg	107
Sapropterin Dihydrochloride Powder Packet 500 mg	107
sapropterin dihydrochloride tab 100 mg	107
Sapropterin Dihydrochloride Tab 100 mg	107
saxagliptin hcl tab 2.5 mg (base equiv)	52
saxagliptin hcl tab 5 mg (base equiv)	52
saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg	51
saxagliptin-metformin hcl tab er 24hr 5-1000 mg	51
saxagliptin-metformin hcl tab er 24hr 5-500 mg	51
scopolamine td patch 72hr 1 mg/3days	55
segesterone acetate-ethinyl estradiol	
see ANNOVERA MIS	95
selegiline hcl cap 5 mg	73
selegiline hcl tab 5 mg	73
selenium sulfide lotion 2.5%	101
selexipag	
see UPTRAVI PACK TAB 200/800	85
see UPTRAVI TAB 1000MCG	85
see UPTRAVI TAB 1200MCG	86
see UPTRAVI TAB 1400MCG	86
see UPTRAVI TAB 1600MCG	86
see UPTRAVI TAB 200MCG	85
see UPTRAVI TAB 400MCG	85
see UPTRAVI TAB 600MCG	85
see UPTRAVI TAB 800MCG	85
selpercatinib	
see RETEVMO CAP 40MG	69
see RETEVMO CAP 80MG	69
selumetinib sulfate	
see KOSELUGO CAP 10MG	69
see KOSELUGO CAP 25MG	69
semaglutide	
see OZEMPIC INJ 2MG/3ML	52
see OZEMPIC INJ 4MG/3ML	52
see OZEMPIC INJ 8MG/3ML	52
see RYBELSUS TAB 14MG	52
see RYBELSUS TAB 3MG	52
see RYBELSUS TAB 7MG	52
serdexmethylphenidate chloride	
dexmethylphenidate hcl	
see AZSTARYS CAP 26.1-5.2	17
see AZSTARYS CAP 39.2-7.8	17
see AZSTARYS CAP 52.3-10	17
SEREVENT DIS AER 50MCG	41
sertraline hcl oral concentrate for solution 20 mg/ml	48
sertraline hcl tab 100 mg	48
sertraline hcl tab 25 mg	48
sertraline hcl tab 50 mg	48
SETLAKIN	
see Levonorgestrel & Ethinyl Estradiol (91-Day Tab 0.15-0.03 mg	89
sevelamer carbonate packet 0.8 gm	111
sevelamer carbonate packet 2.4 gm	111
sevelamer carbonate tab 800 mg	111
sevelamer hcl tab 400 mg	111
sevelamer hcl tab 800 mg	111
SHAROBEL	
see Norethindrone Tab 0.35 mg	95
short ragweed pollen allergen extract	

see RAGWITEK SUB	22	see Folic Acid Tab 400 mcg.....	114
SHUR-SEAL GEL 2%.....	143	SM NICOTINE	
SIKLOS TAB 1000MG	113	see Nicotine Polacrilex Gum 4 mg	135
SIKLOS TAB 100MG	113	see Nicotine Polacrilex Lozenge 2 mg	135
sildenafil citrate for suspension 10 mg/ml	85	SM NICOTINE POLACRILEX	
sildenafil citrate tab 100 mg	85	see Nicotine Polacrilex Gum 2 mg	134
sildenafil citrate tab 20 mg	85	see Nicotine Polacrilex Gum 4 mg	135
sildenafil citrate tab 25 mg	85	see Nicotine Polacrilex Lozenge 4 mg	136
sildenafil citrate tab 50 mg	85	SM NICOTINE TRANSDERMAL S	
silodosin cap 4 mg	112	see Nicotine Td Patch 24hr 14 mg/24hr.....	137
silodosin cap 8 mg	112	see Nicotine Td Patch 24hr 21 mg/24hr.....	137
silver sulfadiazine cream 1%	101	see Nicotine Td Patch 24hr 7 mg/24hr.....	137
Silver Sulfadiazine Cream 1%.....	101	sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	116
SIMBRINZA SUS 1-0.2%	127	sodium chloride soln nebu 0.9%	97
SIMLIYA		sodium chloride soln nebu 10%	97
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)	87	sodium chloride soln nebu 3%	97
SIMPESSE		Sodium Chloride Soln Nebu 3%	97
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7).....	89	sodium chloride soln nebu 7%	97
simvastatin tab 10 mg	58	Sodium Chloride Soln Nebu 7%	97
simvastatin tab 20 mg	58	sodium fluoride	
simvastatin tab 40 mg	58	see FLUORABON DRO	121
simvastatin tab 5 mg	58	sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)	121
simvastatin tab 80 mg	58	sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)	121
siponimod fumarate		sodium fluoride chew tab 1 mg f (from 2.2 mg naf)	121
see MAYZENT PAK STARTER	132	Sodium Fluoride Soln 0.25 mg/drop F (From 0.55 mg/drop Naf)	121
see MAYZENT TAB 0.25MG.....	132	sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)	121
see MAYZENT TAB 1MG	132	sodium fluoride tab 0.5 mg f (from 1.1 mg naf)	121
see MAYZENT TAB 2MG	132	sodium fluoride tab 1 mg f (from 2.2 mg naf)	121
sirolimus oral soln 1 mg/ml	124	sodium phenylbutyrate oral powder 3 gm/teaspoonful	107
sirolimus tab 0.5 mg	124	sodium phenylbutyrate tab 500 mg	107
sirolimus tab 1 mg	124	sodium picosulfate-magnesium oxide-anhydrous citric acid	
sirolimus tab 2 mg	124	see CLENPIQ SOL.....	116
SIRTURO TAB 100MG	64	see PREPOPIK PAK.....	116
SIRTURO TAB 20MG	64	Sodium Polystyrene Sulfonate Oral Susp 15 gm/60ml	124
sitagliptin phosphate		sodium polystyrene sulfonate powder	124
see JANUVIA TAB 100MG	52	sofosbuvir-velpatasvir	
see JANUVIA TAB 25MG	52	see EPCLUSA PAK 150-37.5.....	79
see JANUVIA TAB 50MG	52		
sitagliptin-metformin hcl			
see JANUMET TAB 50-1000	50		
see JANUMET TAB 50-500MG.....	50		
see JANUMET XR TAB 100-1000.....	51		
see JANUMET XR TAB 50-1000	51		
see JANUMET XR TAB 50-500MG.....	51		
SM FOLIC ACID			

see EPCLUSA PAK 200-50MG	79	see BREATHERITE MIS SPACER	118
see EPCLUSA TAB 200-50MG	79	see BREATHERITE MIS W/MASK	118
see EPCLUSA TAB 400-100.....	79	see COMPACT SPAC MIS CHAMBER.....	118
sofosbuvir-velpatasvir-voxilaprevir		see COMPACT SPAC MIS LG MASK.....	118
see VOSEVI TAB.....	79	see COMPACT SPAC MIS MD MASK.....	118
solifenacin succinate tab 10 mg	142	see COMPACT SPAC MIS SM MASK.....	119
solifenacin succinate tab 5 mg	142	see EASIVENT MIS.....	119
SOLIQUA INJ 100/33.....	51	see EASIVENT MIS MASK LG	119
solriamfetol hcl		see EASIVENT MIS MASK MED.....	119
see SUNOSI TAB 150MG	16	see EASIVENT MIS MASK SM	119
see SUNOSI TAB 75MG.....	16	see FLEXICHAMBER MIS	119
sonidegib phosphate		see HOLD CHAMBER MIS ADLT LG	119
see ODOMZO CAP 200MG	66	see HOLD CHAMBER MIS MEDIUM.....	119
SOOLANTRA CRE 1%.....	104	see HOLD CHAMBER MIS SMALL	119
sorafenib tosylate		see INSPIRACHAMB MIS LARGE	119
see NEXAVAR TAB 200MG	69	see INSPIRACHAMB MIS MEDIUM	119
sorafenib tosylate tab 200 mg (base equivalent)		see INSPIRACHAMB MIS MOUTHPC.....	119
.....	70	see INSPIRACHAMB MIS SMALL.....	119
sotalol hcl (afib/afl) tab 120 mg	81	see INSPIREASE MIS DD SYST.....	119
sotalol hcl (afib/afl) tab 160 mg	81	see LITEAIRE MIS.....	119
sotalol hcl (afib/afl) tab 80 mg	81	see MICROCHAMBER MIS	119
sotalol hcl tab 120 mg	81	see MICROSPACER MIS	119
sotalol hcl tab 160 mg	81	see OPTICHAMBER MIS ADV LRG.....	119
sotalol hcl tab 240 mg	81	see OPTICHAMBER MIS ADV MED	119
sotalol hcl tab 80 mg	81	see OPTICHAMBER MIS ADV SM.....	119
spacer/aerosol-holding chamber supplies -		see OPTICHAMBER MIS DIA LG	119
masks		see OPTICHAMBER MIS DIA MD	120
see FLEXICHAMBER MIS MASK LRG	119	see OPTICHAMBER MIS DIA SM	120
see FLEXICHAMBER MIS MASK SM.....	119	see OPTICHAMBER MIS DIAMOND	120
spacer/aerosol-holding chambers		see OPTIHALER MIS.....	120
see AERCHMBR PLS MIS FLOW-VU	118	see POCKET CHAMB MIS	120
see AERCHMBR PLS MIS LRG MASK	118	see POCKET SPACE MIS	120
see AERCHMBR PLS MIS MED MASK.....	118	see PROCHAMBER MIS VHC	120
see AERCHMBR PLS MIS SM MASK	118	see RITEFLO MIS	120
see AERCHMBR Z- MIS STAT PLS.....	118	see VORTEX VALVE MIS CHAMBER	120
see AEROCHAMBER MIS CHAMBER	118	see WATCHHALER MIS	120
see AEROCHAMBER MIS FLOSIGNA	118	spinosad susp 0.9%	104
see AEROCHAMBER MIS MV.....	118	SPIRIVA AER 1.25MCG	39
see AEROCHAMBER MIS PLUS	118	SPIRIVA CAP HANDIHLR	39
see AEROVENT MIS PLUS.....	118	SPIRIVA SPR 2.5MCG.....	39
see BREATHE EASE MIS LG MASK.....	118	spironolactone & hydrochlorothiazide tab 25-25 mg	105
see BREATHE EASE MIS MED MASK	118	spironolactone susp 25 mg/5ml	105
see BREATHE EASE MIS SM MASK.....	118	spironolactone tab 100 mg	106
see BREATHERITE MIS	118	spironolactone tab 25 mg	105
see BREATHERITE MIS LG MASK	118	spironolactone tab 50 mg	105
see BREATHERITE MIS MED MASK	118	SPRINTEC 28	
see BREATHERITE MIS SM MASK	118		

see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg	94
SPRYCEL TAB 100MG.....	70
SPRYCEL TAB 140MG.....	70
SPRYCEL TAB 20MG.....	70
SPRYCEL TAB 50MG.....	70
SPRYCEL TAB 70MG.....	70
SPRYCEL TAB 80MG.....	70
SPS	
see Sodium Polystyrene Sulfonate Oral Susp 15 gm/60ml.....	124
SRONYX	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	89
SSD	
see Silver Sulfadiazine Cream 1%	101
STIOLTO AER 2.5-2.5	41
STIVARGA TAB 40MG	70
STRIVERDI AER 2.5MCG	41
SUBVENITE	
see Lamotrigine Tab 100 mg.....	44
see Lamotrigine Tab 150 mg.....	44
see Lamotrigine Tab 200 mg.....	44
see Lamotrigine Tab 25 mg.....	44
SUBVENITE STARTER KIT/BLU	
see Lamotrigine Tab 35 X 25 mg Starter Kit..	44
SUBVENITE STARTER KIT/GRE	
see Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit.....	44
SUBVENITE STARTER KIT/OR A	
see Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit.....	44
sucralfate tab 1 gm	141
sucroferric oxyhydroxide	
see VELPHORO CHW 500MG	111
sulconazole nitrate cream 1%	100
sulconazole nitrate solution 1%	100
sulfacetamide sodium lotion 10% (acne)	99
sulfacetamide sodium ophth oint 10%	127
sulfacetamide sodium ophth soln 10%	127
sulfacetamide sodium w/ sulfur cleansing pad 10-4%	99
Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%	99
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	128
sulfadiazine tab 500 mg	138
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	35
Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml.....	35
sulfamethoxazole-trimethoprim tab 400-80 mg	35
sulfamethoxazole-trimethoprim tab 800-160 mg	35
SULFAMEZ WASH	
see Sulfacetamide Sodium W/ Sulfur Emulsion 10-1%	99
sulfasalazine tab 500 mg	111
sulfasalazine tab delayed release 500 mg	111
SULFATRIM PEDIATRIC	
see Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml	35
sulindac tab 150 mg	24
sulindac tab 200 mg	24
sumatriptan nasal spray 20 mg/act	121
sumatriptan nasal spray 5 mg/act	121
sumatriptan succinate	
see ONZETRA XSAI MIS 11MG	120
see ZEMBRACE SYM INJ 3/0.5ML.....	121
sumatriptan succinate inj 6 mg/0.5ml	121
sumatriptan succinate solution auto-injector 4 mg/0.5ml	121
sumatriptan succinate solution auto-injector 6 mg/0.5ml	121
sumatriptan succinate solution cartridge 4 mg/0.5ml	121
sumatriptan succinate solution cartridge 6 mg/0.5ml	121
sumatriptan succinate tab 100 mg	121
sumatriptan succinate tab 25 mg	121
sumatriptan succinate tab 50 mg	121
sunitinib malate cap 12.5 mg (base equivalent)	70
sunitinib malate cap 25 mg (base equivalent)	70
sunitinib malate cap 37.5 mg (base equivalent)	70
sunitinib malate cap 50 mg (base equivalent)	70
SUNOSI TAB 150MG	16
SUNOSI TAB 75MG	16
suvorexant	
see BELSOMRA TAB 10MG	116
see BELSOMRA TAB 15MG	116
see BELSOMRA TAB 20MG	116

see BELSOMRA TAB 5MG	116
SYEDA	
see Drospirenone-Ethinyl Estradiol Tab 3-0.03	
mg	88
SYMBICORT AER 160-4.5	41
SYMBICORT AER 80-4.5	41
SYMLINPEN 60 INJ 1000MCG	50
SYMLNPEN 120 INJ 1000MCG.....	50
SYMPROIC TAB 0.2MG	111
SYMTUZA TAB.....	78
SYNAREL SOL 2MG/ML.....	106
SYNJARDY TAB	51
SYNJARDY TAB 12.5-500.....	51
SYNJARDY TAB 5-1000MG	51
SYNJARDY TAB 5-500MG	51
SYNJARDY XR TAB	51
SYNJARDY XR TAB 10-1000.....	51
SYNJARDY XR TAB 25-1000.....	51
SYNJARDY XR TAB 5-1000MG	51
SYNTHROID TAB 100MCG.....	140
SYNTHROID TAB 112MCG.....	140
SYNTHROID TAB 125MCG.....	140
SYNTHROID TAB 137MCG.....	140
SYNTHROID TAB 150MCG.....	140
SYNTHROID TAB 175MCG.....	140
SYNTHROID TAB 200MCG.....	141
SYNTHROID TAB 25MCG	140
SYNTHROID TAB 300MCG.....	141
SYNTHROID TAB 50MCG	140
SYNTHROID TAB 75MCG	140
SYNTHROID TAB 88MCG	140
T	
TABLOID TAB 40MG	65
tacrolimus cap 0.5 mg	124
tacrolimus cap 1 mg	124
tacrolimus cap 5 mg	124
tacrolimus oint 0.03%	103
tacrolimus oint 0.1%	103
tadalafil tab 10 mg	85
tadalafil tab 2.5 mg	85
tadalafil tab 20 mg	85
tadalafil tab 20 mg (pah)	85
Tadalafil Tab 20 mg (Pah)	85
tadalafil tab 5 mg	85
tafluprost preservative free (pf) ophth soln 0.0015%	129
TAGRISSO TAB 40MG	65
TAGRISSO TAB 80MG	66
TALICIA CAP	142
tamoxifen citrate tab 10 mg (base equivalent)	66
tamoxifen citrate tab 20 mg (base equivalent)	66
tamsulosin hcl cap 0.4 mg	112
TARINA 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24).....	93
TARINA FE 1/20 EQ	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg.....	92
tasimelteon capsule 20 mg	116
TAVALISSE TAB 100MG	112
TAVALISSE TAB 150MG	112
TAYSOFY	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Cap 1 mg-20 mcg (24).....	93
tazarotene (acne)	
see ARAZLO LOT 0.045%	97
tazarotene cream 0.1%	101
tazarotene gel 0.05%	101
tazarotene gel 0.1%	101
TAZTIA XT	
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 120 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 180 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 240 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 300 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 360 mg.....	83
telmisartan tab 20 mg	60
telmisartan tab 40 mg	60
telmisartan tab 80 mg	60
telmisartan-amlodipine tab 40-10 mg	63
telmisartan-amlodipine tab 40-5 mg	63
telmisartan-amlodipine tab 80-10 mg	63
telmisartan-amlodipine tab 80-5 mg	63
telmisartan-hydrochlorothiazide tab 40-12.5 mg	63
telmisartan-hydrochlorothiazide tab 80-12.5 mg	63
telmisartan-hydrochlorothiazide tab 80-25 mg	63
temazepam cap 15 mg	115

<i>temazepam cap 22.5 mg</i>	115
<i>temazepam cap 30 mg</i>	115
<i>temazepam cap 7.5 mg</i>	115
<i>temozolomide cap 100 mg</i>	64
<i>temozolomide cap 140 mg</i>	64
<i>temozolomide cap 180 mg</i>	64
<i>temozolomide cap 20 mg</i>	64
<i>temozolomide cap 250 mg</i>	64
<i>temozolomide cap 5 mg</i>	64
TENCON	
see Butalbital-Acetaminophen Tab 50-325 mg	24
<i>tenofovir disoproxil fumarate tab 300 mg</i>	78
<i>terazosin hcl cap 1 mg (base equivalent)</i>	60
<i>terazosin hcl cap 10 mg (base equivalent)</i>	60
<i>terazosin hcl cap 2 mg (base equivalent)</i>	60
<i>terazosin hcl cap 5 mg (base equivalent)</i>	60
<i>terbinafine hcl tab 250 mg</i>	55
<i>terbutaline sulfate tab 2.5 mg</i>	41
<i>terbutaline sulfate tab 5 mg</i>	41
<i>terconazole vaginal cream 0.4%</i>	143
<i>terconazole vaginal cream 0.8%</i>	143
<i>terconazole vaginal suppos 80 mg</i>	143
<i>teriflunomide tab 14 mg</i>	133
<i>teriflunomide tab 7 mg</i>	133
<i>testosterone</i>	
see NATESTO GEL 5.5MG.....	34
<i>testosterone td gel 10mg/act (2%)</i>	34
<i>testosterone td gel 12.5 mg/act (1%)</i>	34
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	34
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	34
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	34
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	34
<i>testosterone td gel 50 mg/5gm (1%)</i>	34
<i>testosterone td soln 30 mg/act</i>	34
<i>tetrabenazine tab 12.5 mg</i>	132
<i>tetrabenazine tab 25 mg</i>	132
<i>tetracycline hcl cap 250 mg</i>	139
<i>tetracycline hcl cap 500 mg</i>	139
TEXACORT SOL 2.5%.....	103
TGT NICOTINE STEP ONE	
see Nicotine Td Patch 24hr 21 mg/24hr	138
TGT NICOTINE STEP THREE	
see Nicotine Td Patch 24hr 7 mg/24hr	137
TGT NICOTINE STEP TWO	
see Nicotine Td Patch 24hr 14 mg/24hr	137
<i>thalidomide</i>	
see THALOMID CAP 100MG	123
see THALOMID CAP 150MG	123
see THALOMID CAP 200MG	123
see THALOMID CAP 50MG	123
THALOMID CAP 100MG	123
THALOMID CAP 150MG	123
THALOMID CAP 200MG	123
THALOMID CAP 50MG	123
<i>theophylline elixir 80 mg/15ml</i>	42
Theophylline Elixir 80 mg/15ml	42
<i>theophylline soln 80 mg/15ml</i>	42
<i>theophylline tab er 12hr 300 mg</i>	42
<i>theophylline tab er 12hr 450 mg</i>	42
<i>theophylline tab er 24hr 400 mg</i>	42
<i>theophylline tab er 24hr 600 mg</i>	42
<i>thioguanine</i>	
see TABLOID TAB 40MG	65
<i>thioridazine hcl tab 10 mg</i>	76
<i>thioridazine hcl tab 100 mg</i>	76
<i>thioridazine hcl tab 25 mg</i>	76
<i>thioridazine hcl tab 50 mg</i>	76
<i>thiothixene cap 1 mg</i>	76
<i>thiothixene cap 10 mg</i>	76
<i>thiothixene cap 2 mg</i>	76
<i>thiothixene cap 5 mg</i>	76
THRIVE	
see Nicotine Polacrilex Gum 2 mg	134
TIADYLT ER	
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 120 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 180 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 240 mg.....	82
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 300 mg.....	83
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 360 mg.....	83
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 420 mg.....	83
<i>tiagabine hcl tab 12 mg</i>	46
<i>tiagabine hcl tab 16 mg</i>	46
<i>tiagabine hcl tab 2 mg</i>	46
<i>tiagabine hcl tab 4 mg</i>	46
<i>ticagrelor</i>	
see BRILINTA TAB 60MG	113
see BRILINTA TAB 90MG	113

TILIA FE	
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg	91
timolol maleate ophth gel forming soln 0.25%	
.....	126
timolol maleate ophth gel forming soln 0.5%	126
timolol maleate ophth soln 0.25%	126
timolol maleate ophth soln 0.5%	126
timolol maleate ophth soln 0.5% (once-daily)	
.....	126
timolol maleate preservative free ophth soln 0.25%	126
timolol maleate preservative free ophth soln 0.5%	126
timolol maleate tab 10 mg	81
timolol maleate tab 20 mg	81
timolol maleate tab 5 mg	81
timothy grass pollen allergen extract	
see GRASTEK SUB 2800BAU.....	22
tinidazole tab 250 mg	35
tinidazole tab 500 mg	35
tiopronin tab 100 mg	112
tiotropium bromide monohydrate	
see SPIRIVA AER 1.25MCG.....	39
see SPIRIVA CAP HANDIHLR.....	39
see SPIRIVA SPR 2.5MCG	39
tiotropium bromide monohydrate inhal cap 18 mcg (base equiv)	39
tiotropium bromide-olodaterol hcl	
see STIOLTO AER 2.5-2.5	41
tirzepatide	
see MOUNJARO INJ 10MG/0.5	52
see MOUNJARO INJ 12.5/0.5	52
see MOUNJARO INJ 15MG/0.5	52
see MOUNJARO INJ 2.5/0.5	52
see MOUNJARO INJ 5MG/0.5	52
see MOUNJARO INJ 7.5/0.5	52
TIVICAY PD TAB 5MG	78
TIVICAY TAB 10MG.....	78
TIVICAY TAB 25MG.....	78
TIVICAY TAB 50MG.....	78
tizanidine hcl cap 2 mg (base equivalent)	125
tizanidine hcl cap 4 mg (base equivalent)	125
tizanidine hcl cap 6 mg (base equivalent)	125
tizanidine hcl tab 2 mg (base equivalent)	125
tizanidine hcl tab 4 mg (base equivalent)	125
TOBRADEX OIN 0.3-0.1%.....	128
tobramycin (ophth)	
see TOBREX OIN 0.3% OP	128
tobramycin nebu soln 300 mg/4ml	22
tobramycin nebu soln 300 mg/5ml	22
tobramycin ophth soln 0.3%	127
tobramycin-dexamethasone	
see TOBRADEX OIN 0.3-0.1%.....	128
tobramycin-dexamethasone ophth susp 0.3-0.1%	
.....	128
TOBREX OIN 0.3% OP	128
TODAY SPONGE MIS	143
tofacitinib citrate	
see XELJANZ SOL 1MG/ML	22
see XELJANZ TAB 10MG	22
see XELJANZ TAB 5MG	22
see XELJANZ XR TAB 11MG.....	23
see XELJANZ XR TAB 22MG.....	23
tolcapone tab 100 mg	71
tolmetin sodium cap 400 mg	24
tolmetin sodium tab 600 mg	24
tolterodine tartrate cap er 24hr 2 mg	142
tolterodine tartrate cap er 24hr 4 mg	142
tolterodine tartrate tab 1 mg	142
tolterodine tartrate tab 2 mg	142
tolvaptan tab 15 mg	108
tolvaptan tab 30 mg	108
topiramate	
see TROKENDI XR CAP 100MG.....	46
see TROKENDI XR CAP 200MG.....	46
see TROKENDI XR CAP 25MG.....	46
see TROKENDI XR CAP 50MG.....	46
topiramate cap er 24hr 100 mg	45
topiramate cap er 24hr 200 mg	45
topiramate cap er 24hr 25 mg	45
topiramate cap er 24hr 50 mg	45
topiramate sprinkle cap 15 mg	45
topiramate sprinkle cap 25 mg	45
topiramate tab 100 mg	46
topiramate tab 200 mg	46
topiramate tab 25 mg	46
topiramate tab 50 mg	46
toremifene citrate tab 60 mg (base equivalent)	
.....	66
torsemide tab 10 mg	105
torsemide tab 100 mg	105
torsemide tab 20 mg	105
torsemide tab 5 mg	105

TOUJEO MAX INJ 300IU/ML.....	53	<i>tretinoiin cream 0.1%</i>	99
TOUJEO SOLO INJ 300IU/ML.....	53	<i>tretinoiin gel 0.01%</i>	99
<i>tramadol hcl oral soln 5 mg/ml</i>	29	<i>tretinoiin gel 0.025%</i>	99
<i>tramadol hcl tab 50 mg</i>	29	<i>tretinoiin gel 0.05%</i>	99
<i>tramadol hcl tab er 24hr 100 mg</i>	30	<i>tretinoiin microsphere gel 0.04%</i>	99
<i>tramadol hcl tab er 24hr 200 mg</i>	30	<i>tretinoiin microsphere gel 0.08%</i>	99
<i>tramadol hcl tab er 24hr 300 mg</i>	30	<i>tretinoiin microsphere gel 0.1%</i>	99
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	30	<i>tretinoiin-benzoyl peroxide</i>	
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	30	see TWYNEO CRE 0.1-3%.....	99
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	30	TREXALL TAB 10MG	65
<i>trandolapril tab 1 mg</i>	59	TREXALL TAB 15MG	65
<i>trandolapril tab 2 mg</i>	59	TREXALL TAB 5MG	65
<i>trandolapril tab 4 mg</i>	59	TREXALL TAB 7.5MG	65
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	63	TREZIX	
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	63	see Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg	31
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	63	<i>triamicinolone acetonide cream 0.025%</i>	103
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	63	<i>triamicinolone acetonide cream 0.1%</i>	103
<i>tranexamic acid tab 650 mg</i>	115	<i>triamicinolone acetonide cream 0.5%</i>	103
<i>tranylcypromine sulfate tab 10 mg</i>	47	Triamcinolone Acetonide Cream 0.5%.....	103
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	129	<i>triamicinolone acetonide dental paste 0.1%</i> ...124	
<i>trazodone hcl tab 100 mg</i>	48	Triamcinolone Acetonide Dental Paste 0.1% ..124	
<i>trazodone hcl tab 150 mg</i>	48	<i>triamicinolone acetonide lotion 0.025%</i>	103
<i>trazodone hcl tab 300 mg</i>	48	<i>triamicinolone acetonide lotion 0.1%</i>	103
<i>trazodone hcl tab 50 mg</i>	48	<i>triamicinolone acetonide oint 0.025%</i>	103
TRECATOR TAB 250MG	64	<i>triamicinolone acetonide oint 0.1%</i>	103
TRELEGY AER 100MCG	42	<i>triamicinolone acetonide oint 0.5%</i>	103
TRELEGY AER 200MCG	42	<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	105
<i>treprosttinil diolamine</i>		see <i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	105
see ORENITRAM TAB 0.125MG.....	85	<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	105
see ORENITRAM TAB 0.25MG.....	85	see <i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	105
see ORENITRAM TAB 1MG	85	<i>triadimenol tab 100 mg</i>	106
see ORENITRAM TAB 2.5MG.....	85	<i>triadimenol tab 50 mg</i>	106
see ORENITRAM TAB 5MG	85	<i>triazolam tab 0.125 mg</i>	115
see ORENITRAM TAB MONTH 1.....	85	<i>triazolam tab 0.25 mg</i>	115
see ORENITRAM TAB MONTH 2.....	85	TRIDERM	
see ORENITRAM TAB MONTH 3.....	85	see Triamcinolone Acetonide Cream 0.5%..103	
TRESIBA FLEX INJ 100UNIT	53	<i>trientine hcl cap 250 mg</i>	122
TRESIBA FLEX INJ 200UNIT	53	TRI-ESTARYLLA	
TRESIBA INJ 100UNIT	53	see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg.....	94
<i>tretinoiin cap 10 mg</i>	71	<i>trifarotene</i>	
<i>tretinoiin cream 0.025%</i>	99	see AKLIEF CRE 0.005%	97
<i>tretinoiin cream 0.05%</i>	99	<i>trifluoperazine hcl tab 1 mg (base equivalent)</i> 76	

trifluoperazine hcl tab 10 mg (base equivalent)	76
trifluoperazine hcl tab 2 mg (base equivalent)	76
trifluoperazine hcl tab 5 mg (base equivalent)	76
trifluridine ophth soln 1%	128
trifluridine-tipiracil	
see LONSURF TAB 15-6.14	67
see LONSURF TAB 20-8.19	67
trihexyphenidyl hcl oral soln 0.4 mg/ml	71
trihexyphenidyl hcl tab 2 mg	71
trihexyphenidyl hcl tab 5 mg	71
TRIJARDY XR TAB	51
TRI-LEGEST FE	
see Norethindrone Ac-Ethynodiol-Diol-Fe Tab 1-20/1-30/1-35 mg-Mcg	91
TRI-LINYAH	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	94
TRI-LO-ESTARYLLA	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	94
TRI-LO-MARZIA	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	94
TRI-LO-MILI	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	94
TRI-LO-SPRINTEC	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	94
trimethobenzamide hcl cap 300 mg	55
trimethoprim tab 100 mg	35
TRI-MILI	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	94
trimipramine maleate cap 100 mg	50
trimipramine maleate cap 25 mg	50
trimipramine maleate cap 50 mg	50
TRINATE	
see Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg	125
TRINTELLIX TAB 10MG	48
TRINTELLIX TAB 20MG	48
TRINTELLIX TAB 5MG	48
TRI-NYMYO	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	94
TRI-SPRINTEC	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	94
TRIUMEQ PD TAB	78
TRIUMEQ TAB	78
TRIVORA-28	
see Levonorgestrel-Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg	90
TRI-VYLIBRA	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	94
TRI-VYLIBRA LO	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	94
TROKENDI XR CAP 100MG	46
TROKENDI XR CAP 200MG	46
TROKENDI XR CAP 25MG	46
TROKENDI XR CAP 50MG	46
tropicamide ophth soln 0.5%	127
tropicamide ophth soln 1%	127
trospium chloride cap er 24hr 60 mg	142
trospium chloride tab 20 mg	143
TRULICITY INJ 0.75/0.5	52
TRULICITY INJ 1.5/0.5	52
TRULICITY INJ 3/0.5	52
TRULICITY INJ 4.5/0.5	52
TWYNEO CRE 0.1-3%	99
TYDEMY	
see Drospirenone-Ethynodiol-Diol-Levomefetil	
Tab 3-0.03-0.451 mg	88
U	
UBRELVY TAB 100MG	120
UBRELVY TAB 50MG	120
ubrogepant	
see UBRELVY TAB 100MG	120
see UBRELVY TAB 50MG	120
ulipristal acetate	
see ELLA TAB 30MG	95
umeclidinium-vilanterol	
see ANORO ELLIPT AER 62.5-25	41
UNITHROID	
see Levothyroxine Sodium Tab 100 mcg	139
see Levothyroxine Sodium Tab 112 mcg	140
see Levothyroxine Sodium Tab 125 mcg	140
see Levothyroxine Sodium Tab 137 mcg	140
see Levothyroxine Sodium Tab 150 mcg	140
see Levothyroxine Sodium Tab 175 mcg	140

see Levothyroxine Sodium Tab 200 mcg	140	valsartan-hydrochlorothiazide tab 320-12.5 mg	63
see Levothyroxine Sodium Tab 25 mcg	139	valsartan-hydrochlorothiazide tab 320-25 mg	63	
see Levothyroxine Sodium Tab 300 mcg	140	valsartan-hydrochlorothiazide tab 80-12.5 mg	63	
see Levothyroxine Sodium Tab 50 mcg	139	VALTOCO SPR 10MG	43	
see Levothyroxine Sodium Tab 75 mcg	139	VALTOCO SPR 15MG	43	
see Levothyroxine Sodium Tab 88 mcg	139	VALTOCO SPR 20MG	43	
upadacitinib		VALTOCO SPR 5MG	43	
see RINVOQ TAB 15MG ER	22	vancomycin hcl cap 125 mg (base equivalent)	36	
see RINVOQ TAB 30MG ER	22	vancomycin hcl cap 250 mg (base equivalent)	36	
see RINVOQ TAB 45MG ER	22	vancomycin hcl for oral soln 25 mg/ml (base		
UPTRAVI PACK TAB 200/800.....	85	equivalent)	36	
UPTRAVI TAB 1000MCG	85	vancomycin hcl for oral soln 50 mg/ml (base		
UPTRAVI TAB 1200MCG	86	equivalent)	36	
UPTRAVI TAB 1400MCG	86	vardenafil hcl orally disintegrating tab 10 mg	85	
UPTRAVI TAB 1600MCG	86	vardenafil hcl tab 10 mg	85	
UPTRAVI TAB 200MCG	85	vardenafil hcl tab 2.5 mg	85	
UPTRAVI TAB 400MCG	85	vardenafil hcl tab 20 mg	85	
UPTRAVI TAB 600MCG	85	vardenafil hcl tab 5 mg	85	
UPTRAVI TAB 800MCG	85	varenicline tartrate tab 0.5 mg (base equiv)	138	
uridine triacetate (emergency treatment)		varenicline tartrate tab 1 mg (base equiv)	138	
see VISTOGARD PAK 10GM.....	54	varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg		
ursodiol cap 300 mg	110	start pack	138	
ursodiol tab 250 mg	110	VASCEPA CAP 0.5GM	57	
ursodiol tab 500 mg	110	VASCEPA CAP 1GM	57	
V		VCF VAGINAL AER CONTRACP	143	
VAGIFEM TAB 10MCG	143	VCF VAGINAL GEL CONTRACE	143	
valacyclovir hcl tab 1 gm	80	VCF VAGINAL MIS CONTRACP	143	
valacyclovir hcl tab 500 mg	80	VELIVET		
valbenazine tosylate		see Desogest-Ethin Est Tab 0.1-0.025/0.125-		
see INGREZZA CAP 40-80MG	132	0.025/0.15-0.025mg-Mg	87	
see INGREZZA CAP 40MG	132	VELPHORO CHW 500MG	111	
see INGREZZA CAP 60MG	132	VELTASSA POW 16.8GM	124	
see INGREZZA CAP 80MG	132	VELTASSA POW 25.2GM	124	
valganciclovir hcl for soln 50 mg/ml (base equiv)	.....	VELTASSA POW 8.4GM	124
.....	79	vemurafenib		
valganciclovir hcl tab 450 mg (base equivalent)	.....	see ZELBORAF TAB 240MG.....	70
.....	79	venlafaxine hcl cap er 24hr 150 mg (base		
valproate sodium oral soln 250 mg/5ml (base		equivalent)	49	
equiv)	47	venlafaxine hcl cap er 24hr 37.5 mg (base		
valproic acid cap 250 mg	47	equivalent)	49	
valsartan tab 160 mg	60	venlafaxine hcl cap er 24hr 75 mg (base		
valsartan tab 320 mg	60	equivalent)	49	
valsartan tab 40 mg	60	venlafaxine hcl tab 100 mg (base equivalent)	49	
valsartan tab 80 mg	60	venlafaxine hcl tab 25 mg (base equivalent)	49	
valsartan-hydrochlorothiazide tab 160-12.5 mg	.....	venlafaxine hcl tab 37.5 mg (base equivalent)	49
.....	63	venlafaxine hcl tab 50 mg (base equivalent)	49	
valsartan-hydrochlorothiazide tab 160-25 mg	63			

venlafaxine hcl tab 75 mg (base equivalent)	49	VIOKACE TAB 20880.....	104
venlafaxine hcl tab er 24hr 225 mg (base equivalent)	49	VIORELE	
verapamil hcl cap er 24hr 100 mg	83	see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)	87
verapamil hcl cap er 24hr 120 mg	83		
verapamil hcl cap er 24hr 180 mg	83		
verapamil hcl cap er 24hr 200 mg	84	VISTOGARD PAK 10GM	54
verapamil hcl cap er 24hr 240 mg	84	VITRAKVI CAP 100MG	70
verapamil hcl cap er 24hr 300 mg	84	VITRAKVI CAP 25MG	70
verapamil hcl cap er 24hr 360 mg	84	VITRAKVI SOL 20MG/ML	70
verapamil hcl tab 120 mg	84	VOLNEA	
verapamil hcl tab 40 mg	84	see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)	87
verapamil hcl tab 80 mg	84		
verapamil hcl tab er 120 mg	84	voriconazole for susp 40 mg/ml	56
verapamil hcl tab er 180 mg	84	voriconazole tab 200 mg	56
verapamil hcl tab er 240 mg	84	voriconazole tab 50 mg	56
vericiguat		vorinostat	
see VERQUVO TAB 10MG	86	see ZOLINZA CAP 100MG	71
see VERQUVO TAB 2.5MG	86	VORTEX VALVE MIS CHAMBER	120
see VERQUVO TAB 5MG	86	vortioxetine hbr	
VERQUVO TAB 10MG	86	see TRINTELLIX TAB 10MG	48
VERQUVO TAB 2.5MG	86	see TRINTELLIX TAB 20MG	48
VERQUVO TAB 5MG.....	86	see TRINTELLIX TAB 5MG	48
VESTURA		VOSEVI TAB	79
see Drosipренone-Ethinyl Estradiol Tab 3-0.02 mg	88	VRAYLAR CAP 1.5-3MG	73
vibegron		VRAYLAR CAP 1.5MG	73
see GEMTESA TAB 75MG.....	143	VRAYLAR CAP 3MG	73
VIBERZI TAB 100MG.....	111	VRAYLAR CAP 4.5MG	73
VIBERZI TAB 75MG.....	111	VRAYLAR CAP 6MG	74
VICTOZA INJ 18MG/3ML	52	VUMERTY CAP 231MG	133
VIENVA		VYFEMLA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg	89	see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg	90
vigabatrin powd pack 500 mg	46	VYLIBRA	
Vigabatrin Powd Pack 500 mg	46	see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg	94
vigabatrin tab 500 mg	46	W	
VIGADRONE		WAKIX TAB 17.8MG	17
see Vigabatrin Powd Pack 500 mg	46	WAKIX TAB 4.45MG	16
vilazodone hcl tab 10 mg	48	warfarin sodium tab 1 mg	42
vilazodone hcl tab 20 mg	48	Warfarin Sodium Tab 1 mg.....	42
vilazodone hcl tab 40 mg	48	warfarin sodium tab 10 mg	42
viloxazine hcl (adhd)		Warfarin Sodium Tab 10 mg.....	42
see QELBREE CAP 100MG ER	16	warfarin sodium tab 2 mg	42
see QELBREE CAP 150MG ER	16	Warfarin Sodium Tab 2 mg.....	42
see QELBREE CAP 200MG ER	16	warfarin sodium tab 2.5 mg	42
VIOKACE TAB 10440.....	104	Warfarin Sodium Tab 2.5 mg.....	42

warfarin sodium tab 3 mg	42	XTAMPZA ER CAP 18MG	30
Warfarin Sodium Tab 3 mg	42	XTAMPZA ER CAP 27MG	30
warfarin sodium tab 4 mg	42	XTAMPZA ER CAP 36MG	30
Warfarin Sodium Tab 4 mg	42	XTAMPZA ER CAP 9MG	30
warfarin sodium tab 5 mg	42	XTANDI CAP 40MG	66
Warfarin Sodium Tab 5 mg	42	XTANDI TAB 40MG	66
warfarin sodium tab 6 mg	42	XTANDI TAB 80MG	67
Warfarin Sodium Tab 6 mg	42	XULANE	
warfarin sodium tab 7.5 mg	42	see Norelgestromin-Ethinyl Estradiol Td Pt wk	
Warfarin Sodium Tab 7.5 mg	42	150-35 mcg/24hr	94
WATCHHALER MIS	120	XULTOPHY INJ 100/3.6	51
WERA		XYWAV SOL 0.5GM/ML	130
see Norethindrone & Ethinyl Estradiol Tab 0.5		Y	
mg-35 mcg	90	YARGESA	
WINLEVI CRE 1%	99	see Miglustat Cap 100 mg	113
WYMZYA FE		YL FOLIC ACID	
see Norethindrone & Ethinyl Estradiol-Fe		see Folic Acid Tab 400 mcg	114
Chew Tab 0.4 mg-35 mcg	91	YONSA TAB 125MG	67
X		YUPELRI SOL	39
XARELTO STAR TAB 15/20MG	42	Z	
XARELTO SUS 1MG/ML	42	ZAFEMY	
XARELTO TAB 10MG	42	see Norelgestromin-Ethinyl Estradiol Td Pt wk	
XARELTO TAB 15MG	42	150-35 mcg/24hr	94
XARELTO TAB 2.5MG	42	zafirlukast tab 10 mg	39
XARELTO TAB 20MG	42	zafirlukast tab 20 mg	39
XCOPRI PAK 100-150	46	zaleplon cap 10 mg	115
XCOPRI PAK 12.5-25	46	zaleplon cap 5 mg	115
XCOPRI PAK 150-200	46	zanamivir	
XCOPRI PAK 50-100MG	46	see RELENZA MIS DISKHALE	80
XCOPRI TAB 100MG	46	zanubrutinib	
XCOPRI TAB 150MG	46	see BRUKINSA CAP 80MG	67
XCOPRI TAB 200MG	46	ZEGALOGUE INJ 0.6/0.6	52
XCOPRI TAB 50MG	46	ZEJULA TAB 100MG	70
XELJANZ SOL 1MG/ML	22	ZEJULA TAB 200MG	70
XELJANZ TAB 10MG	22	ZEJULA TAB 300MG	70
XELJANZ TAB 5MG	22	ZELBORAF TAB 240MG	70
XELJANZ XR TAB 11MG	23	ZEMBRACE SYM INJ 3/0.5ML	121
XELJANZ XR TAB 22MG	23	ZENATANE	
XIFAXAN TAB 550MG	35	see Isotretinoin Cap 10 mg	98
XIGDUO XR TAB 10-1000	51	see Isotretinoin Cap 20 mg	98
XIGDUO XR TAB 10-500MG	51	see Isotretinoin Cap 30 mg	99
XIGDUO XR TAB 2.5-1000	51	see Isotretinoin Cap 40 mg	99
XIGDUO XR TAB 5-1000MG	51	ZENPEP CAP 10000UNT	105
XIGDUO XR TAB 5-500MG	51	ZENPEP CAP 15000UNT	105
IIDRA DRO 5%	128	ZENPEP CAP 20000UNT	105
XOSPATA TAB 40MG	70	ZENPEP CAP 25000UNT	105
XTAMPZA ER CAP 13.5MG	30	ZENPEP CAP 3000UNIT	104

ZENPEP CAP 40000UNT.....	105	<i>zolpidem tartrate tab 10 mg</i>	115
ZENPEP CAP 5000UNIT.....	104	<i>zolpidem tartrate tab 5 mg</i>	115
ZENZEDI		<i>zolpidem tartrate tab er 12.5 mg</i>	116
see Dextroamphetamine Sulfate Tab 10 mg.	13	<i>zolpidem tartrate tab er 6.25 mg</i>	116
see Dextroamphetamine Sulfate Tab 15 mg.	13	<i>zonisamide cap 100 mg</i>	46
see Dextroamphetamine Sulfate Tab 2.5 mg	13	<i>zonisamide cap 25 mg</i>	46
see Dextroamphetamine Sulfate Tab 20 mg.	14	<i>zonisamide cap 50 mg</i>	46
see Dextroamphetamine Sulfate Tab 30 mg.	14	ZORYVE CRE 0.3%	101
see Dextroamphetamine Sulfate Tab 5 mg...	13	ZOVIA 1/35	
see Dextroamphetamine Sulfate Tab 7.5 mg	13	see Ethynodiol Diacetate & Ethinyl Estradiol	
ZEPOSIA 7DAY CAP STR PACK	133	Tab 1 mg-35 mcg.....	88
ZEPOSIA CAP .92MG.....	133	ZUBSOLV SUB 0.7-0.18.....	34
ZEPOSIA CAP STR KIT.....	133	ZUBSOLV SUB 1.4-0.36.....	34
<i>zidovudine cap 100 mg</i>	78	ZUBSOLV SUB 11.4-2.9.....	34
<i>zidovudine syrup 10 mg/ml</i>	78	ZUBSOLV SUB 2.9-0.71.....	34
<i>zidovudine tab 300 mg</i>	78	ZUBSOLV SUB 5.7-1.4.....	34
<i>ziprasidone hcl cap 20 mg</i>	74	ZUBSOLV SUB 8.6-2.1.....	34
<i>ziprasidone hcl cap 40 mg</i>	74	ZUMANDIMINE	
<i>ziprasidone hcl cap 60 mg</i>	74	see Drospirenone-Ethinyl Estradiol Tab 3-0.03	
<i>ziprasidone hcl cap 80 mg</i>	74	mg	88
ZOLINZA CAP 100MG	71	ZYCLARA CRE 3.75%.....	103
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	121	ZYCLARA PUMP CRE 2.5%	103
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	121	ZYCLARA PUMP CRE 3.75%	103
<i>zolmitriptan orally disintegrating tab 5 mg</i> ..	121	ZYDELIG TAB 100MG.....	71
<i>zolmitriptan tab 2.5 mg</i>	121	ZYDELIG TAB 150MG.....	71
<i>zolmitriptan tab 5 mg</i>	121	ZYKADIA TAB 150MG	71

Step Therapy Criteria

Step Therapy Group

Drug Names

Step Therapy Criteria

HPGST ANTIPSYCHOTICS 478-D

VRAYLAR

Coverage will be provided if the member has filled a prescription for a 30 day supply of aripiprazole, clozapine, olanzapine, paliperidone ext-rel, risperidone, quetiapine, quetiapine ext-rel, or ziprasidone within the past 365 days

Step Therapy Group

Drug Names

Step Therapy Criteria

HPGST INSOMNIA AGENTS 406-D

DAYVIGO, QUVIVIQ

Coverage will be provided if the member has filled a prescription for a generic non-benzodiazepine hypnotic (at least 30 day supply within the past 180 days)

Step Therapy Group

Drug Names

Step Therapy Criteria

HPGST SSRI 409-D

TRINTELLIX

Coverage will be provided if the member has filled a prescription of a generic SSRI product (at least a 30 day supply within the past 365 days)

Step Therapy Group

Drug Names

Step Therapy Criteria

HPGST TRIPTANS 410-D

ONZETRA XSAIL, ZEMBRACE SYMTOUCH

Coverage will be provided if the member has filled a prescription of a generic triptan (almotriptan, eletriptan, frovatriptan, sumatriptan, naratriptan, rizatriptan, rizatriptan ODT, zolmitriptan, Sumatriptan-Naproxen Sodium) at least a 30 day supply within the past 180 days

Step Therapy Group

Drug Names

Step Therapy Criteria

OPIOID ER 2219-M

BELBUCA, BUPRENORPHINE, FENTANYL, HYDROCODONE BITARTRATE ER, HYDROMORPHONE HYDROCHLORIDE, METHADONE HYDROCHLORIDE, MORPHINE SULFATE ER, OXYCODONE HYDROCHLORIDE E, TRAMADOL HCL ER, TRAMADOL HYDROCHLORIDE ER, XTAMPZA ER

Coverage will be provided if the member has filled a cumulative 7-day or greater supply of an immediate-release opioid agent within the past 90 days OR has been receiving an extended-release opioid agent for a cumulative 30 days or greater within the past 90 days.

Step Therapy Group

Drug Names

Step Therapy Criteria

OPIOID IR COMBO PRODUCTS 1358-E

ACETAMINOPHEN/CAFFEINE/DI, ACETAMINOPHEN/CODEINE, ACETAMINOPHEN/CODEINE PHO, ENDOCET, HYDROCODONE BITARTRATE/AC, HYDROCODONE/IBUPROFEN, OXYCODONE/ACETAMINOPHEN, TRAMADOL HYDROCHLORIDE/AC, TREZIX

Coverage will be provided to the member for up to a 7-day supply of immediate-release opioids if the member does not have at least a cumulative 7-day supply of an opioid agent (immediate- or extended-release) within the past 90 days.

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