

# SHARP Health Plan

## 2026 Formulary

### List of covered prescription drugs

#### Employer-sponsored plans from Sharp Health Plan

April 2026

This drug list applies to Large Group HMO and Large Group POS products, and the following Small Group HMO products that use a 3-Tier formulary: 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](https://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](https://sharphealthplan.com/login). This document is subject to change and all previous versions are no longer in effect. Last updated 04/01/2026.

## Table of Contents

<b>INTRODUCTION</b> .....	13
<b>DEFINITIONS</b> .....	13
<b>HOW OFTEN DOES THE FORMULARY CHANGE?</b> .....	15
<b>WILL I BE NOTIFIED OF A FORMULARY CHANGE?</b> .....	15
<b>HOW DO I LOCATE A PRESCRIPTION DRUG ON THE FORMULARY?</b> .....	16
<b>HOW DO I KNOW IF THE DRUG LISTED ON THE FORMULARY IS A BRAND OR GENERIC DRUG?</b> .....	16
<b>WHAT IS A DRUG TIER?</b> .....	17
<b>ARE THERE ANY COVERAGE REQUIREMENTS OR LIMITS?</b> .....	17
<b>WHAT IS PRIOR AUTHORIZATION?</b> .....	18
<b>WHAT IS PA**?</b> .....	18
<b>WHAT IS QUANTITY LIMIT?</b> .....	19
<b>WHAT IS STEP THERAPY?</b> .....	19
<b>WHAT IS MO?</b> .....	19
<b>WHAT IS A SPECIALTY DRUG?</b> .....	19
<b>WHAT IS AN ORAL ANTI-CANCER DRUG?</b> .....	19
<b>WHAT IF A DRUG IS NOT LISTED ON THE FORMULARY? WHAT IS A FORMULARY EXCEPTION?</b> .....	20
<b>WHERE CAN I FILL MY PRESCRIPTION DRUG?</b> .....	20
<b>WHAT IS THERAPEUTIC INTERCHANGE?</b> .....	20
<b>WHAT IS GENERIC SUBSTITUTION?</b> .....	20
<b>YOU HAVE THE RIGHT TO APPEAL</b> .....	21
<b>APPEALS DUE TO DENIAL OF COVERAGE FOR A NONFORMULARY DRUG</b> .....	21
<b>ALL OTHER APPEALS</b> .....	21
<b>QUESTIONS</b> .....	21
<b>EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT</b> .....	21
<b>NONDISCRIMINATION NOTICE</b> .....	22
<b>LANGUAGE ASSISTANCE SERVICES</b> .....	23
<b>STEP THERAPY CRITERIA</b> .....	25
<b>ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS</b> .....	26
<b>AMPHETAMINES</b> .....	26
<b>ANOREXIANTS NON-AMPHETAMINE</b> .....	31
<b>ANTI-OBESITY AGENTS</b> .....	31
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER</b> .....	32
<b>DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)</b> .....	33
<b>HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS</b> .....	33
<b>STIMULANTS - MISC</b> .....	33
<b>ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES</b> .....	38
<b>ALLERGENIC EXTRACTS</b> .....	38
<b>AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS</b> .....	38
<b>AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS</b> .....	38
<b>ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION</b> .....	38

ANTIRHEUMATIC - ENZYME INHIBITORS .....	38
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS) .....	39
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS .....	40
PYRIMIDINE SYNTHESIS INHIBITORS .....	41
<b>ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER .....</b>	<b>41</b>
ANALGESIC COMBINATIONS .....	41
SALICYLATES .....	41
<b>ANALGESICS - OPIOID - DRUGS TO TREAT PAIN .....</b>	<b>41</b>
OPIOID AGONISTS .....	41
OPIOID COMBINATIONS .....	46
OPIOID PARTIAL AGONISTS .....	49
<b>ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES .....</b>	<b>51</b>
ANDROGENS .....	51
<b>ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS .....</b>	<b>51</b>
INTRARECTAL STEROIDS .....	51
RECTAL COMBINATIONS .....	51
RECTAL STEROIDS .....	51
VASODILATING AGENTS .....	51
<b>ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES .....</b>	<b>52</b>
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES .....	52
<b>ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS .....</b>	<b>52</b>
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS .....	52
ANTI-INFECTIVE MISC. - COMBINATIONS .....	52
ANTIPROTOZOAL AGENTS .....	52
GLYCOPEPTIDES .....	52
LEPROSTATICS .....	52
LINCOSAMIDES .....	52
MONOBACTAMS .....	53
OXAZOLIDINONES .....	53
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS .....	53
<b>ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS .....</b>	<b>53</b>
ANTIANGINALS-OTHER .....	53
NITRATES .....	53
<b>ANTIANSXIETY AGENTS - DRUGS TO TREAT ANXIETY .....</b>	<b>54</b>
ANTIANSXIETY AGENTS - MISC. .....	54
BENZODIAZEPINES .....	54
<b>ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS .....</b>	<b>55</b>
ANTIARRHYTHMICS TYPE I-A .....	55
ANTIARRHYTHMICS TYPE I-B .....	55
ANTIARRHYTHMICS TYPE I-C .....	55
ANTIARRHYTHMICS TYPE III .....	55
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE .....</b>	<b>56</b>
ANTI-INFLAMMATORY AGENTS .....	56
BRONCHODILATORS - ANTICHOLINERGICS .....	56

LEUKOTRIENE MODULATORS .....	56
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS .....	56
STEROID INHALANTS .....	56
SYMPATHOMIMETICS.....	57
XANTHINES.....	59
<b>ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS .....</b>	<b>59</b>
COUMARIN ANTICOAGULANTS .....	59
DIRECT FACTOR XA INHIBITORS.....	59
THROMBIN INHIBITORS.....	60
<b>ANTICONSULSANTS - DRUGS TO TREAT SEIZURES .....</b>	<b>60</b>
AMPA GLUTAMATE RECEPTOR ANTAGONISTS .....	60
ANTICONSULSANTS - BENZODIAZEPINES .....	60
ANTICONSULSANTS - MISC. ....	61
CARBAMATES .....	63
GABA MODULATORS .....	64
HYDANTOINS.....	64
SUCCINIMIDES.....	64
VALPROIC ACID .....	64
<b>ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION .....</b>	<b>64</b>
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS) .....	64
ANTIDEPRESSANT COMBINATIONS .....	65
ANTIDEPRESSANTS - MISC.....	65
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID .....	65
MONOAMINE OXIDASE INHIBITORS (MAOIS) .....	65
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS) .....	65
SEROTONIN MODULATORS.....	66
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS) .....	66
TRICYCLIC AGENTS .....	67
<b>ANTIDIABETICS - DRUGS TO TREAT DIABETES .....</b>	<b>68</b>
ALPHA-GLUCOSIDASE INHIBITORS .....	68
ANTIDIABETIC COMBINATIONS .....	68
BIGUANIDES .....	69
DIABETIC OTHER .....	70
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS .....	70
INCRETIN MIMETIC AGENTS .....	70
INSULIN.....	71
INSULIN SENSITIZING AGENTS .....	71
MEGLITINIDE ANALOGUES .....	72
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS .....	72
SULFONYLUREAS.....	72
<b>ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA.....</b>	<b>72</b>
ANTIPERISTALTIC AGENTS.....	72
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING .....</b>	<b>72</b>
ANTIDOTES - CHELATING AGENTS.....	72
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING .....	73

OPIOID ANTAGONISTS .....	73
<b>ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING .....</b>	<b>73</b>
5-HT3 RECEPTOR ANTAGONISTS .....	73
ANTIEMETICS - ANTICHOLINERGIC .....	73
ANTIEMETICS - MISCELLANEOUS.....	73
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS .....	73
<b>ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS.....</b>	<b>73</b>
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS .....	73
IMIDAZOLE-RELATED ANTIFUNGALS .....	74
<b>ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES.....</b>	<b>74</b>
ANTIHISTAMINES - ETHANOLAMINES .....	74
ANTIHISTAMINES - NON-SEDATING .....	74
ANTIHISTAMINES - PHENOTHIAZINES .....	74
ANTIHISTAMINES - PIPERIDINES .....	75
<b>ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL .....</b>	<b>75</b>
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS.....	75
ANTIHYPERLIPIDEMICS - COMBINATIONS .....	75
ANTIHYPERLIPIDEMICS - MISC. ....	75
BILE ACID SEQUESTRANTS.....	75
FIBRIC ACID DERIVATIVES.....	75
HMG COA REDUCTASE INHIBITORS.....	76
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS .....	77
NICOTINIC ACID DERIVATIVES.....	77
<b>ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE .....</b>	<b>77</b>
ACE INHIBITORS .....	77
AGENTS FOR PHEOCHROMOCYTOMA .....	78
ANGIOTENSIN II RECEPTOR ANTAGONISTS .....	78
ANTIADRENERGIC ANTIHYPERTENSIVES .....	79
ANTIHYPERTENSIVE COMBINATIONS .....	79
DIRECT RENIN INHIBITORS .....	82
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS) .....	82
VASODILATORS .....	82
<b>ANTIMALARIALS - DRUGS TO TREAT MALARIA.....</b>	<b>82</b>
ANTIMALARIAL COMBINATIONS .....	82
ANTIMALARIALS - DRUGS TO TREAT MALARIA .....	82
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS.....</b>	<b>82</b>
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS .....	82
<b>ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS .....</b>	<b>83</b>
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS.....	83
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER .....</b>	<b>83</b>
ALKYLATING AGENTS.....	83
ANTIMETABOLITES.....	83
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS.....	83
ANTINEOPLASTIC - EGFR INHIBITORS.....	84
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS .....	84

ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS .....	84
ANTINEOPLASTIC - IMMUNOMODULATORS .....	85
ANTINEOPLASTIC COMBINATIONS .....	86
ANTINEOPLASTIC ENZYME INHIBITORS.....	86
ANTINEOPLASTICS MISC.....	91
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS .....	91
MITOTIC INHIBITORS .....	91
<b>ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE</b>	
.....	<b>91</b>
ANTIPARKINSON ADJUNCTIVE THERAPY.....	91
ANTIPARKINSON ANTICHOLINERGICS .....	91
ANTIPARKINSON COMT INHIBITORS .....	91
ANTIPARKINSON DOPAMINERGICS .....	91
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS .....	93
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES .....</b>	<b>94</b>
ANTIMANIC AGENTS.....	94
ANTIPSYCHOTICS - MISC.....	94
BENZISOXAZOLES .....	94
BUTYROPHENONES.....	95
DIBENZAPINES.....	95
DIHYDROINDOLONES.....	96
PHENOTHIAZINES.....	96
QUINOLINONE DERIVATIVES.....	97
THIOXANTHENES.....	97
<b>ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS .....</b>	<b>97</b>
ANTIRETROVIRALS .....	97
ANTIVIRAL COMBINATIONS .....	99
CMV AGENTS.....	99
HEPATITIS AGENTS.....	99
HERPES AGENTS .....	100
INFLUENZA AGENTS.....	100
<b>BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS ...</b>	<b>100</b>
ALPHA-BETA BLOCKERS .....	100
BETA BLOCKERS CARDIO-SELECTIVE.....	101
BETA BLOCKERS NON-SELECTIVE.....	101
<b>CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART</b>	
<b>CONDITIONS .....</b>	<b>102</b>
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART	
CONDITIONS.....	102
<b>CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS .....</b>	<b>104</b>
CARDIAC GLYCOSIDES.....	104
<b>CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION</b>	
<b>CONDITIONS .....</b>	<b>105</b>
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS .....	105
IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION .....	105

PROSTAGLANDIN VASODILATORS .....	106
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS.....	106
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS .....	106
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST .....	107
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR .....	107
SINUS NODE INHIBITORS.....	107
TRANSTHYRETIN STABILIZERS .....	107
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC) .....	107
<b>CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS .....</b>	<b>107</b>
CEPHALOSPORINS - 1ST GENERATION .....	107
CEPHALOSPORINS - 2ND GENERATION .....	108
CEPHALOSPORINS - 3RD GENERATION .....	108
<b>CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL .....</b>	<b>108</b>
COMBINATION CONTRACEPTIVES - ORAL.....	108
COMBINATION CONTRACEPTIVES - TRANSDERMAL .....	116
COMBINATION CONTRACEPTIVES - VAGINAL.....	116
EMERGENCY CONTRACEPTIVES .....	116
PROGESTIN CONTRACEPTIVES - ORAL.....	116
<b>CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE .....</b>	<b>117</b>
GLUCOCORTICOSTEROIDS.....	117
MINERALOCORTICIDS .....	118
<b>COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS ...</b>	<b>118</b>
ANTITUSSIVES - DRUGS TO TREAT COUGH .....	118
COUGH/COLD/ALLERGY COMBINATIONS .....	118
EXPECTORANTS - DRUGS TO TREAT COUGH .....	119
MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS .....	119
MUCOLYTICS - DRUGS TO TREAT COUGH .....	119
<b>DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS .....</b>	<b>119</b>
ACNE PRODUCTS.....	119
ANTI-INFLAMMATORY AGENTS - TOPICAL .....	121
ANTIBIOTICS - TOPICAL.....	121
ANTIFUNGALS - TOPICAL .....	121
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL .....	122
ANTIPSORIATICS.....	122
ANTISEBORRHEIC PRODUCTS .....	123
ANTIVIRALS - TOPICAL .....	123
BURN PRODUCTS .....	123
CORTICOSTEROIDS - TOPICAL .....	123
ECZEMA AGENTS.....	125
EMOLLIENTS .....	125
HAIR GROWTH AGENTS.....	125
IMMUNOMODULATING AGENTS - TOPICAL .....	125
IMMUNOSUPPRESSIVE AGENTS - TOPICAL.....	125
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS .....	125
LOCAL ANESTHETICS - TOPICAL .....	125

PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL .....	125
ROSACEA AGENTS .....	126
SCABICIDES & PEDICULICIDES .....	126
<b>DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS.....</b>	<b>126</b>
DIGESTIVE ENZYMES.....	126
<b>DIURETICS - DRUGS TO TREAT HEART CONDITIONS .....</b>	<b>127</b>
CARBONIC ANHYDRASE INHIBITORS .....	127
DIURETIC COMBINATIONS .....	127
LOOP DIURETICS .....	127
POTASSIUM SPARING DIURETICS .....	127
THIAZIDES AND THIAZIDE-LIKE DIURETICS.....	128
<b>ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES.....</b>	<b>128</b>
BONE DENSITY REGULATORS - DRUGS TO TREAT BONE LOSS .....	128
FERTILITY REGULATORS.....	128
GNRH/LHRH ANTAGONISTS .....	128
HORMONE RECEPTOR MODULATORS - DRUGS TO TREAT BONE LOSS .....	129
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS .....	129
METABOLIC MODIFIERS .....	129
MINERALOCORTICOID RECEPTOR ANTAGONISTS .....	130
POSTERIOR PITUITARY HORMONES .....	130
PROGESTERONE RECEPTOR ANTAGONISTS.....	130
PROLACTIN INHIBITORS.....	130
VASOPRESSIN RECEPTOR ANTAGONISTS .....	130
<b>ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES .....</b>	<b>130</b>
ESTROGEN COMBINATIONS.....	130
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES .....	131
<b>FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS.....</b>	<b>132</b>
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS .....	132
<b>GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS .....</b>	<b>133</b>
5-HT4 RECEPTOR AGONISTS .....	133
GALLSTONE SOLUBILIZING AGENTS .....	133
GASTROINTESTINAL ANTIALLERGY AGENTS .....	133
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS .....	133
GASTROINTESTINAL STIMULANTS .....	133
INFLAMMATORY BOWEL AGENTS .....	133
INTESTINAL ACIDIFIERS.....	133
IRRITABLE BOWEL SYNDROME (IBS) AGENTS .....	134
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS .....	134
PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR(PPAR) AGONISTS .....	134
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS.....	134
<b>GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS.....</b>	<b>134</b>
ALKALINIZERS .....	134
CYSTINOSIS AGENTS .....	134

IGA NEPHROPATHY (IGAN) AGENTS .....	134
PROSTATIC HYPERTROPHY AGENTS .....	135
URINARY STONE AGENTS .....	135
<b>GOUT AGENTS - DRUGS TO TREAT GOUT .....</b>	<b>135</b>
GOUT AGENT COMBINATIONS .....	135
GOUT AGENTS - DRUGS TO TREAT GOUT .....	135
URICOSURICS.....	135
<b>HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS .....</b>	<b>135</b>
HEMATORHEOLOGIC AGENTS .....	135
PLASMA KALLIKREIN INHIBITORS .....	135
PLATELET AGGREGATION INHIBITORS .....	135
<b>HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS .....</b>	<b>136</b>
AGENTS FOR GAUCHER DISEASE .....	136
AGENTS FOR SICKLE CELL DISEASE .....	136
FOLIC ACID/FOLATES .....	136
HEMATOPOIETIC GROWTH FACTORS.....	137
<b>HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS .....</b>	<b>138</b>
HEMOSTATICS - SYSTEMIC .....	138
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS</b>	<b>138</b>
BARBITURATE HYPNOTICS .....	138
HYPNOTICS - TRICYCLIC AGENTS .....	138
NON-BARBITURATE HYPNOTICS .....	138
OREXIN RECEPTOR ANTAGONISTS .....	139
SELECTIVE MELATONIN RECEPTOR AGONISTS .....	139
<b>LAXATIVES - DRUGS TO TREAT CONSTIPATION.....</b>	<b>139</b>
LAXATIVE COMBINATIONS .....	139
LAXATIVES - MISCELLANEOUS.....	139
<b>MACROLIDES - DRUGS TO TREAT INFECTIONS.....</b>	<b>139</b>
AZITHROMYCIN .....	139
CLARITHROMYCIN.....	139
ERYTHROMYCINS .....	140
FIDAXOMICIN .....	140
<b>MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING .....</b>	<b>140</b>
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL.....	140
PARENTERAL THERAPY SUPPLIES .....	140
RESPIRATORY THERAPY SUPPLIES .....	141
<b>MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES .....</b>	<b>142</b>
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG.....	142
MIGRAINE COMBINATIONS.....	142
SEROTONIN AGONISTS .....	142
<b>MINERALS &amp; ELECTROLYTES - DRUGS FOR NUTRITION .....</b>	<b>143</b>
FLUORIDE.....	143
PHOSPHATE .....	144
POTASSIUM .....	144

<b>MISCELLANEOUS THERAPEUTIC CLASSES .....</b>	<b>144</b>
CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING .....	144
IMMUNOMODULATORS - DRUGS TO TREAT CANCER .....	144
IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT .....	145
POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM .....	146
<b>MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT .....</b>	<b>146</b>
ANESTHETICS TOPICAL ORAL .....	146
ANTI-INFECTIVES - THROAT .....	146
STEROIDS - MOUTH/THROAT/DENTAL .....	146
THROAT PRODUCTS - MISC. ....	146
<b>MULTIVITAMINS - DRUGS FOR NUTRITION .....</b>	<b>146</b>
PRENATAL VITAMINS .....	146
<b>MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS .....</b>	<b>147</b>
CENTRAL MUSCLE RELAXANTS .....	147
DIRECT MUSCLE RELAXANTS .....	147
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE .....</b>	<b>147</b>
NASAL AGENT COMBINATIONS .....	147
NASAL ANTIALLERGY .....	147
NASAL ANTICHOLINERGICS .....	148
NASAL STEROIDS .....	148
<b>NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES .....</b>	<b>148</b>
ALS AGENTS .....	148
<b>OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS .....</b>	<b>148</b>
BETA-BLOCKERS - OPHTHALMIC .....	148
CYCLOPLEGIC MYDRIATICS .....	148
MIOTICS .....	149
OPHTHALMIC ADRENERGIC AGENTS .....	149
OPHTHALMIC ANTI-INFECTIVES .....	149
OPHTHALMIC IMMUNOMODULATORS .....	150
OPHTHALMIC STEROIDS .....	150
OPHTHALMICS - MISC. ....	150
PROSTAGLANDINS - OPHTHALMIC .....	151
<b>OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR .....</b>	<b>151</b>
OTIC AGENTS - MISCELLANEOUS .....	151
OTIC ANTI-INFECTIVES .....	151
OTIC COMBINATIONS .....	151
OTIC STEROIDS .....	151
<b>OXYTOCICS - DRUGS FOR PREGNANCY .....</b>	<b>151</b>
OXYTOCICS - DRUGS FOR PREGNANCY .....	151
<b>PENICILLINS - DRUGS TO TREAT INFECTIONS .....</b>	<b>151</b>
AMINOPENICILLINS .....	151
NATURAL PENICILLINS .....	152
PENICILLIN COMBINATIONS .....	152
PENICILLINASE-RESISTANT PENICILLINS .....	152
<b>PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES .....</b>	<b>152</b>

PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES .....	152
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS .....</b>	<b>152</b>
AGENTS FOR CHEMICAL DEPENDENCY .....	152
ANTI-CATAPLECTIC AGENTS .....	153
ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS .....	153
COMBINATION PSYCHOTHERAPEUTICS .....	154
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS .....	154
MOVEMENT DISORDER DRUG THERAPY .....	154
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS .....	154
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS .....	155
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS .....	156
SMOKING DETERRENTS .....	156
<b>RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS .....</b>	<b>159</b>
CYSTIC FIBROSIS AGENTS .....	159
PULMONARY FIBROSIS AGENTS.....	159
<b>SULFONAMIDES - DRUGS TO TREAT INFECTIONS.....</b>	<b>159</b>
SULFONAMIDES - DRUGS TO TREAT INFECTIONS .....	159
<b>TETRACYCLINES - DRUGS TO TREAT INFECTIONS .....</b>	<b>159</b>
TETRACYCLINES - DRUGS TO TREAT INFECTIONS .....	159
<b>THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS.....</b>	<b>160</b>
ANTITHYROID AGENTS .....	160
THYROID HORMONES.....	160
<b>ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID.....</b>	<b>161</b>
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS.....	161
H-2 ANTAGONISTS .....	162
MISC. ANTI-ULCER .....	162
PROTON PUMP INHIBITORS.....	162
ULCER DRUGS - PROSTAGLANDINS .....	163
ULCER THERAPY COMBINATIONS.....	163
<b>URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE .....</b>	<b>163</b>
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC) .....	163
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS .....	163
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS.....	163
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS.....	164
<b>VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS .....</b>	<b>164</b>
MISCELLANEOUS VAGINAL PRODUCTS .....	164
SPERMICIDES.....	164
VAGINAL ANTI-INFECTIVES.....	164
VAGINAL CONTRACEPTIVE - PH MODULATORS.....	164
VAGINAL ESTROGENS .....	164
VAGINAL PROGESTINS .....	164
<b>VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS .....</b>	<b>164</b>

ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION .....	164
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS.....	165
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS.....	165
<b>VITAMINS - DRUGS FOR NUTRITION .....</b>	<b>165</b>
OIL SOLUBLE VITAMINS .....	165
<b>Index.....</b>	<b>166</b>

## INTRODUCTION

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 are in an HMO plan, you should contact your provider for information on how to obtain vaccines. If you are in a Point of Service (POS) plan, you can get vaccines at a network retail pharmacy. Please refer to your Evidence of Coverage for additional information. 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.

“**CARE Agreement**” means a voluntary settlement agreement entered into by the parties. A CARE Agreement includes the same elements as a CARE Plan to support the respondent in accessing community-based services and supports.

**“CARE Plan”** means an individualized, appropriate range of community-based services and supports, which include clinically appropriate behavioral health care and stabilization medications, housing and other supportive services, as appropriate.

**“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”** or “drug” means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term “drug” or “prescription drug” includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan’s prescription drug benefit.

**“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](http://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 Medi-Span® classification system for therapeutic category and class. Medi-Span® 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 in all capital letters after the Generic name in parentheses with the first letter of each 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 ( <b><i>fenofibric acid</i></b> )
Generic-Name that is covered on the Formulary	<b><i>fenofibric acid tab 35mg</i></b>
Generic Drug marketed with a Brand-Name	(Amiodarone Hcl Tab 100 mg) 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](http://sharphealthplan.com/login) and log in to your Sharp Health Plan online account. When you create a Sharp Health Plan online 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 [caremark.com](http://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 [CVSSpecialty.com](http://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/mailemail](http://info.caremark.com/mailemail).

## **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. The enrollee may be required to try an interchangeable product before providing coverage for the equivalent branded prescription drug. Nothing in this section will prohibit or supersede a step therapy exception request.

## **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 Plan does not cover the following Prescription Drugs, except as required by law:

1. When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
2. When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
3. When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
4. When prescribed solely for the purpose of shortening the duration of the common cold.
5. Prescription Drugs available over-the-counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
  - Insulin,
  - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),

- Over-the-counter drugs for reversal of an opioid overdose, or
  - An entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.
6. Replacement of lost or stolen drugs.
  7. Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

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. When an interchangeable biological product is available, the pharmacy may be required to fill your Prescription with the interchangeable biological product unless prior Authorization is obtained and the reference product is determined to be Medically Necessary.

### **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. A copy of the Nondiscrimination Notice can also be accessed at [sharphealthplan.com/members/notices-and-disclosures](http://sharphealthplan.com/members/notices-and-disclosures).

#### **Sharp Health Plan:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternative formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters and language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency. If you need these services, contact Customer Care at 1-800-359-2002 (TTY 711).

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 and Section 1557 Nondiscrimination Coordinator at:

- Address: Sharp Health Plan Compliance Department, Attn: Director of Compliance and Regulatory Affairs Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572

- Email: [shpcompliance@sharp.com](mailto:shpcompliance@sharp.com)

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](http://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/smartscreen/main.jsf](http://ocrportal.hhs.gov/ocr/smartscreen/main.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/complaints/index.html](http://hhs.gov/ocr/complaints/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: [dmhc.ca.gov](http://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 (հեռատիպ) 711).

**فارسی (Farsi):**

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

**Русский (Russian):**

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

**عبرعلا (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل 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।

**ខ្មែរ (Mon Khmer, Cambodian):**

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002(TTY:711)។

**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).

**हिंदी (Hindi):**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें। कॉल करें।

**ภาษาไทย (Thai):**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).

## STEP THERAPY CRITERIA

**Step Therapy Group**

**Drug Names**

OPIOID ER 2219-M

BELBUCA, BUPRENORPHINE, FENTANYL, HYDROCODONE BITARTRATE ER, HYDROMORPHONE HYDROCHLORI, METHADONE HYDROCHLORIDE, MORPHINE SULFATE ER, TRAMADOL HCL ER, TRAMADOL HYDROCHLORIDE ER

**Step Therapy Criteria**

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**

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

**Step Therapy Criteria**

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.



<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b><i>amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg</i></b>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg</i></b>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i></b>	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i></b>	1	PA, QL (270 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i></b>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i></b>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i></b>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i></b>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine tab 5 mg</i></b>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine tab 7.5 mg</i></b>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<b><i>amphetamine-dextroamphetamine tab 10 mg</i></b>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine tab 15 mg</i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>amphetamine-dextroamphetamine 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>amphetamine-dextroamphetamine tab 30 mg</i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<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
<i>dextroamphetamine sulfate tab 2.5 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 2.5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b><i>dextroamphetamine sulfate tab 5 mg</i></b>	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
<b><i>dextroamphetamine sulfate tab 7.5 mg</i></b>	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
<b><i>dextroamphetamine sulfate tab 10 mg</i></b>	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
<b><i>dextroamphetamine sulfate tab 15 mg</i></b>	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
<b><i>dextroamphetamine sulfate tab 20 mg</i></b>	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
<b><i>dextroamphetamine sulfate tab 30 mg</i></b>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
( 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
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>ANOREXIANTS NON-AMPHETAMINE</b>		
<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
( Phentermine Hcl Tab 8 mg) LOMAIRA	1	PA
<i>phentermine hcl tab 37.5 mg</i>	1	PA
<i>phentermine hcl-topiramate cap er 24hr 3.75-23 mg</i>	1	PA
<i>phentermine hcl-topiramate cap er 24hr 7.5-46 mg</i>	1	PA
<i>phentermine hcl-topiramate cap er 24hr 11.25-69 mg</i>	1	PA
<i>phentermine hcl-topiramate cap er 24hr 15-92 mg</i>	1	PA
QSYMIA CAP 3.75-23 ( <i>phentermine hcl-topiramate</i> )	2	PA
QSYMIA CAP 7.5-46MG ( <i>phentermine hcl-topiramate</i> )	2	PA
QSYMIA CAP 11.25-69 ( <i>phentermine hcl-topiramate</i> )	2	PA
QSYMIA CAP 15-92MG ( <i>phentermine hcl-topiramate</i> )	2	PA
<b>ANTI-OBESITY AGENTS</b>		
<i>orlistat cap 120 mg</i>	1	PA
WEGOVY TAB 1.5MG ( <i>semaglutide (weight management)</i> )	2	PA
WEGOVY TAB 4MG ( <i>semaglutide (weight management)</i> )	2	PA

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
WEGOVY TAB 9MG ( <i>semaglutide (weight management)</i> )	2	PA
WEGOVY TAB 25MG ( <i>semaglutide (weight management)</i> )	2	PA, MO
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
QELBREE CAP 200MG ER ( <i>viloxazine hcl (adhd)</i> )	2	QL (270 caps every 75 days), MO
<b>DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)</b>		
SUNOSI TAB 75MG ( <i>solriamfetol hcl</i> )	2	PA, MO
SUNOSI TAB 150MG ( <i>solriamfetol hcl</i> )	2	PA, MO
<b>HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS</b>		
WAKIX TAB 4.45MG ( <i>pitolisant hcl</i> )	2	SP, PA, QL (2 tabs every 1 day)
WAKIX TAB 17.8MG ( <i>pitolisant hcl</i> )	2	SP, PA, QL (2 tabs every 1 day)
<b>STIMULANTS - MISC.</b>		
<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

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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate hcl cap er 30 mg (cd)</i>	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i><b>methylphenidate hcl cap er 40 mg (cd)</b></i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl cap er 50 mg (cd)</b></i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl cap er 60 mg (cd)</b></i>	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl chew tab 2.5 mg</b></i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl chew tab 5 mg</b></i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl chew tab 10 mg</b></i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl soln 5 mg/5ml</b></i>	1	PA, QL (5400 mL every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl soln 10 mg/5ml</b></i>	1	PA, QL (2700 mL every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab 5 mg</b></i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab 10 mg</b></i>	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab 20 mg</b></i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i><b>methylphenidate hcl tab er 10 mg</b></i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er 20 mg</b></i>	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er 24hr 18 mg</b></i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er 24hr 27 mg</b></i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er 24hr 36 mg</b></i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er 24hr 54 mg</b></i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er osmotic release (osm) 18 mg</b></i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er osmotic release (osm) 27 mg</b></i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er osmotic release (osm) 36 mg</b></i>	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er osmotic release (osm) 54 mg</b></i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
<i><b>methylphenidate hcl tab er osmotic release (osm) 72 mg</b></i>	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>methylphenidate td patch 10 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate td patch 15 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<i>methylphenidate td patch 20 mg/9hr</i>	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
<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
ODACTRA SUB ( <i>dust mite mixed 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**

**ANTIRHEUMATIC - ENZYME INHIBITORS**

RINVOQ LQ SOL 1MG/ML ( <i>upadacitinib</i> )	2	SP, PA, QL (12 mL every 1 day); Preferred for Psoriatic Arthritis
RINVOQ TAB 15MG ER ( <i>upadacitinib</i> )	2	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Crohn's Disease, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
RINVOQ TAB 30MG ER ( <i>upadacitinib</i> )	2	SP, PA, QL (1 tab every 1 day); Preferred for Crohn's Disease, Ulcerative Colitis
RINVOQ TAB 45MG ER ( <i>upadacitinib</i> )	2	SP, PA, QL (56 tabs every 56 days); Preferred for Crohn's Disease, Ulcerative Colitis
XELJANZ SOL 1MG/ML ( <i>tofacitinib citrate</i> )	2	SP, PA, QL (10 mL every 1 day)
XELJANZ TAB 5MG ( <i>tofacitinib citrate</i> )	2	SP, PA, QL (2 tabs every 1 day); Preferred for Rheumatoid Arthritis
XELJANZ TAB 10MG ( <i>tofacitinib citrate</i> )	2	SP, PA, QL (2 tabs every 1 day)
XELJANZ XR TAB 11MG ( <i>tofacitinib citrate</i> )	2	SP, PA, QL (1 tab every 1 day); Preferred for Rheumatoid Arthritis
XELJANZ XR TAB 22MG ( <i>tofacitinib citrate</i> )	2	SP, PA, QL (1 tab every 1 day)
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>ibuprofen tab 800 mg</i>	1	MO
( Ibuprofen Tab 800 mg) IBU	1	MO
<i>ibuprofen-famotidine tab 800-26.6 mg</i>	1	PA, 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>indomethacin susp 25 mg/5ml</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
<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
<i>naproxen tab ec 500 mg</i>	1	MO
<i>oxaprozin cap 300 mg</i>	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 tab 600 mg</i>	1	MO
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
OTEZLA TAB 10/20 ( <i>apremilast</i> )	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 10/20/30 ( <i>apremilast</i> )	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 20MG ( <i>apremilast</i> )	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b>OTEZLA TAB 30MG (apremilast)</b>	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
<b>OTEZLA XR TAB 75MG (apremilast)</b>	2	SP, PA, QL (1 tab every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
<b>OTEZLA/XR TAB 28 DAY (apremilast)</b>	2	SP, PA, QL (41 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>		
<b>leflunomide tab 10 mg</b>	1	MO
<b>leflunomide tab 20 mg</b>	1	MO
<b>ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER</b>		
<b>ANALGESIC COMBINATIONS</b>		
<b>butalbital-acetaminophen tab 50-325 mg</b>	1	QL (48 tabs every 25 days)
( Butalbital-Acetaminophen Tab 50-325 mg) TENCON	1	QL (48 tabs every 25 days)
<b>butalbital-acetaminophen-caffeine tab 50-325-40 mg</b>	1	QL (48 tabs every 25 days)
( Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg) BAC	1	QL (48 tabs every 25 days)
<b>butalbital-aspirin-caffeine cap 50-325-40 mg</b>	1	QL (48 caps every 25 days)
<b>SALICYLATES</b>		
( Aspirin Chew Tab 81 mg) ASPIRIN CHILDRENS	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
<b>aspirin tab delayed release 81 mg</b>	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
<b>diflunisal tab 500 mg</b>	1	MO
<b>salsalate tab 750 mg</b>	1	MO
<b>ANALGESICS - OPIOID - DRUGS TO TREAT PAIN</b>		
<b>OPIOID AGONISTS</b>		
<b>codeine sulfate tab 30 mg</b>	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
<b>fentanyl td patch 72hr 12 mcg/hr</b>	1	ST, QL (10 patches every 25 days); PA**

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>fentanyl td patch 72hr 25 mcg/hr</i>	1	ST, QL (10 patches every 25 days); PA**
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	1	ST, QL (10 patches every 25 days); PA**
<i>fentanyl td patch 72hr 50 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 75 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	1	PA; High Strength Requires PA
<i>fentanyl td patch 72hr 100 mcg/hr</i>	1	PA; High Strength Requires PA
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	1	PA; High Strength Requires PA
<i>hydrocodone bitartrate tab er 24hr deter 20 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>	1	ST, QL (30 tabs every 25 days); PA**
<i>hydrocodone bitartrate tab er 24hr deter 100 mg</i>	1	PA; High Strength Requires PA
<i>hydrocodone bitartrate tab er 24hr deter 120 mg</i>	1	PA; High Strength Requires PA
<i>hydromorphone hcl liqd 1 mg/ml</i>	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
<i>hydromorphone hcl tab 2 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>hydromorphone hcl tab 4 mg</i>	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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>hydromorphone hcl tab 8 mg</i>	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
<i>hydromorphone hcl tab er 24hr 8 mg</i>	1	ST, QL (120 tabs every 25 days); PA**
<i>hydromorphone hcl tab er 24hr 12 mg</i>	1	ST, QL (120 tabs every 25 days); PA**
<i>hydromorphone hcl tab er 24hr 16 mg</i>	1	ST, QL (120 tabs every 25 days); PA**
<i>hydromorphone hcl tab er 24hr 32 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
<i>meperidine hcl oral soln 50 mg/5ml</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>meperidine hcl tab 50 mg</i>	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
<i>methadone hcl conc 10 mg/ml</i>	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
<i>methadone hcl soln 5 mg/5ml</i>	1	ST, QL (450 ml every 25 days); PA**
<i>methadone hcl soln 10 mg/5ml</i>	1	ST, QL (300 mL every 25 days); PA**
<i>methadone hcl tab 5 mg</i>	1	ST, QL (90 tabs every 25 days); PA**
<i>methadone hcl tab 10 mg</i>	1	ST, QL (60 tabs every 25 days); PA**
<i>methadone hcl tab for oral susp 40 mg</i>	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
<i>morphine sulfate beads cap er 24hr 30 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 45 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 60 mg</i>	1	ST, QL (30 caps every 25 days); PA**

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>morphine sulfate beads cap er 24hr 75 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 90 mg</i>	1	ST, QL (30 caps every 25 days); PA**
<i>morphine sulfate beads cap er 24hr 120 mg</i>	1	PA; High Strength Requires PA
<i>morphine sulfate cap er 24hr 10 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 20 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<i>morphine sulfate cap er 24hr 30 mg</i>	1	ST, QL (60 caps every 25 days); PA**
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<i>oxycodone hcl tab 5 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>oxycodone hcl tab 10 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>oxycodone hcl tab 15 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
<i>oxycodone hcl tab 20 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>oxycodone hcl tab 30 mg</i>	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
<i>oxymorphone hcl tab 5 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>oxymorphone hcl tab 10 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>tapentadol hcl tab 50 mg</i>	1	PA, QL (120 tabs every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>tapentadol hcl tab 75 mg</i>	1	PA, QL (90 tabs every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19
<i>tapentadol hcl tab 100 mg</i>	1	PA, QL (60 tabs every 25 days); Subject to initial 7-day limit; Subject to initial 3-day limit under age 19
<i>tramadol hcl oral soln 5 mg/ml</i>	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
<i>tramadol hcl tab 50 mg</i>	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
<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
<b>OPIOID COMBINATIONS</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b><i>acetaminophen w/ codeine tab 300-30 mg</i></b>	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
<b><i>acetaminophen w/ codeine tab 300-60 mg</i></b>	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
<b><i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i></b>	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
<b><i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i></b>	1	QL (48 caps every 25 days); Not available under age 12
<b><i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i></b>	1	QL (48 caps every 25 days); Not available under age 12
<b><i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i></b>	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
<b><i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i></b>	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
<b><i>hydrocodone-acetaminophen soln 10-300 mg/15ml</i></b>	1	ST, QL (2025 mL every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
<b><i>hydrocodone-acetaminophen soln 10-325 mg/15ml</i></b>	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
<b><i>hydrocodone-acetaminophen tab 2.5-325 mg</i></b>	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<i>hydrocodone-ibuprofen tab 5-200 mg</i>	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
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	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
<i>hydrocodone-ibuprofen tab 10-200 mg</i>	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
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
( 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
<b><i>oxycodone w/ acetaminophen tab 5-325 mg</i></b>	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
<b><i>oxycodone w/ acetaminophen tab 7.5-325 mg</i></b>	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
<b><i>oxycodone w/ acetaminophen tab 10-325 mg</i></b>	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
<b><i>tramadol-acetaminophen tab 37.5-325 mg</i></b>	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
<b>OPIOID PARTIAL AGONISTS</b>		
BELBUCA MIS 75MCG ( <i>buprenorphine hcl</i> )	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 150MCG ( <i>buprenorphine hcl</i> )	2	ST, QL (60 films every 25 days); PA**

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
BELBUCA MIS 300MCG ( <i>buprenorphine hcl</i> )	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 450MCG ( <i>buprenorphine hcl</i> )	2	ST, QL (60 films every 25 days); PA**
BELBUCA MIS 600MCG ( <i>buprenorphine hcl</i> )	2	PA; High Strength Requires PA
BELBUCA MIS 750MCG ( <i>buprenorphine hcl</i> )	2	PA; High Strength Requires PA
BELBUCA MIS 900MCG ( <i>buprenorphine hcl</i> )	2	PA; High Strength Requires PA
<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	1	
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	1	
<i>buprenorphine td patch weekly 5 mcg/hr</i>	1	ST, QL (4 patches every month); PA**
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	1	ST, QL (4 patches every month); PA**
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZUBSOLV SUB 11.4-2.9 ( <i>buprenorphine hcl-naloxone hcl dihydrate</i> )	2	
<b>ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES</b>		
<b>ANDROGENS</b>		
<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
( Methyltestosterone Oral Tab 10 mg) METHITEST	1	PA, MO
NATESTO GEL 5.5MG ( <i>testosterone</i> )	2	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
<b>ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS</b>		
<b>INTRARECTAL STEROIDS</b>		
<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	
<b>RECTAL COMBINATIONS</b>		
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	1	
PROCTOFOAM AER HC 1% ( <i>hydrocortisone acetate w/ pramoxine</i> )	2	
<b>RECTAL STEROIDS</b>		
<i>hydrocortisone perianal cream 1%</i>	1	
( Hydrocortisone Perianal Cream 1%) PROCTOCORT	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	
<b>VASODILATING AGENTS</b>		
<i>nitroglycerin oint 0.4%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES</b>		
<b>ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES</b>		
<i>albendazole tab 200 mg</i>	1	
EMVERM CHW 100MG ( <i>mebendazole</i> )	2	
<i>ivermectin tab 3 mg</i>	1	
<i>ivermectin tab 6 mg</i>	1	
<i>praziquantel tab 600 mg</i>	1	
<b>ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS</b>		
<b>ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS</b>		
IMPAVIDO CAP 50MG ( <i>miltefosine</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
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>		
<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	
<b>ANTIPROTOZOAL AGENTS</b>		
<i>atovaquone susp 750 mg/5ml</i>	1	
<i>nitazoxanide tab 500 mg</i>	1	
<b>GLYCOPEPTIDES</b>		
<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	
<b>LEPROSTATICS</b>		
<i>dapsone tab 25 mg</i>	1	MO
<i>dapsone tab 100 mg</i>	1	MO
<b>LINCOSAMIDES</b>		
<i>clindamycin hcl cap 75 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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	
<b>MONOBACTAMS</b>		
CAYSTON INH 75MG ( <i>aztreonam lysine</i> )	3	SP, PA
<b>OXAZOLIDINONES</b>		
<i>linezolid for susp 100 mg/5ml</i>	1	
<i>linezolid tab 600 mg</i>	1	
<b>URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS</b>		
<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	
<b>ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS</b>		
<b>ANTIANGINALS-OTHER</b>		
<i>ranolazine tab er 12hr 500 mg</i>	1	MO
<i>ranolazine tab er 12hr 1000 mg</i>	1	MO
<b>NITRATES</b>		
<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
<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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>ANTI-ANXIETY AGENTS - DRUGS TO TREAT ANXIETY</b>		
<b>ANTI-ANXIETY AGENTS - MISC.</b>		
<i>bupirone hcl tab 5 mg</i>	1	
<i>bupirone hcl tab 7.5 mg</i>	1	
<i>bupirone hcl tab 10 mg</i>	1	
<i>bupirone hcl tab 15 mg</i>	1	
<i>bupirone 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	
<b>BENZODIAZEPINES</b>		
<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)
( 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)

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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)
<b>ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS</b>		
<b>ANTIARRHYTHMICS TYPE I-A</b>		
<i>disopyramide phosphate cap 100 mg</i>	1	MO
<i>disopyramide phosphate cap 150 mg</i>	1	MO
<i>quinidine gluconate tab er 324 mg</i>	1	MO
<b>ANTIARRHYTHMICS TYPE I-B</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
<b>ANTIARRHYTHMICS TYPE I-C</b>		
<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
<i>propafenone hcl tab 300 mg</i>	1	MO
<b>ANTIARRHYTHMICS TYPE III</b>		
<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
<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
MULTAQ TAB 400MG ( <i>dronedarone hcl</i> )	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>		
<b>ANTI-INFLAMMATORY AGENTS</b>		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (720 mL every 75 days), MO
<b>BRONCHODILATORS - ANTICHOLINERGICS</b>		
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (938 mL every 75 days), MO
SPIRIVA CAP HANDIHLR ( <i>tiotropium bromide</i> )	1	QL (90 caps every 75 days), MO
SPIRIVA RESP AER 1.25MCG ( <i>tiotropium bromide</i> )	2	QL (3 inhalers every 75 days), MO
SPIRIVA RESP AER 2.5MCG ( <i>tiotropium bromide</i> )	2	QL (3 inhalers every 75 days), MO
YUPELRI SOL 175/3ML ( <i>revefenacin</i> )	2	QL (270 mL every 75 days), MO
<b>LEUKOTRIENE MODULATORS</b>		
<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
<b>SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
<i>roflumilast tab 250 mcg</i>	1	MO
<i>roflumilast tab 500 mcg</i>	1	MO
<b>STEROID INHALANTS</b>		
ASMANEX HFA AER 50MCG ( <i>mometasone furoate (inhalation)</i> )	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 100 MCG ( <i>mometasone furoate (inhalation)</i> )	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 200 MCG ( <i>mometasone furoate (inhalation)</i> )	2	QL (3 inhalers every 75 days), MO
<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (360 mL every 75 days), MO
<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
<i>fluticasone furoate aerosol powder breath activ 50 mcg/act</i>	1	QL (3 inhalers every 75 days), MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>fluticasone furoate aerosol powder breath activ 100 mcg/act</i>	1	QL (90 blisters every 75 days), MO
<i>fluticasone furoate aerosol powder breath activ 200 mcg/act</i>	1	QL (90 blisters every 75 days), MO
<i>fluticasone propionate hfa inhal aer 110 mcg/act</i>	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aer 220 mcg/act</i>	3	QL (6 inhalers every 75 days), MO
<i>fluticasone propionate hfa inhal aero 44 mcg/act</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
<b>SYMPATHOMIMETICS</b>		
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
<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>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act</i>	1	QL (9 inhalers every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
<b><i>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act</i></b>	1	QL (9 inhalers every 75 days), MO
( Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
<b><i>fluticasone-salmeterol aer powder ba 100-50 mcg/act</i></b>	1	QL (180 inhalations every 75 days), MO
( Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
<b><i>fluticasone-salmeterol aer powder ba 250-50 mcg/act</i></b>	1	QL (180 inhalations every 75 days), MO
( Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
<b><i>fluticasone-salmeterol aer powder ba 500-50 mcg/act</i></b>	1	QL (180 inhalations every 75 days), MO
( Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act) WIXELA INHUB	1	QL (180 inhalations every 75 days), MO
<b><i>formoterol fumarate soln nebu 20 mcg/2ml</i></b>	1	QL (360 mL every 75 days), MO
<b><i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i></b>	1	QL (1620 mL every 75 days), MO
<b><i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i></b>	1	QL (900 mL every 75 days), MO
<b><i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i></b>	1	QL (900 mL every 75 days), MO
<b><i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i></b>	1	QL (900 mL every 75 days), MO
<b><i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i></b>	1	QL (270 mL every 75 days), MO
<b><i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i></b>	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
<b><i>terbutaline sulfate tab 2.5 mg</i></b>	1	MO
<b><i>terbutaline sulfate tab 5 mg</i></b>	1	MO
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>XANTHINES</b>		
<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 100 mg</i>	1	MO
<i>theophylline tab er 12hr 200 mg</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
<b>ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS</b>		
<b>COUMARIN ANTICOAGULANTS</b>		
<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
<b>DIRECT FACTOR XA INHIBITORS</b>		
ELIQUIS CAP 0.15MG ( <i>apixaban</i> )	2	MO
ELIQUIS ST P TAB 5MG ( <i>apixaban</i> )	2	
ELIQUIS TAB 0.5MG ( <i>apixaban</i> )	2	MO
ELIQUIS TAB 1.5MG ( <i>apixaban</i> )	2	MO
ELIQUIS TAB 2.5MG ( <i>apixaban</i> )	2	MO
ELIQUIS TAB 2MG ( <i>apixaban</i> )	2	MO
ELIQUIS TAB 5MG ( <i>apixaban</i> )	2	MO
<i>rivaroxaban for susp 1 mg/ml</i>	1	MO
<i>rivaroxaban tab 2.5 mg</i>	1	MO
XARELTO STAR TAB 15/20MG ( <i>rivaroxaban</i> )	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XARELTO TAB 2.5MG ( <i>rivaroxaban</i> )	2	MO
XARELTO TAB 10MG ( <i>rivaroxaban</i> )	2	MO
XARELTO TAB 15MG ( <i>rivaroxaban</i> )	2	MO
XARELTO TAB 20MG ( <i>rivaroxaban</i> )	2	MO
<b>THROMBIN INHIBITORS</b>		
<i>dabigatran etexilate mesylate cap 75 mg (etexilate base eq)</i>	1	MO
<i>dabigatran etexilate mesylate cap 110 mg (etexilate base eq)</i>	1	MO
<i>dabigatran etexilate mesylate cap 150 mg (etexilate base eq)</i>	1	MO
<b>ANTICONSULSANTS - DRUGS TO TREAT SEIZURES</b>		
<b>AMPA GLUTAMATE RECEPTOR ANTAGONISTS</b>		
<i>perampanel susp 0.5 mg/ml</i>	1	MO
<i>perampanel tab 2 mg</i>	1	MO
<i>perampanel tab 4 mg</i>	1	MO
<i>perampanel tab 6 mg</i>	1	MO
<i>perampanel tab 8 mg</i>	1	MO
<i>perampanel tab 10 mg</i>	1	MO
<i>perampanel tab 12 mg</i>	1	MO
<b>ANTICONSULSANTS - BENZODIAZEPINES</b>		
<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	
NAYZILAM SPR 5MG ( <i>midazolam (anticonvulsant)</i> )	2	
VALTOCO SPR 5MG ( <i>diazepam (anticonvulsant)</i> )	2	
VALTOCO SPR 10MG ( <i>diazepam (anticonvulsant)</i> )	2	
VALTOCO SPR 15MG ( <i>diazepam (anticonvulsant)</i> )	2	
VALTOCO SPR 20MG ( <i>diazepam (anticonvulsant)</i> )	2	

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b>ANTICONVULSANTS - MISC.</b>		
<i>brivaracetam oral soln 10 mg/ml</i>	1	MO
<i>brivaracetam tab 10 mg</i>	1	MO
<i>brivaracetam tab 25 mg</i>	1	MO
<i>brivaracetam tab 50 mg</i>	1	MO
<i>brivaracetam tab 75 mg</i>	1	MO
<i>brivaracetam tab 100 mg</i>	1	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
<i>carbamazepine chew tab 200 mg</i>	1	MO
<i>carbamazepine susp 100 mg/5ml</i>	1	MO
<i>carbamazepine tab 200 mg</i>	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>eslicarbazepine acetate tab 200 mg</i>	1	MO
<i>eslicarbazepine acetate tab 400 mg</i>	1	MO
<i>eslicarbazepine acetate tab 600 mg</i>	1	MO
<i>eslicarbazepine acetate tab 800 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) &amp; 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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Lamotrigine Tab 35 X 25 mg Starter Kit) SUBVENITE STARTER KIT/BLU	1	
<b>lamotrigine tab 84 x 25 mg &amp; 14 x 100 mg starter kit</b>	1	
( Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit) SUBVENITE STARTER KIT/GRE	1	
<b>lamotrigine tab 100 mg</b>	1	MO
( Lamotrigine Tab 100 mg) SUBVENITE	1	MO
<b>lamotrigine tab 150 mg</b>	1	MO
( Lamotrigine Tab 150 mg) SUBVENITE	1	MO
<b>lamotrigine tab 200 mg</b>	1	MO
( Lamotrigine Tab 200 mg) SUBVENITE	1	MO
<b>lamotrigine tab chewable dispersible 5 mg</b>	1	MO
<b>lamotrigine tab chewable dispersible 25 mg</b>	1	MO
<b>lamotrigine tab disint 21 x 25 mg &amp; 7 x 50 mg titration kit</b>	1	
<b>lamotrigine tab disint 25 (14) &amp; 50 mg (14) &amp; 100 mg (7) kit</b>	1	
<b>lamotrigine tab disint 42 x 50mg &amp; 14 x 100mg titration kit</b>	1	
<b>lamotrigine tab er 24hr 25 mg</b>	1	MO
<b>lamotrigine tab er 24hr 50 mg</b>	1	MO
<b>lamotrigine tab er 24hr 100 mg</b>	1	MO
<b>lamotrigine tab er 24hr 200 mg</b>	1	MO
<b>lamotrigine tab er 24hr 250 mg</b>	1	MO
<b>lamotrigine tab er 24hr 300 mg</b>	1	MO
<b>levetiracetam oral soln 100 mg/ml</b>	1	MO
<b>levetiracetam tab 250 mg</b>	1	MO
<b>levetiracetam tab 500 mg</b>	1	MO
( Levetiracetam Tab 500 mg) ROWEPR	1	MO
<b>levetiracetam tab 750 mg</b>	1	MO
<b>levetiracetam tab 1000 mg</b>	1	MO
<b>levetiracetam tab disintegrating soluble 250 mg</b>	1	MO
<b>levetiracetam tab disintegrating soluble 500 mg</b>	1	MO
<b>levetiracetam tab er 24hr 500 mg</b>	1	MO
<b>levetiracetam tab er 24hr 750 mg</b>	1	MO
<b>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</b>	1	MO
<b>oxcarbazepine tab 150 mg</b>	1	MO
<b>oxcarbazepine tab 300 mg</b>	1	MO
<b>oxcarbazepine tab 600 mg</b>	1	MO
<b>oxcarbazepine tab er 24hr 150 mg</b>	1	MO
<b>oxcarbazepine tab er 24hr 300 mg</b>	1	MO
<b>oxcarbazepine tab er 24hr 600 mg</b>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>OXTELLAR XR TAB 150MG ( oxcarbazepine)</i>	2	MO
<i>OXTELLAR XR TAB 300MG ( oxcarbazepine)</i>	2	MO
<i>OXTELLAR XR TAB 600MG ( 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 oral soln 25 mg/ml</i>	1	MO
<i>topiramate sprinkle cap 15 mg</i>	1	MO
<i>topiramate sprinkle cap 25 mg</i>	1	MO
<i>topiramate sprinkle cap 50 mg</i>	1	MO
<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
<i>zonisamide cap 25 mg</i>	1	MO
<i>zonisamide cap 50 mg</i>	1	MO
<i>zonisamide cap 100 mg</i>	1	MO
<b>CARBAMATES</b>		
<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
<i>XCOPRI PAK 12.5-25 ( cenobamate)</i>	2	
<i>XCOPRI PAK 50-100MG ( cenobamate)</i>	2	
<i>XCOPRI PAK 100-150 ( cenobamate)</i>	2	MO
<i>XCOPRI PAK 150-200 ( cenobamate)</i>	2	
<i>XCOPRI PAK 150-200 ( cenobamate)</i>	2	MO
<i>XCOPRI TAB 25MG ( cenobamate)</i>	2	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
XCOPRI TAB 50MG ( <i>cenobamate</i> )	2	MO
XCOPRI TAB 100MG ( <i>cenobamate</i> )	2	MO
XCOPRI TAB 150MG ( <i>cenobamate</i> )	2	MO
XCOPRI TAB 200MG ( <i>cenobamate</i> )	2	MO
<b>GABA MODULATORS</b>		
<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)
(Vigabatrin Tab 500 mg) VIGADRONE	1	SP, PA, QL (6 tabs every 1 day)
<b>HYDANTOINS</b>		
<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
<b>SUCCINIMIDES</b>		
<i>ethosuximide cap 250 mg</i>	1	MO
<i>ethosuximide soln 250 mg/5ml</i>	1	MO
<i>methsuximide cap 300 mg</i>	1	MO
<b>VALPROIC ACID</b>		
<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
<b>ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION</b>		
<b>ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>mirtazapine tab 15 mg</i>	1	MO
<i>mirtazapine tab 30 mg</i>	1	MO
<i>mirtazapine tab 45 mg</i>	1	MO
<b>ANTIDEPRESSANT COMBINATIONS</b>		
<i>AUVELITY TAB 45-105MG ( dextromethorphan hydrobromide-bupropion hydrochloride)</i>	2	MO
<b>ANTIDEPRESSANTS - MISC.</b>		
<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
<b>GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID</b>		
<i>ZURZUVAE CAP 20MG ( zuranolone)</i>	2	SP, PA, QL (2 caps every 1 day)
<i>ZURZUVAE CAP 25MG ( zuranolone)</i>	2	SP, PA, QL (2 caps every 1 day)
<i>ZURZUVAE CAP 30MG ( zuranolone)</i>	2	SP, PA, QL (1 cap every 1 day)
<b>MONOAMINE OXIDASE INHIBITORS (MAOIS)</b>		
<i>phenelzine sulfate tab 15 mg</i>	1	MO
<i>tranylcypromine sulfate tab 10 mg</i>	1	MO
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>		
<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
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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 cap 150 mg</i>	1	MO
<i>sertraline hcl cap 200 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
<b>SEROTONIN MODULATORS</b>		
<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
TRINTELLIX TAB 5MG ( <i>vortioxetine hbr</i> )	2	MO
TRINTELLIX TAB 10MG ( <i>vortioxetine hbr</i> )	2	MO
TRINTELLIX TAB 20MG ( <i>vortioxetine hbr</i> )	2	MO
<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
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)</b>		
<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
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>TRICYCLIC AGENTS</b>		
<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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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 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
GLYXAMBI TAB 10-5 MG ( <i>empagliflozin-linagliptin</i> )	2	MO
GLYXAMBI TAB 25-5 MG ( <i>empagliflozin-linagliptin</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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
SOLIQUA INJ 100/33 ( <i>insulin glargine-lixisenatide</i> )	2	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	MO
ZITUVIMET TAB 50-500MG ( <i>sitagliptin free base-metformin hcl</i> )	2	MO
ZITUVIMET TAB 50-1000 ( <i>sitagliptin free base-metformin hcl</i> )	2	MO
ZITUVIMET XR TAB 50-500MG ( <i>sitagliptin free base-metformin hcl</i> )	2	MO
ZITUVIMET XR TAB 50-1000 ( <i>sitagliptin free base-metformin hcl</i> )	2	MO
ZITUVIMET XR TAB 100-1000 ( <i>sitagliptin free base-metformin hcl</i> )	2	MO
<b>BIGUANIDES</b>		
<i>metformin hcl oral soln 500 mg/5ml</i>	1	MO
<i>metformin hcl tab 500 mg</i>	1	MO
<i>metformin hcl tab 625 mg</i>	1	MO
<i>metformin hcl tab 750 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>metformin hcl tab 850 mg</i>	1	MO
<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
<b>DIABETIC OTHER</b>		
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 for inj 1 mg</i>	1	
GVOKE HYPO 1 INJ 0.5/.1ML ( <i>glucagon</i> )	2	
GVOKE HYPO 1 INJ 1/0.2ML ( <i>glucagon</i> )	2	
GVOKE HYPO 2 INJ 0.5/.1ML ( <i>glucagon</i> )	2	
GVOKE HYPO 2 INJ 1/0.2ML ( <i>glucagon</i> )	2	
GVOKE KIT SOL 1/0.2ML ( <i>glucagon</i> )	2	
GVOKE PFS INJ 1/0.2ML ( <i>glucagon</i> )	2	
<i>mifepristone tab 300 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>		
<i>saxagliptin hcl tab 2.5 mg (base equiv)</i>	1	MO
<i>saxagliptin hcl tab 5 mg (base equiv)</i>	1	MO
ZITUVIO TAB 25MG ( <i>sitagliptin</i> )	2	MO
ZITUVIO TAB 50MG ( <i>sitagliptin</i> )	2	MO
ZITUVIO TAB 100MG ( <i>sitagliptin</i> )	2	MO
<b>INCRETIN MIMETIC AGENTS</b>		
<i>liraglutide soln pen-injector 18 mg/3ml (6 mg/ml)</i>	1	PA, MO
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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>INSULIN</b>		
AFREZZA POW 4-8 UNIT ( <i>insulin regular (human)</i> )	3	MO
AFREZZA POW 4-8-12 ( <i>insulin regular (human)</i> )	3	MO
AFREZZA POW 4UNIT ( <i>insulin regular (human)</i> )	3	MO
AFREZZA POW 8 UNIT ( <i>insulin regular (human)</i> )	3	MO
AFREZZA POW 8-12UNIT ( <i>insulin regular (human)</i> )	3	MO
AFREZZA POW 12 UNIT ( <i>insulin regular (human)</i> )	3	MO
FIASP FLEX INJ TOUCH ( <i>insulin aspart (with niacinamide)</i> )	2	MO
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
GLARGIN YFGN INJ 100U/ML	2	MO
GLARGIN YFGN SOL 100U/ML	2	MO
HUMULIN R INJ U-500KWP ( <i>insulin regular (human)</i> )	2	MO
LANTUS INJ 100/ML ( <i>insulin glargine</i> )	2	MO
LANTUS SOLOS INJ 100/ML ( <i>insulin glargine</i> )	2	MO
NOVOLIN INJ 70/30 ( <i>insulin nph isophane &amp; reg (human)</i> )	2	MO; RELION not covered
NOVOLIN INJ 70/30 FP ( <i>insulin nph isophane &amp; 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 &amp; aspart (human)</i> )	2	MO; RELION not covered
NOVOLOG MIX INJ FLEXPEN ( <i>insulin aspart protamine &amp; aspart (human)</i> )	2	MO; RELION not covered
TOUJEO MAX INJ 300/ML ( <i>insulin glargine</i> )	2	MO
TOUJEO SOLO INJ 300/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
<b>INSULIN SENSITIZING AGENTS</b>		
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	1	MO
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	MO
<b>MEGLITINIDE ANALOGUES</b>		
<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
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS</b>		
FARXIGA TAB 5MG ( <i>dapagliflozin propanediol</i> )	2	MO
FARXIGA TAB 10MG ( <i>dapagliflozin propanediol</i> )	2	MO
JARDIANCE TAB 10MG ( <i>empagliflozin</i> )	2	MO
JARDIANCE TAB 25MG ( <i>empagliflozin</i> )	2	MO
<b>SULFONYLUREAS</b>		
<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
<i>glipizide tab er 24hr 5 mg</i>	1	MO
<i>glipizide tab er 24hr 10 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
<b>ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA</b>		
<b>ANTIPERISTALTIC AGENTS</b>		
<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	
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>deferiprone tab 500 mg</i>	1	SP, PA
<i>deferiprone tab 1000 mg</i>	1	SP, PA
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING</b>		
VISTOGARD PAK 10GM ( <i>uridine triacetate (emergency treatment)</i> )	2	QL (20 packets every 5 days)
<b>OPIOID ANTAGONISTS</b>		
<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	
<b>ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
<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)
SANCUSO DIS 3.1MG ( <i>granisetron</i> )	2	QL (2 patches every 21 days)
<b>ANTIEMETICS - ANTICHOLINERGIC</b>		
<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	
<b>ANTIEMETICS - MISCELLANEOUS</b>		
<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)
<b>SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS</b>		
<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 &amp; 125 mg</i>	1	QL (6 caps every 21 days)
<b>ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS</b>		
<b>ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS</b>		
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>griseofulvin ultramicrosize tab 165 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	
<b>IMIDAZOLE-RELATED ANTIFUNGALS</b>		
<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	
<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	
<b>ANTI-HISTAMINES - DRUGS TO TREAT ALLERGIES</b>		
<b>ANTI-HISTAMINES - ETHANOLAMINES</b>		
<i>carbinoxamine maleate extended release susp 4 mg/5ml</i>	1	
<i>carbinoxamine maleate soln 4 mg/5ml</i>	1	
( Carbinoxamine Maleate Soln 4 mg/5ml) CARBZAH	1	
<i>carbinoxamine maleate tab 4 mg</i>	1	
<i>carbinoxamine maleate tab 6 mg</i>	1	
( Carbinoxamine Maleate Tab 6 mg) RYVENT	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	
<b>ANTI-HISTAMINES - NON-SEDATING</b>		
<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	
<b>ANTI-HISTAMINES - PHENOTHIAZINES</b>		
<i>promethazine hcl oral soln 6.25 mg/5ml</i>	1	
<i>promethazine hcl suppos 12.5 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Promethazine Hcl Suppos 12.5 mg) PROMETHEGAN	1	
<b><i>promethazine hcl suppos 25 mg</i></b>	1	
( Promethazine Hcl Suppos 25 mg) PROMETHEGAN	1	
( Promethazine Hcl Suppos 50 mg) PROMETHEGAN	1	
<b><i>promethazine hcl tab 12.5 mg</i></b>	1	
<b><i>promethazine hcl tab 25 mg</i></b>	1	
<b><i>promethazine hcl tab 50 mg</i></b>	1	
<b>ANTIHISTAMINES - PIPERIDINES</b>		
<b><i>cyproheptadine hcl syrup 2 mg/5ml</i></b>	1	
<b><i>cyproheptadine hcl tab 4 mg</i></b>	1	
<b>ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL</b>		
<b>ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS</b>		
NEXLETOL TAB 180MG ( <i>bempedoic acid</i> )	2	MO
<b>ANTIHYPERLIPIDEMICS - COMBINATIONS</b>		
<b><i>ezetimibe-simvastatin tab 10-10 mg</i></b>	1	MO
<b><i>ezetimibe-simvastatin tab 10-20 mg</i></b>	1	MO
<b><i>ezetimibe-simvastatin tab 10-40 mg</i></b>	1	MO
<b><i>ezetimibe-simvastatin tab 10-80 mg</i></b>	1	MO
NEXLIZET TAB 180/10MG ( <i>bempedoic acid-ezetimibe</i> )	2	MO
<b>ANTIHYPERLIPIDEMICS - MISC.</b>		
<b><i>omega-3-acid ethyl esters cap 1 gm</i></b>	1	MO
VASCEPA CAP 0.5GM ( <i>icosapent ethyl</i> )	1	MO
VASCEPA CAP 1GM ( <i>icosapent ethyl</i> )	1	MO
<b>BILE ACID SEQUESTRANTS</b>		
<b><i>cholestyramine light powder 4 gm/dose</i></b>	1	MO
( Cholestyramine Light Powder 4 gm/dose) PREVALITE	1	MO
<b><i>cholestyramine light powder packets 4 gm</i></b>	1	MO
( Cholestyramine Light Powder Packets 4 gm) PREVALITE	1	MO
<b><i>cholestyramine powder 4 gm/dose</i></b>	1	MO
<b><i>cholestyramine powder packets 4 gm</i></b>	1	MO
<b><i>colesevelam hcl packet for susp 3.75 gm</i></b>	1	MO
<b><i>colesevelam hcl tab 625 mg</i></b>	1	MO
<b><i>colestipol hcl granule packets 5 gm</i></b>	1	MO
<b><i>colestipol hcl granules 5 gm</i></b>	1	MO
<b><i>colestipol hcl tab 1 gm</i></b>	1	MO
<b>FIBRIC ACID DERIVATIVES</b>		
<b><i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i></b>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>HMG COA REDUCTASE INHIBITORS</b>		
<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
<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; \$0 copay for members age 40 through 75
<i>pitavastatin calcium tab 2 mg</i>	1	MO; \$0 copay for members age 40 through 75
<i>pitavastatin calcium tab 4 mg</i>	1	MO; \$0 copay for members age 40 through 75
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>		
<i>ezetimibe tab 10 mg</i>	1	MO
<b>NICOTINIC ACID DERIVATIVES</b>		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	1	MO
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	1	MO
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	1	MO
<b>ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE</b>		
<b>ACE INHIBITORS</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>AGENTS FOR PHEOCHROMOCYTOMA</b>		
<i>metyrosine cap 250 mg</i>	1	SP, PA, QL (16 caps every 1 day)
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>telmisartan tab 40 mg</i>	1	MO
<i>telmisartan tab 80 mg</i>	1	MO
<i>valsartan oral soln 4 mg/ml</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
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>		
<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 tab er 24hr 0.17 mg</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>methyldopa tab 250 mg</i>	1	MO
<i>methyldopa tab 500 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
<b>ANTIHYPERTENSIVE COMBINATIONS</b>		
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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 &amp; chlorthalidone tab 50-25 mg</i>	1	MO
<i>atenolol &amp; chlorthalidone tab 100-25 mg</i>	1	MO
<i>benazepril &amp; hydrochlorothiazide tab 5-6.25 mg</i>	1	MO
<i>benazepril &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>benazepril &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>benazepril &amp; hydrochlorothiazide tab 20-25 mg</i>	1	MO
<i>bisoprolol &amp; hydrochlorothiazide tab 2.5-6.25 mg</i>	1	MO
<i>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg</i>	1	MO
<i>bisoprolol &amp; 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
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	MO
<i>captopril &amp; hydrochlorothiazide tab 25-15 mg</i>	1	MO
<i>captopril &amp; hydrochlorothiazide tab 25-25 mg</i>	1	MO
<i>captopril &amp; hydrochlorothiazide tab 50-15 mg</i>	1	MO
<i>captopril &amp; hydrochlorothiazide tab 50-25 mg</i>	1	MO
<i>enalapril maleate &amp; hydrochlorothiazide tab 5-12.5 mg</i>	1	MO
<i>enalapril maleate &amp; hydrochlorothiazide tab 10-25 mg</i>	1	MO
<i>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>fosinopril sodium &amp; 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 &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	MO
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	MO
<i>lisinopril &amp; hydrochlorothiazide tab 20-25 mg</i>	1	MO
<i>losartan potassium &amp; hydrochlorothiazide tab 50-12.5 mg</i>	1	MO
<i>losartan potassium &amp; hydrochlorothiazide tab 100-12.5 mg</i>	1	MO
<i>losartan potassium &amp; hydrochlorothiazide tab 100-25 mg</i>	1	MO
<i>metoprolol &amp; hydrochlorothiazide tab 50-25 mg</i>	1	MO
<i>metoprolol &amp; hydrochlorothiazide tab 100-25 mg</i>	1	MO
<i>metoprolol &amp; 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>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	MO
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	MO
<i>quinapril-hydrochlorothiazide tab 10-12.5 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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>DIRECT RENIN INHIBITORS</b>		
<i>aliskiren fumarate tab 150 mg (base equivalent)</i>	1	MO
<i>aliskiren fumarate tab 300 mg (base equivalent)</i>	1	MO
<b>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</b>		
<i>eplerenone tab 25 mg</i>	1	MO
<i>eplerenone tab 50 mg</i>	1	MO
<b>VASODILATORS</b>		
<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
<b>ANTIMALARIALS - DRUGS TO TREAT MALARIA</b>		
<b>ANTIMALARIAL COMBINATIONS</b>		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
COARTEM TAB 20-120MG ( <i>artemether-lumefantrine</i> )	3	
<b>ANTIMALARIALS - DRUGS TO TREAT MALARIA</b>		
<i>chloroquine phosphate tab 250 mg</i>	1	MO
<i>chloroquine phosphate tab 500 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 100 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 300 mg</i>	1	MO
<i>hydroxychloroquine sulfate tab 400 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	
<i>quinine sulfate cap 324 mg</i>	1	
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS</b>		
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS</b>		
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS</b>		
<b>ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS</b>		
<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
<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	
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER</b>		
<b>ALKYLATING AGENTS</b>		
<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
<i>lomustine cap 10 mg</i>	1	SP; OAC
<i>lomustine cap 40 mg</i>	1	SP; OAC
<i>lomustine cap 100 mg</i>	1	SP; 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
<b>ANTIMETABOLITES</b>		
<i>capecitabine tab 150 mg</i>	1	SP, PA; OAC
<i>capecitabine tab 500 mg</i>	1	SP, PA; OAC
<i>mercaptopurine susp 2000 mg/100ml (20 mg/ml)</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
<b>ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS</b>		
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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
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
<b>ANTINEOPLASTIC - EGFR INHIBITORS</b>		
<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
TAGRISSO TAB 40MG ( <i>osimertinib mesylate</i> )	2	SP, PA, QL (1 tab every 1 day); OAC
TAGRISSO TAB 80MG ( <i>osimertinib mesylate</i> )	2	SP, PA, QL (1 tab every 1 day); OAC
<b>ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS</b>		
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
<b>ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS</b>		
<i>abiraterone acetate tab 250 mg</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
( Abiraterone Acetate Tab 250 mg) ABIRTEGA	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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
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
<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
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
<b>ANTINEOPLASTIC - IMMUNOMODULATORS</b>		
<i>pomalidomide cap 1 mg</i>	1	SP, PA, QL (21 caps every 21 days); OAC
<i>pomalidomide cap 2 mg</i>	1	SP, PA, QL (21 caps every 21 days); OAC
<i>pomalidomide cap 3 mg</i>	1	SP, PA, QL (21 caps every 21 days); OAC
<i>pomalidomide cap 4 mg</i>	1	SP, PA, QL (21 caps every 21 days); OAC
POMALYST CAP 1MG ( <i>pomalidomide</i> )	3	SP, PA; OAC
POMALYST CAP 2MG ( <i>pomalidomide</i> )	3	SP, PA; OAC

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
POMALYST CAP 3MG ( <i>pomalidomide</i> )	3	SP, PA; OAC
POMALYST CAP 4MG ( <i>pomalidomide</i> )	3	SP, PA; OAC
<b>ANTINEOPLASTIC COMBINATIONS</b>		
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
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>		
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
AUGTYRO CAP 40MG ( <i>repotrectinib</i> )	2	SP, PA, QL (8 caps every 1 day); OAC
AUGTYRO CAP 160MG ( <i>repotrectinib</i> )	2	SP, PA, QL (2 caps every 1 day); OAC
BOSULIF CAP 50MG ( <i>bosutinib</i> )	2	SP, PA, QL (1 cap every 1 day); OAC
BOSULIF CAP 100MG ( <i>bosutinib</i> )	2	SP, PA, QL (10 caps 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
BRUKINSA TAB 160MG ( <i>zanubrutinib</i> )	2	SP, PA, QL (2 tabs 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
CABOMETYX TAB 60MG ( <i>cabozantinib s-malate</i> )	2	SP, PA, QL (1 tab every 1 day); OAC

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
CALQUENCE TAB 100MG ( <i>acalabrutinib maleate</i> )	2	PA, QL (2 tabs every 1 day); OAC
<i>dasatinib tab 20 mg</i>	1	SP, PA, QL (3 tabs every 1 day); OAC
<i>dasatinib tab 50 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 70 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 80 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 100 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>dasatinib tab 140 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
<i>everolimus tab 2.5 mg</i>	1	SP, PA, QL (1 tab every 1 day); OAC
( Everolimus Tab 2.5 mg) TORPENZ	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
( Everolimus Tab 5 mg) TORPENZ	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
( Everolimus Tab 7.5 mg) TORPENZ	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
( Everolimus Tab 10 mg) TORPENZ	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
GOMEKLI CAP 1MG ( <i>mirdametinib</i> )	2	SP, PA, QL (42 caps every 21 days); OAC
GOMEKLI CAP 2MG ( <i>mirdametinib</i> )	2	SP, PA, QL (84 caps every 21 days); OAC
GOMEKLI TAB 1MG ( <i>mirdametinib</i> )	2	SP, PA, QL (168 tabs every 21 days); OAC

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
IBRANCE CAP 75MG ( <i>palbociclib</i> )	2	SP, PA, QL (21 caps every 21 days); OAC
IBRANCE CAP 100MG ( <i>palbociclib</i> )	2	SP, PA, QL (21 caps every 21 days); OAC
IBRANCE CAP 125MG ( <i>palbociclib</i> )	2	SP, PA, QL (21 caps every 21 days); OAC
IBRANCE TAB 75MG ( <i>palbociclib</i> )	2	SP, PA, QL (21 tabs every 21 days); OAC
IBRANCE TAB 100MG ( <i>palbociclib</i> )	2	SP, PA, QL (21 tabs every 21 days); OAC
IBRANCE TAB 125MG ( <i>palbociclib</i> )	2	SP, PA, QL (21 tabs every 21 days); OAC
IBTROZI CAP 200MG ( <i>taletrectinib adipate</i> )	2	SP, PA, QL (3 caps every 1 day); 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
JAKAFI TAB 5MG ( <i>ruxolitinib phosphate</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 10MG ( <i>ruxolitinib phosphate</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 15MG ( <i>ruxolitinib phosphate</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 20MG ( <i>ruxolitinib phosphate</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 25MG ( <i>ruxolitinib phosphate</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
KISQALI TAB 200DOSE ( <i>ribociclib succinate</i> )	2	SP, PA, QL (21 tabs every 21 days); OAC
KISQALI TAB 400DOSE ( <i>ribociclib succinate</i> )	2	SP, PA, QL (42 tabs every 21 days); OAC
KISQALI TAB 600DOSE ( <i>ribociclib succinate</i> )	2	SP, PA, QL (63 tabs every 21 days); OAC
KOSELUGO CAP 10MG ( <i>selumetinib sulfite</i> )	2	PA, QL (8 caps every 1 day); OAC
KOSELUGO CAP 25MG ( <i>selumetinib sulfite</i> )	2	PA, QL (4 caps every 1 day); OAC
KRAZATI TAB 200MG ( <i>adagrasib</i> )	2	PA, QL (6 tabs every 1 day); OAC
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	1	SP, PA, QL (6 tabs every 1 day); OAC
LUMAKRAS TAB 120MG ( <i>sotorasib</i> )	2	SP, PA, QL (8 tabs every 1 day); OAC

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
LUMAKRAS TAB 240MG ( <i>sotorasib</i> )	2	SP, PA, QL (4 tabs every 1 day); OAC
LUMAKRAS TAB 320MG ( <i>sotorasib</i> )	2	SP, PA, QL (3 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
MEKINIST SOL 0.05/ML ( <i>trametinib dimethyl sulfoxide</i> )	2	SP, PA, QL (38 mL every 1 day); OAC
MEKINIST TAB 0.5MG ( <i>trametinib dimethyl sulfoxide</i> )	2	SP, PA, QL (3 tabs every 1 day); OAC
MEKINIST TAB 2MG ( <i>trametinib dimethyl sulfoxide</i> )	2	SP, PA, QL (1 tab every 1 day); OAC
MEKTOVI TAB 15MG ( <i>binimetinib</i> )	2	SP, PA, QL (6 tabs every 1 day); OAC
<i>nilotinib hcl cap 50 mg (base equivalent)</i>	1	SP, PA, QL (4 caps every 1 day); OAC
<i>nilotinib hcl cap 150 mg (base equivalent)</i>	1	SP, PA, QL (4 caps every 1 day); OAC
<i>nilotinib hcl cap 200 mg (base equivalent)</i>	1	SP, PA, QL (4 caps every 1 day); OAC
NINLARO CAP 2.3MG ( <i>ixazomib citrate</i> )	2	SP, PA, QL (3 caps every 21 days); OAC
NINLARO CAP 3MG ( <i>ixazomib citrate</i> )	2	SP, PA, QL (3 caps every 21 days); OAC
NINLARO CAP 4MG ( <i>ixazomib citrate</i> )	2	SP, PA, QL (3 caps every 21 days); OAC
<i>pazopanib hcl tab 200 mg (base equiv)</i>	1	SP, PA, QL (4 tabs every 1 day); OAC
PIQRAY 200MG TAB DOSE ( <i>alpelisib</i> )	2	SP, PA, QL (1 tab every 1 day); OAC
PIQRAY 250MG TAB DOSE ( <i>alpelisib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
PIQRAY 300MG TAB DOSE ( <i>alpelisib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 40MG ( <i>selpercatinib</i> )	2	SP, PA, QL (3 tabs every 1 day); OAC
RETEVMO TAB 80MG ( <i>selpercatinib</i> )	2	SP, PA, QL (4 tabs every 1 day); OAC
RETEVMO TAB 120MG ( <i>selpercatinib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 160MG ( <i>selpercatinib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
ROZLYTREK CAP 100MG ( <i>entrectinib</i> )	2	SP, PA, QL (1 cap every 1 day); OAC
ROZLYTREK CAP 200MG ( <i>entrectinib</i> )	2	SP, PA, QL (3 caps every 1 day); OAC
ROZLYTREK PAK 50MG ( <i>entrectinib</i> )	2	SP, PA, QL (12 packets every 1 day); OAC
RYDAPT CAP 25MG ( <i>midostaurin</i> )	2	SP, PA, QL (8 caps every 1 day); OAC
SCEMBLIX TAB 20MG ( <i>asciminib hcl</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
SCEMBLIX TAB 40MG ( <i>asciminib hcl</i> )	2	SP, PA, QL (8 tabs every 1 day); OAC
SCEMBLIX TAB 100MG ( <i>asciminib hcl</i> )	2	SP, PA, QL (4 tabs every 1 day); OAC
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	1	SP, PA, QL (4 tabs 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
TAFINLAR CAP 50MG ( <i>dabrafenib mesylate</i> )	2	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR CAP 75MG ( <i>dabrafenib mesylate</i> )	2	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR TAB 10MG ( <i>dabrafenib mesylate</i> )	2	SP, PA, QL (30 tabs every 1 day); OAC
TRUQAP PAK 160MG ( <i>capivasertib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
TRUQAP PAK 200MG ( <i>capivasertib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
TRUQAP TAB 200MG ( <i>capivasertib</i> )	2	SP, PA, QL (2 tabs every 1 day); OAC
TURALIO CAP 125MG ( <i>pexidartinib hcl</i> )	2	SP, PA, QL (4 caps every 1 day); OAC
VITRAKVI CAP 25MG ( <i>larotrectinib sulfat</i> )	2	SP, PA, QL (6 caps every 1 day); OAC
VITRAKVI CAP 100MG ( <i>larotrectinib sulfat</i> )	2	SP, PA, QL (2 caps every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
ZYKADIA TAB 150MG ( <i>ceritinib</i> )	2	SP, PA, QL (3 tabs every 1 day); OAC
<b>ANTINEOPLASTICS MISC.</b>		
<i>bexarotene cap 75 mg</i>	1	SP, PA; OAC
<i>hydroxyurea cap 500 mg</i>	1	OAC
<i>tretinoin cap 10 mg</i>	1	OAC
<b>CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS</b>		
<i>leucovorin calcium tab 5 mg</i>	1	OAC
( Leucovorin Calcium Tab 5 mg) LEADERLE LEUCOVORIN	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
<i>mesna tab 400 mg</i>	1	OAC
<b>MITOTIC INHIBITORS</b>		
<i>etoposide cap 50 mg</i>	1	OAC
<b>ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE</b>		
<b>ANTIPARKINSON ADJUNCTIVE THERAPY</b>		
<i>carbidopa tab 25 mg</i>	1	MO
<b>ANTIPARKINSON ANTICHOLINERGICS</b>		
<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
<b>ANTIPARKINSON COMT INHIBITORS</b>		
<i>entacapone tab 200 mg</i>	1	MO
<i>tolcapone tab 100 mg</i>	1	MO
<b>ANTIPARKINSON DOPAMINERGICS</b>		
<i>amantadine hcl cap 100 mg</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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 &amp; levodopa cap er 23.75-95 mg</i>	1	MO
<i>carbidopa &amp; levodopa cap er 36.25-145 mg</i>	1	MO
<i>carbidopa &amp; levodopa cap er 48.75-195 mg</i>	1	MO
<i>carbidopa &amp; levodopa cap er 61.25-245 mg</i>	1	MO
<i>carbidopa &amp; levodopa orally disintegrating tab 10-100 mg</i>	1	MO
<i>carbidopa &amp; levodopa orally disintegrating tab 25-100 mg</i>	1	MO
<i>carbidopa &amp; levodopa orally disintegrating tab 25-250 mg</i>	1	MO
<i>carbidopa &amp; levodopa tab 10-100 mg</i>	1	MO
<i>carbidopa &amp; levodopa tab 25-100 mg</i>	1	MO
<i>carbidopa &amp; levodopa tab 25-250 mg</i>	1	MO
<i>carbidopa &amp; levodopa tab er 25-100 mg</i>	1	MO
<i>carbidopa &amp; 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
CREXONT CAP 35-140MG ( <i>carbidopa-levodopa</i> )	2	MO
CREXONT CAP 52.5-210 ( <i>carbidopa-levodopa</i> )	2	MO
CREXONT CAP 70-280MG ( <i>carbidopa-levodopa</i> )	2	MO
CREXONT CAP 87.5-350 ( <i>carbidopa-levodopa</i> )	2	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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
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
<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
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>		
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES</b>		
<b>ANTIMANIC AGENTS</b>		
<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
<i>lithium oral solution 8 meq/5ml</i>	1	MO
<b>ANTIPSYCHOTICS - MISC.</b>		
<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 0.5MG ( <i>cariprazine hcl</i> )	2	MO
VRAYLAR CAP 0.75MG ( <i>cariprazine hcl</i> )	2	MO
VRAYLAR CAP 1.5MG ( <i>cariprazine hcl</i> )	2	MO
VRAYLAR CAP 3MG ( <i>cariprazine hcl</i> )	2	MO
VRAYLAR CAP 4.5MG ( <i>cariprazine hcl</i> )	2	MO
VRAYLAR CAP 6MG ( <i>cariprazine hcl</i> )	2	MO
<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
<b>BENZISOXAZOLES</b>		
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>risperidone tab 3 mg</i>	1	MO
<i>risperidone tab 4 mg</i>	1	MO
<b>BUTYROPHENONES</b>		
<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
<b>DIBENZAPINES</b>		
<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	
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>DIHYDROINDOLONES</b>		
<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
<b>PHENOTHIAZINES</b>		
<i>chlorpromazine hcl conc 30 mg/ml</i>	1	MO
<i>chlorpromazine hcl conc 100 mg/ml</i>	1	MO
<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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	MO
<b>QUINOLINONE DERIVATIVES</b>		
<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
<b>THIOXANTHENES</b>		
<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
<b>ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS</b>		
<b>ANTIRETROVIRALS</b>		
<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)
<i>BIKTARVY TAB ( bictegravir-emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day); (50-200-25 mg)
<i>CIMDUO TAB 300-300 ( lamivudine-tenofovir disoproxil fumarate)</i>	2	SP, QL (1 tab every 1 day)
<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)
<i>DESCOVY TAB 120-15MG ( emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day)
<i>DESCOVY TAB 200/25MG ( emtricitabine-tenofovir alafenamide fumarate)</i>	2	SP, QL (1 tab every 1 day); \$0 copay for PrEP
<i>DOVATO TAB 50-300MG ( dolutegravir sodium-lamivudine)</i>	2	SP, QL (1 tab 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)

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b><i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>emtricitabine caps 200 mg</i></b>	1	SP, QL (1 cap every 1 day)
<b><i>emtricitabine-rilpivirine-tenofovir df tab 200-25-300 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i></b>	1	SP, QL (1 tab every 1 day); \$0 copay for PrEP
<b><i>etravirine tab 100 mg</i></b>	1	SP, QL (4 tabs every 1 day)
<b><i>etravirine tab 200 mg</i></b>	1	SP, QL (2 tabs every 1 day)
<b><i>fosamprenavir calcium tab 700 mg (base equiv)</i></b>	1	SP, QL (4 tabs every 1 day)
<b>GENVOYA TAB (<i>elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide</i>)</b>	2	SP, QL (1 tab every 1 day)
<b>ISENTRESS CHW 25MG (<i>raltegravir potassium</i>)</b>	2	SP, QL (6 tabs every 1 day)
<b>ISENTRESS CHW 100MG (<i>raltegravir potassium</i>)</b>	2	SP, QL (6 tabs every 1 day)
<b>ISENTRESS HD TAB 600MG (<i>raltegravir potassium</i>)</b>	2	SP, QL (2 tabs every 1 day)
<b>ISENTRESS POW 100MG (<i>raltegravir potassium</i>)</b>	2	SP, QL (2 packets every 1 day)
<b>ISENTRESS TAB 400MG (<i>raltegravir potassium</i>)</b>	2	SP, QL (4 tabs every 1 day)
<b><i>lamivudine oral soln 10 mg/ml</i></b>	1	SP, QL (32 mL every 1 day)
<b><i>lamivudine tab 150 mg</i></b>	1	SP, QL (2 tabs every 1 day)
<b><i>lamivudine tab 300 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b><i>lamivudine-zidovudine tab 150-300 mg</i></b>	1	SP, QL (2 tabs every 1 day)
<b><i>lopinavir-ritonavir tab 100-25 mg</i></b>	1	SP, QL (10 tabs every 1 day)
<b><i>lopinavir-ritonavir tab 200-50 mg</i></b>	1	SP, QL (4 tabs every 1 day)
<b><i>maraviroc tab 150 mg</i></b>	1	SP, QL (2 tabs every 1 day)
<b><i>maraviroc tab 300 mg</i></b>	1	SP, QL (4 tabs every 1 day)
<b><i>nevirapine susp 50 mg/5ml</i></b>	1	SP, QL (40 mL every 1 day)
<b><i>nevirapine tab 200 mg</i></b>	1	SP, QL (2 tabs every 1 day)
<b><i>nevirapine tab er 24hr 400 mg</i></b>	1	SP, QL (1 tab every 1 day)
<b>ODEFSEY TAB (<i>emtricitabine-rilpivirine-tenofovir alafenamide fumarate</i>)</b>	2	SP, QL (1 tab every 1 day)
<b>PREZCOBIX TAB 800-150 (<i>darunavir-cobicistat</i>)</b>	3	SP, QL (1 tab every 1 day)
<b><i>rilpivirine hcl tab 25 mg (base equivalent)</i></b>	1	SP, QL (2 tabs every 1 day)
<b><i>ritonavir tab 100 mg</i></b>	1	SP, QL (12 tabs every 1 day)
<b>SYM TUZA TAB (<i>darunavir-cobicistat-emtricitabine-tenofovir alafenamide</i>)</b>	2	SP, QL (1 tab every 1 day)

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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 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)
VIRACEPT TAB 250MG ( <i>nelfinavir mesylate</i> )	3	SP, QL (300 tabs every 30 days)
VIRACEPT TAB 625MG ( <i>nelfinavir mesylate</i> )	3	SP, QL (120 tabs every 30 days)
YEZTUGO TAB 300MG ( <i>lenacapavir sodium</i> )	2	SP, QL (8 tabs every 4 days)
<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)
<b>ANTIVIRAL COMBINATIONS</b>		
PAXLOVID PAK ( <i>nirmatrelvir-ritonavir</i> )	PV	
PAXLOVID TAB 150-100 ( <i>nirmatrelvir-ritonavir</i> )	PV	QL (1 carton every 90 days)
PAXLOVID TAB 300-100 ( <i>nirmatrelvir-ritonavir</i> )	PV	QL (1 carton every 90 days)
<b>CMV AGENTS</b>		
<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
<b>HEPATITIS AGENTS</b>		
<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)
EPCLUSA PAK 150-37.5 ( <i>sofosbuvir-velpatasvir</i> )	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG ( <i>sofosbuvir-velpatasvir</i> )	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG ( <i>sofosbuvir-velpatasvir</i> )	2	SP, PA, QL (2 tabs every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100 ( <i>sofosbuvir-velpatasvir</i> )	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
HARVONI PAK ( <i>ledipasvir-sofosbuvir</i> )	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG ( <i>ledipasvir-sofosbuvir</i> )	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI TAB 45-200MG ( <i>ledipasvir-sofosbuvir</i> )	2	SP, PA, QL (2 tabs every 1 day); For genotypes 1, 4, 5, 6

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
HARVONI TAB 90-400MG ( <i>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
MAVYRET PAK 50-20MG ( <i>glecaprevir-pibrentasvir</i> )	3	SP, PA
MAVYRET TAB 100-40MG ( <i>glecaprevir-pibrentasvir</i> )	3	SP, PA
<i>ribavirin cap 200 mg</i>	1	SP, PA
<i>ribavirin tab 200 mg</i>	1	SP, PA
SOVALDI PAK 150MG ( <i>sofosbuvir</i> )	3	SP, PA
SOVALDI PAK 200MG ( <i>sofosbuvir</i> )	3	SP, PA
SOVALDI TAB 200MG ( <i>sofosbuvir</i> )	3	SP, PA
SOVALDI TAB 400MG ( <i>sofosbuvir</i> )	3	SP, PA
VOSEVI TAB ( <i>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).
ZEPATIER TAB 50-100MG ( <i>elbasvir-grazoprevir</i> )	3	SP, PA

**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	
<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	
RELENZA MIS DISKHALE ( <i>zanamivir</i> )	2	
<i>rimantadine hydrochloride tab 100 mg</i>	1	

**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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<i>labetalol hcl tab 400 mg</i>	1	MO
<b>BETA BLOCKERS CARDIO-SELECTIVE</b>		
<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
LOPRESSOR TAB 12.5MG ( <i>metoprolol tartrate</i> )	2	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
<i>metoprolol tartrate tab 12.5 mg</i>	1	MO
<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
<b>BETA BLOCKERS NON-SELECTIVE</b>		
<i>nadolol tab 20 mg</i>	1	MO
<i>nadolol tab 40 mg</i>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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/af) tab 80 mg</i>	1	MO
<i>sotalol hcl (afib/af) tab 120 mg</i>	1	MO
<i>sotalol hcl (afib/af) 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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg) CARTIA XT	1	MO
<b>diltiazem hcl coated beads cap er 24hr 180 mg</b>	1	MO
( Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg) CARTIA XT	1	MO
<b>diltiazem hcl coated beads cap er 24hr 240 mg</b>	1	MO
( Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg) CARTIA XT	1	MO
<b>diltiazem hcl coated beads cap er 24hr 300 mg</b>	1	MO
( Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg) CARTIA XT	1	MO
<b>diltiazem hcl coated beads cap er 24hr 360 mg</b>	1	MO
<b>diltiazem hcl extended release beads cap er 24hr 120 mg</b>	1	MO
( Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg) TIADYLT ER	1	MO
<b>diltiazem hcl extended release beads cap er 24hr 180 mg</b>	1	MO
( Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg) TIADYLT ER	1	MO
<b>diltiazem hcl extended release beads cap er 24hr 240 mg</b>	1	MO
( Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg) TIADYLT ER	1	MO
<b>diltiazem hcl extended release beads cap er 24hr 300 mg</b>	1	MO
( Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg) TIADYLT ER	1	MO
<b>diltiazem hcl extended release beads cap er 24hr 360 mg</b>	1	MO
( Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg) TIADYLT ER	1	MO
<b>diltiazem hcl extended release beads cap er 24hr 420 mg</b>	1	MO
( Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg) TIADYLT ER	1	MO
<b>diltiazem hcl tab 30 mg</b>	1	MO
<b>diltiazem hcl tab 60 mg</b>	1	MO
<b>diltiazem hcl tab 90 mg</b>	1	MO
<b>diltiazem hcl tab 120 mg</b>	1	MO
<b>felodipine tab er 24hr 2.5 mg</b>	1	MO
<b>felodipine tab er 24hr 5 mg</b>	1	MO
<b>felodipine tab er 24hr 10 mg</b>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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>nimodipine oral soln 60 mg/20ml (3 mg/ml)</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 34 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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS</b>		
<b>CARDIOVASCULAR AGENTS MISC. - COMBINATIONS</b>		

<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>isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg</i>	1	MO
OPSYNVI TAB 10-20MG ( <i>macitentan-tadalafil</i> )	2	SP, PA, QL (1 tab every 1 day)
OPSYNVI TAB 10-40MG ( <i>macitentan-tadalafil</i> )	2	SP, PA, QL (1 tab every 1 day)
<i>sacubitril-valsartan tab 24-26 mg</i>	1	PA, MO
<i>sacubitril-valsartan tab 49-51 mg</i>	1	PA, MO
<i>sacubitril-valsartan tab 97-103 mg</i>	1	PA, MO

**IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION**

<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)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>PROSTAGLANDIN VASODILATORS</b>		
ORENITRAM TAB 0.25MG ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB 0.125MG ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB 1MG ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB 2.5MG ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB 5MG ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB MONTH 1 ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB MONTH 2 ( <i>treprostinil diolamine</i> )	2	SP, PA
ORENITRAM TAB MONTH 3 ( <i>treprostinil diolamine</i> )	2	SP, PA
TYVASO DPI POW 16-32-48 ( <i>treprostinil</i> )	2	SP, PA, QL (9 cartridges every 1 day)
TYVASO DPI POW 16MCG ( <i>treprostinil</i> )	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 32MCG ( <i>treprostinil</i> )	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 48MCG ( <i>treprostinil</i> )	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 64MCG ( <i>treprostinil</i> )	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 80MCG ( <i>treprostinil</i> )	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW INST KIT ( <i>treprostinil</i> )	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW MAIN KIT ( <i>treprostinil</i> )	2	SP, PA, QL (8 cartridges every 1 day)
TYVASO RF KT SOL 0.6MG/ML ( <i>treprostinil</i> )	2	SP, PA, QL (2.9 mL every 1 day)
TYVASO SOL 0.6MG/ML ( <i>treprostinil</i> )	2	SP, PA, QL (2.9 mL every 1 day)
TYVASO ST KT SOL 0.6MG/ML ( <i>treprostinil</i> )	2	SP, PA, QL (2.9 mL every 1 day)
YUTREPIA CAP 26.5MCG ( <i>treprostinil sodium</i> )	2	SP, PA, QL (5 caps every 1 day)
YUTREPIA CAP 53MCG ( <i>treprostinil sodium</i> )	2	SP, PA, QL (5 caps every 1 day)
YUTREPIA CAP 79.5MCG ( <i>treprostinil sodium</i> )	2	SP, PA, QL (5 caps every 1 day)
YUTREPIA CAP 106MCG ( <i>treprostinil sodium</i> )	2	SP, PA, QL (5 caps every 1 day)
<b>PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS</b>		
<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>bosentan tab for oral susp 32 mg</i>	1	SP, PA, QL (4 tabs every 1 day)
OPSUMIT TAB 10MG ( <i>macitentan</i> )	2	SP, PA, QL (1 tab every 1 day)
<b>PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS</b>		
<i>sildenafil citrate for suspension 10 mg/ml</i>	1	SP, PA, QL (224 mL every 30 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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)
TADLIQ SUS 20MG/5ML ( <i>tadalafil (pulmonary hypertension)</i> )	2	SP, PA, QL (10 mL every 1 day)
<b>PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST</b>		
UPTRAVI PACK TAB 200/800 ( <i>selexipag</i> )	2	SP, PA, QL (1 pack every 28 days)
UPTRAVI TAB 200MCG ( <i>selexipag</i> )	2	SP, PA, QL (5 tabs every 1 day)
UPTRAVI TAB 400MCG ( <i>selexipag</i> )	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 600MCG ( <i>selexipag</i> )	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 800MCG ( <i>selexipag</i> )	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1000MCG ( <i>selexipag</i> )	2	SP, PA, QL (2 tabs every 1 day)
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)
<b>PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR</b>		
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)
<b>SINUS NODE INHIBITORS</b>		
<i>ivabradine hcl tab 5 mg (base equiv)</i>	1	MO
<i>ivabradine hcl tab 7.5 mg (base equiv)</i>	1	MO
<b>TRANSTHYRETIN STABILIZERS</b>		
VYNDAMAX CAP 61MG ( <i>tafamidis</i> )	2	SP, PA, QL (1 cap every 1 day)
<b>VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)</b>		
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
<b>CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS</b>		
<b>CEPHALOSPORINS - 1ST GENERATION</b>		
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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	
<b>CEPHALOSPORINS - 2ND GENERATION</b>		
<i>cefaclor cap 250 mg</i>	1	
<i>cefaclor cap 500 mg</i>	1	
<i>cefaclor for susp 250 mg/5ml</i>	1	
<i>cefprozil for susp 125 mg/5ml</i>	1	
<i>cefprozil for susp 250 mg/5ml</i>	1	
<i>cefprozil tab 250 mg</i>	1	
<i>cefprozil tab 500 mg</i>	1	
<i>cefuroxime axetil tab 250 mg</i>	1	
<i>cefuroxime axetil tab 500 mg</i>	1	
<b>CEPHALOSPORINS - 3RD GENERATION</b>		
<i>cefdinir cap 300 mg</i>	1	
<i>cefdinir for susp 125 mg/5ml</i>	1	
<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>cefixime tab 400 mg</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	
<b>CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL</b>		
<b>COMBINATION CONTRACEPTIVES - ORAL</b>		
<i>desogest-eth estrad &amp; 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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) VELIVET	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) APRI	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) CYRED EQ	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ENSKYCE	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) ISIBLOOM	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) JULEBER	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) KALLIGA	PV	MO
( Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) RECLIPSEN	PV	MO
<b>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</b>	PV	MO
<b>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</b>	PV	MO
( Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg) TYDEMY	PV	MO
<b>drospirenone-ethinyl estradiol tab 3-0.02 mg</b>	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
<b>drospirenone-ethinyl estradiol tab 3-0.03 mg</b>	PV	MO
( Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) SYEDA	PV	MO
( Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) ZUMANDIMINE	PV	MO
<b>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-35 mcg</b>	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) VALTYA 1/35	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) ZOVIA 1/35	PV	MO
<b>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-50 mcg</b>	PV	MO
( Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) VALTYA 1/50	PV	MO
<b>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &amp;eth est 0.01 mg</b>	PV	MO
( Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg) RIVELSA	PV	MO
( Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg) ROSYRAH	PV	MO
<b>levonorg-eth est tab 0.1-0.02mg(84) &amp; eth est tab 0.01mg(7)</b>	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
( 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)) SIMPESS	PV	MO
<b>levonorgestrel &amp; ethinyl estradiol (91-day) tab 0.15-0.03 mg</b>	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
<b>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-20 mcg</b>	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( 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) VIENVA	PV	MO
<b>levonorgestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</b>	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
( 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) MARLISSA	PV	MO
( Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg) PORTIA-28	PV	MO
<b>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</b>	PV	MO
( Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) LEVONEST	PV	MO
<b>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</b>	PV	MO
( Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) AMETHYST	PV	MO
( Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) DOLISHALE	PV	MO
<b>levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)</b>	PV	MO
( Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) JOYEAUX	PV	MO
( Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21)) MINZOYA	PV	MO
LO LOESTRIN TAB 1-10-10 ( <b>norethindrone acetate-ethinyl estradiol-fe fum (biphasic)</b> )	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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
( 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
<b>norethindrone &amp; ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</b>	PV	MO
( Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg) WYMZYA FE	PV	MO
( Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg) XELRIA FE	PV	MO
( Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) GALBRIELA	PV	MO
( Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg) KAITLIB FE	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
( Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg) XARAH FE	PV	MO
<b>norethindrone ace &amp; ethinyl estradiol tab 1 mg-20 mcg</b>	PV	MO
( Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) AUROVELA 1/20	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( 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) LUIZZA 1/20	PV	MO
( Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) MICROGESTIN 1/20	PV	MO
<b><i>norethindrone ace &amp; ethinyl estradiol tab 1.5 mg-30 mcg</i></b>	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
( 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) LUIZZA 1.5/30	PV	MO
( Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg) MICROGESTIN 1.5/30	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) FEIRZA 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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b><i>norethindrone ace &amp; ethinyl estradiol-fe tab 1.5 mg-30 mcg</i></b>	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) FEIRZA 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
<b><i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i></b>	PV	MO
( Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24)) CHARLOTTE 24 FE	PV	MO
( 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
<b><i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i></b>	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)) 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)) TARINA 24 FE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( 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
<b>norgestimate &amp; ethinyl estradiol tab 0.25 mg-35 mcg</b>	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
( 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
<b>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</b>	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
<b>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</b>	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-SPRINTEC	PV	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
( 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	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 0.3 mg-30 mcg) TURQOZ	PV	MO
<b>COMBINATION CONTRACEPTIVES - TRANSDERMAL</b>		
<b><i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i></b>	PV	MO
( Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) XULANE	PV	MO
( Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr) ZAFEMY	PV	MO
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>		
<b><i>ANNOVERA MIS ( segesterone acetate-ethinyl estradiol)</i></b>	PV	QL (1 ring every 300 days), MO; Quantity max 1 per fill; Quantity max 1 per 300 days
<b><i>etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr</i></b>	PV	QL (13 rings every 300 days), MO
( Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) ELURYNG	PV	QL (13 rings every 300 days), MO
( Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr) ENILLORING	PV	QL (13 rings every 300 days), MO
<b>EMERGENCY CONTRACEPTIVES</b>		
<b><i>ELLA TAB 30MG ( ulipristal acetate)</i></b>	PV	
( Levonorgestrel Tab 1.5 mg) OPTION 2	PV	MO
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>		
<b><i>norethindrone tab 0.35 mg</i></b>	PV	MO
( Norethindrone Tab 0.35 mg) CAMILA	PV	MO
( Norethindrone Tab 0.35 mg) DEBLITANE	PV	MO
( Norethindrone Tab 0.35 mg) EMZAHH	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) MELEYA	PV	MO
( Norethindrone Tab 0.35 mg) NORA-BE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Norethindrone Tab 0.35 mg) NORLYROC	PV	MO
( Norethindrone Tab 0.35 mg) ORQUIDEA	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>deflazacort susp 22.75 mg/ml</i>	1	SP, PA, QL (54 mL every 30 days)
( Deflazacort Susp 22.75 mg/ml) JAYTHARI	1	SP, PA, QL (54 mL every 30 days)
( Deflazacort Susp 22.75 mg/ml) PYQUVI	1	SP, PA, QL (1.8 mL every 1 day)
<i>deflazacort tab 6 mg</i>	1	SP, PA, QL (2 tabs every 1 day)
( Deflazacort Tab 6 mg) JAYTHARI	1	SP, PA, QL (2 tabs every 1 day)
( Deflazacort Tab 6 mg) KYMBEE	1	SP, PA, QL (2 tabs every 1 day)
<i>deflazacort tab 18 mg</i>	1	SP, PA, QL (1 tab every 1 day)
( Deflazacort Tab 18 mg) JAYTHARI	1	SP, PA, QL (1 tab every 1 day)
( Deflazacort Tab 18 mg) KYMBEE	1	SP, PA, QL (1 tab every 1 day)
<i>deflazacort tab 30 mg</i>	1	SP, PA, QL (1 tab every 1 day)
( Deflazacort Tab 30 mg) JAYTHARI	1	SP, PA, QL (1 tab every 1 day)
( Deflazacort Tab 30 mg) KYMBEE	1	SP, PA, QL (1 tab every 1 day)
<i>deflazacort tab 36 mg</i>	1	SP, PA, QL (1 tab every 1 day)
( Deflazacort Tab 36 mg) JAYTHARI	1	SP, PA, QL (1 tab every 1 day)
( Deflazacort Tab 36 mg) KYMBEE	1	SP, PA, QL (1 tab every 1 day)
<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)) HIDEX 6-DAY	1	
<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	SP, PA, QL (54 mL every 30 days)
<i>hydrocortisone tab 5 mg</i>	1	
<i>hydrocortisone tab 10 mg</i>	1	
<i>hydrocortisone tab 20 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MEDROL TAB 2MG ( <i>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 phosphate oral soln 5 mg/5ml (base equiv)</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 delayed release 1 mg</i>	1	
<i>prednisone tab delayed release 2 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	
UCERIS TAB 9MG ( <i>budesonide</i> )	1	
<b>MINERALOCORTICOIDS</b>		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	MO
<b>COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS</b>		
<b>ANTITUSSIVES - DRUGS TO TREAT COUGH</b>		
<i>benzonatate cap 100 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
( Hydrocodone Bitart-Homatropine Methylbrom 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
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>		
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	Not available under age 12

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>promethazine &amp; phenylephrine syrup 6.25-5 mg/5ml</i>	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	
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
<b>EXPECTORANTS - DRUGS TO TREAT COUGH</b>		
<i>potassium iodide oral soln 1 gm/ml</i>	1	
<b>MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS</b>		
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
<i>sodium chloride soln nebu 7%</i>	1	
<i>sodium chloride soln nebu 10%</i>	1	
<b>MUCOLYTICS - DRUGS TO TREAT COUGH</b>		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
<b>DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS</b>		
<b>ACNE PRODUCTS</b>		
<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
BENZAC AC LIQ 5% WASH ( <i>benzoyl peroxide</i> )	3	
<i>benzoyl peroxide-erythromycin gel 5-3%</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% (twice-daily)</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 PLEDGETS	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Clindamycin Phosphate Swab 1%) CLINDACIN-P	1	
<b>clindamycin phosphate-benzoyl peroxide gel 1-5%</b>	1	
<b>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</b>	1	
<b>clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%</b>	1	
<b>clindamycin phosphate-tretinoin gel 1.2-0.025%</b>	1	PA; PA Required for age greater than or equal to age 35
<b>dapsone gel 5%</b>	1	
<b>dapsone gel 7.5%</b>	1	
EPIDUO FORTE GEL 0.3-2.5% ( <b>adapalene-benzoyl peroxide</b> )	2	
EPIDUO GEL 0.1-2.5% ( <b>adapalene-benzoyl peroxide</b> )	2	
<b>erythromycin gel 2%</b>	1	
( Erythromycin Pads 2%) ERY	1	
<b>erythromycin soln 2%</b>	1	
<b>isotretinoin cap 10 mg</b>	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
<b>isotretinoin cap 20 mg</b>	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
<b>isotretinoin cap 30 mg</b>	1	PA
( Isotretinoin Cap 30 mg) ACCUTANE	1	PA
( Isotretinoin Cap 30 mg) AMNESTEEM	1	PA
( Isotretinoin Cap 30 mg) CLARAVIS	1	PA
( Isotretinoin Cap 30 mg) ZENATANE	1	PA
<b>isotretinoin cap 40 mg</b>	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
<b>sulfacetamide sodium lotion 10% (acne)</b>	1	
<b>tretinoin cream 0.1%</b>	1	PA; PA Required for age greater than or equal to age 35

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>ANTI-INFLAMMATORY AGENTS - TOPICAL</b>		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	
<b>ANTIBIOTICS - TOPICAL</b>		
<i>gentamicin sulfate cream 0.1%</i>	1	
<i>gentamicin sulfate oint 0.1%</i>	1	
<i>mupirocin oint 2%</i>	1	
<b>ANTIFUNGALS - TOPICAL</b>		
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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	
<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	
<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) KLAYESTA	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	
<b>ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL</b>		
<i>bexarotene gel 1%</i>	1	SP, PA
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	
<i>fluorouracil cream 5%</i>	1	
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
<b>ANTIPSORIATICS</b>		
<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	
SOTYKTU TAB 6MG ( <i>deucravacitinib</i> )	2	SP, PA, QL (1 tab every 1 day); Preferred for Psoriasis
<i>tazarotene cream 0.1%</i>	1	PA
<i>tazarotene cream 0.05%</i>	1	PA
<i>tazarotene gel 0.1%</i>	1	PA
<i>tazarotene gel 0.05%</i>	1	PA
VTAMA CRE 1% ( <i>tapinarof</i> )	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>ANTISEBORRHEIC PRODUCTS</b>		
<i>selenium sulfide lotion 2.5%</i>	1	
<i>sulfacetamide sodium shampoo 10%</i>	1	
<b>ANTIVIRALS - TOPICAL</b>		
<i>acyclovir oint 5%</i>	1	
<i>penciclovir cream 1%</i>	1	
<b>BURN PRODUCTS</b>		
<i>silver sulfadiazine cream 1%</i>	1	
( Silver Sulfadiazine Cream 1%) SSD	1	
<b>CORTICOSTEROIDS - TOPICAL</b>		
<i>alclometasone dipropionate cream 0.05%</i>	1	
<i>alclometasone dipropionate oint 0.05%</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	
<i>clobetasol propionate cream 0.05%</i>	1	
<i>clobetasol propionate cream 0.025%</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	

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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>halcinonide soln 0.1%</i>	1	
<i>halobetasol propionate cream 0.05%</i>	1	
<i>halobetasol propionate foam 0.05%</i>	1	
<i>halobetasol propionate oint 0.05%</i>	1	
<i>hydrocortisone acetate cream 2.5%</i>	1	
( Hydrocortisone Acetate Cream 2.5%) MICORT HC	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	
<i>hydrocortisone oint 1%</i>	1	
<i>hydrocortisone oint 2.5%</i>	1	
( Hydrocortisone Soln 2.5%) TEXACORT	1	
<i>hydrocortisone valerate cream 0.2%</i>	1	
<i>hydrocortisone valerate oint 0.2%</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	
<i>triamcinolone acetonide cream 0.1%</i>	1	
<i>triamcinolone acetonide cream 0.5%</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( 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	
<b>ECZEMA AGENTS</b>		
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)
OPZELURA CRE 1.5% ( <i>ruxolitinib phosphate (topical)</i> )	2	PA
<b>EMOLLIENTS</b>		
<i>lactic acid (ammonium lactate) cream 12%</i>	1	
<i>lactic acid (ammonium lactate) lotion 12%</i>	1	
<b>HAIR GROWTH AGENTS</b>		
<i>finasteride tab 1 mg</i>	1	PA
LITFULO CAP 50MG ( <i>ritlecitinib tosylate</i> )	2	SP, PA, QL (1 cap every 1 day)
<b>IMMUNOMODULATING AGENTS - TOPICAL</b>		
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>		
<i>pimecrolimus cream 1%</i>	1	PA
<i>tacrolimus oint 0.1%</i>	1	PA
<i>tacrolimus oint 0.03%</i>	1	PA
<b>KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS</b>		
<i>podofilox gel 0.5%</i>	1	
<i>podofilox soln 0.5%</i>	1	
<b>LOCAL ANESTHETICS - TOPICAL</b>		
<i>ethyl chloride aerosol spray</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
( Lidocaine Patch 5%) LIDOCAN	1	PA
( Lidocaine Patch 5%) TRIDACAINE II	1	PA
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 25 days)
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL</b>		
EUCRISA OIN 2% ( <i>crisaborole</i> )	2	
ZORYVE CRE 0.3% ( <i>roflumilast (topical)</i> )	2	
ZORYVE CRE 0.05% ( <i>roflumilast (topical)</i> )	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZORYVE CRE 0.15% ( <i>roflumilast (topical)</i> )	2	
ZORYVE MIS 0.3% ( <i>roflumilast (topical)</i> )	2	
<b>ROSACEA AGENTS</b>		
<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>ivermectin cream 1%</i>	1	
<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	
<b>SCABICIDES &amp; PEDICULICIDES</b>		
(Crotamiton Lotion 10%) CROTAN	1	
(Crotamiton Lotion 10%) PRURADIK	1	
<i>malathion lotion 0.5%</i>	1	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
<b>DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS</b>		
<b>DIGESTIVE ENZYMES</b>		
CREON CAP 3000UNIT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO
CREON CAP 6000UNIT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO
CREON CAP 12000UNIT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO
CREON CAP 24000UNIT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO
CREON CAP 36000UNIT ( <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
ZENPEP CAP 10000UNIT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO
ZENPEP CAP 15000UNIT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
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
ZENPEP CAP 60000UNT ( <i>pancrelipase (lipase-protease-amylase)</i> )	2	MO
<b>DIURETICS - DRUGS TO TREAT HEART CONDITIONS</b>		
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<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)
(Dichlorphenamide Tab 50 mg) ORMALVI	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
<b>DIURETIC COMBINATIONS</b>		
<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i>	1	MO
<i>spironolactone &amp; hydrochlorothiazide tab 25-25 mg</i>	1	MO
<i>triamterene &amp; hydrochlorothiazide cap 37.5-25 mg</i>	1	MO
<i>triamterene &amp; hydrochlorothiazide tab 37.5-25 mg</i>	1	MO
<i>triamterene &amp; hydrochlorothiazide tab 75-50 mg</i>	1	MO
<b>LOOP DIURETICS</b>		
<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>toremide tab 5 mg</i>	1	MO
<i>toremide tab 10 mg</i>	1	MO
<i>toremide tab 20 mg</i>	1	MO
<i>toremide tab 100 mg</i>	1	MO
<b>POTASSIUM SPARING DIURETICS</b>		
<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>triamterene cap 50 mg</i>	1	MO
<i>triamterene cap 100 mg</i>	1	MO
<b>THIAZIDES AND THIAZIDE-LIKE DIURETICS</b>		
<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
<b>ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES</b>		
<b>BONE DENSITY REGULATORS - DRUGS TO TREAT BONE LOSS</b>		
<i>alendronate sodium oral soln 70 mg/75ml</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
<b>FERTILITY REGULATORS</b>		
<i>clomiphene citrate tab 50 mg</i>	1	Only covered if member has infertility benefit
( Clomiphene Citrate Tab 50 mg) CLOMID	1	Only covered if member has infertility benefit
( Clomiphene Citrate Tab 50 mg) MILOPHENE	1	Only covered if member has infertility benefit
<b>GNRH/LHRH ANTAGONISTS</b>		
ORLISSA TAB 150MG ( <i>elagolix sodium</i> )	2	
ORLISSA TAB 200MG ( <i>elagolix sodium</i> )	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>HORMONE RECEPTOR MODULATORS - DRUGS TO TREAT BONE LOSS</b>		
<i>raloxifene hcl tab 60 mg</i>	1	MO; \$0 copay ages 35 and older for the primary prevention of breast cancer
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
SYNAREL SOL 2MG/ML ( <i>nafarelin acetate</i> )	3	
<b>METABOLIC MODIFIERS</b>		
<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
GALAFOLD CAP 123MG ( <i>migalastat hcl</i> )	2	SP, PA
<i>glycerol phenylbutyrate liquid 1.1 gm/ml</i>	1	SP, PA
<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 SUS 4MG/ML ( <i>nitisinone</i> )	2	SP, PA
<i>paricalcitol cap 1 mcg</i>	1	MO
<i>paricalcitol cap 2 mcg</i>	1	MO
<i>paricalcitol cap 4 mcg</i>	1	MO
PHEBURANE MIS 483/GM ( <i>sodium phenylbutyrate</i> )	2	SP, PA, QL (46.4 gm every 1 day)
<i>sapropterin dihydrochloride powder packet 100 mg</i>	1	SP, PA
( Sapropterin Dihydrochloride Powder Packet 100 mg) JAVYGTOR	1	SP, PA
( Sapropterin Dihydrochloride Powder Packet 100 mg) ZELVYSIA	1	SP, PA
<i>sapropterin dihydrochloride powder packet 500 mg</i>	1	SP, PA
( Sapropterin Dihydrochloride Powder Packet 500 mg) JAVYGTOR	1	SP, PA
( Sapropterin Dihydrochloride Powder Packet 500 mg) ZELVYSIA	1	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>sapropterin dihydrochloride tab 100 mg</b>	1	SP, PA
( Sapropterin Dihydrochloride Tab 100 mg) JAVYGTOR	1	SP, PA
<b>sodium phenylbutyrate oral powder 3 gm/teaspoonful</b>	1	SP, PA, QL (26.6 gm every 1 day)
<b>sodium phenylbutyrate tab 500 mg</b>	1	SP, PA, QL (40 tabs every 1 day)
<b>MINERALOCORTICOID RECEPTOR ANTAGONISTS</b>		
KERENDIA TAB 10MG ( <i>finerenone</i> )	2	PA, MO
KERENDIA TAB 20MG ( <i>finerenone</i> )	2	PA, MO
KERENDIA TAB 40MG ( <i>finerenone</i> )	2	PA, MO
<b>POSTERIOR PITUITARY HORMONES</b>		
<b>desmopressin acetate nasal spray soln 0.01%</b>	1	MO
<b>desmopressin acetate nasal spray soln 0.01% (refrigerated)</b>	1	MO
<b>desmopressin acetate tab 0.1 mg</b>	1	MO
<b>desmopressin acetate tab 0.2 mg</b>	1	MO
<b>PROGESTERONE RECEPTOR ANTAGONISTS</b>		
<b>mifepristone tab 200 mg</b>	1	
<b>PROLACTIN INHIBITORS</b>		
<b>cabergoline tab 0.5 mg</b>	1	
<b>VASOPRESSIN RECEPTOR ANTAGONISTS</b>		
<b>tolvaptan tab 15 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>tolvaptan tab 30 mg</b>	1	SP, PA, QL (1 tab every 1 day)
<b>tolvaptan tab therapy pack 15 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>tolvaptan tab therapy pack 30 &amp; 15 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>tolvaptan tab therapy pack 45 &amp; 15 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>tolvaptan tab therapy pack 60 &amp; 30 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>tolvaptan tab therapy pack 90 &amp; 30 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES</b>		
<b>ESTROGEN COMBINATIONS</b>		
BIJUVA CAP 0.5-100 ( <i>estradiol-progesterone</i> )	2	MO
BIJUVA CAP 1-100MG ( <i>estradiol-progesterone</i> )	2	MO
COMBIPATCH DIS ( <i>estradiol &amp; norethindrone acetate</i> )	2	MO
DUAVEE TAB 0.45-20 ( <i>conjugated estrogens-bazedoxifene</i> )	2	MO
<b>estradiol &amp; norethindrone acetate tab 0.5-0.1 mg</b>	1	MO
( Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg) ABIGALE LO	1	MO
<b>estradiol &amp; norethindrone acetate tab 1-0.5 mg</b>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Estradiol & Norethindrone Acetate Tab 1-0.5 mg) ABIGALE	1	MO
( Estradiol & Norethindrone Acetate Tab 1-0.5 mg) MIMVEY	1	MO
MYFEMBREE TAB ( <i>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-Ethinyl Estradiol Tab 1 mg-5 mcg) JINTELI	1	MO
ORIAHNN CAP ( <i>elagolix sodium-estradiol-norethindrone acetate</i> )	2	
PREMPHASE TAB ( <i>conjugated estrogens-medroxyprogesterone acetate</i> )	2	MO
PREMPRO TAB ( <i>conjugated estrogens-medroxyprogesterone acetate</i> )	2	MO
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
<b>ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES</b>		
<i>estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)</i>	1	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Estradiol Td Patch Twice Weekly 0.1 mg/24hr) LYLLANA	1	MO
<b><i>estradiol td patch twice weekly 0.05 mg/24hr</i></b>	1	MO
( Estradiol Td Patch Twice Weekly 0.05 mg/24hr) DOTTI	1	MO
( Estradiol Td Patch Twice Weekly 0.05 mg/24hr) LYLLANA	1	MO
<b><i>estradiol td patch twice weekly 0.025 mg/24hr</i></b>	1	MO
( Estradiol Td Patch Twice Weekly 0.025 mg/24hr) DOTTI	1	MO
( Estradiol Td Patch Twice Weekly 0.025 mg/24hr) LYLLANA	1	MO
<b><i>estradiol td patch twice weekly 0.075 mg/24hr</i></b>	1	MO
( Estradiol Td Patch Twice Weekly 0.075 mg/24hr) DOTTI	1	MO
( Estradiol Td Patch Twice Weekly 0.075 mg/24hr) LYLLANA	1	MO
<b><i>estradiol td patch twice weekly 0.0375 mg/24hr</i></b>	1	MO
( Estradiol Td Patch Twice Weekly 0.0375 mg/24hr) DOTTI	1	MO
( Estradiol Td Patch Twice Weekly 0.0375 mg/24hr) LYLLANA	1	MO
<b><i>estradiol td patch weekly 0.1 mg/24hr</i></b>	1	MO
<b><i>estradiol td patch weekly 0.05 mg/24hr</i></b>	1	MO
<b><i>estradiol td patch weekly 0.06 mg/24hr</i></b>	1	MO
<b><i>estradiol td patch weekly 0.025 mg/24hr</i></b>	1	MO
<b><i>estradiol td patch weekly 0.075 mg/24hr</i></b>	1	MO
<b><i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i></b>	1	MO
<b><i>estrogens, conjugated tab 0.3 mg</i></b>	1	MO
<b><i>estrogens, conjugated tab 0.9 mg</i></b>	1	MO
<b><i>estrogens, conjugated tab 0.45 mg</i></b>	1	MO
<b><i>estrogens, conjugated tab 0.625 mg</i></b>	1	MO
<b><i>estrogens, conjugated tab 1.25 mg</i></b>	1	MO

**FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS**

***FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS***

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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	
<b>GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS</b>		
<b>5-HT4 RECEPTOR AGONISTS</b>		
<i>prucalopride succinate tab 1 mg (base equivalent)</i>	1	MO
<i>prucalopride succinate tab 2 mg (base equivalent)</i>	1	MO
<b>GALLSTONE SOLUBILIZING AGENTS</b>		
<i>ursodiol cap 300 mg</i>	1	MO
<i>ursodiol tab 250 mg</i>	1	MO
<i>ursodiol tab 500 mg</i>	1	MO
<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	MO
<b>GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS</b>		
<i>lubiprostone cap 8 mcg</i>	1	PA, MO
<i>lubiprostone cap 24 mcg</i>	1	PA, MO
<b>GASTROINTESTINAL STIMULANTS</b>		
<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	
<b>INFLAMMATORY BOWEL AGENTS</b>		
<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 cap er 500 mg</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
VELSIPITY TAB 2MG ( <i>etrasimod arginine</i> )	2	SP, PA, QL (1 tab every 1 day); Preferred for Ulcerative Colitis
<b>INTESTINAL ACIDIFIERS</b>		
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Lactulose (Encephalopathy) Solution 10 gm/15ml) ENULOSE	1	MO
<b>IRRITABLE BOWEL SYNDROME (IBS) AGENTS</b>		
<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>linaclotide</i> )	2	PA, MO
LINZESS CAP 145MCG ( <i>linaclotide</i> )	2	PA, MO
LINZESS CAP 290MCG ( <i>linaclotide</i> )	2	PA, MO
VIBERZI TAB 75MG ( <i>eluxadoline</i> )	2	PA, MO
VIBERZI TAB 100MG ( <i>eluxadoline</i> )	2	PA, MO
<b>PERIPHERAL OPIOID RECEPTOR ANTAGONISTS</b>		
MOVANTIK TAB 12.5MG ( <i>naloxegol oxalate</i> )	2	
MOVANTIK TAB 25MG ( <i>naloxegol oxalate</i> )	2	
SYMPROIC TAB 0.2MG ( <i>naldemedine tosylate</i> )	2	
<b>PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR(PPAR) AGONISTS</b>		
IQIRVO TAB 80MG ( <i>elafibranor</i> )	2	SP, PA, QL (1 tab every 1 day)
<b>PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS</b>		
<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>ferric citrate tab 1 gm (210 mg ferric iron)</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
<b>GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS</b>		
<b>ALKALINIZERS</b>		
( Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg) CYTRA K CRYSTALS	1	
<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	
<b>CYSTINOSIS AGENTS</b>		
CYSTAGON CAP 50MG ( <i>cysteamine bitartrate</i> )	2	SP, PA
CYSTAGON CAP 150MG ( <i>cysteamine bitartrate</i> )	2	SP, PA
<b>IGA NEPHROPATHY (IGAN) AGENTS</b>		
FILSPARI TAB 200MG ( <i>sparsentan</i> )	2	SP, PA, QL (2 tabs every 1 day)
FILSPARI TAB 400MG ( <i>sparsentan</i> )	2	SP, PA, QL (1 tab every 1 day)
VANRAFIA TAB 0.75MG ( <i>atrasentan hcl</i> )	2	SP, PA, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>PROSTATIC HYPERTROPHY AGENTS</b>		
<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
<b>URINARY STONE AGENTS</b>		
<i>tiopronin tab 100 mg</i>	1	SP, PA
<i>tiopronin tab delayed release 100 mg</i>	1	SP, PA
( Tiopronin Tab Delayed Release 100 mg) VENXXIVA	1	SP, PA
<i>tiopronin tab delayed release 300 mg</i>	1	SP, PA
( Tiopronin Tab Delayed Release 300 mg) VENXXIVA	1	SP, PA
<b>GOUT AGENTS - DRUGS TO TREAT GOUT</b>		
<b>GOUT AGENT COMBINATIONS</b>		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	MO
<b>GOUT AGENTS - DRUGS TO TREAT GOUT</b>		
<i>allopurinol tab 100 mg</i>	1	MO
<i>allopurinol tab 200 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
<b>URICOSURICS</b>		
<i>probenecid tab 500 mg</i>	1	MO
<b>HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS</b>		
<b>HEMATORHEOLOGIC AGENTS</b>		
<i>pentoxifylline tab er 400 mg</i>	1	MO
<b>PLASMA KALLIKREIN INHIBITORS</b>		
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
<b>PLATELET AGGREGATION INHIBITORS</b>		
<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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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
<i>ticagrelor tab 60 mg</i>	1	MO
<i>ticagrelor tab 90 mg</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 members capable of pregnancy age 55 years and under, otherwise not covered
( Folic Acid Cap 0.8 mg) FA-8	PV	QL (100 caps every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years 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 members capable of pregnancy age 55 years and under, otherwise not covered
( Folic Acid Tab 400 mcg) FOLATE	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
( Folic Acid Tab 400 mcg) GNP FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Folic Acid Tab 400 mcg) YL FOLIC ACID	PV	QL (100 tabs every 30 days); \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
<b><i>folic acid tab 800 mcg</i></b>	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
( Folic Acid Tab 800 mcg) CVS FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
( Folic Acid Tab 800 mcg) KP FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered
( Folic Acid Tab 800 mcg) QC FOLIC ACID	PV	QL (100 tabs every 30 days), MO; \$0 copay for members capable of pregnancy age 55 years and under, otherwise not covered

**HEMATOPOIETIC GROWTH FACTORS**

ALVAIZ TAB 9MG ( <i>eltrombopag choline</i> )	2	SP, PA, QL (2 tabs every 1 day)
ALVAIZ TAB 18MG ( <i>eltrombopag choline</i> )	2	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 36MG ( <i>eltrombopag choline</i> )	2	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 54MG ( <i>eltrombopag choline</i> )	2	SP, PA, QL (2 tabs every 1 day)
DOPTELET SPR CAP 10MG ( <i>avatrombopag maleate</i> )	2	SP, PA, QL (2 caps every 1 day)
DOPTELET TAB 20MG ( <i>avatrombopag maleate</i> )	2	SP, PA
DOPTELET TAB 20MG ( <i>avatrombopag maleate</i> )	2	SP, PA, QL (1 carton every 5 days); 10 tab carton
DOPTELET TAB 20MG ( <i>avatrombopag maleate</i> )	2	SP, PA, QL (1 carton every 5 days); 15 tab carton
DOPTELET TAB 20MG ( <i>avatrombopag maleate</i> )	2	SP, PA, QL (2 cartons every 30 days); 30 tab carton
<b><i>eltrombopag olamine powder pack for susp 12.5 mg (base eq)</i></b>	1	SP, PA, QL (4 packets every 1 day)
<b><i>eltrombopag olamine powder pack for susp 25 mg (base equiv)</i></b>	1	SP, PA, QL (6 packets every 1 day)
<b><i>eltrombopag olamine tab 12.5 mg (base equiv)</i></b>	1	SP, PA, QL (2 tabs every 1 day)
<b><i>eltrombopag olamine tab 25 mg (base equiv)</i></b>	1	SP, PA, QL (3 tabs every 1 day)
<b><i>eltrombopag olamine tab 50 mg (base equiv)</i></b>	1	SP, PA, QL (3 tabs every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>eltrombopag olamine tab 75 mg (base equiv)</i>	1	SP, PA, QL (2 tabs every 1 day)
<b>HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS</b>		
<b>HEMOSTATICS - SYSTEMIC</b>		
<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	
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS</b>		
<b>BARBITURATE HYPNOTICS</b>		
<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
<b>HYPNOTICS - TRICYCLIC AGENTS</b>		
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
<b>NON-BARBITURATE HYPNOTICS</b>		
<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>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)
<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)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>OREXIN RECEPTOR ANTAGONISTS</b>		
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
QUVIVIQ TAB 25MG ( <i>daridorexant hcl</i> )	2	PA
QUVIVIQ TAB 50MG ( <i>daridorexant hcl</i> )	2	PA
<b>SELECTIVE MELATONIN RECEPTOR AGONISTS</b>		
<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)
<b>LAXATIVES - DRUGS TO TREAT CONSTIPATION</b>		
<b>LAXATIVE COMBINATIONS</b>		
CLENPIQ SOL ( <i>sodium picosulfate-magnesium oxide-anhydrous citric acid</i> )	PV	\$0 copay for members age 45 through 75
<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	
( Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm) GAVILYTE-N/FLAVOR PACK	1	
<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 75
<b>LAXATIVES - MISCELLANEOUS</b>		
<i>lactulose oral crystal packet 10 gm</i>	1	MO
( Lactulose Oral Crystal Packet 10 gm) KRISTALOSE	1	MO
<i>lactulose oral crystal packet 20 gm</i>	1	MO
( Lactulose Oral Crystal Packet 20 gm) KRISTALOSE	1	MO
<i>lactulose solution 10 gm/15ml</i>	1	MO
( Lactulose Solution 10 gm/15ml) CONSTULOSE	1	MO
<b>MACROLIDES - DRUGS TO TREAT INFECTIONS</b>		
<b>AZITHROMYCIN</b>		
<i>azithromycin for susp 100 mg/5ml</i>	1	
<i>azithromycin for susp 200 mg/5ml</i>	1	
<i>azithromycin tab 250 mg</i>	1	
<i>azithromycin tab 500 mg</i>	1	
<i>azithromycin tab 600 mg</i>	1	
<b>CLARITHROMYCIN</b>		
<i>clarithromycin for susp 125 mg/5ml</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>clarithromycin for susp 250 mg/5ml</i>	1	
<i>clarithromycin tab 250 mg</i>	1	
<i>clarithromycin tab 500 mg</i>	1	
<i>clarithromycin tab er 24hr 500 mg</i>	1	
<b>ERYTHROMYCINS</b>		
<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	1	
( Erythromycin Ethylsuccinate Tab 400 mg) E.E.S. 400	1	
<i>erythromycin tab 250 mg</i>	1	
<i>erythromycin tab 500 mg</i>	1	
<i>erythromycin tab delayed release 250 mg</i>	1	
<i>erythromycin tab delayed release 333 mg</i>	1	
<i>erythromycin tab delayed release 500 mg</i>	1	
<i>erythromycin w/ delayed release particles cap 250 mg</i>	1	
<b>FIDAXOMICIN</b>		
<i>fidaxomicin tab 200 mg</i>	1	
<b>MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING</b>		
<b>CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL</b>		
CONDOMS MIS	PV	QL (36 condoms every 75 days), MO
DUREX MIS REALFEEL ( <i>condoms non-latex lubricated - male</i> )	PV	QL (36 condoms every 75 days), MO
FC2 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)
TRUSTEX MIS FLAVORS ( <i>condoms latex non-lubricated - male</i> )	PV	QL (36 condoms every 75 days), MO
<b>PARENTERAL THERAPY SUPPLIES</b>		
BD INSULIN PEN NEEDLES - OTC ( <i>insulin pen needle</i> )	2	
BD INSULIN SYRINGE - OTC ( <i>insulin syringes (disposable)</i> )	2	
BD INSULIN SYRINGE - RX ( <i>insulin syringe/needle u-100</i> )	2	
EMBECTA INSULIN PEN NEEDLES - OTC ( <i>insulin pen needle</i> )	2	
EMBECTA INSULIN SYRINGE - OTC ( <i>insulin syringe/needle u-100</i> )	2	
EMBECTA INSULIN SYRINGE - RX ( <i>insulin syringe/needle u-500</i> )	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>RESPIRATORY THERAPY SUPPLIES</b>		
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 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	
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	
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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
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	
INSPIREASE MIS DD SYST ( <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 DIA LG ( <i>spacer/aerosol-holding chambers</i> )	2	
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	
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	
<b>MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES</b>		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG</b>		
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	
<b>MIGRAINE COMBINATIONS</b>		
<i>ergotamine w/ caffeine tab 1-100 mg</i>	3	
<b>SEROTONIN AGONISTS</b>		
<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)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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)
IMITREX INJ 4MG/0.5 ( <i>sumatriptan succinate</i> )	3	QL (18 injections every 25 days)
IMITREX INJ 6MG/0.5 ( <i>sumatriptan succinate</i> )	3	QL (12 injections 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)
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)
<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 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)
TOSYMRA SOL 10MG ( <i>sumatriptan</i> )	2	QL (18 units every 25 days)
ZEMBRACE SYM INJ 3/0.5ML ( <i>sumatriptan succinate</i> )	2	QL (24 injections every 25 days)
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	1	QL (12 inhalers every 25 days)
<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**

<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<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
<b>PHOSPHATE</b>		
( Potassium Phosphate Monobasic Tab 500 mg) PHOSPHO-TRIN K500	1	MO
<b>POTASSIUM</b>		
<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
<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 15 meq</i>	1	MO
<i>potassium chloride tab er 20 meq (1500 mg)</i>	1	MO
<b>MISCELLANEOUS THERAPEUTIC CLASSES</b>		
<b>CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING</b>		
<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
<b>IMMUNOMODULATORS - DRUGS TO TREAT CANCER</b>		
<i>lenalidomide cap 5 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>lenalidomide cap 10 mg</i>	1	SP, PA, QL (1 cap every 1 day); OAC
<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 (21 caps every 21 days); OAC
<i>lenalidomide cap 25 mg</i>	1	SP, PA, QL (21 caps every 21 days); OAC
<i>lenalidomide caps 2.5 mg</i>	1	SP, PA, QL (1 cap every 1 day); 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 (4 caps every 1 day); OAC
<b>IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT</b>		
<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
<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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<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
<b>POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM</b>		
<i>sodium polystyrene sulfonate powder</i>	1	
( Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml) SPS	1	
<i>sodium polystyrene sulfonate susp 15 gm/60ml</i>	1	
( Sodium Polystyrene Sulfonate Susp 15 gm/60ml) KIONEX	1	
( Sodium Polystyrene Sulfonate Susp 15 gm/60ml) SPS	1	
VELTASSA POW 1GM ( <i>patiomer sorbitex calcium</i> )	2	MO
VELTASSA POW 8.4GM ( <i>patiomer sorbitex calcium</i> )	2	MO
VELTASSA POW 16.8GM ( <i>patiomer sorbitex calcium</i> )	2	MO
VELTASSA POW 25.2GM ( <i>patiomer sorbitex calcium</i> )	2	MO
<b>MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT</b>		
<b>ANESTHETICS TOPICAL ORAL</b>		
<i>lidocaine hcl viscous soln 2%</i>	1	
<b>ANTI-INFECTIVES - THROAT</b>		
<i>clotrimazole troche 10 mg</i>	1	
<i>nystatin susp 100000 unit/ml</i>	1	
<b>STEROIDS - MOUTH/THROAT/DENTAL</b>		
<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	
<b>THROAT PRODUCTS - MISC.</b>		
<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
<b>MULTIVITAMINS - DRUGS FOR NUTRITION</b>		
<b>PRENATAL VITAMINS</b>		
( 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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( 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 oral soln 10 mg/5ml</i>	1	
<i>baclofen susp 25 mg/5ml</i>	1	
<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 15 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>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	
<i>methocarbamol tab 1000 mg</i>	1	
( Methocarbamol Tab 1000 mg) TANLOR	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	

**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)
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**NASAL ANTIALLERGY**

<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	QL (2 bottles every 25 days)
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PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 bottle every 25 days)
<b>NASAL ANTICHOLINERGICS</b>		
<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
<b>NASAL STEROIDS</b>		
<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)
XHANCE MIS 93MCG ( <i>fluticasone propionate (nasal)</i> )	2	QL (2 bottles every 25 days)
<b>NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES</b>		
<b>ALS AGENTS</b>		
RADICAVA ORS SUS 105/5ML ( <i>edaravone</i> )	2	SP, PA, QL (75 mL every 30 days)
RADICAVA ORS SUS STARTER ( <i>edaravone</i> )	2	SP, PA, QL (75 mL every 30 days)
<i>riluzole tab 50 mg</i>	1	MO
<b>OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS</b>		
<b>BETA-BLOCKERS - OPHTHALMIC</b>		
<i>betaxolol hcl ophth soln 0.5%</i>	1	MO
BETOPTIC-S SUS 0.25% OP ( <i>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
<i>timolol ophth soln 0.5%</i>	1	MO
<b>CYCLOPLEGIC MYDRIATICS</b>		
<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
<i>phenylephrine hcl ophth soln 10%</i>	1	
<i>tropicamide ophth soln 0.5%</i>	1	MO
<i>tropicamide ophth soln 1%</i>	1	MO
<b>MIOTICS</b>		
<i>pilocarpine hcl ophth soln 1%</i>	1	MO
<i>pilocarpine hcl ophth soln 1.25%</i>	1	MO
<i>pilocarpine hcl ophth soln 2%</i>	1	MO
<i>pilocarpine hcl ophth soln 4%</i>	1	MO
<b>OPHTHALMIC ADRENERGIC AGENTS</b>		
ALPHAGAN P SOL 0.1% OP ( <i>brimonidine tartrate</i> )	2	MO
ALPHAGAN P SOL 0.15% OP ( <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
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	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 0.5%</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-10000unt op oin</i>	1	
<i>neomycin-polymy-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 soln 10%</i>	1	
<i>tobramycin ophth soln 0.3%</i>	1	
TOBREX OIN 0.3% OP ( <i>tobramycin (ophth)</i> )	3	
<i>trifluridine ophth soln 1%</i>	1	
XDEMVY DRO 0.25% ( <i>lotilaner</i> )	2	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>OPHTHALMIC IMMUNOMODULATORS</b>		
RESTASIS EMU 0.05% OP ( <i>cyclosporine (ophth)</i> )	1	MO
RESTASIS MUL EMU 0.05% OP ( <i>cyclosporine (ophth)</i> )	2	MO
VEVYE DRO 0.1% ( <i>cyclosporine (ophth)</i> )	2	MO
<b>OPHTHALMIC STEROIDS</b>		
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
<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 0.2%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
<i>loteprednol etabonate-tobramycin ophth susp 0.5-0.3%</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	
<b>OPHTHALMICS - MISC.</b>		
<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 0.07% (base equivalent)</i>	1	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
<i>bromfenac sodium ophth soln 0.075% (base equivalent)</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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
<i>olopatadine hcl ophth soln 0.2% (base equivalent)</i>	1	
<b>PROSTAGLANDINS - OPHTHALMIC</b>		
<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
<b>OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR</b>		
<b>OTIC AGENTS - MISCELLANEOUS</b>		
<i>acetic acid otic soln 2%</i>	1	
<b>OTIC ANTI-INFECTIVES</b>		
<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	1	
<i>ofloxacin otic soln 0.3%</i>	1	
<b>OTIC COMBINATIONS</b>		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	1	
<i>ciprofloxacin-hydrocortisone otic susp 0.2-1%</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	
<b>OTIC STEROIDS</b>		
<i>fluocinolone acetonide (otic) oil 0.01%</i>	1	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	1	
<b>OXYTOCICS - DRUGS FOR PREGNANCY</b>		
<b>OXYTOCICS - DRUGS FOR PREGNANCY</b>		
<i>methylergonovine maleate tab 0.2 mg</i>	1	
(Methylergonovine Maleate Tab 0.2 mg)	1	
METHERGINE		
<b>PENICILLINS - DRUGS TO TREAT INFECTIONS</b>		
<b>AMINOPENICILLINS</b>		
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>ampicillin cap 500 mg</i>	1	
<b>NATURAL PENICILLINS</b>		
<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	
<b>PENICILLIN COMBINATIONS</b>		
<i>amoxicillin &amp; k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
AUGMENTIN SUS 125/5ML ( <i>amoxicillin &amp; pot clavulanate</i> )	3	
<b>PENICILLINASE-RESISTANT PENICILLINS</b>		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
<b>PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES</b>		
<b>PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES</b>		
<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
(Norethindrone Acetate Tab 5 mg) GALLIFREY	1	MO
<i>progesterone cap 100 mg</i>	1	MO
<i>progesterone cap 200 mg</i>	1	MO
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS</b>		
<b>AGENTS FOR CHEMICAL DEPENDENCY</b>		
<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
<i>lofexidine hcl tab 0.18 mg (base equivalent)</i>	1	

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b>ANTI-CATAPLECTIC AGENTS</b>		
LUMRYZ PAK 6GM ( <i>sodium oxybate</i> )	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 7.5GM ( <i>sodium oxybate</i> )	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 9GM ( <i>sodium oxybate</i> )	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK STARTER ( <i>sodium oxybate</i> )	2	SP, PA, QL (1 packet every 1 day); 28-day starter pack
LUMRYZ PKG 4.5GM ( <i>sodium oxybate</i> )	2	SP, PA, QL (1 packet every 1 day)
XYWAV SOL 0.5GM/ML ( <i>calcium, magnesium, potassium, &amp; sodium oxybates</i> )	2	PA, QL (18 mL every 1 day)
<b>ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS</b>		
<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 &amp; 21 x 10 mg titration pack</i>	1	
<i>memantine hcl-donepezil hcl cap er 24hr 14-10 mg</i>	1	MO
<i>memantine hcl-donepezil hcl cap er 24hr 21-10 mg</i>	1	MO
<i>memantine hcl-donepezil hcl cap er 24hr 28-10 mg</i>	1	MO
NAMZARIC CAP 7-10MG ( <i>memantine hcl-donepezil hcl</i> )	2	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<b>NAMZARIC CAP 14-10MG ( memantine hcl-donepezil hcl)</b>	2	MO
<b>NAMZARIC CAP 21-10MG ( memantine hcl-donepezil hcl)</b>	2	MO
<b>NAMZARIC CAP 28-10MG ( memantine hcl-donepezil hcl)</b>	2	MO
<b>rivastigmine tartrate cap 1.5 mg (base equivalent)</b>	1	MO
<b>rivastigmine tartrate cap 3 mg (base equivalent)</b>	1	MO
<b>rivastigmine tartrate cap 4.5 mg (base equivalent)</b>	1	MO
<b>rivastigmine tartrate cap 6 mg (base equivalent)</b>	1	MO
<b>rivastigmine td patch 24hr 4.6 mg/24hr</b>	1	MO
<b>rivastigmine td patch 24hr 9.5 mg/24hr</b>	1	MO
<b>rivastigmine td patch 24hr 13.3 mg/24hr</b>	1	MO
<b>COMBINATION PSYCHOTHERAPEUTICS</b>		
<b>chlordiazepoxide-amitriptyline tab 5-12.5 mg</b>	1	MO
<b>chlordiazepoxide-amitriptyline tab 10-25 mg</b>	1	MO
<b>olanzapine-fluoxetine hcl cap 3-25 mg</b>	1	MO
<b>olanzapine-fluoxetine hcl cap 6-25 mg</b>	1	MO
<b>olanzapine-fluoxetine hcl cap 6-50 mg</b>	1	MO
<b>olanzapine-fluoxetine hcl cap 12-25 mg</b>	1	MO
<b>olanzapine-fluoxetine hcl cap 12-50 mg</b>	1	MO
<b>perphenazine-amitriptyline tab 2-10 mg</b>	1	MO
<b>perphenazine-amitriptyline tab 2-25 mg</b>	1	MO
<b>perphenazine-amitriptyline tab 4-10 mg</b>	1	MO
<b>perphenazine-amitriptyline tab 4-25 mg</b>	1	MO
<b>perphenazine-amitriptyline tab 4-50 mg</b>	1	MO
<b>HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS</b>		
<b>ADDYI TAB 100MG ( flibanserin)</b>	3	PA, MO
<b>MOVEMENT DISORDER DRUG THERAPY</b>		
<b>AUSTEDO TAB 6MG ( deutetrabenazine)</b>	2	SP, PA, QL (2 tabs every 1 day)
<b>AUSTEDO TAB 9MG ( deutetrabenazine)</b>	2	SP, PA, QL (4 tabs every 1 day)
<b>AUSTEDO TAB 12MG ( deutetrabenazine)</b>	2	SP, PA, QL (4 tabs every 1 day)
<b>INGREZZA CAP 40-80MG ( valbenazine tosylate)</b>	2	SP, PA, QL (1 cap every 1 day)
<b>INGREZZA CAP 40MG ( valbenazine tosylate)</b>	2	SP, PA, QL (1 cap every 1 day)
<b>INGREZZA CAP 60MG ( valbenazine tosylate)</b>	2	SP, PA, QL (1 cap every 1 day)
<b>INGREZZA CAP 80MG ( valbenazine tosylate)</b>	2	SP, PA, QL (1 cap every 1 day)
<b>tetrabenazine tab 12.5 mg</b>	1	SP, PA, QL (4 tabs every 1 day)
<b>tetrabenazine tab 25 mg</b>	1	SP, PA, QL (2 tabs every 1 day)
<b>MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS</b>		
<b>BAFIERTAM CAP 95MG ( monomethyl fumarate)</b>	2	SP, PA, QL (4 caps every 1 day)
<b>cladribine tab therapy pack 10 mg (4 tabs)</b>	1	SP, PA, QL (20 tabs every 270 days)

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>cladribine tab therapy pack 10 mg (5 tabs)</i>	1	SP, PA, QL (20 tabs every 270 days)
<i>cladribine tab therapy pack 10 mg (6 tabs)</i>	1	SP, PA, QL (20 tabs every 270 days)
<i>cladribine tab therapy pack 10 mg (7 tabs)</i>	1	SP, PA, QL (20 tabs every 270 days)
<i>cladribine tab therapy pack 10 mg (8 tabs)</i>	1	SP, PA, QL (20 tabs every 270 days)
<i>cladribine tab therapy pack 10 mg (9 tabs)</i>	1	SP, PA, QL (20 tabs every 270 days)
<i>cladribine tab therapy pack 10 mg (10 tabs)</i>	1	SP, PA, QL (20 tabs every 270 days)
<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 &amp; 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)
MAYZENT PAK STARTER ( <i>siponimod fumarate</i> )	2	SP, PA, QL (12 tablet starter pack)
MAYZENT PAK STARTER ( <i>siponimod fumarate</i> )	2	SP, PA, QL (7 tabs every 4 days)
MAYZENT TAB 0.25MG ( <i>siponimod fumarate</i> )	2	SP, PA, QL (12 tabs every 5 days)
MAYZENT TAB 1MG ( <i>siponimod fumarate</i> )	2	SP, PA, QL (1 tab every 1 day)
MAYZENT TAB 2MG ( <i>siponimod fumarate</i> )	2	SP, PA, QL (1 tab every 1 day)
<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)
ZEPOSIA 7DAY CAP STR PACK ( <i>ozanimod hcl</i> )	2	SP, PA, QL (7 caps every 7 days); Preferred for Ulcerative Colitis
ZEPOSIA CAP 0.92MG ( <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
<b>POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS</b>		
<i>gabapentin (once-daily) tab 300 mg</i>	1	MO
<i>gabapentin (once-daily) tab 450 mg</i>	1	MO
<i>gabapentin (once-daily) tab 600 mg</i>	1	MO
<i>gabapentin (once-daily) tab 750 mg</i>	1	MO
<i>gabapentin (once-daily) tab 900 mg</i>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS</b>		
<i>pimozide tab 1 mg</i>	1	MO
<i>pimozide tab 2 mg</i>	1	MO
<b>SMOKING DETERRENTS</b>		
<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) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year
( 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) 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 POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
( Nicotine Polacrilex Gum 4 mg) GOODSENSE NICOTINE POLACR	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Nicotine Polacrilex Gum 4 mg) KLS QUIT4	PV	\$0 limited to 2 treatment cycles/year
<b><i>nicotine polacrilex lozenge 2 mg</i></b>	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) 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) 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) SM NICOTINE	PV	\$0 limited to 2 treatment cycles/year
<b><i>nicotine polacrilex lozenge 4 mg</i></b>	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
( Nicotine Polacrilex Lozenge 4 mg) EQ 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 POLACR	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
( Nicotine Polacrilex Lozenge 4 mg) SM NICOTINE POLACRILEX	PV	\$0 limited to 2 treatment cycles/year
<b><i>nicotine td patch 24hr 7 mg/24hr</i></b>	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 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) 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
<b><i>nicotine td patch 24hr 14 mg/24hr</i></b>	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) NICOTINE TRANSDERMAL SYST	PV	\$0 limited to 2 treatment cycles/year
<b><i>nicotine td patch 24hr 21 mg/24hr</i></b>	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) 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
NICOTROL NS SPR 10MG/ML ( <i>nicotine</i> )	PV	\$0 limited to 2 treatment cycles/year
<b><i>varenicline tartrate tab 0.5 mg (base equiv)</i></b>	PV	\$0 limited to 2 treatment cycles/year
<b><i>varenicline tartrate tab 1 mg (base equiv)</i></b>	PV	\$0 limited to 2 treatment cycles/year
<b><i>varenicline tartrate tab 11 x 0.5 mg &amp; 42 x 1 mg start pack</i></b>	PV	\$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS</b>		
<b>CYSTIC FIBROSIS AGENTS</b>		
KALYDECO PAK 25MG ( <i>ivacaftor</i> )	3	SP, PA
KALYDECO PAK 50MG ( <i>ivacaftor</i> )	3	SP, PA
KALYDECO PAK 75MG ( <i>ivacaftor</i> )	3	SP, PA
KALYDECO TAB 150MG ( <i>ivacaftor</i> )	3	SP, PA
<b>PULMONARY FIBROSIS AGENTS</b>		
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 534 mg</i>	1	SP, PA, QL (3 tabs every 1 day)
<i>pirfenidone tab 801 mg</i>	1	SP, PA, QL (3 tabs every 1 day)
<b>SULFONAMIDES - DRUGS TO TREAT INFECTIONS</b>		
<b>SULFONAMIDES - DRUGS TO TREAT INFECTIONS</b>		
<i>sulfadiazine tab 500 mg</i>	1	
<b>TETRACYCLINES - DRUGS TO TREAT INFECTIONS</b>		
<b>TETRACYCLINES - DRUGS TO TREAT INFECTIONS</b>		
<i>demeclocycline hcl tab 150 mg</i>	1	
<i>demeclocycline 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) MONDOXYNE NL	1	
<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	
<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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<b>THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS</b>		
<b>ANTITHYROID AGENTS</b>		
<i>methimazole tab 5 mg</i>	1	MO
<i>methimazole tab 10 mg</i>	1	MO
<i>propylthiouracil tab 50 mg</i>	1	MO
<b>THYROID HORMONES</b>		
<i>levothyroxine sodium tab 25 mcg</i>	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) 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) 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) 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) 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) LEVO-T	1	MO
( 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) 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) 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) LEVO-T	1	MO
( Levothyroxine Sodium Tab 150 mcg) LEVOXYL	1	MO

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

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

**ANTISPASMODICS - DRUGS FOR STOMACH SPASMS**

<b>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</b>	1	
<b>dicyclomine hcl cap 10 mg</b>	1	
<b>dicyclomine hcl oral soln 10 mg/5ml</b>	1	
<b>dicyclomine hcl tab 20 mg</b>	1	
<b>glycopyrrolate oral soln 1 mg/5ml</b>	1	MO
<b>glycopyrrolate tab 1 mg</b>	1	
<b>glycopyrrolate tab 2 mg</b>	1	
<b>hyoscyamine sulfate elixir 0.125 mg/5ml</b>	1	MO

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
( Hyoscyamine Sulfate Elixir 0.125 mg/5ml) HYOSYNE	1	MO
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	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
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	1	MO
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	
<b>H-2 ANTAGONISTS</b>		
<i>cimetidine hcl soln 300 mg/5ml</i>	1	MO
<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
<i>ranitidine hcl tab 150 mg</i>	1	MO
<i>ranitidine hcl tab 300 mg</i>	1	MO
<b>MISC. ANTI-ULCER</b>		
<i>sucralfate tab 1 gm</i>	1	MO
<b>PROTON PUMP INHIBITORS</b>		
<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 pack 2.5 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 5 mg</i>	1	QL (90 packets every year), MO
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	1	QL (90 packets every year), MO
<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

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<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
<b>ULCER DRUGS - PROSTAGLANDINS</b>		
<i>misoprostol tab 100 mcg</i>	1	MO
<i>misoprostol tab 200 mcg</i>	1	MO
<b>ULCER THERAPY COMBINATIONS</b>		
<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap dr 500 &amp; 500 &amp; 30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
TALICIA CAP ( <i>amoxicillin-rifabutin-omeprazole</i> )	2	
<b>URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE</b>		
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)</b>		
<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>tropium chloride cap er 24hr 60 mg</i>	1	MO
<i>tropium chloride tab 20 mg</i>	1	MO
<b>URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS</b>		
GEMTESA TAB 75MG ( <i>vibegron</i> )	2	MO
<i>mirabegron tab er 24 hr 25 mg</i>	1	MO
<i>mirabegron tab er 24 hr 50 mg</i>	1	MO
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>		
<i>bethanechol chloride tab 5 mg</i>	1	
<i>bethanechol chloride tab 10 mg</i>	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
<i>bethanechol chloride tab 25 mg</i>	1	
<i>bethanechol chloride tab 50 mg</i>	1	
<b>URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS</b>		
<i>flavoxate hcl tab 100 mg</i>	1	MO
<b>VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS</b>		
<b>MISCELLANEOUS VAGINAL PRODUCTS</b>		
INTRAROSA SUP 6.5MG ( <i>prasterone vaginal</i> )	3	MO
<b>SPERMICIDES</b>		
ENCARE SUP 100MG ( <i>nonoxynol-9</i> )	PV	
GYNOL II GEL 3% ( <i>nonoxynol-9</i> )	PV	
TODAY SPONGE MIS ( <i>nonoxynol-9</i> )	PV	
VCF VAGINAL GEL CONTRACE ( <i>nonoxynol-9</i> )	PV	
VCF VAGINAL MIS CONTRACP ( <i>nonoxynol-9</i> )	PV	
<b>VAGINAL ANTI-INFECTIVES</b>		
<i>clindamycin phosphate vaginal cream 2%</i>	1	
<i>metronidazole vaginal gel 0.75%</i>	1	
( Miconazole Nitrate Vaginal Suppos 200 mg) MICONAZOLE 3	1	
<i>terconazole vaginal cream 0.4%</i>	1	
<i>terconazole vaginal cream 0.8%</i>	1	
<i>terconazole vaginal suppos 80 mg</i>	1	
<b>VAGINAL CONTRACEPTIVE - PH MODULATORS</b>		
PHEXX GEL ( <i>lactic acid-citric acid-potassium bitartrate</i> )	PV	
<b>VAGINAL ESTROGENS</b>		
<i>estradiol vaginal cream 0.01%</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
<b>VAGINAL PROGESTINS</b>		
CRINONE GEL 4% VAG ( <i>progesterone (vaginal)</i> )	2	
CRINONE GEL 8% VAG ( <i>progesterone (vaginal)</i> )	2	PA
<i>progesterone vaginal insert 100 mg</i>	1	
<b>VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS</b>		
<b>ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION</b>		
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	

<b>PRESCRIPTION DRUG NAME</b>	<b>DRUG TIER</b>	<b>COVERAGE REQUIREMENTS AND LIMITS</b>
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1	
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1	
<b>NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS</b>		
<i>droxidopa cap 100 mg</i>	1	SP, PA, QL (6 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)
<b>VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS</b>		
<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	
<b>VITAMINS - DRUGS FOR NUTRITION</b>		
<b>OIL SOLUBLE VITAMINS</b>		
<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	1	MO
<i>phytonadione tab 5 mg</i>	1	

## Index

<b>A</b>	
<b>abacavir sulfate soln 20 mg/ml (base equiv) ...</b>	97
<b>abacavir sulfate tab 300 mg (base equiv) .....</b>	97
<b>abacavir sulfate-lamivudine tab 600-300 mg ..</b>	97
<b>abacavir-dolutegravir-lamivudine</b>	
see TRIUMEQ PD TAB .....	99
see TRIUMEQ TAB .....	99
<b>ABIGALE</b>	
see Estradiol & Norethindrone Acetate Tab 1- 0.5 mg .....	131
<b>ABIGALE LO</b>	
see Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg .....	130
<b>abiraterone acetate micronized</b>	
see YONSA TAB 125MG .....	85
<b>abiraterone acetate tab 250 mg .....</b>	84
Abiraterone Acetate Tab 250 mg .....	84
<b>abiraterone acetate tab 500 mg .....</b>	84
<b>ABIRTEGA</b>	
see Abiraterone Acetate Tab 250 mg .....	84
<b>abrocitinib</b>	
see CIBINQO TAB 100MG .....	125
see CIBINQO TAB 200MG .....	125
see CIBINQO TAB 50MG .....	125
<b>acalabrutinib maleate</b>	
see CALQUENCE TAB 100MG .....	87
<b>acamprosate calcium tab delayed release 333     mg .....</b>	152
<b>acarbose tab 100 mg .....</b>	68
<b>acarbose tab 25 mg .....</b>	68
<b>acarbose tab 50 mg .....</b>	68
<b>ACCUTANE</b>	
see Isotretinoin Cap 10 mg .....	120
see Isotretinoin Cap 20 mg .....	120
see Isotretinoin Cap 30 mg .....	120
see Isotretinoin Cap 40 mg .....	120
<b>acebutolol hcl cap 200 mg .....</b>	101
<b>acebutolol hcl cap 400 mg .....</b>	101
<b>acetaminophen w/ codeine soln 120-12 mg/5ml     .....</b>	46
<b>acetaminophen w/ codeine tab 300-15 mg .....</b>	46
<b>acetaminophen w/ codeine tab 300-30 mg .....</b>	47
<b>acetaminophen w/ codeine tab 300-60 mg .....</b>	47
<b>acetaminophen-caffeine-dihydrocodeine cap     320.5-30-16 mg .....</b>	47
Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg .....	47
<b>acetazolamide cap er 12hr 500 mg .....</b>	127
<b>acetazolamide tab 125 mg .....</b>	127
<b>acetazolamide tab 250 mg .....</b>	127
<b>acetic acid otic soln 2% .....</b>	151
<b>acetylcysteine inhal soln 10% .....</b>	119
<b>acetylcysteine inhal soln 20% .....</b>	119
<b>acitretin cap 10 mg .....</b>	122
<b>acitretin cap 17.5 mg .....</b>	122
<b>acitretin cap 25 mg .....</b>	122
<b>acyclovir cap 200 mg .....</b>	100
<b>acyclovir oint 5% .....</b>	123
<b>acyclovir susp 200 mg/5ml .....</b>	100
<b>acyclovir tab 400 mg .....</b>	100
<b>acyclovir tab 800 mg .....</b>	100
<b>adagrasib</b>	
see KRAZATI TAB 200MG .....	88
<b>adapalene cream 0.1% .....</b>	119
<b>adapalene gel 0.1% .....</b>	119
<b>adapalene gel 0.3% .....</b>	119
<b>adapalene-benzoyl peroxide</b>	
see EPIDUO FORTE GEL 0.3-2.5% .....	120
see EPIDUO GEL 0.1-2.5% .....	120
<b>adapalene-benzoyl peroxide gel 0.1-2.5% .....</b>	119
<b>adapalene-benzoyl peroxide gel 0.3-2.5% .....</b>	119
<b>ADDYI TAB 100MG .....</b>	154
<b>adefovir dipivoxil tab 10 mg .....</b>	99
<b>ADEMPAS TAB 0.5MG .....</b>	107
<b>ADEMPAS TAB 1.5MG .....</b>	107
<b>ADEMPAS TAB 1MG .....</b>	107
<b>ADEMPAS TAB 2.5MG .....</b>	107
<b>ADEMPAS TAB 2MG .....</b>	107
<b>AERCHMBR PLS MIS LRG MASK .....</b>	141
<b>AERCHMBR PLS MIS MED MASK .....</b>	141
<b>AERCHMBR PLS MIS SM MASK .....</b>	141
<b>AERCHMBR Z- MIS STAT PLS .....</b>	141
<b>AEROCHAMBER MIS CHAMBER .....</b>	141
<b>AEROCHAMBER MIS MV .....</b>	141
<b>AEROCHAMBER MIS PLUS .....</b>	141
<b>AEROVENT MIS PLUS .....</b>	141
<b>AFIRMELLE</b>	

see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg .....	110
AFREZZA POW 12 UNIT .....	71
AFREZZA POW 4-8 UNIT .....	71
AFREZZA POW 4-8-12 .....	71
AFREZZA POW 4UNIT .....	71
AFREZZA POW 8 UNIT .....	71
AFREZZA POW 8-12UNIT .....	71
AIRSUPRA AER 90-80MCG .....	57
AKLIEF CRE 0.005% .....	119
ALA-CORT	
see Hydrocortisone Cream 1% .....	124
<b>albendazole tab 200 mg</b> .....	52
<b>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</b> .....	57
<b>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</b> .....	57
<b>albuterol sulfate soln nebu 0.5% (5 mg/ml)</b> ....	57
<b>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</b> .....	57
<b>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</b> .....	57
<b>albuterol sulfate syrup 2 mg/5ml</b> .....	57
<b>albuterol sulfate tab 2 mg</b> .....	57
<b>albuterol sulfate tab 4 mg</b> .....	57
<b>albuterol-budesonide</b>	
see AIRSUPRA AER 90-80MCG .....	57
<b>alclometasone dipropionate cream 0.05%</b> ....	123
<b>alclometasone dipropionate oint 0.05%</b> .....	123
ALECENSA CAP 150MG .....	86
<b>alectinib hcl</b>	
see ALECENSA CAP 150MG .....	86
<b>alendronate sodium oral soln 70 mg/75ml</b> ....	128
<b>alendronate sodium tab 10 mg</b> .....	128
<b>alendronate sodium tab 35 mg</b> .....	128
<b>alendronate sodium tab 70 mg</b> .....	128
<b>alfuzosin hcl tab er 24hr 10 mg</b> .....	135
<b>aliskiren fumarate tab 150 mg (base equivalent)</b> .....	82
<b>aliskiren fumarate tab 300 mg (base equivalent)</b> .....	82
<b>allopurinol tab 100 mg</b> .....	135
<b>allopurinol tab 200 mg</b> .....	135
<b>allopurinol tab 300 mg</b> .....	135
<b>almotriptan malate tab 12.5 mg</b> .....	142
<b>almotriptan malate tab 6.25 mg</b> .....	142
<b>alosetron hcl tab 0.5 mg (base equiv)</b> .....	134

<b>alosetron hcl tab 1 mg (base equiv)</b> .....	134
<b>alpelisib</b>	
see PIQRAY 200MG TAB DOSE .....	89
see PIQRAY 250MG TAB DOSE .....	89
see PIQRAY 300MG TAB DOSE .....	89
ALPHAGAN P SOL 0.1% OP .....	149
ALPHAGAN P SOL 0.15% OP .....	149
<b>alprazolam orally disintegrating tab 0.25 mg</b> .	54
<b>alprazolam orally disintegrating tab 0.5 mg</b> ...	54
<b>alprazolam orally disintegrating tab 1 mg</b> .....	54
<b>alprazolam orally disintegrating tab 2 mg</b> .....	54
<b>alprazolam tab 0.25 mg</b> .....	54
<b>alprazolam tab 0.5 mg</b> .....	54
<b>alprazolam tab 1 mg</b> .....	54
<b>alprazolam tab 2 mg</b> .....	54
<b>alprazolam tab er 24hr 0.5 mg</b> .....	54
Alprazolam Tab Er 24hr 0.5 mg .....	54
<b>alprazolam tab er 24hr 1 mg</b> .....	54
Alprazolam Tab Er 24hr 1 mg .....	54
<b>alprazolam tab er 24hr 2 mg</b> .....	54
Alprazolam Tab Er 24hr 2 mg .....	54
<b>alprazolam tab er 24hr 3 mg</b> .....	54
Alprazolam Tab Er 24hr 3 mg .....	54
ALPRAZOLAM XR	
see Alprazolam Tab Er 24hr 0.5 mg .....	54
see Alprazolam Tab Er 24hr 1 mg .....	54
see Alprazolam Tab Er 24hr 2 mg .....	54
see Alprazolam Tab Er 24hr 3 mg .....	54
ALTAVERA	
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg.....	111
ALUNBRIG PAK.....	86
ALUNBRIG TAB 180MG .....	86
ALUNBRIG TAB 30MG .....	86
ALUNBRIG TAB 90MG .....	86
ALVAIZ TAB 18MG .....	137
ALVAIZ TAB 36MG .....	137
ALVAIZ TAB 54MG .....	137
ALVAIZ TAB 9MG .....	137
ALYACEN 1/35	
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg .....	112
ALYACEN 7/7/7	
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg .....	115
ALYQ	
see Tadalafil Tab 20 mg (Pah).....	107

<b>amantadine hcl cap 100 mg</b> .....	91	<b>amlodipine besylate-atorvastatin calcium tab 5-20 mg</b> .....	105
<b>amantadine hcl soln 50 mg/5ml</b> .....	92	<b>amlodipine besylate-atorvastatin calcium tab 5-40 mg</b> .....	105
<b>amantadine hcl tab 100 mg</b> .....	92	<b>amlodipine besylate-atorvastatin calcium tab 5-80 mg</b> .....	105
<b>ambrisentan tab 10 mg</b> .....	106	<b>amlodipine besylate-benazepril hcl cap 10-20 mg</b> .....	79
<b>ambrisentan tab 5 mg</b> .....	106	<b>amlodipine besylate-benazepril hcl cap 10-40 mg</b> .....	79
AMETHYST		<b>amlodipine besylate-benazepril hcl cap 2.5-10 mg</b> .....	79
see Levonorgestrel-Ethinyl Estradiol		<b>amlodipine besylate-benazepril hcl cap 5-10 mg</b> .....	79
(Continuous) Tab 90-20 mcg .....	111	.....	79
<b>amiloride &amp; hydrochlorothiazide tab 5-50 mg</b> .....	127	<b>amlodipine besylate-benazepril hcl cap 5-20 mg</b> .....	79
.....	127	.....	79
<b>amiloride hcl tab 5 mg</b> .....	127	<b>amlodipine besylate-benazepril hcl cap 5-40 mg</b> .....	79
<b>aminocaproic acid oral soln 0.25 gm/ml</b> .....	138	.....	79
<b>aminocaproic acid tab 1000 mg</b> .....	138	<b>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</b> .....	80
<b>aminocaproic acid tab 500 mg</b> .....	138	<b>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</b> .....	80
<b>amiodarone hcl tab 100 mg</b> .....	55	<b>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</b> .....	79
Amiodarone Hcl Tab 100 mg .....	16, 55	<b>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</b> .....	79
<b>amiodarone hcl tab 200 mg</b> .....	55	.....	80
Amiodarone Hcl Tab 200 mg .....	55	<b>amlodipine besylate-valsartan tab 10-160 mg</b> .....	80
<b>amiodarone hcl tab 400 mg</b> .....	55	<b>amlodipine besylate-valsartan tab 10-320 mg</b> .....	80
<b>amitriptyline hcl tab 10 mg</b> .....	67	<b>amlodipine besylate-valsartan tab 5-160 mg</b> .....	80
<b>amitriptyline hcl tab 100 mg</b> .....	67	<b>amlodipine besylate-valsartan tab 5-320 mg</b> .....	80
<b>amitriptyline hcl tab 150 mg</b> .....	67	<b>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</b> .....	80
<b>amitriptyline hcl tab 25 mg</b> .....	67	<b>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</b> .....	80
<b>amitriptyline hcl tab 50 mg</b> .....	67	<b>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</b> .....	80
<b>amitriptyline hcl tab 75 mg</b> .....	67	<b>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</b> .....	80
<b>amlodipine besylate tab 10 mg (base equivalent)</b> .....	102	<b>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</b> .....	80
<b>amlodipine besylate tab 2.5 mg (base equivalent)</b> .....	102	AMNESTEEM	
<b>amlodipine besylate tab 5 mg (base equivalent)</b> .....	102	see Isotretinoin Cap 10 mg .....	120
.....	102	see Isotretinoin Cap 20 mg .....	120
<b>amlodipine besylate-atorvastatin calcium tab 10-10 mg</b> .....	105	see Isotretinoin Cap 30 mg .....	120
<b>amlodipine besylate-atorvastatin calcium tab 10-20 mg</b> .....	105	see Isotretinoin Cap 40 mg .....	120
<b>amlodipine besylate-atorvastatin calcium tab 10-40 mg</b> .....	105	<b>amoxapine tab 100 mg</b> .....	67
<b>amlodipine besylate-atorvastatin calcium tab 10-80 mg</b> .....	105	<b>amoxapine tab 150 mg</b> .....	67
<b>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</b> .....	105		
<b>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</b> .....	105		
<b>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</b> .....	105		
<b>amlodipine besylate-atorvastatin calcium tab 5-10 mg</b> .....	105		

<i>amoxapine tab 25 mg</i> .....	67	<i>amphetamine-dextroamphetamine 3-bead cap</i>	
<i>amoxapine tab 50 mg</i> .....	67	<i>er 24hr 25 mg</i> .....	26
<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap dr</i>		<i>amphetamine-dextroamphetamine 3-bead cap</i>	
<i>500 &amp; 500 &amp; 30mg</i> .....	163	<i>er 24hr 37.5 mg</i> .....	27
<i>amoxicillin &amp; k clavulanate for susp 200-28.5</i>		<i>amphetamine-dextroamphetamine 3-bead cap</i>	
<i>mg/5ml</i> .....	152	<i>er 24hr 50 mg</i> .....	27
<i>amoxicillin &amp; k clavulanate for susp 250-62.5</i>		<i>amphetamine-dextroamphetamine cap er 24hr</i>	
<i>mg/5ml</i> .....	152	<i>10 mg</i> .....	27
<i>amoxicillin &amp; k clavulanate for susp 400-57</i>		<i>amphetamine-dextroamphetamine cap er 24hr</i>	
<i>mg/5ml</i> .....	152	<i>15 mg</i> .....	27
<i>amoxicillin &amp; k clavulanate for susp 600-42.9</i>		<i>amphetamine-dextroamphetamine cap er 24hr</i>	
<i>mg/5ml</i> .....	152	<i>20 mg</i> .....	27
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i> .	152	<i>amphetamine-dextroamphetamine cap er 24hr</i>	
<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i> .	152	<i>25 mg</i> .....	27
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i> .	152	<i>amphetamine-dextroamphetamine cap er 24hr</i>	
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-</i>		<i>30 mg</i> .....	27
<i>62.5 mg</i> .....	152	<i>amphetamine-dextroamphetamine cap er 24hr</i>	
<i>amoxicillin &amp; pot clavulanate</i>		<i>5 mg</i> .....	27
see AUGMENTIN SUS 125/5ML .....	152	<i>amphetamine-dextroamphetamine tab 10 mg</i>	
<i>amoxicillin (trihydrate) cap 250 mg</i> .....	151	.....	27
<i>amoxicillin (trihydrate) cap 500 mg</i> .....	151	<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	
<i>amoxicillin (trihydrate) chew tab 125 mg</i> .....	151	.....	28
<i>amoxicillin (trihydrate) chew tab 250 mg</i> .....	151	<i>amphetamine-dextroamphetamine tab 15 mg</i>	
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	151	.....	28
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	151	<i>amphetamine-dextroamphetamine tab 20 mg</i>	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	151	.....	28
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	151	<i>amphetamine-dextroamphetamine tab 30 mg</i>	
<i>amoxicillin (trihydrate) tab 500 mg</i> .....	151	.....	28
<i>amoxicillin (trihydrate) tab 875 mg</i> .....	151	<i>amphetamine-dextroamphetamine tab 5 mg</i> .	27
<i>amoxicillin-rifabutin-omeprazole</i>		<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	
see TALICIA CAP .....	163	.....	27
<i>amphetamine sulfate tab 10 mg</i> .....	26	<i>ampicillin cap 500 mg</i> .....	152
<i>amphetamine sulfate tab 5 mg</i> .....	26	<i>anagrelide hcl cap 0.5 mg</i> .....	135
<i>amphetamine tab extended release</i>		<i>anagrelide hcl cap 1 mg</i> .....	135
<i>disintegrating 12.5 mg</i> .....	26	<i>anastrozole tab 1 mg</i> .....	85
<i>amphetamine tab extended release</i>		ANNOVERA MIS .....	116
<i>disintegrating 15.7 mg</i> .....	26	ANORO ELLIPT AER 62.5-25 .....	57
<i>amphetamine tab extended release</i>		<i>apalutamide</i>	
<i>disintegrating 18.8 mg</i> .....	26	see ERLEADA TAB 240MG .....	85
<i>amphetamine tab extended release</i>		see ERLEADA TAB 60MG .....	85
<i>disintegrating 3.1 mg</i> .....	26	<i>apixaban</i>	
<i>amphetamine tab extended release</i>		see ELIQUIS CAP 0.15MG .....	59
<i>disintegrating 6.3 mg</i> .....	26	see ELIQUIS ST P TAB 5MG .....	59
<i>amphetamine tab extended release</i>		see ELIQUIS TAB 0.5MG .....	59
<i>disintegrating 9.4 mg</i> .....	26	see ELIQUIS TAB 1.5MG .....	59
<i>amphetamine-dextroamphetamine 3-bead cap</i>		see ELIQUIS TAB 2.5MG .....	59
<i>er 24hr 12.5 mg</i> .....	26	see ELIQUIS TAB 2MG .....	59

see ELIQUIS TAB 5MG ..... 59

**apraclonidine hcl ophth soln 0.5% (base equivalent)** ..... 149

**apremilast**

see OTEZLA TAB 10/20 ..... 40

see OTEZLA TAB 10/20/30 ..... 40

see OTEZLA TAB 20MG ..... 40

see OTEZLA TAB 30MG ..... 41

see OTEZLA XR TAB 75MG ..... 41

see OTEZLA/XR TAB 28 DAY ..... 41

**aprepitant capsule 125 mg** ..... 73

**aprepitant capsule 40 mg** ..... 73

**aprepitant capsule 80 mg** ..... 73

**aprepitant capsule therapy pack 80 & 125 mg** 73

APRI

see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg ..... 109

ARANELLE

see Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg ..... 115

**arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)** ..... 57

**aripiprazole oral solution 1 mg/ml** ..... 97

**aripiprazole orally disintegrating tab 10 mg** ... 97

**aripiprazole orally disintegrating tab 15 mg** ... 97

**aripiprazole tab 10 mg** ..... 97

**aripiprazole tab 15 mg** ..... 97

**aripiprazole tab 2 mg** ..... 97

**aripiprazole tab 20 mg** ..... 97

**aripiprazole tab 30 mg** ..... 97

**aripiprazole tab 5 mg** ..... 97

**armodafinil tab 150 mg** ..... 33

**armodafinil tab 200 mg** ..... 33

**armodafinil tab 250 mg** ..... 33

**armodafinil tab 50 mg** ..... 33

**artemether-lumefantrine**

see COARTEM TAB 20-120MG ..... 82

**asciminib hcl**

see SCEMBLIX TAB 100MG ..... 90

see SCEMBLIX TAB 20MG ..... 90

see SCEMBLIX TAB 40MG ..... 90

ASCOMP/CODEINE

see Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg ..... 47

**asenapine maleate sl tab 10 mg (base equiv)** . 95

**asenapine maleate sl tab 2.5 mg (base equiv)** 95

**asenapine maleate sl tab 5 mg (base equiv)** ... 95

ASHLYNA

see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) ..... 110

ASMANEX HFA AER 100 MCG ..... 56

ASMANEX HFA AER 200 MCG ..... 56

ASMANEX HFA AER 50MCG ..... 56

Aspirin Chew Tab 81 mg ..... 41

ASPIRIN CHILDRENS

see Aspirin Chew Tab 81 mg ..... 41

**aspirin tab delayed release 81 mg** ..... 41

**aspirin-dipyridamole cap er 12hr 25-200 mg**. 135

**atazanavir sulfate cap 150 mg (base equiv)** .... 97

**atazanavir sulfate cap 200 mg (base equiv)** .... 97

**atazanavir sulfate cap 300 mg (base equiv)** .... 97

**atenolol & chlorthalidone tab 100-25 mg** ..... 80

**atenolol & chlorthalidone tab 50-25 mg** ..... 80

**atenolol tab 100 mg** ..... 101

**atenolol tab 25 mg** ..... 101

**atenolol tab 50 mg** ..... 101

**atogepant**

see QULIPTA TAB 10MG ..... 142

see QULIPTA TAB 30MG ..... 142

see QULIPTA TAB 60MG ..... 142

**atomoxetine hcl cap 10 mg (base equiv)** ..... 32

**atomoxetine hcl cap 100 mg (base equiv)** ..... 32

**atomoxetine hcl cap 18 mg (base equiv)** ..... 32

**atomoxetine hcl cap 25 mg (base equiv)** ..... 32

**atomoxetine hcl cap 40 mg (base equiv)** ..... 32

**atomoxetine hcl cap 60 mg (base equiv)** ..... 32

**atomoxetine hcl cap 80 mg (base equiv)** ..... 32

**atorvastatin calcium tab 10 mg (base equivalent)** ..... 76

**atorvastatin calcium tab 20 mg (base equivalent)** ..... 76

**atorvastatin calcium tab 40 mg (base equivalent)** ..... 76

**atorvastatin calcium tab 80 mg (base equivalent)** ..... 76

**atovaquone susp 750 mg/5ml** ..... 52

**atovaquone-proguanil hcl tab 250-100 mg** .... 82

**atovaquone-proguanil hcl tab 62.5-25 mg** ..... 82

**atrasentan hcl**

see VANRAFIA TAB 0.75MG ..... 134

**atropine sulfate ophth soln 1%** ..... 148

AUBRA EQ

see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg ..... 110

AUGMENTIN SUS 125/5ML..... 152  
AUGTYRO CAP 160MG ..... 86  
AUGTYRO CAP 40MG ..... 86  
AUROVELA 1.5/30  
    see Norethindrone Ace & Ethinyl Estradiol Tab  
    1.5 mg-30 mcg..... 113  
AUROVELA 1/20  
    see Norethindrone Ace & Ethinyl Estradiol Tab  
    1 mg-20 mcg ..... 112  
AUROVELA 24 FE  
    see Norethindrone Ace-Ethinyl Estradiol-Fe  
    Tab 1 mg-20 mcg (24) ..... 114  
AUROVELA FE 1.5/30  
    see Norethindrone Ace & Ethinyl Estradiol-Fe  
    Tab 1.5 mg-30 mcg..... 114  
AUROVELA FE 1/20  
    see Norethindrone Ace & Ethinyl Estradiol-Fe  
    Tab 1 mg-20 mcg..... 113  
AUSTEDO TAB 12MG ..... 154  
AUSTEDO TAB 6MG ..... 154  
AUSTEDO TAB 9MG ..... 154  
AUVELITY TAB 45-105MG ..... 65  
AUVI-Q INJ 0.15MG ..... 164  
AUVI-Q INJ 0.1MG ..... 164  
AUVI-Q INJ 0.3MG ..... 164  
**avatrombopag maleate**  
    see DOPTLET SPR CAP 10MG ..... 137  
    see DOPTLET TAB 20MG ..... 137  
AVIANE  
    see Levonorgestrel & Ethinyl Estradiol Tab 0.1  
    mg-20 mcg..... 111  
AVIDOXY  
    see Doxycycline Monohydrate Tab 100 mg 159  
**axitinib**  
    see INLYTA TAB 1MG ..... 83  
    see INLYTA TAB 5MG ..... 83  
AYUNA  
    see Levonorgestrel & Ethinyl Estradiol Tab  
    0.15 mg-30 mcg..... 111  
AZASAN  
    see Azathioprine Tab 100 mg ..... 145  
    see Azathioprine Tab 75 mg ..... 145  
**azathioprine tab 100 mg** ..... 145  
Azathioprine Tab 100 mg ..... 145  
**azathioprine tab 50 mg** ..... 145  
**azathioprine tab 75 mg** ..... 145  
Azathioprine Tab 75 mg ..... 145

**azelaic acid**  
    see FINACEA AER 15%..... 126  
**azelaic acid gel 15%**..... 126  
**azelastine hcl nasal spray 0.1% (137 mcg/spray)**  
    ..... 147  
**azelastine hcl ophth soln 0.05%** ..... 150  
**azelastine hcl-fluticasone prop nasal spray 137-  
50 mcg/act** ..... 147  
**azithromycin for susp 100 mg/5ml** ..... 139  
**azithromycin for susp 200 mg/5ml** ..... 139  
**azithromycin tab 250 mg** ..... 139  
**azithromycin tab 500 mg** ..... 139  
**azithromycin tab 600 mg** ..... 139  
AZSTARYS CAP 26.1-5.2..... 33  
AZSTARYS CAP 39.2-7.8..... 33  
AZSTARYS CAP 52.3-10..... 33  
**aztreonam lysine**  
    see CAYSTON INH 75MG..... 53  
AZURETTE  
    see Desogest-Eth Estrad & Eth Estrad Tab 0.15-  
    0.02/0.01 mg(21/5)..... 108  
**B**  
BAC  
    see Butalbital-Acetaminophen-Caffeine Tab  
    50-325-40 mg ..... 41  
**bacitracin ophth oint 500 unit/gm** ..... 149  
**bacitracin-polymyxin b ophth oint**..... 149  
**bacitracin-polymyxin-neomycin-hc ophth oint  
1%**..... 150  
**baclofen oral soln 10 mg/5ml** ..... 147  
**baclofen oral soln 5 mg/5ml**..... 147  
**baclofen susp 25 mg/5ml**..... 147  
**baclofen tab 10 mg**..... 147  
**baclofen tab 15 mg**..... 147  
**baclofen tab 20 mg**..... 147  
**baclofen tab 5 mg**..... 147  
BAFIERTAM CAP 95MG ..... 154  
**balsalazide disodium cap 750 mg** ..... 133  
BALZIVA  
    see Norethindrone & Ethinyl Estradiol Tab 0.4  
    mg-35 mcg ..... 112  
BAQSIMI ONE POW 3MG/DOSE ..... 70  
BAQSIMI TWO POW 3MG/DOSE ..... 70  
BD INSULIN PEN NEEDLES - OTC..... 140  
BD INSULIN SYRINGE - OTC..... 140  
BD INSULIN SYRINGE - RX ..... 140  
**bedaquiline fumarate**

see SIRTURO TAB 100MG .....	83
see SIRTURO TAB 20MG .....	83
BELBUCA MIS 150MCG .....	49
BELBUCA MIS 300MCG .....	50
BELBUCA MIS 450MCG .....	50
BELBUCA MIS 600MCG .....	50
BELBUCA MIS 750MCG .....	50
BELBUCA MIS 75MCG.....	49
BELBUCA MIS 900MCG .....	50
BELSOMRA TAB 10MG .....	139
BELSOMRA TAB 15MG .....	139
BELSOMRA TAB 20MG .....	139
BELSOMRA TAB 5MG .....	139
<b>bempedoic acid</b>	
see NEXLETOL TAB 180MG .....	75
<b>bempedoic acid-ezetimibe</b>	
see NEXLIZET TAB 180/10MG.....	75
<b>benazepril &amp; hydrochlorothiazide tab 10-12.5 mg.....</b>	80
<b>benazepril &amp; hydrochlorothiazide tab 20-12.5 mg.....</b>	80
<b>benazepril &amp; hydrochlorothiazide tab 20-25 mg .....</b>	80
<b>benazepril &amp; hydrochlorothiazide tab 5-6.25 mg .....</b>	80
<b>benazepril hcl tab 10 mg .....</b>	77
<b>benazepril hcl tab 20 mg .....</b>	77
<b>benazepril hcl tab 40 mg .....</b>	77
<b>benazepril hcl tab 5 mg .....</b>	77
BENZAC AC LIQ 5% WASH .....	119
<b>benzonatate cap 100 mg.....</b>	118
<b>benzonatate cap 200 mg.....</b>	118
<b>benzoyl peroxide</b>	
see BENZAC AC LIQ 5% WASH .....	119
<b>benzoyl peroxide-erythromycin gel 5-3% .....</b>	119
<b>benzphetamine hcl tab 50 mg .....</b>	31
<b>benztropine mesylate tab 0.5 mg .....</b>	91
<b>benztropine mesylate tab 1 mg.....</b>	91
<b>benztropine mesylate tab 2 mg.....</b>	91
<b>bepotastine besilate ophth soln 1.5% .....</b>	150
<b>berotralstat hcl</b>	
see ORLADEYO CAP 110MG.....	135
see ORLADEYO CAP 150MG.....	135
<b>besifloxacin hcl</b>	
see BESIVANCE SUS 0.6%.....	149
BESIVANCE SUS 0.6%.....	149
<b>betaine powder for oral solution .....</b>	129

<b>betamethasone dipropionate augmented cream 0.05% .....</b>	123
<b>betamethasone dipropionate augmented gel 0.05% .....</b>	123
<b>betamethasone dipropionate augmented lotion 0.05% .....</b>	123
<b>betamethasone dipropionate augmented oint 0.05% .....</b>	123
<b>betamethasone dipropionate cream 0.05% ..</b>	123
<b>betamethasone dipropionate lotion 0.05% ...</b>	123
<b>betamethasone valerate aerosol foam 0.12% .....</b>	123
<b>betamethasone valerate cream 0.1% (base equivalent) .....</b>	123
<b>betamethasone valerate lotion 0.1% (base equivalent) .....</b>	123
<b>betamethasone valerate oint 0.1% (base equivalent) .....</b>	123
<b>betaxolol hcl (ophth)</b>	
see BETOPTIC-S SUS 0.25% OP .....	148
<b>betaxolol hcl ophth soln 0.5% .....</b>	148
<b>betaxolol hcl tab 10 mg.....</b>	101
<b>betaxolol hcl tab 20 mg.....</b>	101
<b>bethanechol chloride tab 10 mg .....</b>	163
<b>bethanechol chloride tab 25 mg .....</b>	164
<b>bethanechol chloride tab 5 mg .....</b>	163
<b>bethanechol chloride tab 50 mg .....</b>	164
BETOPTIC-S SUS 0.25% OP .....	148
<b>bexarotene cap 75 mg.....</b>	91
<b>bexarotene gel 1% .....</b>	122
<b>bicalutamide tab 50 mg .....</b>	85
<b>bictegravir-emtricitabine-tenofovir alafenamide fumarate</b>	
see BIKTARVY TAB .....	97
BIJUVA CAP 0.5-100 .....	130
BIJUVA CAP 1-100MG .....	130
BIKTARVY TAB .....	97
<b>bimatoprost ophth soln 0.03% .....</b>	151
<b>binimetinib</b>	
see MEKTOVI TAB 15MG .....	89
<b>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg.....</b>	163
<b>bisoprolol &amp; hydrochlorothiazide tab 10-6.25 mg .....</b>	80
<b>bisoprolol &amp; hydrochlorothiazide tab 2.5-6.25 mg .....</b>	80

<b>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg</b>	80
.....	80
<b>bisoprolol fumarate tab 10 mg</b>	101
<b>bisoprolol fumarate tab 5 mg</b>	101
BLISOVI 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24)	114
BLISOVI FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1.5 mg-30 mcg	114
BLISOVI FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg	113
<b>bosentan tab 125 mg</b>	106
<b>bosentan tab 62.5 mg</b>	106
<b>bosentan tab for oral susp 32 mg</b>	106
BOSULIF CAP 100MG	86
BOSULIF CAP 50MG	86
BOSULIF TAB 100MG	86
BOSULIF TAB 400MG	86
BOSULIF TAB 500MG	86
<b>bosutinib</b>	
see BOSULIF CAP 100MG	86
see BOSULIF CAP 50MG	86
see BOSULIF TAB 100MG	86
see BOSULIF TAB 400MG	86
see BOSULIF TAB 500MG	86
BRAFTOVI CAP 75MG	86
BREATHE EASE MIS LG MASK	141
BREATHE EASE MIS MED MASK	141
BREATHE EASE MIS SM MASK	141
BREO ELLIPTA INH 100-25	57
BREO ELLIPTA INH 200-25	57
BREO ELLIPTA INH 50-25MCG	57
BREYNA	
see Budesonide-Formoterol Fumarate Dihyd	
Aerosol 160-4.5 mcg/act	58
see Budesonide-Formoterol Fumarate Dihyd	
Aerosol 80-4.5 mcg/act	58
BREZTRI AERO AER SPHERE	57
BRIELLYN	
see Norethindrone & Ethinyl Estradiol Tab 0.4	
mg-35 mcg	112
<b>brigatinib</b>	
see ALUNBRIG PAK	86
see ALUNBRIG TAB 180MG	86
see ALUNBRIG TAB 30MG	86
see ALUNBRIG TAB 90MG	86
<b>brimonidine tartrate</b>	
see ALPHAGAN P SOL 0.1% OP	149
see ALPHAGAN P SOL 0.15% OP	149
<b>brimonidine tartrate gel 0.33% (base equivalent)</b>	126
<b>brimonidine tartrate ophth soln 0.1%</b>	149
<b>brimonidine tartrate ophth soln 0.15%</b>	149
<b>brimonidine tartrate ophth soln 0.2%</b>	149
<b>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</b>	148
<b>brinzolamide ophth susp 1%</b>	150
<b>brinzolamide-brimonidine tartrate</b>	
see SIMBRINZA SUS 1-0.2%	149
<b>brivaracetam oral soln 10 mg/ml</b>	61
<b>brivaracetam tab 10 mg</b>	61
<b>brivaracetam tab 100 mg</b>	61
<b>brivaracetam tab 25 mg</b>	61
<b>brivaracetam tab 50 mg</b>	61
<b>brivaracetam tab 75 mg</b>	61
<b>bromfenac sodium ophth soln 0.07% (base equivalent)</b>	150
<b>bromfenac sodium ophth soln 0.075% (base equivalent)</b>	150
<b>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</b>	150
<b>bromocriptine mesylate cap 5 mg (base equivalent)</b>	92
<b>bromocriptine mesylate tab 2.5 mg (base equivalent)</b>	92
BRUKINSA CAP 80MG	86
BRUKINSA TAB 160MG	86
BRYHALI LOT 0.01%	123
<b>budesonide</b>	
see UCERIS TAB 9MG	118
<b>budesonide (inhalation)</b>	
see PULMICORT INH 180MCG	57
see PULMICORT INH 90MCG	57
<b>budesonide delayed release particles cap 3 mg</b>	117
<b>budesonide inhalation susp 0.25 mg/2ml</b>	56
<b>budesonide inhalation susp 0.5 mg/2ml</b>	56
<b>budesonide inhalation susp 1 mg/2ml</b>	56
<b>budesonide rectal foam 2 mg/act</b>	51
<b>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act</b>	58

Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act .....	58	<i>bupropion hcl tab 100 mg</i> .....	65
<b><i>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act</i></b> .....	57	<i>bupropion hcl tab 75 mg</i> .....	65
Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act.....	58	<i>bupropion hcl tab er 12hr 100 mg</i> .....	65
<b><i>budesonide-glycopyrrolate-formoterol fumarate</i></b> see BREZTRI AERO AER SPHERE.....	57	<i>bupropion hcl tab er 12hr 150 mg</i> .....	65
<b><i>bumetanide tab 0.5 mg</i></b> .....	127	<i>bupropion hcl tab er 12hr 200 mg</i> .....	65
<b><i>bumetanide tab 1 mg</i></b> .....	127	<i>bupropion hcl tab er 24hr 150 mg</i> .....	65
<b><i>bumetanide tab 2 mg</i></b> .....	127	<i>bupropion hcl tab er 24hr 300 mg</i> .....	65
<b><i>buprenorphine hcl</i></b> see BELBUCA MIS 150MCG .....	49	<i>bupropion hcl tab er 24hr 300 mg</i> .....	65
see BELBUCA MIS 300MCG.....	50	<b><i>buspironone hcl tab 10 mg</i></b> .....	54
see BELBUCA MIS 450MCG.....	50	<b><i>buspironone hcl tab 15 mg</i></b> .....	54
see BELBUCA MIS 600MCG.....	50	<b><i>buspironone hcl tab 30 mg</i></b> .....	54
see BELBUCA MIS 750MCG.....	50	<b><i>buspironone hcl tab 5 mg</i></b> .....	54
see BELBUCA MIS 75MCG .....	49	<b><i>buspironone hcl tab 7.5 mg</i></b> .....	54
see BELBUCA MIS 900MCG.....	50	<b><i>butalbital-acetaminophen tab 50-325 mg</i></b> .....	41
<b><i>buprenorphine hcl sl tab 2 mg (base equiv)</i></b> .....	50	Butalbital-Acetaminophen Tab 50-325 mg .....	41
<b><i>buprenorphine hcl sl tab 8 mg (base equiv)</i></b> .....	50	<b><i>butalbital-acetaminophen-caff w/ cod cap 50- 300-40-30 mg</i></b> .....	47
<b><i>buprenorphine hcl-naloxone hcl dihydrate</i></b> see ZUBSOLV SUB 0.7-0.18 .....	50	<b><i>butalbital-acetaminophen-caff w/ cod cap 50- 325-40-30 mg</i></b> .....	47
see ZUBSOLV SUB 1.4-0.36 .....	50	<b><i>butalbital-acetaminophen-caffeine tab 50-325- 40 mg</i></b> .....	41
see ZUBSOLV SUB 11.4-2.9 .....	51	Butalbital-Acetaminophen-Caffeine Tab 50-325- 40 mg .....	41
see ZUBSOLV SUB 2.9-0.71 .....	50	<b><i>butalbital-aspirin-caff w/ codeine cap 50-325- 40-30 mg</i></b> .....	47
see ZUBSOLV SUB 5.7-1.4 .....	50	Butalbital-Aspirin-Caff W/ Codeine Cap 50-325- 40-30 mg .....	47
see ZUBSOLV SUB 8.6-2.1 .....	50	<b><i>butalbital-aspirin-caffeine cap 50-325-40 mg</i></b> .	41
<b><i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i></b> .....	50	<b><i>butorphanol tartrate nasal soln 10 mg/ml</i></b> .....	50
<b><i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i></b> .....	50	<b>C</b>	
<b><i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i></b> .....	50	<b><i>cabergoline tab 0.5 mg</i></b> .....	130
<b><i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i></b> .....	50	CABOMETYX TAB 20MG.....	86
<b><i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i></b> .....	50	CABOMETYX TAB 40MG.....	86
<b><i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i></b> .....	50	CABOMETYX TAB 60MG.....	86
<b><i>buprenorphine td patch weekly 10 mcg/hr</i></b> .....	50	<b><i>cabozantinib s-malate</i></b> see CABOMETYX TAB 20MG .....	86
<b><i>buprenorphine td patch weekly 15 mcg/hr</i></b> .....	50	see CABOMETYX TAB 40MG .....	86
<b><i>buprenorphine td patch weekly 20 mcg/hr</i></b> .....	50	see CABOMETYX TAB 60MG .....	86
<b><i>buprenorphine td patch weekly 5 mcg/hr</i></b> .....	50	<b><i>calcipotriene oint 0.005%</i></b> .....	122
<b><i>buprenorphine td patch weekly 7.5 mcg/hr</i></b> ....	50	Calcipotriene Oint 0.005% .....	122
<b><i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i></b> .....	156	<b><i>calcipotriene soln 0.005% (50 mcg/ml)</i></b> .....	122
		<b><i>calcipotriene-betamethasone dipropionate</i></b> see ENSTILAR AER .....	124
		<b><i>calcitonin (salmon) nasal soln 200 unit/act</i></b> ...	128
		CALCITRENE see Calcipotriene Oint 0.005% .....	122
		<b><i>calcitriol cap 0.25 mcg</i></b> .....	129
		<b><i>calcitriol cap 0.5 mcg</i></b> .....	129

<i>calcitriol oral soln 1 mcg/ml</i> .....	129	<i>carbamazepine tab 200 mg</i> .....	61
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i> .....	134	<i>carbamazepine tab er 12hr 100 mg</i> .....	61
<i>calcium acetate (phosphate binder) tab 667 mg</i> .....	134	<i>carbamazepine tab er 12hr 200 mg</i> .....	61
<i>calcium, magnesium, potassium, &amp; sodium oxybates</i>		<i>carbamazepine tab er 12hr 400 mg</i> .....	61
see XYWAV SOL 0.5GM/ML .....	153	<i>carbidopa &amp; levodopa cap er 23.75-95 mg</i> .....	92
CALQUENCE TAB 100MG .....	87	<i>carbidopa &amp; levodopa cap er 36.25-145 mg</i> .....	92
CAMILA		<i>carbidopa &amp; levodopa cap er 48.75-195 mg</i> .....	92
see Norethindrone Tab 0.35 mg .....	116	<i>carbidopa &amp; levodopa cap er 61.25-245 mg</i> .....	92
CAMRESE		<i>carbidopa &amp; levodopa orally disintegrating tab 10-100 mg</i> .....	92
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) .....	110	<i>carbidopa &amp; levodopa orally disintegrating tab 25-100 mg</i> .....	92
CAMRESE LO		<i>carbidopa &amp; levodopa orally disintegrating tab 25-250 mg</i> .....	92
see Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7) .....	110	<i>carbidopa &amp; levodopa tab 10-100 mg</i> .....	92
<i>candesartan cilexetil tab 16 mg</i> .....	78	<i>carbidopa &amp; levodopa tab 25-100 mg</i> .....	92
<i>candesartan cilexetil tab 32 mg</i> .....	78	<i>carbidopa &amp; levodopa tab 25-250 mg</i> .....	92
<i>candesartan cilexetil tab 4 mg</i> .....	78	<i>carbidopa &amp; levodopa tab er 25-100 mg</i> .....	92
<i>candesartan cilexetil tab 8 mg</i> .....	78	<i>carbidopa &amp; levodopa tab er 50-200 mg</i> .....	92
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i> .....	80	<i>carbidopa tab 25 mg</i> .....	91
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i> .....	80	<i>carbidopa-levodopa</i>	
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i> .....	80	see CREXONT CAP 35-140MG .....	92
<i>capecitabine tab 150 mg</i> .....	83	see CREXONT CAP 52.5-210 .....	92
<i>capecitabine tab 500 mg</i> .....	83	see CREXONT CAP 70-280MG .....	92
<i>capivasertib</i>		see CREXONT CAP 87.5-350 .....	92
see TRUQAP PAK 160MG .....	90	see DHIVY TAB 25-100MG .....	92
see TRUQAP PAK 200MG .....	90	see RYTARY CAP 145MG .....	93
see TRUQAP TAB 200MG .....	90	see RYTARY CAP 195MG .....	93
<i>captopril &amp; hydrochlorothiazide tab 25-15 mg</i> .....	80	see RYTARY CAP 245MG .....	93
<i>captopril &amp; hydrochlorothiazide tab 25-25 mg</i> .....	80	see RYTARY CAP 95MG .....	93
<i>captopril &amp; hydrochlorothiazide tab 50-15 mg</i> .....	80	<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i> .....	92
<i>captopril &amp; hydrochlorothiazide tab 50-25 mg</i> .....	80	<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i> .....	92
<i>captopril tab 100 mg</i> .....	77	<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i> .....	92
<i>captopril tab 12.5 mg</i> .....	77	<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i> .....	92
<i>captopril tab 25 mg</i> .....	77	<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i> .....	92
<i>captopril tab 50 mg</i> .....	77	<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i> .....	92
<i>carbamazepine cap er 12hr 100 mg</i> .....	61	<i>carbinoxamine maleate extended release susp 4 mg/5ml</i> .....	74
<i>carbamazepine cap er 12hr 200 mg</i> .....	61	<i>carbinoxamine maleate soln 4 mg/5ml</i> .....	74
<i>carbamazepine cap er 12hr 300 mg</i> .....	61	Carbinoxamine Maleate Soln 4 mg/5ml .....	74
<i>carbamazepine chew tab 100 mg</i> .....	61	<i>carbinoxamine maleate tab 4 mg</i> .....	74
<i>carbamazepine chew tab 200 mg</i> .....	61		
<i>carbamazepine susp 100 mg/5ml</i> .....	61		

<b>carbinoxamine maleate tab 6 mg</b> .....	74	<b>cefpodoxime proxetil for susp 50 mg/5ml</b> .....	108
Carbinoxamine Maleate Tab 6 mg .....	74	<b>cefpodoxime proxetil tab 100 mg</b> .....	108
CARBZAH		<b>cefpodoxime proxetil tab 200 mg</b> .....	108
see Carbinoxamine Maleate Soln 4 mg/5ml .	74	<b>cefprozil for susp 125 mg/5ml</b> .....	108
<b>carglumic acid soluble tab 200 mg</b> .....	129	<b>cefprozil for susp 250 mg/5ml</b> .....	108
<b>cariprazine hcl</b>		<b>cefprozil tab 250 mg</b> .....	108
see VRAYLAR CAP 0.5MG .....	94	<b>cefprozil tab 500 mg</b> .....	108
see VRAYLAR CAP 0.75MG .....	94	<b>cefuroxime axetil tab 250 mg</b> .....	108
see VRAYLAR CAP 1.5MG .....	94	<b>cefuroxime axetil tab 500 mg</b> .....	108
see VRAYLAR CAP 3MG .....	94	<b>celecoxib cap 100 mg</b> .....	39
see VRAYLAR CAP 4.5MG .....	94	<b>celecoxib cap 200 mg</b> .....	39
see VRAYLAR CAP 6MG .....	94	<b>celecoxib cap 400 mg</b> .....	39
<b>carisoprodol tab 350 mg</b> .....	147	<b>celecoxib cap 50 mg</b> .....	39
<b>carteolol hcl ophth soln 1%</b> .....	148	<b>cenobamate</b>	
CARTIA XT		see XCOPRI PAK 100-150 .....	63
see Diltiazem Hcl Coated Beads Cap Er 24hr		see XCOPRI PAK 12.5-25 .....	63
120 mg .....	103	see XCOPRI PAK 150-200 .....	63
see Diltiazem Hcl Coated Beads Cap Er 24hr		see XCOPRI PAK 50-100MG .....	63
180 mg .....	103	see XCOPRI TAB 100MG .....	64
see Diltiazem Hcl Coated Beads Cap Er 24hr		see XCOPRI TAB 150MG .....	64
240 mg .....	103	see XCOPRI TAB 200MG .....	64
see Diltiazem Hcl Coated Beads Cap Er 24hr		see XCOPRI TAB 25MG .....	63
300 mg .....	103	see XCOPRI TAB 50MG .....	64
<b>carvedilol phosphate cap er 24hr 10 mg</b> .....	100	<b>cephalexin cap 250 mg</b> .....	107
<b>carvedilol phosphate cap er 24hr 20 mg</b> .....	100	<b>cephalexin cap 500 mg</b> .....	107
<b>carvedilol phosphate cap er 24hr 40 mg</b> .....	101	<b>cephalexin cap 750 mg</b> .....	107
<b>carvedilol phosphate cap er 24hr 80 mg</b> .....	101	<b>cephalexin for susp 125 mg/5ml</b> .....	108
<b>carvedilol tab 12.5 mg</b> .....	101	<b>cephalexin for susp 250 mg/5ml</b> .....	108
<b>carvedilol tab 25 mg</b> .....	101	<b>cephalexin tab 250 mg</b> .....	108
<b>carvedilol tab 3.125 mg</b> .....	101	<b>cephalexin tab 500 mg</b> .....	108
<b>carvedilol tab 6.25 mg</b> .....	101	CERDELGA CAP 84MG .....	136
CAYSTON INH 75MG .....	53	<b>ceritinib</b>	
<b>cefaclor cap 250 mg</b> .....	108	see ZYKADIA TAB 150MG .....	91
<b>cefaclor cap 500 mg</b> .....	108	<b>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</b> .....	74
<b>cefaclor for susp 250 mg/5ml</b> .....	108	<b>cevimeline hcl cap 30 mg</b> .....	146
<b>cefadroxil cap 500 mg</b> .....	107	CHARLOTTE 24 FE	
<b>cefadroxil for susp 250 mg/5ml</b> .....	107	see Norethindrone Ace-Eth Estradiol-Fe Chew	
<b>cefadroxil for susp 500 mg/5ml</b> .....	107	Tab 1 mg-20 mcg (24) .....	114
<b>cefadroxil tab 1 gm</b> .....	107	CHATEAL EQ	
<b>cefdinir cap 300 mg</b> .....	108	see Levonorgestrel & Ethinyl Estradiol Tab	
<b>cefdinir for susp 125 mg/5ml</b> .....	108	0.15 mg-30 mcg .....	111
<b>cefdinir for susp 250 mg/5ml</b> .....	108	<b>chlordiazepoxide hcl cap 10 mg</b> .....	54
<b>cefixime cap 400 mg</b> .....	108	<b>chlordiazepoxide hcl cap 25 mg</b> .....	54
<b>cefixime for susp 100 mg/5ml</b> .....	108	<b>chlordiazepoxide hcl cap 5 mg</b> .....	54
<b>cefixime for susp 200 mg/5ml</b> .....	108	<b>chlordiazepoxide hcl-clidinium bromide cap 5-</b>	
<b>cefixime tab 400 mg</b> .....	108	<b>2.5 mg</b> .....	161
<b>cefpodoxime proxetil for susp 100 mg/5ml</b> ...	108	<b>chlordiazepoxide-amitriptyline tab 10-25 mg</b>	154

<b>chlordiazepoxide-amitriptyline tab 5-12.5 mg</b>	
.....	154
<b>chloroquine phosphate tab 250 mg</b>	82
<b>chloroquine phosphate tab 500 mg</b>	82
<b>chlorpromazine hcl conc 100 mg/ml</b>	96
<b>chlorpromazine hcl conc 30 mg/ml</b>	96
<b>chlorpromazine hcl tab 10 mg</b>	96
<b>chlorpromazine hcl tab 100 mg</b>	96
<b>chlorpromazine hcl tab 200 mg</b>	96
<b>chlorpromazine hcl tab 25 mg</b>	96
<b>chlorpromazine hcl tab 50 mg</b>	96
<b>chlorthalidone tab 25 mg</b>	128
<b>chlorthalidone tab 50 mg</b>	128
<b>chlorzoxazone tab 500 mg</b>	147
<b>cholestyramine light powder 4 gm/dose</b>	75
Cholestyramine Light Powder 4 gm/dose	75
<b>cholestyramine light powder packets 4 gm</b>	75
Cholestyramine Light Powder Packets 4 gm	75
<b>cholestyramine powder 4 gm/dose</b>	75
<b>cholestyramine powder packets 4 gm</b>	75
<b>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</b>	76
<b>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</b>	75
CIBINQO TAB 100MG	125
CIBINQO TAB 200MG	125
CIBINQO TAB 50MG	125
CICLODAN	
see Ciclopirox Solution 8%	121
<b>ciclopirox gel 0.77%</b>	121
<b>ciclopirox olamine cream 0.77% (base equiv)</b>	121
<b>ciclopirox olamine susp 0.77% (base equiv)</b>	121
<b>ciclopirox shampoo 1%</b>	121
<b>ciclopirox solution 8%</b>	121
Ciclopirox Solution 8%	121
<b>cilostazol tab 100 mg</b>	135
<b>cilostazol tab 50 mg</b>	135
CIMDUO TAB 300-300	97
<b>cimetidine hcl soln 300 mg/5ml</b>	162
<b>cimetidine tab 200 mg</b>	162
<b>cimetidine tab 300 mg</b>	162
<b>cimetidine tab 400 mg</b>	162
<b>cimetidine tab 800 mg</b>	162
<b>cinacalcet hcl tab 30 mg (base equiv)</b>	129
<b>cinacalcet hcl tab 60 mg (base equiv)</b>	129
<b>cinacalcet hcl tab 90 mg (base equiv)</b>	129
CIPRO (10%) SUS 500MG/5	132
CIPRO (5%) SUS 250MG/5	132
<b>ciprofloxacin</b>	
see CIPRO (10%) SUS 500MG/5	132
see CIPRO (5%) SUS 250MG/5	132
<b>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</b>	149
<b>ciprofloxacin hcl otic soln 0.2% (base equivalent)</b>	151
<b>ciprofloxacin hcl tab 250 mg (base equiv)</b>	132
<b>ciprofloxacin hcl tab 500 mg (base equiv)</b>	132
<b>ciprofloxacin hcl tab 750 mg (base equiv)</b>	132
<b>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</b>	151
<b>ciprofloxacin-hydrocortisone otic susp 0.2-1%</b>	151
<b>citalopram hydrobromide oral soln 10 mg/5ml</b>	65
<b>citalopram hydrobromide tab 10 mg (base equiv)</b>	65
<b>citalopram hydrobromide tab 20 mg (base equiv)</b>	65
<b>citalopram hydrobromide tab 40 mg (base equiv)</b>	65
<b>cladribine tab therapy pack 10 mg (10 tabs)</b>	155
<b>cladribine tab therapy pack 10 mg (4 tabs)</b>	154
<b>cladribine tab therapy pack 10 mg (5 tabs)</b>	155
<b>cladribine tab therapy pack 10 mg (6 tabs)</b>	155
<b>cladribine tab therapy pack 10 mg (7 tabs)</b>	155
<b>cladribine tab therapy pack 10 mg (8 tabs)</b>	155
<b>cladribine tab therapy pack 10 mg (9 tabs)</b>	155
CLARAVIS	
see Isotretinoin Cap 10 mg	120
see Isotretinoin Cap 20 mg	120
see Isotretinoin Cap 30 mg	120
see Isotretinoin Cap 40 mg	120
<b>clarithromycin for susp 125 mg/5ml</b>	139
<b>clarithromycin for susp 250 mg/5ml</b>	140
<b>clarithromycin tab 250 mg</b>	140
<b>clarithromycin tab 500 mg</b>	140
<b>clarithromycin tab er 24hr 500 mg</b>	140
<b>clascoterone</b>	
see WINLEVI CRE 1%	121
<b>clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)</b>	74
<b>clemastine fumarate tab 2.68 mg</b>	74
CLENPIQ SOL	139
CLINDACIN	

see Clindamycin Phosphate Foam 1% .....	119	see Clomiphene Citrate Tab 50 mg .....	128
CLINDACIN ETZ PLEDGETS		<b>clomiphene citrate tab 50 mg</b> .....	128
see Clindamycin Phosphate Swab 1% .....	119	Clomiphene Citrate Tab 50 mg .....	128
CLINDACIN-P		<b>clomipramine hcl cap 25 mg</b> .....	67
see Clindamycin Phosphate Swab 1% .....	120	<b>clomipramine hcl cap 50 mg</b> .....	67
<b>clindamycin hcl cap 150 mg</b> .....	53	<b>clomipramine hcl cap 75 mg</b> .....	67
<b>clindamycin hcl cap 300 mg</b> .....	53	<b>clonazepam orally disintegrating tab 0.125 mg</b>	
<b>clindamycin hcl cap 75 mg</b> .....	52	.....	60
<b>clindamycin palmitate hcl for soln 75 mg/5ml</b>		<b>clonazepam orally disintegrating tab 0.25 mg</b>	60
<b>(base equiv)</b> .....	53	<b>clonazepam orally disintegrating tab 0.5 mg</b> ..	60
<b>clindamycin phosphate foam 1%</b> .....	119	<b>clonazepam orally disintegrating tab 1 mg</b> ....	60
Clindamycin Phosphate Foam 1% .....	119	<b>clonazepam orally disintegrating tab 2 mg</b> ....	60
<b>clindamycin phosphate gel 1% (twice-daily)</b> .	119	<b>clonazepam tab 0.5 mg</b> .....	60
<b>clindamycin phosphate lotion 1%</b> .....	119	<b>clonazepam tab 1 mg</b> .....	60
<b>clindamycin phosphate soln 1%</b> .....	119	<b>clonazepam tab 2 mg</b> .....	60
<b>clindamycin phosphate swab 1%</b> .....	119	<b>clonidine hcl tab 0.1 mg</b> .....	79
Clindamycin Phosphate Swab 1% .....	119, 120	<b>clonidine hcl tab 0.2 mg</b> .....	79
<b>clindamycin phosphate vaginal cream 2%</b> ....	164	<b>clonidine hcl tab 0.3 mg</b> .....	79
<b>clindamycin phosphate-benzoyl peroxide gel</b>		<b>clonidine hcl tab er 12hr 0.1 mg</b> .....	32
<b>1.2-2.5%</b> .....	120	<b>clonidine tab er 24hr 0.17 mg</b> .....	79
<b>clindamycin phosphate-benzoyl peroxide gel</b>		<b>clonidine td patch weekly 0.1 mg/24hr</b> .....	79
<b>1.2-3.75%</b> .....	120	<b>clonidine td patch weekly 0.2 mg/24hr</b> .....	79
<b>clindamycin phosphate-benzoyl peroxide gel 1-</b>		<b>clonidine td patch weekly 0.3 mg/24hr</b> .....	79
<b>5%</b> .....	120	<b>clopidogrel bisulfate tab 300 mg (base equiv)</b>	
<b>clindamycin phosphate-tretinoin gel 1.2-0.025%</b>		.....	136
.....	120	<b>clopidogrel bisulfate tab 75 mg (base equiv)</b>	135
<b>clindamycin phosph-benzoyl peroxide (refrig)</b>		<b>clorazepate dipotassium tab 15 mg</b> .....	54
<b>gel 1.2 (1)-5%</b> .....	119	<b>clorazepate dipotassium tab 3.75 mg</b> .....	54
Clindamycin Phosph-Benzoyl Peroxide (Refrig)		<b>clorazepate dipotassium tab 7.5 mg</b> .....	54
Gel 1.2 (1)-5% .....	119	<b>clotrimazole cream 1%</b> .....	121
<b>clobazam suspension 2.5 mg/ml</b> .....	60	<b>clotrimazole soln 1%</b> .....	122
<b>clobazam tab 10 mg</b> .....	60	<b>clotrimazole troche 10 mg</b> .....	146
<b>clobazam tab 20 mg</b> .....	60	<b>clotrimazole w/ betamethasone cream 1-0.05%</b>	
<b>clobetasol propionate cream 0.025%</b> .....	123	.....	122
<b>clobetasol propionate cream 0.05%</b> .....	123	<b>clotrimazole w/ betamethasone lotion 1-0.05%</b>	
<b>clobetasol propionate emollient base cream</b>		.....	122
<b>0.05%</b> .....	123	<b>clozapine orally disintegrating tab 100 mg</b> ....	95
<b>clobetasol propionate foam 0.05%</b> .....	123	<b>clozapine orally disintegrating tab 12.5 mg</b> ...	95
<b>clobetasol propionate gel 0.05%</b> .....	123	<b>clozapine orally disintegrating tab 150 mg</b> ....	95
<b>clobetasol propionate lotion 0.05%</b> .....	123	<b>clozapine orally disintegrating tab 200 mg</b> ....	95
<b>clobetasol propionate oint 0.05%</b> .....	123	<b>clozapine orally disintegrating tab 25 mg</b> .....	95
<b>clobetasol propionate shampoo 0.05%</b> .....	123	<b>clozapine tab 100 mg</b> .....	95
Clobetasol Propionate Shampoo 0.05% .....	123	<b>clozapine tab 200 mg</b> .....	95
<b>clobetasol propionate soln 0.05%</b> .....	123	<b>clozapine tab 25 mg</b> .....	95
CLODAN		<b>clozapine tab 50 mg</b> .....	95
see Clobetasol Propionate Shampoo 0.05% 123		COARTEM TAB 20-120MG .....	82
CLOMID		<b>codeine sulfate tab 30 mg</b> .....	41

<b>colchicine cap 0.6 mg</b> .....	135	<b>crisaborole</b>	
<b>colchicine tab 0.6 mg</b> .....	135	see EUCRISA OIN 2% .....	125
<b>colchicine w/ probenecid tab 0.5-500 mg</b> .....	135	<b>cromolyn sodium ophth soln 4%</b> .....	150
<b>colesevelam hcl packet for susp 3.75 gm</b> .....	75	<b>cromolyn sodium oral conc 100 mg/5ml</b> .....	133
<b>colesevelam hcl tab 625 mg</b> .....	75	<b>cromolyn sodium soln nebu 20 mg/2ml</b> .....	56
<b>colestipol hcl granule packets 5 gm</b> .....	75	Crotamiton Lotion 10% .....	126
<b>colestipol hcl granules 5 gm</b> .....	75	CROTAN	
<b>colestipol hcl tab 1 gm</b> .....	75	see Crotamiton Lotion 10% .....	126
COMBIPATCH DIS .....	130	CRYSELLE	
COMPACT SPAC MIS CHAMBER .....	141	see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-	
COMPACT SPAC MIS LG MASK .....	141	30 mcg .....	116
COMPACT SPAC MIS MD MASK.....	141	CVS FOLIC ACID	
COMPACT SPAC MIS SM MASK .....	141	see Folic Acid Tab 800 mcg .....	137
COMPRO		CVS NICOTINE	
see Prochlorperazine Suppos 25 mg .....	96	see Nicotine Polacrilex Gum 2 mg .....	156
<b>condoms - female</b>		see Nicotine Polacrilex Gum 4 mg .....	156
see FC2 FEMALE MIS CONDOM .....	140	CVS NICOTINE GUM	
<b>condoms latex lubricated - male</b>		see Nicotine Polacrilex Gum 4 mg .....	156
see MALE MIS CONDOM.....	140	CVS NICOTINE LOZENGE	
<b>condoms latex non-lubricated - male</b>		see Nicotine Polacrilex Lozenge 2 mg.....	157
see TRUSTEX MIS FLAVORS .....	140	see Nicotine Polacrilex Lozenge 4 mg.....	157
CONDOMS MIS .....	140	CVS NICOTINE POLACRILEX	
<b>condoms non-latex lubricated - male</b>		see Nicotine Polacrilex Gum 2 mg .....	156
see DUREX MIS REALFEEL .....	140	see Nicotine Polacrilex Gum 4 mg .....	156
<b>conjugated estrogens-basedoxifene</b>		see Nicotine Polacrilex Lozenge 2 mg.....	157
see DUAVEE TAB 0.45-20 .....	130	see Nicotine Polacrilex Lozenge 4 mg.....	157
<b>conjugated estrogens-medroxyprogesterone</b>		CVS NICOTINE POLACRILEX S	
<b>acetate</b>		see Nicotine Polacrilex Gum 2 mg .....	156
see PREMPHASE TAB.....	131	CVS NICOTINE TRANSDERMAL	
see PREMPRO TAB.....	131	see Nicotine Td Patch 24hr 14 mg/24hr .....	158
see PREMPRO TAB 0.3-1.5.....	131	see Nicotine Td Patch 24hr 21 mg/24hr .....	158
see PREMPRO TAB 0.45-1.5.....	131	see Nicotine Td Patch 24hr 7 mg/24hr .....	158
see PREMPRO TAB 0.625-5.....	131	<b>cyclobenzaprine hcl tab 10 mg</b> .....	147
CONSTULOSE		<b>cyclobenzaprine hcl tab 5 mg</b> .....	147
see Lactulose Solution 10 gm/15ml .....	139	<b>cyclopentolate hcl ophth soln 1%</b> .....	148
CORTIFOAM AER 90MG .....	51	<b>cyclophosphamide cap 25 mg</b> .....	83
CREON CAP 12000UNT.....	126	<b>cyclophosphamide cap 50 mg</b> .....	83
CREON CAP 24000UNT.....	126	<b>cycloserine cap 250 mg</b> .....	83
CREON CAP 3000UNIT.....	126	<b>cyclosporine (ophth)</b>	
CREON CAP 36000UNT.....	126	see RESTASIS EMU 0.05% OP .....	150
CREON CAP 6000UNIT.....	126	see RESTASIS MUL EMU 0.05% OP .....	150
CREXONT CAP 35-140MG .....	92	see VEVYE DRO 0.1%.....	150
CREXONT CAP 52.5-210 .....	92	<b>cyclosporine cap 100 mg</b> .....	145
CREXONT CAP 70-280MG .....	92	<b>cyclosporine cap 25 mg</b> .....	145
CREXONT CAP 87.5-350 .....	92	<b>cyclosporine modified cap 100 mg</b> .....	145
CRINONE GEL 4% VAG.....	164	Cyclosporine Modified Cap 100 mg .....	145
CRINONE GEL 8% VAG .....	164	<b>cyclosporine modified cap 25 mg</b> .....	145

Cyclosporine Modified Cap 25 mg .....	145	<b>dapsone tab 25 mg</b> .....	52
<b>cyclosporine modified cap 50 mg</b> .....	145	<b>daridorexant hcl</b>	
<b>cyclosporine modified oral soln 100 mg/ml</b> ..	145	see QUVIVIQ TAB 25MG .....	139
Cyclosporine Modified Oral Soln 100 mg/ml ..	145	see QUVIVIQ TAB 50MG .....	139
<b>cyproheptadine hcl syrup 2 mg/5ml</b> .....	75	<b>darifenacin hydrobromide tab er 24hr 15 mg</b>	
<b>cyproheptadine hcl tab 4 mg</b> .....	75	<b>(base equiv)</b> .....	163
CYRED EQ		<b>darifenacin hydrobromide tab er 24hr 7.5 mg</b>	
see Desogestrel & Ethinyl Estradiol Tab 0.15		<b>(base equiv)</b> .....	163
mg-30 mcg .....	109	<b>darolutamide</b>	
CYSTAGON CAP 150MG .....	134	see NUBEQA TAB 300MG .....	85
CYSTAGON CAP 50MG .....	134	<b>darunavir tab 600 mg</b> .....	97
<b>cysteamine bitartrate</b>		<b>darunavir tab 800 mg</b> .....	97
see CYSTAGON CAP 150MG .....	134	<b>darunavir-cobicistat</b>	
see CYSTAGON CAP 50MG .....	134	see PREZCOBIX TAB 800-150 .....	98
CYTRA K CRYSTALS		<b>darunavir-cobicistat-emtricitabine-tenofovir</b>	
see Potassium Citrate & Citric Acid Powder		<b>alafenamide</b>	
Pack 3300-1002 mg .....	134	see SYMTUZA TAB .....	98
<b>D</b>		<b>dasatinib tab 100 mg</b> .....	87
<b>dabigatran etexilate mesylate cap 110 mg</b>		<b>dasatinib tab 140 mg</b> .....	87
<b>(etexilate base eq)</b> .....	60	<b>dasatinib tab 20 mg</b> .....	87
<b>dabigatran etexilate mesylate cap 150 mg</b>		<b>dasatinib tab 50 mg</b> .....	87
<b>(etexilate base eq)</b> .....	60	<b>dasatinib tab 70 mg</b> .....	87
<b>dabigatran etexilate mesylate cap 75 mg</b>		<b>dasatinib tab 80 mg</b> .....	87
<b>(etexilate base eq)</b> .....	60	DASETТА 1/35	
<b>dabrafenib mesylate</b>		see Norethindrone & Ethinyl Estradiol Tab 1	
see TAFINLAR CAP 50MG .....	90	mg-35 mcg .....	112
see TAFINLAR CAP 75MG .....	90	DASETТА 7/7/7	
see TAFINLAR TAB 10MG .....	90	see Norethindrone-Eth Estradiol Tab 0.5-	
<b>dalfampridine tab er 12hr 10 mg</b> .....	155	35/0.75-35/1-35 mg-Mcg .....	115
<b>danazol cap 100 mg</b> .....	51	DAYSEE	
<b>danazol cap 200 mg</b> .....	51	see Levonorg-Eth Est Tab 0.15-0.03mg(84) &	
<b>danazol cap 50 mg</b> .....	51	Eth Est Tab 0.01mg(7) .....	110
<b>dantrolene sodium cap 100 mg</b> .....	147	DEBLITANE	
<b>dantrolene sodium cap 25 mg</b> .....	147	see Norethindrone Tab 0.35 mg .....	116
<b>dantrolene sodium cap 50 mg</b> .....	147	<b>deferasirox granules packet 180 mg</b> .....	72
<b>dapagliflozin propanediol</b>		<b>deferasirox granules packet 360 mg</b> .....	72
see FARXIGA TAB 10MG .....	72	<b>deferasirox granules packet 90 mg</b> .....	72
see FARXIGA TAB 5MG .....	72	<b>deferasirox tab 180 mg</b> .....	72
<b>dapagliflozin propanediol-metformin hcl</b>		<b>deferasirox tab 360 mg</b> .....	72
see XIGDUO XR TAB 10-1000 .....	69	<b>deferasirox tab 90 mg</b> .....	72
see XIGDUO XR TAB 10-500MG .....	69	<b>deferasirox tab for oral susp 125 mg</b> .....	72
see XIGDUO XR TAB 2.5-1000 .....	69	<b>deferasirox tab for oral susp 250 mg</b> .....	72
see XIGDUO XR TAB 5-1000MG .....	69	<b>deferasirox tab for oral susp 500 mg</b> .....	72
see XIGDUO XR TAB 5-500MG .....	69	<b>deferiprone tab 1000 mg</b> .....	73
<b>dapsone gel 5%</b> .....	120	<b>deferiprone tab 500 mg</b> .....	73
<b>dapsone gel 7.5%</b> .....	120	<b>deflazacort</b>	
<b>dapsone tab 100 mg</b> .....	52	see EMFLAZA SUS 22.75/ML .....	117

<b>deflazacort susp 22.75 mg/ml</b> .....	117	<b>desoximetasone oint 0.25%</b> .....	124
Deflazacort Susp 22.75 mg/ml .....	117	<b>desoximetasone spray 0.25%</b> .....	124
<b>deflazacort tab 18 mg</b> .....	117	<b>desvenlafaxine succinate tab er 24hr 100 mg</b>	
Deflazacort Tab 18 mg .....	117	<b>(base equiv)</b> .....	66
<b>deflazacort tab 30 mg</b> .....	117	<b>desvenlafaxine succinate tab er 24hr 25 mg</b>	
Deflazacort Tab 30 mg .....	117	<b>(base equiv)</b> .....	66
<b>deflazacort tab 36 mg</b> .....	117	<b>desvenlafaxine succinate tab er 24hr 50 mg</b>	
Deflazacort Tab 36 mg .....	117	<b>(base equiv)</b> .....	66
<b>deflazacort tab 6 mg</b> .....	117	<b>deucravacitinib</b>	
Deflazacort Tab 6 mg .....	117	see SOTYKTU TAB 6MG .....	122
DELYLA		<b>deutetrabenazine</b>	
see Levonorgestrel & Ethinyl Estradiol Tab 0.1		see AUSTEDO TAB 12MG .....	154
mg-20 mcg .....	111	see AUSTEDO TAB 6MG .....	154
<b>demeclocycline hcl tab 150 mg</b> .....	159	see AUSTEDO TAB 9MG .....	154
<b>demeclocycline hcl tab 300 mg</b> .....	159	<b>dexamethasone elixir 0.5 mg/5ml</b> .....	117
DESCOVY TAB 120-15MG .....	97	<b>dexamethasone sodium phosphate ophth soln</b>	
DESCOVY TAB 200/25MG .....	97	<b>0.1%</b> .....	150
<b>desipramine hcl tab 10 mg</b> .....	67	<b>dexamethasone soln 0.5 mg/5ml</b> .....	117
<b>desipramine hcl tab 100 mg</b> .....	67	<b>dexamethasone tab 0.5 mg</b> .....	117
<b>desipramine hcl tab 150 mg</b> .....	67	<b>dexamethasone tab 0.75 mg</b> .....	117
<b>desipramine hcl tab 25 mg</b> .....	67	<b>dexamethasone tab 1 mg</b> .....	117
<b>desipramine hcl tab 50 mg</b> .....	67	<b>dexamethasone tab 1.5 mg</b> .....	117
<b>desipramine hcl tab 75 mg</b> .....	67	<b>dexamethasone tab 2 mg</b> .....	117
<b>desloratadine tab 5 mg</b> .....	74	<b>dexamethasone tab 4 mg</b> .....	117
<b>desloratadine tab orally disintegrating 2.5 mg</b>		<b>dexamethasone tab 6 mg</b> .....	117
.....	74	<b>dexamethasone tab therapy pack 1.5 mg (21)</b>	
<b>desloratadine tab orally disintegrating 5 mg</b> ..	74	.....	117
<b>desmopressin acetate nasal spray soln 0.01%</b>		Dexamethasone Tab Therapy Pack 1.5 mg (21)	
.....	130	.....	117
<b>desmopressin acetate nasal spray soln 0.01%</b>		<b>dexamethasone tab therapy pack 1.5 mg (35)</b>	
<b>(refrigerated)</b> .....	130	.....	117
<b>desmopressin acetate tab 0.1 mg</b> .....	130	<b>dexamethasone tab therapy pack 1.5 mg (51)</b>	
<b>desmopressin acetate tab 0.2 mg</b> .....	130	.....	117
<b>desogest-eth estrad &amp; eth estrad tab 0.15-</b>		<b>dexmethylphenidate hcl cap er 24 hr 10 mg</b> ....	33
<b>0.02/0.01 mg(21/5)</b> .....	108	<b>dexmethylphenidate hcl cap er 24 hr 15 mg</b> ....	33
Desogest-Eth Estrad & Eth Estrad Tab 0.15-		<b>dexmethylphenidate hcl cap er 24 hr 20 mg</b> ....	33
0.02/0.01 mg(21/5) .....	108	<b>dexmethylphenidate hcl cap er 24 hr 25 mg</b> ....	34
Desogest-Ethin Est Tab 0.1-0.025/0.125-		<b>dexmethylphenidate hcl cap er 24 hr 30 mg</b> ....	34
0.025/0.15-0.025mg-Mg .....	109	<b>dexmethylphenidate hcl cap er 24 hr 35 mg</b> ....	34
Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30		<b>dexmethylphenidate hcl cap er 24 hr 40 mg</b> ....	34
mcg .....	109	<b>dexmethylphenidate hcl cap er 24 hr 5 mg</b> .....	33
<b>desonide cream 0.05%</b> .....	123	<b>dexmethylphenidate hcl tab 10 mg</b> .....	34
<b>desonide lotion 0.05%</b> .....	123	<b>dexmethylphenidate hcl tab 2.5 mg</b> .....	34
<b>desonide oint 0.05%</b> .....	123	<b>dexmethylphenidate hcl tab 5 mg</b> .....	34
<b>desoximetasone cream 0.05%</b> .....	123	<b>dextroamphetamine sulfate cap er 24hr 10 mg</b>	
<b>desoximetasone cream 0.25%</b> .....	123	.....	28
<b>desoximetasone gel 0.05%</b> .....	124		

<b>dextroamphetamine sulfate cap er 24hr 15 mg</b>	
.....	28
<b>dextroamphetamine sulfate cap er 24hr 5 mg</b>	28
<b>dextroamphetamine sulfate oral solution 5 mg/5ml</b>	28
Dextroamphetamine Sulfate Oral Solution 5 mg/5ml	28
<b>dextroamphetamine sulfate tab 10 mg</b>	29
Dextroamphetamine Sulfate Tab 10 mg	29
<b>dextroamphetamine sulfate tab 15 mg</b>	29
Dextroamphetamine Sulfate Tab 15 mg	29
<b>dextroamphetamine sulfate tab 2.5 mg</b>	28
Dextroamphetamine Sulfate Tab 2.5 mg	28
<b>dextroamphetamine sulfate tab 20 mg</b>	29
Dextroamphetamine Sulfate Tab 20 mg	29
<b>dextroamphetamine sulfate tab 30 mg</b>	29
Dextroamphetamine Sulfate Tab 30 mg	30
<b>dextroamphetamine sulfate tab 5 mg</b>	29
Dextroamphetamine Sulfate Tab 5 mg	29
<b>dextroamphetamine sulfate tab 7.5 mg</b>	29
Dextroamphetamine Sulfate Tab 7.5 mg	29
<b>dextromethorphan hydrobromide-bupropion hydrochloride</b>	
see AUVELITY TAB 45-105MG	65
DHIVY TAB 25-100MG	92
<b>diazepam (anticonvulsant)</b>	
see VALTOCO SPR 10MG	60
see VALTOCO SPR 15MG	60
see VALTOCO SPR 20MG	60
see VALTOCO SPR 5MG	60
<b>diazepam conc 5 mg/ml</b>	54
<b>diazepam oral soln 1 mg/ml</b>	54
<b>diazepam rectal gel delivery system 10 mg</b>	60
<b>diazepam rectal gel delivery system 2.5 mg</b>	60
<b>diazepam rectal gel delivery system 20 mg</b>	60
<b>diazepam tab 10 mg</b>	55
<b>diazepam tab 2 mg</b>	55
<b>diazepam tab 5 mg</b>	55
<b>diazoxide susp 50 mg/ml</b>	70
<b>dichlorphenamide tab 50 mg</b>	127
Dichlorphenamide Tab 50 mg	127
<b>diclofenac epolamine patch 1.3%</b>	121
<b>diclofenac potassium tab 50 mg</b>	39
<b>diclofenac sodium (actinic keratoses) gel 3%</b>	122
<b>diclofenac sodium ophth soln 0.1%</b>	150
<b>diclofenac sodium soln 1.5%</b>	121
<b>diclofenac sodium tab delayed release 25 mg</b>	39
<b>diclofenac sodium tab delayed release 50 mg</b>	39
<b>diclofenac sodium tab delayed release 75 mg</b>	39
<b>diclofenac sodium tab er 24hr 100 mg</b>	39
<b>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</b>	39
<b>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</b>	39
<b>dicloxacillin sodium cap 250 mg</b>	152
<b>dicloxacillin sodium cap 500 mg</b>	152
<b>dicyclomine hcl cap 10 mg</b>	161
<b>dicyclomine hcl oral soln 10 mg/5ml</b>	161
<b>dicyclomine hcl tab 20 mg</b>	161
<b>diethylpropion hcl tab 25 mg</b>	31
<b>diethylpropion hcl tab er 24hr 75 mg</b>	31
<b>diflunisal tab 500 mg</b>	41
<b>difluprednate ophth emulsion 0.05%</b>	150
<b>digoxin oral soln 0.05 mg/ml</b>	104
<b>digoxin tab 125 mcg (0.125 mg)</b>	104
<b>digoxin tab 250 mcg (0.25 mg)</b>	104
<b>digoxin tab 62.5 mcg (0.0625 mg)</b>	104
<b>diltiazem hcl cap er 12hr 120 mg</b>	102
<b>diltiazem hcl cap er 12hr 60 mg</b>	102
<b>diltiazem hcl cap er 12hr 90 mg</b>	102
<b>diltiazem hcl cap er 24hr 120 mg</b>	102
Diltiazem Hcl Cap Er 24hr 120 mg	102
<b>diltiazem hcl cap er 24hr 180 mg</b>	102
Diltiazem Hcl Cap Er 24hr 180 mg	102
<b>diltiazem hcl cap er 24hr 240 mg</b>	102
Diltiazem Hcl Cap Er 24hr 240 mg	102
<b>diltiazem hcl coated beads cap er 24hr 120 mg</b>	102
.....	102
Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg	103
.....	103
<b>diltiazem hcl coated beads cap er 24hr 180 mg</b>	103
.....	103
Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg	103
.....	103
<b>diltiazem hcl coated beads cap er 24hr 240 mg</b>	103
.....	103
Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg	103
.....	103
<b>diltiazem hcl coated beads cap er 24hr 300 mg</b>	103
.....	103
Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg	103
.....	103
<b>diltiazem hcl coated beads cap er 24hr 360 mg</b>	103
.....	103

<b>diltiazem hcl extended release beads cap er</b>	
<b>24hr 120 mg</b> .....	103
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 120 mg .....	103
<b>diltiazem hcl extended release beads cap er</b>	
<b>24hr 180 mg</b> .....	103
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 180 mg .....	103
<b>diltiazem hcl extended release beads cap er</b>	
<b>24hr 240 mg</b> .....	103
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 240 mg .....	103
<b>diltiazem hcl extended release beads cap er</b>	
<b>24hr 300 mg</b> .....	103
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 300 mg .....	103
<b>diltiazem hcl extended release beads cap er</b>	
<b>24hr 360 mg</b> .....	103
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 360 mg .....	103
<b>diltiazem hcl extended release beads cap er</b>	
<b>24hr 420 mg</b> .....	103
Diltiazem Hcl Extended Release Beads Cap Er	
24hr 420 mg .....	103
<b>diltiazem hcl tab 120 mg</b> .....	103
<b>diltiazem hcl tab 30 mg</b> .....	103
<b>diltiazem hcl tab 60 mg</b> .....	103
<b>diltiazem hcl tab 90 mg</b> .....	103
DILT-XR	
see Diltiazem Hcl Cap Er 24hr 120 mg .....	102
see Diltiazem Hcl Cap Er 24hr 180 mg .....	102
see Diltiazem Hcl Cap Er 24hr 240 mg .....	102
<b>dimethyl fumarate capsule delayed release 120</b>	
<b>mg</b> .....	155
<b>dimethyl fumarate capsule delayed release 240</b>	
<b>mg</b> .....	155
<b>dimethyl fumarate capsule dr starter pack 120</b>	
<b>mg &amp; 240 mg</b> .....	155
<b>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</b>	
.....	72
<b>diphenoxylate w/ atropine tab 2.5-0.025 mg.</b>	72
<b>dipyridamole tab 25 mg</b> .....	136
<b>dipyridamole tab 50 mg</b> .....	136
<b>dipyridamole tab 75 mg</b> .....	136
<b>disopyramide phosphate cap 100 mg</b> .....	55
<b>disopyramide phosphate cap 150 mg</b> .....	55
<b>disulfiram tab 250 mg</b> .....	152
<b>disulfiram tab 500 mg</b> .....	152
<b>divalproex sodium cap delayed release sprinkle</b>	
<b>125 mg</b> .....	64
<b>divalproex sodium tab delayed release 125 mg</b>	
.....	64
<b>divalproex sodium tab delayed release 250 mg</b>	
.....	64
<b>divalproex sodium tab delayed release 500 mg</b>	
.....	64
<b>divalproex sodium tab er 24 hr 250 mg</b> .....	64
<b>divalproex sodium tab er 24 hr 500 mg</b> .....	64
<b>dofetilide cap 125 mcg (0.125 mg)</b> .....	55
<b>dofetilide cap 250 mcg (0.25 mg)</b> .....	55
<b>dofetilide cap 500 mcg (0.5 mg)</b> .....	55
DOLISHALE	
see Levonorgestrel-Ethinyl Estradiol	
(Continuous) Tab 90-20 mcg .....	111
<b>dolutegravir sodium</b>	
see TIVICAY PD TAB 5MG .....	99
see TIVICAY TAB 50MG .....	99
<b>dolutegravir sodium-lamivudine</b>	
see DOVATO TAB 50-300MG .....	97
<b>donepezil hydrochloride orally disintegrating</b>	
<b>tab 10 mg</b> .....	153
<b>donepezil hydrochloride orally disintegrating</b>	
<b>tab 5 mg</b> .....	153
<b>donepezil hydrochloride tab 10 mg</b> .....	153
<b>donepezil hydrochloride tab 23 mg</b> .....	153
<b>donepezil hydrochloride tab 5 mg</b> .....	153
DOPTELET SPR CAP 10MG .....	137
DOPTELET TAB 20MG .....	137
<b>dorzolamide hcl ophth soln 2%</b> .....	150
<b>dorzolamide hcl-timolol maleate ophth soln 2-</b>	
<b>0.5%</b> .....	148
<b>dorzolamide hcl-timolol maleate pf ophth soln</b>	
<b>2-0.5%</b> .....	148
DOTTI	
see Estradiol Td Patch Twice Weekly 0.025	
mg/24hr .....	132
see Estradiol Td Patch Twice Weekly 0.0375	
mg/24hr .....	132
see Estradiol Td Patch Twice Weekly 0.05	
mg/24hr .....	132
see Estradiol Td Patch Twice Weekly 0.075	
mg/24hr .....	132
see Estradiol Td Patch Twice Weekly 0.1	
mg/24hr .....	131

DOVATO TAB 50-300MG .....	97	Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg.....	109
<b>doxazosin mesylate tab 1 mg</b> .....	79	<b>droxidopa cap 100 mg</b> .....	165
<b>doxazosin mesylate tab 2 mg</b> .....	79	<b>droxidopa cap 200 mg</b> .....	165
<b>doxazosin mesylate tab 4 mg</b> .....	79	<b>droxidopa cap 300 mg</b> .....	165
<b>doxazosin mesylate tab 8 mg</b> .....	79	DUAVEE TAB 0.45-20.....	130
<b>doxepin hcl (sleep) tab 3 mg (base equiv)</b> .....	138	<b>dulaglutide</b>	
<b>doxepin hcl (sleep) tab 6 mg (base equiv)</b> .....	138	see TRULICITY INJ 0.75/0.5 .....	70
<b>doxepin hcl cap 10 mg</b> .....	67	see TRULICITY INJ 1.5/0.5 .....	70
<b>doxepin hcl cap 100 mg</b> .....	67	see TRULICITY INJ 3/0.5 .....	70
<b>doxepin hcl cap 150 mg</b> .....	67	see TRULICITY INJ 4.5/0.5 .....	70
<b>doxepin hcl cap 25 mg</b> .....	67	<b>duloxetine hcl enteric coated pellets cap 20 mg (base eq)</b> .....	66
<b>doxepin hcl cap 50 mg</b> .....	67	<b>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</b> .....	66
<b>doxepin hcl cap 75 mg</b> .....	67	<b>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</b> .....	67
<b>doxepin hcl conc 10 mg/ml</b> .....	67	<b>duloxetine hcl enteric coated pellets cap 60 mg (base eq)</b> .....	67
<b>doxercalciferol cap 0.5 mcg</b> .....	129	DUREX MIS REALFEEL.....	140
<b>doxercalciferol cap 1 mcg</b> .....	129	<b>dust mite mixed allergen extract</b>	
<b>doxercalciferol cap 2.5 mcg</b> .....	129	see ODACTRA SUB.....	38
<b>doxycycline (rosacea)</b>		<b>dutasteride cap 0.5 mg</b> .....	135
see ORACEA CAP 40MG .....	126	<b>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</b> ....	135
<b>doxycycline hyclate cap 100 mg</b> .....	159	<b>E</b>	
<b>doxycycline hyclate cap 50 mg</b> .....	159	E.E.S. 400	
<b>doxycycline hyclate tab 100 mg</b> .....	159	see Erythromycin Ethylsuccinate Tab 400 mg .....	140
<b>doxycycline monohydrate cap 100 mg</b> .....	159	EASIVENT MIS .....	141
Doxycycline Monohydrate Cap 100 mg .....	159	EASIVENT MIS MASK LG .....	141
<b>doxycycline monohydrate cap 50 mg</b> .....	159	EASIVENT MIS MASK MED .....	141
<b>doxycycline monohydrate for susp 25 mg/5ml</b> .....	159	EASIVENT MIS MASK SM.....	141
<b>doxycycline monohydrate tab 100 mg</b> .....	159	<b>econazole nitrate cream 1%</b> .....	122
Doxycycline Monohydrate Tab 100 mg .....	159	<b>edaravone</b>	
<b>doxycycline monohydrate tab 150 mg</b> .....	159	see RADICAVA ORS SUS 105/5ML .....	148
<b>doxycycline monohydrate tab 50 mg</b> .....	159	see RADICAVA ORS SUS STARTER .....	148
<b>doxycycline monohydrate tab 75 mg</b> .....	159	<b>efavirenz tab 600 mg</b> .....	97
<b>doxylamine-pyridoxine tab delayed release 10-10 mg</b> .....	73	<b>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</b> .....	97
<b>dronabinol cap 10 mg</b> .....	73	<b>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</b> .....	98
<b>dronabinol cap 2.5 mg</b> .....	73	<b>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</b> .....	98
<b>dronabinol cap 5 mg</b> .....	73	<b>elafibranor</b>	
<b>dronedarone hcl</b>		see IQIRVO TAB 80MG .....	134
see MULTAQ TAB 400MG .....	55	<b>elagolix sodium</b>	
<b>drospirenone-ethinyl estradiol tab 3-0.02 mg</b> 109		see ORILISSA TAB 150MG .....	128
Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 109			
<b>drospirenone-ethinyl estradiol tab 3-0.03 mg</b> 109			
Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg 109			
<b>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</b> .....	109		
<b>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</b> .....	109		

see ORILISSA TAB 200MG .....	128	see Etonogestrel-Ethinyl Estradiol Va Ring	
<b>elagolix sodium-estradiol-norethindrone</b>		0.12-0.015 mg/24hr .....	116
<b>acetate</b>		<b>eluxadoline</b>	
see ORIAHNN CAP .....	131	see VIBERZI TAB 100MG .....	134
<b>elbasvir-grazoprevir</b>		see VIBERZI TAB 75MG .....	134
see ZEPATIER TAB 50-100MG .....	100	<b>elvitegravir-cobicistat-emtricitabine-tenofovir</b>	
<b>eletriptan hydrobromide tab 20 mg (base</b>		<b>alafenamide</b>	
<b>equivalent)</b> .....	142	see GENVOYA TAB.....	98
<b>eletriptan hydrobromide tab 40 mg (base</b>		EMBECTA INSULIN PEN NEEDLES - OTC.....	140
<b>equivalent)</b> .....	143	EMBECTA INSULIN SYRINGE - OTC.....	140
<b>eliglustat tartrate</b>		EMBECTA INSULIN SYRINGE - RX.....	140
see CERDELGA CAP 84MG .....	136	EMFLAZA SUS 22.75/ML .....	117
ELINEST		<b>empagliflozin</b>	
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-		see JARDIANCE TAB 10MG .....	72
30 mcg.....	116	see JARDIANCE TAB 25MG .....	72
ELIQUIS CAP 0.15MG.....	59	<b>empagliflozin-linagliptin</b>	
ELIQUIS ST P TAB 5MG .....	59	see GLYXAMBI TAB 10-5 MG .....	68
ELIQUIS TAB 0.5MG .....	59	see GLYXAMBI TAB 25-5 MG .....	68
ELIQUIS TAB 1.5MG .....	59	<b>empagliflozin-linagliptin-metformin</b>	
ELIQUIS TAB 2.5MG .....	59	see TRIJARDY XR TAB .....	69
ELIQUIS TAB 2MG .....	59	<b>empagliflozin-metformin hcl</b>	
ELIQUIS TAB 5MG .....	59	see SYNJARDY TAB .....	69
ELITE-OB		see SYNJARDY TAB 12.5-500 .....	69
see Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-		see SYNJARDY TAB 5-1000MG .....	69
1.25 mg .....	147	see SYNJARDY TAB 5-500MG .....	69
ELIXOPHYLLIN		see SYNJARDY XR TAB .....	69
see Theophylline Elixir 80 mg/15ml .....	59	see SYNJARDY XR TAB 10-1000 .....	69
ELLA TAB 30MG .....	116	see SYNJARDY XR TAB 25-1000 .....	69
<b>eltrombopag choline</b>		see SYNJARDY XR TAB 5-1000MG .....	69
see ALVAIZ TAB 18MG .....	137	<b>emtricitabine caps 200 mg</b> .....	98
see ALVAIZ TAB 36MG .....	137	<b>emtricitabine-rilpivirine-tenofovir alafenamide</b>	
see ALVAIZ TAB 54MG .....	137	<b>fumarate</b>	
see ALVAIZ TAB 9MG.....	137	see ODEFSEY TAB .....	98
<b>eltrombopag olamine powder pack for susp 12.5</b>		<b>emtricitabine-rilpivirine-tenofovir df tab 200-25-</b>	
<b>mg (base eq)</b> .....	137	<b>300 mg</b> .....	98
<b>eltrombopag olamine powder pack for susp 25</b>		<b>emtricitabine-tenofovir alafenamide fumarate</b>	
<b>mg (base equiv)</b> .....	137	see DESCOVY TAB 120-15MG.....	97
<b>eltrombopag olamine tab 12.5 mg (base equiv)</b>		see DESCOVY TAB 200/25MG .....	97
.....	137	<b>emtricitabine-tenofovir disoproxil fumarate tab</b>	
<b>eltrombopag olamine tab 25 mg (base equiv)</b>		<b>100-150 mg</b> .....	98
.....	137	<b>emtricitabine-tenofovir disoproxil fumarate tab</b>	
<b>eltrombopag olamine tab 50 mg (base equiv)</b>		<b>133-200 mg</b> .....	98
.....	137	<b>emtricitabine-tenofovir disoproxil fumarate tab</b>	
<b>eltrombopag olamine tab 75 mg (base equiv)</b>		<b>167-250 mg</b> .....	98
.....	138	<b>emtricitabine-tenofovir disoproxil fumarate tab</b>	
ELURYNG		<b>200-300 mg</b> .....	98
		EMVERM CHW 100MG .....	52

EMZAHH	
see Norethindrone Tab 0.35 mg	116
<b>enalapril maleate &amp; hydrochlorothiazide tab 10-25 mg</b>	80
<b>enalapril maleate &amp; hydrochlorothiazide tab 5-12.5 mg</b>	80
<b>enalapril maleate oral soln 1 mg/ml</b>	77
<b>enalapril maleate tab 10 mg</b>	77
<b>enalapril maleate tab 2.5 mg</b>	77
<b>enalapril maleate tab 20 mg</b>	77
<b>enalapril maleate tab 5 mg</b>	77
ENCARE SUP 100MG	164
<b>encorafenib</b>	
see BRAFTOVI CAP 75MG	86
ENDOCET	
see Oxycodone W/ Acetaminophen Tab 10-325 mg	49
see Oxycodone W/ Acetaminophen Tab 2.5-325 mg	49
see Oxycodone W/ Acetaminophen Tab 5-325 mg	49
see Oxycodone W/ Acetaminophen Tab 7.5-325 mg	49
ENILLORING	
see Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr	116
ENSKYCE	
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg	109
ENSTILAR AER	124
<b>entacapone tab 200 mg</b>	91
<b>entecavir tab 0.5 mg</b>	99
<b>entecavir tab 1 mg</b>	99
<b>entrectinib</b>	
see ROZLYTREK CAP 100MG	90
see ROZLYTREK CAP 200MG	90
see ROZLYTREK PAK 50MG	90
ENULOSE	
see Lactulose (Encephalopathy) Solution 10 gm/15ml	134
<b>enzalutamide</b>	
see XTANDI CAP 40MG	85
see XTANDI TAB 40MG	85
see XTANDI TAB 80MG	85
EPCLUSA PAK 150-37.5	99
EPCLUSA PAK 200-50MG	99
EPCLUSA TAB 200-50MG	99
EPCLUSA TAB 400-100	99
EPIDUO FORTE GEL 0.3-2.5%	120
EPIDUO GEL 0.1-2.5%	120
<b>epinastine hcl ophth soln 0.05%</b>	150
<b>epinephrine (anaphylaxis)</b>	
see AUVI-Q INJ 0.15MG	164
see AUVI-Q INJ 0.1MG	164
see AUVI-Q INJ 0.3MG	164
<b>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</b>	165
<b>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</b>	165
<b>eplerenone tab 25 mg</b>	82
<b>eplerenone tab 50 mg</b>	82
EQ NICOTINE	
see Nicotine Td Patch 24hr 14 mg/24hr	158
see Nicotine Td Patch 24hr 21 mg/24hr	158
EQ NICOTINE LOZENGES	
see Nicotine Polacrilex Lozenge 4 mg	157
EQ NICOTINE POLACRILEX	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Gum 4 mg	156
see Nicotine Polacrilex Lozenge 2 mg	157
see Nicotine Polacrilex Lozenge 4 mg	157
EQ NICOTINE STEP 3	
see Nicotine Td Patch 24hr 7 mg/24hr	158
<b>ergocalciferol cap 1.25 mg (50000 unit)</b>	165
<b>ergotamine w/ caffeine tab 1-100 mg</b>	142
ERIVEDGE CAP 150MG	84
ERLEADA TAB 240MG	85
ERLEADA TAB 60MG	85
<b>erlotinib hcl tab 100 mg (base equivalent)</b>	84
<b>erlotinib hcl tab 150 mg (base equivalent)</b>	84
<b>erlotinib hcl tab 25 mg (base equivalent)</b>	84
ERRIN	
see Norethindrone Tab 0.35 mg	116
ERY	
see Erythromycin Pads 2%	120
<b>erythromycin ethylsuccinate for susp 200 mg/5ml</b>	140
<b>erythromycin ethylsuccinate for susp 400 mg/5ml</b>	140
Erythromycin Ethylsuccinate Tab 400 mg	140
<b>erythromycin gel 2%</b>	120
<b>erythromycin ophth oint 5 mg/gm</b>	149
Erythromycin Pads 2%	120
<b>erythromycin soln 2%</b>	120

<i>erythromycin tab 250 mg</i> .....	140	<i>estradiol tab 0.5 mg</i> .....	131
<i>erythromycin tab 500 mg</i> .....	140	<i>estradiol tab 1 mg</i> .....	131
<i>erythromycin tab delayed release 250 mg</i> .....	140	<i>estradiol tab 2 mg</i> .....	131
<i>erythromycin tab delayed release 333 mg</i> .....	140	<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i> .....	131
<i>erythromycin tab delayed release 500 mg</i> .....	140	<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i> .....	131
<i>erythromycin w/ delayed release particles cap</i>		<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i> .....	131
<i>250 mg</i> .....	140	<i>estradiol td gel 1 mg/gm (0.1%)</i> .....	131
<i>escitalopram oxalate soln 5 mg/5ml (base</i>		<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i> .....	131
<i>equiv)</i> .....	65	<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	
<i>escitalopram oxalate tab 10 mg (base equiv)</i> .	65	.....	132
<i>escitalopram oxalate tab 20 mg (base equiv)</i> .	65	Estradiol Td Patch Twice Weekly 0.025 mg/24hr	
<i>escitalopram oxalate tab 5 mg (base equiv)</i> ...	65	.....	132
<i>eslicarbazepine acetate tab 200 mg</i> .....	61	<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	
<i>eslicarbazepine acetate tab 400 mg</i> .....	61	.....	132
<i>eslicarbazepine acetate tab 600 mg</i> .....	61	Estradiol Td Patch Twice Weekly 0.0375 mg/24hr	
<i>eslicarbazepine acetate tab 800 mg</i> .....	61	.....	132
<i>esomeprazole magnesium cap delayed release</i>		<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	
<i>20 mg (base eq)</i> .....	162	.....	132
<i>esomeprazole magnesium cap delayed release</i>		Estradiol Td Patch Twice Weekly 0.05 mg/24hr	
<i>40 mg (base eq)</i> .....	162	.....	132
<i>esomeprazole magnesium for delayed release</i>		<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	
<i>susp pack 2.5 mg</i> .....	162	.....	132
<i>esomeprazole magnesium for delayed release</i>		Estradiol Td Patch Twice Weekly 0.075 mg/24hr	
<i>susp packet 10 mg</i> .....	162	.....	132
<i>esomeprazole magnesium for delayed release</i>		<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	131
<i>susp packet 20 mg</i> .....	162	Estradiol Td Patch Twice Weekly 0.1 mg/24hr	
<i>esomeprazole magnesium for delayed release</i>		.....	131, 132
<i>susp packet 40 mg</i> .....	162	<i>estradiol td patch weekly 0.025 mg/24hr</i> .....	132
<i>esomeprazole magnesium for delayed release</i>		<i>estradiol td patch weekly 0.0375 mg/24hr (37.5</i>	
<i>susp packet 5 mg</i> .....	162	<i>mcg/24hr)</i> .....	132
ESTARYLLA		<i>estradiol td patch weekly 0.05 mg/24hr</i> .....	132
see Norgestimate & Ethinyl Estradiol Tab 0.25		<i>estradiol td patch weekly 0.06 mg/24hr</i> .....	132
mg-35 mcg.....	115	<i>estradiol td patch weekly 0.075 mg/24hr</i> .....	132
<i>estazolam tab 1 mg</i> .....	138	<i>estradiol td patch weekly 0.1 mg/24hr</i> .....	132
<i>estazolam tab 2 mg</i> .....	138	<i>estradiol vaginal</i>	
<i>estradiol &amp; norethindrone acetate</i>		see IMVEXXY MAIN SUP 10MCG .....	164
see COMBIPATCH DIS.....	130	see IMVEXXY MAIN SUP 4MCG .....	164
<i>estradiol &amp; norethindrone acetate tab 0.5-0.1</i>		see IMVEXXY STRT SUP 10MCG .....	164
<i>mg</i> .....	130	see IMVEXXY STRT SUP 4MCG.....	164
Estradiol & Norethindrone Acetate Tab 0.5-0.1		see VAGIFEM TAB 10MCG .....	164
mg.....	130	<i>estradiol vaginal cream 0.01%</i> .....	164
<i>estradiol &amp; norethindrone acetate tab 1-0.5 mg</i>		<i>estradiol valerate-dienogest</i>	
.....	130	see NATAZIA TAB.....	112
Estradiol & Norethindrone Acetate Tab 1-0.5 mg		<i>estradiol-progesterone</i>	
.....	131	see BIJUVA CAP 0.5-100.....	130
<i>estradiol gel 0.06% (0.75 mg/1.25 gm metered-</i>		see BIJUVA CAP 1-100MG.....	130
<i>dose pump)</i> .....	131	<i>estrogens, conjugated tab 0.3 mg</i> .....	132

<b>estrogens, conjugated tab 0.45 mg</b> .....	132
<b>estrogens, conjugated tab 0.625 mg</b> .....	132
<b>estrogens, conjugated tab 0.9 mg</b> .....	132
<b>estrogens, conjugated tab 1.25 mg</b> .....	132
<b>eszopiclone tab 1 mg</b> .....	138
<b>eszopiclone tab 2 mg</b> .....	138
<b>eszopiclone tab 3 mg</b> .....	138
<b>ethacrynic acid tab 25 mg</b> .....	127
<b>ethambutol hcl tab 100 mg</b> .....	83
<b>ethambutol hcl tab 400 mg</b> .....	83
<b>ethosuximide cap 250 mg</b> .....	64
<b>ethosuximide soln 250 mg/5ml</b> .....	64
<b>ethyl chloride aerosol spray</b> .....	125
<b>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-35 mcg</b> .....	109
Ethinodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg .....	109, 110
<b>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-50 mcg</b> .....	110
Ethinodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg .....	110
<b>etodolac cap 200 mg</b> .....	39
<b>etodolac cap 300 mg</b> .....	39
<b>etodolac tab 400 mg</b> .....	39
<b>etodolac tab 500 mg</b> .....	39
<b>etodolac tab er 24hr 400 mg</b> .....	39
<b>etodolac tab er 24hr 500 mg</b> .....	39
<b>etodolac tab er 24hr 600 mg</b> .....	39
<b>etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr</b> .....	116
Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr .....	116
<b>etoposide cap 50 mg</b> .....	91
<b>etrasimod arginine</b> see VELSIPITY TAB 2MG .....	133
<b>etravirine tab 100 mg</b> .....	98
<b>etravirine tab 200 mg</b> .....	98
EUCRISA OIN 2% .....	125
<b>everolimus tab 0.25 mg</b> .....	145
<b>everolimus tab 0.5 mg</b> .....	145
<b>everolimus tab 0.75 mg</b> .....	145
<b>everolimus tab 1 mg</b> .....	145
<b>everolimus tab 10 mg</b> .....	87
Everolimus Tab 10 mg .....	87
<b>everolimus tab 2.5 mg</b> .....	87
Everolimus Tab 2.5 mg .....	87
<b>everolimus tab 5 mg</b> .....	87
Everolimus Tab 5 mg .....	87
<b>everolimus tab 7.5 mg</b> .....	87
Everolimus Tab 7.5 mg .....	87
<b>everolimus tab for oral susp 2 mg</b> .....	87
<b>everolimus tab for oral susp 3 mg</b> .....	87
<b>everolimus tab for oral susp 5 mg</b> .....	87
<b>exemestane tab 25 mg</b> .....	85
<b>ezetimibe tab 10 mg</b> .....	77
<b>ezetimibe-simvastatin tab 10-10 mg</b> .....	75
<b>ezetimibe-simvastatin tab 10-20 mg</b> .....	75
<b>ezetimibe-simvastatin tab 10-40 mg</b> .....	75
<b>ezetimibe-simvastatin tab 10-80 mg</b> .....	75
<b>F</b>	
FA-8 see Folic Acid Cap 0.8 mg .....	136
FALMINA see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg .....	111
<b>famciclovir tab 125 mg</b> .....	100
<b>famciclovir tab 250 mg</b> .....	100
<b>famciclovir tab 500 mg</b> .....	100
<b>famotidine for susp 40 mg/5ml</b> .....	162
<b>famotidine tab 20 mg</b> .....	162
<b>famotidine tab 40 mg</b> .....	162
FARXIGA TAB 10MG .....	72
FARXIGA TAB 5MG .....	72
FC2 FEMALE MIS CONDOM .....	140
<b>febuxostat tab 40 mg</b> .....	135
<b>febuxostat tab 80 mg</b> .....	135
FEIRZA 1.5/30 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg .....	114
FEIRZA 1/20 see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg .....	113
<b>felbamate susp 600 mg/5ml</b> .....	63
<b>felbamate tab 400 mg</b> .....	63
<b>felbamate tab 600 mg</b> .....	63
<b>felodipine tab er 24hr 10 mg</b> .....	103
<b>felodipine tab er 24hr 2.5 mg</b> .....	103
<b>felodipine tab er 24hr 5 mg</b> .....	103
<b>fenofibrate cap 150 mg</b> .....	76
<b>fenofibrate micronized cap 134 mg</b> .....	76
<b>fenofibrate micronized cap 200 mg</b> .....	76
<b>fenofibrate micronized cap 43 mg</b> .....	76
<b>fenofibrate micronized cap 67 mg</b> .....	76
<b>fenofibrate tab 145 mg</b> .....	76

<b>fenofibrate tab 160 mg</b> .....	76	<b>fluconazole tab 50 mg</b> .....	74
<b>fenofibrate tab 48 mg</b> .....	76	<b>flucytosine cap 250 mg</b> .....	73
<b>fenofibrate tab 54 mg</b> .....	76	<b>fludrocortisone acetate tab 0.1 mg</b> .....	118
<b>fenofibric acid tab 105 mg</b> .....	76	<b>flunisolide nasal soln 25 mcg/act (0.025%)</b> ...	148
<b>fenofibric acid tab 35 mg</b> .....	76	<b>fluocinolone acetonide (otic) oil 0.01%</b> .....	151
<b>fentanyl td patch 72hr 100 mcg/hr</b> .....	42	<b>fluocinolone acetonide cream 0.01%</b> .....	124
<b>fentanyl td patch 72hr 12 mcg/hr</b> .....	41	<b>fluocinolone acetonide cream 0.025%</b> .....	124
<b>fentanyl td patch 72hr 25 mcg/hr</b> .....	42	<b>fluocinolone acetonide oil 0.01% (body oil)</b> ...	124
<b>fentanyl td patch 72hr 37.5 mcg/hr</b> .....	42	<b>fluocinolone acetonide oil 0.01% (scalp oil)</b> ...	124
<b>fentanyl td patch 72hr 50 mcg/hr</b> .....	42	<b>fluocinolone acetonide oint 0.025%</b> .....	124
<b>fentanyl td patch 72hr 62.5 mcg/hr</b> .....	42	<b>fluocinolone acetonide soln 0.01%</b> .....	124
<b>fentanyl td patch 72hr 75 mcg/hr</b> .....	42	<b>fluocinonide cream 0.05%</b> .....	124
<b>fentanyl td patch 72hr 87.5 mcg/hr</b> .....	42	<b>fluocinonide emulsified base cream 0.05%</b> ...	124
<b>ferric citrate tab 1 gm (210 mg ferric iron)</b> ...	134	<b>fluocinonide gel 0.05%</b> .....	124
<b>fesoterodine fumarate tab er 24hr 4 mg</b> .....	163	<b>fluocinonide oint 0.05%</b> .....	124
<b>fesoterodine fumarate tab er 24hr 8 mg</b> .....	163	<b>fluocinonide soln 0.05%</b> .....	124
FIASP FLEX INJ TOUCH .....	71	<b>fluorometholone ophth susp 0.1%</b> .....	150
FIASP INJ 100/ML.....	71	<b>fluorouracil cream 5%</b> .....	122
FIASP PENFIL INJ U-100 .....	71	<b>fluorouracil soln 2%</b> .....	122
<b>fidaxomicin tab 200 mg</b> .....	140	<b>fluorouracil soln 5%</b> .....	122
FILSPARI TAB 200MG.....	134	<b>fluoxetine hcl cap 10 mg</b> .....	65
FILSPARI TAB 400MG.....	134	<b>fluoxetine hcl cap 20 mg</b> .....	65
FINACEA AER 15%.....	126	<b>fluoxetine hcl cap 40 mg</b> .....	65
<b>finasteride tab 1 mg</b> .....	125	<b>fluoxetine hcl cap delayed release 90 mg</b> .....	65
<b>finasteride tab 5 mg</b> .....	135	<b>fluoxetine hcl solution 20 mg/5ml</b> .....	65
<b>finerenone</b>		<b>fluoxetine hcl tab 10 mg</b> .....	65
see KERENDIA TAB 10MG .....	130	<b>fluoxetine hcl tab 20 mg</b> .....	65
see KERENDIA TAB 20MG .....	130	<b>fluphenazine hcl elixir 2.5 mg/5ml</b> .....	96
see KERENDIA TAB 40MG .....	130	<b>fluphenazine hcl oral conc 5 mg/ml</b> .....	96
<b> fingolimod hcl cap 0.5 mg (base equiv)</b> .....	155	<b>fluphenazine hcl tab 1 mg</b> .....	96
FINZALA		<b>fluphenazine hcl tab 10 mg</b> .....	96
see Norethindrone Ace-Eth Estradiol-Fe Chew		<b>fluphenazine hcl tab 2.5 mg</b> .....	96
Tab 1 mg-20 mcg (24) .....	114	<b>fluphenazine hcl tab 5 mg</b> .....	96
<b>flavoxate hcl tab 100 mg</b> .....	164	<b>flurbiprofen sodium ophth soln 0.03%</b> .....	150
<b>flecainide acetate tab 100 mg</b> .....	55	<b>flurbiprofen tab 100 mg</b> .....	39
<b>flecainide acetate tab 150 mg</b> .....	55	<b>flurbiprofen tab 50 mg</b> .....	39
<b>flecainide acetate tab 50 mg</b> .....	55	<b>fluticasone furoate aerosol powder breath activ</b>	
FLEXICHAMBER MIS .....	141	<b>100 mcg/act</b> .....	57
FLEXICHAMBER MIS MASK LRG .....	141	<b>fluticasone furoate aerosol powder breath activ</b>	
FLEXICHAMBER MIS MASK SM .....	141	<b>200 mcg/act</b> .....	57
<b>flibanserin</b>		<b>fluticasone furoate aerosol powder breath activ</b>	
see ADDYI TAB 100MG.....	154	<b>50 mcg/act</b> .....	56
<b>fluconazole for susp 10 mg/ml</b> .....	74	<b>fluticasone furoate-vilanterol</b>	
<b>fluconazole for susp 40 mg/ml</b> .....	74	see BREO ELLIPTA INH 100-25 .....	57
<b>fluconazole tab 100 mg</b> .....	74	see BREO ELLIPTA INH 200-25 .....	57
<b>fluconazole tab 150 mg</b> .....	74	see BREO ELLIPTA INH 50-25MCG .....	57
<b>fluconazole tab 200 mg</b> .....	74	<b>fluticasone propionate (nasal)</b>	

see XHANCE MIS 93MCG .....	148
<b>fluticasone propionate cream 0.05%</b> .....	124
<b>fluticasone propionate hfa inhal aer 110 mcg/act</b> .....	57
<b>fluticasone propionate hfa inhal aer 220 mcg/act</b> .....	57
<b>fluticasone propionate hfa inhal aero 44 mcg/act</b> .....	57
<b>fluticasone propionate lotion 0.05%</b> .....	124
<b>fluticasone propionate nasal susp 50 mcg/act</b> .....	148
<b>fluticasone propionate oint 0.005%</b> .....	124
<b>fluticasone-salmeterol aer powder ba 100-50 mcg/act</b> .....	58
Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act .....	58
<b>fluticasone-salmeterol aer powder ba 250-50 mcg/act</b> .....	58
Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act .....	58
<b>fluticasone-salmeterol aer powder ba 500-50 mcg/act</b> .....	58
Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act .....	58
<b>fluticasone-umeclidinium-vilanterol</b>	
see TRELEGY AER 100MCG .....	58
see TRELEGY AER 200MCG .....	58
<b>fluvastatin sodium cap 20 mg (base equivalent)</b> .....	76
<b>fluvastatin sodium cap 40 mg (base equivalent)</b> .....	76
<b>fluvastatin sodium tab er 24 hr 80 mg (base equivalent)</b> .....	76
<b>fluvoxamine maleate cap er 24hr 100 mg</b> .....	65
<b>fluvoxamine maleate cap er 24hr 150 mg</b> .....	65
<b>fluvoxamine maleate tab 100 mg</b> .....	66
<b>fluvoxamine maleate tab 25 mg</b> .....	65
<b>fluvoxamine maleate tab 50 mg</b> .....	65
FOLATE	
see Folic Acid Tab 400 mcg .....	136
<b>folic acid cap 0.8 mg</b> .....	136
Folic Acid Cap 0.8 mg .....	136
<b>folic acid tab 1 mg</b> .....	136
<b>folic acid tab 400 mcg</b> .....	136
Folic Acid Tab 400 mcg .....	136, 137
<b>folic acid tab 800 mcg</b> .....	137
Folic Acid Tab 800 mcg .....	137

<b>formoterol fumarate soln nebu 20 mcg/2ml</b> ...	58
<b>fosamprenavir calcium tab 700 mg (base equiv)</b> .....	98
<b>fosfomycin tromethamine powd pack 3 gm (base equivalent)</b> .....	53
<b>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</b> .....	80
<b>fosinopril sodium &amp; hydrochlorothiazide tab 20-12.5 mg</b> .....	81
<b>fosinopril sodium tab 10 mg</b> .....	77
<b>fosinopril sodium tab 20 mg</b> .....	77
<b>fosinopril sodium tab 40 mg</b> .....	78
<b>frovatriptan succinate tab 2.5 mg (base equivalent)</b> .....	143
<b>furosemide oral soln 10 mg/ml</b> .....	127
<b>furosemide oral soln 8 mg/ml</b> .....	127
<b>furosemide tab 20 mg</b> .....	127
<b>furosemide tab 40 mg</b> .....	127
<b>furosemide tab 80 mg</b> .....	127
FYAVOLV	
see Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg .....	131
see Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg .....	131

## G

<b>gabapentin (once-daily) tab 300 mg</b> .....	155
<b>gabapentin (once-daily) tab 450 mg</b> .....	155
<b>gabapentin (once-daily) tab 600 mg</b> .....	155
<b>gabapentin (once-daily) tab 750 mg</b> .....	155
<b>gabapentin (once-daily) tab 900 mg</b> .....	155
<b>gabapentin cap 100 mg</b> .....	61
<b>gabapentin cap 300 mg</b> .....	61
<b>gabapentin cap 400 mg</b> .....	61
<b>gabapentin oral soln 250 mg/5ml</b> .....	61
<b>gabapentin tab 600 mg</b> .....	61
<b>gabapentin tab 800 mg</b> .....	61
GALAFOLD CAP 123MG .....	129
<b>galantamine hydrobromide cap er 24hr 16 mg</b> .....	153
<b>galantamine hydrobromide cap er 24hr 24 mg</b> .....	153
<b>galantamine hydrobromide cap er 24hr 8 mg</b> .....	153
<b>galantamine hydrobromide oral soln 4 mg/ml</b> .....	153
<b>galantamine hydrobromide tab 12 mg</b> .....	153
<b>galantamine hydrobromide tab 4 mg</b> .....	153

<b>galantamine hydrobromide tab 8 mg</b> .....	153	<b>glipizide tab er 24hr 10 mg</b> .....	72
GALBRIELA		<b>glipizide tab er 24hr 2.5 mg</b> .....	72
see Norethindrone & Ethinyl Estradiol-Fe		<b>glipizide tab er 24hr 5 mg</b> .....	72
Chew Tab 0.8 mg-25 mcg .....	112	<b>glipizide-metformin hcl tab 2.5-250 mg</b> .....	68
GALLIFREY		<b>glipizide-metformin hcl tab 2.5-500 mg</b> .....	68
see Norethindrone Acetate Tab 5 mg .....	152	<b>glipizide-metformin hcl tab 5-500 mg</b> .....	68
<b>gatifloxacin ophth soln 0.5%</b> .....	149	<b>glucagon</b>	
GAVILYTE-C		see BAQSIMI ONE POW 3MG/DOSE .....	70
see Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate		see BAQSIMI TWO POW 3MG/DOSE .....	70
For Soln 240 gm.....	139	see GVOKE HYPO 1 INJ 0.5/.1ML .....	70
GAVILYTE-G		see GVOKE HYPO 1 INJ 1/0.2ML .....	70
see Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate		see GVOKE HYPO 2 INJ 0.5/.1ML .....	70
For Soln 236 gm.....	139	see GVOKE HYPO 2 INJ 1/0.2ML .....	70
GAVILYTE-N/FLAVOR PACK		see GVOKE KIT SOL 1/0.2ML .....	70
see Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420		see GVOKE PFS INJ 1/0.2ML .....	70
gm.....	139	<b>glucagon for inj 1 mg</b> .....	70
GAVRETO CAP 100MG.....	87	<b>glyburide tab 1.25 mg</b> .....	72
<b>gefitinib tab 250 mg</b> .....	84	<b>glyburide tab 2.5 mg</b> .....	72
<b>gemfibrozil tab 600 mg</b> .....	76	<b>glyburide tab 5 mg</b> .....	72
GEMMILY		<b>glyburide-metformin tab 1.25-250 mg</b> .....	68
see Norethindrone Ace-Ethinyl Estradiol-Fe		<b>glyburide-metformin tab 2.5-500 mg</b> .....	68
Cap 1 mg-20 mcg (24) .....	114	<b>glyburide-metformin tab 5-500 mg</b> .....	68
GEMTESA TAB 75MG.....	163	<b>glycerol phenylbutyrate liquid 1.1 gm/ml</b> .....	129
GENGRAF		<b>glycopyrrolate oral soln 1 mg/5ml</b> .....	161
see Cyclosporine Modified Cap 100 mg .....	145	<b>glycopyrrolate tab 1 mg</b> .....	161
see Cyclosporine Modified Cap 25 mg.....	145	<b>glycopyrrolate tab 2 mg</b> .....	161
see Cyclosporine Modified Oral Soln 100		GLYXAMBI TAB 10-5 MG .....	68
mg/ml.....	145	GLYXAMBI TAB 25-5 MG .....	68
<b>gentamicin sulfate cream 0.1%</b> .....	121	GNP FOLIC ACID	
<b>gentamicin sulfate oint 0.1%</b> .....	121	see Folic Acid Tab 400 mcg .....	136
<b>gentamicin sulfate ophth soln 0.3%</b> .....	149	GNP NICOTINE MINI LOZENGE	
GENVOYA TAB.....	98	see Nicotine Polacrilex Lozenge 2 mg.....	157
<b>gilteritinib fumarate</b>		GNP NICOTINE POLACRILEX	
see XOSPATA TAB 40MG.....	91	see Nicotine Polacrilex Gum 4 mg .....	156
GLARGIN YFGN INJ 100U/ML.....	71	see Nicotine Polacrilex Lozenge 2 mg.....	157
GLARGIN YFGN SOL 100U/ML .....	71	see Nicotine Polacrilex Lozenge 4 mg.....	157
<b>glecaprevir-pibrentasvir</b>		GNP NICOTINE POLACRILEX M	
see MAVYRET PAK 50-20MG .....	100	see Nicotine Polacrilex Lozenge 4 mg.....	157
see MAVYRET TAB 100-40MG .....	100	GNP NICOTINE TRANSDERMAL	
GLEOSTINE CAP 100MG .....	83	see Nicotine Td Patch 24hr 14 mg/24hr .....	158
GLEOSTINE CAP 10MG .....	83	see Nicotine Td Patch 24hr 7 mg/24hr .....	158
GLEOSTINE CAP 40MG .....	83	GOMEKLI CAP 1MG .....	87
<b>glimepiride tab 1 mg</b> .....	72	GOMEKLI CAP 2MG .....	87
<b>glimepiride tab 2 mg</b> .....	72	GOMEKLI TAB 1MG .....	87
<b>glimepiride tab 4 mg</b> .....	72	GOODSENSE NICOTINE	
<b>glipizide tab 10 mg</b> .....	72	see Nicotine Polacrilex Lozenge 2 mg.....	157
<b>glipizide tab 5 mg</b> .....	72	see Nicotine Polacrilex Lozenge 4 mg.....	157

GOODSENSE NICOTINE POLACR	
see Nicotine Polacrilex Gum 2 mg.....	156
see Nicotine Polacrilex Gum 4 mg.....	156
see Nicotine Polacrilex Lozenge 4 mg.....	157
<b>granisetron</b>	
see SANCUSO DIS 3.1MG .....	73
<b>granisetron hcl tab 1 mg</b> .....	73
<b>grass mixed pollens allergen extract</b>	
see ORALAIR SUB 300 IR .....	38
GRASTEK SUB 2800BAU .....	38
<b>griseofulvin microsize susp 125 mg/5ml</b> .....	73
<b>griseofulvin microsize tab 500 mg</b> .....	73
<b>griseofulvin ultramicrosize tab 125 mg</b> .....	73
<b>griseofulvin ultramicrosize tab 165 mg</b> .....	74
<b>griseofulvin ultramicrosize tab 250 mg</b> .....	74
<b>guanfacine hcl tab 1 mg</b> .....	79
<b>guanfacine hcl tab 2 mg</b> .....	79
<b>guanfacine hcl tab er 24hr 1 mg (base equiv)</b> .	32
<b>guanfacine hcl tab er 24hr 2 mg (base equiv)</b> .	32
<b>guanfacine hcl tab er 24hr 3 mg (base equiv)</b> .	32
<b>guanfacine hcl tab er 24hr 4 mg (base equiv)</b> .	32
GVOKE HYPO 1 INJ 0.5/.1ML .....	70
GVOKE HYPO 1 INJ 1/0.2ML .....	70
GVOKE HYPO 2 INJ 0.5/.1ML .....	70
GVOKE HYPO 2 INJ 1/0.2ML .....	70
GVOKE KIT SOL 1/0.2ML .....	70
GVOKE PFS INJ 1/0.2ML .....	70
GYNOL II GEL 3%.....	164
<b>H</b>	
HAILEY 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol Tab	
1.5 mg-30 mcg.....	113
HAILEY 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24) .....	114
HAILEY FE 1.5/30	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1.5 mg-30 mcg.....	114
HAILEY FE 1/20	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg.....	113
<b>halcinonide soln 0.1%</b> .....	124
<b>halobetasol propionate</b>	
see BRYHALI LOT 0.01% .....	123
<b>halobetasol propionate cream 0.05%</b> .....	124
<b>halobetasol propionate foam 0.05%</b> .....	124
<b>halobetasol propionate oint 0.05%</b> .....	124
<b>haloperidol lactate oral conc 2 mg/ml</b> .....	95
<b>haloperidol tab 0.5 mg</b> .....	95
<b>haloperidol tab 1 mg</b> .....	95
<b>haloperidol tab 10 mg</b> .....	95
<b>haloperidol tab 2 mg</b> .....	95
<b>haloperidol tab 20 mg</b> .....	95
<b>haloperidol tab 5 mg</b> .....	95
HARVONI PAK .....	99
HARVONI PAK 45-200MG .....	99
HARVONI TAB 45-200MG .....	99
HARVONI TAB 90-400MG .....	100
HEATHER	
see Norethindrone Tab 0.35 mg .....	116
HIDEX 6-DAY	
see Dexamethasone Tab Therapy Pack 1.5 mg	
(21).....	117
HOLD CHAMBER MIS ADLT LG.....	142
HOLD CHAMBER MIS MEDIUM .....	142
HOLD CHAMBER MIS SMALL .....	142
HUMULIN R INJ U-500KWP.....	71
<b>hydralazine hcl tab 10 mg</b> .....	82
<b>hydralazine hcl tab 100 mg</b> .....	82
<b>hydralazine hcl tab 25 mg</b> .....	82
<b>hydralazine hcl tab 50 mg</b> .....	82
<b>hydrochlorothiazide cap 12.5 mg</b> .....	128
<b>hydrochlorothiazide tab 12.5 mg</b> .....	128
<b>hydrochlorothiazide tab 25 mg</b> .....	128
<b>hydrochlorothiazide tab 50 mg</b> .....	128
<b>hydrocod polst-chlorphen polst er susp 10-8</b>	
<b>mg/5ml</b> .....	118
<b>hydrocodone bitart-homatropine methylbrom</b>	
<b>soln 5-1.5 mg/5ml</b> .....	118
Hydrocodone Bitart-Homatropine Methylbrom	
Soln 5-1.5 mg/5ml .....	118
<b>hydrocodone bitart-homatropine</b>	
<b>methylbromide tab 5-1.5 mg</b> .....	118
<b>hydrocodone bitartrate cap er 12hr 10 mg</b> .....	42
<b>hydrocodone bitartrate cap er 12hr 15 mg</b> .....	42
<b>hydrocodone bitartrate cap er 12hr 20 mg</b> .....	42
<b>hydrocodone bitartrate cap er 12hr 30 mg</b> .....	42
<b>hydrocodone bitartrate cap er 12hr 40 mg</b> .....	42
<b>hydrocodone bitartrate cap er 12hr 50 mg</b> .....	42
<b>hydrocodone bitartrate tab er 24hr deter 100</b>	
<b>mg</b> .....	42
<b>hydrocodone bitartrate tab er 24hr deter 120</b>	
<b>mg</b> .....	42

<b>hydrocodone bitartrate tab er 24hr deter 20 mg</b>	Hydrocortisone Perianal Cream 2.5% .....	51
.....	Hydrocortisone Soln 2.5%.....	124
<b>hydrocodone bitartrate tab er 24hr deter 30 mg</b>	<b>hydrocortisone tab 10 mg</b> .....	117
.....	<b>hydrocortisone tab 20 mg</b> .....	117
<b>hydrocodone bitartrate tab er 24hr deter 40 mg</b>	<b>hydrocortisone tab 5 mg</b> .....	117
.....	<b>hydrocortisone valerate cream 0.2%</b> .....	124
<b>hydrocodone bitartrate tab er 24hr deter 60 mg</b>	<b>hydrocortisone valerate oint 0.2%</b> .....	124
.....	<b>hydrocortisone w/ acetic acid otic soln 1-2%</b>	151
<b>hydrocodone bitartrate tab er 24hr deter 80 mg</b>	HYDROMET	
.....	see Hydrocodone Bitart-Homatropine	
<b>hydrocodone-acetaminophen soln 10-300</b>	Methylbrom Soln 5-1.5 mg/5ml .....	118
<b>mg/15ml</b> .....	<b>hydromorphone hcl liqd 1 mg/ml</b> .....	42
<b>hydrocodone-acetaminophen soln 10-325</b>	<b>hydromorphone hcl tab 2 mg</b> .....	42
<b>mg/15ml</b> .....	<b>hydromorphone hcl tab 4 mg</b> .....	42
<b>hydrocodone-acetaminophen soln 7.5-325</b>	<b>hydromorphone hcl tab 8 mg</b> .....	43
<b>mg/15ml</b> .....	<b>hydromorphone hcl tab er 24hr 12 mg</b> .....	43
<b>hydrocodone-acetaminophen tab 10-300 mg</b> .	<b>hydromorphone hcl tab er 24hr 16 mg</b> .....	43
<b>hydrocodone-acetaminophen tab 10-325 mg</b> .	<b>hydromorphone hcl tab er 24hr 32 mg</b> .....	43
<b>hydrocodone-acetaminophen tab 2.5-325 mg</b>	<b>hydromorphone hcl tab er 24hr 8 mg</b> .....	43
<b>hydrocodone-acetaminophen tab 5-300 mg</b> ...	<b>hydroxychloroquine sulfate tab 100 mg</b> .....	82
<b>hydrocodone-acetaminophen tab 5-325 mg</b> ...	<b>hydroxychloroquine sulfate tab 200 mg</b> .....	82
<b>hydrocodone-acetaminophen tab 7.5-300 mg</b>	<b>hydroxychloroquine sulfate tab 300 mg</b> .....	82
<b>hydrocodone-acetaminophen tab 7.5-325 mg</b>	<b>hydroxychloroquine sulfate tab 400 mg</b> .....	82
<b>hydrocodone-ibuprofen tab 10-200 mg</b> .....	<b>hydroxyurea (sickle cell disease)</b>	
<b>hydrocodone-ibuprofen tab 5-200 mg</b> .....	see SIKLOS TAB 1000MG .....	136
<b>hydrocodone-ibuprofen tab 7.5-200 mg</b> .....	see SIKLOS TAB 100MG.....	136
<b>hydrocortisone acetate (intrarectal)</b>	<b>hydroxyurea cap 500 mg</b> .....	91
see CORTIFOAM AER 90MG .....	<b>hydroxyzine hcl syrup 10 mg/5ml</b> .....	54
<b>hydrocortisone acetate cream 2.5%</b> .....	<b>hydroxyzine hcl tab 10 mg</b> .....	54
Hydrocortisone Acetate Cream 2.5%.....	<b>hydroxyzine hcl tab 25 mg</b> .....	54
<b>hydrocortisone acetate w/ pramoxine</b>	<b>hydroxyzine hcl tab 50 mg</b> .....	54
see PROCTOFOAM AER HC 1% .....	<b>hydroxyzine pamoate cap 100 mg</b> .....	54
<b>hydrocortisone acetate w/ pramoxine perianal</b>	<b>hydroxyzine pamoate cap 25 mg</b> .....	54
<b>cream 1-1%</b> .....	<b>hydroxyzine pamoate cap 50 mg</b> .....	54
<b>hydrocortisone butyrate cream 0.1%</b> .....	<b>hyoscyamine sulfate elixir 0.125 mg/5ml</b> .....	161
<b>hydrocortisone butyrate oint 0.1%</b> .....	Hyoscyamine Sulfate Elixir 0.125 mg/5ml .....	162
<b>hydrocortisone butyrate soln 0.1%</b> .....	<b>hyoscyamine sulfate sl tab 0.125 mg</b> .....	162
<b>hydrocortisone cream 1%</b> .....	<b>hyoscyamine sulfate soln 0.125 mg/ml</b> .....	162
Hydrocortisone Cream 1% .....	Hyoscyamine Sulfate Soln 0.125 mg/ml .....	162
<b>hydrocortisone cream 2.5%</b> .....	<b>hyoscyamine sulfate tab 0.125 mg</b> .....	162
<b>hydrocortisone enema 100 mg/60ml</b> .....	<b>hyoscyamine sulfate tab disint 0.125 mg</b> .....	162
<b>hydrocortisone lotion 2.5%</b> .....	HYOSYNE	
<b>hydrocortisone oint 1%</b> .....	see Hyoscyamine Sulfate Elixir 0.125 mg/5ml	
<b>hydrocortisone oint 2.5%</b> .....	.....	162
<b>hydrocortisone perianal cream 1%</b> .....	see Hyoscyamine Sulfate Soln 0.125 mg/ml	162
Hydrocortisone Perianal Cream 1% .....		
<b>hydrocortisone perianal cream 2.5%</b> .....		

<b>I</b>	
<b><i>ibandronate sodium tab 150 mg (base equivalent)</i></b> .....	128
IBRANCE CAP 100MG .....	88
IBRANCE CAP 125MG .....	88
IBRANCE CAP 75MG .....	88
IBRANCE TAB 100MG .....	88
IBRANCE TAB 125MG .....	88
IBRANCE TAB 75MG .....	88
IBTROZI CAP 200MG .....	88
IBU	
see Ibuprofen Tab 400 mg .....	39
see Ibuprofen Tab 600 mg .....	39
see Ibuprofen Tab 800 mg .....	40
<b><i>ibuprofen susp 100 mg/5ml</i></b> .....	39
<b><i>ibuprofen tab 400 mg</i></b> .....	39
Ibuprofen Tab 400 mg .....	39
<b><i>ibuprofen tab 600 mg</i></b> .....	39
Ibuprofen Tab 600 mg .....	39
<b><i>ibuprofen tab 800 mg</i></b> .....	40
Ibuprofen Tab 800 mg .....	40
<b><i>ibuprofen-famotidine tab 800-26.6 mg</i></b> .....	40
ICLEVIA	
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg .....	110
<b><i>icosapent ethyl</i></b>	
see VASCEPA CAP 0.5GM .....	75
see VASCEPA CAP 1GM .....	75
ILEVRO DRO 0.3% OP .....	150
<b><i>imatinib mesylate tab 100 mg (base equivalent)</i></b> .....	88
<b><i>imatinib mesylate tab 400 mg (base equivalent)</i></b> .....	88
<b><i>imipramine hcl tab 10 mg</i></b> .....	68
<b><i>imipramine hcl tab 25 mg</i></b> .....	68
<b><i>imipramine hcl tab 50 mg</i></b> .....	68
<b><i>imipramine pamoate cap 100 mg</i></b> .....	68
<b><i>imipramine pamoate cap 125 mg</i></b> .....	68
<b><i>imipramine pamoate cap 150 mg</i></b> .....	68
<b><i>imipramine pamoate cap 75 mg</i></b> .....	68
<b><i>imiquimod cream 3.75%</i></b> .....	125
<b><i>imiquimod cream 5%</i></b> .....	125
IMITREX INJ 4MG/0.5 .....	143
IMITREX INJ 6MG/0.5 .....	143
IMPAVIDO CAP 50MG .....	52
IMVEXXY MAIN SUP 10MCG .....	164
IMVEXXY MAIN SUP 4MCG .....	164
IMVEXXY STRT SUP 10MCG .....	164
IMVEXXY STRT SUP 4MCG .....	164
INATAL GT	
see Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg .....	146
INBRIJA CAP 42MG .....	92
INCASSIA	
see Norethindrone Tab 0.35 mg .....	116
<b><i>indapamide tab 1.25 mg</i></b> .....	128
<b><i>indapamide tab 2.5 mg</i></b> .....	128
<b><i>indomethacin cap 25 mg</i></b> .....	40
<b><i>indomethacin cap 50 mg</i></b> .....	40
<b><i>indomethacin cap er 75 mg</i></b> .....	40
<b><i>indomethacin suppos 50 mg</i></b> .....	40
<b><i>indomethacin susp 25 mg/5ml</i></b> .....	40
INGREZZA CAP 40-80MG .....	154
INGREZZA CAP 40MG .....	154
INGREZZA CAP 60MG .....	154
INGREZZA CAP 80MG .....	154
INLYTA TAB 1MG .....	83
INLYTA TAB 5MG .....	83
INSPIREASE MIS DD SYST .....	142
<b><i>insulin aspart</i></b>	
see NOVOLOG INJ 100/ML .....	71
see NOVOLOG INJ FLEXPEN .....	71
see NOVOLOG INJ PENFILL .....	71
<b><i>insulin aspart (with niacinamide)</i></b>	
see FIASP FLEX INJ TOUCH .....	71
see FIASP INJ 100/ML .....	71
see FIASP PENFIL INJ U-100 .....	71
<b><i>insulin aspart protamine &amp; aspart (human)</i></b>	
see NOVOLOG MIX INJ 70/30 .....	71
see NOVOLOG MIX INJ FLEXPEN .....	71
<b><i>insulin degludec</i></b>	
see TRESIBA FLEX INJ 100UNIT .....	71
see TRESIBA FLEX INJ 200UNIT .....	71
see TRESIBA INJ 100UNIT .....	71
<b><i>insulin degludec-liraglutide</i></b>	
see XULTOPHY INJ 100/3.6 .....	69
<b><i>insulin glargine</i></b>	
see LANTUS INJ 100/ML .....	71
see LANTUS SOLOS INJ 100/ML .....	71
see TOUJEO MAX INJ 300/ML .....	71
see TOUJEO SOLO INJ 300/ML .....	71
<b><i>insulin glargine-lixisenatide</i></b>	
see SOLIQUA INJ 100/33 .....	69
<b><i>insulin nph (human) (isophane)</i></b>	

see NOVOLIN N INJ 100 UNIT .....	71	ISENTRESS POW 100MG .....	98
see NOVOLIN N INJ U-100 .....	71	ISENTRESS TAB 400MG .....	98
<b>insulin nph isophane &amp; reg (human)</b>		ISIBLOOM	
see NOVOLIN INJ 70/30 .....	71	see Desogestrel & Ethinyl Estradiol Tab 0.15	
see NOVOLIN INJ 70/30 FP .....	71	mg-30 mcg .....	109
<b>insulin pen needle</b>		<b>isoniazid syrup 50 mg/5ml</b> .....	83
see BD INSULIN PEN NEEDLES - OTC .....	140	<b>isoniazid tab 100 mg</b> .....	83
see EMBECTA INSULIN PEN NEEDLES - OTC	140	<b>isoniazid tab 300 mg</b> .....	83
<b>insulin regular (human)</b>		<b>isosorbide dinitrate tab 10 mg</b> .....	53
see AFREZZA POW 12 UNIT .....	71	<b>isosorbide dinitrate tab 20 mg</b> .....	53
see AFREZZA POW 4-8 UNIT .....	71	<b>isosorbide dinitrate tab 30 mg</b> .....	53
see AFREZZA POW 4-8-12 .....	71	<b>isosorbide dinitrate tab 5 mg</b> .....	53
see AFREZZA POW 4UNIT .....	71	<b>isosorbide dinitrate-hydralazine hcl tab 20-37.5</b>	
see AFREZZA POW 8 UNIT .....	71	<b>mg</b> .....	105
see AFREZZA POW 8-12UNIT .....	71	<b>isosorbide mononitrate tab er 24hr 120 mg</b> ....	53
see HUMULIN R INJ U-500KWP .....	71	<b>isosorbide mononitrate tab er 24hr 30 mg</b> .....	53
see NOVOLIN R INJ 100 UNIT .....	71	<b>isosorbide mononitrate tab er 24hr 60 mg</b> .....	53
see NOVOLIN R INJ U-100 .....	71	<b>isotretinoin cap 10 mg</b> .....	120
<b>insulin syringe/needle u-100</b>		Isotretinoin Cap 10 mg .....	120
see BD INSULIN SYRINGE - RX .....	140	<b>isotretinoin cap 20 mg</b> .....	120
see EMBECTA INSULIN SYRINGE - OTC .....	140	Isotretinoin Cap 20 mg .....	120
<b>insulin syringe/needle u-500</b>		<b>isotretinoin cap 30 mg</b> .....	120
see EMBECTA INSULIN SYRINGE - RX .....	140	Isotretinoin Cap 30 mg .....	120
<b>insulin syringes (disposable)</b>		<b>isotretinoin cap 40 mg</b> .....	120
see BD INSULIN SYRINGE - OTC .....	140	Isotretinoin Cap 40 mg .....	120
INTRAROSA SUP 6.5MG .....	164	<b>isradipine cap 2.5 mg</b> .....	104
INTROVALE		<b>isradipine cap 5 mg</b> .....	104
see Levonorgestrel & Ethinyl Estradiol (91-Day)		<b>itraconazole cap 100 mg</b> .....	74
Tab 0.15-0.03 mg .....	110	<b>itraconazole oral soln 10 mg/ml</b> .....	74
<b>ipratropium bromide inhal soln 0.02%</b> .....	56	<b>ivabradine hcl tab 5 mg (base equiv)</b> .....	107
<b>ipratropium bromide nasal soln 0.03% (21</b>		<b>ivabradine hcl tab 7.5 mg (base equiv)</b> .....	107
<b>mcg/spray)</b> .....	148	<b>ivacaftor</b>	
<b>ipratropium bromide nasal soln 0.06% (42</b>		see KALYDECO PAK 25MG .....	159
<b>mcg/spray)</b> .....	148	see KALYDECO PAK 50MG .....	159
<b>ipratropium-albuterol nebu soln 0.5-2.5(3)</b>		see KALYDECO PAK 75MG .....	159
<b>mg/3ml</b> .....	58	see KALYDECO TAB 150MG .....	159
IQIRVO TAB 80MG .....	134	<b>ivermectin cream 1%</b> .....	126
<b>irbesartan tab 150 mg</b> .....	78	<b>ivermectin tab 3 mg</b> .....	52
<b>irbesartan tab 300 mg</b> .....	78	<b>ivermectin tab 6 mg</b> .....	52
<b>irbesartan tab 75 mg</b> .....	78	<b>ixazomib citrate</b>	
<b>irbesartan-hydrochlorothiazide tab 150-12.5 mg</b>		see NINLARO CAP 2.3MG .....	89
.....	81	see NINLARO CAP 3MG .....	89
<b>irbesartan-hydrochlorothiazide tab 300-12.5 mg</b>		see NINLARO CAP 4MG .....	89
.....	81	<b>J</b>	
ISENTRESS CHW 100MG .....	98	JAIMIESS	
ISENTRESS CHW 25MG .....	98	see Levonorg-Eth Est Tab 0.15-0.03mg(84) &	
ISENTRESS HD TAB 600MG .....	98	Eth Est Tab 0.01mg(7) .....	110

JAKAFI TAB 10MG .....	88	JUNEL 1.5/30	
JAKAFI TAB 15MG .....	88	see Norethindrone Ace & Ethinyl Estradiol Tab	
JAKAFI TAB 20MG .....	88	1.5 mg-30 mcg.....	113
JAKAFI TAB 25MG .....	88	JUNEL 1/20	
JAKAFI TAB 5MG .....	88	see Norethindrone Ace & Ethinyl Estradiol Tab	
JANTOVEN		1 mg-20 mcg.....	113
see Warfarin Sodium Tab 1 mg .....	59	JUNEL FE 1.5/30	
see Warfarin Sodium Tab 10 mg .....	59	see Norethindrone Ace & Ethinyl Estradiol-Fe	
see Warfarin Sodium Tab 2 mg .....	59	Tab 1.5 mg-30 mcg.....	114
see Warfarin Sodium Tab 2.5 mg .....	59	JUNEL FE 1/20	
see Warfarin Sodium Tab 3 mg .....	59	see Norethindrone Ace & Ethinyl Estradiol-Fe	
see Warfarin Sodium Tab 4 mg .....	59	Tab 1 mg-20 mcg.....	113
see Warfarin Sodium Tab 5 mg .....	59	JUNEL FE 24	
see Warfarin Sodium Tab 6 mg .....	59	see Norethindrone Ace-Ethinyl Estradiol-Fe	
see Warfarin Sodium Tab 7.5 mg .....	59	Tab 1 mg-20 mcg (24) .....	114
JARDIANCE TAB 10MG .....	72	<b>K</b>	
JARDIANCE TAB 25MG .....	72	KAITLIB FE	
JASMIEL		see Norethindrone & Ethinyl Estradiol-Fe	
see Drospirenone-Ethinyl Estradiol Tab 3-0.02		Chew Tab 0.8 mg-25 mcg .....	112
mg.....	109	KALLIGA	
JAVYGTOR		see Desogestrel & Ethinyl Estradiol Tab 0.15	
see Sapropterin Dihydrochloride Powder		mg-30 mcg.....	109
Packet 100 mg .....	129	KALYDECO PAK 25MG .....	159
see Sapropterin Dihydrochloride Powder		KALYDECO PAK 50MG .....	159
Packet 500 mg .....	129	KALYDECO PAK 75MG .....	159
see Sapropterin Dihydrochloride Tab 100 mg		KALYDECO TAB 150MG .....	159
.....	130	KARIVA	
JAYTHARI		see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
see Deflazacort Susp 22.75 mg/ml.....	117	0.02/0.01 mg(21/5).....	108
see Deflazacort Tab 18 mg .....	117	KELNOR 1/35	
see Deflazacort Tab 30 mg .....	117	see Ethynodiol Diacetate & Ethinyl Estradiol	
see Deflazacort Tab 36 mg .....	117	Tab 1 mg-35 mcg.....	109
see Deflazacort Tab 6 mg.....	117	KERENDIA TAB 10MG .....	130
JENCYCLA		KERENDIA TAB 20MG .....	130
see Norethindrone Tab 0.35 mg .....	116	KERENDIA TAB 40MG .....	130
JINTELI		<b>ketoconazole cream 2%</b> .....	122
see Norethindrone Acetate-Ethinyl Estradiol		<b>ketoconazole shampoo 2%</b> .....	122
Tab 1 mg-5 mcg .....	131	<b>ketoconazole tab 200 mg</b> .....	74
JOLESSA		<b>ketorolac tromethamine ophth soln 0.4%</b> .....	151
see Levonorgestrel & Ethinyl Estradiol (91-Day)		<b>ketorolac tromethamine ophth soln 0.5%</b> .....	151
Tab 0.15-0.03 mg .....	110	<b>ketorolac tromethamine tab 10 mg</b> .....	40
JOYEAUX		KIONEX	
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1		see Sodium Polystyrene Sulfonate Susp 15	
mg-20 mcg (21) .....	111	gm/60ml .....	146
JULEBER		KISQALI TAB 200DOSE.....	88
see Desogestrel & Ethinyl Estradiol Tab 0.15		KISQALI TAB 400DOSE.....	88
mg-30 mcg .....	109	KISQALI TAB 600DOSE.....	88

KLAYESTA	
see Nystatin Topical Powder 100000 unit/gm	
.....	122
KLOR-CON	
see Potassium Chloride Powder Packet 20 meq	
.....	144
KLOR-CON 10	
see Potassium Chloride Tab Er 10 meq	144
KLOR-CON M10	
see Potassium Chloride Microencapsulated	
Crys Er Tab 10 meq	144
KLOR-CON M15	
see Potassium Chloride Microencapsulated	
Crys Er Tab 15 meq	144
KLOR-CON M20	
see Potassium Chloride Microencapsulated	
Crys Er Tab 20 meq	144
KLS QUIT2	
see Nicotine Polacrilex Gum 2 mg	156
see Nicotine Polacrilex Lozenge 2 mg	157
KLS QUIT4	
see Nicotine Polacrilex Gum 4 mg	157
see Nicotine Polacrilex Lozenge 4 mg	157
KOSELUGO CAP 10MG	88
KOSELUGO CAP 25MG	88
KOURZEQ	
see Triamcinolone Acetonide Dental Paste	
0.1%.....	146
KP FOLIC ACID	
see Folic Acid Tab 800 mcg	137
KRAZATI TAB 200MG	88
KRISTALOSE	
see Lactulose Oral Crystal Packet 10 gm	139
see Lactulose Oral Crystal Packet 20 gm	139
KURVELO	
see Levonorgestrel & Ethinyl Estradiol Tab	
0.15 mg-30 mcg.....	111
KYMBEE	
see Deflazacort Tab 18 mg	117
see Deflazacort Tab 30 mg	117
see Deflazacort Tab 36 mg	117
see Deflazacort Tab 6 mg	117
<b>L</b>	
<b>labetalol hcl tab 100 mg</b>	101
<b>labetalol hcl tab 200 mg</b>	101
<b>labetalol hcl tab 300 mg</b>	101
<b>labetalol hcl tab 400 mg</b>	101
<b>lacosamide oral solution 10 mg/ml</b>	61
<b>lacosamide tab 100 mg</b>	61
<b>lacosamide tab 150 mg</b>	61
<b>lacosamide tab 200 mg</b>	61
<b>lacosamide tab 50 mg</b>	61
<b>lactic acid (ammonium lactate) cream 12%</b>	125
<b>lactic acid (ammonium lactate) lotion 12%</b>	125
<b>lactic acid-citric acid-potassium bitartrate</b>	
see PHEXX GEL.....	164
<b>lactulose (encephalopathy) solution 10</b>	
<b>gm/15ml</b>	133
Lactulose (Encephalopathy) Solution 10 gm/15ml	134
<b>lactulose oral crystal packet 10 gm</b>	139
Lactulose Oral Crystal Packet 10 gm	139
<b>lactulose oral crystal packet 20 gm</b>	139
Lactulose Oral Crystal Packet 20 gm	139
<b>lactulose solution 10 gm/15ml</b>	139
Lactulose Solution 10 gm/15ml	139
<b>lamivudine oral soln 10 mg/ml</b>	98
<b>lamivudine tab 100 mg (hbv)</b>	100
<b>lamivudine tab 150 mg</b>	98
<b>lamivudine tab 300 mg</b>	98
<b>lamivudine-tenofovir disoproxil fumarate</b>	
see CIMDUO TAB 300-300.....	97
<b>lamivudine-zidovudine tab 150-300 mg</b>	98
<b>lamotrigine orally disintegrating tab 100 mg</b>	61
<b>lamotrigine orally disintegrating tab 200 mg</b>	61
<b>lamotrigine orally disintegrating tab 25 mg</b>	61
<b>lamotrigine orally disintegrating tab 50 mg</b>	61
<b>lamotrigine tab 100 mg</b>	62
Lamotrigine Tab 100 mg	62
<b>lamotrigine tab 150 mg</b>	62
Lamotrigine Tab 150 mg	62
<b>lamotrigine tab 200 mg</b>	62
Lamotrigine Tab 200 mg	62
<b>lamotrigine tab 25 mg</b>	61
Lamotrigine Tab 25 mg	61
<b>lamotrigine tab 25 mg (42) &amp; 100 mg (7) starter</b>	
<b>kit</b>	61
Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter	
Kit	61
<b>lamotrigine tab 35 x 25 mg starter kit</b>	61
Lamotrigine Tab 35 X 25 mg Starter Kit	62
<b>lamotrigine tab 84 x 25 mg &amp; 14 x 100 mg</b>	
<b>starter kit</b>	62

Lamotrigine Tab 84 X 25 mg & 14 X 100 mg	see HARVONI PAK .....	99
Starter Kit .....	see HARVONI PAK 45-200MG .....	99
<b>lamotrigine tab chewable dispersible 25 mg</b> ...	see HARVONI TAB 45-200MG .....	99
<b>lamotrigine tab chewable dispersible 5 mg</b> .....	see HARVONI TAB 90-400MG .....	100
<b>lamotrigine tab disint 21 x 25 mg &amp; 7 x 50 mg</b>	<b>leflunomide tab 10 mg</b> .....	41
<b>titration kit</b> .....	<b>leflunomide tab 20 mg</b> .....	41
<b>lamotrigine tab disint 25 (14) &amp; 50 mg (14) &amp;</b>	<b>lenacapavir sodium</b>	
<b>100 mg (7) kit</b> .....	see YEZTUGO TAB 300MG .....	99
<b>lamotrigine tab disint 42 x 50mg &amp; 14 x 100mg</b>	<b>lenalidomide cap 10 mg</b> .....	145
<b>titration kit</b> .....	<b>lenalidomide cap 15 mg</b> .....	145
<b>lamotrigine tab er 24hr 100 mg</b> .....	<b>lenalidomide cap 20 mg</b> .....	145
<b>lamotrigine tab er 24hr 200 mg</b> .....	<b>lenalidomide cap 25 mg</b> .....	145
<b>lamotrigine tab er 24hr 25 mg</b> .....	<b>lenalidomide cap 5 mg</b> .....	144
<b>lamotrigine tab er 24hr 250 mg</b> .....	<b>lenalidomide caps 2.5 mg</b> .....	145
<b>lamotrigine tab er 24hr 300 mg</b> .....	<b>lenvatinib mesylate</b>	
<b>lamotrigine tab er 24hr 50 mg</b> .....	see LENVIMA CAP 10 MG .....	84
<b>lansoprazole cap delayed release 15 mg</b> .....	see LENVIMA CAP 12MG .....	84
<b>lansoprazole cap delayed release 30 mg</b> .....	see LENVIMA CAP 14 MG .....	84
LANTUS INJ 100/ML.....	see LENVIMA CAP 18 MG .....	84
LANTUS SOLOS INJ 100/ML .....	see LENVIMA CAP 20 MG .....	84
<b>lapatinib ditosylate tab 250 mg (base equiv)</b> ..	see LENVIMA CAP 24 MG .....	84
LARIN 1.5/30	see LENVIMA CAP 4MG .....	84
see Norethindrone Ace & Ethinyl Estradiol Tab	see LENVIMA CAP 8 MG .....	84
1.5 mg-30 mcg.....	LENVIMA CAP 10 MG .....	84
LARIN 1/20	LENVIMA CAP 12MG .....	84
see Norethindrone Ace & Ethinyl Estradiol Tab	LENVIMA CAP 14 MG .....	84
1 mg-20 mcg .....	LENVIMA CAP 18 MG .....	84
LARIN 24 FE	LENVIMA CAP 20 MG .....	84
see Norethindrone Ace-Ethinyl Estradiol-Fe	LENVIMA CAP 24 MG .....	84
Tab 1 mg-20 mcg (24) .....	LENVIMA CAP 4MG .....	84
LARIN FE 1.5/30	LENVIMA CAP 8 MG .....	84
see Norethindrone Ace & Ethinyl Estradiol-Fe	LESSINA	
Tab 1.5 mg-30 mcg.....	see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
LARIN FE 1/20	mg-20 mcg.....	111
see Norethindrone Ace & Ethinyl Estradiol-Fe	<b>letrozole tab 2.5 mg</b> .....	85
Tab 1 mg-20 mcg.....	<b>leucovorin calcium tab 10 mg</b> .....	91
<b>larotrectinib sulfate</b>	<b>leucovorin calcium tab 15 mg</b> .....	91
see VITRAKVI CAP 100MG .....	<b>leucovorin calcium tab 25 mg</b> .....	91
see VITRAKVI CAP 25MG.....	<b>leucovorin calcium tab 5 mg</b> .....	91
see VITRAKVI SOL 20MG/ML .....	Leucovorin Calcium Tab 5 mg.....	91
<b>lasmiditan succinate</b>	<b>levalbuterol hcl soln nebu 0.31 mg/3ml (base</b>	
see REYVOW TAB 100MG .....	<b>equiv)</b> .....	58
see REYVOW TAB 50MG .....	<b>levalbuterol hcl soln nebu 0.63 mg/3ml (base</b>	
<b>latanoprost ophth soln 0.005%</b> .....	<b>equiv)</b> .....	58
LEDERLE LEUCOVORIN	<b>levalbuterol hcl soln nebu 1.25 mg/3ml (base</b>	
see Leucovorin Calcium Tab 5 mg.....	<b>equiv)</b> .....	58
<b>ledipasvir-sofosbuvir</b>		

<b>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</b> .....	58	<b>levonorgestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</b> .....	111
<b>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</b> .....	58	Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg.....	111
<b>levamlodipine maleate tab 2.5 mg</b> .....	104	Levonorgestrel Tab 1.5 mg .....	116
<b>levamlodipine maleate tab 5 mg</b> .....	104	<b>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</b> .....	111
<b>levetiracetam oral soln 100 mg/ml</b> .....	62	Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg .....	111
<b>levetiracetam tab 1000 mg</b> .....	62	<b>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</b> .....	111
<b>levetiracetam tab 250 mg</b> .....	62	Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg .....	111
<b>levetiracetam tab 500 mg</b> .....	62	<b>levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)</b> .....	111
Levetiracetam Tab 500 mg .....	62	Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21) .....	111
<b>levetiracetam tab 750 mg</b> .....	62	<b>levonorg-eth est tab 0.1-0.02mg(84) &amp; eth est tab 0.01mg(7)</b> .....	110
<b>levetiracetam tab disintegrating soluble 250 mg</b> .....	62	Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7) .....	110
<b>levetiracetam tab disintegrating soluble 500 mg</b> .....	62	Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) .....	110
<b>levetiracetam tab er 24hr 500 mg</b> .....	62	LEVO-T	
<b>levetiracetam tab er 24hr 750 mg</b> .....	62	see Levothyroxine Sodium Tab 100 mcg .....	160
<b>levobunolol hcl ophth soln 0.5%</b> .....	148	see Levothyroxine Sodium Tab 112 mcg .....	160
<b>levocarnitine oral soln 1 gm/10ml (10%)</b> .....	129	see Levothyroxine Sodium Tab 125 mcg .....	160
<b>levocarnitine tab 330 mg</b> .....	129	see Levothyroxine Sodium Tab 137 mcg .....	160
<b>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</b> .....	74	see Levothyroxine Sodium Tab 150 mcg .....	160
<b>levocetirizine dihydrochloride tab 5 mg</b> .....	74	see Levothyroxine Sodium Tab 175 mcg .....	161
<b>levodopa</b>		see Levothyroxine Sodium Tab 200 mcg .....	161
see INBRIJA CAP 42MG .....	92	see Levothyroxine Sodium Tab 25 mcg .....	160
<b>levofloxacin ophth soln 0.5%</b> .....	149	see Levothyroxine Sodium Tab 300 mcg .....	161
<b>levofloxacin ophth soln 1.5%</b> .....	149	see Levothyroxine Sodium Tab 50 mcg .....	160
<b>levofloxacin oral soln 25 mg/ml</b> .....	132	see Levothyroxine Sodium Tab 75 mcg .....	160
<b>levofloxacin tab 250 mg</b> .....	132	see Levothyroxine Sodium Tab 88 mcg .....	160
<b>levofloxacin tab 500 mg</b> .....	133	<b>levothyroxine sodium</b>	
<b>levofloxacin tab 750 mg</b> .....	133	see SYNTHROID TAB 100MCG .....	161
LEVONEST		see SYNTHROID TAB 112MCG .....	161
see Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg.....	111	see SYNTHROID TAB 125MCG .....	161
<b>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &amp;eth est 0.01 mg</b> .....	110	see SYNTHROID TAB 137MCG .....	161
Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg .....	110	see SYNTHROID TAB 150MCG .....	161
<b>levonorgestrel &amp; ethinyl estradiol (91-day) tab 0.15-0.03 mg</b> .....	110	see SYNTHROID TAB 175MCG .....	161
Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg.....	110	see SYNTHROID TAB 200MCG .....	161
<b>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-20 mcg</b> .....	110	see SYNTHROID TAB 25MCG .....	161
Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg .....	110, 111	see SYNTHROID TAB 300MCG .....	161
		see SYNTHROID TAB 50MCG .....	161

see SYNTHROID TAB 75MCG .....	161	see LINZESS CAP 145MCG .....	134
see SYNTHROID TAB 88MCG .....	161	see LINZESS CAP 290MCG .....	134
<b>levothyroxine sodium tab 100 mcg</b> .....	160	see LINZESS CAP 72MCG .....	134
Levothyroxine Sodium Tab 100 mcg .....	160	<b>linezolid for susp 100 mg/5ml</b> .....	53
<b>levothyroxine sodium tab 112 mcg</b> .....	160	<b>linezolid tab 600 mg</b> .....	53
Levothyroxine Sodium Tab 112 mcg .....	160	LINZESS CAP 145MCG .....	134
<b>levothyroxine sodium tab 125 mcg</b> .....	160	LINZESS CAP 290MCG .....	134
Levothyroxine Sodium Tab 125 mcg .....	160	LINZESS CAP 72MCG .....	134
<b>levothyroxine sodium tab 137 mcg</b> .....	160	LIOMNY	
Levothyroxine Sodium Tab 137 mcg .....	160	see Liothyronine Sodium Tab 25 mcg .....	161
<b>levothyroxine sodium tab 150 mcg</b> .....	160	see Liothyronine Sodium Tab 5 mcg .....	161
Levothyroxine Sodium Tab 150 mcg .....	160, 161	see Liothyronine Sodium Tab 50 mcg .....	161
<b>levothyroxine sodium tab 175 mcg</b> .....	161	<b>liothyronine sodium tab 25 mcg</b> .....	161
Levothyroxine Sodium Tab 175 mcg .....	161	Liothyronine Sodium Tab 25 mcg .....	161
<b>levothyroxine sodium tab 200 mcg</b> .....	161	<b>liothyronine sodium tab 5 mcg</b> .....	161
Levothyroxine Sodium Tab 200 mcg .....	161	Liothyronine Sodium Tab 5 mcg .....	161
<b>levothyroxine sodium tab 25 mcg</b> .....	160	<b>liothyronine sodium tab 50 mcg</b> .....	161
Levothyroxine Sodium Tab 25 mcg .....	160	Liothyronine Sodium Tab 50 mcg .....	161
<b>levothyroxine sodium tab 300 mcg</b> .....	161	<b>liraglutide soln pen-injector 18 mg/3ml (6</b>	
Levothyroxine Sodium Tab 300 mcg .....	161	<b>mg/ml)</b> .....	70
<b>levothyroxine sodium tab 50 mcg</b> .....	160	<b>lisdexamphetamine dimesylate cap 10 mg</b> .....	30
Levothyroxine Sodium Tab 50 mcg .....	160	<b>lisdexamphetamine dimesylate cap 20 mg</b> .....	30
<b>levothyroxine sodium tab 75 mcg</b> .....	160	<b>lisdexamphetamine dimesylate cap 30 mg</b> .....	30
Levothyroxine Sodium Tab 75 mcg .....	160	<b>lisdexamphetamine dimesylate cap 40 mg</b> .....	30
<b>levothyroxine sodium tab 88 mcg</b> .....	160	<b>lisdexamphetamine dimesylate cap 50 mg</b> .....	30
Levothyroxine Sodium Tab 88 mcg .....	160	<b>lisdexamphetamine dimesylate cap 60 mg</b> .....	30
LEVOXYL		<b>lisdexamphetamine dimesylate cap 70 mg</b> .....	30
see Levothyroxine Sodium Tab 100 mcg .....	160	<b>lisdexamphetamine dimesylate chew tab 10 mg</b> .....	30
see Levothyroxine Sodium Tab 112 mcg .....	160	<b>lisdexamphetamine dimesylate chew tab 20 mg</b> .....	30
see Levothyroxine Sodium Tab 125 mcg .....	160	<b>lisdexamphetamine dimesylate chew tab 30 mg</b> .....	30
see Levothyroxine Sodium Tab 137 mcg .....	160	<b>lisdexamphetamine dimesylate chew tab 40 mg</b> .....	31
see Levothyroxine Sodium Tab 150 mcg .....	160	<b>lisdexamphetamine dimesylate chew tab 50 mg</b> .....	31
see Levothyroxine Sodium Tab 175 mcg .....	161	<b>lisdexamphetamine dimesylate chew tab 60 mg</b> .....	31
see Levothyroxine Sodium Tab 200 mcg .....	161	<b>lisinopril &amp; hydrochlorothiazide tab 10-12.5 mg</b>	
see Levothyroxine Sodium Tab 25 mcg .....	160	.....	81
see Levothyroxine Sodium Tab 50 mcg .....	160	<b>lisinopril &amp; hydrochlorothiazide tab 20-12.5 mg</b>	
see Levothyroxine Sodium Tab 75 mcg .....	160	.....	81
see Levothyroxine Sodium Tab 88 mcg .....	160	<b>lisinopril &amp; hydrochlorothiazide tab 20-25 mg</b> .....	81
<b>lidocaine hcl soln 4%</b> .....	125	<b>lisinopril tab 10 mg</b> .....	78
<b>lidocaine hcl viscous soln 2%</b> .....	146	<b>lisinopril tab 2.5 mg</b> .....	78
<b>lidocaine oint 5%</b> .....	125	<b>lisinopril tab 20 mg</b> .....	78
<b>lidocaine patch 5%</b> .....	125	<b>lisinopril tab 30 mg</b> .....	78
Lidocaine Patch 5% .....	125	<b>lisinopril tab 40 mg</b> .....	78
<b>lidocaine-prilocaine cream 2.5-2.5%</b> .....	125	<b>lisinopril tab 5 mg</b> .....	78
LIDOCAN		LITFULO CAP 50MG .....	125
see Lidocaine Patch 5% .....	125	<b>lithium carbonate cap 150 mg</b> .....	94
<b>linaclotide</b>		<b>lithium carbonate cap 300 mg</b> .....	94

<i>lithium carbonate cap 600 mg</i> .....	94	<i>losartan potassium &amp; hydrochlorothiazide tab</i>	
<i>lithium carbonate tab 300 mg</i> .....	94	<b>100-25 mg</b> .....	81
<i>lithium carbonate tab er 300 mg</i> .....	94	<i>losartan potassium &amp; hydrochlorothiazide tab</i>	
<i>lithium carbonate tab er 450 mg</i> .....	94	<b>50-12.5 mg</b> .....	81
<i>lithium oral solution 8 meq/5ml</i> .....	94	<i>losartan potassium tab 100 mg</i> .....	78
LO LOESTRIN TAB 1-10-10.....	111	<i>losartan potassium tab 25 mg</i> .....	78
LOESTRIN 1.5/30-21		<i>losartan potassium tab 50 mg</i> .....	78
see Norethindrone Ace & Ethinyl Estradiol Tab		<i>loteprednol etabonate ophth gel 0.5%</i> .....	150
1.5 mg-30 mcg.....	113	<i>loteprednol etabonate ophth susp 0.2%</i> .....	150
LOESTRIN 1/20-21		<i>loteprednol etabonate ophth susp 0.5%</i> .....	150
see Norethindrone Ace & Ethinyl Estradiol Tab		<i>loteprednol etabonate-tobramycin ophth susp</i>	
1 mg-20 mcg.....	113	<b>0.5-0.3%</b> .....	150
LOESTRIN FE 1.5/30		<i>lotilaner</i>	
see Norethindrone Ace & Ethinyl Estradiol-Fe		see XDEMVY DRO 0.25%.....	149
Tab 1.5 mg-30 mcg.....	114	<i>lovastatin tab 10 mg</i> .....	76
LOESTRIN FE 1/20		<i>lovastatin tab 20 mg</i> .....	76
see Norethindrone Ace & Ethinyl Estradiol-Fe		<i>lovastatin tab 40 mg</i> .....	76
Tab 1 mg-20 mcg.....	113	LOW-OGESTREL	
<i>lofexidine hcl tab 0.18 mg (base equivalent)</i> .	152	see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-	
LOJAIMIESS		30 mcg.....	116
see Levonorg-Eth Est Tab 0.1-0.02mg(84) &		<i>loxapine succinate cap 10 mg</i> .....	95
Eth Est Tab 0.01mg(7).....	110	<i>loxapine succinate cap 25 mg</i> .....	95
LOMAIRA		<i>loxapine succinate cap 5 mg</i> .....	95
see Phentermine Hcl Tab 8 mg.....	31	<i>loxapine succinate cap 50 mg</i> .....	95
<i>lomustine</i>		LO-ZUMANDIMINE	
see GLEOSTINE CAP 100MG.....	83	see Drospirenone-Ethinyl Estradiol Tab 3-0.02	
see GLEOSTINE CAP 10MG.....	83	mg.....	109
see GLEOSTINE CAP 40MG.....	83	<i>lubiprostone cap 24 mcg</i> .....	133
<i>lomustine cap 10 mg</i> .....	83	<i>lubiprostone cap 8 mcg</i> .....	133
<i>lomustine cap 100 mg</i> .....	83	LUIZZA 1.5/30	
<i>lomustine cap 40 mg</i> .....	83	see Norethindrone Ace & Ethinyl Estradiol Tab	
LONSURF TAB 15-6.14.....	86	1.5 mg-30 mcg.....	113
LONSURF TAB 20-8.19.....	86	LUIZZA 1/20	
<i>loperamide hcl cap 2 mg</i> .....	72	see Norethindrone Ace & Ethinyl Estradiol Tab	
<i>lopinavir-ritonavir tab 100-25 mg</i> .....	98	1 mg-20 mcg.....	113
<i>lopinavir-ritonavir tab 200-50 mg</i> .....	98	LUMAKRAS TAB 120MG.....	88
LOPRESSOR TAB 12.5MG.....	101	LUMAKRAS TAB 240MG.....	89
<i>lorazepam conc 2 mg/ml</i> .....	55	LUMAKRAS TAB 320MG.....	89
<i>lorazepam tab 0.5 mg</i> .....	55	LUMRYZ PAK 6GM.....	153
<i>lorazepam tab 1 mg</i> .....	55	LUMRYZ PAK 7.5GM.....	153
<i>lorazepam tab 2 mg</i> .....	55	LUMRYZ PAK 9GM.....	153
LORYNA		LUMRYZ PAK STARTER.....	153
see Drospirenone-Ethinyl Estradiol Tab 3-0.02		LUMRYZ PKG 4.5GM.....	153
mg.....	109	<i>lurasidone hcl tab 120 mg</i> .....	94
<i>losartan potassium &amp; hydrochlorothiazide tab</i>		<i>lurasidone hcl tab 20 mg</i> .....	94
<b>100-12.5 mg</b> .....	81	<i>lurasidone hcl tab 40 mg</i> .....	94
		<i>lurasidone hcl tab 60 mg</i> .....	94

<b><i>lurasidone hcl tab 80 mg</i></b> .....	94	MEDROL TAB 2MG .....	118
LUTERA		<b><i>medroxyprogesterone acetate tab 10 mg</i></b> ....	152
see Levonorgestrel & Ethinyl Estradiol Tab 0.1		<b><i>medroxyprogesterone acetate tab 2.5 mg</i></b> ....	152
mg-20 mcg.....	111	<b><i>medroxyprogesterone acetate tab 5 mg</i></b> .....	152
LYLEQ		<b><i>mefenamic acid cap 250 mg</i></b> .....	40
see Norethindrone Tab 0.35 mg .....	116	<b><i>mefloquine hcl tab 250 mg</i></b> .....	82
LYLLANA		<b><i>megestrol acetate susp 40 mg/ml</i></b> .....	85
see Estradiol Td Patch Twice Weekly 0.025		<b><i>megestrol acetate susp 625 mg/5ml</i></b> .....	152
mg/24hr .....	132	<b><i>megestrol acetate tab 20 mg</i></b> .....	85
see Estradiol Td Patch Twice Weekly 0.0375		<b><i>megestrol acetate tab 40 mg</i></b> .....	85
mg/24hr .....	132	MEKINIST SOL 0.05/ML .....	89
see Estradiol Td Patch Twice Weekly 0.05		MEKINIST TAB 0.5MG.....	89
mg/24hr .....	132	MEKINIST TAB 2MG.....	89
see Estradiol Td Patch Twice Weekly 0.075		MEKTOVI TAB 15MG .....	89
mg/24hr .....	132	MELEYA	
see Estradiol Td Patch Twice Weekly 0.1		see Norethindrone Tab 0.35 mg .....	116
mg/24hr .....	132	<b><i>meloxicam susp 7.5 mg/5ml</i></b> .....	40
LYNPARZA TAB 100MG .....	89	<b><i>meloxicam tab 15 mg</i></b> .....	40
LYNPARZA TAB 150MG .....	89	<b><i>meloxicam tab 7.5 mg</i></b> .....	40
LYZA		<b><i>memantine hcl cap er 24hr 14 mg</i></b> .....	153
see Norethindrone Tab 0.35 mg .....	116	<b><i>memantine hcl cap er 24hr 21 mg</i></b> .....	153
<b>M</b>		<b><i>memantine hcl cap er 24hr 28 mg</i></b> .....	153
<b><i>macitentan</i></b>		<b><i>memantine hcl cap er 24hr 7 mg</i></b> .....	153
see OPSUMIT TAB 10MG .....	106	<b><i>memantine hcl oral solution 2 mg/ml</i></b> .....	153
<b><i>macitentan-tadalafil</i></b>		<b><i>memantine hcl tab 10 mg</i></b> .....	153
see OPSYNVI TAB 10-20MG .....	105	<b><i>memantine hcl tab 28 x 5 mg &amp; 21 x 10 mg</i></b>	
see OPSYNVI TAB 10-40MG .....	105	<b><i>titration pack</i></b> .....	153
<b><i>malathion lotion 0.5%</i></b> .....	126	<b><i>memantine hcl tab 5 mg</i></b> .....	153
MALE MIS CONDOM .....	140	<b><i>memantine hcl-donepezil hcl</i></b>	
<b><i>maraviroc tab 150 mg</i></b> .....	98	see NAMZARIC CAP 14-10MG .....	154
<b><i>maraviroc tab 300 mg</i></b> .....	98	see NAMZARIC CAP 21-10MG .....	154
MARLISSA		see NAMZARIC CAP 28-10MG .....	154
see Levonorgestrel & Ethinyl Estradiol Tab		see NAMZARIC CAP 7-10MG .....	153
0.15 mg-30 mcg.....	111	<b><i>memantine hcl-donepezil hcl cap er 24hr 14-10</i></b>	
MAVYRET PAK 50-20MG .....	100	<b><i>mg</i></b> .....	153
MAVYRET TAB 100-40MG .....	100	<b><i>memantine hcl-donepezil hcl cap er 24hr 21-10</i></b>	
MAYZENT PAK STARTER .....	155	<b><i>mg</i></b> .....	153
MAYZENT TAB 0.25MG .....	155	<b><i>memantine hcl-donepezil hcl cap er 24hr 28-10</i></b>	
MAYZENT TAB 1MG.....	155	<b><i>mg</i></b> .....	153
MAYZENT TAB 2MG.....	155	<b><i>meperidine hcl oral soln 50 mg/5ml</i></b> .....	43
<b><i>mebendazole</i></b>		<b><i>meperidine hcl tab 50 mg</i></b> .....	43
see EMVERM CHW 100MG.....	52	<b><i>meprobamate tab 200 mg</i></b> .....	54
<b><i>meclizine hcl tab 12.5 mg</i></b> .....	73	<b><i>meprobamate tab 400 mg</i></b> .....	54
<b><i>meclizine hcl tab 25 mg</i></b> .....	73	<b><i>mercaptopurine susp 2000 mg/100ml (20</i></b>	
<b><i>meclizine hcl tab 50 mg</i></b> .....	73	<b><i>mg/ml)</i></b> .....	83
<b><i>meclofenamate sodium cap 100 mg</i></b> .....	40	<b><i>mercaptopurine tab 50 mg</i></b> .....	83
<b><i>meclofenamate sodium cap 50 mg</i></b> .....	40	<b><i>mesalamine cap dr 400 mg</i></b> .....	133

<b>mesalamine cap er 24hr 0.375 gm</b> .....	133	<b>methsuximide cap 300 mg</b> .....	64
<b>mesalamine cap er 500 mg</b> .....	133	<b>methyl dopa tab 250 mg</b> .....	79
<b>mesalamine enema 4 gm</b> .....	133	<b>methyl dopa tab 500 mg</b> .....	79
<b>mesalamine suppos 1000 mg</b> .....	133	<b>methylergonovine maleate tab 0.2 mg</b> .....	151
<b>mesalamine tab delayed release 1.2 gm</b> .....	133	Methylergonovine Maleate Tab 0.2 mg .....	151
<b>mesalamine tab delayed release 800 mg</b> .....	133	<b>methylphenidate hcl cap er 10 mg (cd)</b> .....	34
<b>mesna tab 400 mg</b> .....	91	<b>methylphenidate hcl cap er 20 mg (cd)</b> .....	34
<b>metaxalone tab 800 mg</b> .....	147	<b>methylphenidate hcl cap er 24hr 10 mg (la)</b> ....	34
<b>metformin hcl oral soln 500 mg/5ml</b> .....	69	<b>methylphenidate hcl cap er 24hr 10 mg (xr)</b> ....	34
<b>metformin hcl tab 1000 mg</b> .....	70	<b>methylphenidate hcl cap er 24hr 15 mg (xr)</b> ....	35
<b>metformin hcl tab 500 mg</b> .....	69	<b>methylphenidate hcl cap er 24hr 20 mg (la)</b> ....	35
<b>metformin hcl tab 625 mg</b> .....	69	<b>methylphenidate hcl cap er 24hr 20 mg (xr)</b> ....	35
<b>metformin hcl tab 750 mg</b> .....	69	<b>methylphenidate hcl cap er 24hr 30 mg (la)</b> ....	35
<b>metformin hcl tab 850 mg</b> .....	70	<b>methylphenidate hcl cap er 24hr 30 mg (xr)</b> ....	35
<b>metformin hcl tab er 24hr 500 mg</b> .....	70	<b>methylphenidate hcl cap er 24hr 40 mg (la)</b> ....	35
<b>metformin hcl tab er 24hr 750 mg</b> .....	70	<b>methylphenidate hcl cap er 24hr 40 mg (xr)</b> ....	35
<b>methadone hcl conc 10 mg/ml</b> .....	43	<b>methylphenidate hcl cap er 24hr 50 mg (xr)</b> ....	35
Methadone Hcl Conc 10 mg/ml .....	43	<b>methylphenidate hcl cap er 24hr 60 mg (la)</b> ....	35
<b>methadone hcl soln 10 mg/5ml</b> .....	43	<b>methylphenidate hcl cap er 24hr 60 mg (xr)</b> ....	35
<b>methadone hcl soln 5 mg/5ml</b> .....	43	<b>methylphenidate hcl cap er 30 mg (cd)</b> .....	35
<b>methadone hcl tab 10 mg</b> .....	43	<b>methylphenidate hcl cap er 40 mg (cd)</b> .....	36
<b>methadone hcl tab 5 mg</b> .....	43	<b>methylphenidate hcl cap er 50 mg (cd)</b> .....	36
<b>methadone hcl tab for oral susp 40 mg</b> .....	43	<b>methylphenidate hcl cap er 60 mg (cd)</b> .....	36
Methadone Hcl Tab For Oral Susp 40 mg .....	43	<b>methylphenidate hcl chew tab 10 mg</b> .....	36
METHADONE HYDROCHLORIDE I		<b>methylphenidate hcl chew tab 2.5 mg</b> .....	36
see Methadone Hcl Conc 10 mg/ml .....	43	<b>methylphenidate hcl chew tab 5 mg</b> .....	36
METHADOSE		<b>methylphenidate hcl soln 10 mg/5ml</b> .....	36
see Methadone Hcl Tab For Oral Susp 40 mg	43	<b>methylphenidate hcl soln 5 mg/5ml</b> .....	36
<b>methamphetamine hcl tab 5 mg</b> .....	31	<b>methylphenidate hcl tab 10 mg</b> .....	36
<b>methazolamide tab 25 mg</b> .....	127	<b>methylphenidate hcl tab 20 mg</b> .....	36
<b>methazolamide tab 50 mg</b> .....	127	<b>methylphenidate hcl tab 5 mg</b> .....	36
<b>methenamine hippurate tab 1 gm</b> .....	53	<b>methylphenidate hcl tab er 10 mg</b> .....	37
<b>methenamine mandelate tab 0.5 gm</b> .....	53	<b>methylphenidate hcl tab er 20 mg</b> .....	37
METHERGINE		<b>methylphenidate hcl tab er 24hr 18 mg</b> .....	37
see Methylergonovine Maleate Tab 0.2 mg	151	<b>methylphenidate hcl tab er 24hr 27 mg</b> .....	37
<b>methimazole tab 10 mg</b> .....	160	<b>methylphenidate hcl tab er 24hr 36 mg</b> .....	37
<b>methimazole tab 5 mg</b> .....	160	<b>methylphenidate hcl tab er 24hr 54 mg</b> .....	37
METHITEST		<b>methylphenidate hcl tab er osmotic release</b>	
see Methyltestosterone Oral Tab 10 mg .....	51	<b>(osm) 18 mg</b> .....	37
<b>methocarbamol tab 1000 mg</b> .....	147	<b>methylphenidate hcl tab er osmotic release</b>	
Methocarbamol Tab 1000 mg .....	147	<b>(osm) 27 mg</b> .....	37
<b>methocarbamol tab 500 mg</b> .....	147	<b>methylphenidate hcl tab er osmotic release</b>	
<b>methocarbamol tab 750 mg</b> .....	147	<b>(osm) 36 mg</b> .....	37
<b>methotrexate sodium tab 2.5 mg (base equiv)</b>	83	<b>methylphenidate hcl tab er osmotic release</b>	
<b>methoxsalen rapid cap 10 mg</b> .....	122	<b>(osm) 54 mg</b> .....	37
<b>methscopolamine bromide tab 2.5 mg</b> .....	162	<b>methylphenidate hcl tab er osmotic release</b>	
<b>methscopolamine bromide tab 5 mg</b> .....	162	<b>(osm) 72 mg</b> .....	37

<i>methylphenidate td patch 10 mg/9hr</i> .....	38	<i>metronidazole cap 375 mg</i> .....	52
<i>methylphenidate td patch 15 mg/9hr</i> .....	38	<i>metronidazole cream 0.75%</i> .....	126
<i>methylphenidate td patch 20 mg/9hr</i> .....	38	<i>metronidazole gel 0.75%</i> .....	126
<i>methylphenidate td patch 30 mg/9hr</i> .....	38	<i>metronidazole gel 1%</i> .....	126
<i>methylprednisolone</i>		<i>metronidazole lotion 0.75%</i> .....	126
see MEDROL TAB 2MG .....	118	<i>metronidazole tab 250 mg</i> .....	52
<i>methylprednisolone tab 16 mg</i> .....	118	<i>metronidazole tab 500 mg</i> .....	52
<i>methylprednisolone tab 32 mg</i> .....	118	<i>metronidazole vaginal gel 0.75%</i> .....	164
<i>methylprednisolone tab 4 mg</i> .....	118	<i>metyrosine cap 250 mg</i> .....	78
<i>methylprednisolone tab 8 mg</i> .....	118	<i>mexiletine hcl cap 150 mg</i> .....	55
<i>methylprednisolone tab therapy pack 4 mg (21)</i>		<i>mexiletine hcl cap 200 mg</i> .....	55
.....	118	<i>mexiletine hcl cap 250 mg</i> .....	55
<i>methyltestosterone cap 10 mg</i> .....	51	MIBELAS 24 FE	
Methyltestosterone Oral Tab 10 mg .....	51	see Norethindrone Ace-Eth Estradiol-Fe Chew	
<i>metoclopramide hcl orally disintegrating tab 5</i>		Tab 1 mg-20 mcg (24) .....	114
<i>mg (base eq)</i> .....	133	MICONAZOLE 3	
<i>metoclopramide hcl soln 5 mg/5ml (10</i>		see Miconazole Nitrate Vaginal Suppos 200 mg	
<i>mg/10ml) (base equiv)</i> .....	133	.....	164
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>		Miconazole Nitrate Vaginal Suppos 200 mg....	164
.....	133	MICORT HC	
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>		see Hydrocortisone Acetate Cream 2.5% ....	124
.....	133	MICROCHAMBER MIS .....	142
<i>metolazone tab 10 mg</i> .....	128	MICROGESTIN 1.5/30	
<i>metolazone tab 2.5 mg</i> .....	128	see Norethindrone Ace & Ethinyl Estradiol Tab	
<i>metolazone tab 5 mg</i> .....	128	1.5 mg-30 mcg .....	113
<i>metoprolol &amp; hydrochlorothiazide tab 100-25</i>		MICROGESTIN 1/20	
<i>mg</i> .....	81	see Norethindrone Ace & Ethinyl Estradiol Tab	
<i>metoprolol &amp; hydrochlorothiazide tab 100-50</i>		1 mg-20 mcg .....	113
<i>mg</i> .....	81	MICROGESTIN FE 1.5/30	
<i>metoprolol &amp; hydrochlorothiazide tab 50-25 mg</i>		see Norethindrone Ace & Ethinyl Estradiol-Fe	
.....	81	Tab 1.5 mg-30 mcg .....	114
<i>metoprolol succinate tab er 24hr 100 mg</i>		MICROGESTIN FE 1/20	
<i>(tartrate equiv)</i> .....	101	see Norethindrone Ace & Ethinyl Estradiol-Fe	
<i>metoprolol succinate tab er 24hr 200 mg</i>		Tab 1 mg-20 mcg .....	113
<i>(tartrate equiv)</i> .....	101	MICROSPACER MIS .....	142
<i>metoprolol succinate tab er 24hr 25 mg</i>		<i>midazolam (anticonvulsant)</i>	
<i>(tartrate equiv)</i> .....	101	see NAYZILAM SPR 5MG .....	60
<i>metoprolol succinate tab er 24hr 50 mg</i>		<i>midazolam hcl syrup 2 mg/ml (base equivalent)</i>	
<i>(tartrate equiv)</i> .....	101	.....	138
<i>metoprolol tartrate</i>		<i>midodrine hcl tab 10 mg</i> .....	165
see LOPRESSOR TAB 12.5MG .....	101	<i>midodrine hcl tab 2.5 mg</i> .....	165
<i>metoprolol tartrate tab 100 mg</i> .....	101	<i>midodrine hcl tab 5 mg</i> .....	165
<i>metoprolol tartrate tab 12.5 mg</i> .....	101	<i>midostaurin</i>	
<i>metoprolol tartrate tab 25 mg</i> .....	101	see RYDAPT CAP 25MG .....	90
<i>metoprolol tartrate tab 37.5 mg</i> .....	101	<i>mifepristone tab 200 mg</i> .....	130
<i>metoprolol tartrate tab 50 mg</i> .....	101	<i>mifepristone tab 300 mg</i> .....	70
<i>metoprolol tartrate tab 75 mg</i> .....	101	<i>migalastat hcl</i>	

see GALAFOLD CAP 123MG .....	129	<b>molindone hcl tab 25 mg</b> .....	96
<b>miglitol tab 100 mg</b> .....	68	<b>molindone hcl tab 5 mg</b> .....	96
<b>miglitol tab 25 mg</b> .....	68	<b>mometasone furoate (inhalation)</b>	
<b>miglitol tab 50 mg</b> .....	68	see ASMANEX HFA AER 100 MCG .....	56
<b>miglustat cap 100 mg</b> .....	136	see ASMANEX HFA AER 200 MCG .....	56
Miglustat Cap 100 mg .....	136	see ASMANEX HFA AER 50MCG .....	56
MILI		<b>mometasone furoate cream 0.1%</b> .....	124
see Norgestimate & Ethinyl Estradiol Tab 0.25		<b>mometasone furoate nasal susp 50 mcg/act</b>	148
mg-35 mcg .....	115	<b>mometasone furoate oint 0.1%</b> .....	124
MILOPHENE		<b>mometasone furoate solution 0.1% (lotion)</b> ..	124
see Clomiphene Citrate Tab 50 mg .....	128	MONDOXYNE NL	
<b>miltefosine</b>		see Doxycycline Monohydrate Cap 100 mg	159
see IMPAVIDO CAP 50MG .....	52	MONO-LINYAH	
MIMVEY		see Norgestimate & Ethinyl Estradiol Tab 0.25	
see Estradiol & Norethindrone Acetate Tab 1-		mg-35 mcg .....	115
0.5 mg .....	131	<b>monomethyl fumarate</b>	
<b>minocycline hcl cap 100 mg</b> .....	159	see BAFIERTAM CAP 95MG .....	154
<b>minocycline hcl cap 50 mg</b> .....	159	<b>montelukast sodium chew tab 4 mg (base equiv)</b>	
<b>minocycline hcl cap 75 mg</b> .....	159	.....	56
<b>minocycline hcl tab 100 mg</b> .....	159	<b>montelukast sodium chew tab 5 mg (base equiv)</b>	
<b>minocycline hcl tab 50 mg</b> .....	159	.....	56
<b>minocycline hcl tab 75 mg</b> .....	159	<b>montelukast sodium oral granules packet 4 mg</b>	
<b>minoxidil tab 10 mg</b> .....	82	<b>(base equiv)</b> .....	56
<b>minoxidil tab 2.5 mg</b> .....	82	<b>montelukast sodium tab 10 mg (base equiv)</b> ..	56
MINZOYA		<b>morphine sulfate beads cap er 24hr 120 mg</b> ...	44
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1		<b>morphine sulfate beads cap er 24hr 30 mg</b> .....	43
mg-20 mcg (21) .....	111	<b>morphine sulfate beads cap er 24hr 45 mg</b> .....	43
<b>mirabegron tab er 24 hr 25 mg</b> .....	163	<b>morphine sulfate beads cap er 24hr 60 mg</b> .....	43
<b>mirabegron tab er 24 hr 50 mg</b> .....	163	<b>morphine sulfate beads cap er 24hr 75 mg</b> .....	44
<b>mirdametinib</b>		<b>morphine sulfate beads cap er 24hr 90 mg</b> .....	44
see GOMEKLI CAP 1MG .....	87	<b>morphine sulfate cap er 24hr 10 mg</b> .....	44
see GOMEKLI CAP 2MG .....	87	<b>morphine sulfate cap er 24hr 100 mg</b> .....	44
see GOMEKLI TAB 1MG.....	87	<b>morphine sulfate cap er 24hr 20 mg</b> .....	44
<b>mirtazapine orally disintegrating tab 15 mg</b> ...	64	<b>morphine sulfate cap er 24hr 30 mg</b> .....	44
<b>mirtazapine orally disintegrating tab 30 mg</b> ...	64	<b>morphine sulfate cap er 24hr 50 mg</b> .....	44
<b>mirtazapine orally disintegrating tab 45 mg</b> ...	64	<b>morphine sulfate cap er 24hr 60 mg</b> .....	44
<b>mirtazapine tab 15 mg</b> .....	65	<b>morphine sulfate cap er 24hr 80 mg</b> .....	44
<b>mirtazapine tab 30 mg</b> .....	65	<b>morphine sulfate oral soln 10 mg/5ml</b> .....	44
<b>mirtazapine tab 45 mg</b> .....	65	<b>morphine sulfate oral soln 100 mg/5ml (20</b>	
<b>mirtazapine tab 7.5 mg</b> .....	64	<b>mg/ml)</b> .....	44
<b>misoprostol tab 100 mcg</b> .....	163	<b>morphine sulfate oral soln 20 mg/5ml</b> .....	44
<b>misoprostol tab 200 mcg</b> .....	163	<b>morphine sulfate tab 15 mg</b> .....	44
<b>modafinil tab 100 mg</b> .....	38	<b>morphine sulfate tab 30 mg</b> .....	44
<b>modafinil tab 200 mg</b> .....	38	<b>morphine sulfate tab er 100 mg</b> .....	44
<b>moexipril hcl tab 15 mg</b> .....	78	<b>morphine sulfate tab er 15 mg</b> .....	44
<b>moexipril hcl tab 7.5 mg</b> .....	78	<b>morphine sulfate tab er 200 mg</b> .....	45
<b>molindone hcl tab 10 mg</b> .....	96	<b>morphine sulfate tab er 30 mg</b> .....	44

<i>morphine sulfate tab er 60 mg</i> .....	44	<i>naproxen sodium tab 275 mg</i> .....	40
MOUNJARO INJ 10MG/0.5 .....	70	<i>naproxen sodium tab 550 mg</i> .....	40
MOUNJARO INJ 12.5/0.5 .....	70	<i>naproxen tab 250 mg</i> .....	40
MOUNJARO INJ 15MG/0.5 .....	70	<i>naproxen tab 375 mg</i> .....	40
MOUNJARO INJ 2.5/0.5 .....	70	<i>naproxen tab 500 mg</i> .....	40
MOUNJARO INJ 5MG/0.5 .....	70	<i>naproxen tab ec 375 mg</i> .....	40
MOUNJARO INJ 7.5/0.5 .....	70	<i>naproxen tab ec 500 mg</i> .....	40
MOVANTIK TAB 12.5MG .....	134	<i>naratriptan hcl tab 1 mg (base equiv)</i> .....	143
MOVANTIK TAB 25MG .....	134	<i>naratriptan hcl tab 2.5 mg (base equiv)</i> .....	143
<b><i>moxifloxacin hcl ophth soln 0.5% (base eq) (2</i></b>		NATAZIA TAB .....	112
<b><i>times daily)</i></b> .....	149	<b><i>nateglinide tab 120 mg</i></b> .....	72
<b><i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i></b>		<b><i>nateglinide tab 60 mg</i></b> .....	72
.....	149	NATESTO GEL 5.5MG .....	51
<b><i>moxifloxacin hcl tab 400 mg (base equiv)</i></b> .....	133	NAYZILAM SPR 5MG .....	60
MULTAQ TAB 400MG .....	55	<b><i>nebivolol hcl tab 10 mg (base equivalent)</i></b> .....	101
<b><i>mupirocin oint 2%</i></b> .....	121	<b><i>nebivolol hcl tab 2.5 mg (base equivalent)</i></b> .....	101
<b><i>mycophenolate mofetil cap 250 mg</i></b> .....	145	<b><i>nebivolol hcl tab 20 mg (base equivalent)</i></b> .....	101
<b><i>mycophenolate mofetil for oral susp 200 mg/ml</i></b>		<b><i>nebivolol hcl tab 5 mg (base equivalent)</i></b> .....	101
.....	145	NECON 0.5/35-28	
<b><i>mycophenolate mofetil tab 500 mg</i></b> .....	145	see Norethindrone & Ethinyl Estradiol Tab 0.5	
<b><i>mycophenolate sodium tab dr 180 mg</i></b>		mg-35 mcg .....	112
<b><i>(mycophenolic acid equiv)</i></b> .....	145	<b><i>nefazodone hcl tab 100 mg</i></b> .....	66
<b><i>mycophenolate sodium tab dr 360 mg</i></b>		<b><i>nefazodone hcl tab 150 mg</i></b> .....	66
<b><i>(mycophenolic acid equiv)</i></b> .....	145	<b><i>nefazodone hcl tab 200 mg</i></b> .....	66
MYFEMBREE TAB .....	131	<b><i>nefazodone hcl tab 250 mg</i></b> .....	66
<b>N</b>		<b><i>nefazodone hcl tab 50 mg</i></b> .....	66
<b><i>nabumetone tab 500 mg</i></b> .....	40	<b><i>nelfinavir mesylate</i></b>	
<b><i>nabumetone tab 750 mg</i></b> .....	40	see VIRACEPT TAB 250MG .....	99
<b><i>nadolol tab 20 mg</i></b> .....	101	see VIRACEPT TAB 625MG .....	99
<b><i>nadolol tab 40 mg</i></b> .....	101	<b><i>neomycin sulfate tab 500 mg</i></b> .....	38
<b><i>nadolol tab 80 mg</i></b> .....	102	<b><i>neomycin-bacitrac zn-polymyx 5(3.5)mg-</i></b>	
<b><i>nafarelin acetate</i></b>		<b><i>400unt-10000unt op oin</i></b> .....	149
see SYNAREL SOL 2MG/ML .....	129	<b><i>neomycin-polymy-gramicid op sol 1.75-10000-</i></b>	
<b><i>naftifine hcl cream 1%</i></b> .....	122	<b><i>0.025mg-unt-mg/ml</i></b> .....	149
<b><i>naftifine hcl cream 2%</i></b> .....	122	<b><i>neomycin-polymyxin-dexamethasone ophth</i></b>	
<b><i>naftifine hcl gel 2%</i></b> .....	122	<b><i>oint 0.1%</i></b> .....	150
<b><i>naldemedine tosylate</i></b>		<b><i>neomycin-polymyxin-dexamethasone ophth</i></b>	
see SYMPROIC TAB 0.2MG .....	134	<b><i>susp 0.1%</i></b> .....	150
<b><i>naloxegol oxalate</i></b>		<b><i>neomycin-polymyxin-hc ophth susp</i></b> .....	150
see MOVANTIK TAB 12.5MG .....	134	<b><i>neomycin-polymyxin-hc otic soln 1%</i></b> .....	151
see MOVANTIK TAB 25MG .....	134	<b><i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-</i></b>	
<b><i>naloxone hcl nasal spray 4 mg/0.1ml</i></b> .....	73	<b><i>10000 unit/ml-1%</i></b> .....	151
<b><i>naltrexone hcl tab 50 mg</i></b> .....	73	<b><i>nepafenac</i></b>	
NAMZARIC CAP 14-10MG .....	154	see ILEVRO DRO 0.3% OP .....	150
NAMZARIC CAP 21-10MG .....	154	NEUAC	
NAMZARIC CAP 28-10MG .....	154	see Clindamycin Phosph-Benzoyl Peroxide	
NAMZARIC CAP 7-10MG .....	153	(Refrig) Gel 1.2 (1)-5% .....	119

NEUPRO DIS 1MG/24HR .....	92	<i>nifedipine cap 20 mg</i> .....	104
NEUPRO DIS 2MG/24HR .....	92	<i>nifedipine tab er 24hr 30 mg</i> .....	104
NEUPRO DIS 3MG/24HR .....	92	<i>nifedipine tab er 24hr 60 mg</i> .....	104
NEUPRO DIS 4MG/24HR .....	92	<i>nifedipine tab er 24hr 90 mg</i> .....	104
NEUPRO DIS 6MG/24HR .....	93	<i>nifedipine tab er 24hr osmotic release 30 mg</i>	104
NEUPRO DIS 8MG/24HR .....	93	<i>nifedipine tab er 24hr osmotic release 60 mg</i>	104
<i>nevirapine susp 50 mg/5ml</i> .....	98	<i>nifedipine tab er 24hr osmotic release 90 mg</i>	104
<i>nevirapine tab 200 mg</i> .....	98	NIKKI	
<i>nevirapine tab er 24hr 400 mg</i> .....	98	see Drospirenone-Ethinyl Estradiol Tab 3-0.02	
NEXLETOL TAB 180MG .....	75	mg .....	109
NEXLIZET TAB 180/10MG .....	75	<i>nilotinib hcl cap 150 mg (base equivalent)</i> .....	89
<i>niacin tab er 1000 mg (antihyperlipidemic)</i> .....	77	<i>nilotinib hcl cap 200 mg (base equivalent)</i> .....	89
<i>niacin tab er 500 mg (antihyperlipidemic)</i> .....	77	<i>nilotinib hcl cap 50 mg (base equivalent)</i> .....	89
<i>niacin tab er 750 mg (antihyperlipidemic)</i> .....	77	<i>nilutamide tab 150 mg</i> .....	85
<i>nicardipine hcl cap 20 mg</i> .....	104	<i>nimodipine cap 30 mg</i> .....	104
<i>nicardipine hcl cap 30 mg</i> .....	104	<i>nimodipine oral soln 60 mg/20ml (3 mg/ml)</i>	104
NICORELIEF		NINLARO CAP 2.3MG .....	89
see Nicotine Polacrilex Gum 2 mg .....	156	NINLARO CAP 3MG .....	89
<i>nicotine</i>		NINLARO CAP 4MG .....	89
see NICOTROL NS SPR 10MG/ML .....	158	<i>nintedanib esylate</i>	
NICOTINE MINI LOZENGE		see OFEV CAP 100MG .....	159
see Nicotine Polacrilex Lozenge 2 mg .....	157	see OFEV CAP 150MG .....	159
see Nicotine Polacrilex Lozenge 4 mg .....	157	<i>niraparib tosylate</i>	
<i>nicotine polacrilex gum 2 mg</i> .....	156	see ZEJULA TAB 100MG .....	91
Nicotine Polacrilex Gum 2 mg .....	156	see ZEJULA TAB 200MG .....	91
<i>nicotine polacrilex gum 4 mg</i> .....	156	see ZEJULA TAB 300MG .....	91
Nicotine Polacrilex Gum 4 mg .....	156, 157	<i>nirmatrelvir-ritonavir</i>	
<i>nicotine polacrilex lozenge 2 mg</i> .....	157	see PAXLOVID PAK .....	99
Nicotine Polacrilex Lozenge 2 mg .....	157	see PAXLOVID TAB 150-100 .....	99
<i>nicotine polacrilex lozenge 4 mg</i> .....	157	see PAXLOVID TAB 300-100 .....	99
Nicotine Polacrilex Lozenge 4 mg .....	157, 158	<i>nisoldipine tab er 24hr 17 mg</i> .....	104
NICOTINE STEP 1		<i>nisoldipine tab er 24hr 34 mg</i> .....	104
see Nicotine Td Patch 24hr 21 mg/24hr .....	158	<i>nisoldipine tab er 24hr 8.5 mg</i> .....	104
NICOTINE STEP 3		<i>nitazoxanide tab 500 mg</i> .....	52
see Nicotine Td Patch 24hr 7 mg/24hr .....	158	<i>nitisinone</i>	
<i>nicotine td patch 24hr 14 mg/24hr</i> .....	158	see ORFADIN SUS 4MG/ML .....	129
Nicotine Td Patch 24hr 14 mg/24hr .....	158	<i>nitisinone cap 10 mg</i> .....	129
<i>nicotine td patch 24hr 21 mg/24hr</i> .....	158	<i>nitisinone cap 2 mg</i> .....	129
Nicotine Td Patch 24hr 21 mg/24hr .....	158	<i>nitisinone cap 20 mg</i> .....	129
<i>nicotine td patch 24hr 7 mg/24hr</i> .....	158	<i>nitisinone cap 5 mg</i> .....	129
Nicotine Td Patch 24hr 7 mg/24hr .....	158	<i>nitrofurantoin macrocrystalline cap 100 mg</i> ...	53
NICOTINE TRANSDERMAL SYST		<i>nitrofurantoin macrocrystalline cap 25 mg</i> .....	53
see Nicotine Td Patch 24hr 14 mg/24hr .....	158	<i>nitrofurantoin macrocrystalline cap 50 mg</i> .....	53
see Nicotine Td Patch 24hr 21 mg/24hr .....	158	<i>nitrofurantoin monohydrate macrocrystalline</i>	
see Nicotine Td Patch 24hr 7 mg/24hr .....	158	<i>cap 100 mg</i> .....	53
NICOTROL NS SPR 10MG/ML .....	158	<i>nitrofurantoin susp 25 mg/5ml</i> .....	53
<i>nifedipine cap 10 mg</i> .....	104	<i>nitroglycerin oint 0.4%</i> .....	51

<b>nitroglycerin sl tab 0.3 mg</b> .....	53	Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5	114
<b>nitroglycerin sl tab 0.4 mg</b> .....	53	mg-30 mcg .....	114
<b>nitroglycerin sl tab 0.6 mg</b> .....	53	<b>norethindrone ace-eth estradiol-fe chew tab 1</b>	
<b>nitroglycerin td patch 24hr 0.1 mg/hr</b> .....	53	<b>mg-20 mcg (24)</b> .....	114
<b>nitroglycerin td patch 24hr 0.2 mg/hr</b> .....	53	Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1	
<b>nitroglycerin td patch 24hr 0.4 mg/hr</b> .....	53	mg-20 mcg (24) .....	114
<b>nitroglycerin td patch 24hr 0.6 mg/hr</b> .....	53	<b>norethindrone ace-ethinyl estradiol-fe cap 1 mg-</b>	
<b>nitroglycerin tl soln 0.4 mg/spray (400</b>		<b>20 mcg (24)</b> .....	114
<b>mcg/spray)</b> .....	53	Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1	
<b>nizatidine cap 150 mg</b> .....	162	mg-20 mcg (24) .....	114
<b>nizatidine cap 300 mg</b> .....	162	Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1	
<b>nonoxynol-9</b>		mg-20 mcg (24) .....	114
see ENCARE SUP 100MG .....	164	<b>norethindrone acetate tab 5 mg</b> .....	152
see GYNOL II GEL 3% .....	164	Norethindrone Acetate Tab 5 mg .....	152
see TODAY SPONGE MIS .....	164	<b>norethindrone acetate-ethinyl estradiol tab 0.5</b>	
see VCF VAGINAL GEL CONTRACE .....	164	<b>mg-2.5 mcg</b> .....	131
see VCF VAGINAL MIS CONTRACP .....	164	Norethindrone Acetate-Ethinyl Estradiol Tab 0.5	
<b>NORA-BE</b>		mg-2.5 mcg .....	131
see Norethindrone Tab 0.35 mg .....	116	<b>norethindrone acetate-ethinyl estradiol tab 1</b>	
<b>norelgestromin-ethinyl estradiol td ptwk 150-35</b>		<b>mg-5 mcg</b> .....	131
<b>mcg/24hr</b> .....	116	Norethindrone Acetate-Ethinyl Estradiol Tab 1	
Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35		mg-5 mcg .....	131
mcg/24hr .....	116	<b>norethindrone acetate-ethinyl estradiol-fe fum</b>	
Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35		<b>(biphasic)</b>	
mcg .....	112	see LO LOESTRIN TAB 1-10-10 .....	111
Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35		Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-	
mcg .....	112	30/1-35 mg-Mcg .....	112
Norethindrone & Ethinyl Estradiol Tab 1 mg-35		<b>norethindrone tab 0.35 mg</b> .....	116
mcg .....	112	Norethindrone Tab 0.35 mg .....	116, 117
<b>norethindrone &amp; ethinyl estradiol-fe chew tab</b>		Norethindrone-Eth Estradiol Tab 0.5-35/0.75-	
<b>0.4 mg-35 mcg</b> .....	112	35/1-35 mg-Mcg .....	115
Norethindrone & Ethinyl Estradiol-Fe Chew Tab		Norethindrone-Eth Estradiol Tab 0.5-35/1-	
0.4 mg-35 mcg .....	112	35/0.5-35 mg-Mcg .....	115
Norethindrone & Ethinyl Estradiol-Fe Chew Tab		<b>norgestimate &amp; ethinyl estradiol tab 0.25 mg-35</b>	
0.8 mg-25 mcg .....	112	<b>mcg</b> .....	115
<b>norethindrone ace &amp; ethinyl estradiol tab 1 mg-</b>		Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35	
<b>20 mcg</b> .....	112	mcg .....	115
Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-		<b>norgestimate-eth estrad tab 0.18-25/0.215-</b>	
20 mcg .....	112, 113	<b>25/0.25-25 mg-mcg</b> .....	115
<b>norethindrone ace &amp; ethinyl estradiol tab 1.5</b>		Norgestimate-Eth Estrad Tab 0.18-25/0.215-	
<b>mg-30 mcg</b> .....	113	25/0.25-25 mg-Mcg .....	115
Norethindrone Ace & Ethinyl Estradiol Tab 1.5		<b>norgestimate-eth estrad tab 0.18-35/0.215-</b>	
mg-30 mcg .....	113	<b>35/0.25-35 mg-mcg</b> .....	115
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1		Norgestimate-Eth Estrad Tab 0.18-35/0.215-	
mg-20 mcg .....	113	35/0.25-35 mg-Mcg .....	115, 116
<b>norethindrone ace &amp; ethinyl estradiol-fe tab 1.5</b>		Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg	
<b>mg-30 mcg</b> .....	114	.....	116

NORLYROC	
see Norethindrone Tab 0.35 mg .....	117
NORTREL 0.5/35 (28)	
see Norethindrone & Ethinyl Estradiol Tab 0.5	
mg-35 mcg .....	112
NORTREL 1/35	
see Norethindrone & Ethinyl Estradiol Tab 1	
mg-35 mcg .....	112
NORTREL 7/7/7	
see Norethindrone-Eth Estradiol Tab 0.5-	
35/0.75-35/1-35 mg-Mcg .....	115
<b>nortriptyline hcl cap 10 mg</b> .....	68
<b>nortriptyline hcl cap 25 mg</b> .....	68
<b>nortriptyline hcl cap 50 mg</b> .....	68
<b>nortriptyline hcl cap 75 mg</b> .....	68
<b>nortriptyline hcl soln 10 mg/5ml</b> .....	68
NOVOLIN INJ 70/30 .....	71
NOVOLIN INJ 70/30 FP .....	71
NOVOLIN N INJ 100 UNIT .....	71
NOVOLIN N INJ U-100 .....	71
NOVOLIN R INJ 100 UNIT .....	71
NOVOLIN R INJ U-100 .....	71
NOVOLOG INJ 100/ML .....	71
NOVOLOG INJ FLEXPEN .....	71
NOVOLOG INJ PENFILL .....	71
NOVOLOG MIX INJ 70/30 .....	71
NOVOLOG MIX INJ FLEXPEN .....	71
NUBEQA TAB 300MG .....	85
NURTEC TAB 75MG ODT .....	142
NYAMYC	
see Nystatin Topical Powder 100000 unit/gm	
.....	122
NYLIA 1/35	
see Norethindrone & Ethinyl Estradiol Tab 1	
mg-35 mcg .....	112
NYLIA 7/7/7	
see Norethindrone-Eth Estradiol Tab 0.5-	
35/0.75-35/1-35 mg-Mcg .....	115
<b>nystatin cream 100000 unit/gm</b> .....	122
<b>nystatin oint 100000 unit/gm</b> .....	122
<b>nystatin susp 100000 unit/ml</b> .....	146
<b>nystatin tab 500000 unit</b> .....	74
<b>nystatin topical powder 100000 unit/gm</b> .....	122
Nystatin Topical Powder 100000 unit/gm .....	122
<b>nystatin-triamcinolone cream 100000-0.1</b>	
<b>unit/gm-%</b> .....	122

<b>nystatin-triamcinolone oint 100000-0.1</b>	
<b>unit/gm-%</b> .....	122
NYSTOP	
see Nystatin Topical Powder 100000 unit/gm	
.....	122
<b>O</b>	
ODACTRA SUB .....	38
ODEFSEY TAB .....	98
ODOMZO CAP 200MG .....	84
OFEV CAP 100MG .....	159
OFEV CAP 150MG .....	159
<b>ofloxacin ophth soln 0.3%</b> .....	149
<b>ofloxacin otic soln 0.3%</b> .....	151
<b>ofloxacin tab 300 mg</b> .....	133
<b>ofloxacin tab 400 mg</b> .....	133
<b>olanzapine orally disintegrating tab 10 mg</b> .....	95
<b>olanzapine orally disintegrating tab 15 mg</b> .....	95
<b>olanzapine orally disintegrating tab 20 mg</b> .....	95
<b>olanzapine orally disintegrating tab 5 mg</b> .....	95
<b>olanzapine tab 10 mg</b> .....	95
<b>olanzapine tab 15 mg</b> .....	95
<b>olanzapine tab 2.5 mg</b> .....	95
<b>olanzapine tab 20 mg</b> .....	95
<b>olanzapine tab 5 mg</b> .....	95
<b>olanzapine tab 7.5 mg</b> .....	95
<b>olanzapine-fluoxetine hcl cap 12-25 mg</b> .....	154
<b>olanzapine-fluoxetine hcl cap 12-50 mg</b> .....	154
<b>olanzapine-fluoxetine hcl cap 3-25 mg</b> .....	154
<b>olanzapine-fluoxetine hcl cap 6-25 mg</b> .....	154
<b>olanzapine-fluoxetine hcl cap 6-50 mg</b> .....	154
<b>olaparib</b>	
see LYNPARZA TAB 100MG .....	89
see LYNPARZA TAB 150MG .....	89
<b>olmesartan medoxomil tab 20 mg</b> .....	78
<b>olmesartan medoxomil tab 40 mg</b> .....	78
<b>olmesartan medoxomil tab 5 mg</b> .....	78
<b>olmesartan medoxomil-hydrochlorothiazide tab</b>	
<b>20-12.5 mg</b> .....	81
<b>olmesartan medoxomil-hydrochlorothiazide tab</b>	
<b>40-12.5 mg</b> .....	81
<b>olmesartan medoxomil-hydrochlorothiazide tab</b>	
<b>40-25 mg</b> .....	81
<b>olmesartan-amlodipine-hydrochlorothiazide tab</b>	
<b>20-5-12.5 mg</b> .....	81
<b>olmesartan-amlodipine-hydrochlorothiazide tab</b>	
<b>40-10-12.5 mg</b> .....	81

<b>olmesartan-amlodipine-hydrochlorothiazide tab</b>	
<b>40-10-25 mg</b> .....	81
<b>olmesartan-amlodipine-hydrochlorothiazide tab</b>	
<b>40-5-12.5 mg</b> .....	81
<b>olmesartan-amlodipine-hydrochlorothiazide tab</b>	
<b>40-5-25 mg</b> .....	81
<b>olodaterol hcl</b>	
see STRIVERDI AER 2.5MCG .....	58
<b>olopatadine hcl nasal soln 0.6%</b> .....	148
<b>olopatadine hcl ophth soln 0.2% (base</b>	
<b>equivalent)</b> .....	151
<b>omega-3-acid ethyl esters cap 1 gm</b> .....	75
<b>omeprazole cap delayed release 10 mg</b> .....	162
<b>omeprazole cap delayed release 20 mg</b> .....	162
<b>omeprazole cap delayed release 40 mg</b> .....	163
<b>ondansetron hcl oral soln 4 mg/5ml</b> .....	73
<b>ondansetron hcl tab 24 mg</b> .....	73
<b>ondansetron hcl tab 4 mg</b> .....	73
<b>ondansetron hcl tab 8 mg</b> .....	73
<b>ondansetron orally disintegrating tab 4 mg</b> .....	73
<b>ondansetron orally disintegrating tab 8 mg</b> .....	73
OPSUMIT TAB 10MG .....	106
OPSYNVI TAB 10-20MG .....	105
OPSYNVI TAB 10-40MG .....	105
OPTICHAMBER MIS DIA LG .....	142
OPTICHAMBER MIS DIA MD .....	142
OPTICHAMBER MIS DIA SM .....	142
OPTICHAMBER MIS DIAMOND .....	142
OPTION 2	
see Levonorgestrel Tab 1.5 mg .....	116
OPZELURA CRE 1.5% .....	125
ORACEA CAP 40MG .....	126
ORALAIR SUB 300 IR .....	38
ORALONE DENTAL PASTE	
see Triamcinolone Acetonide Dental Paste	
0.1% .....	146
ORENITRAM TAB 0.125MG .....	106
ORENITRAM TAB 0.25MG .....	106
ORENITRAM TAB 1MG .....	106
ORENITRAM TAB 2.5MG .....	106
ORENITRAM TAB 5MG .....	106
ORENITRAM TAB MONTH 1 .....	106
ORENITRAM TAB MONTH 2 .....	106
ORENITRAM TAB MONTH 3 .....	106
ORFADIN SUS 4MG/ML .....	129
ORIAHNN CAP .....	131
ORLISSA TAB 150MG .....	128
ORLISSA TAB 200MG .....	128
ORLADEYO CAP 110MG .....	135
ORLADEYO CAP 150MG .....	135
<b>orlistat cap 120 mg</b> .....	31
ORMALVI	
see Dichlorphenamide Tab 50 mg .....	127
<b>orphenadrine citrate tab er 12hr 100 mg</b> .....	147
ORQUIDEA	
see Norethindrone Tab 0.35 mg .....	117
<b>oseltamivir phosphate cap 30 mg (base equiv)</b>	
.....	100
<b>oseltamivir phosphate cap 45 mg (base equiv)</b>	
.....	100
<b>oseltamivir phosphate cap 75 mg (base equiv)</b>	
.....	100
<b>oseltamivir phosphate for susp 6 mg/ml (base</b>	
<b>equiv)</b> .....	100
<b>osimertinib mesylate</b>	
see TAGRISSO TAB 40MG .....	84
see TAGRISSO TAB 80MG .....	84
OTEZLA TAB 10/20 .....	40
OTEZLA TAB 10/20/30 .....	40
OTEZLA TAB 20MG .....	40
OTEZLA TAB 30MG .....	41
OTEZLA XR TAB 75MG .....	41
OTEZLA/XR TAB 28 DAY .....	41
<b>oxaprozin cap 300 mg</b> .....	40
<b>oxaprozin tab 600 mg</b> .....	40
<b>oxazepam cap 10 mg</b> .....	55
<b>oxazepam cap 15 mg</b> .....	55
<b>oxazepam cap 30 mg</b> .....	55
<b>oxcarbazepine</b>	
see OXTELLAR XR TAB 150MG .....	63
see OXTELLAR XR TAB 300MG .....	63
see OXTELLAR XR TAB 600MG .....	63
<b>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</b> ..	62
<b>oxcarbazepine tab 150 mg</b> .....	62
<b>oxcarbazepine tab 300 mg</b> .....	62
<b>oxcarbazepine tab 600 mg</b> .....	62
<b>oxcarbazepine tab er 24hr 150 mg</b> .....	62
<b>oxcarbazepine tab er 24hr 300 mg</b> .....	62
<b>oxcarbazepine tab er 24hr 600 mg</b> .....	62
<b>oxiconazole nitrate cream 1%</b> .....	122
OXTELLAR XR TAB 150MG .....	63
OXTELLAR XR TAB 300MG .....	63
OXTELLAR XR TAB 600MG .....	63
<b>oxybutynin chloride solution 5 mg/5ml</b> .....	163

<b>oxybutynin chloride tab 5 mg</b> .....	163	<b>paliperidone tab er 24hr 9 mg</b> .....	94
<b>oxybutynin chloride tab er 24hr 10 mg</b> .....	163	<b>pancrelipase (lipase-protease-amylase)</b>	
<b>oxybutynin chloride tab er 24hr 15 mg</b> .....	163	see CREON CAP 12000UNT .....	126
<b>oxybutynin chloride tab er 24hr 5 mg</b> .....	163	see CREON CAP 24000UNT .....	126
<b>oxycodone hcl cap 5 mg</b> .....	45	see CREON CAP 3000UNIT .....	126
<b>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</b> ..	45	see CREON CAP 36000UNT .....	126
<b>oxycodone hcl soln 5 mg/5ml</b> .....	45	see CREON CAP 6000UNIT .....	126
<b>oxycodone hcl tab 10 mg</b> .....	45	see VIOKACE TAB 10440 .....	126
<b>oxycodone hcl tab 15 mg</b> .....	45	see VIOKACE TAB 20880 .....	126
<b>oxycodone hcl tab 20 mg</b> .....	45	see ZENPEP CAP 10000UNT .....	126
<b>oxycodone hcl tab 30 mg</b> .....	45	see ZENPEP CAP 15000UNT .....	126
<b>oxycodone hcl tab 5 mg</b> .....	45	see ZENPEP CAP 20000UNT .....	127
<b>oxycodone w/ acetaminophen tab 10-325 mg</b>	49	see ZENPEP CAP 25000UNT .....	127
Oxycodone W/ Acetaminophen Tab 10-325 mg	49	see ZENPEP CAP 3000UNIT .....	126
<b>oxycodone w/ acetaminophen tab 2.5-325 mg</b>	48	see ZENPEP CAP 40000UNT .....	127
.....	48	see ZENPEP CAP 5000UNIT .....	126
Oxycodone W/ Acetaminophen Tab 2.5-325 mg	49	see ZENPEP CAP 60000UNT .....	127
.....	49	<b>pantoprazole sodium ec tab 20 mg (base equiv)</b>	
<b>oxycodone w/ acetaminophen tab 5-325 mg</b> ..	49	.....	163
Oxycodone W/ Acetaminophen Tab 5-325 mg	49	<b>pantoprazole sodium ec tab 40 mg (base equiv)</b>	
<b>oxycodone w/ acetaminophen tab 7.5-325 mg</b>	49	.....	163
.....	49	<b>paricalcitol cap 1 mcg</b> .....	129
Oxycodone W/ Acetaminophen Tab 7.5-325 mg	49	<b>paricalcitol cap 2 mcg</b> .....	129
.....	49	<b>paricalcitol cap 4 mcg</b> .....	129
<b>oxymorphone hcl tab 10 mg</b> .....	45	<b>paroxetine hcl oral susp 10 mg/5ml (base equiv)</b>	
<b>oxymorphone hcl tab 5 mg</b> .....	45	.....	66
<b>ozanimod hcl</b>		<b>paroxetine hcl tab 10 mg</b> .....	66
see ZEPOSIA 7DAY CAP STR PACK .....	155	<b>paroxetine hcl tab 20 mg</b> .....	66
see ZEPOSIA CAP 0.92MG .....	155	<b>paroxetine hcl tab 30 mg</b> .....	66
see ZEPOSIA CAP STR KIT .....	155	<b>paroxetine hcl tab 40 mg</b> .....	66
OZEMPIC INJ 2MG/3ML .....	70	<b>paroxetine hcl tab er 24hr 12.5 mg</b> .....	66
OZEMPIC INJ 4MG/3ML .....	70	<b>paroxetine hcl tab er 24hr 25 mg</b> .....	66
OZEMPIC INJ 8MG/3ML .....	70	<b>paroxetine hcl tab er 24hr 37.5 mg</b> .....	66
<b>P</b>		<b>patiromer sorbitex calcium</b>	
<b>PACERONE</b>		see VELTASSA POW 16.8GM .....	146
see Amiodarone Hcl Tab 100 mg .....	16, 55	see VELTASSA POW 1GM .....	146
see Amiodarone Hcl Tab 200 mg .....	55	see VELTASSA POW 25.2GM .....	146
<b>palbociclib</b>		see VELTASSA POW 8.4GM .....	146
see IBRANCE CAP 100MG .....	88	PAXLOVID PAK .....	99
see IBRANCE CAP 125MG .....	88	PAXLOVID TAB 150-100 .....	99
see IBRANCE CAP 75MG .....	88	PAXLOVID TAB 300-100 .....	99
see IBRANCE TAB 100MG .....	88	<b>pazopanib hcl tab 200 mg (base equiv)</b> .....	89
see IBRANCE TAB 125MG .....	88	<b>peg 3350-kcl-na bicarb-nacl-na sulfate for soln</b>	
see IBRANCE TAB 75MG .....	88	<b>236 gm</b> .....	139
<b>paliperidone tab er 24hr 1.5 mg</b> .....	94	Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln	
<b>paliperidone tab er 24hr 3 mg</b> .....	94	236 gm .....	139
<b>paliperidone tab er 24hr 6 mg</b> .....	94		

Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm .....	139	<b>phenobarbital tab 60 mg</b> .....	138
<b>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</b>	139	<b>phenobarbital tab 64.8 mg</b> .....	138
Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm .....	139	<b>phenobarbital tab 97.2 mg</b> .....	138
<b>perciclovir cream 1%</b> .....	123	<b>phenoxybenzamine hcl cap 10 mg</b> .....	78
<b>penicillamine cap 250 mg</b> .....	144	<b>phentermine hcl cap 15 mg</b> .....	31
<b>penicillamine tab 250 mg</b> .....	144	<b>phentermine hcl cap 30 mg</b> .....	31
<b>penicillin v potassium for soln 125 mg/5ml</b> ...	152	<b>phentermine hcl cap 37.5 mg</b> .....	31
<b>penicillin v potassium for soln 250 mg/5ml</b> ...	152	<b>phentermine hcl tab 37.5 mg</b> .....	31
<b>penicillin v potassium tab 250 mg</b> .....	152	Phentermine Hcl Tab 8 mg .....	31
<b>penicillin v potassium tab 500 mg</b> .....	152	<b>phentermine hcl-topiramate</b>	
<b>pentamidine isethionate for nebulization soln</b>		see QSYMIA CAP 11.25-69 .....	31
<b>300 mg</b> .....	52	see QSYMIA CAP 15-92MG .....	31
<b>pentazocine w/ naloxone hcl tab 50-0.5 mg</b> ...	50	see QSYMIA CAP 3.75-23 .....	31
<b>pentoxifylline tab er 400 mg</b> .....	135	see QSYMIA CAP 7.5-46MG .....	31
<b>perampanel susp 0.5 mg/ml</b> .....	60	<b>phentermine hcl-topiramate cap er 24hr 11.25-69 mg</b> .....	31
<b>perampanel tab 10 mg</b> .....	60	<b>phentermine hcl-topiramate cap er 24hr 15-92 mg</b> .....	31
<b>perampanel tab 12 mg</b> .....	60	<b>phentermine hcl-topiramate cap er 24hr 3.75-23 mg</b> .....	31
<b>perampanel tab 2 mg</b> .....	60	<b>phentermine hcl-topiramate cap er 24hr 7.5-46 mg</b> .....	31
<b>perampanel tab 4 mg</b> .....	60	<b>phenylephrine hcl ophth soln 10%</b> .....	149
<b>perampanel tab 6 mg</b> .....	60	<b>phenylephrine hcl ophth soln 2.5%</b> .....	148
<b>perampanel tab 8 mg</b> .....	60	<b>phenytoin chew tab 50 mg</b> .....	64
<b>perindopril erbumine tab 2 mg</b> .....	78	<b>phenytoin sodium extended cap 100 mg</b> .....	64
<b>perindopril erbumine tab 4 mg</b> .....	78	<b>phenytoin sodium extended cap 200 mg</b> .....	64
<b>perindopril erbumine tab 8 mg</b> .....	78	<b>phenytoin sodium extended cap 300 mg</b> .....	64
<b>permethrin cream 5%</b> .....	126	<b>phenytoin susp 125 mg/5ml</b> .....	64
<b>perphenazine tab 16 mg</b> .....	96	PHEXX GEL.....	164
<b>perphenazine tab 2 mg</b> .....	96	PHILITH	
<b>perphenazine tab 4 mg</b> .....	96	see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg .....	112
<b>perphenazine tab 8 mg</b> .....	96	PHOSPHO-TRIN K500	
<b>perphenazine-amitriptyline tab 2-10 mg</b> .....	154	see Potassium Phosphate Monobasic Tab 500 mg .....	144
<b>perphenazine-amitriptyline tab 2-25 mg</b> .....	154	<b>phytonadione tab 5 mg</b> .....	165
<b>perphenazine-amitriptyline tab 4-10 mg</b> .....	154	<b>pilocarpine hcl ophth soln 1%</b> .....	149
<b>perphenazine-amitriptyline tab 4-25 mg</b> .....	154	<b>pilocarpine hcl ophth soln 1.25%</b> .....	149
<b>perphenazine-amitriptyline tab 4-50 mg</b> .....	154	<b>pilocarpine hcl ophth soln 2%</b> .....	149
<b>pexidartinib hcl</b>		<b>pilocarpine hcl ophth soln 4%</b> .....	149
see TURALIO CAP 125MG .....	90	<b>pilocarpine hcl tab 5 mg</b> .....	146
PHEBURANE MIS 483/GM.....	129	<b>pilocarpine hcl tab 7.5 mg</b> .....	146
<b>phendimetrazine tartrate tab 35 mg</b> .....	31	<b>pimecrolimus cream 1%</b> .....	125
<b>phenelzine sulfate tab 15 mg</b> .....	65	<b>pimozide tab 1 mg</b> .....	156
<b>phenobarbital elixir 20 mg/5ml</b> .....	138	<b>pimozide tab 2 mg</b> .....	156
<b>phenobarbital tab 100 mg</b> .....	138	PIMTREA	
<b>phenobarbital tab 15 mg</b> .....	138		
<b>phenobarbital tab 16.2 mg</b> .....	138		
<b>phenobarbital tab 30 mg</b> .....	138		
<b>phenobarbital tab 32.4 mg</b> .....	138		

see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5).....	108	POMALYST CAP 1MG .....	85
<b><i>pindolol tab 10 mg</i></b> .....	102	POMALYST CAP 2MG .....	85
<b><i>pindolol tab 5 mg</i></b> .....	102	POMALYST CAP 3MG .....	86
<b><i>pioglitazone hcl tab 15 mg (base equiv)</i></b> .....	71	POMALYST CAP 4MG .....	86
<b><i>pioglitazone hcl tab 30 mg (base equiv)</i></b> .....	72	PORTIA-28	
<b><i>pioglitazone hcl tab 45 mg (base equiv)</i></b> .....	72	see Levonorgestrel & Ethinyl Estradiol Tab	
<b><i>pioglitazone hcl-glimepiride tab 30-2 mg</i></b> .....	68	0.15 mg-30 mcg.....	111
<b><i>pioglitazone hcl-glimepiride tab 30-4 mg</i></b> .....	68	<b><i>posaconazole susp 40 mg/ml</i></b> .....	74
<b><i>pioglitazone hcl-metformin hcl tab 15-500 mg</i></b> .....	68	<b><i>potassium chloride cap er 10 meq</i></b> .....	144
<b><i>pioglitazone hcl-metformin hcl tab 15-850 mg</i></b> .....	68	<b><i>potassium chloride cap er 8 meq</i></b> .....	144
PIQRAY 200MG TAB DOSE .....	89	<b><i>potassium chloride microencapsulated crys er tab 10 meq</i></b> .....	144
PIQRAY 250MG TAB DOSE .....	89	Potassium Chloride Microencapsulated Crys Er Tab 10 meq .....	144
PIQRAY 300MG TAB DOSE .....	89	<b><i>potassium chloride microencapsulated crys er tab 15 meq</i></b> .....	144
<b><i>pirfenidone cap 267 mg</i></b> .....	159	Potassium Chloride Microencapsulated Crys Er Tab 15 meq .....	144
<b><i>pirfenidone tab 267 mg</i></b> .....	159	<b><i>potassium chloride microencapsulated crys er tab 20 meq</i></b> .....	144
<b><i>pirfenidone tab 534 mg</i></b> .....	159	Potassium Chloride Microencapsulated Crys Er Tab 20 meq .....	144
<b><i>pirfenidone tab 801 mg</i></b> .....	159	<b><i>potassium chloride oral soln 10% (20 meq/15ml)</i></b> .....	144
<b><i>piroxicam cap 10 mg</i></b> .....	40	<b><i>potassium chloride oral soln 20% (40 meq/15ml)</i></b> .....	144
<b><i>piroxicam cap 20 mg</i></b> .....	40	<b><i>potassium chloride powder packet 20 meq</i></b> ...	144
<b><i>pitavastatin calcium tab 1 mg</i></b> .....	76	Potassium Chloride Powder Packet 20 meq....	144
<b><i>pitavastatin calcium tab 2 mg</i></b> .....	76	<b><i>potassium chloride tab er 10 meq</i></b> .....	144
<b><i>pitavastatin calcium tab 4 mg</i></b> .....	76	Potassium Chloride Tab Er 10 meq .....	144
<b><i>pitolisant hcl</i></b>		<b><i>potassium chloride tab er 15 meq</i></b> .....	144
see WAKIX TAB 17.8MG .....	33	<b><i>potassium chloride tab er 20 meq (1500 mg)</i></b> .....	144
see WAKIX TAB 4.45MG .....	33	<b><i>potassium chloride tab er 8 meq (600 mg)</i></b> ....	144
PNV-DHA		Potassium Citrate & Citric Acid Powder Pack 3300-1002 mg.....	134
see Prenat W/o A W/feum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg .....	146	<b><i>potassium citrate tab er 10 meq (1080 mg)</i></b> ..	134
PNV-SELECT		<b><i>potassium citrate tab er 15 meq (1620 mg)</i></b> ..	134
see Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg .....	147	<b><i>potassium citrate tab er 5 meq (540 mg)</i></b> .....	134
POCKET CHAMB MIS .....	142	<b><i>potassium iodide oral soln 1 gm/ml</i></b> .....	119
POCKET SPACE MIS.....	142	Potassium Phosphate Monobasic Tab 500 mg	144
<b><i>podofilox gel 0.5%</i></b> .....	125	<b><i>pralsetinib</i></b>	
<b><i>podofilox soln 0.5%</i></b> .....	125	see GAVRETO CAP 100MG.....	87
<b><i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i></b> .....	149	<b><i>pramipexole dihydrochloride tab 0.125 mg</i></b> .....	93
<b><i>pomalidomide</i></b>		<b><i>pramipexole dihydrochloride tab 0.25 mg</i></b> .....	93
see POMALYST CAP 1MG .....	85	<b><i>pramipexole dihydrochloride tab 0.5 mg</i></b> .....	93
see POMALYST CAP 2MG .....	85	<b><i>pramipexole dihydrochloride tab 0.75 mg</i></b> .....	93
see POMALYST CAP 3MG .....	86	<b><i>pramipexole dihydrochloride tab 1 mg</i></b> .....	93
see POMALYST CAP 4MG .....	86		
<b><i>pomalidomide cap 1 mg</i></b> .....	85		
<b><i>pomalidomide cap 2 mg</i></b> .....	85		
<b><i>pomalidomide cap 3 mg</i></b> .....	85		
<b><i>pomalidomide cap 4 mg</i></b> .....	85		

<b>pramipexole dihydrochloride tab 1.5 mg</b> .....	93	<b>prednisone tab therapy pack 5 mg (21)</b> .....	118
<b>pramipexole dihydrochloride tab er 24hr 0.375 mg</b> .....	93	<b>prednisone tab therapy pack 5 mg (48)</b> .....	118
<b>pramipexole dihydrochloride tab er 24hr 0.75 mg</b> .....	93	<b>pregabalin cap 100 mg</b> .....	63
<b>pramipexole dihydrochloride tab er 24hr 1.5 mg</b> .....	93	<b>pregabalin cap 150 mg</b> .....	63
<b>pramipexole dihydrochloride tab er 24hr 2.25 mg</b> .....	93	<b>pregabalin cap 200 mg</b> .....	63
<b>pramipexole dihydrochloride tab er 24hr 3 mg</b> .....	93	<b>pregabalin cap 225 mg</b> .....	63
<b>pramipexole dihydrochloride tab er 24hr 3.75 mg</b> .....	93	<b>pregabalin cap 25 mg</b> .....	63
<b>pramipexole dihydrochloride tab er 24hr 4.5 mg</b> .....	93	<b>pregabalin cap 300 mg</b> .....	63
<b>prasterone vaginal</b>		<b>pregabalin cap 50 mg</b> .....	63
see INTRAROSA SUP 6.5MG .....	164	<b>pregabalin cap 75 mg</b> .....	63
<b>prasugrel hcl tab 10 mg (base equiv)</b> .....	136	<b>pregabalin soln 20 mg/ml</b> .....	63
<b>prasugrel hcl tab 5 mg (base equiv)</b> .....	136	<b>pregabalin tab er 24hr 165 mg</b> .....	156
<b>pravastatin sodium tab 10 mg</b> .....	76	<b>pregabalin tab er 24hr 330 mg</b> .....	156
<b>pravastatin sodium tab 20 mg</b> .....	76	<b>pregabalin tab er 24hr 82.5 mg</b> .....	156
<b>pravastatin sodium tab 40 mg</b> .....	77	PREMPHASE TAB .....	131
<b>pravastatin sodium tab 80 mg</b> .....	77	PREMPRO TAB .....	131
<b>praziquantel tab 600 mg</b> .....	52	PREMPRO TAB 0.3-1.5 .....	131
<b>prazosin hcl cap 1 mg</b> .....	79	PREMPRO TAB 0.45-1.5 .....	131
<b>prazosin hcl cap 2 mg</b> .....	79	PREMPRO TAB 0.625-5 .....	131
<b>prazosin hcl cap 5 mg</b> .....	79	Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg .....	146
PRED SOD PHO SOL 1% OP .....	150	PRENATAL 19	
<b>prednisolone acetate ophth susp 1%</b> .....	150	see Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg .....	147
<b>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</b> .....	118	Prenatal Vit W/ Dss-Iron Carbonyl-Fa Tab 90-1 mg.....	146
<b>prednisolone sod phosphate oral soln 5 mg/5ml (base equiv)</b> .....	118	Prenatal Vit W/ Fe Fumarate-Fa Chew Tab 29-1 mg.....	147
<b>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</b> .....	118	Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg.	147
<b>prednisolone soln 15 mg/5ml</b> .....	118	Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg .....	147
<b>prednisolone tab 5 mg</b> .....	118	Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg .....	147
<b>prednisone oral soln 5 mg/5ml</b> .....	118	PREVALITE	
<b>prednisone tab 1 mg</b> .....	118	see Cholestyramine Light Powder 4 gm/dose .....	75
<b>prednisone tab 10 mg</b> .....	118	see Cholestyramine Light Powder Packets 4 gm .....	75
<b>prednisone tab 2.5 mg</b> .....	118	PREZCOBIX TAB 800-150.....	98
<b>prednisone tab 20 mg</b> .....	118	<b>primaquine phosphate tab 26.3 mg (15 mg base)</b> .....	82
<b>prednisone tab 5 mg</b> .....	118	<b>primidone tab 250 mg</b> .....	63
<b>prednisone tab 50 mg</b> .....	118	<b>primidone tab 50 mg</b> .....	63
<b>prednisone tab delayed release 1 mg</b> .....	118	<b>probenecid tab 500 mg</b> .....	135
<b>prednisone tab delayed release 2 mg</b> .....	118	PROCENTRA	
<b>prednisone tab therapy pack 10 mg (21)</b> .....	118	see Dextroamphetamine Sulfate Oral Solution 5 mg/5ml .....	28
<b>prednisone tab therapy pack 10 mg (48)</b> .....	118		

PROCHAMBER MIS VHC .....	142	<i>propranolol hcl cap er 24hr 160 mg</i> .....	102
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i> .....	96	<i>propranolol hcl cap er 24hr 60 mg</i> .....	102
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i> .....	96	<i>propranolol hcl cap er 24hr 80 mg</i> .....	102
<i>prochlorperazine suppos 25 mg</i> .....	96	<i>propranolol hcl oral soln 20 mg/5ml</i> .....	102
Prochlorperazine Suppos 25 mg .....	96	<i>propranolol hcl oral soln 40 mg/5ml</i> .....	102
PROCTOCORT		<i>propranolol hcl tab 10 mg</i> .....	102
see Hydrocortisone Perianal Cream 1% .....	51	<i>propranolol hcl tab 20 mg</i> .....	102
PROCTOFOAM AER HC 1% .....	51	<i>propranolol hcl tab 40 mg</i> .....	102
PROCTO-MED HC		<i>propranolol hcl tab 60 mg</i> .....	102
see Hydrocortisone Perianal Cream 2.5% .....	51	<i>propranolol hcl tab 80 mg</i> .....	102
PROCTOSOL HC		<i>propylthiouracil tab 50 mg</i> .....	160
see Hydrocortisone Perianal Cream 2.5% .....	51	<i>protriptyline hcl tab 10 mg</i> .....	68
PROCTOZONE-HC		<i>protriptyline hcl tab 5 mg</i> .....	68
see Hydrocortisone Perianal Cream 2.5% .....	51	<i>prucalopride succinate tab 1 mg (base equivalent)</i> .....	133
<i>progesterone (vaginal)</i>		<i>prucalopride succinate tab 2 mg (base equivalent)</i> .....	133
see CRINONE GEL 4% VAG .....	164	PRURADIK	
see CRINONE GEL 8% VAG .....	164	see Crotamiton Lotion 10% .....	126
<i>progesterone cap 100 mg</i> .....	152	<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i> .....	119
<i>progesterone cap 200 mg</i> .....	152	PULMICORT INH 180MCG .....	57
<i>progesterone vaginal insert 100 mg</i> .....	164	PULMICORT INH 90MCG .....	57
<i>promethazine &amp; phenylephrine syrup 6.25-5 mg/5ml</i> .....	119	PYQUVI	
<i>promethazine hcl oral soln 6.25 mg/5ml</i> .....	74	see Deflazacort Susp 22.75 mg/ml .....	117
<i>promethazine hcl suppos 12.5 mg</i> .....	74	<i>pyrazinamide tab 500 mg</i> .....	83
Promethazine Hcl Suppos 12.5 mg .....	75	<i>pyridostigmine bromide oral soln 60 mg/5ml</i> .	82
<i>promethazine hcl suppos 25 mg</i> .....	75	<i>pyridostigmine bromide tab 60 mg</i> .....	82
Promethazine Hcl Suppos 25 mg .....	75	<i>pyridostigmine bromide tab er 180 mg</i> .....	82
Promethazine Hcl Suppos 50 mg .....	75	<i>pyrimethamine tab 25 mg</i> .....	82
<i>promethazine hcl tab 12.5 mg</i> .....	75	<b>Q</b>	
<i>promethazine hcl tab 25 mg</i> .....	75	QC FOLIC ACID	
<i>promethazine hcl tab 50 mg</i> .....	75	see Folic Acid Tab 800 mcg .....	137
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i> .....	119	QELBREE CAP 100MG ER .....	32
<i>promethazine-dm syrup 6.25-15 mg/5ml</i> .....	119	QELBREE CAP 150MG ER .....	32
PROMETHEGAN		QELBREE CAP 200MG ER .....	33
see Promethazine Hcl Suppos 12.5 mg .....	75	QSYMIA CAP 11.25-69 .....	31
see Promethazine Hcl Suppos 25 mg .....	75	QSYMIA CAP 15-92MG .....	31
see Promethazine Hcl Suppos 50 mg .....	75	QSYMIA CAP 3.75-23 .....	31
<i>propafenone hcl cap er 12hr 225 mg</i> .....	55	QSYMIA CAP 7.5-46MG .....	31
<i>propafenone hcl cap er 12hr 325 mg</i> .....	55	<i>quetiapine fumarate tab 100 mg</i> .....	95
<i>propafenone hcl cap er 12hr 425 mg</i> .....	55	<i>quetiapine fumarate tab 150 mg</i> .....	95
<i>propafenone hcl tab 150 mg</i> .....	55	<i>quetiapine fumarate tab 200 mg</i> .....	95
<i>propafenone hcl tab 225 mg</i> .....	55	<i>quetiapine fumarate tab 25 mg</i> .....	95
<i>propafenone hcl tab 300 mg</i> .....	55	<i>quetiapine fumarate tab 300 mg</i> .....	96
<i>propranolol hcl cap er 24hr 120 mg</i> .....	102	<i>quetiapine fumarate tab 400 mg</i> .....	96
		<i>quetiapine fumarate tab 50 mg</i> .....	95

<i>quetiapine fumarate tab er 24hr 150 mg</i> .....	96	see MYFEMBREE TAB.....	131
<i>quetiapine fumarate tab er 24hr 200 mg</i> .....	96	<i>repaglinide tab 0.5 mg</i> .....	72
<i>quetiapine fumarate tab er 24hr 300 mg</i> .....	96	<i>repaglinide tab 1 mg</i> .....	72
<i>quetiapine fumarate tab er 24hr 400 mg</i> .....	96	<i>repaglinide tab 2 mg</i> .....	72
<i>quetiapine fumarate tab er 24hr 50 mg</i> .....	96	<i>repotrectinib</i>	
<i>quinapril hcl tab 10 mg</i> .....	78	see AUGTYRO CAP 160MG.....	86
<i>quinapril hcl tab 20 mg</i> .....	78	see AUGTYRO CAP 40MG.....	86
<i>quinapril hcl tab 40 mg</i> .....	78	RESTASIS EMU 0.05% OP.....	150
<i>quinapril hcl tab 5 mg</i> .....	78	RESTASIS MUL EMU 0.05% OP.....	150
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	81	RETEVMO TAB 120MG.....	89
<i>quinidine gluconate tab er 324 mg</i> .....	55	RETEVMO TAB 160MG.....	89
<i>quinine sulfate cap 324 mg</i> .....	82	RETEVMO TAB 40MG.....	89
QULIPTA TAB 10MG.....	142	RETEVMO TAB 80MG.....	89
QULIPTA TAB 30MG.....	142	<i>revefenacin</i>	
QULIPTA TAB 60MG.....	142	see YUPELRI SOL 175/3ML.....	56
QUVIVIQ TAB 25MG.....	139	REYVOW TAB 100MG.....	143
QUVIVIQ TAB 50MG.....	139	REYVOW TAB 50MG.....	143
<b>R</b>		<i>ribavirin cap 200 mg</i> .....	100
<i>rabeprazole sodium ec tab 20 mg</i> .....	163	<i>ribavirin tab 200 mg</i> .....	100
RADICAVA ORS SUS 105/5ML.....	148	<i>ribociclib succinate</i>	
RADICAVA ORS SUS STARTER.....	148	see KISQALI TAB 200DOSE.....	88
RAGWITEK SUB.....	38	see KISQALI TAB 400DOSE.....	88
<i>raloxifene hcl tab 60 mg</i> .....	129	see KISQALI TAB 600DOSE.....	88
<i>raltegravir potassium</i>		<i>rifabutin cap 150 mg</i> .....	83
see ISENTRESS CHW 100MG.....	98	<i>rifampin cap 150 mg</i> .....	83
see ISENTRESS CHW 25MG.....	98	<i>rifampin cap 300 mg</i> .....	83
see ISENTRESS HD TAB 600MG.....	98	<i>rifaximin</i>	
see ISENTRESS POW 100MG.....	98	see XIFAXAN TAB 550MG.....	52
see ISENTRESS TAB 400MG.....	98	<i>rilpivirine hcl tab 25 mg (base equivalent)</i> .....	98
<i>ramelteon tab 8 mg</i> .....	139	<i>riluzole tab 50 mg</i> .....	148
<i>ramipril cap 1.25 mg</i> .....	78	<i>rimantadine hydrochloride tab 100 mg</i> .....	100
<i>ramipril cap 10 mg</i> .....	78	<i>rimegepant sulfate</i>	
<i>ramipril cap 2.5 mg</i> .....	78	see NURTEC TAB 75MG ODT.....	142
<i>ramipril cap 5 mg</i> .....	78	RINVOQ LQ SOL 1MG/ML.....	38
<i>ranitidine hcl tab 150 mg</i> .....	162	RINVOQ TAB 15MG ER.....	38
<i>ranitidine hcl tab 300 mg</i> .....	162	RINVOQ TAB 30MG ER.....	39
<i>ranolazine tab er 12hr 1000 mg</i> .....	53	RINVOQ TAB 45MG ER.....	39
<i>ranolazine tab er 12hr 500 mg</i> .....	53	<i>riociguat</i>	
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i> ...	93	see ADEMPAS TAB 0.5MG.....	107
<i>rasagiline mesylate tab 1 mg (base equiv)</i> .....	93	see ADEMPAS TAB 1.5MG.....	107
RECLIPSEN		see ADEMPAS TAB 1MG.....	107
see Desogestrel & Ethinyl Estradiol Tab 0.15		see ADEMPAS TAB 2.5MG.....	107
mg-30 mcg.....	109	see ADEMPAS TAB 2MG.....	107
<i>regorafenib</i>		<i>risedronate sodium tab 150 mg</i> .....	128
see STIVARGA TAB 40MG.....	90	<i>risedronate sodium tab 30 mg</i> .....	128
RELENZA MIS DISKHALE.....	100	<i>risedronate sodium tab 35 mg</i> .....	128
<i>relugolix-estradiol-norethindrone acetate</i>		<i>risedronate sodium tab 5 mg</i> .....	128

<i>risedronate sodium tab delayed release 35 mg</i>	128	<i>rizatRIPTAN benzoate tab 5 mg (base equivalent)</i>	143
<i>risperidone orally disintegrating tab 0.25 mg</i>	94	<i>roflumilast (topical)</i>	
<i>risperidone orally disintegrating tab 0.5 mg</i>	94	see ZORYVE CRE 0.05%	125
<i>risperidone orally disintegrating tab 1 mg</i>	94	see ZORYVE CRE 0.15%	126
<i>risperidone orally disintegrating tab 2 mg</i>	94	see ZORYVE CRE 0.3%	125
<i>risperidone orally disintegrating tab 3 mg</i>	94	see ZORYVE MIS 0.3%	126
<i>risperidone orally disintegrating tab 4 mg</i>	94	<i>roflumilast tab 250 mcg</i>	56
<i>risperidone soln 1 mg/ml</i>	94	<i>roflumilast tab 500 mcg</i>	56
<i>risperidone tab 0.25 mg</i>	94	<i>ropinirole hydrochloride tab 0.25 mg</i>	93
<i>risperidone tab 0.5 mg</i>	94	<i>ropinirole hydrochloride tab 0.5 mg</i>	93
<i>risperidone tab 1 mg</i>	94	<i>ropinirole hydrochloride tab 1 mg</i>	93
<i>risperidone tab 2 mg</i>	94	<i>ropinirole hydrochloride tab 2 mg</i>	93
<i>risperidone tab 3 mg</i>	95	<i>ropinirole hydrochloride tab 3 mg</i>	93
<i>risperidone tab 4 mg</i>	95	<i>ropinirole hydrochloride tab 4 mg</i>	93
RITFLO MIS	142	<i>ropinirole hydrochloride tab 5 mg</i>	93
<i>ritlecitinib tosylate</i>		<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	93
see LITFULO CAP 50MG	125	<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	93
<i>ritonavir tab 100 mg</i>	98	<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	93
<i>rivaroxaban</i>		<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	93
see XARELTO STAR TAB 15/20MG	59	<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	93
see XARELTO TAB 10MG	60	<i>rosuvastatin calcium tab 10 mg</i>	77
see XARELTO TAB 15MG	60	<i>rosuvastatin calcium tab 20 mg</i>	77
see XARELTO TAB 2.5MG	60	<i>rosuvastatin calcium tab 40 mg</i>	77
see XARELTO TAB 20MG	60	<i>rosuvastatin calcium tab 5 mg</i>	77
<i>rivaroxaban for susp 1 mg/ml</i>	59	ROSYRAH	
<i>rivaroxaban tab 2.5 mg</i>	59	see Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg & eth Est 0.01 mg	110
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	154	<i>rotigotine</i>	
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	154	see NEUPRO DIS 1MG/24HR	92
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	154	see NEUPRO DIS 2MG/24HR	92
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	154	see NEUPRO DIS 3MG/24HR	92
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	154	see NEUPRO DIS 4MG/24HR	92
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	154	see NEUPRO DIS 6MG/24HR	93
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	154	see NEUPRO DIS 8MG/24HR	93
RIVELSA		ROWEEPRA	
see Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg & eth Est 0.01 mg	110	see Levetiracetam Tab 500 mg	62
<i>rizatRIPTAN benzoate oral disintegrating tab 10 mg (base eq)</i>	143	ROZLYTREK CAP 100MG	90
<i>rizatRIPTAN benzoate oral disintegrating tab 5 mg (base eq)</i>	143	ROZLYTREK CAP 200MG	90
<i>rizatRIPTAN benzoate tab 10 mg (base equivalent)</i>	143	ROZLYTREK PAK 50MG	90
		<i>rufinamide susp 40 mg/ml</i>	63
		<i>rufinamide tab 200 mg</i>	63

<b>rufinamide tab 400 mg</b> .....	63	SCEMBLIX TAB 40MG .....	90
<b>ruxolitinib phosphate</b>		<b>scopolamine td patch 72hr 1 mg/3days</b> .....	73
see JAKAFI TAB 10MG .....	88	<b>segesterone acetate-ethinyl estradiol</b>	
see JAKAFI TAB 15MG .....	88	see ANNOVERA MIS .....	116
see JAKAFI TAB 20MG .....	88	<b>selegiline hcl cap 5 mg</b> .....	93
see JAKAFI TAB 25MG .....	88	<b>selegiline hcl tab 5 mg</b> .....	93
see JAKAFI TAB 5MG .....	88	<b>selenium sulfide lotion 2.5%</b> .....	123
<b>ruxolitinib phosphate (topical)</b>		<b>selexipag</b>	
see OPZELURA CRE 1.5%.....	125	see UPTRAVI PACK TAB 200/800.....	107
RYBELSUS TAB 14MG .....	70	see UPTRAVI TAB 1000MCG .....	107
RYBELSUS TAB 3MG .....	70	see UPTRAVI TAB 1200MCG .....	107
RYBELSUS TAB 7MG .....	70	see UPTRAVI TAB 1400MCG .....	107
RYDAPT CAP 25MG.....	90	see UPTRAVI TAB 1600MCG .....	107
RYTARY CAP 145MG .....	93	see UPTRAVI TAB 200MCG .....	107
RYTARY CAP 195MG .....	93	see UPTRAVI TAB 400MCG .....	107
RYTARY CAP 245MG .....	93	see UPTRAVI TAB 600MCG .....	107
RYTARY CAP 95MG .....	93	see UPTRAVI TAB 800MCG .....	107
RYVENT		<b>selpercatinib</b>	
see Carbinoxamine Maleate Tab 6 mg .....	74	see RETEVMO TAB 120MG .....	89
<b>S</b>		see RETEVMO TAB 160MG .....	89
<b>sacubitril-valsartan tab 24-26 mg</b> .....	105	see RETEVMO TAB 40MG .....	89
<b>sacubitril-valsartan tab 49-51 mg</b> .....	105	see RETEVMO TAB 80MG .....	89
<b>sacubitril-valsartan tab 97-103 mg</b> .....	105	<b>selumetinib sulfate</b>	
<b>salmeterol xinafoate</b>		see KOSELUGO CAP 10MG .....	88
see SEREVENT DIS AER 50MCG .....	58	see KOSELUGO CAP 25MG .....	88
<b>salsalate tab 750 mg</b> .....	41	<b>semaglutide</b>	
SANCUSO DIS 3.1MG.....	73	see OZEMPIC INJ 2MG/3ML .....	70
<b>sapropterin dihydrochloride powder packet 100 mg</b> .....	129	see OZEMPIC INJ 4MG/3ML .....	70
Sapropterin Dihydrochloride Powder Packet 100 mg.....	129	see OZEMPIC INJ 8MG/3ML .....	70
<b>sapropterin dihydrochloride powder packet 500 mg</b> .....	129	see RYBELSUS TAB 14MG .....	70
Sapropterin Dihydrochloride Powder Packet 500 mg.....	129	see RYBELSUS TAB 3MG .....	70
<b>sapropterin dihydrochloride tab 100 mg</b> .....	130	see RYBELSUS TAB 7MG .....	70
Sapropterin Dihydrochloride Tab 100 mg .....	130	<b>semaglutide (weight management)</b>	
<b>saxagliptin hcl tab 2.5 mg (base equiv)</b> .....	70	see WEGOVY TAB 1.5MG .....	31
<b>saxagliptin hcl tab 5 mg (base equiv)</b> .....	70	see WEGOVY TAB 25MG .....	32
<b>saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg</b> .....	68	see WEGOVY TAB 4MG .....	31
<b>saxagliptin-metformin hcl tab er 24hr 5-1000 mg</b> .....	68	see WEGOVY TAB 9MG .....	32
<b>saxagliptin-metformin hcl tab er 24hr 5-500 mg</b> .....	68	<b>serdexmethylphenidate chloride-dexmethylphenidate hcl</b>	
SCEMBLIX TAB 100MG .....	90	see AZSTARYS CAP 26.1-5.2.....	33
SCEMBLIX TAB 20MG .....	90	see AZSTARYS CAP 39.2-7.8.....	33
		see AZSTARYS CAP 52.3-10.....	33
		SEREVENT DIS AER 50MCG .....	58
		<b>sertraline hcl cap 150 mg</b> .....	66
		<b>sertraline hcl cap 200 mg</b> .....	66
		<b>sertraline hcl oral concentrate for solution 20 mg/ml</b> .....	66

<b>sertraline hcl tab 100 mg</b> .....	66	SIRTURO TAB 100MG .....	83
<b>sertraline hcl tab 25 mg</b> .....	66	SIRTURO TAB 20MG .....	83
<b>sertraline hcl tab 50 mg</b> .....	66	<b>sitagliptin</b>	
SETLAKIN		see ZITUVIO TAB 100MG .....	70
see Levonorgestrel & Ethinyl Estradiol (91-Day)		see ZITUVIO TAB 25MG .....	70
Tab 0.15-0.03 mg .....	110	see ZITUVIO TAB 50MG .....	70
<b>sevelamer carbonate packet 0.8 gm</b> .....	134	<b>sitagliptin free base-metformin hcl</b>	
<b>sevelamer carbonate packet 2.4 gm</b> .....	134	see ZITUVIMET TAB 50-1000 .....	69
<b>sevelamer carbonate tab 800 mg</b> .....	134	see ZITUVIMET TAB 50-500MG .....	69
<b>sevelamer hcl tab 400 mg</b> .....	134	see ZITUVIMET XR TAB 100-1000 .....	69
<b>sevelamer hcl tab 800 mg</b> .....	134	see ZITUVIMET XR TAB 50-1000.....	69
SHAROBEL		see ZITUVIMET XR TAB 50-500MG .....	69
see Norethindrone Tab 0.35 mg .....	117	SM NICOTINE	
<b>short ragweed pollen allergen extract</b>		see Nicotine Polacrilex Lozenge 2 mg.....	157
see RAGWITEK SUB .....	38	SM NICOTINE POLACRILEX	
SIKLOS TAB 1000MG .....	136	see Nicotine Polacrilex Lozenge 4 mg.....	158
SIKLOS TAB 100MG.....	136	<b>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-</b>	
<b>sildenafil citrate for suspension 10 mg/ml</b> .....	106	<b>1.6 gm/177ml</b> .....	139
<b>sildenafil citrate tab 100 mg</b> .....	105	<b>sodium chloride soln nebu 0.9%</b> .....	119
<b>sildenafil citrate tab 20 mg</b> .....	107	<b>sodium chloride soln nebu 10%</b> .....	119
<b>sildenafil citrate tab 25 mg</b> .....	105	<b>sodium chloride soln nebu 3%</b> .....	119
<b>sildenafil citrate tab 50 mg</b> .....	105	<b>sodium chloride soln nebu 7%</b> .....	119
<b>silodosin cap 4 mg</b> .....	135	<b>sodium fluoride chew tab 0.25 mg f (from 0.55</b>	
<b>silodosin cap 8 mg</b> .....	135	<b>mg naf)</b> .....	143
<b>silver sulfadiazine cream 1%</b> .....	123	<b>sodium fluoride chew tab 0.5 mg f (from 1.1 mg</b>	
Silver Sulfadiazine Cream 1%.....	123	<b>naf)</b> .....	143
SIMBRINZA SUS 1-0.2% .....	149	<b>sodium fluoride chew tab 1 mg f (from 2.2 mg</b>	
SIMLIYA		<b>naf)</b> .....	144
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-		<b>sodium fluoride soln 0.5 mg/ml f (from 1.1</b>	
0.02/0.01 mg(21/5).....	108	<b>mg/ml naf)</b> .....	144
SIMPESSE		<b>sodium fluoride tab 0.5 mg f (from 1.1 mg naf)</b>	
see Levonorg-Eth Est Tab 0.15-0.03mg(84) &		.....	144
Eth Est Tab 0.01mg(7) .....	110	<b>sodium fluoride tab 1 mg f (from 2.2 mg naf)</b> 144	
<b>simvastatin tab 10 mg</b> .....	77	<b>sodium oxybate</b>	
<b>simvastatin tab 20 mg</b> .....	77	see LUMRYZ PAK 6GM .....	153
<b>simvastatin tab 40 mg</b> .....	77	see LUMRYZ PAK 7.5GM .....	153
<b>simvastatin tab 5 mg</b> .....	77	see LUMRYZ PAK 9GM .....	153
<b>simvastatin tab 80 mg</b> .....	77	see LUMRYZ PAK STARTER .....	153
<b>siponimod fumarate</b>		see LUMRYZ PKG 4.5GM.....	153
see MAYZENT PAK STARTER .....	155	<b>sodium phenylbutyrate</b>	
see MAYZENT TAB 0.25MG .....	155	see PHEBURANE MIS 483/GM.....	129
see MAYZENT TAB 1MG .....	155	<b>sodium phenylbutyrate oral powder 3</b>	
see MAYZENT TAB 2MG .....	155	<b>gm/teaspoonful</b> .....	130
<b>sirolimus oral soln 1 mg/ml</b> .....	145	<b>sodium phenylbutyrate tab 500 mg</b> .....	130
<b>sirolimus tab 0.5 mg</b> .....	145	<b>sodium picosulfate-magnesium oxide-</b>	
<b>sirolimus tab 1 mg</b> .....	146	<b>anhydrous citric acid</b>	
<b>sirolimus tab 2 mg</b> .....	146	see CLENPIQ SOL .....	139

<b>sodium polystyrene sulfonate powder</b> .....	146	see FLEXICHAMBER MIS MASK LRG .....	141
Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml.....	146	see FLEXICHAMBER MIS MASK SM .....	141
<b>sodium polystyrene sulfonate susp 15 gm/60ml</b> .....	146	<b>spacer/aerosol-holding chambers</b>	
Sodium Polystyrene Sulfonate Susp 15 gm/60ml .....	146	see AERCHMBR PLS MIS LRG MASK .....	141
<b>sofosbuvir</b>		see AERCHMBR PLS MIS MED MASK .....	141
see SOVALDI PAK 150MG .....	100	see AERCHMBR PLS MIS SM MASK .....	141
see SOVALDI PAK 200MG .....	100	see AERCHMBR Z- MIS STAT PLS .....	141
see SOVALDI TAB 200MG .....	100	see AEROCHAMBER MIS CHAMBER .....	141
see SOVALDI TAB 400MG .....	100	see AEROCHAMBER MIS MV .....	141
<b>sofosbuvir-velpatasvir</b>		see AEROCHAMBER MIS PLUS.....	141
see EPCLUSA PAK 150-37.5.....	99	see AEROVENT MIS PLUS.....	141
see EPCLUSA PAK 200-50MG.....	99	see BREATHE EASE MIS LG MASK .....	141
see EPCLUSA TAB 200-50MG.....	99	see BREATHE EASE MIS MED MASK .....	141
see EPCLUSA TAB 400-100.....	99	see BREATHE EASE MIS SM MASK .....	141
<b>sofosbuvir-velpatasvir-voxilaprevir</b>		see COMPACT SPAC MIS CHAMBER .....	141
see VOSEVI TAB .....	100	see COMPACT SPAC MIS LG MASK .....	141
<b>solifenacin succinate tab 10 mg</b> .....	163	see COMPACT SPAC MIS MD MASK.....	141
<b>solifenacin succinate tab 5 mg</b> .....	163	see COMPACT SPAC MIS SM MASK .....	141
SOLIQUA INJ 100/33.....	69	see EASIVENT MIS .....	141
<b>solriamfetol hcl</b>		see EASIVENT MIS MASK LG .....	141
see SUNOSI TAB 150MG .....	33	see EASIVENT MIS MASK MED .....	141
see SUNOSI TAB 75MG .....	33	see EASIVENT MIS MASK SM .....	141
<b>sonidegib phosphate</b>		see FLEXICHAMBER MIS .....	141
see ODOMZO CAP 200MG .....	84	see HOLD CHAMBER MIS ADLT LG .....	142
<b>sorafenib tosylate tab 200 mg (base equivalent)</b> .....	90	see HOLD CHAMBER MIS MEDIUM .....	142
<b>sotalol hcl (afib/af) tab 120 mg</b> .....	102	see HOLD CHAMBER MIS SMALL .....	142
<b>sotalol hcl (afib/af) tab 160 mg</b> .....	102	see INSPIREASE MIS DD SYST .....	142
<b>sotalol hcl (afib/af) tab 80 mg</b> .....	102	see MICROCHAMBER MIS.....	142
<b>sotalol hcl tab 120 mg</b> .....	102	see MICROSPACER MIS .....	142
<b>sotalol hcl tab 160 mg</b> .....	102	see OPTICHAMBER MIS DIA LG .....	142
<b>sotalol hcl tab 240 mg</b> .....	102	see OPTICHAMBER MIS DIA MD .....	142
<b>sotalol hcl tab 80 mg</b> .....	102	see OPTICHAMBER MIS DIA SM .....	142
<b>sotorasib</b>		see OPTICHAMBER MIS DIAMOND .....	142
see LUMAKRAS TAB 120MG .....	88	see POCKET CHAMB MIS .....	142
see LUMAKRAS TAB 240MG .....	89	see POCKET SPACE MIS.....	142
see LUMAKRAS TAB 320MG .....	89	see PROCHAMBER MIS VHC .....	142
SOTYKTU TAB 6MG.....	122	see RITEFLO MIS.....	142
SOVALDI PAK 150MG .....	100	<b>sparsentan</b>	
SOVALDI PAK 200MG .....	100	see FILSPARI TAB 200MG.....	134
SOVALDI TAB 200MG .....	100	see FILSPARI TAB 400MG.....	134
SOVALDI TAB 400MG .....	100	<b>spinosad susp 0.9%</b> .....	126
<b>spacer/aerosol-holding chamber supplies - masks</b>		SPIRIVA CAP HANDIHLR .....	56
		SPIRIVA RESP AER 1.25MCG .....	56
		SPIRIVA RESP AER 2.5MCG .....	56
		<b>spironolactone &amp; hydrochlorothiazide tab 25-25 mg</b> .....	127
		<b>spironolactone susp 25 mg/5ml</b> .....	127

<b>spironolactone tab 100 mg</b> .....	128	<b>sulfasalazine tab delayed release 500 mg</b> .....	133
<b>spironolactone tab 25 mg</b> .....	127	SULFATRIM PEDIATRIC	
<b>spironolactone tab 50 mg</b> .....	127	see Sulfamethoxazole-Trimethoprim Susp 200-	
SPRINTEC 28		40 mg/5ml .....	52
see Norgestimate & Ethinyl Estradiol Tab 0.25		<b>sulindac tab 150 mg</b> .....	40
mg-35 mcg .....	115	<b>sulindac tab 200 mg</b> .....	40
SPS		<b>sumatriptan</b>	
see Sodium Polystyrene Sulfonate Rectal Susp		see TOSYMRA SOL 10MG .....	143
30 gm/120ml .....	146	<b>sumatriptan nasal spray 20 mg/act</b> .....	143
see Sodium Polystyrene Sulfonate Susp 15		<b>sumatriptan nasal spray 5 mg/act</b> .....	143
gm/60ml .....	146	<b>sumatriptan succinate</b>	
SSD		see IMITREX INJ 4MG/0.5 .....	143
see Silver Sulfadiazine Cream 1% .....	123	see IMITREX INJ 6MG/0.5 .....	143
STIOLTO AER 2.5-2.5 .....	58	see ZEMBRACE SYM INJ 3/0.5ML .....	143
STIVARGA TAB 40MG .....	90	<b>sumatriptan succinate inj 6 mg/0.5ml</b> .....	143
STRIVERDI AER 2.5MCG .....	58	<b>sumatriptan succinate solution auto-injector 6</b>	
SUBVENITE		<b>mg/0.5ml</b> .....	143
see Lamotrigine Tab 100 mg .....	62	<b>sumatriptan succinate tab 100 mg</b> .....	143
see Lamotrigine Tab 150 mg .....	62	<b>sumatriptan succinate tab 25 mg</b> .....	143
see Lamotrigine Tab 200 mg .....	62	<b>sumatriptan succinate tab 50 mg</b> .....	143
see Lamotrigine Tab 25 mg .....	61	<b>sunitinib malate cap 12.5 mg (base equivalent)</b>	
SUBVENITE STARTER KIT/BLU		.....	90
see Lamotrigine Tab 35 X 25 mg Starter Kit ..	62	<b>sunitinib malate cap 25 mg (base equivalent)</b>	90
SUBVENITE STARTER KIT/GRE		<b>sunitinib malate cap 37.5 mg (base equivalent)</b>	
see Lamotrigine Tab 84 X 25 mg & 14 X 100 mg		.....	90
Starter Kit .....	62	<b>sunitinib malate cap 50 mg (base equivalent)</b>	90
SUBVENITE STARTER KIT/ORA		SUNOSI TAB 150MG .....	33
see Lamotrigine Tab 25 mg (42) & 100 mg (7)		SUNOSI TAB 75MG .....	33
Starter Kit .....	61	<b>suvorexant</b>	
<b>sucralfate tab 1 gm</b> .....	162	see BELSOMRA TAB 10MG .....	139
<b>sulconazole nitrate cream 1%</b> .....	122	see BELSOMRA TAB 15MG .....	139
<b>sulconazole nitrate solution 1%</b> .....	122	see BELSOMRA TAB 20MG .....	139
<b>sulfacetamide sodium lotion 10% (acne)</b> .....	120	see BELSOMRA TAB 5MG .....	139
<b>sulfacetamide sodium ophth soln 10%</b> .....	149	SYEDA	
<b>sulfacetamide sodium shampoo 10%</b> .....	123	see Drospirenone-Ethinyl Estradiol Tab 3-0.03	
<b>sulfacetamide sodium-prednisolone ophth soln</b>		mg .....	109
<b>10-0.23(0.25)%</b> .....	150	SYMPROIC TAB 0.2MG .....	134
<b>sulfadiazine tab 500 mg</b> .....	159	SYMTUZA TAB .....	98
<b>sulfamethoxazole-trimethoprim susp 200-40</b>		SYNAREL SOL 2MG/ML .....	129
<b>mg/5ml</b> .....	52	SYNJARDY TAB .....	69
Sulfamethoxazole-Trimethoprim Susp 200-40		SYNJARDY TAB 12.5-500 .....	69
mg/5ml .....	52	SYNJARDY TAB 5-1000MG .....	69
<b>sulfamethoxazole-trimethoprim tab 400-80 mg</b>		SYNJARDY TAB 5-500MG .....	69
.....	52	SYNJARDY XR TAB .....	69
<b>sulfamethoxazole-trimethoprim tab 800-160 mg</b>		SYNJARDY XR TAB 10-1000 .....	69
.....	52	SYNJARDY XR TAB 25-1000 .....	69
<b>sulfasalazine tab 500 mg</b> .....	133	SYNJARDY XR TAB 5-1000MG .....	69

SYNTHROID TAB 100MCG .....	161
SYNTHROID TAB 112MCG .....	161
SYNTHROID TAB 125MCG .....	161
SYNTHROID TAB 137MCG .....	161
SYNTHROID TAB 150MCG .....	161
SYNTHROID TAB 175MCG .....	161
SYNTHROID TAB 200MCG .....	161
SYNTHROID TAB 25MCG .....	161
SYNTHROID TAB 300MCG .....	161
SYNTHROID TAB 50MCG .....	161
SYNTHROID TAB 75MCG .....	161
SYNTHROID TAB 88MCG .....	161

## T

<b>tacrolimus cap 0.5 mg</b> .....	146
<b>tacrolimus cap 1 mg</b> .....	146
<b>tacrolimus cap 5 mg</b> .....	146
<b>tacrolimus oint 0.03%</b> .....	125
<b>tacrolimus oint 0.1%</b> .....	125
<b>tadalafil (pulmonary hypertension)</b>	
see TADLIQ SUS 20MG/5ML .....	107
<b>tadalafil tab 10 mg</b> .....	105
<b>tadalafil tab 2.5 mg</b> .....	105
<b>tadalafil tab 20 mg</b> .....	105
<b>tadalafil tab 20 mg (pah)</b> .....	107
Tadalafil Tab 20 mg (Pah) .....	107
<b>tadalafil tab 5 mg</b> .....	105
TADLIQ SUS 20MG/5ML.....	107
<b>tafamidis</b>	
see VYNDAMAX CAP 61MG .....	107
TAFINLAR CAP 50MG.....	90
TAFINLAR CAP 75MG.....	90
TAFINLAR TAB 10MG.....	90
<b>tafluprost preservative free (pf) ophth soln</b>	
<b>0.0015%</b> .....	151
TAGRISO TAB 40MG .....	84
TAGRISO TAB 80MG .....	84
<b>taletrectinib adipate</b>	
see IBTROZI CAP 200MG .....	88
TALICIA CAP.....	163
<b>tamoxifen citrate tab 10 mg (base equivalent)</b>	85
<b>tamoxifen citrate tab 20 mg (base equivalent)</b>	85
<b>tamsulosin hcl cap 0.4 mg</b> .....	135
TANLOR	
see Methocarbamol Tab 1000 mg .....	147
<b>tapentadol hcl tab 100 mg</b> .....	46
<b>tapentadol hcl tab 50 mg</b> .....	45
<b>tapentadol hcl tab 75 mg</b> .....	46

<b>tapinarof</b>	
see VTAMA CRE 1%.....	122
TARINA 24 FE	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg (24) .....	114
TARINA FE 1/20 EQ	
see Norethindrone Ace & Ethinyl Estradiol-Fe	
Tab 1 mg-20 mcg.....	113
<b>tasimelton capsule 20 mg</b> .....	139
TAYSOFY	
see Norethindrone Ace-Ethinyl Estradiol-Fe	
Cap 1 mg-20 mcg (24).....	114
<b>tazarotene cream 0.05%</b> .....	122
<b>tazarotene cream 0.1%</b> .....	122
<b>tazarotene gel 0.05%</b> .....	122
<b>tazarotene gel 0.1%</b> .....	122
<b>telmisartan tab 20 mg</b> .....	78
<b>telmisartan tab 40 mg</b> .....	79
<b>telmisartan tab 80 mg</b> .....	79
<b>telmisartan-amlodipine tab 40-10 mg</b> .....	81
<b>telmisartan-amlodipine tab 40-5 mg</b> .....	81
<b>telmisartan-amlodipine tab 80-10 mg</b> .....	81
<b>telmisartan-amlodipine tab 80-5 mg</b> .....	81
<b>telmisartan-hydrochlorothiazide tab 40-12.5 mg</b>	
.....	81
<b>telmisartan-hydrochlorothiazide tab 80-12.5 mg</b>	
.....	81
<b>telmisartan-hydrochlorothiazide tab 80-25 mg</b>	
.....	81
<b>temazepam cap 15 mg</b> .....	138
<b>temazepam cap 22.5 mg</b> .....	138
<b>temazepam cap 30 mg</b> .....	138
<b>temazepam cap 7.5 mg</b> .....	138
<b>temozolomide cap 100 mg</b> .....	83
<b>temozolomide cap 140 mg</b> .....	83
<b>temozolomide cap 180 mg</b> .....	83
<b>temozolomide cap 20 mg</b> .....	83
<b>temozolomide cap 250 mg</b> .....	83
<b>temozolomide cap 5 mg</b> .....	83
TENCON	
see Butalbital-Acetaminophen Tab 50-325 mg	
.....	41
<b>tenofovir disoproxil fumarate tab 300 mg</b> .....	99
<b>terazosin hcl cap 1 mg (base equivalent)</b> .....	79
<b>terazosin hcl cap 10 mg (base equivalent)</b> .....	79
<b>terazosin hcl cap 2 mg (base equivalent)</b> .....	79
<b>terazosin hcl cap 5 mg (base equivalent)</b> .....	79

<b>terbinafine hcl tab 250 mg</b> .....	74
<b>terbutaline sulfate tab 2.5 mg</b> .....	58
<b>terbutaline sulfate tab 5 mg</b> .....	58
<b>terconazole vaginal cream 0.4%</b> .....	164
<b>terconazole vaginal cream 0.8%</b> .....	164
<b>terconazole vaginal suppos 80 mg</b> .....	164
<b>teriflunomide tab 14 mg</b> .....	155
<b>teriflunomide tab 7 mg</b> .....	155
<b>testosterone</b>	
see NATESTO GEL 5.5MG.....	51
<b>testosterone td gel 12.5 mg/act (1%)</b> .....	51
<b>testosterone td gel 20.25 mg/1.25gm (1.62%)</b> .....	51
<b>testosterone td gel 20.25 mg/act (1.62%)</b> .....	51
<b>testosterone td gel 25 mg/2.5gm (1%)</b> .....	51
<b>testosterone td gel 40.5 mg/2.5gm (1.62%)</b> .....	51
<b>testosterone td gel 50 mg/5gm (1%)</b> .....	51
<b>testosterone td soln 30 mg/act</b> .....	51
<b>tetrabenazine tab 12.5 mg</b> .....	154
<b>tetrabenazine tab 25 mg</b> .....	154
<b>tetracycline hcl cap 250 mg</b> .....	159
<b>tetracycline hcl cap 500 mg</b> .....	159
<b>TEXACORT</b>	
see Hydrocortisone Soln 2.5%.....	124
<b>thalidomide</b>	
see THALOMID CAP 100MG.....	145
see THALOMID CAP 50MG.....	145
<b>THALOMID CAP 100MG</b> .....	145
<b>THALOMID CAP 50MG</b> .....	145
<b>theophylline elixir 80 mg/15ml</b> .....	59
<b>Theophylline Elixir 80 mg/15ml</b> .....	59
<b>theophylline soln 80 mg/15ml</b> .....	59
<b>theophylline tab er 12hr 100 mg</b> .....	59
<b>theophylline tab er 12hr 200 mg</b> .....	59
<b>theophylline tab er 12hr 300 mg</b> .....	59
<b>theophylline tab er 12hr 450 mg</b> .....	59
<b>theophylline tab er 24hr 400 mg</b> .....	59
<b>theophylline tab er 24hr 600 mg</b> .....	59
<b>thioridazine hcl tab 10 mg</b> .....	96
<b>thioridazine hcl tab 100 mg</b> .....	96
<b>thioridazine hcl tab 25 mg</b> .....	96
<b>thioridazine hcl tab 50 mg</b> .....	96
<b>thiothixene cap 1 mg</b> .....	97
<b>thiothixene cap 10 mg</b> .....	97
<b>thiothixene cap 2 mg</b> .....	97
<b>thiothixene cap 5 mg</b> .....	97
<b>THRIVE</b>	
see Nicotine Polacrilex Gum 2 mg.....	156

<b>TIADYL T ER</b>	
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 120 mg.....	103
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 180 mg.....	103
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 240 mg.....	103
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 300 mg.....	103
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 360 mg.....	103
see Diltiazem Hcl Extended Release Beads Cap	
Er 24hr 420 mg.....	103
<b>tiagabine hcl tab 12 mg</b> .....	64
<b>tiagabine hcl tab 16 mg</b> .....	64
<b>tiagabine hcl tab 2 mg</b> .....	64
<b>tiagabine hcl tab 4 mg</b> .....	64
<b>ticagrelor tab 60 mg</b> .....	136
<b>ticagrelor tab 90 mg</b> .....	136
<b>TILIA FE</b>	
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-	
20/1-30/1-35 mg-Mcg.....	112
<b>timolol maleate ophth gel forming soln 0.25%</b>	
.....	148
<b>timolol maleate ophth gel forming soln 0.5%</b>	148
<b>timolol maleate ophth soln 0.25%</b> .....	148
<b>timolol maleate ophth soln 0.5%</b> .....	148
<b>timolol maleate ophth soln 0.5% (once-daily)</b>	
.....	148
<b>timolol maleate preservative free ophth soln</b>	
<b>0.25%</b> .....	148
<b>timolol maleate preservative free ophth soln</b>	
<b>0.5%</b> .....	148
<b>timolol maleate tab 10 mg</b> .....	102
<b>timolol maleate tab 20 mg</b> .....	102
<b>timolol maleate tab 5 mg</b> .....	102
<b>timolol ophth soln 0.5%</b> .....	148
<b>timothy grass pollen allergen extract</b>	
see GRASTEK SUB 2800BAU.....	38
<b>tinidazole tab 250 mg</b> .....	52
<b>tinidazole tab 500 mg</b> .....	52
<b>tiopronin tab 100 mg</b> .....	135
<b>tiopronin tab delayed release 100 mg</b> .....	135
<b>Tiopronin Tab Delayed Release 100 mg</b> .....	135
<b>tiopronin tab delayed release 300 mg</b> .....	135
<b>Tiopronin Tab Delayed Release 300 mg</b> .....	135
<b>tiotropium bromide</b>	

see SPIRIVA CAP HANDHLR.....	56	<b>tolvaptan tab therapy pack 45 &amp; 15 mg</b> .....	130
see SPIRIVA RESP AER 1.25MCG .....	56	<b>tolvaptan tab therapy pack 60 &amp; 30 mg</b> .....	130
see SPIRIVA RESP AER 2.5MCG.....	56	<b>tolvaptan tab therapy pack 90 &amp; 30 mg</b> .....	130
<b>tiotropium bromide-olodaterol hcl</b>		<b>topiramate cap er 24hr 100 mg</b> .....	63
see STIOLTO AER 2.5-2.5.....	58	<b>topiramate cap er 24hr 200 mg</b> .....	63
<b>tirzepatide</b>		<b>topiramate cap er 24hr 25 mg</b> .....	63
see MOUNJARO INJ 10MG/0.5.....	70	<b>topiramate cap er 24hr 50 mg</b> .....	63
see MOUNJARO INJ 12.5/0.5.....	70	<b>topiramate oral soln 25 mg/ml</b> .....	63
see MOUNJARO INJ 15MG/0.5.....	70	<b>topiramate sprinkle cap 15 mg</b> .....	63
see MOUNJARO INJ 2.5/0.5 .....	70	<b>topiramate sprinkle cap 25 mg</b> .....	63
see MOUNJARO INJ 5MG/0.5 .....	70	<b>topiramate sprinkle cap 50 mg</b> .....	63
see MOUNJARO INJ 7.5/0.5 .....	70	<b>topiramate tab 100 mg</b> .....	63
TIVICAY PD TAB 5MG .....	99	<b>topiramate tab 200 mg</b> .....	63
TIVICAY TAB 50MG .....	99	<b>topiramate tab 25 mg</b> .....	63
<b>tizanidine hcl cap 2 mg (base equivalent)</b> .....	147	<b>topiramate tab 50 mg</b> .....	63
<b>tizanidine hcl cap 4 mg (base equivalent)</b> .....	147	<b>toremifene citrate tab 60 mg (base equivalent)</b>	
<b>tizanidine hcl cap 6 mg (base equivalent)</b> .....	147	.....	85
<b>tizanidine hcl tab 2 mg (base equivalent)</b> .....	147	<b>TORPENZ</b>	
<b>tizanidine hcl tab 4 mg (base equivalent)</b> .....	147	see Everolimus Tab 10 mg .....	87
TOBRADEX OIN 0.3-0.1%.....	150	see Everolimus Tab 2.5 mg .....	87
<b>tobramycin (ophth)</b>		see Everolimus Tab 5 mg .....	87
see TOBREX OIN 0.3% OP .....	149	see Everolimus Tab 7.5 mg .....	87
<b>tobramycin nebu soln 300 mg/4ml</b> .....	38	<b>torseamide tab 10 mg</b> .....	127
<b>tobramycin nebu soln 300 mg/5ml</b> .....	38	<b>torseamide tab 100 mg</b> .....	127
<b>tobramycin ophth soln 0.3%</b> .....	149	<b>torseamide tab 20 mg</b> .....	127
<b>tobramycin-dexamethasone</b>		<b>torseamide tab 5 mg</b> .....	127
see TOBRADEX OIN 0.3-0.1%.....	150	TOSYMRA SOL 10MG .....	143
<b>tobramycin-dexamethasone ophth susp 0.3-0.1%</b> .....	150	TOUJEO MAX INJ 300/ML .....	71
TOBREX OIN 0.3% OP .....	149	TOUJEO SOLO INJ 300/ML .....	71
TODAY SPONGE MIS.....	164	<b>tramadol hcl oral soln 5 mg/ml</b> .....	46
<b>tofacitinib citrate</b>		<b>tramadol hcl tab 50 mg</b> .....	46
see XELJANZ SOL 1MG/ML .....	39	<b>tramadol hcl tab er 24hr 100 mg</b> .....	46
see XELJANZ TAB 10MG .....	39	<b>tramadol hcl tab er 24hr 200 mg</b> .....	46
see XELJANZ TAB 5MG .....	39	<b>tramadol hcl tab er 24hr 300 mg</b> .....	46
see XELJANZ XR TAB 11MG.....	39	<b>tramadol hcl tab er 24hr biphasic release 100 mg</b> .....	46
see XELJANZ XR TAB 22MG.....	39	<b>tramadol hcl tab er 24hr biphasic release 200 mg</b> .....	46
<b>tolcapone tab 100 mg</b> .....	91	<b>tramadol hcl tab er 24hr biphasic release 300 mg</b> .....	46
<b>tolmetin sodium tab 600 mg</b> .....	40	<b>tramadol-acetaminophen tab 37.5-325 mg</b> ....	49
<b>tolterodine tartrate cap er 24hr 2 mg</b> .....	163	<b>trametinib dimethyl sulfoxide</b>	
<b>tolterodine tartrate cap er 24hr 4 mg</b> .....	163	see MEKINIST SOL 0.05/ML .....	89
<b>tolterodine tartrate tab 1 mg</b> .....	163	see MEKINIST TAB 0.5MG .....	89
<b>tolterodine tartrate tab 2 mg</b> .....	163	see MEKINIST TAB 2MG .....	89
<b>tolvaptan tab 15 mg</b> .....	130	<b>trandolapril tab 1 mg</b> .....	78
<b>tolvaptan tab 30 mg</b> .....	130	<b>trandolapril tab 2 mg</b> .....	78
<b>tolvaptan tab therapy pack 15 mg</b> .....	130		
<b>tolvaptan tab therapy pack 30 &amp; 15 mg</b> .....	130		

<b>trandolapril tab 4 mg</b> .....	78	<b>tretinoin cream 0.1%</b> .....	120
<b>trandolapril-verapamil hcl tab er 1-240 mg</b> .....	81	<b>tretinoin gel 0.01%</b> .....	121
<b>trandolapril-verapamil hcl tab er 2-180 mg</b> .....	81	<b>tretinoin gel 0.025%</b> .....	121
<b>trandolapril-verapamil hcl tab er 2-240 mg</b> .....	81	<b>tretinoin gel 0.05%</b> .....	121
<b>trandolapril-verapamil hcl tab er 4-240 mg</b> .....	82	<b>tretinoin microsphere gel 0.04%</b> .....	121
<b>tranexamic acid tab 650 mg</b> .....	138	<b>tretinoin microsphere gel 0.08%</b> .....	121
<b>tranylcypramine sulfate tab 10 mg</b> .....	65	<b>tretinoin microsphere gel 0.1%</b> .....	121
<b>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</b> .....	151	<b>tretinoin-benzoyl peroxide</b> see TWYNEO CRE 0.1-3% .....	121
<b>trazodone hcl tab 100 mg</b> .....	66	TREZIX see Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg.....	47
<b>trazodone hcl tab 150 mg</b> .....	66	<b>triamcinolone acetonide cream 0.025%</b> .....	125
<b>trazodone hcl tab 300 mg</b> .....	66	<b>triamcinolone acetonide cream 0.1%</b> .....	124
<b>trazodone hcl tab 50 mg</b> .....	66	<b>triamcinolone acetonide cream 0.5%</b> .....	124
TRELEGY AER 100MCG .....	58	Triamcinolone Acetonide Cream 0.5% .....	125
TRELEGY AER 200MCG .....	58	<b>triamcinolone acetonide dental paste 0.1%</b> ..	146
<b>treprostinil</b> see TYVASO DPI POW 16-32-48 .....	106	Triamcinolone Acetonide Dental Paste 0.1% ..	146
see TYVASO DPI POW 16MCG .....	106	<b>triamcinolone acetonide lotion 0.025%</b> .....	125
see TYVASO DPI POW 32MCG .....	106	<b>triamcinolone acetonide lotion 0.1%</b> .....	125
see TYVASO DPI POW 48MCG .....	106	<b>triamcinolone acetonide oint 0.025%</b> .....	125
see TYVASO DPI POW 64MCG .....	106	<b>triamcinolone acetonide oint 0.1%</b> .....	125
see TYVASO DPI POW 80MCG .....	106	<b>triamcinolone acetonide oint 0.5%</b> .....	125
see TYVASO DPI POW INST KIT .....	106	<b>triamterene &amp; hydrochlorothiazide cap 37.5-25 mg</b> .....	127
see TYVASO DPI POW MAIN KIT .....	106	<b>triamterene &amp; hydrochlorothiazide tab 37.5-25 mg</b> .....	127
see TYVASO RF KT SOL 0.6MG/ML .....	106	<b>triamterene &amp; hydrochlorothiazide tab 75-50 mg</b> .....	127
see TYVASO SOL 0.6MG/ML .....	106	<b>triamterene cap 100 mg</b> .....	128
see TYVASO ST KT SOL 0.6MG/ML .....	106	<b>triamterene cap 50 mg</b> .....	128
<b>treprostinil diolamine</b> see ORENITRAM TAB 0.125MG .....	106	<b>triazolam tab 0.125 mg</b> .....	138
see ORENITRAM TAB 0.25MG .....	106	<b>triazolam tab 0.25 mg</b> .....	138
see ORENITRAM TAB 1MG .....	106	TRIDACAINE II see Lidocaine Patch 5%.....	125
see ORENITRAM TAB 2.5MG .....	106	TRIDERM see Triamcinolone Acetonide Cream 0.5%..	125
see ORENITRAM TAB 5MG .....	106	<b>trientine hcl cap 250 mg</b> .....	144
see ORENITRAM TAB MONTH 1 .....	106	TRI-ESTARYLLA see Norgestimate-Eth Estrad Tab 0.18- 35/0.215-35/0.25-35 mg-Mcg.....	115
see ORENITRAM TAB MONTH 2 .....	106	<b>trifarotene</b> see AKLIEF CRE 0.005% .....	119
see ORENITRAM TAB MONTH 3 .....	106	<b>trifluoperazine hcl tab 1 mg (base equivalent)</b> 96	
<b>treprostinil sodium</b> see YUTREPIA CAP 106MCG .....	106	<b>trifluoperazine hcl tab 10 mg (base equivalent)</b> .....	97
see YUTREPIA CAP 26.5MCG .....	106	<b>trifluoperazine hcl tab 2 mg (base equivalent)</b> 96	
see YUTREPIA CAP 53MCG .....	106		
see YUTREPIA CAP 79.5MCG .....	106		
TRESIBA FLEX INJ 100UNIT .....	71		
TRESIBA FLEX INJ 200UNIT .....	71		
TRESIBA INJ 100UNIT .....	71		
<b>tretinoin cap 10 mg</b> .....	91		
<b>tretinoin cream 0.025%</b> .....	121		
<b>tretinoin cream 0.05%</b> .....	121		

<b>trifluoperazine hcl tab 5 mg (base equivalent)</b>	96
<b>trifluridine ophth soln 1%</b>	149
<b>trifluridine-tipiracil</b>	
see LONSURF TAB 15-6.14	86
see LONSURF TAB 20-8.19	86
<b>trihexyphenidyl hcl oral soln 0.4 mg/ml</b>	91
<b>trihexyphenidyl hcl tab 2 mg</b>	91
<b>trihexyphenidyl hcl tab 5 mg</b>	91
TRIJARDY XR TAB	69
TRI-LEGEST FE	
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg	112
TRI-LINYAH	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	115
TRI-LO-ESTARYLLA	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	115
TRI-LO-MARZIA	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	115
TRI-LO-MILI	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	115
TRI-LO-SPRINTEC	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	115
<b>trimethobenzamide hcl cap 300 mg</b>	73
<b>trimethoprim tab 100 mg</b>	52
TRI-MILI	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	115
<b>trimipramine maleate cap 100 mg</b>	68
<b>trimipramine maleate cap 25 mg</b>	68
<b>trimipramine maleate cap 50 mg</b>	68
TRINATE	
see Prenatal Vit W/ Fe Fumarate-Fa Tab 28-1 mg	147
TRINTELLIX TAB 10MG	66
TRINTELLIX TAB 20MG	66
TRINTELLIX TAB 5MG	66
TRI-SPRINTEC	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	115
TRIUMEQ PD TAB	99
TRIUMEQ TAB	99
TRI-VYLIBRA	
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg	116
TRI-VYLIBRA LO	
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg	115
<b>tropicamide ophth soln 0.5%</b>	149
<b>tropicamide ophth soln 1%</b>	149
<b>tropium chloride cap er 24hr 60 mg</b>	163
<b>tropium chloride tab 20 mg</b>	163
TRULICITY INJ 0.75/0.5	70
TRULICITY INJ 1.5/0.5	70
TRULICITY INJ 3/0.5	70
TRULICITY INJ 4.5/0.5	70
TRUQAP PAK 160MG	90
TRUQAP PAK 200MG	90
TRUQAP TAB 200MG	90
TRUSTEX MIS FLAVORS	140
TURALIO CAP 125MG	90
TURQOZ	
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg	116
TWYNEO CRE 0.1-3%	121
TYDEMY	
see Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg	109
TYVASO DPI POW 16-32-48	106
TYVASO DPI POW 16MCG	106
TYVASO DPI POW 32MCG	106
TYVASO DPI POW 48MCG	106
TYVASO DPI POW 64MCG	106
TYVASO DPI POW 80MCG	106
TYVASO DPI POW INST KIT	106
TYVASO DPI POW MAIN KIT	106
TYVASO RF KT SOL 0.6MG/ML	106
TYVASO SOL 0.6MG/ML	106
TYVASO ST KT SOL 0.6MG/ML	106
<b>U</b>	
UBRELVY TAB 100MG	142
UBRELVY TAB 50MG	142
<b>ubrogepant</b>	
see UBRELVY TAB 100MG	142
see UBRELVY TAB 50MG	142
UCERIS TAB 9MG	118
<b>ulipristal acetate</b>	
see ELLA TAB 30MG	116
<b>umeclidinium-vilanterol</b>	
see ANORO ELLIPT AER 62.5-25	57

## UNITHROID

see Levothyroxine Sodium Tab 100 mcg	160
see Levothyroxine Sodium Tab 112 mcg	160
see Levothyroxine Sodium Tab 125 mcg	160
see Levothyroxine Sodium Tab 137 mcg	160
see Levothyroxine Sodium Tab 150 mcg	161
see Levothyroxine Sodium Tab 175 mcg	161
see Levothyroxine Sodium Tab 200 mcg	161
see Levothyroxine Sodium Tab 25 mcg	160
see Levothyroxine Sodium Tab 300 mcg	161
see Levothyroxine Sodium Tab 50 mcg	160
see Levothyroxine Sodium Tab 75 mcg	160
see Levothyroxine Sodium Tab 88 mcg	160

## **upadacitinib**

see RINVOQ LQ SOL 1MG/ML	38
see RINVOQ TAB 15MG ER	38
see RINVOQ TAB 30MG ER	39
see RINVOQ TAB 45MG ER	39
UPTRAVI PACK TAB 200/800	107
UPTRAVI TAB 1000MCG	107
UPTRAVI TAB 1200MCG	107
UPTRAVI TAB 1400MCG	107
UPTRAVI TAB 1600MCG	107
UPTRAVI TAB 200MCG	107
UPTRAVI TAB 400MCG	107
UPTRAVI TAB 600MCG	107
UPTRAVI TAB 800MCG	107

## **uridine triacetate (emergency treatment)**

see VISTOGARD PAK 10GM	73
<b>ursodiol cap 300 mg</b>	133
<b>ursodiol tab 250 mg</b>	133
<b>ursodiol tab 500 mg</b>	133

## **V**

VAGIFEM TAB 10MCG	164
<b>valacyclovir hcl tab 1 gm</b>	100
<b>valacyclovir hcl tab 500 mg</b>	100
<b>valbenazine tosylate</b>	
see INGREZZA CAP 40-80MG	154
see INGREZZA CAP 40MG	154
see INGREZZA CAP 60MG	154
see INGREZZA CAP 80MG	154
<b>valganciclovir hcl for soln 50 mg/ml (base equiv)</b>	99
<b>valganciclovir hcl tab 450 mg (base equivalent)</b>	99
<b>valproate sodium oral soln 250 mg/5ml (base equiv)</b>	64

<b>valproic acid cap 250 mg</b>	64
<b>valsartan oral soln 4 mg/ml</b>	79
<b>valsartan tab 160 mg</b>	79
<b>valsartan tab 320 mg</b>	79
<b>valsartan tab 40 mg</b>	79
<b>valsartan tab 80 mg</b>	79
<b>valsartan-hydrochlorothiazide tab 160-12.5 mg</b>	82
<b>valsartan-hydrochlorothiazide tab 160-25 mg</b>	82
<b>valsartan-hydrochlorothiazide tab 320-12.5 mg</b>	82
<b>valsartan-hydrochlorothiazide tab 320-25 mg</b>	82
<b>valsartan-hydrochlorothiazide tab 80-12.5 mg</b>	82
VALTOCO SPR 10MG	60
VALTOCO SPR 15MG	60
VALTOCO SPR 20MG	60
VALTOCO SPR 5MG	60
VALTYA 1/35	
see Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg	109
VALTYA 1/50	
see Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg	110
<b>vancomycin hcl cap 125 mg (base equivalent)</b>	52
<b>vancomycin hcl cap 250 mg (base equivalent)</b>	52
<b>vancomycin hcl for oral soln 25 mg/ml (base equivalent)</b>	52
<b>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</b>	52
VANRAFIA TAB 0.75MG	134
<b>ildenafil hcl orally disintegrating tab 10 mg</b>	105
<b>ildenafil hcl tab 10 mg</b>	105
<b>ildenafil hcl tab 2.5 mg</b>	105
<b>ildenafil hcl tab 20 mg</b>	105
<b>ildenafil hcl tab 5 mg</b>	105
<b>varenicline tartrate tab 0.5 mg (base equiv)</b>	158
<b>varenicline tartrate tab 1 mg (base equiv)</b>	158
<b>varenicline tartrate tab 11 x 0.5 mg &amp; 42 x 1 mg start pack</b>	158
VASCEPA CAP 0.5GM	75
VASCEPA CAP 1GM	75
VCF VAGINAL GEL CONTRACE	164
VCF VAGINAL MIS CONTRACP	164
VELIVET	
see Desogest-Ethin Est Tab 0.1-0.025/0.125- 0.025/0.15-0.025mg-Mg	109

VELSIPITY TAB 2MG .....	133	VIBERZI TAB 100MG .....	134
VELTASSA POW 16.8GM .....	146	VIBERZI TAB 75MG .....	134
VELTASSA POW 1GM.....	146	VIENVA	
VELTASSA POW 25.2GM .....	146	see Levonorgestrel & Ethinyl Estradiol Tab 0.1	
VELTASSA POW 8.4GM .....	146	mg-20 mcg .....	111
<b>venlafaxine hcl cap er 24hr 150 mg (base</b>		<b>vigabatrin powd pack 500 mg</b> .....	64
<b>equivalent)</b> .....	67	Vigabatrin Powd Pack 500 mg .....	64
<b>venlafaxine hcl cap er 24hr 37.5 mg (base</b>		<b>vigabatrin tab 500 mg</b> .....	64
<b>equivalent)</b> .....	67	Vigabatrin Tab 500 mg .....	64
<b>venlafaxine hcl cap er 24hr 75 mg (base</b>		VIGADRONE	
<b>equivalent)</b> .....	67	see Vigabatrin Powd Pack 500 mg .....	64
<b>venlafaxine hcl tab 100 mg (base equivalent)</b> .	67	see Vigabatrin Tab 500 mg .....	64
<b>venlafaxine hcl tab 25 mg (base equivalent)</b> ...	67	<b>vilazodone hcl tab 10 mg</b> .....	66
<b>venlafaxine hcl tab 37.5 mg (base equivalent)</b>	67	<b>vilazodone hcl tab 20 mg</b> .....	66
<b>venlafaxine hcl tab 50 mg (base equivalent)</b> ...	67	<b>vilazodone hcl tab 40 mg</b> .....	66
<b>venlafaxine hcl tab 75 mg (base equivalent)</b> ...	67	<b>viloxazine hcl (adhd)</b>	
<b>venlafaxine hcl tab er 24hr 225 mg (base</b>		see QELBREE CAP 100MG ER.....	32
<b>equivalent)</b> .....	67	see QELBREE CAP 150MG ER.....	32
VENXXIVA		see QELBREE CAP 200MG ER.....	33
see Tiopronin Tab Delayed Release 100 mg	135	VIOKACE TAB 10440 .....	126
see Tiopronin Tab Delayed Release 300 mg	135	VIOKACE TAB 20880 .....	126
<b>verapamil hcl cap er 24hr 100 mg</b> .....	104	VIORELE	
<b>verapamil hcl cap er 24hr 120 mg</b> .....	104	see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
<b>verapamil hcl cap er 24hr 180 mg</b> .....	104	0.02/0.01 mg(21/5).....	108
<b>verapamil hcl cap er 24hr 200 mg</b> .....	104	VIRACEPT TAB 250MG .....	99
<b>verapamil hcl cap er 24hr 240 mg</b> .....	104	VIRACEPT TAB 625MG .....	99
<b>verapamil hcl cap er 24hr 300 mg</b> .....	104	<b>vismodegib</b>	
<b>verapamil hcl cap er 24hr 360 mg</b> .....	104	see ERIVEDGE CAP 150MG .....	84
<b>verapamil hcl tab 120 mg</b> .....	104	VISTOGARD PAK 10GM .....	73
<b>verapamil hcl tab 40 mg</b> .....	104	VITRAKVI CAP 100MG .....	90
<b>verapamil hcl tab 80 mg</b> .....	104	VITRAKVI CAP 25MG .....	90
<b>verapamil hcl tab er 120 mg</b> .....	104	VITRAKVI SOL 20MG/ML.....	91
<b>verapamil hcl tab er 180 mg</b> .....	104	VOLNEA	
<b>verapamil hcl tab er 240 mg</b> .....	104	see Desogest-Eth Estrad & Eth Estrad Tab 0.15-	
<b>vericiguat</b>		0.02/0.01 mg(21/5).....	108
see VERQUVO TAB 10MG .....	107	<b>voriconazole for susp 40 mg/ml</b> .....	74
see VERQUVO TAB 2.5MG .....	107	<b>voriconazole tab 200 mg</b> .....	74
see VERQUVO TAB 5MG .....	107	<b>voriconazole tab 50 mg</b> .....	74
VERQUVO TAB 10MG .....	107	<b>vortioxetine hbr</b>	
VERQUVO TAB 2.5MG .....	107	see TRINTELLIX TAB 10MG .....	66
VERQUVO TAB 5MG .....	107	see TRINTELLIX TAB 20MG .....	66
VESTURA		see TRINTELLIX TAB 5MG.....	66
see Drospirenone-Ethinyl Estradiol Tab 3-0.02		VOSEVI TAB .....	100
mg.....	109	VRAYLAR CAP 0.5MG .....	94
VEVYE DRO 0.1%.....	150	VRAYLAR CAP 0.75MG .....	94
<b>vibegron</b>		VRAYLAR CAP 1.5MG .....	94
see GEMTESA TAB 75MG .....	163	VRAYLAR CAP 3MG.....	94

VRAYLAR CAP 4.5MG.....	94
VRAYLAR CAP 6MG.....	94
VTAMA CRE 1%.....	122
VYFEMLA	
see Norethindrone & Ethinyl Estradiol Tab 0.4	
mg-35 mcg.....	112
VYLIBRA	
see Norgestimate & Ethinyl Estradiol Tab 0.25	
mg-35 mcg.....	115
VYNDAMAX CAP 61MG.....	107
<b>W</b>	
WAKIX TAB 17.8MG.....	33
WAKIX TAB 4.45MG.....	33
<b>warfarin sodium tab 1 mg</b> .....	59
Warfarin Sodium Tab 1 mg.....	59
<b>warfarin sodium tab 10 mg</b> .....	59
Warfarin Sodium Tab 10 mg.....	59
<b>warfarin sodium tab 2 mg</b> .....	59
Warfarin Sodium Tab 2 mg.....	59
<b>warfarin sodium tab 2.5 mg</b> .....	59
Warfarin Sodium Tab 2.5 mg.....	59
<b>warfarin sodium tab 3 mg</b> .....	59
Warfarin Sodium Tab 3 mg.....	59
<b>warfarin sodium tab 4 mg</b> .....	59
Warfarin Sodium Tab 4 mg.....	59
<b>warfarin sodium tab 5 mg</b> .....	59
Warfarin Sodium Tab 5 mg.....	59
<b>warfarin sodium tab 6 mg</b> .....	59
Warfarin Sodium Tab 6 mg.....	59
<b>warfarin sodium tab 7.5 mg</b> .....	59
Warfarin Sodium Tab 7.5 mg.....	59
WEGOVIY TAB 1.5MG.....	31
WEGOVIY TAB 25MG.....	32
WEGOVIY TAB 4MG.....	31
WEGOVIY TAB 9MG.....	32
WERA	
see Norethindrone & Ethinyl Estradiol Tab 0.5	
mg-35 mcg.....	112
WINLEVI CRE 1%.....	121
WIXELA INHUB	
see Fluticasone-Salmeterol Aer Powder Ba	
100-50 mcg/act.....	58
see Fluticasone-Salmeterol Aer Powder Ba	
250-50 mcg/act.....	58
see Fluticasone-Salmeterol Aer Powder Ba	
500-50 mcg/act.....	58
WYMZYA FE	

see Norethindrone & Ethinyl Estradiol-Fe	
Chew Tab 0.4 mg-35 mcg.....	112
<b>X</b>	
XARAH FE	
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-	
20/1-30/1-35 mg-Mcg.....	112
XARELTO STAR TAB 15/20MG.....	59
XARELTO TAB 10MG.....	60
XARELTO TAB 15MG.....	60
XARELTO TAB 2.5MG.....	60
XARELTO TAB 20MG.....	60
XCOPRI PAK 100-150.....	63
XCOPRI PAK 12.5-25.....	63
XCOPRI PAK 150-200.....	63
XCOPRI PAK 50-100MG.....	63
XCOPRI TAB 100MG.....	64
XCOPRI TAB 150MG.....	64
XCOPRI TAB 200MG.....	64
XCOPRI TAB 25MG.....	63
XCOPRI TAB 50MG.....	64
XDEMVIY DRO 0.25%.....	149
XELJANZ SOL 1MG/ML.....	39
XELJANZ TAB 10MG.....	39
XELJANZ TAB 5MG.....	39
XELJANZ XR TAB 11MG.....	39
XELJANZ XR TAB 22MG.....	39
XELRIA FE	
see Norethindrone & Ethinyl Estradiol-Fe	
Chew Tab 0.4 mg-35 mcg.....	112
XHANCE MIS 93MCG.....	148
XIFAXAN TAB 550MG.....	52
XIGDUO XR TAB 10-1000.....	69
XIGDUO XR TAB 10-500MG.....	69
XIGDUO XR TAB 2.5-1000.....	69
XIGDUO XR TAB 5-1000MG.....	69
XIGDUO XR TAB 5-500MG.....	69
XOSPATA TAB 40MG.....	91
XTANDI CAP 40MG.....	85
XTANDI TAB 40MG.....	85
XTANDI TAB 80MG.....	85
XULANE	
see Norelgestromin-Ethinyl Estradiol Td Ptwk	
150-35 mcg/24hr.....	116
XULTOPHY INJ 100/3.6.....	69
XYWAV SOL 0.5GM/ML.....	153
<b>Y</b>	
YARGESA	

see Miglustat Cap 100 mg .....	136	see Dextroamphetamine Sulfate Tab 15 mg .	29
YEZTUGO TAB 300MG .....	99	see Dextroamphetamine Sulfate Tab 2.5 mg	28
YL FOLIC ACID		see Dextroamphetamine Sulfate Tab 20 mg .	29
see Folic Acid Tab 400 mcg .....	137	see Dextroamphetamine Sulfate Tab 30 mg .	30
YONSA TAB 125MG .....	85	see Dextroamphetamine Sulfate Tab 5 mg ...	29
YUPELRI SOL 175/3ML.....	56	see Dextroamphetamine Sulfate Tab 7.5 mg	29
YUTREPIA CAP 106MCG .....	106	ZEPATIER TAB 50-100MG.....	100
YUTREPIA CAP 26.5MCG .....	106	ZEPOSIA 7DAY CAP STR PACK .....	155
YUTREPIA CAP 53MCG .....	106	ZEPOSIA CAP 0.92MG.....	155
YUTREPIA CAP 79.5MCG .....	106	ZEPOSIA CAP STR KIT.....	155
<b>Z</b>		<b>zidovudine cap 100 mg</b> .....	99
ZAFEMY		<b>zidovudine syrup 10 mg/ml</b> .....	99
see Norelgestromin-Ethinyl Estradiol Td Ptwk		<b>zidovudine tab 300 mg</b> .....	99
150-35 mcg/24hr.....	116	<b>ziprasidone hcl cap 20 mg</b> .....	94
<b>zafirlukast tab 10 mg</b> .....	56	<b>ziprasidone hcl cap 40 mg</b> .....	94
<b>zafirlukast tab 20 mg</b> .....	56	<b>ziprasidone hcl cap 60 mg</b> .....	94
<b>zaleplon cap 10 mg</b> .....	138	<b>ziprasidone hcl cap 80 mg</b> .....	94
<b>zaleplon cap 5 mg</b> .....	138	ZITUVIMET TAB 50-1000.....	69
<b>zanamivir</b>		ZITUVIMET TAB 50-500MG.....	69
see RELENZA MIS DISKHALE .....	100	ZITUVIMET XR TAB 100-1000 .....	69
<b>zanubrutinib</b>		ZITUVIMET XR TAB 50-1000 .....	69
see BRUKINSA CAP 80MG .....	86	ZITUVIMET XR TAB 50-500MG .....	69
see BRUKINSA TAB 160MG .....	86	ZITUVIO TAB 100MG .....	70
ZEJULA TAB 100MG .....	91	ZITUVIO TAB 25MG .....	70
ZEJULA TAB 200MG .....	91	ZITUVIO TAB 50MG .....	70
ZEJULA TAB 300MG .....	91	<b>zolmitriptan nasal spray 2.5 mg/spray unit</b> ..	143
ZELVYSIA		<b>zolmitriptan nasal spray 5 mg/spray unit</b> .....	143
see Sapropterin Dihydrochloride Powder		<b>zolmitriptan orally disintegrating tab 2.5 mg</b>	143
Packet 100 mg .....	129	<b>zolmitriptan orally disintegrating tab 5 mg</b> ..	143
see Sapropterin Dihydrochloride Powder		<b>zolmitriptan tab 2.5 mg</b> .....	143
Packet 500 mg .....	129	<b>zolmitriptan tab 5 mg</b> .....	143
ZEMBRACE SYM INJ 3/0.5ML.....	143	<b>zolpidem tartrate tab 10 mg</b> .....	138
ZENATANE		<b>zolpidem tartrate tab 5 mg</b> .....	138
see Isotretinoin Cap 10 mg .....	120	<b>zolpidem tartrate tab er 12.5 mg</b> .....	138
see Isotretinoin Cap 20 mg .....	120	<b>zolpidem tartrate tab er 6.25 mg</b> .....	138
see Isotretinoin Cap 30 mg .....	120	<b>zonisamide cap 100 mg</b> .....	63
see Isotretinoin Cap 40 mg .....	120	<b>zonisamide cap 25 mg</b> .....	63
ZENPEP CAP 10000UNT.....	126	<b>zonisamide cap 50 mg</b> .....	63
ZENPEP CAP 15000UNT.....	126	ZORYVE CRE 0.05%.....	125
ZENPEP CAP 20000UNT.....	127	ZORYVE CRE 0.15%.....	126
ZENPEP CAP 25000UNT.....	127	ZORYVE CRE 0.3%.....	125
ZENPEP CAP 3000UNIT.....	126	ZORYVE MIS 0.3% .....	126
ZENPEP CAP 40000UNT.....	127	ZOVIA 1/35	
ZENPEP CAP 5000UNIT.....	126	see Ethynodiol Diacetate & Ethinyl Estradiol	
ZENPEP CAP 60000UNT.....	127	Tab 1 mg-35 mcg.....	110
ZENZEDI		ZUBSOLV SUB 0.7-0.18.....	50
see Dextroamphetamine Sulfate Tab 10 mg .	29	ZUBSOLV SUB 1.4-0.36.....	50

ZUBSOLV SUB 11.4-2.9 .....	51	see ZURZUVAE CAP 20MG .....	65
ZUBSOLV SUB 2.9-0.71 .....	50	see ZURZUVAE CAP 25MG .....	65
ZUBSOLV SUB 5.7-1.4 .....	50	see ZURZUVAE CAP 30MG .....	65
ZUBSOLV SUB 8.6-2.1 .....	50	ZURZUVAE CAP 20MG .....	65
ZUMANDIMINE		ZURZUVAE CAP 25MG .....	65
see Drospirenone-Ethinyl Estradiol Tab 3-0.03		ZURZUVAE CAP 30MG .....	65
mg.....	109	ZYKADIA TAB 150MG .....	91
<b><i>zuranolone</i></b>			

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