SHARP Health Plan

2026 Formulary

List of covered prescription drugs

Employer-sponsored plans from Sharp Health Plan

November 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 NG9 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 NG1, Silver POS NG 1, Custom Employer Groups

An electronic version of this Prescription Drug List is available on the Sharp Health Plan website, by visiting sharphealthplan.com/search-drug-list. You can find specific cost sharing information in your plan's coverage documents by logging in to your Sharp Connect account on our website by visiting sharphealthplan.com/login. This document is subject to change and all previous versions are no longer in effect. Last updated 11/01/2026.

Table of Contents

INTRODUCTION 13
DEFINITIONS 13
HOW OFTEN DOES THE FORMULARY CHANGE? 15
WILL I BE NOTIFIED OF A FORMULARY CHANGE? 15
HOW DO I LOCATE A PRESCRIPTION DRUG ON THE FORMULARY? 16
HOW DO I KNOW IF THE DRUG LISTED ON THE FORMULARY IS A BRAND OR GENERIC DRUG? 16
WHAT IS A DRUG TIER? 17
ARE THERE ANY COVERAGE REQUIREMENTS OR LIMITS? 17
WHAT IS PRIOR AUTHORIZATION? 18
WHAT IS PA?** 18
WHAT IS QUANTITY LIMIT? 19
WHAT IS STEP THERAPY? 19
WHAT IS MO? 19
WHAT IS A SPECIALTY DRUG? 19
WHAT IS AN ORAL ANTI-CANCER DRUG? 19
WHAT IF A DRUG IS NOT LISTED ON THE FORMULARY? WHAT IS A FORMULARY EXCEPTION? 20
WHERE CAN I FILL MY PRESCRIPTION DRUG? 20
WHAT IS THERAPEUTIC INTERCHANGE? 20
WHAT IS GENERIC SUBSTITUTION? 20
YOU HAVE THE RIGHT TO APPEAL 21
APPEALS DUE TO DENIAL OF COVERAGE FOR A NONFORMULARY DRUG 21
ALL OTHER APPEALS 21
QUESTIONS 21
EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT 21
NONDISCRIMINATION NOTICE 22
LANGUAGE ASSISTANCE SERVICES 23
STEP THERAPY CRITERIA 25
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS 26
AMPHETAMINES 26
ANOREXIANTS NON-AMPHETAMINE 31
ANTI-OBESITY AGENTS 31
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER 32
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS) 33
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS 33
STIMULANTS - MISC. 33
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES 38
ALLERGENIC EXTRACTS 38
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS 38
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS 38
ANALGESICS - ANTI-INFLAMMATORY - DRUGS TO TREAT PAIN AND INFLAMMATION 39

ANTIRHEUMATIC - ENZYME INHIBITORS 39
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS) 39
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS 41
PYRIMIDINE SYNTHESIS INHIBITORS 41
ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER 41
ANALGESIC COMBINATIONS 41
SALICYLATES 42
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN 42
OPIOID AGONISTS 42
OPIOID COMBINATIONS 45
OPIOID PARTIAL AGONISTS 48
ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES 49
ANDROGENS 49
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS 49
INTRARECTAL STEROIDS 49
RECTAL COMBINATIONS 49
RECTAL STEROIDS 49
VASODILATING AGENTS 50
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES 50
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES 50
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS 50
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS 50
ANTI-INFECTIVE MISC. - COMBINATIONS 50
ANTIPROTOZOAL AGENTS 50
GLYCOPEPTIDES 50
LEPROSTATICS 50
LINCOSAMIDES 51
MONOBACTAMS 51
OXAZOLIDINONES 51
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS 51
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS 51
ANTIANGINALS-OTHER 51
NITRATES 51
ANTIANXIETY AGENTS - DRUGS TO TREAT ANXIETY 52
ANTIANXIETY AGENTS - MISC. 52
BENZODIAZEPINES 52
ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS 53
ANTIARRHYTHMICS TYPE I-A 53
ANTIARRHYTHMICS TYPE I-B 53
ANTIARRHYTHMICS TYPE I-C 53
ANTIARRHYTHMICS TYPE III 53
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE 54
ANTI-INFLAMMATORY AGENTS 54
BRONCHODILATORS - ANTICHOLINERGICS 54

LEUKOTRIENE MODULATORS 54
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS 54
STEROID INHALANTS 54
SYMPATHOMIMETICS 55
XANTHINES 57
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS 57
COUMARIN ANTICOAGULANTS 57
DIRECT FACTOR XA INHIBITORS 57
THROMBIN INHIBITORS 58
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES 58
AMPA GLUTAMATE RECEPTOR ANTAGONISTS 58
ANTICONVULSANTS - BENZODIAZEPINES 58
ANTICONVULSANTS - MISC. 59
CARBAMATES 62
GABA MODULATORS 62
HYDANTOINS 62
SUCCINIMIDES 62
VALPROIC ACID 62
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION 63
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS) 63
ANTIDEPRESSANT COMBINATIONS 63
ANTIDEPRESSANTS - MISC. 63
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID 63
MONOAMINE OXIDASE INHIBITORS (MAOIS) 63
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS) 63
SEROTONIN MODULATORS 64
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS) 65
TRICYCLIC AGENTS 65
ANTIDIABETICS - DRUGS TO TREAT DIABETES 66
ALPHA-GLUCOSIDASE INHIBITORS 66
ANTIDIABETIC COMBINATIONS 67
BIGUANIDES 68
DIABETIC OTHER 68
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS 68
INCRETIN MIMETIC AGENTS 69
INSULIN 69
INSULIN SENSITIZING AGENTS 70
MEGLITINIDE ANALOGUES 70
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS 70
SULFONYLUREAS 70
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA 71
ANTIPERISTALTIC AGENTS 71
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING 71
ANTIDOTES - CHELATING AGENTS 71
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING 71

OPIOID ANTAGONISTS 71
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING 71
5-HT3 RECEPTOR ANTAGONISTS 71
ANTIEMETICS - ANTICHOLINERGIC 72
ANTIEMETICS - MISCELLANEOUS 72
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS 72
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS 72
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS 72
IMIDAZOLE-RELATED ANTIFUNGALS 72
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES 73
ANTIHISTAMINES - ETHANOLAMINES 73
ANTIHISTAMINES - NON-SEDATING 73
ANTIHISTAMINES - PHENOTHIAZINES 73
ANTIHISTAMINES - PIPERIDINES 73
ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL 73
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS 73
ANTIHYPERLIPIDEMICS - COMBINATIONS 73
ANTIHYPERLIPIDEMICS - MISC. 74
BILE ACID SEQUESTRANTS 74
FIBRIC ACID DERIVATIVES 74
HMG COA REDUCTASE INHIBITORS 74
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS 75
NICOTINIC ACID DERIVATIVES 75
ANTIHYPERTENSIVES - DRUGS TO TREAT HIGH BLOOD PRESSURE 76
ACE INHIBITORS 76
AGENTS FOR PHEOCHROMOCYTOMA 77
ANGIOTENSIN II RECEPTOR ANTAGONISTS 77
ANTIADRENERGIC ANTIHYPERTENSIVES 77
ANTIHYPERTENSIVE COMBINATIONS 78
DIRECT RENIN INHIBITORS 80
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS) 80
VASODILATORS 80
ANTIMALARIALS - DRUGS TO TREAT MALARIA 81
ANTIMALARIAL COMBINATIONS 81
ANTIMALARIALS - DRUGS TO TREAT MALARIA 81
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS 81
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS 81
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS 81
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS 81
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER 81
ALKYLATING AGENTS 81
ANTIMETABOLITES 82
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS 82
ANTINEOPLASTIC - EGFR INHIBITORS 82
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS 83

ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS 83
ANTINEOPLASTIC - IMMUNOMODULATORS 84
ANTINEOPLASTIC COMBINATIONS 84
ANTINEOPLASTIC ENZYME INHIBITORS 84
ANTINEOPLASTICS MISC. 90
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS 90
MITOTIC INHIBITORS 90
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE 90
ANTIPARKINSON ADJUNCTIVE THERAPY 90
ANTIPARKINSON ANTICHOLINERGICS 90
ANTIPARKINSON COMT INHIBITORS 90
ANTIPARKINSON DOPAMINERGICS 90
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS 92
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES 93
ANTIMANIC AGENTS 93
ANTIPSYCHOTICS - MISC. 93
BENZISOXAZOLES 93
BUTYROPHENONES 94
DIBENZAPINES 94
DIHYDROINDOLONES 95
PHENOTHIAZINES 95
QUINOLINONE DERIVATIVES 96
THIOXANTHENES 96
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS 96
ANTIRETROVIRALS 96
ANTIVIRAL COMBINATIONS 98
CMV AGENTS 98
HEPATITIS AGENTS 98
HERPES AGENTS 99
INFLUENZA AGENTS 99
MISC. ANTIVIRALS 99
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS 100
ALPHA-BETA BLOCKERS 100
BETA BLOCKERS CARDIO-SELECTIVE 100
BETA BLOCKERS NON-SELECTIVE 101
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS 101
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS 101
CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS 103
CARDIAC GLYCOSIDES 103
CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS 104
CARDIAC MYOSIN INHIBITORS 104

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS 104
IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION 104
PROSTAGLANDIN VASODILATORS 105
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS 105
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS 106
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST 106
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR 106
SINUS NODE INHIBITORS 106
TRANSTHYRETIN STABILIZERS 106
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC) 106
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS 107
CEPHALOSPORINS - 1ST GENERATION 107
CEPHALOSPORINS - 2ND GENERATION 107
CEPHALOSPORINS - 3RD GENERATION 107
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL 107
COMBINATION CONTRACEPTIVES - ORAL 107
COMBINATION CONTRACEPTIVES - TRANSDERMAL 115
COMBINATION CONTRACEPTIVES - VAGINAL 115
EMERGENCY CONTRACEPTIVES 115
PROGESTIN CONTRACEPTIVES - ORAL 115
CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE 116
GLUCOCORTICOSTEROIDS 116
MINERALOCORTICOIDS 117
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS ... 117
ANTITUSSIVES - DRUGS TO TREAT COUGH 117
COUGH/COLD/ALLERGY COMBINATIONS 118
EXPECTORANTS - DRUGS TO TREAT COUGH 118
MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS 118
MUCOLYTICS - DRUGS TO TREAT COUGH 118
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS 118
ACNE PRODUCTS 118
ANTI-INFLAMMATORY AGENTS - TOPICAL 120
ANTIBIOTICS - TOPICAL 120
ANTIFUNGALS - TOPICAL 120
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL 121
ANTIPSORIATICS 121
ANTISEBORRHEIC PRODUCTS 121
ANTIVIRALS - TOPICAL 121
BURN PRODUCTS 122
CORTICOSTEROIDS - TOPICAL 122
ECZEMA AGENTS 124
EMOLLIENTS 124
HAIR GROWTH AGENTS 124
IMMUNOMODULATING AGENTS - TOPICAL 124
IMMUNOSUPPRESSIVE AGENTS - TOPICAL 124

KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS 124
LOCAL ANESTHETICS - TOPICAL 124
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL 124
ROSACEA AGENTS 124
SCABICIDES & PEDICULICIDES 125
DIAGNOSTIC PRODUCTS - PRODUCTS FOR DIAGNOSIS 125
DIAGNOSTIC PRODUCTS, MISC. 125
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS 125
DIGESTIVE ENZYMES 125
DIURETICS - DRUGS TO TREAT HEART CONDITIONS 126
CARBONIC ANHYDRASE INHIBITORS 126
DIURETIC COMBINATIONS 126
LOOP DIURETICS 126
POTASSIUM SPARING DIURETICS 126
THIAZIDES AND THIAZIDE-LIKE DIURETICS 127
ENDOCRINE AND METABOLIC AGENTS - MISC. - DRUGS TO REGULATE HORMONES 127
BONE DENSITY REGULATORS - DRUGS TO TREAT BONE LOSS 127
FERTILITY REGULATORS 127
GNRH/LHRH ANTAGONISTS 127
HORMONE RECEPTOR MODULATORS - DRUGS TO TREAT BONE LOSS 127
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS 127
METABOLIC MODIFIERS 128
MINERALOCORTICOID RECEPTOR ANTAGONISTS 129
POSTERIOR PITUITARY HORMONES 129
PROGESTERONE RECEPTOR ANTAGONISTS 129
PROLACTIN INHIBITORS 129
VASOPRESSIN RECEPTOR ANTAGONISTS 129
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES 129
ESTROGEN COMBINATIONS 129
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES 130
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS 131
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS 131
GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS 132
5-HT4 RECEPTOR AGONISTS 132
GALLSTONE SOLUBILIZING AGENTS 132
GASTROINTESTINAL ANTIALLERGY AGENTS 132
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS 132
GASTROINTESTINAL STIMULANTS 132
INFLAMMATORY BOWEL AGENTS 132
INTESTINAL ACIDIFIERS 132
IRRITABLE BOWEL SYNDROME (IBS) AGENTS 133
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS 133
PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR(PPAR) AGONISTS 133
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS 133

GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS **133**
ALKALINIZERS 133
CYSTINOSIS AGENTS 133
IGA NEPHROPATHY (IGAN) AGENTS 133
PROSTATIC HYPERTROPHY AGENTS 133
URINARY STONE AGENTS 134
GOUT AGENTS - DRUGS TO TREAT GOUT **134**
GOUT AGENT COMBINATIONS 134
GOUT AGENTS - DRUGS TO TREAT GOUT 134
URICOSURICS 134
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS **134**
HEMATORHEOLOGIC AGENTS 134
PLASMA KALLIKREIN INHIBITORS 134
PLATELET AGGREGATION INHIBITORS 134
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS **135**
AGENTS FOR GAUCHER DISEASE 135
AGENTS FOR SICKLE CELL DISEASE 135
FOLIC ACID/FOLATES 135
HEMATOPOIETIC GROWTH FACTORS 136
HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS **137**
HEMOSTATICS - SYSTEMIC 137
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS **137**
BARBITURATE HYPNOTICS 137
HYPNOTICS - TRICYCLIC AGENTS 137
NON-BARBITURATE HYPNOTICS 137
OREXIN RECEPTOR ANTAGONISTS 138
SELECTIVE MELATONIN RECEPTOR AGONISTS 138
LAXATIVES - DRUGS TO TREAT CONSTIPATION **138**
LAXATIVE COMBINATIONS 138
LAXATIVES - MISCELLANEOUS 138
MACROLIDES - DRUGS TO TREAT INFECTIONS **138**
AZITHROMYCIN 138
CLARITHROMYCIN 139
ERYTHROMYCINS 139
FIDAXOMICIN 139
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING **139**
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL 139
PARENTERAL THERAPY SUPPLIES 139
RESPIRATORY THERAPY SUPPLIES 140
MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES **141**
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG 141
MIGRAINE COMBINATIONS 141
SEROTONIN AGONISTS 141

MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION 142
FLUORIDE 142
PHOSPHATE 143
POTASSIUM 143
MISCELLANEOUS THERAPEUTIC CLASSES 143
CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING 143
IMMUNOMODULATORS - DRUGS TO TREAT CANCER 144
IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT 144
POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM 145
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT 145
ANESTHETICS TOPICAL ORAL 145
ANTI-INFECTIVES - THROAT 145
STEROIDS - MOUTH/THROAT/DENTAL 145
THROAT PRODUCTS - MISC. 145
MULTIVITAMINS - DRUGS FOR NUTRITION 145
PRENATAL VITAMINS 145
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS 146
CENTRAL MUSCLE RELAXANTS 146
DIRECT MUSCLE RELAXANTS 146
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE 146
NASAL AGENT COMBINATIONS 146
NASAL ANTIALLERGY 146
NASAL ANTICHOLINERGICS 147
NASAL STEROIDS 147
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES 147
ALS AGENTS 147
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS 147
BETA-BLOCKERS - OPHTHALMIC 147
CYCLOPLEGIC MYDRIATICS 147
MIOTICS 148
OPHTHALMIC ADRENERGIC AGENTS 148
OPHTHALMIC ANTI-INFECTIVES 148
OPHTHALMIC IMMUNOMODULATORS 148
OPHTHALMIC STEROIDS 149
OPHTHALMICS - MISC. 149
PROSTAGLANDINS - OPHTHALMIC 150
OTIC AGENTS - DRUGS TO TREAT CONDITIONS OF THE EAR 150
OTIC AGENTS - MISCELLANEOUS 150
OTIC ANTI-INFECTIVES 150
OTIC COMBINATIONS 150
OTIC STEROIDS 150
OXYTOCICS - DRUGS FOR PREGNANCY 150
OXYTOCICS - DRUGS FOR PREGNANCY 150
PENICILLINS - DRUGS TO TREAT INFECTIONS 150
AMINOPENICILLINS 150

NATURAL PENICILLINS 151
PENICILLIN COMBINATIONS 151
PENICILLINASE-RESISTANT PENICILLINS 151
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES 151
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES 151
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS 151
AGENTS FOR CHEMICAL DEPENDENCY 151
ANTI-CATAPLECTIC AGENTS 152
ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS 152
COMBINATION PSYCHOTHERAPEUTICS 153
FIBROMYALGIA AGENTS 153
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS 153
MOVEMENT DISORDER DRUG THERAPY 153
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS 154
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS 155
PSEUDOBULBAR AFFECT (PBA) AGENTS 155
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS 155
SMOKING DETERRENTS 155
RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS 158
CYSTIC FIBROSIS AGENTS 158
PULMONARY FIBROSIS AGENTS 158
SULFONAMIDES - DRUGS TO TREAT INFECTIONS 158
SULFONAMIDES - DRUGS TO TREAT INFECTIONS 158
TETRACYCLINES - DRUGS TO TREAT INFECTIONS 158
TETRACYCLINES - DRUGS TO TREAT INFECTIONS 158
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS 159
ANTITHYROID AGENTS 159
THYROID HORMONES 159
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID 160
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS 160
H-2 ANTAGONISTS 161
MISC. ANTI-ULCER 161
PROTON PUMP INHIBITORS 161
ULCER DRUGS - PROSTAGLANDINS 162
ULCER THERAPY COMBINATIONS 162
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE 162
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC) 162
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS 162
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS 162
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS 163
VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS 163
MISCELLANEOUS VAGINAL PRODUCTS 163

SPERMICIDES 163
VAGINAL ANTI-INFECTIVES 163
VAGINAL CONTRACEPTIVE - PH MODULATORS 163
VAGINAL ESTROGENS 163
VAGINAL PROGESTINS 163
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS 163
ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION 163
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS 164
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS 164
VITAMINS - DRUGS FOR NUTRITION 164
OIL SOLUBLE VITAMINS 164
Index 165

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.

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 ***(fenofibric acid)***
Generic-Name that is covered on the Formulary	***fenofibric acid tab 35mg***
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 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. 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 to enroll. You can also take your Specialty drug prescription to a CVS retail pharmacy. Your Prescription will be sent to CVS Specialty® Pharmacy to be filled. You may return to your local CVS pharmacy to pick up your Prescription.

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

WHAT IS THERAPEUTIC INTERCHANGE?

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

WHAT IS GENERIC SUBSTITUTION?

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

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

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

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website sharphealthplan.com. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/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.

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.**

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، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید (TTY:711) 1-800-359-2002 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。

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

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

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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: ถ้าคุณพดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).

STEP THERAPY CRITERIA

Step Therapy Group	OPIOID ER 2219-M
Drug Names	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	OPIOID IR COMBO PRODUCTS 1358-E
Drug Names	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.

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AMPHETAMINES		
amphetamine sulfate tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine sulfate tab 10 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine tab extended release disintegrating 3.1 mg	1	PA, QL (180 tabs every 75 days), MO; PA required for age greater than or equal to age 19
amphetamine tab extended release disintegrating 6.3 mg	1	PA, QL (180 tabs every 75 days), MO; PA required for age greater than or equal to age 19
amphetamine tab extended release disintegrating 9.4 mg	1	PA, QL (180 tabs every 75 days), MO; PA required for age greater than or equal to age 19
amphetamine tab extended release disintegrating 12.5 mg	1	PA, QL (90 tabs every 75 days), MO; PA required for age greater than or equal to age 19
amphetamine tab extended release disintegrating 15.7 mg	1	PA, QL (90 tabs every 75 days), MO; PA required for age greater than or equal to age 19
amphetamine tab extended release disintegrating 18.8 mg	1	PA, QL (90 tabs every 75 days), MO; PA required for age greater than or equal to age 19
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amphetamine-dextroamphetamine tab 12.5 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 15 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 20 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
amphetamine-dextroamphetamine tab 30 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 5 mg	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 10 mg	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate cap er 24hr 15 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate oral solution 5 mg/5ml	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Oral Solution 5 mg/5ml) PROCENTRA	1	PA, QL (3600 mL every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 2.5 mg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dextroamphetamine sulfate tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
(Dextroamphetamine Sulfate Tab 5 mg) ZENZEDI	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dextroamphetamine sulfate tab 7.5 mg	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
dextroamphetamine sulfate tab 10 mg	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
dextroamphetamine sulfate tab 15 mg	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
dextroamphetamine sulfate tab 20 mg	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
dextroamphetamine sulfate tab 30 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
lisdexamfetamine dimesylate chew tab 40 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 50 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
lisdexamfetamine dimesylate chew tab 60 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methamphetamine hcl tab 5 mg	1	PA, QL (450 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
ANOREXIANTS NON-AMPHETAMINE		
benzphetamine hcl tab 50 mg	1	PA
diethylpropion hcl tab 25 mg	1	PA
diethylpropion hcl tab er 24hr 75 mg	1	PA
phendimetrazine tartrate tab 35 mg	1	PA
phentermine hcl cap 15 mg	1	PA
phentermine hcl cap 30 mg	1	PA
phentermine hcl cap 37.5 mg	1	PA
(Phentermine Hcl Tab 8 mg) LOMAIRA	1	PA
phentermine hcl tab 37.5 mg	1	PA
phentermine hcl-topiramate cap er 24hr 3.75-23 mg	1	PA
phentermine hcl-topiramate cap er 24hr 7.5-46 mg	1	PA
phentermine hcl-topiramate cap er 24hr 11.25-69 mg	1	PA
phentermine hcl-topiramate cap er 24hr 15-92 mg	1	PA
QSYMIA CAP 3.75-23 ***(phentermine hcl-topiramate)***	2	PA
QSYMIA CAP 7.5-46MG ***(phentermine hcl-topiramate)***	2	PA
QSYMIA CAP 11.25-69 ***(phentermine hcl-topiramate)***	2	PA
QSYMIA CAP 15-92MG ***(phentermine hcl-topiramate)***	2	PA
ANTI-OBESITY AGENTS		
FOUNDAYO TAB 0.8MG ***(orforglipron calcium (weight management))***	2	PA
FOUNDAYO TAB 2.5MG ***(orforglipron calcium (weight management))***	2	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FOUNDAYO TAB 5.5MG ***(orforglipron calcium (weight management))***	2	PA, MO
FOUNDAYO TAB 9MG ***(orforglipron calcium (weight management))***	2	PA, MO
FOUNDAYO TAB 14.5MG ***(orforglipron calcium (weight management))***	2	PA, MO
FOUNDAYO TAB 17.2MG ***(orforglipron calcium (weight management))***	2	PA, MO
orlistat cap 120 mg	1	PA
WEGOVY TAB 1.5MG ***(semaglutide (weight management))***	2	PA
WEGOVY TAB 4MG ***(semaglutide (weight management))***	2	PA
WEGOVY TAB 9MG ***(semaglutide (weight management))***	2	PA
WEGOVY TAB 25MG ***(semaglutide (weight management))***	2	PA, MO
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS - DRUGS TO TREAT ATTENTION-DEFICIT/HYPERACTIVITY DISORDER		
atomoxetine hcl cap 10 mg (base equiv)	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 18 mg (base equiv)	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 25 mg (base equiv)	1	PA, QL (360 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 40 mg (base equiv)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 60 mg (base equiv)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
atomoxetine hcl cap 80 mg (base equiv)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
atomoxetine hcl cap 100 mg (base equiv)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
clonidine hcl tab er 12hr 0.1 mg	1	MO
guanfacine hcl tab er 24hr 1 mg (base equiv)	1	MO
guanfacine hcl tab er 24hr 2 mg (base equiv)	1	MO
guanfacine hcl tab er 24hr 3 mg (base equiv)	1	MO
guanfacine hcl tab er 24hr 4 mg (base equiv)	1	MO
QELBREE CAP 100MG ER ***(viloxazine hcl (adhd))***	2	QL (270 caps every 75 days), MO
QELBREE CAP 150MG ER ***(viloxazine hcl (adhd))***	2	QL (270 caps every 75 days), MO
QELBREE CAP 200MG ER ***(viloxazine hcl (adhd))***	2	QL (270 caps every 75 days), MO
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG ***(solriamfetol hcl)***	2	PA, MO
SUNOSI TAB 150MG ***(solriamfetol hcl)***	2	PA, MO
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG ***(pitolisant hcl)***	2	SP, PA, QL (2 tabs every 1 day)
WAKIX TAB 17.8MG ***(pitolisant hcl)***	2	SP, PA, QL (2 tabs every 1 day)
STIMULANTS - MISC.		
armodafinil tab 50 mg	1	PA, MO
armodafinil tab 150 mg	1	PA, MO
armodafinil tab 200 mg	1	PA, MO
armodafinil tab 250 mg	1	PA, MO
AZSTARYS CAP 26.1-5.2 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	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 ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	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. ***(serdexmethylphenidate chloride-dexmethylphenidate hcl)***	2	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 5 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dexmethylphenidate hcl cap er 24 hr 10 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 15 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 20 mg	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 25 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 30 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 35 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl cap er 24 hr 40 mg	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl tab 2.5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl tab 5 mg	1	PA, QL (360 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
dexmethylphenidate hcl tab 10 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 10 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl cap er 20 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 10 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 10 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 15 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 20 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 20 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 30 mg (la)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 30 mg (xr)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 40 mg (la)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 40 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 50 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl cap er 24hr 60 mg (la)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 24hr 60 mg (xr)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 30 mg (cd)	1	PA, QL (180 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 40 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 50 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl cap er 60 mg (cd)	1	PA, QL (90 caps every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 2.5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl chew tab 10 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl soln 5 mg/5ml	1	PA, QL (5400 mL every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl soln 10 mg/5ml	1	PA, QL (2700 mL every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl tab 5 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 10 mg	1	PA, QL (540 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab 20 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 10 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 20 mg	1	PA, QL (270 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 18 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 27 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 36 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er 24hr 54 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 18 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 27 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylphenidate hcl tab er osmotic release (osm) 36 mg	1	PA, QL (180 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 54 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate hcl tab er osmotic release (osm) 72 mg	1	PA, QL (90 tabs every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 10 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 15 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 20 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
methylphenidate td patch 30 mg/9hr	1	PA, QL (90 patches every 75 days), MO; PA Required for age greater than or equal to age 19
modafinil tab 100 mg	1	PA, MO
modafinil tab 200 mg	1	PA, MO
ALLERGENIC EXTRACTS/BIOLOGICALS MISC - DRUGS FOR ALLERGIES		
ALLERGENIC EXTRACTS		
GRASTEK SUB 2800BAU ***(timothy grass pollen allergen extract)***	2	PA, MO
ODACTRA SUB ***(dust mite mixed allergen extract)***	2	PA, MO
ORALAIR SUB 300 IR ***(grass mixed pollens allergen extract)***	2	PA, MO
RAGWITEK SUB ***(short ragweed pollen allergen extract)***	2	PA, MO
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS		
AMINOGLYCOSIDES - DRUGS TO TREAT INFECTIONS		
neomycin sulfate tab 500 mg	1	
tobramycin nebu soln 300 mg/4ml	1	SP, PA, QL (8 mL every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tobramycin nebu soln 300 mg/5ml	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 ***(upadacitinib)***	2	SP, PA, QL (12 mL every 1 day); Preferred for Psoriatic Arthritis
RINVOQ TAB 15MG ER ***(upadacitinib)***	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
RINVOQ TAB 30MG ER ***(upadacitinib)***	2	SP, PA, QL (1 tab every 1 day); Preferred for Crohn's Disease, Ulcerative Colitis
RINVOQ TAB 45MG ER ***(upadacitinib)***	2	SP, PA, QL (84 tabs every 84 days); Preferred for Crohn's Disease, Ulcerative Colitis
tofacitinib citrate oral soln 1 mg/ml (base equivalent)	1	SP, PA, QL (10 mL every 1 day); Preferred for Psoriatic Arthritis
tofacitinib citrate tab 5 mg (base equivalent)	1	SP, PA, QL (2 tabs every 1 day); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
tofacitinib citrate tab 10 mg (base equivalent)	1	SP, PA, QL (2 tabs every 1 day); Preferred for Ulcerative Colitis
tofacitinib citrate tab er 24hr 11 mg (base equivalent)	1	SP, PA, QL (1 tab every 1 day); Preferred for Ankylosing Spondylitis, Psoriatic Arthritis, Rheumatoid Arthritis, Ulcerative Colitis
tofacitinib citrate tab er 24hr 22 mg (base equivalent)	1	SP, PA, QL (1 tab every 1 day); Preferred for Ulcerative Colitis
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap 50 mg	1	MO
celecoxib cap 100 mg	1	MO
celecoxib cap 200 mg	1	MO
celecoxib cap 400 mg	1	MO
diclofenac potassium tab 50 mg	1	MO
diclofenac sodium tab delayed release 25 mg	1	MO
diclofenac sodium tab delayed release 50 mg	1	MO
diclofenac sodium tab delayed release 75 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diclofenac sodium tab er 24hr 100 mg	1	MO
diclofenac w/ misoprostol tab delayed release 50-0.2 mg	1	MO
diclofenac w/ misoprostol tab delayed release 75-0.2 mg	1	MO
etodolac cap 200 mg	1	MO
etodolac cap 300 mg	1	MO
etodolac tab 400 mg	1	MO
etodolac tab 500 mg	1	MO
etodolac tab er 24hr 400 mg	1	MO
etodolac tab er 24hr 500 mg	1	MO
etodolac tab er 24hr 600 mg	1	MO
flurbiprofen tab 50 mg	1	MO
flurbiprofen tab 100 mg	1	MO
ibuprofen susp 100 mg/5ml	1	
ibuprofen tab 400 mg	1	MO
(Ibuprofen Tab 400 mg) IBU	1	MO
ibuprofen tab 600 mg	1	MO
(Ibuprofen Tab 600 mg) IBU	1	MO
ibuprofen tab 800 mg	1	MO
(Ibuprofen Tab 800 mg) IBU	1	MO
ibuprofen-famotidine tab 800-26.6 mg	1	PA, MO
indomethacin cap 25 mg	1	MO
indomethacin cap 50 mg	1	MO
indomethacin cap er 75 mg	1	MO
indomethacin suppos 50 mg	1	MO
indomethacin susp 25 mg/5ml	1	MO
ketorolac tromethamine tab 10 mg	1	
meclofenamate sodium cap 50 mg	1	MO
meclofenamate sodium cap 100 mg	1	MO
mefenamic acid cap 250 mg	1	MO
meloxicam susp 7.5 mg/5ml	1	MO
meloxicam tab 7.5 mg	1	MO
meloxicam tab 15 mg	1	MO
nabumetone tab 500 mg	1	MO
nabumetone tab 750 mg	1	MO
naproxen sodium tab 275 mg	1	MO
naproxen sodium tab 550 mg	1	MO
naproxen tab 250 mg	1	MO
naproxen tab 375 mg	1	MO
naproxen tab 500 mg	1	MO
naproxen tab ec 375 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
naproxen tab ec 500 mg	1	MO
oxaprozin cap 300 mg	1	MO
oxaprozin tab 600 mg	1	MO
piroxicam cap 10 mg	1	MO
piroxicam cap 20 mg	1	MO
sulindac tab 150 mg	1	MO
sulindac tab 200 mg	1	MO
tolmetin sodium tab 600 mg	1	MO
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20 ***(apremilast)***	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 10/20/30 ***(apremilast)***	2	SP, PA, QL (55 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 20MG ***(apremilast)***	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA TAB 30MG ***(apremilast)***	2	SP, PA, QL (2 tabs every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA XR TAB 75MG ***(apremilast)***	2	SP, PA, QL (1 tab every 1 day); Preferred for Psoriasis, Psoriatic Arthritis
OTEZLA/XR TAB 28 DAY ***(apremilast)***	2	SP, PA, QL (41 tabs every 28 days); Preferred for Psoriasis, Psoriatic Arthritis
PYRIMIDINE SYNTHESIS INHIBITORS		
leflunomide tab 10 mg	1	MO
leflunomide tab 20 mg	1	MO
ANALGESICS - NONNARCOTIC - DRUGS TO TREAT PAIN AND FEVER		
ANALGESIC COMBINATIONS		
butalbital-acetaminophen tab 50-325 mg	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen Tab 50-325 mg) TENCON	1	QL (48 tabs every 25 days)
butalbital-acetaminophen-caffeine tab 50-325-40 mg	1	QL (48 tabs every 25 days)
(Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg) BAC	1	QL (48 tabs every 25 days)
butalbital-aspirin-caffeine cap 50-325-40 mg	1	QL (48 caps every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SALICYLATES		
(Aspirin Chew Tab 81 mg) ASPIRIN CHILDRENS	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
aspirin tab delayed release 81 mg	PV	QL (100 tabs every 30 days); $0 copay for members capable of pregnancy age 12-59 years at risk for preeclampsia, otherwise not covered
diflunisal tab 500 mg	1	MO
salsalate tab 750 mg	1	MO
ANALGESICS - OPIOID - DRUGS TO TREAT PAIN		
OPIOID AGONISTS		
codeine sulfate tab 30 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
fentanyl td patch 72hr 12 mcg/hr	1	ST; PA**
fentanyl td patch 72hr 25 mcg/hr	1	ST; PA**
fentanyl td patch 72hr 37.5 mcg/hr	1	ST; PA**
fentanyl td patch 72hr 50 mcg/hr	1	PA
fentanyl td patch 72hr 62.5 mcg/hr	1	PA
fentanyl td patch 72hr 75 mcg/hr	1	PA
fentanyl td patch 72hr 87.5 mcg/hr	1	PA; High Strength Requires PA
fentanyl td patch 72hr 100 mcg/hr	1	PA
hydrocodone bitartrate cap er 12hr 10 mg	1	ST; PA**
hydrocodone bitartrate cap er 12hr 15 mg	1	ST; PA**
hydrocodone bitartrate cap er 12hr 20 mg	1	ST; PA**
hydrocodone bitartrate cap er 12hr 30 mg	1	ST; PA**
hydrocodone bitartrate cap er 12hr 40 mg	1	ST; PA**
hydrocodone bitartrate cap er 12hr 50 mg	1	PA; High Strength Requires PA
hydrocodone bitartrate tab er 24hr deter 20 mg	1	ST; PA**
hydrocodone bitartrate tab er 24hr deter 30 mg	1	ST; PA**
hydrocodone bitartrate tab er 24hr deter 40 mg	1	ST; PA**
hydrocodone bitartrate tab er 24hr deter 60 mg	1	ST; PA**
hydrocodone bitartrate tab er 24hr deter 80 mg	1	ST; PA**
hydrocodone bitartrate tab er 24hr deter 100 mg	1	PA; High Strength Requires PA
hydrocodone bitartrate tab er 24hr deter 120 mg	1	PA; High Strength Requires PA
hydromorphone hcl liqd 1 mg/ml	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydromorphone hcl tab 2 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 4 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab 8 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydromorphone hcl tab er 24hr 8 mg	1	ST; PA**
hydromorphone hcl tab er 24hr 12 mg	1	ST; PA**
hydromorphone hcl tab er 24hr 16 mg	1	ST; PA**
hydromorphone hcl tab er 24hr 32 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
meperidine hcl oral soln 50 mg/5ml	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
meperidine hcl tab 50 mg	1	PA
methadone hcl conc 10 mg/ml	1	QL (30 mL every 25 days)
(Methadone Hcl Conc 10 mg/ml) METHADONE HYDROCHLORIDE I	1	PA; Indicated for opioid addiction
methadone hcl soln 5 mg/5ml	1	ST; PA**
methadone hcl soln 10 mg/5ml	1	ST; PA**
methadone hcl tab 5 mg	1	ST; PA**
methadone hcl tab 10 mg	1	ST; PA**
methadone hcl tab for oral susp 40 mg	1	QL (9 tabs every 25 days); Indicated for opioid addiction
(Methadone Hcl Tab For Oral Susp 40 mg) METHADOSE	1	QL (9 tabs every 25 days); Indicated for opioid addiction
morphine sulfate beads cap er 24hr 30 mg	1	ST; PA**
morphine sulfate beads cap er 24hr 45 mg	1	ST; PA**
morphine sulfate beads cap er 24hr 60 mg	1	ST; PA**
morphine sulfate beads cap er 24hr 75 mg	1	ST; PA**
morphine sulfate beads cap er 24hr 90 mg	1	ST; PA**
morphine sulfate beads cap er 24hr 120 mg	1	PA; High Strength Requires PA
morphine sulfate oral soln 10 mg/5ml	1	PA
morphine sulfate oral soln 20 mg/5ml	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
morphine sulfate tab 15 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate tab 30 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
morphine sulfate tab er 15 mg	1	ST; PA**
morphine sulfate tab er 30 mg	1	ST; PA**
morphine sulfate tab er 60 mg	1	PA; High Strength Requires PA
morphine sulfate tab er 100 mg	1	PA; High Strength Requires PA
morphine sulfate tab er 200 mg	1	PA; High Strength Requires PA
oxycodone hcl cap 5 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone hcl conc 100 mg/5ml (20 mg/ml)	1	PA
oxycodone hcl soln 5 mg/5ml	1	PA
oxycodone hcl tab 5 mg	1	PA
oxycodone hcl tab 10 mg	1	PA
oxycodone hcl tab 15 mg	1	PA
oxycodone hcl tab 20 mg	1	PA
oxycodone hcl tab 30 mg	1	PA
oxymorphone hcl tab 5 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxymorphone hcl tab 10 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
tapentadol hcl tab 50 mg	1	PA; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19
tapentadol hcl tab 75 mg	1	PA; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19
tapentadol hcl tab 100 mg	1	PA; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19
tramadol hcl oral soln 5 mg/ml	1	PA; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
tramadol hcl tab 50 mg	1	PA
tramadol hcl tab er 24hr 100 mg	1	ST; PA**; Not available under age 12
tramadol hcl tab er 24hr 200 mg	1	PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tramadol hcl tab er 24hr 300 mg	1	PA
tramadol hcl tab er 24hr biphasic release 200 mg	1	PA; High Strength Requires PA; Not available under age 12
tramadol hcl tab er 24hr biphasic release 300 mg	1	PA; High Strength Requires PA; Not available under age 12
OPIOID COMBINATIONS		
acetaminophen w/ codeine soln 120-12 mg/5ml	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
acetaminophen w/ codeine tab 300-15 mg	1	ST, QL (400 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-30 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
acetaminophen w/ codeine tab 300-60 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg	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
butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg	1	QL (48 caps every 25 days); Not available under age 12
butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg	1	QL (48 caps every 25 days); Not available under age 12
butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	PA, QL (2700 mL every 25 days)
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	PA, QL (2700 mL every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen soln 10-300 mg/15ml	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
hydrocodone-acetaminophen tab 2.5-325 mg	1	PA, QL (240 tabs every 25 days); If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 5-300 mg	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 5-325 mg	1	PA, QL (240 tabs every 25 days)
hydrocodone-acetaminophen tab 7.5-300 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 7.5-325 mg	1	PA, QL (180 tabs every 25 days)
hydrocodone-acetaminophen tab 10-300 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-acetaminophen tab 10-325 mg	1	PA, QL (180 tabs every 25 days)
hydrocodone-ibuprofen tab 5-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
hydrocodone-ibuprofen tab 7.5-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hydrocodone-ibuprofen tab 10-200 mg	1	ST, QL (50 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 2.5-325 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 2.5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 5-325 mg	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 5-325 mg) ENDOCET	1	ST, QL (360 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 7.5-325 mg	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 7.5-325 mg) ENDOCET	1	ST, QL (240 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
oxycodone w/ acetaminophen tab 10-325 mg	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
(Oxycodone W/ Acetaminophen Tab 10-325 mg) ENDOCET	1	ST, QL (180 tabs every 25 days); PA**; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tramadol-acetaminophen tab 37.5-325 mg	1	ST, QL (40 tabs every 25 days); PA**; Subject to initial 7-day limit; Subject to initial 3-day limit under age 19; Not available under age 12
OPIOID PARTIAL AGONISTS		
BELBUCA MIS 75MCG ***(buprenorphine hcl)***	2	ST; PA**
BELBUCA MIS 150MCG ***(buprenorphine hcl)***	2	ST; PA**
BELBUCA MIS 300MCG ***(buprenorphine hcl)***	2	ST; PA**
BELBUCA MIS 450MCG ***(buprenorphine hcl)***	2	ST; PA**
BELBUCA MIS 600MCG ***(buprenorphine hcl)***	2	PA; High Strength Requires PA
BELBUCA MIS 750MCG ***(buprenorphine hcl)***	2	PA; High Strength Requires PA
BELBUCA MIS 900MCG ***(buprenorphine hcl)***	2	PA; High Strength Requires PA
buprenorphine hcl sl tab 2 mg (base equiv)	1	
buprenorphine hcl sl tab 8 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	
buprenorphine td patch weekly 5 mcg/hr	1	ST; PA**
buprenorphine td patch weekly 7.5 mcg/hr	1	ST; PA**
buprenorphine td patch weekly 10 mcg/hr	1	ST; PA**
buprenorphine td patch weekly 15 mcg/hr	1	PA
buprenorphine td patch weekly 20 mcg/hr	1	PA
butorphanol tartrate nasal soln 10 mg/ml	1	
pentazocine w/ naloxone hcl tab 50-0.5 mg	1	PA; Subject to initial 7-day limit; If age 19 or younger, subject to initial 3-day limit
ZUBSOLV SUB 0.7-0.18 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 1.4-0.36 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 2.9-0.71 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZUBSOLV SUB 5.7-1.4 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 8.6-2.1 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ZUBSOLV SUB 11.4-2.9 ***(buprenorphine hcl-naloxone hcl dihydrate)***	2	
ANDROGENS-ANABOLIC - DRUGS TO REGULATE MALE HORMONES		
ANDROGENS		
danazol cap 50 mg	1	
danazol cap 100 mg	1	
danazol cap 200 mg	1	
methyltestosterone cap 10 mg	1	PA, MO
(Methyltestosterone Oral Tab 10 mg) METHITEST	1	PA, MO
NATESTO GEL 5.5MG ***(testosterone)***	2	PA, MO
testosterone td gel 12.5 mg/act (1%)	1	PA, MO
testosterone td gel 20.25 mg/1.25gm (1.62%)	1	PA, MO
testosterone td gel 20.25 mg/act (1.62%)	1	PA, MO
testosterone td gel 25 mg/2.5gm (1%)	1	PA, MO
testosterone td gel 40.5 mg/2.5gm (1.62%)	1	PA, MO
testosterone td gel 50 mg/5gm (1%)	1	PA, MO
testosterone td soln 30 mg/act	1	PA, MO
ANORECTAL AND RELATED PRODUCTS - RECTAL PREPARATIONS		
INTRARECTAL STEROIDS		
budesonide rectal foam 2 mg/act	1	
CORTIFOAM AER 90MG ***(hydrocortisone acetate (intrarectal))***	2	
hydrocortisone enema 100 mg/60ml	1	
RECTAL COMBINATIONS		
hydrocortisone acetate w/ pramoxine perianal cream 1-1%	1	
PROCTOFOAM AER HC 1% ***(hydrocortisone acetate w/ pramoxine)***	2	
RECTAL STEROIDS		
hydrocortisone perianal cream 1%	1	
(Hydrocortisone Perianal Cream 1%) PROCTOCORT	1	
hydrocortisone perianal cream 2.5%	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	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VASODILATING AGENTS		
nitroglycerin oint 0.4%	1	
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
ANTHELMINTICS - DRUGS TO TREAT INFECTIONS OF PARASITES		
albendazole tab 200 mg	1	
EMVERM CHW 100MG ***(mebendazole)***	2	
ivermectin tab 3 mg	1	
ivermectin tab 6 mg	1	
praziquantel tab 600 mg	1	
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
ANTI-INFECTIVE AGENTS - MISC. - DRUGS TO TREAT INFECTIONS		
metronidazole cap 375 mg	1	
metronidazole tab 250 mg	1	
metronidazole tab 500 mg	1	
pentamidine isethionate for nebulization soln 300 mg	1	
tinidazole tab 250 mg	1	
tinidazole tab 500 mg	1	
trimethoprim tab 100 mg	1	
XIFAXAN TAB 550MG ***(rifaximin)***	2	MO
ANTI-INFECTIVE MISC. - COMBINATIONS		
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
(Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml) SULFATRIM PEDIATRIC	1	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
ANTIPROTOZOAL AGENTS		
atovaquone susp 750 mg/5ml	1	
nitazoxanide tab 500 mg	1	
GLYCOPEPTIDES		
vancomycin hcl cap 125 mg (base equivalent)	1	
vancomycin hcl cap 250 mg (base equivalent)	1	
vancomycin hcl for oral soln 25 mg/ml (base equivalent)	1	
vancomycin hcl for oral soln 50 mg/ml (base equivalent)	1	
LEPROSTATICS		
dapsone tab 25 mg	1	MO
dapsone tab 100 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LINCOSAMIDES		
clindamycin hcl cap 75 mg	1	
clindamycin hcl cap 150 mg	1	
clindamycin hcl cap 300 mg	1	
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	1	
MONOBACTAMS		
CAYSTON INH 75MG ***(aztreonam lysine)***	3	SP, PA
OXAZOLIDINONES		
linezolid for susp 100 mg/5ml	1	
linezolid tab 600 mg	1	
URINARY ANTI-INFECTIVES - DRUGS TO TREAT URINARY TRACT INFECTIONS		
fosfomycin tromethamine powd pack 3 gm (base equivalent)	1	
methenamine hippurate tab 1 gm	1	
methenamine mandelate tab 0.5 gm	1	
nitrofurantoin macrocrystalline cap 25 mg	1	
nitrofurantoin macrocrystalline cap 50 mg	1	
nitrofurantoin macrocrystalline cap 100 mg	1	
nitrofurantoin monohydrate macrocrystalline cap 100 mg	1	
nitrofurantoin susp 25 mg/5ml	1	
ANTIANGINAL AGENTS - DRUGS TO TREAT HEART CONDITIONS		
ANTIANGINALS-OTHER		
ranolazine tab er 12hr 500 mg	1	MO
ranolazine tab er 12hr 1000 mg	1	MO
NITRATES		
isosorbide dinitrate tab 5 mg	1	MO
isosorbide dinitrate tab 10 mg	1	MO
isosorbide dinitrate tab 20 mg	1	MO
isosorbide dinitrate tab 30 mg	1	MO
isosorbide mononitrate tab 10 mg	1	MO
isosorbide mononitrate tab 20 mg	1	MO
isosorbide mononitrate tab er 24hr 30 mg	1	MO
isosorbide mononitrate tab er 24hr 60 mg	1	MO
isosorbide mononitrate tab er 24hr 120 mg	1	MO
nitroglycerin oint 2%	1	MO
(Nitroglycerin Oint 2%) NITRO-BID	1	MO
nitroglycerin sl tab 0.3 mg	1	MO
nitroglycerin sl tab 0.4 mg	1	MO
nitroglycerin sl tab 0.6 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
nitroglycerin td patch 24hr 0.1 mg/hr	1	MO
nitroglycerin td patch 24hr 0.2 mg/hr	1	MO
nitroglycerin td patch 24hr 0.4 mg/hr	1	MO
nitroglycerin td patch 24hr 0.6 mg/hr	1	MO
nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)	1	MO
ANTIANXIETY AGENTS - DRUGS TO TREAT ANXIETY		
ANTIANXIETY AGENTS - MISC.		
buspirone hcl tab 5 mg	1	
buspirone hcl tab 7.5 mg	1	
buspirone hcl tab 10 mg	1	
buspirone hcl tab 15 mg	1	
buspirone hcl tab 30 mg	1	
hydroxyzine hcl syrup 10 mg/5ml	1	
hydroxyzine hcl tab 10 mg	1	
hydroxyzine hcl tab 25 mg	1	
hydroxyzine hcl tab 50 mg	1	
hydroxyzine pamoate cap 25 mg	1	
hydroxyzine pamoate cap 50 mg	1	
hydroxyzine pamoate cap 100 mg	1	
meprobamate tab 200 mg	1	
meprobamate tab 400 mg	1	
BENZODIAZEPINES		
alprazolam orally disintegrating tab 0.5 mg	1	QL (150 tabs every 25 days)
alprazolam orally disintegrating tab 0.25 mg	1	QL (150 tabs every 25 days)
alprazolam orally disintegrating tab 1 mg	1	QL (150 tabs every 25 days)
alprazolam orally disintegrating tab 2 mg	1	QL (150 tabs every 25 days)
alprazolam tab 0.5 mg	1	QL (150 tabs every 25 days)
alprazolam tab 0.25 mg	1	QL (150 tabs every 25 days)
alprazolam tab 1 mg	1	QL (150 tabs every 25 days)
alprazolam tab 2 mg	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 0.5 mg	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 0.5 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 1 mg	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 1 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 2 mg	1	QL (150 tabs every 25 days)
(Alprazolam Tab Er 24hr 2 mg) ALPRAZOLAM XR	1	QL (150 tabs every 25 days)
alprazolam tab er 24hr 3 mg	1	QL (90 tabs every 25 days)
(Alprazolam Tab Er 24hr 3 mg) ALPRAZOLAM XR	1	QL (90 tabs every 25 days)
chlordiazepoxide hcl cap 5 mg	1	QL (360 caps every 25 days)
chlordiazepoxide hcl cap 10 mg	1	QL (360 caps every 25 days)
chlordiazepoxide hcl cap 25 mg	1	QL (360 caps every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clorazepate dipotassium tab 3.75 mg	1	QL (180 tabs every 25 days)
clorazepate dipotassium tab 7.5 mg	1	QL (180 tabs every 25 days)
clorazepate dipotassium tab 15 mg	1	QL (180 tabs every 25 days)
diazepam conc 5 mg/ml	1	QL (240 mL every 25 days)
(Diazepam Conc 5 mg/ml) DIAZEPAM INTENSOL	1	QL (240 mL every 25 days)
diazepam oral soln 1 mg/ml	1	QL (1200 mL every 25 days)
diazepam tab 2 mg	1	QL (120 tabs every 25 days)
diazepam tab 5 mg	1	QL (120 tabs every 25 days)
diazepam tab 10 mg	1	QL (120 tabs every 25 days)
lorazepam conc 2 mg/ml	1	QL (150 mL every 25 days)
lorazepam tab 0.5 mg	1	QL (150 tabs every 25 days)
lorazepam tab 1 mg	1	QL (150 tabs every 25 days)
lorazepam tab 2 mg	1	QL (150 tabs every 25 days)
oxazepam cap 10 mg	1	QL (120 caps every 25 days)
oxazepam cap 15 mg	1	QL (120 caps every 25 days)
oxazepam cap 30 mg	1	QL (120 caps every 25 days)
ANTIARRHYTHMICS - DRUGS TO TREAT HEART CONDITIONS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide phosphate cap 100 mg	1	MO
disopyramide phosphate cap 150 mg	1	MO
quinidine gluconate tab er 324 mg	1	MO
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap 150 mg	1	MO
mexiletine hcl cap 200 mg	1	MO
mexiletine hcl cap 250 mg	1	MO
ANTIARRHYTHMICS TYPE I-C		
flecainide acetate tab 50 mg	1	MO
flecainide acetate tab 100 mg	1	MO
flecainide acetate tab 150 mg	1	MO
propafenone hcl cap er 12hr 225 mg	1	MO
propafenone hcl cap er 12hr 325 mg	1	MO
propafenone hcl cap er 12hr 425 mg	1	MO
propafenone hcl tab 150 mg	1	MO
propafenone hcl tab 225 mg	1	MO
propafenone hcl tab 300 mg	1	MO
ANTIARRHYTHMICS TYPE III		
amiodarone hcl tab 100 mg	1	MO
(Amiodarone Hcl Tab 100 mg) PACERONE	1	MO
amiodarone hcl tab 200 mg	1	MO
(Amiodarone Hcl Tab 200 mg) PACERONE	1	MO
amiodarone hcl tab 400 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dofetilide cap 125 mcg (0.125 mg)	1	SP
dofetilide cap 250 mcg (0.25 mg)	1	SP
dofetilide cap 500 mcg (0.5 mg)	1	SP
MULTAQ TAB 400MG ***(dronedarone hcl)***	2	MO
ANTIASTHMATIC AND BRONCHODILATOR AGENTS - DRUGS TO TREAT ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
ANTI-INFLAMMATORY AGENTS		
cromolyn sodium soln nebu 20 mg/2ml	1	QL (720 mL every 75 days), MO
BRONCHODILATORS - ANTICHOLINERGICS		
ipratropium bromide hfa inhal aerosol 17 mcg/act	1	QL (6 inhalers every 75 days), MO
ipratropium bromide inhal soln 0.02%	1	QL (938 mL every 75 days), MO
SPIRIVA CAP HANDIHLR ***(tiotropium bromide)***	1	QL (90 caps every 75 days), MO
SPIRIVA RESP AER 1.25MCG ***(tiotropium bromide)***	2	QL (3 inhalers every 75 days), MO
SPIRIVA RESP AER 2.5MCG ***(tiotropium bromide)***	2	QL (3 inhalers every 75 days), MO
YUPELRI NEB 175/3ML ***(revefenacin)***	2	QL (270 mL every 75 days), MO
LEUKOTRIENE MODULATORS		
montelukast sodium chew tab 4 mg (base equiv)	1	MO
montelukast sodium chew tab 5 mg (base equiv)	1	MO
montelukast sodium oral granules packet 4 mg (base equiv)	1	MO
montelukast sodium tab 10 mg (base equiv)	1	MO
zafirlukast tab 10 mg	1	MO
zafirlukast tab 20 mg	1	MO
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
roflumilast tab 250 mcg	1	MO
roflumilast tab 500 mcg	1	MO
STEROID INHALANTS		
ASMANEX HFA AER 50MCG ***(mometasone furoate (inhalation))***	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 100 MCG ***(mometasone furoate (inhalation))***	2	QL (3 inhalers every 75 days), MO
ASMANEX HFA AER 200 MCG ***(mometasone furoate (inhalation))***	2	QL (3 inhalers every 75 days), MO
beclomethasone diprop inhal aero soln 40 mcg/act (50/valve)	1	QL (6 inhalers every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
beclomethasone diprop inhal aers 100 mcg/act (80/delivery)	1	QL (6 inhalers every 75 days), MO
budesonide inhalation susp 0.5 mg/2ml	1	QL (360 mL every 75 days), MO
budesonide inhalation susp 0.25 mg/2ml	1	QL (540 mL every 75 days), MO
budesonide inhalation susp 1 mg/2ml	1	QL (180 mL every 75 days), MO
fluticasone furoate aerosol powder breath activ 50 mcg/act	1	QL (3 inhalers every 75 days), MO
fluticasone furoate aerosol powder breath activ 100 mcg/act	1	QL (90 blisters every 75 days), MO
fluticasone furoate aerosol powder breath activ 200 mcg/act	1	QL (90 blisters every 75 days), MO
fluticasone propionate hfa inhal aer 110 mcg/act	3	QL (6 inhalers every 75 days), MO
fluticasone propionate hfa inhal aer 220 mcg/act	3	QL (6 inhalers every 75 days), MO
fluticasone propionate hfa inhal aero 44 mcg/act	3	QL (6 inhalers every 75 days), MO
PULMICORT INH 90MCG ***(budesonide (inhalation))***	2	QL (9 inhalers every 75 days), MO
PULMICORT INH 180MCG ***(budesonide (inhalation))***	2	QL (6 inhalers every 75 days), MO
SYMPATHOMIMETICS		
AIRSUPRA AER 90-80MCG ***(albuterol-budesonide)***	2	QL (9 inhalers every 75 days)
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	1	MO
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	1	QL (6 inhalers every 75 days), MO
albuterol sulfate soln nebu 0.5% (5 mg/ml)	1	QL (360 vials every 75 days), MO
albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)	1	QL (1125 mL every 75 days), MO
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)	1	QL (1125 mL every 75 days), MO
albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)	1	QL (1125 mL every 75 days), MO
albuterol sulfate syrup 2 mg/5ml	1	MO
albuterol sulfate tab 2 mg	1	MO
albuterol sulfate tab 4 mg	1	MO
ANORO ELLIPT AER 62.5-25 ***(umeclidinium-vilanterol)***	2	QL (180 blisters every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	1	QL (360 mL every 75 days), MO
BREO ELLIPTA INH 50-25MCG ***(fluticasone furoate-vilanterol)***	2	QL (3 inhalers every 75 days), MO
BREO ELLIPTA INH 100-25 ***(fluticasone furoate-vilanterol)***	2	QL (180 blisters every 75 days), MO
BREO ELLIPTA INH 200-25 ***(fluticasone furoate-vilanterol)***	2	QL (180 blisters every 75 days), MO
BREZTRI AERO AER 9MCG ***(budesonide-glycopyrrolate-formoterol fumarate)***	2	QL (3 inhalers every 75 days), MO
BREZTRI AERO AER 18MCG ***(budesonide-glycopyrrolate-formoterol fumarate)***	2	QL (3 inhalers every 75 days), MO
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act	1	QL (9 inhalers every 75 days), MO
(Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act) BREYNA	1	QL (9 inhalers every 75 days), MO
budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act	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
fluticasone-salmeterol aer powder ba 100-50 mcg/act	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
fluticasone-salmeterol aer powder ba 250-50 mcg/act	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
fluticasone-salmeterol aer powder ba 500-50 mcg/act	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
formoterol fumarate soln nebu 20 mcg/2ml	1	QL (360 mL every 75 days), MO
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	QL (1620 mL every 75 days), MO
levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)	1	QL (900 mL every 75 days), MO
levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)	1	QL (900 mL every 75 days), MO
levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)	1	QL (900 mL every 75 days), MO
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)	1	QL (270 mL every 75 days), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)	1	QL (6 inhalers every 75 days), MO
SEREVENT DIS AER 50MCG ***(salmeterol xinafoate)***	2	QL (180 inhalations every 75 days), MO
STIOLTO AER 2.5-2.5 ***(tiotropium bromide-olodaterol hcl)***	2	QL (3 inhalers every 75 days), MO
STRIVERDI AER 2.5MCG ***(olodaterol hcl)***	2	QL (3 inhalers every 75 days), MO
terbutaline sulfate tab 2.5 mg	1	MO
terbutaline sulfate tab 5 mg	1	MO
TRELEGY AER 100MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (3 inhalers every 75 days), MO
TRELEGY AER 100MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (3 packages every 75 days), MO
TRELEGY AER 200MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (3 inhalers every 75 days), MO
TRELEGY AER 200MCG ***(fluticasone-umeclidinium-vilanterol)***	2	QL (3 packages every 75 days), MO
XANTHINES		
theophylline elixir 80 mg/15ml	1	MO
(Theophylline Elixir 80 mg/15ml) ELIXOPHYLLIN	1	MO
theophylline soln 80 mg/15ml	1	MO
theophylline tab er 12hr 100 mg	1	MO
theophylline tab er 12hr 200 mg	1	MO
theophylline tab er 12hr 300 mg	1	MO
theophylline tab er 12hr 450 mg	1	MO
theophylline tab er 24hr 400 mg	1	MO
theophylline tab er 24hr 600 mg	1	MO
ANTICOAGULANTS - DRUGS TO PREVENT BLOOD CLOTS		
COUMARIN ANTICOAGULANTS		
warfarin sodium tab 1 mg	1	MO
warfarin sodium tab 2 mg	1	MO
warfarin sodium tab 2.5 mg	1	MO
warfarin sodium tab 3 mg	1	MO
warfarin sodium tab 4 mg	1	MO
warfarin sodium tab 5 mg	1	MO
warfarin sodium tab 6 mg	1	MO
warfarin sodium tab 7.5 mg	1	MO
warfarin sodium tab 10 mg	1	MO
DIRECT FACTOR XA INHIBITORS		
ELIQUIS CAP 0.15MG ***(apixaban)***	2	MO
ELIQUIS ST P TAB 5MG ***(apixaban)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ELIQUIS TAB 0.5MG ***(apixaban)***	2	MO
ELIQUIS TAB 1.5MG ***(apixaban)***	2	MO
ELIQUIS TAB 2.5MG ***(apixaban)***	2	MO
ELIQUIS TAB 2MG ***(apixaban)***	2	MO
ELIQUIS TAB 5MG ***(apixaban)***	2	MO
rivaroxaban for susp 1 mg/ml	1	MO
rivaroxaban tab 2.5 mg	1	MO
XARELTO STAR TAB 15/20MG ***(rivaroxaban)***	2	
XARELTO SUS 1MG/ML ***(rivaroxaban)***	2	MO
XARELTO TAB 2.5MG ***(rivaroxaban)***	2	MO
XARELTO TAB 10MG ***(rivaroxaban)***	2	MO
XARELTO TAB 15MG ***(rivaroxaban)***	2	MO
XARELTO TAB 20MG ***(rivaroxaban)***	2	MO
THROMBIN INHIBITORS		
dabigatran etexilate mesylate cap 75 mg (etexilate base eq)	1	MO
dabigatran etexilate mesylate cap 110 mg (etexilate base eq)	1	MO
dabigatran etexilate mesylate cap 150 mg (etexilate base eq)	1	MO
ANTICONVULSANTS - DRUGS TO TREAT SEIZURES		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
perampanel susp 0.5 mg/ml	1	MO
perampanel tab 2 mg	1	MO
perampanel tab 4 mg	1	MO
perampanel tab 6 mg	1	MO
perampanel tab 8 mg	1	MO
perampanel tab 10 mg	1	MO
perampanel tab 12 mg	1	MO
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam suspension 2.5 mg/ml	1	MO
clobazam tab 10 mg	1	MO
clobazam tab 20 mg	1	MO
clonazepam orally disintegrating tab 0.5 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 0.25 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 0.125 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 1 mg	1	QL (300 tabs every 25 days)
clonazepam orally disintegrating tab 2 mg	1	QL (300 tabs every 25 days)
clonazepam tab 0.5 mg	1	QL (300 tabs every 25 days)
clonazepam tab 1 mg	1	QL (300 tabs every 25 days)
clonazepam tab 2 mg	1	QL (300 tabs every 25 days)
diazepam rectal gel delivery system 2.5 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diazepam rectal gel delivery system 10 mg	1	
diazepam rectal gel delivery system 20 mg	1	
NAYZILAM SPR 5MG ***(midazolam (anticonvulsant))***	2	
VALTOCO SPR 5MG ***(diazepam (anticonvulsant))***	2	
VALTOCO SPR 10MG ***(diazepam (anticonvulsant))***	2	
VALTOCO SPR 15MG ***(diazepam (anticonvulsant))***	2	
VALTOCO SPR 20MG ***(diazepam (anticonvulsant))***	2	
ANTICONVULSANTS - MISC.		
brivaracetam oral soln 10 mg/ml	1	MO
brivaracetam tab 10 mg	1	MO
brivaracetam tab 25 mg	1	MO
brivaracetam tab 50 mg	1	MO
brivaracetam tab 75 mg	1	MO
brivaracetam tab 100 mg	1	MO
carbamazepine cap er 12hr 100 mg	1	MO
carbamazepine cap er 12hr 200 mg	1	MO
carbamazepine cap er 12hr 300 mg	1	MO
carbamazepine chew tab 100 mg	1	MO
carbamazepine chew tab 200 mg	1	MO
carbamazepine susp 100 mg/5ml	1	MO
carbamazepine tab 200 mg	1	MO
carbamazepine tab er 12hr 100 mg	1	MO
carbamazepine tab er 12hr 200 mg	1	MO
carbamazepine tab er 12hr 400 mg	1	MO
CARBATROL CAP 100MG ***(carbamazepine)***	2	MO
CARBATROL CAP 200MG ***(carbamazepine)***	2	MO
CARBATROL CAP 300MG ***(carbamazepine)***	2	MO
eslicarbazepine acetate tab 200 mg	1	MO
eslicarbazepine acetate tab 400 mg	1	MO
eslicarbazepine acetate tab 600 mg	1	MO
eslicarbazepine acetate tab 800 mg	1	MO
gabapentin cap 100 mg	1	MO
gabapentin cap 200 mg	1	MO
gabapentin cap 300 mg	1	MO
gabapentin cap 400 mg	1	MO
gabapentin oral soln 250 mg/5ml	1	MO
gabapentin tab 600 mg	1	MO
gabapentin tab 800 mg	1	MO
lacosamide oral solution 10 mg/ml	1	MO
lacosamide tab 50 mg	1	MO
lacosamide tab 100 mg	1	MO
lacosamide tab 150 mg	1	MO

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levetiracetam tab disintegrating soluble 250 mg	1	MO
levetiracetam tab disintegrating soluble 500 mg	1	MO
levetiracetam tab er 24hr 500 mg	1	MO
levetiracetam tab er 24hr 750 mg	1	MO
oxcarbazepine susp 300 mg/5ml (60 mg/ml)	1	MO
oxcarbazepine tab 150 mg	1	MO
oxcarbazepine tab 300 mg	1	MO
oxcarbazepine tab 600 mg	1	MO
oxcarbazepine tab er 24hr 150 mg	1	MO
oxcarbazepine tab er 24hr 300 mg	1	MO
oxcarbazepine tab er 24hr 600 mg	1	MO
OXTELLAR XR TAB 150MG ***(oxcarbazepine)***	2	MO
OXTELLAR XR TAB 300MG ***(oxcarbazepine)***	2	MO
OXTELLAR XR TAB 600MG ***(oxcarbazepine)***	2	MO
pregabalin cap 25 mg	1	MO
pregabalin cap 50 mg	1	MO
pregabalin cap 75 mg	1	MO
pregabalin cap 100 mg	1	MO
pregabalin cap 150 mg	1	MO
pregabalin cap 200 mg	1	MO
pregabalin cap 225 mg	1	MO
pregabalin cap 300 mg	1	MO
pregabalin soln 20 mg/ml	1	MO
primidone tab 50 mg	1	MO
primidone tab 250 mg	1	MO
rufinamide susp 40 mg/ml	1	MO
rufinamide tab 200 mg	1	MO
rufinamide tab 400 mg	1	MO
topiramate cap er 24hr 25 mg	1	MO
topiramate cap er 24hr 50 mg	1	MO
topiramate cap er 24hr 100 mg	1	MO
topiramate cap er 24hr 200 mg	1	MO
topiramate oral soln 25 mg/ml	1	MO
topiramate sprinkle cap 15 mg	1	MO
topiramate sprinkle cap 25 mg	1	MO
topiramate sprinkle cap 50 mg	1	MO
topiramate tab 25 mg	1	MO
topiramate tab 50 mg	1	MO
topiramate tab 100 mg	1	MO
topiramate tab 200 mg	1	MO
zonisamide cap 25 mg	1	MO
zonisamide cap 50 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
zonisamide cap 100 mg	1	MO
CARBAMATES		
felbamate susp 600 mg/5ml	1	MO
felbamate tab 400 mg	1	MO
felbamate tab 600 mg	1	MO
XCOPRI PAK 12.5-25 ***(cenobamate)***	2	
XCOPRI PAK 50-100MG ***(cenobamate)***	2	
XCOPRI PAK 100-150 ***(cenobamate)***	2	MO
XCOPRI PAK 150-200 ***(cenobamate)***	2	
XCOPRI PAK 150-200 ***(cenobamate)***	2	MO
XCOPRI TAB 25MG ***(cenobamate)***	2	MO
XCOPRI TAB 50MG ***(cenobamate)***	2	MO
XCOPRI TAB 100MG ***(cenobamate)***	2	MO
XCOPRI TAB 150MG ***(cenobamate)***	2	MO
XCOPRI TAB 200MG ***(cenobamate)***	2	MO
GABA MODULATORS		
tiagabine hcl tab 2 mg	1	MO
tiagabine hcl tab 4 mg	1	MO
tiagabine hcl tab 12 mg	1	MO
tiagabine hcl tab 16 mg	1	MO
vigabatrin powd pack 500 mg	1	SP, PA, QL (6 packets every 1 day)
(Vigabatrin Powd Pack 500 mg) VIGADRONE	1	SP, PA, QL (6 packets every 1 day)
vigabatrin tab 500 mg	1	SP, PA, QL (6 tabs every 1 day)
(Vigabatrin Tab 500 mg) VIGADRONE	1	SP, PA, QL (6 tabs every 1 day)
HYDANTOINS		
phenytoin chew tab 50 mg	1	MO
phenytoin sodium extended cap 100 mg	1	MO
phenytoin sodium extended cap 200 mg	1	MO
(Phenytoin Sodium Extended Cap 200 mg) PHENYTEK	1	MO
phenytoin sodium extended cap 300 mg	1	MO
(Phenytoin Sodium Extended Cap 300 mg) PHENYTEK	1	MO
phenytoin susp 125 mg/5ml	1	MO
SUCCINIMIDES		
ethosuximide cap 250 mg	1	MO
ethosuximide soln 250 mg/5ml	1	MO
methsuximide cap 300 mg	1	MO
VALPROIC ACID		
divalproex sodium cap delayed release sprinkle 125 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
divalproex sodium tab delayed release 125 mg	1	MO
divalproex sodium tab delayed release 250 mg	1	MO
divalproex sodium tab delayed release 500 mg	1	MO
divalproex sodium tab er 24 hr 250 mg	1	MO
divalproex sodium tab er 24 hr 500 mg	1	MO
valproate sodium oral soln 250 mg/5ml (base equiv)	1	MO
valproic acid cap 250 mg	1	MO
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
mirtazapine orally disintegrating tab 15 mg	1	MO
mirtazapine orally disintegrating tab 30 mg	1	MO
mirtazapine orally disintegrating tab 45 mg	1	MO
mirtazapine tab 7.5 mg	1	MO
mirtazapine tab 15 mg	1	MO
mirtazapine tab 30 mg	1	MO
mirtazapine tab 45 mg	1	MO
ANTIDEPRESSANT COMBINATIONS		
AUVELITY TAB 45-105MG ***(dextromethorphan hydrobromide-bupropion hydrochloride)***	2	MO
ANTIDEPRESSANTS - MISC.		
bupropion hcl tab 75 mg	1	MO
bupropion hcl tab 100 mg	1	MO
bupropion hcl tab er 12hr 100 mg	1	MO
bupropion hcl tab er 12hr 150 mg	1	MO
bupropion hcl tab er 12hr 200 mg	1	MO
bupropion hcl tab er 24hr 150 mg	1	MO
bupropion hcl tab er 24hr 300 mg	1	MO
GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID		
ZURZUVAE CAP 20MG ***(zuranolone)***	2	SP, PA, QL (2 caps every 1 day)
ZURZUVAE CAP 25MG ***(zuranolone)***	2	SP, PA, QL (2 caps every 1 day)
ZURZUVAE CAP 30MG ***(zuranolone)***	2	SP, PA, QL (1 cap every 1 day)
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
phenelzine sulfate tab 15 mg	1	MO
tranylcypromine sulfate tab 10 mg	1	MO
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
citalopram hydrobromide cap 30 mg	1	MO
citalopram hydrobromide oral soln 10 mg/5ml	1	MO
citalopram hydrobromide tab 10 mg (base equiv)	1	MO
citalopram hydrobromide tab 20 mg (base equiv)	1	MO
citalopram hydrobromide tab 40 mg (base equiv)	1	MO
escitalopram oxalate soln 5 mg/5ml (base equiv)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
escitalopram oxalate tab 5 mg (base equiv)	1	MO
escitalopram oxalate tab 10 mg (base equiv)	1	MO
escitalopram oxalate tab 20 mg (base equiv)	1	MO
fluoxetine hcl cap 10 mg	1	MO
fluoxetine hcl cap 20 mg	1	MO
fluoxetine hcl cap 40 mg	1	MO
fluoxetine hcl cap delayed release 90 mg	1	MO
fluoxetine hcl solution 20 mg/5ml	1	MO
fluoxetine hcl tab 10 mg	1	MO
fluoxetine hcl tab 20 mg	1	MO
fluvoxamine maleate cap er 24hr 100 mg	1	MO
fluvoxamine maleate cap er 24hr 150 mg	1	MO
fluvoxamine maleate tab 25 mg	1	MO
fluvoxamine maleate tab 50 mg	1	MO
fluvoxamine maleate tab 100 mg	1	MO
paroxetine hcl oral susp 10 mg/5ml (base equiv)	1	MO
paroxetine hcl tab 10 mg	1	MO
paroxetine hcl tab 20 mg	1	MO
paroxetine hcl tab 30 mg	1	MO
paroxetine hcl tab 40 mg	1	MO
paroxetine hcl tab er 24hr 12.5 mg	1	MO
paroxetine hcl tab er 24hr 25 mg	1	MO
paroxetine hcl tab er 24hr 37.5 mg	1	MO
sertraline hcl cap 150 mg	1	MO
sertraline hcl cap 200 mg	1	MO
sertraline hcl oral concentrate for solution 20 mg/ml	1	MO
sertraline hcl tab 25 mg	1	MO
sertraline hcl tab 50 mg	1	MO
sertraline hcl tab 100 mg	1	MO
SEROTONIN MODULATORS		
nefazodone hcl tab 50 mg	1	MO
nefazodone hcl tab 100 mg	1	MO
nefazodone hcl tab 150 mg	1	MO
nefazodone hcl tab 200 mg	1	MO
nefazodone hcl tab 250 mg	1	MO
trazodone hcl tab 25 mg	1	MO
trazodone hcl tab 50 mg	1	MO
trazodone hcl tab 75 mg	1	MO
trazodone hcl tab 100 mg	1	MO
trazodone hcl tab 150 mg	1	MO
trazodone hcl tab 300 mg	1	MO
TRINTELLIX TAB 5MG ***(vortioxetine hbr)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
TRINTELLIX TAB 10MG ***(vortioxetine hbr)***	2	MO
TRINTELLIX TAB 20MG ***(vortioxetine hbr)***	2	MO
vilazodone hcl tab 10 mg	1	MO
vilazodone hcl tab 20 mg	1	MO
vilazodone hcl tab 40 mg	1	MO
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
desvenlafaxine succinate tab er 24hr 25 mg (base equiv)	1	MO
desvenlafaxine succinate tab er 24hr 50 mg (base equiv)	1	MO
desvenlafaxine succinate tab er 24hr 100 mg (base equiv)	1	MO
duloxetine hcl enteric coated pellets cap 20 mg (base eq)	1	MO
duloxetine hcl enteric coated pellets cap 30 mg (base eq)	1	MO
duloxetine hcl enteric coated pellets cap 40 mg (base eq)	1	MO
duloxetine hcl enteric coated pellets cap 60 mg (base eq)	1	MO
venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)	1	MO
venlafaxine hcl cap er 24hr 75 mg (base equivalent)	1	MO
venlafaxine hcl cap er 24hr 150 mg (base equivalent)	1	MO
venlafaxine hcl tab 25 mg (base equivalent)	1	MO
venlafaxine hcl tab 37.5 mg (base equivalent)	1	MO
venlafaxine hcl tab 50 mg (base equivalent)	1	MO
venlafaxine hcl tab 75 mg (base equivalent)	1	MO
venlafaxine hcl tab 100 mg (base equivalent)	1	MO
venlafaxine hcl tab er 24hr 225 mg (base equivalent)	1	MO
TRICYCLIC AGENTS		
amitriptyline hcl tab 10 mg	1	MO
amitriptyline hcl tab 25 mg	1	MO
amitriptyline hcl tab 50 mg	1	MO
amitriptyline hcl tab 75 mg	1	MO
amitriptyline hcl tab 100 mg	1	MO
amitriptyline hcl tab 150 mg	1	MO
amoxapine tab 25 mg	1	MO
amoxapine tab 50 mg	1	MO
amoxapine tab 100 mg	1	MO
amoxapine tab 150 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
clomipramine hcl cap 25 mg	1	MO
clomipramine hcl cap 50 mg	1	MO
clomipramine hcl cap 75 mg	1	MO
desipramine hcl tab 10 mg	1	MO
desipramine hcl tab 25 mg	1	MO
desipramine hcl tab 50 mg	1	MO
desipramine hcl tab 75 mg	1	MO
desipramine hcl tab 100 mg	1	MO
desipramine hcl tab 150 mg	1	MO
doxepin hcl cap 10 mg	1	MO
doxepin hcl cap 25 mg	1	MO
doxepin hcl cap 50 mg	1	MO
doxepin hcl cap 75 mg	1	MO
doxepin hcl cap 100 mg	1	MO
doxepin hcl cap 150 mg	1	MO
doxepin hcl conc 10 mg/ml	1	MO
imipramine hcl tab 10 mg	1	MO
imipramine hcl tab 25 mg	1	MO
imipramine hcl tab 50 mg	1	MO
imipramine pamoate cap 75 mg	1	MO
imipramine pamoate cap 100 mg	1	MO
imipramine pamoate cap 125 mg	1	MO
imipramine pamoate cap 150 mg	1	MO
nortriptyline hcl cap 10 mg	1	MO
nortriptyline hcl cap 25 mg	1	MO
nortriptyline hcl cap 50 mg	1	MO
nortriptyline hcl cap 75 mg	1	MO
nortriptyline hcl soln 10 mg/5ml	1	MO
protriptyline hcl tab 5 mg	1	MO
protriptyline hcl tab 10 mg	1	MO
trimipramine maleate cap 25 mg	1	MO
trimipramine maleate cap 50 mg	1	MO
trimipramine maleate cap 100 mg	1	MO
ANTIDIABETICS - DRUGS TO TREAT DIABETES		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab 25 mg	1	MO
acarbose tab 50 mg	1	MO
acarbose tab 100 mg	1	MO
miglitol tab 25 mg	1	MO
miglitol tab 50 mg	1	MO
miglitol tab 100 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIDIABETIC COMBINATIONS		
dapagliflozin-metformin hcl tab er 24hr 5-500 mg	1	MO
dapagliflozin-metformin hcl tab er 24hr 5-1000 mg	1	MO
dapagliflozin-metformin hcl tab er 24hr 10-500 mg	1	MO
dapagliflozin-metformin hcl tab er 24hr 10-1000 mg	1	MO
dapagliflozin-saxagliptin tab 10-5 mg	1	MO
glipizide-metformin hcl tab 2.5-250 mg	1	MO
glipizide-metformin hcl tab 2.5-500 mg	1	MO
glipizide-metformin hcl tab 5-500 mg	1	MO
glyburide-metformin tab 1.25-250 mg	1	MO
glyburide-metformin tab 2.5-500 mg	1	MO
glyburide-metformin tab 5-500 mg	1	MO
GLYXAMBI TAB 10-5 MG ***(empagliflozin-linagliptin)***	2	MO
GLYXAMBI TAB 25-5 MG ***(empagliflozin-linagliptin)***	2	MO
pioglitazone hcl-glimepiride tab 30-2 mg	1	MO
pioglitazone hcl-glimepiride tab 30-4 mg	1	MO
pioglitazone hcl-metformin hcl tab 15-500 mg	1	MO
pioglitazone hcl-metformin hcl tab 15-850 mg	1	MO
saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg	1	MO
saxagliptin-metformin hcl tab er 24hr 5-500 mg	1	MO
saxagliptin-metformin hcl tab er 24hr 5-1000 mg	1	MO
sitagliptin phosphate-metformin hcl tab 50-500 mg	1	MO
sitagliptin phosphate-metformin hcl tab 50-1000 mg	1	MO
sitagliptin phosphate-metformin hcl tab er 24hr 50-500 mg	1	MO
sitagliptin phosphate-metformin hcl tab er 24hr 50-1000 mg	1	MO
sitagliptin phosphate-metformin hcl tab er 24hr 100-1000 mg	1	MO
SOLIQUA INJ 100/33 ***(insulin glargine-lixisenatide)***	2	MO
SYNJARDY TAB ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY TAB 5-500MG ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY TAB 5-1000MG ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY TAB 12.5-500 ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY XR TAB ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY XR TAB 5-1000MG ***(empagliflozin-metformin hcl)***	2	MO
SYNJARDY XR TAB 10-1000 ***(empagliflozin-metformin hcl)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SYNJARDY XR TAB 25-1000 ***(empagliflozin-metformin hcl)***	2	MO
TRIJARDY XR TAB ***(empagliflozin-linagliptin-metformin)***	2	MO
XIGDUO XR TAB 2.5-1000 ***(dapagliflozin-metformin hcl)***	2	MO
XULTOPHY INJ 100/3.6 ***(insulin degludec-liraglutide)***	2	MO
ZITUVIMET TAB 50-500MG ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET TAB 50-1000 ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET XR TAB 50-500MG ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET XR TAB 50-1000 ***(sitagliptin free base-metformin hcl)***	2	MO
ZITUVIMET XR TAB 100-1000 ***(sitagliptin free base-metformin hcl)***	2	MO
BIGUANIDES		
metformin hcl oral soln 500 mg/5ml	1	MO
metformin hcl tab 500 mg	1	MO
metformin hcl tab 850 mg	1	MO
metformin hcl tab 1000 mg	1	MO
metformin hcl tab er 24hr 500 mg	1	MO
metformin hcl tab er 24hr 750 mg	1	MO
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE ***(glucagon)***	2	
BAQSIMI TWO POW 3MG/DOSE ***(glucagon)***	2	
diazoxide susp 50 mg/ml	1	MO
glucagon for inj 1 mg	1	
GVOKE HYPO 1 INJ 0.5/.1ML ***(glucagon)***	2	
GVOKE HYPO 1 INJ 1/0.2ML ***(glucagon)***	2	
GVOKE HYPO 2 INJ 0.5/.1ML ***(glucagon)***	2	
GVOKE HYPO 2 INJ 1/0.2ML ***(glucagon)***	2	
GVOKE KIT SOL 1/0.2ML ***(glucagon)***	2	
GVOKE PFS INJ 1/0.2ML ***(glucagon)***	2	
mifepristone tab 300 mg	1	SP, PA, QL (4 tabs every 1 day)
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
saxagliptin hcl tab 2.5 mg (base equiv)	1	MO
saxagliptin hcl tab 5 mg (base equiv)	1	MO
sitagliptin phosphate tab 25 mg (base equiv)	1	MO
sitagliptin phosphate tab 50 mg (base equiv)	1	MO
sitagliptin phosphate tab 100 mg (base equiv)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZITUVIO TAB 25MG ***(sitagliptin)***	2	MO
ZITUVIO TAB 50MG ***(sitagliptin)***	2	MO
ZITUVIO TAB 100MG ***(sitagliptin)***	2	MO
INCRETIN MIMETIC AGENTS		
liraglutide soln pen-injector 18 mg/3ml (6 mg/ml)	1	PA, MO
MOUNJARO INJ 2.5/0.5 ***(tirzepatide)***	2	PA
MOUNJARO INJ 5MG/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 7.5/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 10MG/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 12.5/0.5 ***(tirzepatide)***	2	PA, MO
MOUNJARO INJ 15MG/0.5 ***(tirzepatide)***	2	PA, MO
OZEMPIC INJ 2MG/3ML ***(semaglutide)***	2	PA, MO
OZEMPIC INJ 4MG/3ML ***(semaglutide)***	2	PA, MO
OZEMPIC INJ 8MG/3ML ***(semaglutide)***	2	PA, MO
OZEMPIC TAB 1.5MG ***(semaglutide)***	2	PA
OZEMPIC TAB 4MG ***(semaglutide)***	2	PA, MO
OZEMPIC TAB 9MG ***(semaglutide)***	2	PA, MO
RYBELSUS TAB 3MG ***(semaglutide)***	2	PA
RYBELSUS TAB 7MG ***(semaglutide)***	2	PA, MO
RYBELSUS TAB 14MG ***(semaglutide)***	2	PA, MO
TRULICITY INJ 0.75/0.5 ***(dulaglutide)***	2	PA, MO
TRULICITY INJ 1.5/0.5 ***(dulaglutide)***	2	PA, MO
TRULICITY INJ 3/0.5 ***(dulaglutide)***	2	PA, MO
TRULICITY INJ 4.5/0.5 ***(dulaglutide)***	2	PA, MO
INSULIN		
AFREZZA POW 4-8 UNIT ***(insulin regular (human))***	3	MO
AFREZZA POW 4-8-12 ***(insulin regular (human))***	3	MO
AFREZZA POW 4UNIT ***(insulin regular (human))***	3	MO
AFREZZA POW 8 UNIT ***(insulin regular (human))***	3	MO
AFREZZA POW 8-12UNIT ***(insulin regular (human))***	3	MO
AFREZZA POW 12 UNIT ***(insulin regular (human))***	3	MO
AWIQLI FLEX INJ 700UNIT ***(insulin icodec-abae)***	2	MO
FIASP FLEX INJ TOUCH ***(insulin aspart (with niacinamide))***	2	MO
FIASP INJ 100/ML ***(insulin aspart (with niacinamide))***	2	MO
FIASP PENFIL INJ U-100 ***(insulin aspart (with niacinamide))***	2	MO
GLARGIN YFGN INJ 100U/ML	2	MO
GLARGIN YFGN SOL 100U/ML	2	MO
HUMULIN R INJ U-500KWP ***(insulin regular (human))***	2	MO
LANTUS INJ 100/ML ***(insulin glargine)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LANTUS SOLOS INJ 100/ML ***(insulin glargine)***	2	MO
NOVOLIN INJ 70/30 ***(insulin nph isophane & reg (human))***	2	MO; RELION not covered
NOVOLIN INJ 70/30 FP ***(insulin nph isophane & reg (human))***	2	MO; RELION not covered
NOVOLIN N INJ 100 UNIT ***(insulin nph (human) (isophane))***	2	MO; RELION not covered
NOVOLIN N INJ U-100 ***(insulin nph (human) (isophane))***	2	MO; RELION not covered
NOVOLIN R INJ 100 UNIT ***(insulin regular (human))***	2	MO
NOVOLIN R INJ U-100 ***(insulin regular (human))***	2	MO; RELION not covered
NOVOLOG INJ 100/ML ***(insulin aspart)***	2	MO; RELION not covered
NOVOLOG INJ FLEXPEN ***(insulin aspart)***	2	MO; RELION not covered
NOVOLOG INJ PENFILL ***(insulin aspart)***	2	MO; RELION not covered
NOVOLOG MIX INJ 70/30 ***(insulin aspart protamine & aspart (human))***	2	MO; RELION not covered
NOVOLOG MIX INJ FLEXPEN ***(insulin aspart protamine & aspart (human))***	2	MO; RELION not covered
TOUJEO MAX INJ 300/ML ***(insulin glargine)***	2	MO
TOUJEO SOLO INJ 300/ML ***(insulin glargine)***	2	MO
TRESIBA FLEX INJ 100UNIT ***(insulin degludec)***	2	MO
TRESIBA FLEX INJ 200UNIT ***(insulin degludec)***	2	MO
TRESIBA INJ 100UNIT ***(insulin degludec)***	2	MO
INSULIN SENSITIZING AGENTS		
pioglitazone hcl tab 15 mg (base equiv)	1	MO
pioglitazone hcl tab 30 mg (base equiv)	1	MO
pioglitazone hcl tab 45 mg (base equiv)	1	MO
MEGLITINIDE ANALOGUES		
nateglinide tab 60 mg	1	MO
nateglinide tab 120 mg	1	MO
repaglinide tab 0.5 mg	1	MO
repaglinide tab 1 mg	1	MO
repaglinide tab 2 mg	1	MO
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
dapagliflozin tab 5 mg	1	MO
dapagliflozin tab 10 mg	1	MO
JARDIANCE TAB 10MG ***(empagliflozin)***	2	MO
JARDIANCE TAB 25MG ***(empagliflozin)***	2	MO
SULFONYLUREAS		
glimepiride tab 1 mg	1	MO
glimepiride tab 2 mg	1	MO
glimepiride tab 4 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
glipizide tab 5 mg	1	MO
glipizide tab 10 mg	1	MO
glipizide tab 15 mg	1	MO
glipizide tab er 24hr 2.5 mg	1	MO
glipizide tab er 24hr 5 mg	1	MO
glipizide tab er 24hr 10 mg	1	MO
glyburide tab 1.25 mg	1	MO
glyburide tab 2.5 mg	1	MO
glyburide tab 5 mg	1	MO
ANTIDIARRHEAL/PROBIOTIC AGENTS - DRUGS TO TREAT DIARRHEA		
ANTIPERISTALTIC AGENTS		
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	1	
diphenoxylate w/ atropine tab 2.5-0.025 mg	1	
loperamide hcl cap 2 mg	1	
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
ANTIDOTES - CHELATING AGENTS		
deferasirox granules packet 90 mg	1	SP, PA
deferasirox granules packet 180 mg	1	SP, PA
deferasirox granules packet 360 mg	1	SP, PA
deferasirox tab 90 mg	1	SP, PA
deferasirox tab 180 mg	1	SP, PA
deferasirox tab 360 mg	1	SP, PA
deferasirox tab for oral susp 125 mg	1	SP, PA
deferasirox tab for oral susp 250 mg	1	SP, PA
deferasirox tab for oral susp 500 mg	1	SP, PA
deferiprone tab 500 mg	1	SP, PA
deferiprone tab 1000 mg	1	SP, PA
ANTIDOTES AND SPECIFIC ANTAGONISTS - DRUGS FOR OVERDOSE OR POISONING		
VISTOGARD PAK 10GM ***(uridine triacetate (emergency treatment))***	2	QL (20 packets every 5 days)
OPIOID ANTAGONISTS		
naltrexone hcl tab 50 mg	1	
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
5-HT3 RECEPTOR ANTAGONISTS		
granisetron hcl tab 1 mg	1	
ondansetron hcl oral soln 4 mg/5ml	1	
ondansetron hcl tab 4 mg	1	
ondansetron hcl tab 8 mg	1	
ondansetron hcl tab 24 mg	1	
ondansetron orally disintegrating tab 4 mg	1	
ondansetron orally disintegrating tab 8 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SANCUSO DIS 3.1MG ***(granisetron)***	2	PA
ANTIEMETICS - ANTICHOLINERGIC		
meclizine hcl tab 12.5 mg	1	
meclizine hcl tab 25 mg	1	
meclizine hcl tab 50 mg	1	
scopolamine td patch 72hr 1 mg/3days	1	
trimethobenzamide hcl cap 300 mg	1	
ANTIEMETICS - MISCELLANEOUS		
doxylamine-pyridoxine tab delayed release 10-10 mg	1	
dronabinol cap 2.5 mg	1	QL (60 caps every 25 days)
dronabinol cap 5 mg	1	QL (60 caps every 25 days)
dronabinol cap 10 mg	1	QL (60 caps every 25 days)
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant capsule 40 mg	1	QL (3 caps every 180 days)
aprepitant capsule 80 mg	1	QL (4 caps every 21 days)
aprepitant capsule 125 mg	1	QL (2 caps every 21 days)
aprepitant capsule therapy pack 80 & 125 mg	1	QL (6 capsules every 21 days)
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
flucytosine cap 250 mg	1	
griseofulvin microsize susp 125 mg/5ml	1	
griseofulvin microsize tab 500 mg	1	
griseofulvin ultramicrosize tab 125 mg	1	
griseofulvin ultramicrosize tab 165 mg	1	
griseofulvin ultramicrosize tab 250 mg	1	
nystatin tab 500000 unit	1	
terbinafine hcl tab 250 mg	1	
IMIDAZOLE-RELATED ANTIFUNGALS		
fluconazole for susp 10 mg/ml	1	
fluconazole for susp 40 mg/ml	1	
fluconazole tab 50 mg	1	
fluconazole tab 100 mg	1	
fluconazole tab 150 mg	1	
fluconazole tab 200 mg	1	
itraconazole cap 100 mg	1	PA
itraconazole oral soln 10 mg/ml	1	PA
ketoconazole tab 200 mg	1	
posaconazole susp 40 mg/ml	1	MO
voriconazole for susp 40 mg/ml	1	
voriconazole tab 50 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
voriconazole tab 200 mg	1	
ANTIHISTAMINES - DRUGS TO TREAT ALLERGIES		
ANTIHISTAMINES - ETHANOLAMINES		
carbinoxamine maleate extended release susp 4 mg/5ml	1	
carbinoxamine maleate soln 4 mg/5ml	1	
(Carbinoxamine Maleate Soln 4 mg/5ml) CARBZAH	1	
carbinoxamine maleate tab 4 mg	1	
carbinoxamine maleate tab 6 mg	1	
(Carbinoxamine Maleate Tab 6 mg) RYVENT	1	
clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)	1	
clemastine fumarate tab 2.68 mg	1	
ANTIHISTAMINES - NON-SEDATING		
cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)	1	
desloratadine tab 5 mg	1	
desloratadine tab orally disintegrating 2.5 mg	1	
desloratadine tab orally disintegrating 5 mg	1	
levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)	1	
levocetirizine dihydrochloride tab 5 mg	1	
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine hcl oral soln 6.25 mg/5ml	1	
promethazine hcl suppos 12.5 mg	1	
(Promethazine Hcl Suppos 12.5 mg) PROMETHEGAN	1	
promethazine hcl suppos 25 mg	1	
(Promethazine Hcl Suppos 25 mg) PROMETHEGAN	1	
(Promethazine Hcl Suppos 50 mg) PROMETHEGAN	1	
promethazine hcl tab 12.5 mg	1	
promethazine hcl tab 25 mg	1	
promethazine hcl tab 50 mg	1	
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine hcl syrup 2 mg/5ml	1	
cyproheptadine hcl tab 4 mg	1	
ANTIHYPERLIPIDEMICS - DRUGS TO TREAT HIGH CHOLESTEROL		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB 180MG ***(bempedoic acid)***	2	MO
ANTIHYPERLIPIDEMICS - COMBINATIONS		
ezetimibe-simvastatin tab 10-10 mg	1	MO
ezetimibe-simvastatin tab 10-20 mg	1	MO
ezetimibe-simvastatin tab 10-40 mg	1	MO

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
atorvastatin calcium tab 80 mg (base equivalent)	1	MO
fluvastatin sodium cap 20 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
fluvastatin sodium cap 40 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
fluvastatin sodium tab er 24 hr 80 mg (base equivalent)	1	MO; $0 copay for members age 40 through 75
lovastatin tab 10 mg	1	MO; $0 copay for members age 40 through 75
lovastatin tab 20 mg	1	MO; $0 copay for members age 40 through 75
lovastatin tab 40 mg	1	MO; $0 copay for members age 40 through 75
pitavastatin calcium tab 1 mg	1	MO; $0 copay for members age 40 through 75
pitavastatin calcium tab 2 mg	1	MO; $0 copay for members age 40 through 75
pitavastatin calcium tab 4 mg	1	MO; $0 copay for members age 40 through 75
pravastatin sodium tab 10 mg	1	MO
pravastatin sodium tab 20 mg	1	MO
pravastatin sodium tab 40 mg	1	MO
pravastatin sodium tab 80 mg	1	MO
rosuvastatin calcium tab 5 mg	1	MO
rosuvastatin calcium tab 10 mg	1	MO
rosuvastatin calcium tab 20 mg	1	MO
rosuvastatin calcium tab 40 mg	1	MO
simvastatin tab 5 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 10 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 20 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 40 mg	1	MO; $0 copay for members age 40 through 75
simvastatin tab 80 mg	1	MO
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab 10 mg	1	MO
NICOTINIC ACID DERIVATIVES		
niacin tab er 500 mg (antihyperlipidemic)	1	MO
niacin tab er 750 mg (antihyperlipidemic)	1	MO
niacin tab er 1000 mg (antihyperlipidemic)	1	MO

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
AGENTS FOR PHEOCHROMOCYTOMA		
metyrosine cap 250 mg	1	SP, PA, QL (16 caps every 1 day)
phenoxybenzamine hcl cap 10 mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
azilsartan medoxomil tab 40 mg	1	MO
azilsartan medoxomil tab 80 mg	1	MO
candesartan cilexetil tab 4 mg	1	MO
candesartan cilexetil tab 8 mg	1	MO
candesartan cilexetil tab 16 mg	1	MO
candesartan cilexetil tab 32 mg	1	MO
irbesartan tab 75 mg	1	MO
irbesartan tab 150 mg	1	MO
irbesartan tab 300 mg	1	MO
losartan potassium tab 25 mg	1	MO
losartan potassium tab 50 mg	1	MO
losartan potassium tab 100 mg	1	MO
olmesartan medoxomil tab 5 mg	1	MO
olmesartan medoxomil tab 20 mg	1	MO
olmesartan medoxomil tab 40 mg	1	MO
telmisartan tab 20 mg	1	MO
telmisartan tab 40 mg	1	MO
telmisartan tab 80 mg	1	MO
valsartan oral soln 4 mg/ml	1	MO
valsartan tab 40 mg	1	MO
valsartan tab 80 mg	1	MO
valsartan tab 160 mg	1	MO
valsartan tab 320 mg	1	MO
ANTIADRENERGIC ANTIHYPERTENSIVES		
clonidine hcl tab 0.1 mg	1	MO
clonidine hcl tab 0.2 mg	1	MO
clonidine hcl tab 0.3 mg	1	MO
clonidine hcl tab 0.05 mg	1	MO
clonidine tab er 24hr 0.17 mg	1	MO
clonidine td patch weekly 0.1 mg/24hr	1	MO
clonidine td patch weekly 0.2 mg/24hr	1	MO
clonidine td patch weekly 0.3 mg/24hr	1	MO
doxazosin mesylate tab 1 mg	1	MO
doxazosin mesylate tab 2 mg	1	MO
doxazosin mesylate tab 4 mg	1	MO
doxazosin mesylate tab 8 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
guanfacine hcl tab 1 mg	1	MO
guanfacine hcl tab 2 mg	1	MO
methyldopa tab 250 mg	1	MO
methyldopa tab 500 mg	1	MO
prazosin hcl cap 1 mg	1	MO
prazosin hcl cap 2 mg	1	MO
prazosin hcl cap 5 mg	1	MO
terazosin hcl cap 1 mg (base equivalent)	1	MO
terazosin hcl cap 2 mg (base equivalent)	1	MO
terazosin hcl cap 5 mg (base equivalent)	1	MO
terazosin hcl cap 10 mg (base equivalent)	1	MO
ANTIHYPERTENSIVE COMBINATIONS		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-10 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-20 mg	1	MO
amlodipine besylate-benazepril hcl cap 5-40 mg	1	MO
amlodipine besylate-benazepril hcl cap 10-20 mg	1	MO
amlodipine besylate-benazepril hcl cap 10-40 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	1	MO
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	1	MO
amlodipine besylate-valsartan tab 5-160 mg	1	MO
amlodipine besylate-valsartan tab 5-320 mg	1	MO
amlodipine besylate-valsartan tab 10-160 mg	1	MO
amlodipine besylate-valsartan tab 10-320 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	1	MO
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	1	MO
atenolol & chlorthalidone tab 50-25 mg	1	MO
atenolol & chlorthalidone tab 100-25 mg	1	MO
benazepril & hydrochlorothiazide tab 5-6.25 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
benazepril & hydrochlorothiazide tab 10-12.5 mg	1	MO
benazepril & hydrochlorothiazide tab 20-12.5 mg	1	MO
benazepril & hydrochlorothiazide tab 20-25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	MO
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	1	MO
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	1	MO
captopril & hydrochlorothiazide tab 25-15 mg	1	MO
captopril & hydrochlorothiazide tab 25-25 mg	1	MO
captopril & hydrochlorothiazide tab 50-15 mg	1	MO
captopril & hydrochlorothiazide tab 50-25 mg	1	MO
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	MO
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	MO
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	1	MO
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	1	MO
irbesartan-hydrochlorothiazide tab 150-12.5 mg	1	MO
irbesartan-hydrochlorothiazide tab 300-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 10-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 20-12.5 mg	1	MO
lisinopril & hydrochlorothiazide tab 20-25 mg	1	MO
losartan potassium & hydrochlorothiazide tab 50-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 100-12.5 mg	1	MO
losartan potassium & hydrochlorothiazide tab 100-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 50-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 100-25 mg	1	MO
metoprolol & hydrochlorothiazide tab 100-50 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	1	MO
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	1	MO
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	1	MO
quinapril-hydrochlorothiazide tab 10-12.5 mg	1	MO
telmisartan-amlodipine tab 40-5 mg	1	MO
telmisartan-amlodipine tab 40-10 mg	1	MO
telmisartan-amlodipine tab 80-5 mg	1	MO
telmisartan-amlodipine tab 80-10 mg	1	MO
telmisartan-hydrochlorothiazide tab 40-12.5 mg	1	MO
telmisartan-hydrochlorothiazide tab 80-12.5 mg	1	MO
telmisartan-hydrochlorothiazide tab 80-25 mg	1	MO
trandolapril-verapamil hcl tab er 1-240 mg	1	MO
trandolapril-verapamil hcl tab er 2-180 mg	1	MO
trandolapril-verapamil hcl tab er 2-240 mg	1	MO
trandolapril-verapamil hcl tab er 4-240 mg	1	MO
valsartan-hydrochlorothiazide tab 80-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 160-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 160-25 mg	1	MO
valsartan-hydrochlorothiazide tab 320-12.5 mg	1	MO
valsartan-hydrochlorothiazide tab 320-25 mg	1	MO
DIRECT RENIN INHIBITORS		
aliskiren fumarate tab 150 mg (base equivalent)	1	MO
aliskiren fumarate tab 300 mg (base equivalent)	1	MO
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
eplerenone tab 25 mg	1	MO
eplerenone tab 50 mg	1	MO
VASODILATORS		
hydralazine hcl tab 10 mg	1	MO
hydralazine hcl tab 25 mg	1	MO
hydralazine hcl tab 50 mg	1	MO
hydralazine hcl tab 100 mg	1	MO
minoxidil tab 2.5 mg	1	MO
minoxidil tab 10 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
ANTIMALARIAL COMBINATIONS		
atovaquone-proguanil hcl tab 62.5-25 mg	1	
atovaquone-proguanil hcl tab 250-100 mg	1	
COARTEM TAB 20-120MG ***(artemether-lumefantrine)***	3	
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
chloroquine phosphate tab 250 mg	1	MO
chloroquine phosphate tab 500 mg	1	MO
hydroxychloroquine sulfate tab 100 mg	1	MO
hydroxychloroquine sulfate tab 200 mg	1	MO
hydroxychloroquine sulfate tab 300 mg	1	MO
hydroxychloroquine sulfate tab 400 mg	1	MO
mefloquine hcl tab 250 mg	1	MO
primaquine phosphate tab 26.3 mg (15 mg base)	1	
pyrimethamine tab 25 mg	1	
quinine sulfate cap 324 mg	1	
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS - DRUGS TO TREAT MUSCLE DISORDERS		
pyridostigmine bromide oral soln 60 mg/5ml	1	
pyridostigmine bromide tab 60 mg	1	
pyridostigmine bromide tab er 180 mg	1	
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
ANTIMYCOBACTERIAL AGENTS - DRUGS TO TREAT INFECTIONS		
cycloserine cap 250 mg	1	
ethambutol hcl tab 100 mg	1	
ethambutol hcl tab 400 mg	1	
isoniazid syrup 50 mg/5ml	1	MO
isoniazid tab 100 mg	1	MO
isoniazid tab 300 mg	1	MO
pyrazinamide tab 500 mg	1	
rifabutin cap 150 mg	1	
rifampin cap 150 mg	1	
rifampin cap 300 mg	1	
rifapentine tab 150 mg	1	
SIRTURO TAB 20MG ***(bedaquiline fumarate)***	3	
SIRTURO TAB 100MG ***(bedaquiline fumarate)***	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
cyclophosphamide cap 25 mg	1	OAC
cyclophosphamide cap 50 mg	1	OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
GLEOSTINE CAP 40MG ***(lomustine)***	3	SP; OAC
lomustine cap 10 mg	1	SP; OAC
lomustine cap 40 mg	1	SP; OAC
lomustine cap 100 mg	1	SP; OAC
temozolomide cap 5 mg	1	SP, PA; OAC
temozolomide cap 20 mg	1	SP, PA; OAC
temozolomide cap 100 mg	1	SP, PA; OAC
temozolomide cap 140 mg	1	SP, PA; OAC
temozolomide cap 180 mg	1	SP, PA; OAC
temozolomide cap 250 mg	1	SP, PA; OAC
ANTIMETABOLITES		
capecitabine tab 150 mg	1	SP, PA; OAC
capecitabine tab 500 mg	1	SP, PA; OAC
mercaptopurine susp 2000 mg/100ml (20 mg/ml)	1	SP, PA; OAC
mercaptopurine tab 50 mg	1	OAC
methotrexate sodium tab 2.5 mg (base equiv)	1	OAC
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG ***(axitinib)***	2	SP, PA, QL (8 tabs every 1 day); OAC
INLYTA TAB 5MG ***(axitinib)***	2	SP, PA, QL (4 tabs every 1 day); OAC
LENVIMA CAP 4MG ***(lenvatinib mesylate)***	2	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 8 MG ***(lenvatinib mesylate)***	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 10 MG ***(lenvatinib mesylate)***	2	SP, PA, QL (1 cap every 1 day); OAC
LENVIMA CAP 12MG ***(lenvatinib mesylate)***	2	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 14 MG ***(lenvatinib mesylate)***	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 18 MG ***(lenvatinib mesylate)***	2	SP, PA, QL (3 caps every 1 day); OAC
LENVIMA CAP 20 MG ***(lenvatinib mesylate)***	2	SP, PA, QL (2 caps every 1 day); OAC
LENVIMA CAP 24 MG ***(lenvatinib mesylate)***	2	SP, PA, QL (3 caps every 1 day); OAC
ANTINEOPLASTIC - EGFR INHIBITORS		
erlotinib hcl tab 25 mg (base equivalent)	1	SP, PA, QL (2 tabs every 1 day); OAC
erlotinib hcl tab 100 mg (base equivalent)	1	SP, PA, QL (1 tab every 1 day); OAC

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
XTANDI TAB 40MG ***(enzalutamide)***	2	SP, PA, QL (4 tabs every 1 day); OAC
XTANDI TAB 80MG ***(enzalutamide)***	2	SP, PA, QL (2 tabs every 1 day); OAC
YONSA TAB 125MG ***(abiraterone acetate micronized)***	2	SP, PA, QL (4 tabs every 1 day); OAC
ANTINEOPLASTIC - IMMUNOMODULATORS		
pomalidomide cap 1 mg	1	SP, PA, QL (21 caps every 21 days); OAC
pomalidomide cap 2 mg	1	SP, PA, QL (21 caps every 21 days); OAC
pomalidomide cap 3 mg	1	SP, PA, QL (21 caps every 21 days); OAC
pomalidomide cap 4 mg	1	SP, PA, QL (21 caps every 21 days); OAC
POMALYST CAP 1MG ***(pomalidomide)***	3	SP, PA; OAC
POMALYST CAP 2MG ***(pomalidomide)***	3	SP, PA; OAC
POMALYST CAP 3MG ***(pomalidomide)***	3	SP, PA; OAC
POMALYST CAP 4MG ***(pomalidomide)***	3	SP, PA; OAC
ANTINEOPLASTIC COMBINATIONS		
LONSURF TAB 15-6.14 ***(trifluridine-tipiracil)***	2	SP, PA, QL (100 tabs every 28 days); OAC
LONSURF TAB 20-8.19 ***(trifluridine-tipiracil)***	2	SP, PA, QL (100 tabs every 28 days); OAC
ANTINEOPLASTIC ENZYME INHIBITORS		
ALECENSA CAP 150MG ***(alectinib hcl)***	2	SP, PA, QL (8 caps every 1 day); OAC
ALUNBRIG PAK ***(brigatinib)***	2	PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 30MG ***(brigatinib)***	2	PA, QL (4 tabs every 1 day); OAC
ALUNBRIG TAB 90MG ***(brigatinib)***	2	PA, QL (1 tab every 1 day); OAC
ALUNBRIG TAB 180MG ***(brigatinib)***	2	PA, QL (1 tab every 1 day); OAC
AUGTYRO CAP 40MG ***(repotrectinib)***	2	PA, QL (8 caps every 1 day); OAC
AUGTYRO CAP 160MG ***(repotrectinib)***	2	PA, QL (2 caps every 1 day); OAC
BOSULIF CAP 50MG ***(bosutinib)***	2	SP, PA, QL (1 cap every 1 day); OAC
BOSULIF CAP 100MG ***(bosutinib)***	2	SP, PA, QL (10 caps every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BOSULIF TAB 100MG ***(bosutinib)***	2	SP, PA, QL (3 tabs every 1 day); OAC
BOSULIF TAB 400MG ***(bosutinib)***	2	SP, PA, QL (1 tab every 1 day); OAC
BOSULIF TAB 500MG ***(bosutinib)***	2	SP, PA, QL (1 tab every 1 day); OAC
bosutinib tab 100 mg	1	SP, PA, QL (3 tabs every 1 day); OAC
bosutinib tab 400 mg	1	SP, PA, QL (1 tab every 1 day); OAC
bosutinib tab 500 mg	1	SP, PA, QL (1 tab every 1 day); OAC
BRAFTOVI CAP 75MG ***(encorafenib)***	2	SP, PA, QL (6 caps every 1 day); OAC
BRUKINSA CAP 80MG ***(zanubrutinib)***	2	PA, QL (4 caps every 1 day); OAC
BRUKINSA TAB 160MG ***(zanubrutinib)***	2	PA, QL (2 tabs every 1 day); OAC
CABOMETYX TAB 20MG ***(cabozantinib s-malate)***	2	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 40MG ***(cabozantinib s-malate)***	2	SP, PA, QL (1 tab every 1 day); OAC
CABOMETYX TAB 60MG ***(cabozantinib s-malate)***	2	SP, PA, QL (1 tab every 1 day); OAC
CALQUENCE TAB 100MG ***(acalabrutinib maleate)***	2	PA, QL (2 tabs every 1 day); OAC
dasatinib tab 20 mg	1	SP, PA, QL (3 tabs every 1 day); OAC
dasatinib tab 50 mg	1	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 70 mg	1	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 80 mg	1	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 100 mg	1	SP, PA, QL (1 tab every 1 day); OAC
dasatinib tab 140 mg	1	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 2.5 mg	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
(Everolimus Tab 2.5 mg) YULITHIRA	1	SP, PA, QL (1 tab every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
everolimus tab 5 mg	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
(Everolimus Tab 5 mg) YULITHIRA	1	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 7.5 mg	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
(Everolimus Tab 7.5 mg) YULITHIRA	1	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab 10 mg	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
(Everolimus Tab 10 mg) YULITHIRA	1	SP, PA, QL (1 tab every 1 day); OAC
everolimus tab for oral susp 2 mg	1	SP, PA, QL (2 tabs every 1 day); OAC
everolimus tab for oral susp 3 mg	1	SP, PA, QL (3 tabs every 1 day); OAC
everolimus tab for oral susp 5 mg	1	SP, PA, QL (2 tabs every 1 day); OAC
GAVRETO CAP 100MG ***(pralsetinib)***	2	PA, QL (4 caps every 1 day); OAC
GOMEKLI CAP 1MG ***(mirdametinib)***	2	PA, QL (42 caps every 21 days); OAC
GOMEKLI CAP 2MG ***(mirdametinib)***	2	PA, QL (84 caps every 21 days); OAC
GOMEKLI TAB 1MG ***(mirdametinib)***	2	PA, QL (168 tabs every 21 days); OAC
IBRANCE CAP 125MG ***(palbociclib)***	2	SP, PA, QL (21 caps every 21 days); OAC
IBRANCE TAB 75MG ***(palbociclib)***	2	SP, PA, QL (21 tabs every 21 days); OAC
IBRANCE TAB 100MG ***(palbociclib)***	2	SP, PA, QL (21 tabs every 21 days); OAC
IBRANCE TAB 125MG ***(palbociclib)***	2	SP, PA, QL (21 tabs every 21 days); OAC
IBTROZI CAP 200MG ***(taletrectinib adipate)***	2	PA, QL (3 caps every 1 day); OAC
imatinib mesylate tab 100 mg (base equivalent)	1	SP, PA, QL (4 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
imatinib mesylate tab 400 mg (base equivalent)	1	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 5MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 10MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 15MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 20MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI TAB 25MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (2 tabs every 1 day); OAC
JAKAFI XR TAB 11MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (1 tab every 1 day); OAC
JAKAFI XR TAB 22MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (1 tab every 1 day); OAC
JAKAFI XR TAB 33MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (1 tab every 1 day); OAC
JAKAFI XR TAB 44MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (1 tab every 1 day); OAC
JAKAFI XR TAB 55MG ***(ruxolitinib phosphate)***	2	SP, PA, QL (1 tab every 1 day); OAC
KISQALI TAB 200DOSE ***(ribociclib succinate)***	2	SP, PA, QL (21 tabs every 21 days); OAC
KISQALI TAB 400DOSE ***(ribociclib succinate)***	2	SP, PA, QL (42 tabs every 21 days); OAC
KISQALI TAB 600DOSE ***(ribociclib succinate)***	2	SP, PA, QL (63 tabs every 21 days); OAC
KOSELUGO CAP 5MG ***(selumetinib sulfate)***	2	PA, QL (20 caps every 1 day); OAC
KOSELUGO CAP 7.5MG ***(selumetinib sulfate)***	2	PA, QL (12 caps every 1 day); OAC
KOSELUGO CAP 10MG ***(selumetinib sulfate)***	2	PA, QL (8 caps every 1 day); OAC
KOSELUGO CAP 25MG ***(selumetinib sulfate)***	2	PA, QL (4 caps every 1 day); OAC
KRAZATI TAB 200MG ***(adagrasib)***	2	PA, QL (6 tabs every 1 day); OAC
lapatinib ditosylate tab 250 mg (base equiv)	1	SP, PA, QL (6 tabs every 1 day); OAC
LUMAKRAS TAB 120MG ***(sotorasib)***	2	SP, PA, QL (8 tabs every 1 day); OAC
LUMAKRAS TAB 240MG ***(sotorasib)***	2	SP, PA, QL (4 tabs every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LUMAKRAS TAB 320MG ***(sotorasib)***	2	SP, PA, QL (3 tabs every 1 day); OAC
LYNPARZA TAB 100MG ***(olaparib)***	2	SP, PA, QL (4 tabs every 1 day); OAC
LYNPARZA TAB 150MG ***(olaparib)***	2	SP, PA, QL (4 tabs every 1 day); OAC
MEKINIST SOL 0.05/ML ***(trametinib dimethyl sulfoxide)***	2	SP, PA, QL (38.572 mL every 1 day); OAC
MEKINIST TAB 0.5MG ***(trametinib dimethyl sulfoxide)***	2	SP, PA, QL (3 tabs every 1 day); OAC
MEKINIST TAB 2MG ***(trametinib dimethyl sulfoxide)***	2	SP, PA, QL (1 tab every 1 day); OAC
MEKTOVI TAB 15MG ***(binimetinib)***	2	SP, PA, QL (6 tabs every 1 day); OAC
nilotinib hcl cap 50 mg (base equivalent)	1	SP, PA, QL (4 caps every 1 day); OAC
nilotinib hcl cap 150 mg (base equivalent)	1	SP, PA, QL (4 caps every 1 day); OAC
nilotinib hcl cap 200 mg (base equivalent)	1	SP, PA, QL (4 caps every 1 day); OAC
NINLARO CAP 2.3MG ***(ixazomib citrate)***	2	SP, PA, QL (3 caps every 21 days); OAC
NINLARO CAP 3MG ***(ixazomib citrate)***	2	SP, PA, QL (3 caps every 21 days); OAC
NINLARO CAP 4MG ***(ixazomib citrate)***	2	SP, PA, QL (3 caps every 21 days); OAC
pazopanib hcl tab 200 mg (base equiv)	1	SP, PA, QL (4 tabs every 1 day); OAC
PIQRAY 200MG TAB DOSE ***(alpelisib)***	2	PA, QL (1 tab every 1 day); OAC
PIQRAY 250MG TAB DOSE ***(alpelisib)***	2	PA, QL (2 tabs every 1 day); OAC
PIQRAY 300MG TAB DOSE ***(alpelisib)***	2	PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 40MG ***(selpercatinib)***	2	SP, PA, QL (3 tabs every 1 day); OAC
RETEVMO TAB 80MG ***(selpercatinib)***	2	SP, PA, QL (4 tabs every 1 day); OAC
RETEVMO TAB 120MG ***(selpercatinib)***	2	SP, PA, QL (2 tabs every 1 day); OAC
RETEVMO TAB 160MG ***(selpercatinib)***	2	SP, PA, QL (2 tabs every 1 day); OAC
ROZLYTREK CAP 100MG ***(entrectinib)***	2	SP, PA, QL (1 cap every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ROZLYTREK CAP 200MG ***(entrectinib)***	2	SP, PA, QL (3 caps every 1 day); OAC
ROZLYTREK PAK 50MG ***(entrectinib)***	2	SP, PA, QL (12 packets every 1 day); OAC
RYDAPT CAP 25MG ***(midostaurin)***	2	SP, PA, QL (8 caps every 1 day); OAC
SCEMBLIX TAB 20MG ***(asciminib hcl)***	2	PA, QL (2 tabs every 1 day); OAC
SCEMBLIX TAB 40MG ***(asciminib hcl)***	2	PA, QL (8 tabs every 1 day); OAC
SCEMBLIX TAB 100MG ***(asciminib hcl)***	2	PA, QL (4 tabs every 1 day); OAC
sorafenib tosylate tab 200 mg (base equivalent)	1	SP, PA, QL (4 tabs every 1 day); OAC
STIVARGA TAB 40MG ***(regorafenib)***	2	SP, PA, QL (3 tabs every 1 day); OAC
sunitinib malate cap 12.5 mg (base equivalent)	1	SP, PA, QL (1 cap every 1 day); OAC
sunitinib malate cap 25 mg (base equivalent)	1	SP, PA, QL (1 cap every 1 day); OAC
sunitinib malate cap 37.5 mg (base equivalent)	1	SP, PA, QL (1 cap every 1 day); OAC
sunitinib malate cap 50 mg (base equivalent)	1	SP, PA, QL (1 cap every 1 day); OAC
TAFINLAR CAP 50MG ***(dabrafenib mesylate)***	2	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR CAP 75MG ***(dabrafenib mesylate)***	2	SP, PA, QL (4 caps every 1 day); OAC
TAFINLAR TAB 10MG ***(dabrafenib mesylate)***	2	SP, PA, QL (30 tabs every 1 day); OAC
TRUQAP PAK 160MG ***(capivasertib)***	2	PA, QL (64 tabs every 28 days); OAC
TRUQAP PAK 200MG ***(capivasertib)***	2	PA, QL (32 tabs every 28 days); OAC
TRUQAP PAK 200MG ***(capivasertib)***	2	PA, QL (64 tabs every 28 days); OAC
TRUQAP TAB 200MG ***(capivasertib)***	2	PA, QL (2 tabs every 1 day); OAC
TURALIO CAP 125MG ***(pexidartinib hcl)***	2	PA, QL (4 caps every 1 day); OAC
VITRAKVI CAP 25MG ***(larotrectinib sulfate)***	2	SP, PA, QL (6 caps every 1 day); OAC
VITRAKVI CAP 100MG ***(larotrectinib sulfate)***	2	SP, PA, QL (2 caps every 1 day); OAC

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VITRAKVI SOL 20MG/ML ***(larotrectinib sulfate)***	2	SP, PA, QL (10 mL every 1 day); OAC
XOSPATA TAB 40MG ***(gilteritinib fumarate)***	2	SP, PA, QL (3 tabs every 1 day); OAC
ZEJULA TAB 100MG ***(niraparib tosylate)***	2	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 200MG ***(niraparib tosylate)***	2	SP, PA, QL (1 tab every 1 day); OAC
ZEJULA TAB 300MG ***(niraparib tosylate)***	2	SP, PA, QL (1 tab every 1 day); OAC
ZYKADIA TAB 150MG ***(ceritinib)***	2	SP, PA, QL (3 tabs every 1 day); OAC
ANTINEOPLASTICS MISC.		
bexarotene cap 75 mg	1	SP, PA; OAC
hydroxyurea cap 500 mg	1	OAC
tretinoin cap 10 mg	1	OAC
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
leucovorin calcium tab 5 mg	1	OAC
(Leucovorin Calcium Tab 5 mg) LEDERLE LEUCOVORIN	1	OAC
leucovorin calcium tab 10 mg	1	OAC
leucovorin calcium tab 15 mg	1	OAC
leucovorin calcium tab 25 mg	1	OAC
mesna tab 400 mg	1	OAC
MITOTIC INHIBITORS		
etoposide cap 50 mg	1	OAC
ANTIPARKINSON AND RELATED THERAPY AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
ANTIPARKINSON ADJUNCTIVE THERAPY		
carbidopa tab 25 mg	1	MO
ANTIPARKINSON ANTICHOLINERGICS		
benztropine mesylate tab 0.5 mg	1	MO
benztropine mesylate tab 1 mg	1	MO
benztropine mesylate tab 2 mg	1	MO
trihexyphenidyl hcl oral soln 0.4 mg/ml	1	MO
trihexyphenidyl hcl tab 2 mg	1	MO
trihexyphenidyl hcl tab 5 mg	1	MO
ANTIPARKINSON COMT INHIBITORS		
entacapone tab 200 mg	1	MO
tolcapone tab 100 mg	1	MO
ANTIPARKINSON DOPAMINERGICS		
amantadine hcl cap 100 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
amantadine hcl soln 50 mg/5ml	1	MO
amantadine hcl tab 100 mg	1	MO
bromocriptine mesylate cap 5 mg (base equivalent)	1	MO
bromocriptine mesylate tab 2.5 mg (base equivalent)	1	MO
carbidopa & levodopa cap er 23.75-95 mg	1	MO
carbidopa & levodopa cap er 36.25-145 mg	1	MO
carbidopa & levodopa cap er 48.75-195 mg	1	MO
carbidopa & levodopa cap er 61.25-245 mg	1	MO
carbidopa & levodopa orally disintegrating tab 10-100 mg	1	MO
carbidopa & levodopa orally disintegrating tab 25-100 mg	1	MO
carbidopa & levodopa orally disintegrating tab 25-250 mg	1	MO
carbidopa & levodopa tab 10-100 mg	1	MO
carbidopa & levodopa tab 25-100 mg	1	MO
carbidopa & levodopa tab 25-250 mg	1	MO
carbidopa & levodopa tab er 25-100 mg	1	MO
carbidopa & levodopa tab er 50-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 25-100-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	1	MO
carbidopa-levodopa-entacapone tabs 50-200-200 mg	1	MO
CREXONT CAP 35-140MG ***(carbidopa-levodopa)***	2	MO
CREXONT CAP 52.5-210 ***(carbidopa-levodopa)***	2	MO
CREXONT CAP 70-280MG ***(carbidopa-levodopa)***	2	MO
CREXONT CAP 87.5-350 ***(carbidopa-levodopa)***	2	MO
DHIVY TAB 25-100MG ***(carbidopa-levodopa)***	3	MO
INBRIJA CAP 42MG ***(levodopa)***	2	PA, QL (10 caps every 1 day), MO
NEUPRO DIS 1MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 2MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 3MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 4MG/24HR ***(rotigotine)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NEUPRO DIS 6MG/24HR ***(rotigotine)***	2	MO
NEUPRO DIS 8MG/24HR ***(rotigotine)***	2	MO
pramipexole dihydrochloride tab 0.5 mg	1	MO
pramipexole dihydrochloride tab 0.25 mg	1	MO
pramipexole dihydrochloride tab 0.75 mg	1	MO
pramipexole dihydrochloride tab 0.125 mg	1	MO
pramipexole dihydrochloride tab 1 mg	1	MO
pramipexole dihydrochloride tab 1.5 mg	1	MO
pramipexole dihydrochloride tab er 24hr 0.75 mg	1	MO
pramipexole dihydrochloride tab er 24hr 0.375 mg	1	MO
pramipexole dihydrochloride tab er 24hr 1.5 mg	1	MO
pramipexole dihydrochloride tab er 24hr 2.25 mg	1	MO
pramipexole dihydrochloride tab er 24hr 3 mg	1	MO
pramipexole dihydrochloride tab er 24hr 3.75 mg	1	MO
pramipexole dihydrochloride tab er 24hr 4.5 mg	1	MO
ropinirole hydrochloride tab 0.5 mg	1	MO
ropinirole hydrochloride tab 0.25 mg	1	MO
ropinirole hydrochloride tab 1 mg	1	MO
ropinirole hydrochloride tab 2 mg	1	MO
ropinirole hydrochloride tab 3 mg	1	MO
ropinirole hydrochloride tab 4 mg	1	MO
ropinirole hydrochloride tab 5 mg	1	MO
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)	1	MO
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)	1	MO
RYTARY CAP 95MG ***(carbidopa-levodopa)***	2	MO
RYTARY CAP 145MG ***(carbidopa-levodopa)***	2	MO
RYTARY CAP 195MG ***(carbidopa-levodopa)***	2	MO
RYTARY CAP 245MG ***(carbidopa-levodopa)***	2	MO
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
rasagiline mesylate tab 0.5 mg (base equiv)	1	MO
rasagiline mesylate tab 1 mg (base equiv)	1	MO
selegiline hcl cap 5 mg	1	MO
selegiline hcl tab 5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTIPSYCHOTICS/ANTIMANIC AGENTS - DRUGS TO TREAT PSYCHOSES		
ANTIMANIC AGENTS		
lithium carbonate cap 150 mg	1	MO
lithium carbonate cap 300 mg	1	MO
lithium carbonate cap 600 mg	1	MO
lithium carbonate tab 300 mg	1	MO
lithium carbonate tab er 300 mg	1	MO
lithium carbonate tab er 450 mg	1	MO
lithium oral solution 8 meq/5ml	1	MO
LITHOBID TAB 300MG ***(lithium carbonate)***	2	MO
ANTIPSYCHOTICS - MISC.		
lurasidone hcl tab 20 mg	1	MO
lurasidone hcl tab 40 mg	1	MO
lurasidone hcl tab 60 mg	1	MO
lurasidone hcl tab 80 mg	1	MO
lurasidone hcl tab 120 mg	1	MO
VRAYLAR CAP 0.5MG ***(cariprazine hcl)***	2	MO
VRAYLAR CAP 0.75MG ***(cariprazine hcl)***	2	MO
VRAYLAR CAP 1.5MG ***(cariprazine hcl)***	2	MO
VRAYLAR CAP 3MG ***(cariprazine hcl)***	2	MO
VRAYLAR CAP 4.5MG ***(cariprazine hcl)***	2	MO
VRAYLAR CAP 6MG ***(cariprazine hcl)***	2	MO
ziprasidone hcl cap 20 mg	1	MO
ziprasidone hcl cap 40 mg	1	MO
ziprasidone hcl cap 60 mg	1	MO
ziprasidone hcl cap 80 mg	1	MO
BENZISOXAZOLES		
paliperidone tab er 24hr 1.5 mg	1	MO
paliperidone tab er 24hr 3 mg	1	MO
paliperidone tab er 24hr 6 mg	1	MO
paliperidone tab er 24hr 9 mg	1	MO
risperidone orally disintegrating tab 0.5 mg	1	MO
risperidone orally disintegrating tab 0.25 mg	1	MO
risperidone orally disintegrating tab 1 mg	1	MO
risperidone orally disintegrating tab 2 mg	1	MO
risperidone orally disintegrating tab 3 mg	1	MO
risperidone orally disintegrating tab 4 mg	1	MO
risperidone soln 1 mg/ml	1	MO
risperidone tab 0.5 mg	1	MO
risperidone tab 0.25 mg	1	MO
risperidone tab 1 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
risperidone tab 2 mg	1	MO
risperidone tab 3 mg	1	MO
risperidone tab 4 mg	1	MO
BUTYROPHENONES		
haloperidol lactate oral conc 2 mg/ml	1	MO
haloperidol tab 0.5 mg	1	MO
haloperidol tab 1 mg	1	MO
haloperidol tab 2 mg	1	MO
haloperidol tab 5 mg	1	MO
haloperidol tab 10 mg	1	MO
haloperidol tab 20 mg	1	MO
DIBENZAPINES		
asenapine maleate sl tab 2.5 mg (base equiv)	1	MO
asenapine maleate sl tab 5 mg (base equiv)	1	MO
asenapine maleate sl tab 10 mg (base equiv)	1	MO
clozapine orally disintegrating tab 12.5 mg	1	
clozapine orally disintegrating tab 25 mg	1	
clozapine orally disintegrating tab 100 mg	1	
clozapine orally disintegrating tab 150 mg	1	
clozapine orally disintegrating tab 200 mg	1	
clozapine tab 25 mg	1	
clozapine tab 50 mg	1	
clozapine tab 100 mg	1	
clozapine tab 200 mg	1	
loxapine succinate cap 5 mg	1	MO
loxapine succinate cap 10 mg	1	MO
loxapine succinate cap 25 mg	1	MO
loxapine succinate cap 50 mg	1	MO
olanzapine orally disintegrating tab 5 mg	1	MO
olanzapine orally disintegrating tab 10 mg	1	MO
olanzapine orally disintegrating tab 15 mg	1	MO
olanzapine orally disintegrating tab 20 mg	1	MO
olanzapine tab 2.5 mg	1	MO
olanzapine tab 5 mg	1	MO
olanzapine tab 7.5 mg	1	MO
olanzapine tab 10 mg	1	MO
olanzapine tab 15 mg	1	MO
olanzapine tab 20 mg	1	MO
quetiapine fumarate tab 25 mg	1	MO
quetiapine fumarate tab 50 mg	1	MO
quetiapine fumarate tab 100 mg	1	MO
quetiapine fumarate tab 150 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
quetiapine fumarate tab 200 mg	1	MO
quetiapine fumarate tab 300 mg	1	MO
quetiapine fumarate tab 400 mg	1	MO
quetiapine fumarate tab er 24hr 50 mg	1	MO
quetiapine fumarate tab er 24hr 150 mg	1	MO
quetiapine fumarate tab er 24hr 200 mg	1	MO
quetiapine fumarate tab er 24hr 300 mg	1	MO
quetiapine fumarate tab er 24hr 400 mg	1	MO
DIHYDROINDOLONES		
molindone hcl tab 5 mg	1	MO
molindone hcl tab 10 mg	1	MO
molindone hcl tab 25 mg	1	MO
PHENOTHIAZINES		
chlorpromazine hcl conc 30 mg/ml	1	MO
chlorpromazine hcl conc 100 mg/ml	1	MO
chlorpromazine hcl tab 10 mg	1	MO
chlorpromazine hcl tab 25 mg	1	MO
chlorpromazine hcl tab 50 mg	1	MO
chlorpromazine hcl tab 100 mg	1	MO
chlorpromazine hcl tab 200 mg	1	MO
fluphenazine hcl elixir 2.5 mg/5ml	1	MO
fluphenazine hcl oral conc 5 mg/ml	1	MO
fluphenazine hcl tab 1 mg	1	MO
fluphenazine hcl tab 2.5 mg	1	MO
fluphenazine hcl tab 5 mg	1	MO
fluphenazine hcl tab 10 mg	1	MO
perphenazine tab 2 mg	1	MO
perphenazine tab 4 mg	1	MO
perphenazine tab 8 mg	1	MO
perphenazine tab 16 mg	1	MO
prochlorperazine maleate tab 5 mg (base equivalent)	1	MO
prochlorperazine maleate tab 10 mg (base equivalent)	1	MO
prochlorperazine suppos 25 mg	1	
(Prochlorperazine Suppos 25 mg) COMPRO	1	
thioridazine hcl tab 10 mg	1	MO
thioridazine hcl tab 25 mg	1	MO
thioridazine hcl tab 50 mg	1	MO
thioridazine hcl tab 100 mg	1	MO
trifluoperazine hcl tab 1 mg (base equivalent)	1	MO
trifluoperazine hcl tab 2 mg (base equivalent)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
trifluoperazine hcl tab 5 mg (base equivalent)	1	MO
trifluoperazine hcl tab 10 mg (base equivalent)	1	MO
QUINOLINONE DERIVATIVES		
aripiprazole oral solution 1 mg/ml	1	MO
aripiprazole orally disintegrating tab 10 mg	1	MO
aripiprazole orally disintegrating tab 15 mg	1	MO
aripiprazole tab 2 mg	1	MO
aripiprazole tab 5 mg	1	MO
aripiprazole tab 10 mg	1	MO
aripiprazole tab 15 mg	1	MO
aripiprazole tab 20 mg	1	MO
aripiprazole tab 30 mg	1	MO
THIOXANTHENES		
thiothixene cap 1 mg	1	MO
thiothixene cap 2 mg	1	MO
thiothixene cap 5 mg	1	MO
thiothixene cap 10 mg	1	MO
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
ANTIRETROVIRALS		
abacavir sulfate soln 20 mg/ml (base equiv)	1	SP, QL (30 mL every 1 day)
abacavir sulfate tab 300 mg (base equiv)	1	SP, QL (2 tabs every 1 day)
abacavir sulfate-lamivudine tab 600-300 mg	1	SP, QL (1 tab every 1 day)
APTIVUS CAP 250MG ***(tipranavir)***	2	SP, QL (4 caps every 1 day)
atazanavir sulfate cap 150 mg (base equiv)	1	SP, QL (1 cap every 1 day)
atazanavir sulfate cap 200 mg (base equiv)	1	SP, QL (2 caps every 1 day)
atazanavir sulfate cap 300 mg (base equiv)	1	SP, QL (1 cap every 1 day)
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (1 tab every 1 day)
BIKTARVY TAB ***(bictegravir-emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (1 tab every 1 day); (50-200-25 mg)
CIMDUO TAB 300-300 ***(lamivudine-tenofovir disoproxil fumarate)***	2	SP, QL (1 tab every 1 day)
darunavir tab 600 mg	1	SP, QL (2 tabs every 1 day)
darunavir tab 800 mg	1	SP, QL (1 tab every 1 day)
DESCOVY TAB 120-15MG ***(emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (1 tab every 1 day)
DESCOVY TAB 200/25MG ***(emtricitabine-tenofovir alafenamide fumarate)***	2	SP, QL (1 tab every 1 day); $0 copay for PrEP
DOVATO TAB 50-300MG ***(dolutegravir sodium-lamivudine)***	2	SP, QL (1 tab every 1 day)
efavirenz tab 600 mg	1	SP, QL (1 tab every 1 day)

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
SYMTUZA TAB ***(darunavir-cobicistat-emtricitabine-tenofovir alafenamide)***	2	SP, QL (1 tab every 1 day)
tenofovir disoproxil fumarate tab 300 mg	1	SP, QL (1 tab every 1 day)
TIVICAY PD TAB 5MG ***(dolutegravir sodium)***	2	SP, QL (12 tabs every 1 day)
TIVICAY TAB 50MG ***(dolutegravir sodium)***	2	SP, QL (2 tabs every 1 day)
TRIUMEQ PD TAB ***(abacavir-dolutegravir-lamivudine)***	2	SP, QL (6 tabs every 1 day)
TRIUMEQ TAB ***(abacavir-dolutegravir-lamivudine)***	2	SP, QL (1 tab every 1 day)
VIRACEPT TAB 250MG ***(nelfinavir mesylate)***	3	SP, QL (300 tabs every 30 days)
VIRACEPT TAB 625MG ***(nelfinavir mesylate)***	3	SP, QL (120 tabs every 30 days)
YEZTUGO TAB 300MG ***(lenacapavir sodium)***	2	SP, QL (8 tabs every 4 days)
zidovudine cap 100 mg	1	SP, QL (6 caps every 1 day)
zidovudine syrup 10 mg/ml	1	SP, QL (64 mL every 1 day)
zidovudine tab 300 mg	1	SP, QL (2 tabs every 1 day)
ANTIVIRAL COMBINATIONS		
PAXLOVID PAK ***(nirmatrelvir-ritonavir)***	PV	
PAXLOVID TAB 150-100 ***(nirmatrelvir-ritonavir)***	PV	
PAXLOVID TAB 300-100 ***(nirmatrelvir-ritonavir)***	PV	
CMV AGENTS		
valganciclovir hcl for soln 50 mg/ml (base equiv)	1	QL (38.134 mL every 1 day), MO
valganciclovir hcl tab 450 mg (base equivalent)	1	QL (4 tabs every 1 day), MO
HEPATITIS AGENTS		
adefovir dipivoxil tab 10 mg	1	SP
entecavir tab 0.5 mg	1	SP, QL (1 tab every 1 day)
entecavir tab 1 mg	1	SP, QL (1 tab every 1 day)
EPCLUSA PAK 150-37.5 ***(sofosbuvir-velpatasvir)***	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG ***(sofosbuvir-velpatasvir)***	2	SP, PA, QL (2 packets every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG ***(sofosbuvir-velpatasvir)***	2	SP, PA, QL (2 tabs every 1 day); For genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100 ***(sofosbuvir-velpatasvir)***	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 2, 3, 4, 5, 6
HARVONI PAK ***(ledipasvir-sofosbuvir)***	2	SP, PA, QL (1 packet every 1 day); For genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG ***(ledipasvir-sofosbuvir)***	2	SP, PA, QL (2 packets every 1 day); For genotypes 1, 4, 5, 6

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
HARVONI TAB 45-200MG ***(ledipasvir-sofosbuvir)***	2	SP, PA, QL (2 tabs every 1 day); For genotypes 1, 4, 5, 6
HARVONI TAB 90-400MG ***(ledipasvir-sofosbuvir)***	2	SP, PA, QL (1 tab every 1 day); For genotypes 1, 4, 5, 6
lamivudine tab 100 mg (hbv)	1	SP
MAVYRET PAK 50-20MG ***(glecaprevir-pibrentasvir)***	3	SP, PA
MAVYRET TAB 100-40MG ***(glecaprevir-pibrentasvir)***	3	SP, PA
ribavirin cap 200 mg	1	SP
ribavirin tab 200 mg	1	SP
SOVALDI PAK 150MG ***(sofosbuvir)***	3	SP, PA
SOVALDI PAK 200MG ***(sofosbuvir)***	3	SP, PA
SOVALDI TAB 200MG ***(sofosbuvir)***	3	SP, PA
SOVALDI TAB 400MG ***(sofosbuvir)***	3	SP, PA
VOSEVI TAB ***(sofosbuvir-velpatasvir-voxilaprevir)***	2	SP, PA, QL (1 tab every 1 day); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).
HERPES AGENTS		
acyclovir cap 200 mg	1	
acyclovir susp 200 mg/5ml	1	
acyclovir tab 400 mg	1	
acyclovir tab 800 mg	1	
famciclovir tab 125 mg	1	
famciclovir tab 250 mg	1	
famciclovir tab 500 mg	1	
valacyclovir hcl tab 1 gm	1	
valacyclovir hcl tab 500 mg	1	
INFLUENZA AGENTS		
oseltamivir phosphate cap 30 mg (base equiv)	1	
oseltamivir phosphate cap 45 mg (base equiv)	1	
oseltamivir phosphate cap 75 mg (base equiv)	1	
oseltamivir phosphate for susp 6 mg/ml (base equiv)	1	
RELENZA MIS DISKHALE ***(zanamivir)***	2	
rimantadine hydrochloride tab 100 mg	1	
MISC. ANTIVIRALS		
LAGEVRIO CAP 200MG ***(molnupiravir)***	PV	QL (40 caps every 90 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BETA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
ALPHA-BETA BLOCKERS		
carvedilol phosphate cap er 24hr 10 mg	1	MO
carvedilol phosphate cap er 24hr 20 mg	1	MO
carvedilol phosphate cap er 24hr 40 mg	1	MO
carvedilol phosphate cap er 24hr 80 mg	1	MO
carvedilol tab 3.125 mg	1	MO
carvedilol tab 6.25 mg	1	MO
carvedilol tab 12.5 mg	1	MO
carvedilol tab 25 mg	1	MO
labetalol hcl tab 100 mg	1	MO
labetalol hcl tab 200 mg	1	MO
labetalol hcl tab 300 mg	1	MO
labetalol hcl tab 400 mg	1	MO
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol hcl cap 200 mg	1	MO
acebutolol hcl cap 400 mg	1	MO
atenolol tab 25 mg	1	MO
atenolol tab 50 mg	1	MO
atenolol tab 100 mg	1	MO
betaxolol hcl tab 10 mg	1	MO
betaxolol hcl tab 20 mg	1	MO
bisoprolol fumarate tab 5 mg	1	MO
bisoprolol fumarate tab 10 mg	1	MO
LOPRESSOR TAB 12.5MG ***(metoprolol tartrate)***	2	MO
metoprolol succinate tab er 24hr 25 mg (tartrate equiv)	1	MO
metoprolol succinate tab er 24hr 50 mg (tartrate equiv)	1	MO
metoprolol succinate tab er 24hr 100 mg (tartrate equiv)	1	MO
metoprolol succinate tab er 24hr 200 mg (tartrate equiv)	1	MO
metoprolol tartrate tab 12.5 mg	1	MO
metoprolol tartrate tab 25 mg	1	MO
metoprolol tartrate tab 37.5 mg	1	MO
metoprolol tartrate tab 50 mg	1	MO
metoprolol tartrate tab 75 mg	1	MO
metoprolol tartrate tab 100 mg	1	MO
nebivolol hcl tab 2.5 mg (base equivalent)	1	MO
nebivolol hcl tab 5 mg (base equivalent)	1	MO
nebivolol hcl tab 10 mg (base equivalent)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
nebivolol hcl tab 20 mg (base equivalent)	1	MO
BETA BLOCKERS NON-SELECTIVE		
nadolol tab 20 mg	1	MO
nadolol tab 40 mg	1	MO
nadolol tab 80 mg	1	MO
pindolol tab 5 mg	1	MO
pindolol tab 10 mg	1	MO
propranolol hcl cap er 24hr 60 mg	1	MO
propranolol hcl cap er 24hr 80 mg	1	MO
propranolol hcl cap er 24hr 120 mg	1	MO
propranolol hcl cap er 24hr 160 mg	1	MO
propranolol hcl oral soln 20 mg/5ml	1	MO
propranolol hcl oral soln 40 mg/5ml	1	MO
propranolol hcl tab 10 mg	1	MO
propranolol hcl tab 20 mg	1	MO
propranolol hcl tab 40 mg	1	MO
propranolol hcl tab 60 mg	1	MO
propranolol hcl tab 80 mg	1	MO
sotalol hcl (afib/afl) tab 80 mg	1	MO
sotalol hcl (afib/afl) tab 120 mg	1	MO
sotalol hcl (afib/afl) tab 160 mg	1	MO
sotalol hcl tab 80 mg	1	MO
sotalol hcl tab 120 mg	1	MO
sotalol hcl tab 160 mg	1	MO
sotalol hcl tab 240 mg	1	MO
timolol maleate tab 5 mg	1	MO
timolol maleate tab 10 mg	1	MO
timolol maleate tab 20 mg	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		
amlodipine besylate tab 2.5 mg (base equivalent)	1	MO
amlodipine besylate tab 5 mg (base equivalent)	1	MO
amlodipine besylate tab 10 mg (base equivalent)	1	MO
diltiazem hcl cap er 12hr 60 mg	1	MO
diltiazem hcl cap er 12hr 90 mg	1	MO
diltiazem hcl cap er 12hr 120 mg	1	MO
diltiazem hcl cap er 24hr 120 mg	1	MO
(Diltiazem Hcl Cap Er 24hr 120 mg) DILT-XR	1	MO
diltiazem hcl cap er 24hr 180 mg	1	MO

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
diltiazem hcl tab 120 mg	1	MO
felodipine tab er 24hr 2.5 mg	1	MO
felodipine tab er 24hr 5 mg	1	MO
felodipine tab er 24hr 10 mg	1	MO
isradipine cap 2.5 mg	1	MO
isradipine cap 5 mg	1	MO
levamlodipine maleate tab 2.5 mg	1	MO
levamlodipine maleate tab 5 mg	1	MO
nicardipine hcl cap 20 mg	1	MO
nicardipine hcl cap 30 mg	1	MO
nifedipine cap 10 mg	1	MO
nifedipine cap 20 mg	1	MO
nifedipine tab er 24hr 30 mg	1	MO
nifedipine tab er 24hr 60 mg	1	MO
nifedipine tab er 24hr 90 mg	1	MO
nifedipine tab er 24hr osmotic release 30 mg	1	MO
nifedipine tab er 24hr osmotic release 60 mg	1	MO
nifedipine tab er 24hr osmotic release 90 mg	1	MO
nimodipine cap 30 mg	1	
nimodipine oral soln 60 mg/20ml (3 mg/ml)	1	
nisoldipine tab er 24hr 8.5 mg	1	MO
nisoldipine tab er 24hr 17 mg	1	MO
nisoldipine tab er 24hr 34 mg	1	MO
verapamil hcl cap er 24hr 100 mg	1	MO
verapamil hcl cap er 24hr 120 mg	1	MO
verapamil hcl cap er 24hr 180 mg	1	MO
verapamil hcl cap er 24hr 200 mg	1	MO
verapamil hcl cap er 24hr 240 mg	1	MO
verapamil hcl cap er 24hr 300 mg	1	MO
verapamil hcl cap er 24hr 360 mg	1	MO
verapamil hcl tab 40 mg	1	MO
verapamil hcl tab 80 mg	1	MO
verapamil hcl tab 120 mg	1	MO
verapamil hcl tab er 120 mg	1	MO
verapamil hcl tab er 180 mg	1	MO
verapamil hcl tab er 240 mg	1	MO
CARDIOTONICS - DRUGS TO TREAT HEART CONDITIONS		
CARDIAC GLYCOSIDES		
digoxin oral soln 0.05 mg/ml	1	MO
digoxin tab 62.5 mcg (0.0625 mg)	1	MO
digoxin tab 125 mcg (0.125 mg)	1	MO
digoxin tab 250 mcg (0.25 mg)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
LANOXIN TAB 0.0625MG ***(digoxin)***	2	MO
CARDIOVASCULAR AGENTS - MISC. - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP 2.5MG ***(mavacamten)***	2	SP, PA, QL (1 cap every 1 day)
CAMZYOS CAP 5MG ***(mavacamten)***	2	SP, PA, QL (1 cap every 1 day)
CAMZYOS CAP 10MG ***(mavacamten)***	2	SP, PA, QL (1 cap every 1 day)
CAMZYOS CAP 15MG ***(mavacamten)***	2	SP, PA, QL (1 cap every 1 day)
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 5-80 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-10 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-20 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-40 mg	1	MO
amlodipine besylate-atorvastatin calcium tab 10-80 mg	1	MO
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg	1	MO
OPSYNVI TAB 10-20MG ***(macitentan-tadalafil)***	2	SP, PA, QL (1 tab every 1 day)
OPSYNVI TAB 10-40MG ***(macitentan-tadalafil)***	2	SP, PA, QL (1 tab every 1 day)
sacubitril-valsartan tab 24-26 mg	1	PA, MO
sacubitril-valsartan tab 49-51 mg	1	PA, MO
sacubitril-valsartan tab 97-103 mg	1	PA, MO
IMPOTENCE AGENTS - DRUGS TO TREAT ERECTILE DYSFUNCTION		
sildenafil citrate tab 25 mg	1	PA, QL (8 tabs every 21 days)
sildenafil citrate tab 50 mg	1	PA, QL (8 tabs every 21 days)
sildenafil citrate tab 100 mg	1	PA, QL (8 tabs every 21 days)
tadalafil tab 2.5 mg	1	PA, QL (1 tab every 1 day), MO
tadalafil tab 5 mg	1	PA, QL (1 tab every 1 day), MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tadalafil tab 10 mg	1	PA, QL (8 tabs every 21 days)
tadalafil tab 20 mg	1	PA, QL (8 tabs every 21 days)
vardenafil hcl orally disintegrating tab 10 mg	1	PA, QL (8 tabs every 21 days)
vardenafil hcl tab 2.5 mg	1	PA, QL (8 tabs every 21 days)
vardenafil hcl tab 5 mg	1	PA, QL (8 tabs every 21 days)
vardenafil hcl tab 10 mg	1	PA, QL (8 tabs every 21 days)
vardenafil hcl tab 20 mg	1	PA, QL (8 tabs every 21 days)
PROSTAGLANDIN VASODILATORS		
ORENITRAM TAB 0.25MG ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB 0.125MG ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB 1MG ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB 2.5MG ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB 5MG ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB MONTH 1 ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB MONTH 2 ***(treprostinil diolamine)***	2	SP, PA
ORENITRAM TAB MONTH 3 ***(treprostinil diolamine)***	2	SP, PA
TYVASO DPI POW 16-32-48 ***(treprostinil)***	2	SP, PA, QL (9 cartridges every 1 day)
TYVASO DPI POW 16MCG ***(treprostinil)***	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 32MCG ***(treprostinil)***	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 48-80MCG ***(treprostinil)***	2	SP, PA
TYVASO DPI POW 48MCG ***(treprostinil)***	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 64MCG ***(treprostinil)***	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW 80MCG ***(treprostinil)***	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW INST KIT ***(treprostinil)***	2	SP, PA, QL (4 cartridges every 1 day)
TYVASO DPI POW MAIN KIT ***(treprostinil)***	2	SP, PA, QL (8 cartridges every 1 day)
TYVASO RF KT SOL 0.6MG/ML ***(treprostinil)***	2	SP, PA, QL (2.9 mL every 1 day)
TYVASO SOL 0.6MG/ML ***(treprostinil)***	2	SP, PA, QL (2.9 mL every 1 day)
TYVASO ST KT SOL 0.6MG/ML ***(treprostinil)***	2	SP, PA, QL (2.9 mL every 1 day)
YUTREPIA CAP 26.5MCG ***(treprostinil sodium)***	2	SP, PA, QL (5 caps every 1 day)
YUTREPIA CAP 53MCG ***(treprostinil sodium)***	2	SP, PA, QL (5 caps every 1 day)
YUTREPIA CAP 79.5MCG ***(treprostinil sodium)***	2	SP, PA, QL (5 caps every 1 day)
YUTREPIA CAP 106MCG ***(treprostinil sodium)***	2	SP, PA, QL (5 caps every 1 day)
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab 5 mg	1	SP, PA, QL (1 tab every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ambrisentan tab 10 mg	1	SP, PA, QL (1 tab every 1 day)
bosentan tab 62.5 mg	1	SP, PA, QL (2 tabs every 1 day)
bosentan tab 125 mg	1	SP, PA, QL (2 tabs every 1 day)
bosentan tab for oral susp 32 mg	1	SP, PA, QL (4 tabs every 1 day)
macitentan tab 10 mg	1	SP, PA, QL (1 tab every 1 day)
OPSUMIT TAB 10MG ***(macitentan)***	2	SP, PA, QL (1 tab every 1 day)
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
sildenafil citrate for suspension 10 mg/ml	1	SP, PA, QL (26.134 mL every 1 day)
sildenafil citrate tab 20 mg	1	SP, PA, QL (12 tabs every 1 day)
tadalafil tab 20 mg (pah)	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 ***(tadalafil (pulmonary hypertension))***	2	SP, PA, QL (10 mL every 1 day)
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI PACK TAB 200/800 ***(selexipag)***	2	SP, PA, QL (1 pack every 28 days)
UPTRAVI TAB 100MCG ***(selexipag)***	2	SP, PA
UPTRAVI TAB 150MCG ***(selexipag)***	2	SP, PA
UPTRAVI TAB 200MCG ***(selexipag)***	2	SP, PA, QL (5 tabs every 1 day)
UPTRAVI TAB 400MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 600MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 800MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1000MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1200MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1400MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
UPTRAVI TAB 1600MCG ***(selexipag)***	2	SP, PA, QL (2 tabs every 1 day)
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG ***(riociguat)***	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1.5MG ***(riociguat)***	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 1MG ***(riociguat)***	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2.5MG ***(riociguat)***	2	SP, PA, QL (3 tabs every 1 day)
ADEMPAS TAB 2MG ***(riociguat)***	2	SP, PA, QL (3 tabs every 1 day)
SINUS NODE INHIBITORS		
ivabradine hcl tab 5 mg (base equiv)	1	MO
ivabradine hcl tab 7.5 mg (base equiv)	1	MO
TRANSTHYRETIN STABILIZERS		
VYNDAMAX CAP 61MG ***(tafamidis)***	2	SP, PA, QL (1 cap every 1 day)
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG ***(vericiguat)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
VERQUVO TAB 5MG ***(vericiguat)***	2	MO
VERQUVO TAB 10MG ***(vericiguat)***	2	MO
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap 500 mg	1	
cefadroxil for susp 250 mg/5ml	1	
cefadroxil for susp 500 mg/5ml	1	
cefadroxil tab 1 gm	1	
cephalexin cap 250 mg	1	
cephalexin cap 500 mg	1	
cephalexin cap 750 mg	1	
cephalexin for susp 125 mg/5ml	1	
cephalexin for susp 250 mg/5ml	1	
cephalexin tab 250 mg	1	
cephalexin tab 500 mg	1	
CEPHALOSPORINS - 2ND GENERATION		
cefaclor cap 250 mg	1	
cefaclor cap 500 mg	1	
cefaclor for susp 250 mg/5ml	1	
cefprozil for susp 125 mg/5ml	1	
cefprozil for susp 250 mg/5ml	1	
cefprozil tab 250 mg	1	
cefprozil tab 500 mg	1	
cefuroxime axetil tab 250 mg	1	
cefuroxime axetil tab 500 mg	1	
CEPHALOSPORINS - 3RD GENERATION		
cefdinir cap 300 mg	1	
cefdinir for susp 125 mg/5ml	1	
cefdinir for susp 250 mg/5ml	1	
cefixime cap 400 mg	1	
cefixime for susp 100 mg/5ml	1	
cefixime for susp 200 mg/5ml	1	
cefixime tab 400 mg	1	
cefpodoxime proxetil for susp 50 mg/5ml	1	
cefpodoxime proxetil for susp 100 mg/5ml	1	
cefpodoxime proxetil tab 100 mg	1	
cefpodoxime proxetil tab 200 mg	1	
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
COMBINATION CONTRACEPTIVES - ORAL		
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) AZURETTE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) KARIVA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) PIMTREA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) SIMLIYA	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VIORELE	PV	MO
(Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5)) VOLNEA	PV	MO
(Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg) VELIVET	PV	MO
(Desogestrel & 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
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	PV	MO
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	PV	MO
(Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg) TYDEMY	PV	MO
drospirenone-ethinyl estradiol tab 3-0.02 mg	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
drospirenone-ethinyl estradiol tab 3-0.03 mg	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) SYEDA	PV	MO
(Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg) ZUMANDIMINE	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
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg) ZOVIA 1/35	PV	MO
(Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg) VALTYA 1/50	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
(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)) SIMPESSE	PV	MO
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	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
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AFIRMELLE	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AUBRA EQ	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) AVIANE	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) DELYLA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) FALMINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LESSINA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) LUTERA	PV	MO
(Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg) VIENVA	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
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	PV	MO
(Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg) LEVONEST	PV	MO
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) AMETHYST	PV	MO
(Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg) DOLISHALE	PV	MO
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21)	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 ***(norethindrone acetate-ethinyl estradiol-fe fum (biphasic))***	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NATAZIA TAB ***(estradiol valerate-dienogest)***	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
(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
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) AUROVELA 1/20	PV	MO
(Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg) JUNEL 1/20	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
(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
(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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	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
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)	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
(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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	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
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	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
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	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
(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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	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
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS ***(segesterone acetate-ethinyl estradiol)***	PV	QL (1 ring every 300 days), MO; Quantity max 1 per fill; Quantity max 1 per 300 days
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr	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
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG ***(ulipristal acetate)***	PV	
(Levonorgestrel Tab 1.5 mg) OPTION 2	PV	MO
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab 0.35 mg	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
(Norethindrone Tab 0.35 mg) NORLYROC	PV	MO
(Norethindrone Tab 0.35 mg) ORQUIDEA	PV	MO
(Norethindrone Tab 0.35 mg) SHAROBEL	PV	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
CORTICOSTEROIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
GLUCOCORTICOSTEROIDS		
budesonide delayed release particles cap 3 mg	1	
deflazacort susp 22.75 mg/ml	1	SP, PA, QL (1.8 mL every 1 day)
(Deflazacort Susp 22.75 mg/ml) JAYTHARI	1	SP, PA, QL (1.8 mL every 1 day)
(Deflazacort Susp 22.75 mg/ml) KYMBEE	1	SP, PA, QL (1.8 mL every 1 day)
(Deflazacort Susp 22.75 mg/ml) PYQUVI	1	SP, PA, QL (1.8 mL every 1 day)
deflazacort tab 6 mg	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)
deflazacort tab 18 mg	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)
deflazacort tab 30 mg	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)
deflazacort tab 36 mg	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)
dexamethasone elixir 0.5 mg/5ml	1	
dexamethasone soln 0.5 mg/5ml	1	
dexamethasone tab 0.5 mg	1	
dexamethasone tab 0.75 mg	1	
dexamethasone tab 1 mg	1	
dexamethasone tab 1.5 mg	1	
dexamethasone tab 2 mg	1	
dexamethasone tab 4 mg	1	
dexamethasone tab 6 mg	1	
dexamethasone tab therapy pack 1.5 mg (21)	1	
(Dexamethasone Tab Therapy Pack 1.5 mg (21)) HIDEX 6-DAY	1	
dexamethasone tab therapy pack 1.5 mg (35)	1	
dexamethasone tab therapy pack 1.5 mg (51)	1	
EMFLAZA SUS 22.75/ML ***(deflazacort)***	3	SP, PA, QL (54 mL every 30 days)
hydrocortisone tab 5 mg	1	
hydrocortisone tab 10 mg	1	
hydrocortisone tab 20 mg	1	
MEDROL TAB 2MG ***(methylprednisolone)***	3	
methylprednisolone tab 4 mg	1	
methylprednisolone tab 8 mg	1	
methylprednisolone tab 16 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
methylprednisolone tab 32 mg	1	
methylprednisolone tab therapy pack 4 mg (21)	1	
prednisolone sod phos orally disintegr tab 10 mg (base eq)	1	
prednisolone sod phos orally disintegr tab 15 mg (base eq)	1	
prednisolone sod phos orally disintegr tab 30 mg (base eq)	1	
prednisolone sod phosphate oral soln 5 mg/5ml (base equiv)	1	
prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)	1	
prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)	1	
prednisolone soln 15 mg/5ml	1	
prednisolone tab 5 mg	1	
prednisone oral soln 5 mg/5ml	1	
prednisone tab 1 mg	1	
prednisone tab 2.5 mg	1	
prednisone tab 5 mg	1	
prednisone tab 10 mg	1	
prednisone tab 20 mg	1	
prednisone tab 50 mg	1	
prednisone tab delayed release 1 mg	1	
prednisone tab delayed release 2 mg	1	
prednisone tab delayed release 5 mg	1	
prednisone tab therapy pack 5 mg (21)	1	
prednisone tab therapy pack 5 mg (48)	1	
prednisone tab therapy pack 10 mg (21)	1	
prednisone tab therapy pack 10 mg (48)	1	
UCERIS TAB 9MG ***(budesonide)***	1	
MINERALOCORTICOIDS		
fludrocortisone acetate tab 0.1 mg	1	MO
COUGH/COLD/ALLERGY - DRUGS TO TREAT COUGH, COLD, AND ALLERGY SYMPTOMS		
ANTITUSSIVES - DRUGS TO TREAT COUGH		
benzonatate cap 100 mg	1	
benzonatate cap 200 mg	1	
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	1	Not available under age 6
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	1	Not available under age 6

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
COUGH/COLD/ALLERGY COMBINATIONS		
hydrocod polst-chlorphen polst er susp 10-8 mg/5ml	1	
promethazine & phenylephrine syrup 6.25-5 mg/5ml	1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	1	
promethazine-dm syrup 6.25-15 mg/5ml	1	
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	1	
EXPECTORANTS - DRUGS TO TREAT COUGH		
potassium iodide oral soln 1 gm/ml	1	
MISC. RESPIRATORY INHALANTS - DRUGS TO TREAT BREATHING DISORDERS		
sodium chloride soln nebu 0.9%	1	
sodium chloride soln nebu 3%	1	
sodium chloride soln nebu 7%	1	
sodium chloride soln nebu 10%	1	
MUCOLYTICS - DRUGS TO TREAT COUGH		
acetylcysteine inhal soln 10%	1	
acetylcysteine inhal soln 20%	1	
DERMATOLOGICALS - DRUGS TO TREAT SKIN CONDITIONS		
ACNE PRODUCTS		
adapalene cream 0.1%	1	PA; PA Required for age greater than or equal to age 35
adapalene gel 0.1%	1	PA; PA Required for age greater than or equal to age 35
adapalene gel 0.3%	1	PA; PA Required for age greater than or equal to age 35
adapalene-benzoyl peroxide gel 0.1-2.5%	1	
adapalene-benzoyl peroxide gel 0.3-2.5%	1	
AKLIEF CRE 0.005% ***(trifarotene)***	2	PA
BENZAC AC LIQ 5% WASH ***(benzoyl peroxide)***	3	
benzoyl peroxide-erythromycin gel 5-3%	1	
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	1	
(Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5%) NEUAC	1	
clindamycin phosphate foam 1%	1	
(Clindamycin Phosphate Foam 1%) CLINDACIN	1	
clindamycin phosphate gel 1% (twice-daily)	1	
clindamycin phosphate lotion 1%	1	
clindamycin phosphate soln 1%	1	
clindamycin phosphate swab 1%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Clindamycin Phosphate Swab 1%) CLINDACIN ETZ PLEDGETS	1	
(Clindamycin Phosphate Swab 1%) CLINDACIN-P	1	
clindamycin phosphate-benzoyl peroxide gel 1-5%	1	
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	1	
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%	1	
clindamycin phosphate-tretinoin gel 1.2-0.025%	1	PA; PA Required for age greater than or equal to age 35
dapsone gel 5%	1	
dapsone gel 7.5%	1	
erythromycin gel 2%	1	
(Erythromycin Pads 2%) ERY	1	
erythromycin soln 2%	1	
isotretinoin cap 10 mg	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
isotretinoin cap 20 mg	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
isotretinoin cap 30 mg	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
isotretinoin cap 40 mg	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
sulfacetamide sodium lotion 10% (acne)	1	
tretinoin cream 0.1%	1	PA; PA Required for age greater than or equal to age 35
tretinoin cream 0.05%	1	PA; PA Required for age greater than or equal to age 35

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tretinoin cream 0.025%	1	PA; PA Required for age greater than or equal to age 35
tretinoin gel 0.01%	1	PA; PA Required for age greater than or equal to age 35
tretinoin gel 0.05%	1	PA; PA Required for age greater than or equal to age 35
tretinoin gel 0.025%	1	PA; PA Required for age greater than or equal to age 35
tretinoin microsphere gel 0.1%	1	PA; PA Required for age greater than or equal to age 35
tretinoin microsphere gel 0.04%	1	PA; PA Required for age greater than or equal to age 35
tretinoin microsphere gel 0.08%	1	PA; PA Required for age greater than or equal to age 35
WINLEVI CRE 1% ***(clascoterone)***	2	PA
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac epolamine patch 1.3%	1	
diclofenac sodium soln 1.5%	1	
ANTIBIOTICS - TOPICAL		
gentamicin sulfate cream 0.1%	1	
gentamicin sulfate oint 0.1%	1	
mupirocin oint 2%	1	
ANTIFUNGALS - TOPICAL		
ciclopirox gel 0.77%	1	
ciclopirox olamine cream 0.77% (base equiv)	1	
ciclopirox olamine susp 0.77% (base equiv)	1	
ciclopirox shampoo 1%	1	
ciclopirox solution 8%	1	PA
(Ciclopirox Solution 8%) CICLODAN	1	PA
clotrimazole cream 1%	1	
clotrimazole soln 1%	1	
clotrimazole w/ betamethasone cream 1-0.05%	1	
clotrimazole w/ betamethasone lotion 1-0.05%	1	
econazole nitrate cream 1%	1	
ketoconazole cream 2%	1	
ketoconazole shampoo 2%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
naftifine hcl cream 1%	1	
naftifine hcl cream 2%	1	
naftifine hcl gel 2%	1	
nystatin cream 100000 unit/gm	1	
nystatin oint 100000 unit/gm	1	
nystatin topical powder 100000 unit/gm	1	
(Nystatin Topical Powder 100000 unit/gm) KLAYESTA	1	
(Nystatin Topical Powder 100000 unit/gm) NYSTOP	1	
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	1	
oxiconazole nitrate cream 1%	1	
sulconazole nitrate cream 1%	1	
sulconazole nitrate solution 1%	1	
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
bexarotene gel 1%	1	SP, PA
diclofenac sodium (actinic keratoses) gel 3%	1	
fluorouracil cream 5%	1	
fluorouracil soln 2%	1	
fluorouracil soln 5%	1	
ANTIPSORIATICS		
acitretin cap 10 mg	1	PA
acitretin cap 17.5 mg	1	PA
acitretin cap 25 mg	1	PA
calcipotriene oint 0.005%	1	PA
(Calcipotriene Oint 0.005%) CALCITRENE	1	PA
calcipotriene soln 0.005% (50 mcg/ml)	1	PA
ICOTYDE TAB 200MG ***(icotrokinra hcl)***	2	SP, PA, QL (1 tab every 1 day)
methoxsalen rapid cap 10 mg	1	
SOTYKTU TAB 6MG ***(deucravacitinib)***	2	SP, PA, QL (1 tab every 1 day); Preferred for Psoriasis
tazarotene cream 0.1%	1	PA
tazarotene cream 0.05%	1	PA
tazarotene gel 0.1%	1	PA
tazarotene gel 0.05%	1	PA
VTAMA CRE 1% ***(tapinarof)***	2	PA
ANTISEBORRHEIC PRODUCTS		
selenium sulfide lotion 2.5%	1	
ANTIVIRALS - TOPICAL		
acyclovir oint 5%	1	
penciclovir cream 1%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
BURN PRODUCTS		
silver sulfadiazine cream 1%	1	
(Silver Sulfadiazine Cream 1%) SSD	1	
CORTICOSTEROIDS - TOPICAL		
alclometasone dipropionate cream 0.05%	1	
alclometasone dipropionate oint 0.05%	1	
betamethasone dipropionate augmented cream 0.05%	1	
betamethasone dipropionate augmented gel 0.05%	1	
betamethasone dipropionate augmented lotion 0.05%	1	
betamethasone dipropionate augmented oint 0.05%	1	
betamethasone dipropionate cream 0.05%	1	
betamethasone dipropionate lotion 0.05%	1	
betamethasone valerate aerosol foam 0.12%	1	
betamethasone valerate cream 0.1% (base equivalent)	1	
betamethasone valerate lotion 0.1% (base equivalent)	1	
betamethasone valerate oint 0.1% (base equivalent)	1	
BRYHALI LOT 0.01% ***(halobetasol propionate)***	2	
clobetasol propionate cream 0.05%	1	
clobetasol propionate emollient base cream 0.05%	1	
clobetasol propionate foam 0.05%	1	
clobetasol propionate gel 0.05%	1	
clobetasol propionate lotion 0.05%	1	
clobetasol propionate oint 0.05%	1	
clobetasol propionate shampoo 0.05%	1	
(Clobetasol Propionate Shampoo 0.05%) CLODAN	1	
clobetasol propionate soln 0.05%	1	
desonide cream 0.05%	1	
desonide lotion 0.05%	1	
desonide oint 0.05%	1	
desoximetasone cream 0.05%	1	
desoximetasone cream 0.25%	1	
desoximetasone gel 0.05%	1	
desoximetasone oint 0.25%	1	
desoximetasone spray 0.25%	1	
ENSTILAR AER ***(calcipotriene-betamethasone dipropionate)***	2	PA
fluocinolone acetonide cream 0.01%	1	
fluocinolone acetonide cream 0.025%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
fluocinolone acetonide oil 0.01% (body oil)	1	
fluocinolone acetonide oil 0.01% (scalp oil)	1	
fluocinolone acetonide oint 0.025%	1	
fluocinolone acetonide soln 0.01%	1	
fluocinonide cream 0.05%	1	
fluocinonide emulsified base cream 0.05%	1	
fluocinonide gel 0.05%	1	
fluocinonide oint 0.05%	1	
fluocinonide soln 0.05%	1	
fluticasone propionate cream 0.05%	1	
fluticasone propionate lotion 0.05%	1	
fluticasone propionate oint 0.005%	1	
halcinonide soln 0.1%	1	
halobetasol propionate cream 0.05%	1	
halobetasol propionate foam 0.05%	1	
halobetasol propionate oint 0.05%	1	
hydrocortisone acetate cream 2.5%	1	
hydrocortisone butyrate cream 0.1%	1	
hydrocortisone butyrate oint 0.1%	1	
hydrocortisone butyrate soln 0.1%	1	
hydrocortisone cream 1%	1	
(Hydrocortisone Cream 1%) ALA-CORT	1	
hydrocortisone cream 2.5%	1	
hydrocortisone lotion 2.5%	1	
hydrocortisone oint 1%	1	
hydrocortisone oint 2.5%	1	
(Hydrocortisone Soln 2.5%) TEXACORT	1	
hydrocortisone valerate cream 0.2%	1	
hydrocortisone valerate oint 0.2%	1	
mometasone furoate cream 0.1%	1	
mometasone furoate oint 0.1%	1	
mometasone furoate solution 0.1% (lotion)	1	
triamcinolone acetonide cream 0.1%	1	
triamcinolone acetonide cream 0.5%	1	
(Triamcinolone Acetonide Cream 0.5%) TRIDERM	1	
triamcinolone acetonide cream 0.025%	1	
triamcinolone acetonide lotion 0.1%	1	
triamcinolone acetonide lotion 0.025%	1	
triamcinolone acetonide oint 0.1%	1	
triamcinolone acetonide oint 0.5%	1	
triamcinolone acetonide oint 0.025%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ECZEMA AGENTS		
CIBINQO TAB 50MG ***(abrocitinib)***	2	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 100MG ***(abrocitinib)***	2	SP, PA, QL (1 tab every 1 day)
CIBINQO TAB 200MG ***(abrocitinib)***	2	SP, PA, QL (1 tab every 1 day)
OPZELURA CRE 1.5% ***(ruxolitinib phosphate (topical))***	2	PA
EMOLLIENTS		
lactic acid (ammonium lactate) cream 12%	1	
lactic acid (ammonium lactate) lotion 12%	1	
HAIR GROWTH AGENTS		
finasteride tab 1 mg	1	PA
LITFULO CAP 50MG ***(ritlecitinib tosylate)***	2	SP, PA, QL (1 cap every 1 day)
IMMUNOMODULATING AGENTS - TOPICAL		
imiquimod cream 3.75%	1	
imiquimod cream 5%	1	
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
pimecrolimus cream 1%	1	PA
tacrolimus oint 0.1%	1	PA
tacrolimus oint 0.03%	1	PA
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS		
podofilox gel 0.5%	1	
podofilox soln 0.5%	1	
LOCAL ANESTHETICS - TOPICAL		
lidocaine hcl soln 4%	1	QL (50 mL every 25 days)
lidocaine oint 5%	1	QL (50 gm every 25 days)
lidocaine patch 5%	1	PA
(Lidocaine Patch 5%) LIDOCAN	1	PA
(Lidocaine Patch 5%) TRIDACAINE III	1	PA
lidocaine-prilocaine cream 2.5-2.5%	1	QL (30 gm every 25 days)
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2% ***(crisaborole)***	2	PA
ZORYVE CRE 0.3% ***(roflumilast (topical))***	2	PA
ZORYVE CRE 0.05% ***(roflumilast (topical))***	2	PA
ZORYVE CRE 0.15% ***(roflumilast (topical))***	2	PA
ZORYVE MIS 0.3% ***(roflumilast (topical))***	2	PA
ROSACEA AGENTS		
azelaic acid gel 15%	1	
brimonidine tartrate gel 0.33% (base equivalent)	1	
FINACEA AER 15% ***(azelaic acid)***	2	
ivermectin cream 1%	1	
metronidazole cream 0.75%	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
metronidazole gel 0.75%	1	
metronidazole gel 1%	1	
metronidazole lotion 0.75%	1	
ORACEA CAP 40MG ***(doxycycline (rosacea))***	1	
oxymetazoline hcl cream 1%	1	
SCABICIDES & PEDICULICIDES		
(Crotamiton Lotion 10%) CROTAN	1	
(Crotamiton Lotion 10%) PRURADIK	1	
malathion lotion 0.5%	1	
permethrin cream 5%	1	
spinosad susp 0.9%	1	
DIAGNOSTIC PRODUCTS - PRODUCTS FOR DIAGNOSIS		
DIAGNOSTIC PRODUCTS, MISC.		
ultrasound - gel	1	
DIGESTIVE AIDS - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
DIGESTIVE ENZYMES		
CREON CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 6000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 12000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 24000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
CREON CAP 36000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
VIOKACE TAB 10440 ***(pancrelipase (lipase-protease-amylase))***	2	MO
VIOKACE TAB 20880 ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 3000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 5000UNIT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 10000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 15000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 20000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 25000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZENPEP CAP 40000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
ZENPEP CAP 60000UNT ***(pancrelipase (lipase-protease-amylase))***	2	MO
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide cap er 12hr 500 mg	1	MO
acetazolamide tab 125 mg	1	MO
acetazolamide tab 250 mg	1	MO
dichlorphenamide tab 50 mg	1	SP, PA, QL (4 tabs every 1 day)
(Dichlorphenamide Tab 50 mg) ORMALVI	1	SP, PA, QL (4 tabs every 1 day)
methazolamide tab 25 mg	1	MO
methazolamide tab 50 mg	1	MO
DIURETIC COMBINATIONS		
amiloride & hydrochlorothiazide tab 5-50 mg	1	MO
spironolactone & hydrochlorothiazide tab 25-25 mg	1	MO
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	MO
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	MO
triamterene & hydrochlorothiazide tab 75-50 mg	1	MO
LOOP DIURETICS		
bumetanide tab 0.5 mg	1	MO
bumetanide tab 1 mg	1	MO
bumetanide tab 2 mg	1	MO
ethacrynic acid tab 25 mg	1	MO
furosemide oral soln 8 mg/ml	1	MO
furosemide oral soln 10 mg/ml	1	MO
furosemide tab 20 mg	1	MO
furosemide tab 40 mg	1	MO
furosemide tab 80 mg	1	MO
torsemide tab 5 mg	1	MO
torsemide tab 10 mg	1	MO
torsemide tab 20 mg	1	MO
torsemide tab 100 mg	1	MO
POTASSIUM SPARING DIURETICS		
amiloride hcl tab 5 mg	1	MO
spironolactone susp 25 mg/5ml	1	MO
spironolactone tab 25 mg	1	MO
spironolactone tab 50 mg	1	MO
spironolactone tab 100 mg	1	MO
triamterene cap 50 mg	1	MO
triamterene cap 100 mg	1	MO

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
METABOLIC MODIFIERS		
betaine powder for oral solution	1	SP, PA
calcitriol cap 0.5 mcg	1	MO
calcitriol cap 0.25 mcg	1	MO
calcitriol oral soln 1 mcg/ml	1	MO
carglumic acid soluble tab 200 mg	1	SP, PA
cinacalcet hcl tab 30 mg (base equiv)	1	SP, PA, QL (2 tabs every 1 day)
cinacalcet hcl tab 60 mg (base equiv)	1	SP, PA, QL (2 tabs every 1 day)
cinacalcet hcl tab 90 mg (base equiv)	1	SP, PA, QL (4 tabs every 1 day)
doxercalciferol cap 0.5 mcg	1	MO
doxercalciferol cap 1 mcg	1	MO
doxercalciferol cap 2.5 mcg	1	MO
GALAFOLD CAP 123MG ***(migalastat hcl)***	2	PA, MO
glycerol phenylbutyrate liquid 1.1 gm/ml	1	SP, PA
levocarnitine oral soln 1 gm/10ml (10%)	1	MO
levocarnitine tab 330 mg	1	MO
nitisinone cap 2 mg	1	SP, PA
nitisinone cap 5 mg	1	SP, PA
nitisinone cap 10 mg	1	SP, PA
nitisinone cap 20 mg	1	SP, PA
ORFADIN CAP 2MG ***(nitisinone)***	2	SP, PA
ORFADIN CAP 5MG ***(nitisinone)***	2	SP, PA
ORFADIN CAP 10MG ***(nitisinone)***	2	SP, PA
ORFADIN CAP 20MG ***(nitisinone)***	2	SP, PA
ORFADIN SUS 4MG/ML ***(nitisinone)***	2	PA, MO
paricalcitol cap 1 mcg	1	MO
paricalcitol cap 2 mcg	1	MO
paricalcitol cap 4 mcg	1	MO
PHEBURANE MIS 483/GM ***(sodium phenylbutyrate)***	2	SP, PA, QL (46.4 gm every 1 day)
sapropterin dihydrochloride powder packet 100 mg	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 100 mg) JAVYGTOR	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 100 mg) ZELVYSIA	1	SP, PA
sapropterin dihydrochloride powder packet 500 mg	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 500 mg) JAVYGTOR	1	SP, PA
(Sapropterin Dihydrochloride Powder Packet 500 mg) ZELVYSIA	1	SP, PA
sapropterin dihydrochloride tab 100 mg	1	SP, PA

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Sapropterin Dihydrochloride Tab 100 mg) JAVYGTOR	1	SP, PA
sodium phenylbutyrate oral powder 3 gm/teaspoonful	1	SP, PA, QL (26.6 gm every 1 day)
sodium phenylbutyrate tab 500 mg	1	SP, PA, QL (40 tabs every 1 day)
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG ***(finerenone)***	2	PA, MO
KERENDIA TAB 20MG ***(finerenone)***	2	PA, MO
KERENDIA TAB 40MG ***(finerenone)***	2	PA, MO
POSTERIOR PITUITARY HORMONES		
desmopressin acetate nasal spray soln 0.01%	1	MO
desmopressin acetate nasal spray soln 0.01% (refrigerated)	1	MO
desmopressin acetate tab 0.1 mg	1	MO
desmopressin acetate tab 0.2 mg	1	MO
PROGESTERONE RECEPTOR ANTAGONISTS		
mifepristone tab 200 mg	1	
PROLACTIN INHIBITORS		
cabergoline tab 0.5 mg	1	
VASOPRESSIN RECEPTOR ANTAGONISTS		
tolvaptan (hyponatremia) tab 15 mg	1	SP, PA
tolvaptan (hyponatremia) tab 30 mg	1	SP, PA
tolvaptan tab 15 mg	1	SP, PA
tolvaptan tab 30 mg	1	SP, PA
tolvaptan tab therapy pack 15 mg	1	SP, PA, QL (2 tabs every 1 day)
tolvaptan tab therapy pack 30 & 15 mg	1	SP, PA, QL (2 tabs every 1 day)
tolvaptan tab therapy pack 45 & 15 mg	1	SP, PA, QL (2 tabs every 1 day)
tolvaptan tab therapy pack 60 & 30 mg	1	SP, PA, QL (2 tabs every 1 day)
tolvaptan tab therapy pack 90 & 30 mg	1	SP, PA, QL (2 tabs every 1 day)
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
ESTROGEN COMBINATIONS		
BIJUVA CAP 0.5-100 ***(estradiol-progesterone)***	2	MO
BIJUVA CAP 1-100MG ***(estradiol-progesterone)***	2	MO
COMBIPATCH DIS ***(estradiol & norethindrone acetate)***	2	MO
DUAVEE TAB 0.45-20 ***(conjugated estrogens-bazedoxifene)***	2	MO
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	MO
(Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg) ABIGALE LO	1	MO
estradiol & norethindrone acetate tab 1-0.5 mg	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 ***(relugolix-estradiol-norethindrone acetate)***	2	
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	MO
(Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg) FYAVOLV	1	MO
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	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 ***(elagolix sodium-estradiol-norethindrone acetate)***	2	
PREMPHASE TAB ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB 0.3-1.5 ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB 0.45-1.5 ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
PREMPRO TAB 0.625-5 ***(conjugated estrogens-medroxyprogesterone acetate)***	2	MO
ESTROGENS - DRUGS TO REGULATE FEMALE HORMONES		
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump)	1	MO
estradiol tab 0.5 mg	1	MO
estradiol tab 1 mg	1	MO
estradiol tab 2 mg	1	MO
estradiol td gel 0.5 mg/0.5gm (0.1%)	1	MO
estradiol td gel 0.25 mg/0.25gm (0.1%)	1	MO
estradiol td gel 0.75 mg/0.75gm (0.1%)	1	MO
estradiol td gel 1 mg/gm (0.1%)	1	MO
estradiol td gel 1.25 mg/1.25gm (0.1%)	1	MO
estradiol td patch twice weekly 0.1 mg/24hr	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
estradiol td patch twice weekly 0.05 mg/24hr	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
estradiol td patch twice weekly 0.025 mg/24hr	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
estradiol td patch twice weekly 0.075 mg/24hr	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
estradiol td patch twice weekly 0.0375 mg/24hr	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
estradiol td patch weekly 0.1 mg/24hr	1	MO
estradiol td patch weekly 0.05 mg/24hr	1	MO
estradiol td patch weekly 0.06 mg/24hr	1	MO
estradiol td patch weekly 0.025 mg/24hr	1	MO
estradiol td patch weekly 0.075 mg/24hr	1	MO
estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)	1	MO
estrogens, conjugated tab 0.3 mg	1	MO
estrogens, conjugated tab 0.9 mg	1	MO
estrogens, conjugated tab 0.45 mg	1	MO
estrogens, conjugated tab 0.625 mg	1	MO
estrogens, conjugated tab 1.25 mg	1	MO
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
CIPRO (5%) SUS 250MG/5 ***(ciprofloxacin)***	3	
CIPRO (10%) SUS 500MG/5 ***(ciprofloxacin)***	3	
ciprofloxacin hcl tab 250 mg (base equiv)	1	
ciprofloxacin hcl tab 500 mg (base equiv)	1	
ciprofloxacin hcl tab 750 mg (base equiv)	1	
levofloxacin oral soln 25 mg/ml	1	
levofloxacin tab 250 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
levofloxacin tab 500 mg	1	
levofloxacin tab 750 mg	1	
moxifloxacin hcl tab 400 mg (base equiv)	1	
ofloxacin tab 400 mg	1	
GASTROINTESTINAL AGENTS - MISC. - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
5-HT4 RECEPTOR AGONISTS		
prucalopride succinate tab 1 mg (base equivalent)	1	MO
prucalopride succinate tab 2 mg (base equivalent)	1	MO
GALLSTONE SOLUBILIZING AGENTS		
ursodiol cap 300 mg	1	MO
ursodiol tab 250 mg	1	MO
ursodiol tab 500 mg	1	MO
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn sodium oral conc 100 mg/5ml	1	MO
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
lubiprostone cap 8 mcg	1	PA, MO
lubiprostone cap 24 mcg	1	PA, MO
GASTROINTESTINAL STIMULANTS		
metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)	1	
metoclopramide hcl tab 5 mg (base equivalent)	1	
metoclopramide hcl tab 10 mg (base equivalent)	1	
INFLAMMATORY BOWEL AGENTS		
balsalazide disodium cap 750 mg	1	
mesalamine cap dr 400 mg	1	MO
mesalamine cap er 24hr 0.375 gm	1	MO
mesalamine cap er 250 mg	1	MO
mesalamine cap er 500 mg	1	MO
mesalamine enema 4 gm	1	
mesalamine suppos 1000 mg	1	
mesalamine tab delayed release 1.2 gm	1	MO
mesalamine tab delayed release 800 mg	1	
sulfasalazine tab 500 mg	1	MO
sulfasalazine tab delayed release 500 mg	1	MO
VELSIPITY TAB 2MG ***(etrasimod arginine)***	2	SP, PA, QL (1 tab every 1 day); Preferred for Ulcerative Colitis
INTESTINAL ACIDIFIERS		
lactulose (encephalopathy) solution 10 gm/15ml	1	MO
(Lactulose (Encephalopathy) Solution 10 gm/15ml) ENULOSE	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron hcl tab 0.5 mg (base equiv)	1	PA, MO
alosetron hcl tab 1 mg (base equiv)	1	PA, MO
LINZESS CAP 72MCG ***(linaclotide)***	2	PA, MO
LINZESS CAP 145MCG ***(linaclotide)***	2	PA, MO
LINZESS CAP 290MCG ***(linaclotide)***	2	PA, MO
VIBERZI TAB 75MG ***(eluxadoline)***	2	PA, MO
VIBERZI TAB 100MG ***(eluxadoline)***	2	PA, MO
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
MOVANTIK TAB 12.5MG ***(naloxegol oxalate)***	2	
MOVANTIK TAB 25MG ***(naloxegol oxalate)***	2	
SYMPROIC TAB 0.2MG ***(naldemedine tosylate)***	2	
PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR(PPAR) AGONISTS		
IQIRVO TAB 80MG ***(elafibranor)***	2	SP, PA, QL (1 tab every 1 day)
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
AURYXIA TAB 210MG ***(ferric citrate)***	2	MO
calcium acetate (phosphate binder) cap 667 mg (169 mg ca)	1	MO
calcium acetate (phosphate binder) tab 667 mg	1	MO
ferric citrate tab 1 gm (210 mg ferric iron)	1	MO
sevelamer carbonate packet 0.8 gm	1	MO
sevelamer carbonate packet 2.4 gm	1	MO
sevelamer carbonate tab 800 mg	1	MO
sevelamer hcl tab 400 mg	1	MO
sevelamer hcl tab 800 mg	1	MO
GENITOURINARY AGENTS - MISCELLANEOUS - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
ALKALINIZERS		
potassium citrate tab er 5 meq (540 mg)	1	
potassium citrate tab er 10 meq (1080 mg)	1	
potassium citrate tab er 15 meq (1620 mg)	1	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG ***(cysteamine bitartrate)***	2	SP, PA
CYSTAGON CAP 150MG ***(cysteamine bitartrate)***	2	SP, PA
IGA NEPHROPATHY (IGAN) AGENTS		
FILSPARI TAB 200MG ***(sparsentan)***	2	SP, PA, QL (4 tabs every 1 day)
FILSPARI TAB 400MG ***(sparsentan)***	2	SP, PA, QL (2 tabs every 1 day)
VANRAFIA TAB 0.75MG ***(atrasentan hcl)***	2	PA, QL (1 tab every 1 day), MO
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl tab er 24hr 10 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
dutasteride cap 0.5 mg	1	MO
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	1	MO
finasteride tab 5 mg	1	MO
silodosin cap 4 mg	1	MO
silodosin cap 8 mg	1	MO
tamsulosin hcl cap 0.4 mg	1	MO
URINARY STONE AGENTS		
tiopronin tab 100 mg	1	SP, PA
tiopronin tab delayed release 100 mg	1	SP, PA
(Tiopronin Tab Delayed Release 100 mg) VENXXIVA	1	SP, PA
tiopronin tab delayed release 300 mg	1	SP, PA
(Tiopronin Tab Delayed Release 300 mg) VENXXIVA	1	SP, PA
GOUT AGENTS - DRUGS TO TREAT GOUT		
GOUT AGENT COMBINATIONS		
colchicine w/ probenecid tab 0.5-500 mg	1	MO
GOUT AGENTS - DRUGS TO TREAT GOUT		
allopurinol tab 100 mg	1	MO
allopurinol tab 200 mg	1	MO
allopurinol tab 300 mg	1	MO
colchicine cap 0.6 mg	1	
colchicine tab 0.6 mg	1	
febuxostat tab 40 mg	1	MO
febuxostat tab 80 mg	1	MO
URICOSURICS		
probenecid tab 500 mg	1	MO
HEMATOLOGICAL AGENTS - MISC. - DRUGS TO TREAT BLOOD DISORDERS		
HEMATORHEOLOGIC AGENTS		
pentoxifylline tab er 400 mg	1	MO
PLASMA KALLIKREIN INHIBITORS		
ORLADEYO CAP 110MG ***(berotralstat hcl)***	2	PA, QL (1 cap every 1 day), MO
ORLADEYO CAP 150MG ***(berotralstat hcl)***	2	PA, QL (1 cap every 1 day), MO
ORLADEYO PAK 72MG ***(berotralstat hcl)***	2	PA, QL (1 packet every 1 day), MO
ORLADEYO PAK 96MG ***(berotralstat hcl)***	2	PA, QL (1 packet every 1 day), MO
ORLADEYO PAK 108MG ***(berotralstat hcl)***	2	PA, QL (1 packet every 1 day), MO
ORLADEYO PAK 132MG ***(berotralstat hcl)***	2	PA, QL (1 packet every 1 day), MO
PLATELET AGGREGATION INHIBITORS		
anagrelide hcl cap 0.5 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
anagrelide hcl cap 1 mg	1	MO
aspirin-dipyridamole cap er 12hr 25-200 mg	1	MO
cilostazol tab 50 mg	1	MO
cilostazol tab 100 mg	1	MO
clopidogrel bisulfate tab 75 mg (base equiv)	1	MO
clopidogrel bisulfate tab 300 mg (base equiv)	1	
dipyridamole tab 25 mg	1	MO
dipyridamole tab 50 mg	1	MO
dipyridamole tab 75 mg	1	MO
prasugrel hcl tab 5 mg (base equiv)	1	MO
prasugrel hcl tab 10 mg (base equiv)	1	MO
ticagrelor tab 60 mg	1	MO
ticagrelor tab 90 mg	1	MO
HEMATOPOIETIC AGENTS - DRUGS TO TREAT BLOOD DISORDERS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG ***(eliglustat tartrate)***	2	SP, PA, QL (2 caps every 1 day)
miglustat cap 100 mg	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 ***(hydroxyurea (sickle cell disease))***	2	
SIKLOS TAB 1000MG ***(hydroxyurea (sickle cell disease))***	2	
FOLIC ACID/FOLATES		
folic acid cap 0.8 mg	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
folic acid tab 1 mg	1	MO
folic acid tab 400 mcg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
(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
folic acid tab 800 mcg	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 ***(eltrombopag choline)***	2	SP, PA, QL (2 tabs every 1 day)
ALVAIZ TAB 18MG ***(eltrombopag choline)***	2	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 36MG ***(eltrombopag choline)***	2	SP, PA, QL (3 tabs every 1 day)
ALVAIZ TAB 54MG ***(eltrombopag choline)***	2	SP, PA, QL (2 tabs every 1 day)
DOPTELET SPR CAP 10MG ***(avatrombopag maleate)***	2	SP, PA, QL (2 caps every 1 day)
DOPTELET TAB 20MG ***(avatrombopag maleate)***	2	SP, PA
DOPTELET TAB 20MG ***(avatrombopag maleate)***	2	SP, PA, QL (1 carton every 5 days); 10 tab carton
DOPTELET TAB 20MG ***(avatrombopag maleate)***	2	SP, PA, QL (1 carton every 5 days); 15 tab carton
DOPTELET TAB 20MG ***(avatrombopag maleate)***	2	SP, PA, QL (2 cartons every 30 days); 30 tab carton
eltrombopag olamine powder pack for susp 12.5 mg (base eq)	1	SP, PA, QL (4 packets every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
eltrombopag olamine powder pack for susp 25 mg (base equiv)	1	SP, PA, QL (6 packets every 1 day)
eltrombopag olamine tab 12.5 mg (base equiv)	1	SP, PA, QL (2 tabs every 1 day)
eltrombopag olamine tab 25 mg (base equiv)	1	SP, PA, QL (3 tabs every 1 day)
eltrombopag olamine tab 50 mg (base equiv)	1	SP, PA, QL (3 tabs every 1 day)
eltrombopag olamine tab 75 mg (base equiv)	1	SP, PA, QL (2 tabs every 1 day)
HEMOSTATICS - DRUGS TO TREAT BLOOD DISORDERS		
HEMOSTATICS - SYSTEMIC		
aminocaproic acid oral soln 0.25 gm/ml	1	
aminocaproic acid tab 500 mg	1	
aminocaproic acid tab 1000 mg	1	
tranexamic acid tab 650 mg	1	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS - DRUGS TO TREAT SLEEP DISORDERS		
BARBITURATE HYPNOTICS		
phenobarbital elixir 20 mg/5ml	1	MO
phenobarbital tab 15 mg	1	MO
phenobarbital tab 16.2 mg	1	MO
phenobarbital tab 30 mg	1	MO
phenobarbital tab 32.4 mg	1	MO
phenobarbital tab 60 mg	1	MO
phenobarbital tab 64.8 mg	1	MO
phenobarbital tab 97.2 mg	1	MO
phenobarbital tab 100 mg	1	MO
HYPNOTICS - TRICYCLIC AGENTS		
doxepin hcl (sleep) tab 3 mg (base equiv)	1	
doxepin hcl (sleep) tab 6 mg (base equiv)	1	
NON-BARBITURATE HYPNOTICS		
estazolam tab 1 mg	1	QL (15 tabs every 25 days)
estazolam tab 2 mg	1	QL (15 tabs every 25 days)
eszopiclone tab 1 mg	1	QL (15 tabs every 25 days)
eszopiclone tab 2 mg	1	QL (15 tabs every 25 days)
eszopiclone tab 3 mg	1	QL (15 tabs every 25 days)
midazolam hcl syrup 2 mg/ml (base equivalent)	1	
temazepam cap 7.5 mg	1	QL (15 caps every 25 days)
temazepam cap 15 mg	1	QL (15 caps every 25 days)
temazepam cap 22.5 mg	1	QL (15 caps every 25 days)
temazepam cap 30 mg	1	QL (15 caps every 25 days)
triazolam tab 0.25 mg	1	QL (10 tabs every 25 days)
triazolam tab 0.125 mg	1	QL (10 tabs every 25 days)
zaleplon cap 5 mg	1	QL (15 caps every 25 days)
zaleplon cap 10 mg	1	QL (15 caps every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
zolpidem tartrate tab 5 mg	1	QL (15 tabs every 25 days)
zolpidem tartrate tab 10 mg	1	QL (15 tabs every 25 days)
zolpidem tartrate tab er 6.25 mg	1	QL (15 tabs every 25 days)
zolpidem tartrate tab er 12.5 mg	1	QL (15 tabs every 25 days)
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB 5MG ***(suvorexant)***	2	PA
BELSOMRA TAB 10MG ***(suvorexant)***	2	PA
BELSOMRA TAB 15MG ***(suvorexant)***	2	PA
BELSOMRA TAB 20MG ***(suvorexant)***	2	PA
QUVIVIQ TAB 25MG ***(daridorexant hcl)***	2	PA
QUVIVIQ TAB 50MG ***(daridorexant hcl)***	2	PA
SELECTIVE MELATONIN RECEPTOR AGONISTS		
ramelteon tab 8 mg	1	QL (15 tabs every 25 days)
tasimelteon capsule 20 mg	1	SP, PA, QL (1 cap every 1 day)
LAXATIVES - DRUGS TO TREAT CONSTIPATION		
LAXATIVE COMBINATIONS		
CLENPIQ SOL ***(sodium picosulfate-magnesium oxide-anhydrous citric acid)***	2	$0 copay for members age 45 through 75
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	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	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
(Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm) GAVILYTE-N/FLAVOR PACK	1	
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	1	
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml	1	$0 copay for members age 45 through 75
LAXATIVES - MISCELLANEOUS		
lactulose oral crystal packet 10 gm	1	MO
(Lactulose Oral Crystal Packet 10 gm) KRISTALOSE	1	MO
lactulose oral crystal packet 20 gm	1	MO
(Lactulose Oral Crystal Packet 20 gm) KRISTALOSE	1	MO
lactulose solution 10 gm/15ml	1	MO
(Lactulose Solution 10 gm/15ml) CONSTULOSE	1	MO
MACROLIDES - DRUGS TO TREAT INFECTIONS		
AZITHROMYCIN		
azithromycin for susp 100 mg/5ml	1	
azithromycin for susp 200 mg/5ml	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
azithromycin tab 250 mg	1	
azithromycin tab 500 mg	1	
azithromycin tab 600 mg	1	
CLARITHROMYCIN		
clarithromycin for susp 125 mg/5ml	1	
clarithromycin for susp 250 mg/5ml	1	
clarithromycin tab 250 mg	1	
clarithromycin tab 500 mg	1	
clarithromycin tab er 24hr 500 mg	1	
ERYTHROMYCINS		
erythromycin ethylsuccinate for susp 200 mg/5ml	1	
erythromycin ethylsuccinate for susp 400 mg/5ml	1	
(Erythromycin Ethylsuccinate Tab 400 mg) E.E.S. 400	1	
erythromycin tab 250 mg	1	
erythromycin tab 500 mg	1	
erythromycin tab delayed release 250 mg	1	
erythromycin tab delayed release 333 mg	1	
erythromycin tab delayed release 500 mg	1	
erythromycin w/ delayed release particles cap 250 mg	1	
FIDAXOMICIN		
fidaxomicin tab 200 mg	1	
MEDICAL DEVICES AND SUPPLIES - MEDICAL DEVICES AND SUPPLIES FOR DIAGNOSIS, TREATMENT, OR MONITORING		
CONTRACEPTIVES - DRUGS FOR BIRTH CONTROL		
CONDOMS MIS	PV	QL (36 condoms every 75 days), MO
DUREX MIS REALFEEL ***(condoms non-latex lubricated - male)***	PV	QL (36 condoms every 75 days), MO
FC2 FEMALE MIS CONDOM ***(condoms - female)***	PV	QL (36 condoms every 75 days)
MALE MIS CONDOM ***(condoms latex lubricated - male)***	PV	QL (36 condoms every 75 days)
TRUSTEX MIS FLAVORS ***(condoms latex non-lubricated - male)***	PV	QL (36 condoms every 75 days), MO
PARENTERAL THERAPY SUPPLIES		
BD INSULIN PEN NEEDLES - OTC ***(insulin pen needle)***	2	
BD INSULIN SYRINGE - OTC ***(insulin syringes (disposable))***	2	
BD INSULIN SYRINGE - RX ***(insulin syringe/needle u-100)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
EMBECTA INSULIN PEN NEEDLES - OTC ***(insulin pen needle)***	2	
EMBECTA INSULIN SYRINGE - OTC ***(insulin syringe/needle u-100)***	2	
EMBECTA INSULIN SYRINGE - RX ***(insulin syringe/needle u-500)***	2	
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS LRG MASK ***(spacer/aerosol-holding chambers)***	2	
AERCHMBR PLS MIS MED MASK ***(spacer/aerosol-holding chambers)***	2	
AERCHMBR PLS MIS SM MASK ***(spacer/aerosol-holding chambers)***	2	
AERCHMBR Z- MIS STAT PLS ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS CHAMBER ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS MV ***(spacer/aerosol-holding chambers)***	2	
AEROCHAMBER MIS PLUS ***(spacer/aerosol-holding chambers)***	2	
AEROVENT MIS PLUS ***(spacer/aerosol-holding chambers)***	2	
BREATHE EASE MIS LG MASK ***(spacer/aerosol-holding chambers)***	2	
BREATHE EASE MIS MED MASK ***(spacer/aerosol-holding chambers)***	2	
BREATHE EASE MIS SM MASK ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS CHAMBER ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS LG MASK ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS MD MASK ***(spacer/aerosol-holding chambers)***	2	
COMPACT SPAC MIS SM MASK ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS MASK LG ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS MASK MED ***(spacer/aerosol-holding chambers)***	2	
EASIVENT MIS MASK SM ***(spacer/aerosol-holding chambers)***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
FLEXICHAMBER MIS ***(spacer/aerosol-holding chambers)***	2	
FLEXICHAMBER MIS MASK LRG ***(spacer/aerosol-holding chamber supplies - masks)***	2	
FLEXICHAMBER MIS MASK SM ***(spacer/aerosol-holding chamber supplies - masks)***	2	
HOLD CHAMBER MIS ADLT LG ***(spacer/aerosol-holding chambers)***	2	
HOLD CHAMBER MIS MEDIUM ***(spacer/aerosol-holding chambers)***	2	
HOLD CHAMBER MIS SMALL ***(spacer/aerosol-holding chambers)***	2	
INSPIREASE MIS DD SYST ***(spacer/aerosol-holding chambers)***	2	
MICROCHAMBER MIS ***(spacer/aerosol-holding chambers)***	2	
MICROSPACER MIS ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIA LG ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIA MD ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIA SM ***(spacer/aerosol-holding chambers)***	2	
OPTICHAMBER MIS DIAMOND ***(spacer/aerosol-holding chambers)***	2	
POCKET CHAMB MIS ***(spacer/aerosol-holding chambers)***	2	
POCKET SPACE MIS ***(spacer/aerosol-holding chambers)***	2	
RITEFLO MIS ***(spacer/aerosol-holding chambers)***	2	
MIGRAINE PRODUCTS - DRUGS TO TREAT SEVERE HEADACHES		
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG		
NURTEC TAB 75MG ODT ***(rimegepant sulfate)***	2	
QULIPTA TAB 10MG ***(atogepant)***	2	MO
QULIPTA TAB 30MG ***(atogepant)***	2	MO
QULIPTA TAB 60MG ***(atogepant)***	2	MO
UBRELVY TAB 50MG ***(ubrogepant)***	2	
UBRELVY TAB 100MG ***(ubrogepant)***	2	
MIGRAINE COMBINATIONS		
ergotamine w/ caffeine tab 1-100 mg	3	
SEROTONIN AGONISTS		
almotriptan malate tab 6.25 mg	1	QL (12 tabs every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
almotriptan malate tab 12.5 mg	1	QL (12 tabs every 25 days)
eletriptan hydrobromide tab 20 mg (base equivalent)	1	QL (12 tabs every 25 days)
eletriptan hydrobromide tab 40 mg (base equivalent)	1	QL (12 tabs every 25 days)
frovatriptan succinate tab 2.5 mg (base equivalent)	1	QL (18 tabs every 25 days)
IMITREX INJ 4MG/0.5 ***(sumatriptan succinate)***	3	QL (18 injections every 25 days)
IMITREX INJ 6MG/0.5 ***(sumatriptan succinate)***	3	QL (12 injections every 25 days)
naratriptan hcl tab 1 mg (base equiv)	1	QL (12 tabs every 25 days)
naratriptan hcl tab 2.5 mg (base equiv)	1	QL (12 tabs every 25 days)
rizatriptan benzoate oral disintegrating tab 5 mg (base eq)	1	QL (18 tabs every 25 days)
rizatriptan benzoate oral disintegrating tab 10 mg (base eq)	1	QL (18 tabs every 25 days)
rizatriptan benzoate tab 5 mg (base equivalent)	1	QL (18 tabs every 25 days)
rizatriptan benzoate tab 10 mg (base equivalent)	1	QL (18 tabs every 25 days)
sumatriptan nasal spray 5 mg/act	1	QL (24 sprays (4 boxes) every 25 days)
sumatriptan nasal spray 20 mg/act	1	QL (12 sprays (2 boxes) every 25 days)
sumatriptan succinate inj 6 mg/0.5ml	1	QL (12 injections every 25 days)
sumatriptan succinate solution auto-injector 6 mg/0.5ml	1	QL (12 injections every 25 days)
sumatriptan succinate tab 25 mg	1	QL (12 tabs every 25 days)
sumatriptan succinate tab 50 mg	1	QL (12 tabs every 25 days)
sumatriptan succinate tab 100 mg	1	QL (12 tabs every 25 days)
TOSYMRA SOL 10MG ***(sumatriptan)***	2	QL (18 units every 25 days)
ZEMBRACE SYM INJ 3/0.5ML ***(sumatriptan succinate)***	2	QL (24 injections every 25 days)
zolmitriptan nasal spray 5 mg/spray unit	1	QL (12 bottles every 25 days)
zolmitriptan orally disintegrating tab 2.5 mg	1	QL (12 tabs every 25 days)
zolmitriptan orally disintegrating tab 5 mg	1	QL (12 tabs every 25 days)
zolmitriptan tab 2.5 mg	1	QL (12 tabs every 25 days)
zolmitriptan tab 5 mg	1	QL (12 tabs every 25 days)
MINERALS & ELECTROLYTES - DRUGS FOR NUTRITION		
FLUORIDE		
sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)	1	MO; $0 applies for ages 5 and under
sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)	1	MO; $0 applies for ages 5 and under

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
sodium fluoride chew tab 1 mg f (from 2.2 mg naf)	1	MO
sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)	1	MO; $0 applies for ages 5 and under
sodium fluoride tab 0.5 mg f (from 1.1 mg naf)	1	MO; $0 applies for ages 5 and under
sodium fluoride tab 1 mg f (from 2.2 mg naf)	1	MO
PHOSPHATE		
(Potassium Phosphate Monobasic Tab 500 mg) PHOSPHO-TRIN K500	1	MO
POTASSIUM		
potassium chloride cap er 8 meq	1	MO
potassium chloride cap er 10 meq	1	MO
potassium chloride microencapsulated crys er tab 10 meq	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 10 meq) KLOR-CON M10	1	MO
potassium chloride microencapsulated crys er tab 15 meq	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 15 meq) KLOR-CON M15	1	MO
potassium chloride microencapsulated crys er tab 20 meq	1	MO
(Potassium Chloride Microencapsulated Crys Er Tab 20 meq) KLOR-CON M20	1	MO
potassium chloride oral soln 10% (20 meq/15ml)	1	MO
potassium chloride oral soln 20% (40 meq/15ml)	1	MO
potassium chloride powder packet 20 meq	1	MO
(Potassium Chloride Powder Packet 20 meq) KLOR-CON	1	MO
potassium chloride tab er 8 meq (600 mg)	1	MO
(Potassium Chloride Tab Er 8 meq (600 mg)) KLOR-CON 8	1	MO
potassium chloride tab er 10 meq	1	MO
(Potassium Chloride Tab Er 10 meq) KLOR-CON 10	1	MO
potassium chloride tab er 15 meq	1	MO
potassium chloride tab er 20 meq (1500 mg)	1	MO
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS - DRUGS FOR OVERDOSE OR POISONING		
penicillamine cap 250 mg	1	SP
penicillamine tab 250 mg	1	SP
trientine hcl cap 250 mg	1	SP

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
IMMUNOMODULATORS - DRUGS TO TREAT CANCER		
lenalidomide cap 5 mg	1	SP, PA, QL (1 cap every 1 day)
lenalidomide cap 10 mg	1	SP, PA, QL (1 cap every 1 day)
lenalidomide cap 15 mg	1	SP, PA, QL (1 cap every 1 day)
lenalidomide cap 20 mg	1	SP, PA, QL (21 caps every 21 days)
lenalidomide cap 25 mg	1	SP, PA, QL (21 caps every 21 days)
lenalidomide caps 2.5 mg	1	SP, PA, QL (1 cap every 1 day)
THALOMID CAP 50MG ***(thalidomide)***	2	SP, PA, QL (1 cap every 1 day); OAC
THALOMID CAP 100MG ***(thalidomide)***	2	SP, PA, QL (4 caps every 1 day); OAC
IMMUNOSUPPRESSIVE AGENTS - DRUGS FOR TRANSPLANT		
azathioprine tab 50 mg	1	MO
azathioprine tab 75 mg	1	MO
(Azathioprine Tab 75 mg) AZASAN	1	MO
azathioprine tab 100 mg	1	MO
(Azathioprine Tab 100 mg) AZASAN	1	MO
cyclosporine cap 25 mg	1	SP
cyclosporine cap 100 mg	1	SP
cyclosporine modified cap 25 mg	1	SP
(Cyclosporine Modified Cap 25 mg) GENGRAF	1	SP
cyclosporine modified cap 50 mg	1	SP
cyclosporine modified cap 100 mg	1	SP
(Cyclosporine Modified Cap 100 mg) GENGRAF	1	SP
cyclosporine modified oral soln 100 mg/ml	1	SP
everolimus tab 0.5 mg	1	SP
everolimus tab 0.25 mg	1	SP
everolimus tab 0.75 mg	1	SP
everolimus tab 1 mg	1	SP
mycophenolate mofetil cap 250 mg	1	SP
mycophenolate mofetil for oral susp 200 mg/ml	1	SP
mycophenolate mofetil tab 500 mg	1	SP
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)	1	SP
mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)	1	SP
sirolimus oral soln 1 mg/ml	1	SP
sirolimus tab 0.5 mg	1	SP
sirolimus tab 1 mg	1	SP
sirolimus tab 2 mg	1	SP

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
tacrolimus cap 0.5 mg	1	SP
tacrolimus cap 1 mg	1	SP
tacrolimus cap 5 mg	1	SP
tacrolimus cap er 24hr 0.5 mg	1	SP
tacrolimus cap er 24hr 1 mg	1	SP
tacrolimus cap er 24hr 5 mg	1	SP
POTASSIUM REMOVING AGENTS - DRUGS TO LOWER POTASSIUM		
sodium polystyrene sulfonate powder	1	
(Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml) SPS	1	
sodium polystyrene sulfonate susp 15 gm/60ml	1	
(Sodium Polystyrene Sulfonate Susp 15 gm/60ml) KIONEX	1	
(Sodium Polystyrene Sulfonate Susp 15 gm/60ml) SPS	1	
VELTASSA POW 1GM ***(patiromer sorbitex calcium)***	2	MO
VELTASSA POW 8.4GM ***(patiromer sorbitex calcium)***	2	MO
VELTASSA POW 16.8GM ***(patiromer sorbitex calcium)***	2	MO
VELTASSA POW 25.2GM ***(patiromer sorbitex calcium)***	2	MO
MOUTH/THROAT/DENTAL AGENTS - DRUGS FOR THE MOUTH AND THROAT		
ANESTHETICS TOPICAL ORAL		
lidocaine hcl viscous soln 2%	1	
ANTI-INFECTIVES - THROAT		
clotrimazole troche 10 mg	1	
nystatin susp 100000 unit/ml	1	
STEROIDS - MOUTH/THROAT/DENTAL		
triamcinolone acetonide dental paste 0.1%	1	
(Triamcinolone Acetonide Dental Paste 0.1%) KOURZEQ	1	
(Triamcinolone Acetonide Dental Paste 0.1%) ORALONE DENTAL PASTE	1	
THROAT PRODUCTS - MISC.		
cevimeline hcl cap 30 mg	1	MO
pilocarpine hcl tab 5 mg	1	MO
pilocarpine hcl tab 7.5 mg	1	MO
MULTIVITAMINS - DRUGS FOR NUTRITION		
PRENATAL VITAMINS		
(Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg) PNV-DHA	1	

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/ Iron Carbonyl-Fa Tab 50-1.25 mg) ELITE-OB	1	
MUSCULOSKELETAL THERAPY AGENTS - DRUGS TO TREAT MUSCLE SPASMS		
CENTRAL MUSCLE RELAXANTS		
baclofen oral soln 5 mg/5ml	1	
baclofen oral soln 10 mg/5ml	1	
baclofen susp 25 mg/5ml	1	
baclofen tab 5 mg	1	
baclofen tab 10 mg	1	
baclofen tab 15 mg	1	
baclofen tab 20 mg	1	
carisoprodol tab 350 mg	1	PA
chlorzoxazone tab 500 mg	1	
cyclobenzaprine hcl tab 5 mg	1	
cyclobenzaprine hcl tab 10 mg	1	
metaxalone tab 800 mg	1	
methocarbamol tab 500 mg	1	
methocarbamol tab 750 mg	1	
methocarbamol tab 1000 mg	1	
(Methocarbamol Tab 1000 mg) TANLOR	1	
orphenadrine citrate tab er 12hr 100 mg	1	
tizanidine hcl cap 2 mg (base equivalent)	1	
tizanidine hcl cap 4 mg (base equivalent)	1	
tizanidine hcl cap 6 mg (base equivalent)	1	
tizanidine hcl cap 8 mg (base equivalent)	1	
tizanidine hcl tab 2 mg (base equivalent)	1	
tizanidine hcl tab 4 mg (base equivalent)	1	
DIRECT MUSCLE RELAXANTS		
dantrolene sodium cap 25 mg	1	
dantrolene sodium cap 50 mg	1	
dantrolene sodium cap 100 mg	1	
NASAL AGENTS - SYSTEMIC AND TOPICAL - DRUGS FOR THE NOSE		
NASAL AGENT COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act	1	QL (1 bottle every 25 days)
NASAL ANTIALLERGY		
azelastine hcl nasal spray 0.1% (137 mcg/spray)	1	QL (2 bottles every 25 days)
olopatadine hcl nasal soln 0.6%	1	QL (1 bottle every 25 days)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NASAL ANTICHOLINERGICS		
ipratropium bromide nasal soln 0.03% (21 mcg/spray)	1	MO
ipratropium bromide nasal soln 0.06% (42 mcg/spray)	1	MO
NASAL STEROIDS		
flunisolide nasal soln 25 mcg/act (0.025%)	1	QL (3 bottles every 25 days)
fluticasone propionate nasal susp 50 mcg/act	1	QL (1 bottle every 25 days)
mometasone furoate nasal susp 50 mcg/act	1	QL (34 gm every 25 days)
XHANCE MIS 93MCG ***(fluticasone propionate (nasal))***	2	QL (2 bottles every 25 days)
NEUROMUSCULAR AGENTS - DRUGS FOR THE NERVES AND MUSCLES		
ALS AGENTS		
RADICAVA ORS SUS 105/5ML ***(edaravone)***	2	SP, PA, QL (2.5 mL every 1 day)
RADICAVA ORS SUS STARTER ***(edaravone)***	2	SP, PA, QL (2.5 mL every 1 day)
riluzole tab 50 mg	1	MO
OPHTHALMIC AGENTS - DRUGS TO TREAT EYE CONDITIONS		
BETA-BLOCKERS - OPHTHALMIC		
betaxolol hcl ophth soln 0.5%	1	MO
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	1	MO
carteolol hcl ophth soln 1%	1	MO
dorzolamide hcl-timolol maleate ophth soln 2-0.5%	1	MO
dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%	1	MO
levobunolol hcl ophth soln 0.5%	1	MO
timolol maleate ophth gel forming soln 0.5%	1	MO
timolol maleate ophth gel forming soln 0.25%	1	MO
timolol maleate ophth soln 0.5%	1	MO
timolol maleate ophth soln 0.5% (once-daily)	1	MO
timolol maleate ophth soln 0.25%	1	MO
timolol maleate preservative free ophth soln 0.5%	1	MO
timolol maleate preservative free ophth soln 0.25%	1	MO
timolol ophth soln 0.5%	1	MO
CYCLOPLEGIC MYDRIATICS		
atropine sulfate ophth soln 1%	1	MO
cyclopentolate hcl ophth soln 1%	1	MO
phenylephrine hcl ophth soln 2.5%	1	
phenylephrine hcl ophth soln 10%	1	
tropicamide ophth soln 0.5%	1	MO
tropicamide ophth soln 1%	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
MIOTICS		
pilocarpine hcl ophth soln 1%	1	MO
pilocarpine hcl ophth soln 1.25%	1	MO
pilocarpine hcl ophth soln 2%	1	MO
pilocarpine hcl ophth soln 4%	1	MO
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1% OP ***(brimonidine tartrate)***	2	MO
ALPHAGAN P SOL 0.15% OP ***(brimonidine tartrate)***	2	MO
apraclonidine hcl ophth soln 0.5% (base equivalent)	1	
brimonidine tartrate ophth soln 0.1%	1	MO
brimonidine tartrate ophth soln 0.2%	1	MO
brimonidine tartrate ophth soln 0.15%	1	MO
SIMBRINZA SUS 1-0.2% ***(brinzolamide-brimonidine tartrate)***	2	MO
OPHTHALMIC ANTI-INFECTIVES		
bacitracin-polymyxin b ophth oint	1	
BESIVANCE SUS 0.6% ***(besifloxacin hcl)***	2	
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	1	
erythromycin ophth oint 5 mg/gm	1	
gatifloxacin ophth soln 0.5%	1	
gentamicin sulfate ophth soln 0.3%	1	
levofloxacin ophth soln 0.5%	1	
levofloxacin ophth soln 1.5%	1	
moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)	1	
moxifloxacin hcl ophth soln 0.5% (base equiv)	1	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	1	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	1	
ofloxacin ophth soln 0.3%	1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	
sulfacetamide sodium ophth soln 10%	1	
tobramycin ophth soln 0.3%	1	
TOBREX OIN 0.3% OP ***(tobramycin (ophth))***	3	
trifluridine ophth soln 1%	1	
XDEMVY DRO 0.25% ***(lotilaner)***	2	PA
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS EMU 0.05% OP ***(cyclosporine (ophth))***	1	MO
RESTASIS MUL EMU 0.05% OP ***(cyclosporine (ophth))***	2	MO
VEVYE DRO 0.1% ***(cyclosporine (ophth))***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
OPHTHALMIC STEROIDS		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1	
dexamethasone sodium phosphate ophth soln 0.1%	1	
difluprednate ophth emulsion 0.05%	1	
fluorometholone ophth susp 0.1%	1	
loteprednol etabonate ophth gel 0.5%	1	
loteprednol etabonate ophth susp 0.2%	1	
loteprednol etabonate ophth susp 0.5%	1	
loteprednol etabonate-tobramycin ophth susp 0.5-0.3%	1	
neomycin-polymyxin-dexamethasone ophth oint 0.1%	1	
neomycin-polymyxin-dexamethasone ophth susp 0.1%	1	
neomycin-polymyxin-hc ophth susp	1	
PRED SOD PHO SOL 1% OP	3	
prednisolone acetate ophth susp 1%	1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	1	
TOBRADEX OIN 0.3-0.1% ***(tobramycin-dexamethasone)***	2	
tobramycin-dexamethasone ophth susp 0.3-0.1%	1	
OPHTHALMICS - MISC.		
azelastine hcl ophth soln 0.05%	1	
bepotastine besilate ophth soln 1.5%	1	
brinzolamide ophth susp 1%	1	MO
bromfenac sodium ophth soln 0.07% (base equivalent)	1	
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	1	
bromfenac sodium ophth soln 0.075% (base equivalent)	1	
cromolyn sodium ophth soln 4%	1	
diclofenac sodium ophth soln 0.1%	1	
dorzolamide hcl ophth soln 2%	1	MO
epinastine hcl ophth soln 0.05%	1	
flurbiprofen sodium ophth soln 0.03%	1	
ILEVRO DRO 0.3% OP ***(nepafenac)***	2	
ketorolac tromethamine ophth soln 0.4%	1	
ketorolac tromethamine ophth soln 0.5%	1	
olopatadine hcl ophth soln 0.2% (base equivalent)	1	

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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NATURAL PENICILLINS		
penicillin v potassium for soln 125 mg/5ml	1	
penicillin v potassium for soln 250 mg/5ml	1	
penicillin v potassium tab 250 mg	1	
penicillin v potassium tab 500 mg	1	
PENICILLIN COMBINATIONS		
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml	1	
amoxicillin & k clavulanate for susp 400-57 mg/5ml	1	
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml	1	
amoxicillin & k clavulanate tab 250-125 mg	1	
amoxicillin & k clavulanate tab 500-125 mg	1	
amoxicillin & k clavulanate tab 875-125 mg	1	
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg	1	
AUGMENTIN SUS 125/5ML ***(amoxicillin & pot clavulanate)***	3	
PENICILLINASE-RESISTANT PENICILLINS		
dicloxacillin sodium cap 250 mg	1	
dicloxacillin sodium cap 500 mg	1	
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
PROGESTINS - DRUGS TO REGULATE FEMALE HORMONES		
medroxyprogesterone acetate tab 2.5 mg	1	MO
medroxyprogesterone acetate tab 5 mg	1	MO
medroxyprogesterone acetate tab 10 mg	1	MO
megestrol acetate susp 625 mg/5ml	1	MO
norethindrone acetate tab 5 mg	1	MO
(Norethindrone Acetate Tab 5 mg) GALLIFREY	1	MO
progesterone cap 100 mg	1	MO
progesterone cap 200 mg	1	MO
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
AGENTS FOR CHEMICAL DEPENDENCY		
acamprosate calcium tab delayed release 333 mg	1	MO
disulfiram tab 250 mg	1	MO
disulfiram tab 500 mg	1	MO
lofexidine hcl tab 0.18 mg (base equivalent)	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ANTI-CATAPLECTIC AGENTS		
LUMRYZ PAK 6GM ***(sodium oxybate)***	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 7.5GM ***(sodium oxybate)***	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK 9GM ***(sodium oxybate)***	2	SP, PA, QL (1 packet every 1 day)
LUMRYZ PAK STARTER ***(sodium oxybate)***	2	SP, PA, QL (1 packet every 1 day); 28-day starter pack
LUMRYZ PKG 4.5GM ***(sodium oxybate)***	2	SP, PA, QL (1 packet every 1 day)
sodium oxybate oral solution 500 mg/ml	1	SP, PA, QL (18 mL every 1 day)
XYWAV SOL 0.5GM/ML ***(calcium, magnesium, potassium, & sodium oxybates)***	2	PA, QL (18 mL every 1 day)
ANTIDEMENTIA AGENTS - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
donepezil hydrochloride orally disintegrating tab 5 mg	1	MO
donepezil hydrochloride orally disintegrating tab 10 mg	1	MO
donepezil hydrochloride tab 5 mg	1	MO
donepezil hydrochloride tab 10 mg	1	MO
donepezil hydrochloride tab 23 mg	1	MO
galantamine hydrobromide cap er 24hr 8 mg	1	MO
galantamine hydrobromide cap er 24hr 16 mg	1	MO
galantamine hydrobromide cap er 24hr 24 mg	1	MO
galantamine hydrobromide oral soln 4 mg/ml	1	MO
galantamine hydrobromide tab 4 mg	1	MO
galantamine hydrobromide tab 8 mg	1	MO
galantamine hydrobromide tab 12 mg	1	MO
memantine hcl cap er 24hr 7 mg	1	MO
memantine hcl cap er 24hr 14 mg	1	MO
memantine hcl cap er 24hr 21 mg	1	MO
memantine hcl cap er 24hr 28 mg	1	MO
memantine hcl oral solution 2 mg/ml	1	MO
memantine hcl tab 5 mg	1	MO
memantine hcl tab 10 mg	1	MO
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	1	
memantine hcl-donepezil hcl cap er 24hr 14-10 mg	1	MO
memantine hcl-donepezil hcl cap er 24hr 21-10 mg	1	MO
memantine hcl-donepezil hcl cap er 24hr 28-10 mg	1	MO
NAMZARIC CAP 7-10MG ***(memantine hcl-donepezil hcl)***	2	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
NAMZARIC CAP 14-10MG ***(memantine hcl-donepezil hcl)***	2	MO
NAMZARIC CAP 21-10MG ***(memantine hcl-donepezil hcl)***	2	MO
NAMZARIC CAP 28-10MG ***(memantine hcl-donepezil hcl)***	2	MO
rivastigmine tartrate cap 1.5 mg (base equivalent)	1	MO
rivastigmine tartrate cap 3 mg (base equivalent)	1	MO
rivastigmine tartrate cap 4.5 mg (base equivalent)	1	MO
rivastigmine tartrate cap 6 mg (base equivalent)	1	MO
rivastigmine td patch 24hr 4.6 mg/24hr	1	MO
rivastigmine td patch 24hr 9.5 mg/24hr	1	MO
rivastigmine td patch 24hr 13.3 mg/24hr	1	MO
COMBINATION PSYCHOTHERAPEUTICS		
chlordiazepoxide-amitriptyline tab 5-12.5 mg	1	MO
chlordiazepoxide-amitriptyline tab 10-25 mg	1	MO
olanzapine-fluoxetine hcl cap 3-25 mg	1	MO
olanzapine-fluoxetine hcl cap 6-25 mg	1	MO
olanzapine-fluoxetine hcl cap 6-50 mg	1	MO
olanzapine-fluoxetine hcl cap 12-25 mg	1	MO
olanzapine-fluoxetine hcl cap 12-50 mg	1	MO
perphenazine-amitriptyline tab 2-10 mg	1	MO
perphenazine-amitriptyline tab 2-25 mg	1	MO
perphenazine-amitriptyline tab 4-10 mg	1	MO
perphenazine-amitriptyline tab 4-25 mg	1	MO
perphenazine-amitriptyline tab 4-50 mg	1	MO
FIBROMYALGIA AGENTS		
milnacipran hcl tab 12.5 mg	1	MO
milnacipran hcl tab 12.5 mg (5) & 25 mg (8) & 50 mg (42) pak	1	
milnacipran hcl tab 25 mg	1	MO
milnacipran hcl tab 50 mg	1	MO
milnacipran hcl tab 100 mg	1	MO
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
ADDYI TAB 100MG ***(flibanserin)***	3	PA, MO
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB 6MG ***(deutetrabenazine)***	2	SP, PA, QL (2 tabs every 1 day)
AUSTEDO TAB 9MG ***(deutetrabenazine)***	2	SP, PA, QL (4 tabs every 1 day)
AUSTEDO TAB 12MG ***(deutetrabenazine)***	2	SP, PA, QL (4 tabs every 1 day)
INGREZZA CAP 40-80MG ***(valbenazine tosylate)***	2	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 40MG ***(valbenazine tosylate)***	2	SP, PA, QL (1 cap every 1 day)
INGREZZA CAP 60MG ***(valbenazine tosylate)***	2	SP, PA, QL (1 cap every 1 day)

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
INGREZZA CAP 80MG ***(valbenazine tosylate)***	2	SP, PA, QL (1 cap every 1 day)
tetrabenazine tab 12.5 mg	1	SP, PA, QL (4 tabs every 1 day)
tetrabenazine tab 25 mg	1	SP, PA, QL (2 tabs every 1 day)
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
BAFIERTAM CAP 95MG ***(monomethyl fumarate)***	2	SP, PA, QL (4 caps every 1 day)
cladribine tab therapy pack 10 mg (4 tabs)	1	SP, PA, QL (20 tabs every 270 days)
cladribine tab therapy pack 10 mg (5 tabs)	1	SP, PA, QL (20 tabs every 270 days)
cladribine tab therapy pack 10 mg (6 tabs)	1	SP, PA, QL (20 tabs every 270 days)
cladribine tab therapy pack 10 mg (7 tabs)	1	SP, PA, QL (20 tabs every 270 days)
cladribine tab therapy pack 10 mg (8 tabs)	1	SP, PA, QL (20 tabs every 270 days)
cladribine tab therapy pack 10 mg (9 tabs)	1	SP, PA, QL (20 tabs every 270 days)
cladribine tab therapy pack 10 mg (10 tabs)	1	SP, PA, QL (20 tabs every 270 days)
dalfampridine tab er 12hr 10 mg	1	SP, PA, QL (2 tabs every 1 day)
dimethyl fumarate capsule delayed release 120 mg	1	SP, PA, QL (14 caps every 28 days)
dimethyl fumarate capsule delayed release 240 mg	1	SP, PA, QL (2 caps every 1 day)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	1	SP, PA, QL (60 caps every 30 days)
fingolimod hcl cap 0.5 mg (base equiv)	1	SP, PA, QL (1 cap every 1 day)
MAYZENT PAK STARTER ***(siponimod fumarate)***	2	SP, PA, QL (12 tabs every 5 days)
MAYZENT PAK STARTER ***(siponimod fumarate)***	2	SP, PA, QL (7 tabs every 4 days)
MAYZENT TAB 0.25MG ***(siponimod fumarate)***	2	SP, PA, QL (12 tabs every 5 days)
MAYZENT TAB 1MG ***(siponimod fumarate)***	2	SP, PA, QL (1 tab every 1 day)
MAYZENT TAB 2MG ***(siponimod fumarate)***	2	SP, PA, QL (1 tab every 1 day)
teriflunomide tab 7 mg	1	SP, PA, QL (1 tab every 1 day)
teriflunomide tab 14 mg	1	SP, PA, QL (1 tab every 1 day)
ZEPOSIA 7DAY CAP STR PACK ***(ozanimod hcl)***	2	SP, PA, QL (7 caps every 7 days); Preferred for Ulcerative Colitis
ZEPOSIA CAP 0.92MG ***(ozanimod hcl)***	2	SP, PA, QL (1 cap every 1 day); Preferred for Ulcerative Colitis

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
ZEPOSIA CAP STR KIT ***(ozanimod hcl)***	2	SP, PA, QL (28 caps every 28 days); Preferred for Ulcerative Colitis
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
gabapentin (once-daily) tab 300 mg	1	MO
gabapentin (once-daily) tab 450 mg	1	MO
gabapentin (once-daily) tab 600 mg	1	MO
gabapentin (once-daily) tab 750 mg	1	MO
gabapentin (once-daily) tab 900 mg	1	MO
GRALISE TAB 300MG ***(gabapentin (once-daily))***	2	MO
GRALISE TAB 450MG ***(gabapentin (once-daily))***	2	MO
GRALISE TAB 600MG ***(gabapentin (once-daily))***	2	MO
GRALISE TAB 750MG ***(gabapentin (once-daily))***	2	MO
GRALISE TAB 900MG ***(gabapentin (once-daily))***	2	MO
pregabalin tab er 24hr 82.5 mg	1	MO
pregabalin tab er 24hr 165 mg	1	MO
pregabalin tab er 24hr 330 mg	1	MO
PSEUDOBULBAR AFFECT (PBA) AGENTS		
dextromethorphan hbr-quinidine sulfate cap 20-10 mg	1	MO
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
pimozide tab 1 mg	1	MO
pimozide tab 2 mg	1	MO
SMOKING DETERRENTS		
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	1	$0 limited to 2 treatment cycles/year
nicotine polacrilex gum 2 mg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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
nicotine polacrilex gum 4 mg	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) GOODSENSE NICOTINE POLACR	PV	$0 limited to 2 treatment cycles/year
(Nicotine Polacrilex Gum 4 mg) KLS QUIT4	PV	$0 limited to 2 treatment cycles/year
nicotine polacrilex lozenge 2 mg	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) 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
nicotine polacrilex lozenge 4 mg	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

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(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) SM NICOTINE POLACRILEX	PV	$0 limited to 2 treatment cycles/year
nicotine td patch 24hr 7 mg/24hr	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
nicotine td patch 24hr 14 mg/24hr	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
nicotine td patch 24hr 21 mg/24hr	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) GNP NICOTINE TRANSDERMAL	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 ***(nicotine)***	PV	$0 limited to 2 treatment cycles/year

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
varenicline tartrate tab 0.5 mg (base equiv)	1	
varenicline tartrate tab 1 mg (base equiv)	1	
varenicline tartrate tab 1 mg (base equiv)	1	$0 limited to 2 treatment cycles/year
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack	1	
RESPIRATORY AGENTS - MISC. - DRUGS TO TREAT BREATHING DISORDERS		
CYSTIC FIBROSIS AGENTS		
KALYDECO PAK 25MG ***(ivacaftor)***	3	SP, PA
KALYDECO PAK 50MG ***(ivacaftor)***	3	SP, PA
KALYDECO PAK 75MG ***(ivacaftor)***	3	SP, PA
KALYDECO TAB 150MG ***(ivacaftor)***	3	SP, PA
PULMONARY FIBROSIS AGENTS		
JASCAYD TAB 9MG ***(nerandomilast)***	2	SP, PA, QL (2 tabs every 1 day)
JASCAYD TAB 18MG ***(nerandomilast)***	2	SP, PA, QL (2 tabs every 1 day)
nintedanib esylate cap 100 mg (base equivalent)	1	SP, PA, QL (2 caps every 1 day)
nintedanib esylate cap 150 mg (base equivalent)	1	SP, PA, QL (2 caps every 1 day)
OFEV CAP 100MG ***(nintedanib esylate)***	2	SP, PA, QL (2 caps every 1 day)
OFEV CAP 150MG ***(nintedanib esylate)***	2	SP, PA, QL (2 caps every 1 day)
pirfenidone cap 267 mg	1	SP, PA, QL (9 caps every 1 day)
pirfenidone tab 267 mg	1	SP, PA, QL (9 tabs every 1 day)
pirfenidone tab 534 mg	1	SP, PA, QL (3 tabs every 1 day)
pirfenidone tab 801 mg	1	SP, PA, QL (3 tabs every 1 day)
SULFONAMIDES - DRUGS TO TREAT INFECTIONS		
SULFONAMIDES - DRUGS TO TREAT INFECTIONS		
sulfadiazine tab 500 mg	1	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
demeclocycline hcl tab 150 mg	1	
demeclocycline hcl tab 300 mg	1	
doxycycline hyclate cap 50 mg	1	
doxycycline hyclate cap 100 mg	1	
doxycycline hyclate tab 100 mg	1	
doxycycline monohydrate cap 50 mg	1	
doxycycline monohydrate cap 100 mg	1	
(Doxycycline Monohydrate Cap 100 mg) MONDOXYNE NL	1	
doxycycline monohydrate for susp 25 mg/5ml	1	
doxycycline monohydrate tab 50 mg	1	
doxycycline monohydrate tab 75 mg	1	
doxycycline monohydrate tab 100 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Doxycycline Monohydrate Tab 100 mg) AVIDOXY	1	
doxycycline monohydrate tab 150 mg	1	
minocycline hcl cap 50 mg	1	
minocycline hcl cap 75 mg	1	
minocycline hcl cap 100 mg	1	
minocycline hcl tab 50 mg	1	
minocycline hcl tab 75 mg	1	
minocycline hcl tab 100 mg	1	
tetracycline hcl cap 250 mg	1	
tetracycline hcl cap 500 mg	1	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
ANTITHYROID AGENTS		
methimazole tab 5 mg	1	MO
methimazole tab 10 mg	1	MO
propylthiouracil tab 50 mg	1	MO
THYROID HORMONES		
levothyroxine sodium tab 25 mcg	1	MO
(Levothyroxine Sodium Tab 25 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 25 mcg) UNITHROID	1	MO
levothyroxine sodium tab 50 mcg	1	MO
(Levothyroxine Sodium Tab 50 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 50 mcg) UNITHROID	1	MO
levothyroxine sodium tab 75 mcg	1	MO
(Levothyroxine Sodium Tab 75 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 75 mcg) UNITHROID	1	MO
levothyroxine sodium tab 88 mcg	1	MO
(Levothyroxine Sodium Tab 88 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 88 mcg) UNITHROID	1	MO
levothyroxine sodium tab 100 mcg	1	MO
(Levothyroxine Sodium Tab 100 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 100 mcg) UNITHROID	1	MO
levothyroxine sodium tab 112 mcg	1	MO
(Levothyroxine Sodium Tab 112 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 112 mcg) UNITHROID	1	MO
levothyroxine sodium tab 125 mcg	1	MO
(Levothyroxine Sodium Tab 125 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 125 mcg) UNITHROID	1	MO
levothyroxine sodium tab 137 mcg	1	MO
(Levothyroxine Sodium Tab 137 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 137 mcg) UNITHROID	1	MO
levothyroxine sodium tab 150 mcg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
(Levothyroxine Sodium Tab 150 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 150 mcg) UNITHROID	1	MO
levothyroxine sodium tab 175 mcg	1	MO
(Levothyroxine Sodium Tab 175 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 175 mcg) UNITHROID	1	MO
levothyroxine sodium tab 200 mcg	1	MO
(Levothyroxine Sodium Tab 200 mcg) LEVOXYL	1	MO
(Levothyroxine Sodium Tab 200 mcg) UNITHROID	1	MO
levothyroxine sodium tab 300 mcg	1	MO
(Levothyroxine Sodium Tab 300 mcg) UNITHROID	1	MO
liothyronine sodium tab 5 mcg	1	MO
(Liothyronine Sodium Tab 5 mcg) LIOMNY	1	MO
liothyronine sodium tab 25 mcg	1	MO
(Liothyronine Sodium Tab 25 mcg) LIOMNY	1	MO
liothyronine sodium tab 50 mcg	1	MO
(Liothyronine Sodium Tab 50 mcg) LIOMNY	1	MO
SYNTHROID TAB 25MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 50MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 75MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 88MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 100MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 112MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 125MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 137MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 150MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 175MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 200MCG ***(levothyroxine sodium)***	2	MO
SYNTHROID TAB 300MCG ***(levothyroxine sodium)***	2	MO
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS - DRUGS FOR ULCERS AND STOMACH ACID		
ANTISPASMODICS - DRUGS FOR STOMACH SPASMS		
chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg	1	
dicyclomine hcl cap 10 mg	1	
dicyclomine hcl oral soln 10 mg/5ml	1	
dicyclomine hcl tab 20 mg	1	
glycopyrrolate oral soln 1 mg/5ml	1	MO
glycopyrrolate tab 1 mg	1	
glycopyrrolate tab 2 mg	1	
hyoscyamine sulfate elixir 0.125 mg/5ml	1	MO
(Hyoscyamine Sulfate Elixir 0.125 mg/5ml) HYOSYNE	1	MO
hyoscyamine sulfate sl tab 0.125 mg	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
hyoscyamine sulfate soln 0.125 mg/ml	1	MO
(Hyoscyamine Sulfate Soln 0.125 mg/ml) HYOSYNE	1	MO
hyoscyamine sulfate tab 0.125 mg	1	MO
hyoscyamine sulfate tab disint 0.125 mg	1	MO
methscopolamine bromide tab 2.5 mg	1	
methscopolamine bromide tab 5 mg	1	
H-2 ANTAGONISTS		
cimetidine hcl soln 300 mg/5ml	1	MO
cimetidine tab 200 mg	1	
cimetidine tab 300 mg	1	MO
cimetidine tab 400 mg	1	MO
cimetidine tab 800 mg	1	MO
famotidine for susp 40 mg/5ml	1	MO
famotidine tab 20 mg	1	MO
famotidine tab 40 mg	1	MO
nizatidine cap 150 mg	1	MO
nizatidine cap 300 mg	1	MO
ranitidine hcl tab 150 mg	1	MO
ranitidine hcl tab 300 mg	1	MO
MISC. ANTI-ULCER		
sucralfate tab 1 gm	1	MO
PROTON PUMP INHIBITORS		
esomeprazole magnesium cap delayed release 20 mg (base eq)	1	MO
esomeprazole magnesium cap delayed release 40 mg (base eq)	1	MO
esomeprazole magnesium for delayed release susp pack 2.5 mg	1	MO
esomeprazole magnesium for delayed release susp packet 5 mg	1	MO
esomeprazole magnesium for delayed release susp packet 10 mg	1	MO
esomeprazole magnesium for delayed release susp packet 20 mg	1	MO
esomeprazole magnesium for delayed release susp packet 40 mg	1	MO
lansoprazole cap delayed release 15 mg	1	MO
lansoprazole cap delayed release 30 mg	1	MO
omeprazole cap delayed release 10 mg	1	MO
omeprazole cap delayed release 20 mg	1	MO
omeprazole cap delayed release 40 mg	1	MO
pantoprazole sodium ec tab 20 mg (base equiv)	1	MO

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
pantoprazole sodium ec tab 40 mg (base equiv)	1	MO
rabeprazole sodium ec tab 20 mg	1	MO
ULCER DRUGS - PROSTAGLANDINS		
misoprostol tab 100 mcg	1	MO
misoprostol tab 200 mcg	1	MO
ULCER THERAPY COMBINATIONS		
amoxicil cap &clarithro tab &lansopraz cap dr 500 &500 &30mg	1	
bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg	1	
TALICIA CAP ***(amoxicillin-rifabutin-omeprazole)***	2	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)	1	MO
darifenacin hydrobromide tab er 24hr 15 mg (base equiv)	1	MO
fesoterodine fumarate tab er 24hr 4 mg	1	MO
fesoterodine fumarate tab er 24hr 8 mg	1	MO
oxybutynin chloride solution 5 mg/5ml	1	MO
oxybutynin chloride tab 2.5 mg	1	MO
oxybutynin chloride tab 5 mg	1	MO
oxybutynin chloride tab er 24hr 5 mg	1	MO
oxybutynin chloride tab er 24hr 10 mg	1	MO
oxybutynin chloride tab er 24hr 15 mg	1	MO
solifenacin succinate tab 5 mg	1	MO
solifenacin succinate tab 10 mg	1	MO
tolterodine tartrate cap er 24hr 2 mg	1	MO
tolterodine tartrate cap er 24hr 4 mg	1	MO
tolterodine tartrate tab 1 mg	1	MO
tolterodine tartrate tab 2 mg	1	MO
trospium chloride cap er 24hr 60 mg	1	MO
trospium chloride tab 20 mg	1	MO
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB 75MG ***(vibegron)***	2	MO
mirabegron granules for oral extended release susp 8 mg/ml	1	MO
mirabegron tab er 24 hr 25 mg	1	MO
mirabegron tab er 24 hr 50 mg	1	MO
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol chloride tab 5 mg	1	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
bethanechol chloride tab 10 mg	1	
bethanechol chloride tab 25 mg	1	
bethanechol chloride tab 50 mg	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
flavoxate hcl tab 100 mg	1	MO
VAGINAL AND RELATED PRODUCTS - DRUGS TO TREAT VAGINAL CONDITIONS		
MISCELLANEOUS VAGINAL PRODUCTS		
INTRAROSA SUP 6.5MG ***(prasterone vaginal)***	3	MO
SPERMICIDES		
ENCARE SUP 100MG ***(nonoxynol-9)***	PV	
GYNOL II GEL 3% ***(nonoxynol-9)***	PV	
TODAY SPONGE MIS ***(nonoxynol-9)***	PV	
VCF VAGINAL GEL CONTRACE ***(nonoxynol-9)***	PV	
VCF VAGINAL MIS CONTRACP ***(nonoxynol-9)***	PV	
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal cream 2%	1	
metronidazole vaginal gel 0.75%	1	
(Miconazole Nitrate Vaginal Suppos 200 mg) MICONAZOLE 3	1	
terconazole vaginal cream 0.4%	1	
terconazole vaginal cream 0.8%	1	
terconazole vaginal suppos 80 mg	1	
VAGINAL CONTRACEPTIVE - PH MODULATORS		
PHEXX GEL ***(lactic acid-citric acid-potassium bitartrate)***	PV	
VAGINAL ESTROGENS		
estradiol vaginal cream 0.01%	1	MO
IMVEXXY MAIN SUP 4MCG ***(estradiol vaginal)***	2	MO
IMVEXXY MAIN SUP 10MCG ***(estradiol vaginal)***	2	MO
IMVEXXY STRT SUP 4MCG ***(estradiol vaginal)***	2	MO
IMVEXXY STRT SUP 10MCG ***(estradiol vaginal)***	2	MO
VAGIFEM TAB 10MCG ***(estradiol vaginal)***	1	MO
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG ***(progesterone (vaginal))***	2	
CRINONE GEL 8% VAG ***(progesterone (vaginal))***	2	PA
progesterone vaginal insert 100 mg	1	
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ANAPHYLAXIS THERAPY AGENTS - DRUGS FOR ACUTE ALLERGIC REACTION		
AUVI-Q INJ 0.1MG ***(epinephrine (anaphylaxis))***	2	
AUVI-Q INJ 0.3MG ***(epinephrine (anaphylaxis))***	2	
AUVI-Q INJ 0.15MG ***(epinephrine (anaphylaxis))***	2	

PRESCRIPTION DRUG NAME	DRUG TIER	COVERAGE REQUIREMENTS AND LIMITS
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)	1	
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)	1	
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
droxidopa cap 100 mg	1	SP, PA, QL (6 caps every 1 day)
droxidopa cap 200 mg	1	SP, PA, QL (6 caps every 1 day)
droxidopa cap 300 mg	1	SP, PA, QL (6 caps every 1 day)
VASOPRESSORS - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
midodrine hcl tab 2.5 mg	1	
midodrine hcl tab 5 mg	1	
midodrine hcl tab 10 mg	1	
VITAMINS - DRUGS FOR NUTRITION		
OIL SOLUBLE VITAMINS		
ergocalciferol cap 1.25 mg (50000 unit)	1	MO
phytonadione tab 5 mg	1	

Index

A

abacavir sulfate soln 20 mg/ml (base equiv) ... 96
abacavir sulfate tab 300 mg (base equiv) 96
abacavir sulfate-lamivudine tab 600-300 mg .. 96
abacavir-dolutegravir-lamivudine
see TRIUMEQ PD TAB 98
see TRIUMEQ TAB 98
ABIGALE
see Estradiol & Norethindrone Acetate Tab 1-0.5 mg 130
ABIGALE LO
see Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg 129
abiraterone acetate micronized
see YONSA TAB 125MG 84
abiraterone acetate tab 250 mg 83
Abiraterone Acetate Tab 250 mg 83
abiraterone acetate tab 500 mg 83
ABIRTEGA
see Abiraterone Acetate Tab 250 mg 83
abrocitinib
see CIBINQO TAB 100MG 124
see CIBINQO TAB 200MG 124
see CIBINQO TAB 50MG 124
acalabrutinib maleate
see CALQUENCE TAB 100MG 85
acamprosate calcium tab delayed release 333 mg 151
acarbose tab 100 mg 66
acarbose tab 25 mg 66
acarbose tab 50 mg 66
ACCUTANE
see Isotretinoin Cap 10 mg 119
see Isotretinoin Cap 20 mg 119
see Isotretinoin Cap 30 mg 119
see Isotretinoin Cap 40 mg 119
acebutolol hcl cap 200 mg 100
acebutolol hcl cap 400 mg 100
acetaminophen w/ codeine soln 120-12 mg/5ml 45
acetaminophen w/ codeine tab 300-15 mg 45
acetaminophen w/ codeine tab 300-30 mg 45
acetaminophen w/ codeine tab 300-60 mg 45
acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg 45
Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg 45
acetazolamide cap er 12hr 500 mg 126
acetazolamide tab 125 mg 126
acetazolamide tab 250 mg 126
acetic acid otic soln 2% 150
acetylcysteine inhal soln 10% 118
acetylcysteine inhal soln 20% 118
acitretin cap 10 mg 121
acitretin cap 17.5 mg 121
acitretin cap 25 mg 121
acyclovir cap 200 mg 99
acyclovir oint 5% 121
acyclovir susp 200 mg/5ml 99
acyclovir tab 400 mg 99
acyclovir tab 800 mg 99
adagrasib
see KRAZATI TAB 200MG 87
adapalene cream 0.1% 118
adapalene gel 0.1% 118
adapalene gel 0.3% 118
adapalene-benzoyl peroxide gel 0.1-2.5% 118
adapalene-benzoyl peroxide gel 0.3-2.5% 118
ADDYI TAB 100MG 153
adefovir dipivoxil tab 10 mg 98
ADEMPAS TAB 0.5MG 106
ADEMPAS TAB 1.5MG 106
ADEMPAS TAB 1MG 106
ADEMPAS TAB 2.5MG 106
ADEMPAS TAB 2MG 106
AERCHMBR PLS MIS LRG MASK 140
AERCHMBR PLS MIS MED MASK 140
AERCHMBR PLS MIS SM MASK 140
AERCHMBR Z- MIS STAT PLS 140
AEROCHAMBER MIS CHAMBER 140
AEROCHAMBER MIS MV 140
AEROCHAMBER MIS PLUS 140
AEROVENT MIS PLUS 140
AFIRMELLE
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 109
AFREZZA POW 12 UNIT 69

AFREZZA POW 4-8 UNIT 69
AFREZZA POW 4-8-12 69
AFREZZA POW 4UNIT 69
AFREZZA POW 8 UNIT 69
AFREZZA POW 8-12UNIT 69
AIRSUPRA AER 90-80MCG 55
AKLIEF CRE 0.005% 118
ALA-CORT
see Hydrocortisone Cream 1% 123
albendazole tab 200 mg 50
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv) 55
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml) 55
albuterol sulfate soln nebu 0.5% (5 mg/ml) 55
albuterol sulfate soln nebu 0.63 mg/3ml (base equiv) 55
albuterol sulfate soln nebu 1.25 mg/3ml (base equiv) 55
albuterol sulfate syrup 2 mg/5ml 55
albuterol sulfate tab 2 mg 55
albuterol sulfate tab 4 mg 55
albuterol-budesonide
see AIRSUPRA AER 90-80MCG 55
alclometasone dipropionate cream 0.05% 122
alclometasone dipropionate oint 0.05% 122
ALECENSA CAP 150MG 84
alectinib hcl
see ALECENSA CAP 150MG 84
alendronate sodium oral soln 70 mg/75ml 127
alendronate sodium tab 10 mg 127
alendronate sodium tab 35 mg 127
alendronate sodium tab 70 mg 127
alfuzosin hcl tab er 24hr 10 mg 133
aliskiren fumarate tab 150 mg (base equivalent) 80
aliskiren fumarate tab 300 mg (base equivalent) 80
allopurinol tab 100 mg 134
allopurinol tab 200 mg 134
allopurinol tab 300 mg 134
almotriptan malate tab 12.5 mg 142
almotriptan malate tab 6.25 mg 141
alosetron hcl tab 0.5 mg (base equiv) 133
alosetron hcl tab 1 mg (base equiv) 133
alpelisib
see PIQRAY 200MG TAB DOSE 88
see PIQRAY 250MG TAB DOSE 88
see PIQRAY 300MG TAB DOSE 88
ALPHAGAN P SOL 0.1% OP 148
ALPHAGAN P SOL 0.15% OP 148
alprazolam orally disintegrating tab 0.25 mg 52
alprazolam orally disintegrating tab 0.5 mg 52
alprazolam orally disintegrating tab 1 mg 52
alprazolam orally disintegrating tab 2 mg 52
alprazolam tab 0.25 mg 52
alprazolam tab 0.5 mg 52
alprazolam tab 1 mg 52
alprazolam tab 2 mg 52
alprazolam tab er 24hr 0.5 mg 52
Alprazolam Tab Er 24hr 0.5 mg 52
alprazolam tab er 24hr 1 mg 52
Alprazolam Tab Er 24hr 1 mg 52
alprazolam tab er 24hr 2 mg 52
Alprazolam Tab Er 24hr 2 mg 52
alprazolam tab er 24hr 3 mg 52
Alprazolam Tab Er 24hr 3 mg 52
ALPRAZOLAM XR
see Alprazolam Tab Er 24hr 0.5 mg 52
see Alprazolam Tab Er 24hr 1 mg 52
see Alprazolam Tab Er 24hr 2 mg 52
see Alprazolam Tab Er 24hr 3 mg 52
ALTAVERA
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
ALUNBRIG PAK 84
ALUNBRIG TAB 180MG 84
ALUNBRIG TAB 30MG 84
ALUNBRIG TAB 90MG 84
ALVAIZ TAB 18MG 136
ALVAIZ TAB 36MG 136
ALVAIZ TAB 54MG 136
ALVAIZ TAB 9MG 136
ALYACEN 1/35
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg 111
ALYACEN 7/7/7
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg 113
ALYQ
see Tadalafil Tab 20 mg (Pah) 106
amantadine hcl cap 100 mg 90
amantadine hcl soln 50 mg/5ml 91
amantadine hcl tab 100 mg 91

ambrisentan tab 10 mg 106
ambrisentan tab 5 mg 105
AMETHYST
see Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg 110
amiloride & hydrochlorothiazide tab 5-50 mg 126
amiloride hcl tab 5 mg 126
aminocaproic acid oral soln 0.25 gm/ml 137
aminocaproic acid tab 1000 mg 137
aminocaproic acid tab 500 mg 137
amiodarone hcl tab 100 mg 53
Amiodarone Hcl Tab 100 mg 16, 53
amiodarone hcl tab 200 mg 53
Amiodarone Hcl Tab 200 mg 53
amiodarone hcl tab 400 mg 53
amitriptyline hcl tab 10 mg 65
amitriptyline hcl tab 100 mg 65
amitriptyline hcl tab 150 mg 65
amitriptyline hcl tab 25 mg 65
amitriptyline hcl tab 50 mg 65
amitriptyline hcl tab 75 mg 65
amlodipine besylate tab 10 mg (base equivalent) 101
amlodipine besylate tab 2.5 mg (base equivalent) 101
amlodipine besylate tab 5 mg (base equivalent) 101
amlodipine besylate-atorvastatin calcium tab 10-10 mg 104
amlodipine besylate-atorvastatin calcium tab 10-20 mg 104
amlodipine besylate-atorvastatin calcium tab 10-40 mg 104
amlodipine besylate-atorvastatin calcium tab 10-80 mg 104
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg 104
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg 104
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg 104
amlodipine besylate-atorvastatin calcium tab 5-10 mg 104
amlodipine besylate-atorvastatin calcium tab 5-20 mg 104
amlodipine besylate-atorvastatin calcium tab 5-40 mg 104
amlodipine besylate-atorvastatin calcium tab 5-80 mg 104
amlodipine besylate-benazepril hcl cap 10-20 mg 78
amlodipine besylate-benazepril hcl cap 10-40 mg 78
amlodipine besylate-benazepril hcl cap 2.5-10 mg 78
amlodipine besylate-benazepril hcl cap 5-10 mg 78
amlodipine besylate-benazepril hcl cap 5-20 mg 78
amlodipine besylate-benazepril hcl cap 5-40 mg 78
amlodipine besylate-olmesartan medoxomil tab 10-20 mg 78
amlodipine besylate-olmesartan medoxomil tab 10-40 mg 78
amlodipine besylate-olmesartan medoxomil tab 5-20 mg 78
amlodipine besylate-olmesartan medoxomil tab 5-40 mg 78
amlodipine besylate-valsartan tab 10-160 mg 78
amlodipine besylate-valsartan tab 10-320 mg 78
amlodipine besylate-valsartan tab 5-160 mg .. 78
amlodipine besylate-valsartan tab 5-320 mg .. 78
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg 78
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg 78
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg 78
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg 78
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg 78
AMNESTEEM
see Isotretinoin Cap 10 mg 119
see Isotretinoin Cap 20 mg 119
see Isotretinoin Cap 30 mg 119
see Isotretinoin Cap 40 mg 119
amoxapine tab 100 mg 65
amoxapine tab 150 mg 65
amoxapine tab 25 mg 65
amoxapine tab 50 mg 65

amoxicil cap &clarithro tab &lansopraz cap dr 500 &500 &30mg 162
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml 151
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml 151
amoxicillin & k clavulanate for susp 400-57 mg/5ml 151
amoxicillin & k clavulanate for susp 600-42.9 mg/5ml 151
amoxicillin & k clavulanate tab 250-125 mg . 151
amoxicillin & k clavulanate tab 500-125 mg . 151
amoxicillin & k clavulanate tab 875-125 mg . 151
amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg 151
amoxicillin & pot clavulanate
see AUGMENTIN SUS 125/5ML 151
amoxicillin (trihydrate) cap 250 mg 150
amoxicillin (trihydrate) cap 500 mg 150
amoxicillin (trihydrate) chew tab 125 mg 150
amoxicillin (trihydrate) chew tab 250 mg 150
amoxicillin (trihydrate) for susp 125 mg/5ml 150
amoxicillin (trihydrate) for susp 200 mg/5ml 150
amoxicillin (trihydrate) for susp 250 mg/5ml 150
amoxicillin (trihydrate) for susp 400 mg/5ml 150
amoxicillin (trihydrate) tab 500 mg 150
amoxicillin (trihydrate) tab 875 mg 150
amoxicillin-rifabutin-omeprazole
see TALICIA CAP 162
amphetamine sulfate tab 10 mg 26
amphetamine sulfate tab 5 mg 26
amphetamine tab extended release disintegrating 12.5 mg 26
amphetamine tab extended release disintegrating 15.7 mg 26
amphetamine tab extended release disintegrating 18.8 mg 26
amphetamine tab extended release disintegrating 3.1 mg 26
amphetamine tab extended release disintegrating 6.3 mg 26
amphetamine tab extended release disintegrating 9.4 mg 26
amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5 mg 26
amphetamine-dextroamphetamine 3-bead cap er 24hr 25 mg 26
amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5 mg 27
amphetamine-dextroamphetamine 3-bead cap er 24hr 50 mg 27
amphetamine-dextroamphetamine cap er 24hr 10 mg 27
amphetamine-dextroamphetamine cap er 24hr 15 mg 27
amphetamine-dextroamphetamine cap er 24hr 20 mg 27
amphetamine-dextroamphetamine cap er 24hr 25 mg 27
amphetamine-dextroamphetamine cap er 24hr 30 mg 27
amphetamine-dextroamphetamine cap er 24hr 5 mg 27
amphetamine-dextroamphetamine tab 10 mg 27
amphetamine-dextroamphetamine tab 12.5 mg 28
amphetamine-dextroamphetamine tab 15 mg 28
amphetamine-dextroamphetamine tab 20 mg 28
amphetamine-dextroamphetamine tab 30 mg 28
amphetamine-dextroamphetamine tab 5 mg . 27
amphetamine-dextroamphetamine tab 7.5 mg 27
ampicillin cap 500 mg 150
anagrelide hcl cap 0.5 mg 134
anagrelide hcl cap 1 mg 135
anastrozole tab 1 mg 83
ANNOVERA MIS 115
ANORO ELLIPT AER 62.5-25 55
apalutamide
see ERLEADA TAB 240MG 83
see ERLEADA TAB 60MG 83
apixaban
see ELIQUIS CAP 0.15MG 57
see ELIQUIS ST P TAB 5MG 57
see ELIQUIS TAB 0.5MG 58
see ELIQUIS TAB 1.5MG 58
see ELIQUIS TAB 2.5MG 58
see ELIQUIS TAB 2MG 58
see ELIQUIS TAB 5MG 58

apraclonidine hcl ophth soln 0.5% (base equivalent) 148
apremilast
see OTEZLA TAB 10/20 41
see OTEZLA TAB 10/20/30 41
see OTEZLA TAB 20MG 41
see OTEZLA TAB 30MG 41
see OTEZLA XR TAB 75MG 41
see OTEZLA/XR TAB 28 DAY 41
aprepitant capsule 125 mg 72
aprepitant capsule 40 mg 72
aprepitant capsule 80 mg 72
aprepitant capsule therapy pack 80 & 125 mg 72
APRI
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
APTIVUS CAP 250MG 96
ARANELLE
see Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg 114
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv) 56
aripiprazole oral solution 1 mg/ml 96
aripiprazole orally disintegrating tab 10 mg ... 96
aripiprazole orally disintegrating tab 15 mg ... 96
aripiprazole tab 10 mg 96
aripiprazole tab 15 mg 96
aripiprazole tab 2 mg 96
aripiprazole tab 20 mg 96
aripiprazole tab 30 mg 96
aripiprazole tab 5 mg 96
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 81
asciminib hcl
see SCEMBLIX TAB 100MG 89
see SCEMBLIX TAB 20MG 89
see SCEMBLIX TAB 40MG 89
ASCOMP/CODEINE
see Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg 45
asenapine maleate sl tab 10 mg (base equiv) . 94
asenapine maleate sl tab 2.5 mg (base equiv) 94
asenapine maleate sl tab 5 mg (base equiv) ... 94
ASHLYNA
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) 109
ASMANEX HFA AER 100 MCG 54
ASMANEX HFA AER 200 MCG 54
ASMANEX HFA AER 50MCG 54
Aspirin Chew Tab 81 mg 42
ASPIRIN CHILDRENS
see Aspirin Chew Tab 81 mg 42
aspirin tab delayed release 81 mg 42
aspirin-dipyridamole cap er 12hr 25-200 mg. 135
atazanavir sulfate cap 150 mg (base equiv) 96
atazanavir sulfate cap 200 mg (base equiv) 96
atazanavir sulfate cap 300 mg (base equiv) 96
atenolol & chlorthalidone tab 100-25 mg 78
atenolol & chlorthalidone tab 50-25 mg 78
atenolol tab 100 mg 100
atenolol tab 25 mg 100
atenolol tab 50 mg 100
atogepant
see QULIPTA TAB 10MG 141
see QULIPTA TAB 30MG 141
see QULIPTA TAB 60MG 141
atomoxetine hcl cap 10 mg (base equiv) 32
atomoxetine hcl cap 100 mg (base equiv) 33
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) 74
atorvastatin calcium tab 20 mg (base equivalent) 74
atorvastatin calcium tab 40 mg (base equivalent) 74
atorvastatin calcium tab 80 mg (base equivalent) 75
atovaquone susp 750 mg/5ml 50
atovaquone-proguanil hcl tab 250-100 mg 81
atovaquone-proguanil hcl tab 62.5-25 mg 81
atrasentan hcl
see VANRAFIA TAB 0.75MG 133
atropine sulfate ophth soln 1% 147
AUBRA EQ
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110

AUGMENTIN SUS 125/5ML 151
AUGTYRO CAP 160MG 84
AUGTYRO CAP 40MG 84
AUROVELA 1.5/30
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
AUROVELA 1/20
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 111
AUROVELA 24 FE
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113
AUROVELA FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 112
AUROVELA FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
AURYXIA TAB 210MG 133
AUSTEDO TAB 12MG 153
AUSTEDO TAB 6MG 153
AUSTEDO TAB 9MG 153
AUVELITY TAB 45-105MG 63
AUVI-Q INJ 0.15MG 163
AUVI-Q INJ 0.1MG 163
AUVI-Q INJ 0.3MG 163
avatrombopag maleate
see DOPTELET SPR CAP 10MG 136
see DOPTELET TAB 20MG 136
AVIANE
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110
AVIDOXY
see Doxycycline Monohydrate Tab 100 mg 159
AWIQLI FLEX INJ 700UNIT 69
axitinib
see INLYTA TAB 1MG 82
see INLYTA TAB 5MG 82
AYUNA
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
AZASAN
see Azathioprine Tab 100 mg 144
see Azathioprine Tab 75 mg 144
azathioprine tab 100 mg 144
Azathioprine Tab 100 mg 144
azathioprine tab 50 mg 144
azathioprine tab 75 mg 144
Azathioprine Tab 75 mg 144
azelaic acid
see FINACEA AER 15% 124
azelaic acid gel 15% 124
azelastine hcl nasal spray 0.1% (137 mcg/spray) 146
azelastine hcl ophth soln 0.05% 149
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act 146
azilsartan medoxomil tab 40 mg 77
azilsartan medoxomil tab 80 mg 77
azithromycin for susp 100 mg/5ml 138
azithromycin for susp 200 mg/5ml 138
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 51
AZURETTE
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 107
B
BAC
see Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg 41
bacitracin-polymyxin b ophth oint 148
bacitracin-polymyxin-neomycin-hc ophth oint 1% 149
baclofen oral soln 10 mg/5ml 146
baclofen oral soln 5 mg/5ml 146
baclofen susp 25 mg/5ml 146
baclofen tab 10 mg 146
baclofen tab 15 mg 146
baclofen tab 20 mg 146
baclofen tab 5 mg 146
BAFIERTAM CAP 95MG 154
balsalazide disodium cap 750 mg 132
BALZIVA
see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg 111
BAQSIMI ONE POW 3MG/DOSE 68
BAQSIMI TWO POW 3MG/DOSE 68
BD INSULIN PEN NEEDLES - OTC 139

BD INSULIN SYRINGE - OTC 139
BD INSULIN SYRINGE - RX 139
beclomethasone diprop inhal aero soln 40 mcg/act (50/valve) 54
beclomethasone diprop inhal aers 100 mcg/act (80/delivery) 55
bedaquiline fumarate
see SIRTURO TAB 100MG 81
see SIRTURO TAB 20MG 81
BELBUCA MIS 150MCG 48
BELBUCA MIS 300MCG 48
BELBUCA MIS 450MCG 48
BELBUCA MIS 600MCG 48
BELBUCA MIS 750MCG 48
BELBUCA MIS 75MCG 48
BELBUCA MIS 900MCG 48
BELSOMRA TAB 10MG 138
BELSOMRA TAB 15MG 138
BELSOMRA TAB 20MG 138
BELSOMRA TAB 5MG 138
bempedoic acid
see NEXLETOL TAB 180MG 73
bempedoic acid-ezetimibe
see NEXLIZET TAB 180/10MG 74
benazepril & hydrochlorothiazide tab 10-12.5 mg 79
benazepril & hydrochlorothiazide tab 20-12.5 mg 79
benazepril & hydrochlorothiazide tab 20-25 mg 79
benazepril & hydrochlorothiazide tab 5-6.25 mg 78
benazepril hcl tab 10 mg 76
benazepril hcl tab 20 mg 76
benazepril hcl tab 40 mg 76
benazepril hcl tab 5 mg 76
BENZAC AC LIQ 5% WASH 118
benzonatate cap 100 mg 117
benzonatate cap 200 mg 117
benzoyl peroxide
see BENZAC AC LIQ 5% WASH 118
benzoyl peroxide-erythromycin gel 5-3% 118
benzphetamine hcl tab 50 mg 31
benztropine mesylate tab 0.5 mg 90
benztropine mesylate tab 1 mg 90
benztropine mesylate tab 2 mg 90
bepotastine besilate ophth soln 1.5% 149
berotralstat hcl
see ORLADEYO CAP 110MG 134
see ORLADEYO CAP 150MG 134
see ORLADEYO PAK 108MG 134
see ORLADEYO PAK 132MG 134
see ORLADEYO PAK 72MG 134
see ORLADEYO PAK 96MG 134
besifloxacin hcl
see BESIVANCE SUS 0.6% 148
BESIVANCE SUS 0.6% 148
betaine powder for oral solution 128
betamethasone dipropionate augmented cream 0.05% 122
betamethasone dipropionate augmented gel 0.05% 122
betamethasone dipropionate augmented lotion 0.05% 122
betamethasone dipropionate augmented oint 0.05% 122
betamethasone dipropionate cream 0.05% 122
betamethasone dipropionate lotion 0.05% 122
betamethasone valerate aerosol foam 0.12% 122
betamethasone valerate cream 0.1% (base equivalent) 122
betamethasone valerate lotion 0.1% (base equivalent) 122
betamethasone valerate oint 0.1% (base equivalent) 122
betaxolol hcl ophth soln 0.5% 147
betaxolol hcl tab 10 mg 100
betaxolol hcl tab 20 mg 100
bethanechol chloride tab 10 mg 163
bethanechol chloride tab 25 mg 163
bethanechol chloride tab 5 mg 162
bethanechol chloride tab 50 mg 163
bexarotene cap 75 mg 90
bexarotene gel 1% 121
bicalutamide tab 50 mg 83
bictegravir-emtricitabine-tenofovir alafenamide fumarate
see BIKTARVY TAB 96
BIJUVA CAP 0.5-100 129
BIJUVA CAP 1-100MG 129
BIKTARVY TAB 96
bimatoprost ophth soln 0.01% 150
bimatoprost ophth soln 0.03% 150

binimetinib
see MEKTOVI TAB 15MG 88
bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg 162
bisoprolol & hydrochlorothiazide tab 10-6.25 mg 79
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg 79
bisoprolol & hydrochlorothiazide tab 5-6.25 mg 79
bisoprolol fumarate tab 10 mg 100
bisoprolol fumarate tab 5 mg 100
BLISOVI 24 FE
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113
BLISOVI FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 112
BLISOVI FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
bosentan tab 125 mg 106
bosentan tab 62.5 mg 106
bosentan tab for oral susp 32 mg 106
BOSULIF CAP 100MG 84
BOSULIF CAP 50MG 84
BOSULIF TAB 100MG 85
BOSULIF TAB 400MG 85
BOSULIF TAB 500MG 85
bosutinib
see BOSULIF CAP 100MG 84
see BOSULIF CAP 50MG 84
see BOSULIF TAB 100MG 85
see BOSULIF TAB 400MG 85
see BOSULIF TAB 500MG 85
bosutinib tab 100 mg 85
bosutinib tab 400 mg 85
bosutinib tab 500 mg 85
BRAFTOVI CAP 75MG 85
BREATHE EASE MIS LG MASK 140
BREATHE EASE MIS MED MASK 140
BREATHE EASE MIS SM MASK 140
BREO ELLIPTA INH 100-25 56
BREO ELLIPTA INH 200-25 56
BREO ELLIPTA INH 50-25MCG 56
BREYNA
see Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act 56
see Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act 56
BREZTRI AERO AER 18MCG 56
BREZTRI AERO AER 9MCG 56
BRIELLYN
see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg 111
brigatinib
see ALUNBRIG PAK 84
see ALUNBRIG TAB 180MG 84
see ALUNBRIG TAB 30MG 84
see ALUNBRIG TAB 90MG 84
brimonidine tartrate
see ALPHAGAN P SOL 0.1% OP 148
see ALPHAGAN P SOL 0.15% OP 148
brimonidine tartrate gel 0.33% (base equivalent) 124
brimonidine tartrate ophth soln 0.1% 148
brimonidine tartrate ophth soln 0.15% 148
brimonidine tartrate ophth soln 0.2% 148
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5% 147
brinzolamide ophth susp 1% 149
brinzolamide-brimonidine tartrate
see SIMBRINZA SUS 1-0.2% 148
brivaracetam oral soln 10 mg/ml 59
brivaracetam tab 10 mg 59
brivaracetam tab 100 mg 59
brivaracetam tab 25 mg 59
brivaracetam tab 50 mg 59
brivaracetam tab 75 mg 59
bromfenac sodium ophth soln 0.07% (base equivalent) 149
bromfenac sodium ophth soln 0.075% (base equivalent) 149
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily) 149
bromocriptine mesylate cap 5 mg (base equivalent) 91
bromocriptine mesylate tab 2.5 mg (base equivalent) 91
BRUKINSA CAP 80MG 85
BRUKINSA TAB 160MG 85
BRYHALI LOT 0.01% 122
budesonide

see UCERIS TAB 9MG 117
budesonide (inhalation)
see PULMICORT INH 180MCG 55
see PULMICORT INH 90MCG 55
budesonide delayed release particles cap 3 mg 116
budesonide inhalation susp 0.25 mg/2ml 55
budesonide inhalation susp 0.5 mg/2ml 55
budesonide inhalation susp 1 mg/2ml 55
budesonide rectal foam 2 mg/act 49
budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act 56
Budesonide-Formoterol Fumarate Dihyd Aerosol 160-4.5 mcg/act 56
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act 56
Budesonide-Formoterol Fumarate Dihyd Aerosol 80-4.5 mcg/act 56
budesonide-glycopyrrolate-formoterol fumarate
see BREZTRI AERO AER 18MCG 56
see BREZTRI AERO AER 9MCG 56
bumetanide tab 0.5 mg 126
bumetanide tab 1 mg 126
bumetanide tab 2 mg 126
buprenorphine hcl
see BELBUCA MIS 150MCG 48
see BELBUCA MIS 300MCG 48
see BELBUCA MIS 450MCG 48
see BELBUCA MIS 600MCG 48
see BELBUCA MIS 750MCG 48
see BELBUCA MIS 75MCG 48
see BELBUCA MIS 900MCG 48
buprenorphine hcl sl tab 2 mg (base equiv) 48
buprenorphine hcl sl tab 8 mg (base equiv) 48
buprenorphine hcl-naloxone hcl dihydrate
see ZUBSOLV SUB 0.7-0.18 48
see ZUBSOLV SUB 1.4-0.36 48
see ZUBSOLV SUB 11.4-2.9 49
see ZUBSOLV SUB 2.9-0.71 48
see ZUBSOLV SUB 5.7-1.4 49
see ZUBSOLV SUB 8.6-2.1 49
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) 48
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) 48
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) 48
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) 48
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv) 48
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv) 48
buprenorphine td patch weekly 10 mcg/hr 48
buprenorphine td patch weekly 15 mcg/hr 48
buprenorphine td patch weekly 20 mcg/hr 48
buprenorphine td patch weekly 5 mcg/hr 48
buprenorphine td patch weekly 7.5 mcg/hr 48
bupropion hcl (smoking deterrent) tab er 12hr 150 mg 155
bupropion hcl tab 100 mg 63
bupropion hcl tab 75 mg 63
bupropion hcl tab er 12hr 100 mg 63
bupropion hcl tab er 12hr 150 mg 63
bupropion hcl tab er 12hr 200 mg 63
bupropion hcl tab er 24hr 150 mg 63
bupropion hcl tab er 24hr 300 mg 63
buspirone hcl tab 10 mg 52
buspirone hcl tab 15 mg 52
buspirone hcl tab 30 mg 52
buspirone hcl tab 5 mg 52
buspirone hcl tab 7.5 mg 52
butalbital-acetaminophen tab 50-325 mg 41
Butalbital-Acetaminophen Tab 50-325 mg 41
butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg 45
butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg 45
butalbital-acetaminophen-caffeine tab 50-325-40 mg 41
Butalbital-Acetaminophen-Caffeine Tab 50-325-40 mg 41
butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg 45
Butalbital-Aspirin-Caff W/ Codeine Cap 50-325-40-30 mg 45
butalbital-aspirin-caffeine cap 50-325-40 mg . 41
butorphanol tartrate nasal soln 10 mg/ml 48
C
cabergoline tab 0.5 mg 129
CABOMETYX TAB 20MG 85
CABOMETYX TAB 40MG 85
CABOMETYX TAB 60MG 85
cabozantinib s-malate

see CABOMETYX TAB 20MG 85
see CABOMETYX TAB 40MG 85
see CABOMETYX TAB 60MG 85
calcipotriene oint 0.005% 121
Calcipotriene Oint 0.005% 121
calcipotriene soln 0.005% (50 mcg/ml) 121
calcipotriene-betamethasone dipropionate
see ENSTILAR AER 122
calcitonin (salmon) nasal soln 200 unit/act ... 127
CALCITRENE
see Calcipotriene Oint 0.005% 121
calcitriol cap 0.25 mcg 128
calcitriol cap 0.5 mcg 128
calcitriol oral soln 1 mcg/ml 128
calcium acetate (phosphate binder) cap 667 mg (169 mg ca) 133
calcium acetate (phosphate binder) tab 667 mg 133
calcium, magnesium, potassium, & sodium oxybates
see XYWAV SOL 0.5GM/ML 152
CALQUENCE TAB 100MG 85
CAMILA
see Norethindrone Tab 0.35 mg 115
CAMRESE
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) 109
CAMRESE LO
see Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7) 109
CAMZYOS CAP 10MG 104
CAMZYOS CAP 15MG 104
CAMZYOS CAP 2.5MG 104
CAMZYOS CAP 5MG 104
candesartan cilexetil tab 16 mg 77
candesartan cilexetil tab 32 mg 77
candesartan cilexetil tab 4 mg 77
candesartan cilexetil tab 8 mg 77
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg 79
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg 79
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg 79
capecitabine tab 150 mg 82
capecitabine tab 500 mg 82
capivasertib
see TRUQAP PAK 160MG 89
see TRUQAP PAK 200MG 89
see TRUQAP TAB 200MG 89
captopril & hydrochlorothiazide tab 25-15 mg 79
captopril & hydrochlorothiazide tab 25-25 mg 79
captopril & hydrochlorothiazide tab 50-15 mg 79
captopril & hydrochlorothiazide tab 50-25 mg 79
captopril tab 100 mg 76
captopril tab 12.5 mg 76
captopril tab 25 mg 76
captopril tab 50 mg 76
carbamazepine
see CARBATROL CAP 100MG 59
see CARBATROL CAP 200MG 59
see CARBATROL CAP 300MG 59
carbamazepine cap er 12hr 100 mg 59
carbamazepine cap er 12hr 200 mg 59
carbamazepine cap er 12hr 300 mg 59
carbamazepine chew tab 100 mg 59
carbamazepine chew tab 200 mg 59
carbamazepine susp 100 mg/5ml 59
carbamazepine tab 200 mg 59
carbamazepine tab er 12hr 100 mg 59
carbamazepine tab er 12hr 200 mg 59
carbamazepine tab er 12hr 400 mg 59
CARBATROL CAP 100MG 59
CARBATROL CAP 200MG 59
CARBATROL CAP 300MG 59
carbidopa & levodopa cap er 23.75-95 mg 91
carbidopa & levodopa cap er 36.25-145 mg 91
carbidopa & levodopa cap er 48.75-195 mg 91
carbidopa & levodopa cap er 61.25-245 mg 91
carbidopa & levodopa orally disintegrating tab 10-100 mg 91
carbidopa & levodopa orally disintegrating tab 25-100 mg 91
carbidopa & levodopa orally disintegrating tab 25-250 mg 91
carbidopa & levodopa tab 10-100 mg 91
carbidopa & levodopa tab 25-100 mg 91
carbidopa & levodopa tab 25-250 mg 91
carbidopa & levodopa tab er 25-100 mg 91
carbidopa & levodopa tab er 50-200 mg 91
carbidopa tab 25 mg 90
carbidopa-levodopa
see CREXONT CAP 35-140MG 91
see CREXONT CAP 52.5-210 91

see CREXONT CAP 70-280MG 91
see CREXONT CAP 87.5-350..... 91
see DHIVY TAB 25-100MG 91
see RYTARY CAP 145MG 92
see RYTARY CAP 195MG 92
see RYTARY CAP 245MG 92
see RYTARY CAP 95MG 92
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg 91
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg 91
carbidopa-levodopa-entacapone tabs 25-100-200 mg 91
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg..... 91
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg 91
carbidopa-levodopa-entacapone tabs 50-200-200 mg 91
carbinoxamine maleate extended release susp 4 mg/5ml 73
carbinoxamine maleate soln 4 mg/5ml 73
Carbinoxamine Maleate Soln 4 mg/5ml 73
carbinoxamine maleate tab 4 mg 73
carbinoxamine maleate tab 6 mg 73
Carbinoxamine Maleate Tab 6 mg 73
CARBZAH
see Carbinoxamine Maleate Soln 4 mg/5ml . 73
carglumic acid soluble tab 200 mg 128
cariprazine hcl
see VRAYLAR CAP 0.5MG..... 93
see VRAYLAR CAP 0.75MG..... 93
see VRAYLAR CAP 1.5MG..... 93
see VRAYLAR CAP 3MG 93
see VRAYLAR CAP 4.5MG..... 93
see VRAYLAR CAP 6MG 93
carisoprodol tab 350 mg 146
carteolol hcl ophth soln 1%..... 147
CARTIA XT
see Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg 102
see Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg 102
see Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg 102
see Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg 102
carvedilol phosphate cap er 24hr 10 mg 100
carvedilol phosphate cap er 24hr 20 mg 100
carvedilol phosphate cap er 24hr 40 mg 100
carvedilol phosphate cap er 24hr 80 mg 100
carvedilol tab 12.5 mg..... 100
carvedilol tab 25 mg 100
carvedilol tab 3.125 mg 100
carvedilol tab 6.25 mg..... 100
CAYSTON INH 75MG 51
cefaclor cap 250 mg..... 107
cefaclor cap 500 mg..... 107
cefaclor for susp 250 mg/5ml..... 107
cefadroxil cap 500 mg 107
cefadroxil for susp 250 mg/5ml 107
cefadroxil for susp 500 mg/5ml 107
cefadroxil tab 1 gm..... 107
cefdinir cap 300 mg 107
cefdinir for susp 125 mg/5ml 107
cefdinir for susp 250 mg/5ml 107
cefixime cap 400 mg..... 107
cefixime for susp 100 mg/5ml..... 107
cefixime for susp 200 mg/5ml..... 107
cefixime tab 400 mg 107
cefpodoxime proxetil for susp 100 mg/5ml... 107
cefpodoxime proxetil for susp 50 mg/5ml..... 107
cefpodoxime proxetil tab 100 mg 107
cefpodoxime proxetil tab 200 mg 107
cefprozil for susp 125 mg/5ml..... 107
cefprozil for susp 250 mg/5ml..... 107
cefprozil tab 250 mg..... 107
cefprozil tab 500 mg..... 107
cefuroxime axetil tab 250 mg..... 107
cefuroxime axetil tab 500 mg..... 107
celecoxib cap 100 mg 39
celecoxib cap 200 mg 39
celecoxib cap 400 mg 39
celecoxib cap 50 mg 39
cenobamate
see XCOPRI PAK 100-150 62
see XCOPRI PAK 12.5-25 62
see XCOPRI PAK 150-200 62
see XCOPRI PAK 50-100MG 62
see XCOPRI TAB 100MG 62
see XCOPRI TAB 150MG 62
see XCOPRI TAB 200MG 62
see XCOPRI TAB 25MG..... 62
see XCOPRI TAB 50MG..... 62

cephalexin cap 250 mg 107
cephalexin cap 500 mg 107
cephalexin cap 750 mg 107
cephalexin for susp 125 mg/5ml 107
cephalexin for susp 250 mg/5ml 107
cephalexin tab 250 mg 107
cephalexin tab 500 mg 107
CERDELGA CAP 84MG 135
ceritinib
see ZYKADIA TAB 150MG 90
cetirizine hcl oral soln 1 mg/ml (5 mg/5ml) 73
cevimeline hcl cap 30 mg 145
CHARLOTTE 24 FE
see Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24) 113
CHATEAL EQ
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
chlordiazepoxide hcl cap 10 mg 52
chlordiazepoxide hcl cap 25 mg 52
chlordiazepoxide hcl cap 5 mg 52
chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg 160
chlordiazepoxide-amitriptyline tab 10-25 mg 153
chlordiazepoxide-amitriptyline tab 5-12.5 mg 153
chloroquine phosphate tab 250 mg 81
chloroquine phosphate tab 500 mg 81
chlorpromazine hcl conc 100 mg/ml 95
chlorpromazine hcl conc 30 mg/ml 95
chlorpromazine hcl tab 10 mg 95
chlorpromazine hcl tab 100 mg 95
chlorpromazine hcl tab 200 mg 95
chlorpromazine hcl tab 25 mg 95
chlorpromazine hcl tab 50 mg 95
chlorthalidone tab 25 mg 127
chlorthalidone tab 50 mg 127
chlorzoxazone tab 500 mg 146
cholestyramine light powder 4 gm/dose 74
Cholestyramine Light Powder 4 gm/dose 74
cholestyramine light powder packets 4 gm 74
Cholestyramine Light Powder Packets 4 gm 74
cholestyramine powder 4 gm/dose 74
cholestyramine powder packets 4 gm 74
choline fenofibrate cap dr 135 mg (fenofibric acid equiv) 74
choline fenofibrate cap dr 45 mg (fenofibric acid equiv) 74
CIBINQO TAB 100MG 124
CIBINQO TAB 200MG 124
CIBINQO TAB 50MG 124
CICLODAN
see Ciclopirox Solution 8% 120
ciclopirox gel 0.77% 120
ciclopirox olamine cream 0.77% (base equiv) 120
ciclopirox olamine susp 0.77% (base equiv) ... 120
ciclopirox shampoo 1% 120
ciclopirox solution 8% 120
Ciclopirox Solution 8% 120
cilostazol tab 100 mg 135
cilostazol tab 50 mg 135
CIMDUO TAB 300-300 96
cimetidine hcl soln 300 mg/5ml 161
cimetidine tab 200 mg 161
cimetidine tab 300 mg 161
cimetidine tab 400 mg 161
cimetidine tab 800 mg 161
cinacalcet hcl tab 30 mg (base equiv) 128
cinacalcet hcl tab 60 mg (base equiv) 128
cinacalcet hcl tab 90 mg (base equiv) 128
CIPRO (10%) SUS 500MG/5 131
CIPRO (5%) SUS 250MG/5 131
ciprofloxacin
see CIPRO (10%) SUS 500MG/5 131
see CIPRO (5%) SUS 250MG/5 131
ciprofloxacin hcl ophth soln 0.3% (base equivalent) 148
ciprofloxacin hcl otic soln 0.2% (base equivalent) 150
ciprofloxacin hcl tab 250 mg (base equiv) 131
ciprofloxacin hcl tab 500 mg (base equiv) 131
ciprofloxacin hcl tab 750 mg (base equiv) 131
ciprofloxacin-dexamethasone otic susp 0.3-0.1% 150
ciprofloxacin-hydrocortisone otic susp 0.2-1% 150
citalopram hydrobromide cap 30 mg 63
citalopram hydrobromide oral soln 10 mg/5ml 63
citalopram hydrobromide tab 10 mg (base equiv) 63
citalopram hydrobromide tab 20 mg (base equiv) 63

citalopram hydrobromide tab 40 mg (base equiv) 63
cladribine tab therapy pack 10 mg (10 tabs) . 154
cladribine tab therapy pack 10 mg (4 tabs) ... 154
cladribine tab therapy pack 10 mg (5 tabs) ... 154
cladribine tab therapy pack 10 mg (6 tabs) ... 154
cladribine tab therapy pack 10 mg (7 tabs) ... 154
cladribine tab therapy pack 10 mg (8 tabs) ... 154
cladribine tab therapy pack 10 mg (9 tabs) ... 154
CLARAVIS
see Isotretinoin Cap 10 mg 119
see Isotretinoin Cap 20 mg 119
see Isotretinoin Cap 30 mg 119
see Isotretinoin Cap 40 mg 119
clarithromycin for susp 125 mg/5ml..... 139
clarithromycin for susp 250 mg/5ml..... 139
clarithromycin tab 250 mg..... 139
clarithromycin tab 500 mg..... 139
clarithromycin tab er 24hr 500 mg 139
clascoterone
see WINLEVI CRE 1% 120
clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)..... 73
clemastine fumarate tab 2.68 mg..... 73
CLENPIQ SOL 138
CLINDACIN
see Clindamycin Phosphate Foam 1% 118
CLINDACIN ETZ PLEDGETS
see Clindamycin Phosphate Swab 1%..... 119
CLINDACIN-P
see Clindamycin Phosphate Swab 1%..... 119
clindamycin hcl cap 150 mg 51
clindamycin hcl cap 300 mg 51
clindamycin hcl cap 75 mg 51
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv) 51
clindamycin phosphate foam 1% 118
Clindamycin Phosphate Foam 1% 118
clindamycin phosphate gel 1% (twice-daily) . 118
clindamycin phosphate lotion 1% 118
clindamycin phosphate soln 1% 118
clindamycin phosphate swab 1% 118
Clindamycin Phosphate Swab 1%..... 119
clindamycin phosphate vaginal cream 2%..... 163
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%..... 119
clindamycin phosphate-benzoyl peroxide gel 1.2-3.75%..... 119
clindamycin phosphate-benzoyl peroxide gel 1-5%..... 119
clindamycin phosphate-tretinoin gel 1.2-0.025% 119
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5% 118
Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5% 118
clobazam suspension 2.5 mg/ml..... 58
clobazam tab 10 mg 58
clobazam tab 20 mg 58
clobetasol propionate cream 0.05% 122
clobetasol propionate emollient base cream 0.05% 122
clobetasol propionate foam 0.05%..... 122
clobetasol propionate gel 0.05%..... 122
clobetasol propionate lotion 0.05%..... 122
clobetasol propionate oint 0.05% 122
clobetasol propionate shampoo 0.05% 122
Clobetasol Propionate Shampoo 0.05% 122
clobetasol propionate soln 0.05%..... 122
CLODAN
see Clobetasol Propionate Shampoo 0.05% 122
CLOMID
see Clomiphene Citrate Tab 50 mg 127
clomiphene citrate tab 50 mg 127
Clomiphene Citrate Tab 50 mg..... 127
clomipramine hcl cap 25 mg..... 66
clomipramine hcl cap 50 mg..... 66
clomipramine hcl cap 75 mg..... 66
clonazepam orally disintegrating tab 0.125 mg 58
clonazepam orally disintegrating tab 0.25 mg 58
clonazepam orally disintegrating tab 0.5 mg.. 58
clonazepam orally disintegrating tab 1 mg..... 58
clonazepam orally disintegrating tab 2 mg..... 58
clonazepam tab 0.5 mg..... 58
clonazepam tab 1 mg 58
clonazepam tab 2 mg 58
clonidine hcl tab 0.05 mg 77
clonidine hcl tab 0.1 mg 77
clonidine hcl tab 0.2 mg 77
clonidine hcl tab 0.3 mg 77
clonidine hcl tab er 12hr 0.1 mg..... 33
clonidine tab er 24hr 0.17 mg 77

clonidine td patch weekly 0.1 mg/24hr 77
clonidine td patch weekly 0.2 mg/24hr 77
clonidine td patch weekly 0.3 mg/24hr 77
clopidogrel bisulfate tab 300 mg (base equiv) 135
clopidogrel bisulfate tab 75 mg (base equiv) 135
clorazepate dipotassium tab 15 mg 53
clorazepate dipotassium tab 3.75 mg 53
clorazepate dipotassium tab 7.5 mg 53
clotrimazole cream 1% 120
clotrimazole soln 1% 120
clotrimazole troche 10 mg 145
clotrimazole w/ betamethasone cream 1-0.05% 120
clotrimazole w/ betamethasone lotion 1-0.05% 120
clozapine orally disintegrating tab 100 mg 94
clozapine orally disintegrating tab 12.5 mg 94
clozapine orally disintegrating tab 150 mg 94
clozapine orally disintegrating tab 200 mg 94
clozapine orally disintegrating tab 25 mg 94
clozapine tab 100 mg 94
clozapine tab 200 mg 94
clozapine tab 25 mg 94
clozapine tab 50 mg 94
COARTEM TAB 20-120MG 81
codeine sulfate tab 30 mg 42
colchicine cap 0.6 mg 134
colchicine tab 0.6 mg 134
colchicine w/ probenecid tab 0.5-500 mg 134
colesevelam hcl packet for susp 3.75 gm 74
colesevelam hcl tab 625 mg 74
colestipol hcl granule packets 5 gm 74
colestipol hcl granules 5 gm 74
colestipol hcl tab 1 gm 74
COMBIPATCH DIS 129
COMPACT SPAC MIS CHAMBER 140
COMPACT SPAC MIS LG MASK 140
COMPACT SPAC MIS MD MASK 140
COMPACT SPAC MIS SM MASK 140
COMPRO
see Prochlorperazine Suppos 25 mg 95
condoms - female
see FC2 FEMALE MIS CONDOM 139
condoms latex lubricated - male
see MALE MIS CONDOM 139
condoms latex non-lubricated - male
see TRUSTEX MIS FLAVORS 139
CONDOMS MIS 139
condoms non-latex lubricated - male
see DUREX MIS REALFEEL 139
conjugated estrogens-bazedoxifene
see DUAVEE TAB 0.45-20 129
conjugated estrogens-medroxyprogesterone acetate
see PREMPHASE TAB 130
see PREMPRO TAB 130
see PREMPRO TAB 0.3-1.5 130
see PREMPRO TAB 0.45-1.5 130
see PREMPRO TAB 0.625-5 130
CONSTULOSE
see Lactulose Solution 10 gm/15ml 138
CORTIFOAM AER 90MG 49
CREON CAP 12000UNT 125
CREON CAP 24000UNT 125
CREON CAP 3000UNIT 125
CREON CAP 36000UNT 125
CREON CAP 6000UNIT 125
CREXONT CAP 35-140MG 91
CREXONT CAP 52.5-210 91
CREXONT CAP 70-280MG 91
CREXONT CAP 87.5-350 91
CRINONE GEL 4% VAG 163
CRINONE GEL 8% VAG 163
crisaborole
see EUCRISA OIN 2% 124
cromolyn sodium ophth soln 4% 149
cromolyn sodium oral conc 100 mg/5ml 132
cromolyn sodium soln nebu 20 mg/2ml 54
Crotamiton Lotion 10% 125
CROTAN
see Crotamiton Lotion 10% 125
CRYSELLE
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg 114
CVS FOLIC ACID
see Folic Acid Tab 800 mcg 136
CVS NICOTINE
see Nicotine Polacrilex Gum 2 mg 155
see Nicotine Polacrilex Gum 4 mg 156
CVS NICOTINE GUM
see Nicotine Polacrilex Gum 4 mg 156
CVS NICOTINE LOZENGE
see Nicotine Polacrilex Lozenge 2 mg 156

see Nicotine Polacrilex Lozenge 4 mg 156
CVS NICOTINE POLACRILEX
see Nicotine Polacrilex Gum 2 mg 155
see Nicotine Polacrilex Gum 4 mg 156
see Nicotine Polacrilex Lozenge 2 mg 156
see Nicotine Polacrilex Lozenge 4 mg 156
CVS NICOTINE POLACRILEX S
see Nicotine Polacrilex Gum 2 mg 155
CVS NICOTINE TRANSDERMAL
see Nicotine Td Patch 24hr 14 mg/24hr 157
see Nicotine Td Patch 24hr 21 mg/24hr 157
see Nicotine Td Patch 24hr 7 mg/24hr 157
cyclobenzaprine hcl tab 10 mg 146
cyclobenzaprine hcl tab 5 mg 146
cyclopentolate hcl ophth soln 1% 147
cyclophosphamide cap 25 mg 81
cyclophosphamide cap 50 mg 81
cycloserine cap 250 mg 81
cyclosporine (ophth)
see RESTASIS EMU 0.05% OP 148
see RESTASIS MUL EMU 0.05% OP 148
see VEVYE DRO 0.1% 148
cyclosporine cap 100 mg 144
cyclosporine cap 25 mg 144
cyclosporine modified cap 100 mg 144
Cyclosporine Modified Cap 100 mg 144
cyclosporine modified cap 25 mg 144
Cyclosporine Modified Cap 25 mg 144
cyclosporine modified cap 50 mg 144
cyclosporine modified oral soln 100 mg/ml ... 144
cyproheptadine hcl syrup 2 mg/5ml 73
cyproheptadine hcl tab 4 mg 73
CYRED EQ
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
CYSTAGON CAP 150MG 133
CYSTAGON CAP 50MG 133
cysteamine bitartrate
see CYSTAGON CAP 150MG 133
see CYSTAGON CAP 50MG 133
D
dabigatran etexilate mesylate cap 110 mg (etexilate base eq) 58
dabigatran etexilate mesylate cap 150 mg (etexilate base eq) 58
dabigatran etexilate mesylate cap 75 mg (etexilate base eq) 58
dabrafenib mesylate
see TAFINLAR CAP 50MG 89
see TAFINLAR CAP 75MG 89
see TAFINLAR TAB 10MG 89
dalfampridine tab er 12hr 10 mg 154
danazol cap 100 mg 49
danazol cap 200 mg 49
danazol cap 50 mg 49
dantrolene sodium cap 100 mg 146
dantrolene sodium cap 25 mg 146
dantrolene sodium cap 50 mg 146
dapagliflozin tab 10 mg 70
dapagliflozin tab 5 mg 70
dapagliflozin-metformin hcl
see XIGDUO XR TAB 2.5-1000 68
dapagliflozin-metformin hcl tab er 24hr 10-1000 mg 67
dapagliflozin-metformin hcl tab er 24hr 10-500 mg 67
dapagliflozin-metformin hcl tab er 24hr 5-1000 mg 67
dapagliflozin-metformin hcl tab er 24hr 5-500 mg 67
dapagliflozin-saxagliptin tab 10-5 mg 67
dapsone gel 5% 119
dapsone gel 7.5% 119
dapsone tab 100 mg 50
dapsone tab 25 mg 50
daridorexant hcl
see QUVIVIQ TAB 25MG 138
see QUVIVIQ TAB 50MG 138
darifenacin hydrobromide tab er 24hr 15 mg (base equiv) 162
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv) 162
darolutamide
see NUBEQA TAB 300MG 83
darunavir tab 600 mg 96
darunavir tab 800 mg 96
darunavir-cobicistat
see PREZCOBIX TAB 800-150 97
darunavir-cobicistat-emtricitabine-tenofovir alafenamide
see SYMTUZA TAB 98
dasatinib tab 100 mg 85
dasatinib tab 140 mg 85
dasatinib tab 20 mg 85

dasatinib tab 50 mg 85
dasatinib tab 70 mg 85
dasatinib tab 80 mg 85
DASETTA 1/35
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg 111
DASETTA 7/7/7
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg 113
DAYSEE
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) 109
DEBLITANE
see Norethindrone Tab 0.35 mg 115
deferasirox granules packet 180 mg 71
deferasirox granules packet 360 mg 71
deferasirox granules packet 90 mg 71
deferasirox tab 180 mg 71
deferasirox tab 360 mg 71
deferasirox tab 90 mg 71
deferasirox tab for oral susp 125 mg 71
deferasirox tab for oral susp 250 mg 71
deferasirox tab for oral susp 500 mg 71
deferiprone tab 1000 mg 71
deferiprone tab 500 mg 71
deflazacort
see EMFLAZA SUS 22.75/ML 116
deflazacort susp 22.75 mg/ml 116
Deflazacort Susp 22.75 mg/ml 116
deflazacort tab 18 mg 116
Deflazacort Tab 18 mg 116
deflazacort tab 30 mg 116
Deflazacort Tab 30 mg 116
deflazacort tab 36 mg 116
Deflazacort Tab 36 mg 116
deflazacort tab 6 mg 116
Deflazacort Tab 6 mg 116
DELYLA
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110
demeclocycline hcl tab 150 mg 158
demeclocycline hcl tab 300 mg 158
DESCOVY TAB 120-15MG 96
DESCOVY TAB 200/25MG 96
desipramine hcl tab 10 mg 66
desipramine hcl tab 100 mg 66
desipramine hcl tab 150 mg 66
desipramine hcl tab 25 mg 66
desipramine hcl tab 50 mg 66
desipramine hcl tab 75 mg 66
desloratadine tab 5 mg 73
desloratadine tab orally disintegrating 2.5 mg 73
desloratadine tab orally disintegrating 5 mg .. 73
desmopressin acetate nasal spray soln 0.01% 129
desmopressin acetate nasal spray soln 0.01% (refrigerated) 129
desmopressin acetate tab 0.1 mg 129
desmopressin acetate tab 0.2 mg 129
Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 107, 108
Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg 108
Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
desonide cream 0.05% 122
desonide lotion 0.05% 122
desonide oint 0.05% 122
desoximetasone cream 0.05% 122
desoximetasone cream 0.25% 122
desoximetasone gel 0.05% 122
desoximetasone oint 0.25% 122
desoximetasone spray 0.25% 122
desvenlafaxine succinate tab er 24hr 100 mg (base equiv) 65
desvenlafaxine succinate tab er 24hr 25 mg (base equiv) 65
desvenlafaxine succinate tab er 24hr 50 mg (base equiv) 65
deucravacitinib
see SOTYKTU TAB 6MG 121
deutetrabenazine
see AUSTEDO TAB 12MG 153
see AUSTEDO TAB 6MG 153
see AUSTEDO TAB 9MG 153
dexamethasone elixir 0.5 mg/5ml 116
dexamethasone sodium phosphate ophth soln 0.1% 149
dexamethasone soln 0.5 mg/5ml 116
dexamethasone tab 0.5 mg 116
dexamethasone tab 0.75 mg 116
dexamethasone tab 1 mg 116
dexamethasone tab 1.5 mg 116

dexamethasone tab 2 mg 116
dexamethasone tab 4 mg 116
dexamethasone tab 6 mg 116
dexamethasone tab therapy pack 1.5 mg (21) 116
Dexamethasone Tab Therapy Pack 1.5 mg (21) 116
dexamethasone tab therapy pack 1.5 mg (35) 116
dexamethasone tab therapy pack 1.5 mg (51) 116
dexmethylphenidate hcl cap er 24 hr 10 mg 34
dexmethylphenidate hcl cap er 24 hr 15 mg 34
dexmethylphenidate hcl cap er 24 hr 20 mg 34
dexmethylphenidate hcl cap er 24 hr 25 mg 34
dexmethylphenidate hcl cap er 24 hr 30 mg 34
dexmethylphenidate hcl cap er 24 hr 35 mg 34
dexmethylphenidate hcl cap er 24 hr 40 mg 34
dexmethylphenidate hcl cap er 24 hr 5 mg 33
dexmethylphenidate hcl tab 10 mg 34
dexmethylphenidate hcl tab 2.5 mg 34
dexmethylphenidate hcl tab 5 mg 34
dextroamphetamine sulfate cap er 24hr 10 mg 28
dextroamphetamine sulfate cap er 24hr 15 mg 28
dextroamphetamine sulfate cap er 24hr 5 mg 28
dextroamphetamine sulfate oral solution 5 mg/5ml 28
Dextroamphetamine Sulfate Oral Solution 5 mg/5ml 28
dextroamphetamine sulfate tab 10 mg 29
Dextroamphetamine Sulfate Tab 10 mg 29
dextroamphetamine sulfate tab 15 mg 29
Dextroamphetamine Sulfate Tab 15 mg 29
dextroamphetamine sulfate tab 2.5 mg 28
Dextroamphetamine Sulfate Tab 2.5 mg 28
dextroamphetamine sulfate tab 20 mg 29
Dextroamphetamine Sulfate Tab 20 mg 29
dextroamphetamine sulfate tab 30 mg 29
Dextroamphetamine Sulfate Tab 30 mg 30
dextroamphetamine sulfate tab 5 mg 29
Dextroamphetamine Sulfate Tab 5 mg 29
dextroamphetamine sulfate tab 7.5 mg 29
Dextroamphetamine Sulfate Tab 7.5 mg 29
dextromethorphan hbr-quinidine sulfate cap 20-10 mg 155
dextromethorphan hydrobromide-bupropion hydrochloride
see AUVELITY TAB 45-105MG 63
DHIVY TAB 25-100MG 91
diazepam (anticonvulsant)
see VALTOCO SPR 10MG 59
see VALTOCO SPR 15MG 59
see VALTOCO SPR 20MG 59
see VALTOCO SPR 5MG 59
diazepam conc 5 mg/ml 53
Diazepam Conc 5 mg/ml 53
DIAZEPAM INTENSOL
see Diazepam Conc 5 mg/ml 53
diazepam oral soln 1 mg/ml 53
diazepam rectal gel delivery system 10 mg 59
diazepam rectal gel delivery system 2.5 mg 58
diazepam rectal gel delivery system 20 mg 59
diazepam tab 10 mg 53
diazepam tab 2 mg 53
diazepam tab 5 mg 53
diazoxide susp 50 mg/ml 68
dichlorphenamide tab 50 mg 126
Dichlorphenamide Tab 50 mg 126
diclofenac epolamine patch 1.3% 120
diclofenac potassium tab 50 mg 39
diclofenac sodium (actinic keratoses) gel 3% 121
diclofenac sodium ophth soln 0.1% 149
diclofenac sodium soln 1.5% 120
diclofenac sodium tab delayed release 25 mg 39
diclofenac sodium tab delayed release 50 mg 39
diclofenac sodium tab delayed release 75 mg 39
diclofenac sodium tab er 24hr 100 mg 40
diclofenac w/ misoprostol tab delayed release 50-0.2 mg 40
diclofenac w/ misoprostol tab delayed release 75-0.2 mg 40
dicloxacillin sodium cap 250 mg 151
dicloxacillin sodium cap 500 mg 151
dicyclomine hcl cap 10 mg 160
dicyclomine hcl oral soln 10 mg/5ml 160
dicyclomine hcl tab 20 mg 160
diethylpropion hcl tab 25 mg 31
diethylpropion hcl tab er 24hr 75 mg 31
diflunisal tab 500 mg 42
difluprednate ophth emulsion 0.05% 149
digoxin
see LANOXIN TAB 0.0625MG 104

digoxin oral soln 0.05 mg/ml 103
digoxin tab 125 mcg (0.125 mg) 103
digoxin tab 250 mcg (0.25 mg) 103
digoxin tab 62.5 mcg (0.0625 mg) 103
diltiazem hcl cap er 12hr 120 mg 101
diltiazem hcl cap er 12hr 60 mg 101
diltiazem hcl cap er 12hr 90 mg 101
diltiazem hcl cap er 24hr 120 mg 101
Diltiazem Hcl Cap Er 24hr 120 mg 101
diltiazem hcl cap er 24hr 180 mg 101
Diltiazem Hcl Cap Er 24hr 180 mg 102
diltiazem hcl cap er 24hr 240 mg 102
Diltiazem Hcl Cap Er 24hr 240 mg 102
diltiazem hcl coated beads cap er 24hr 120 mg 102
Diltiazem Hcl Coated Beads Cap Er 24hr 120 mg 102
diltiazem hcl coated beads cap er 24hr 180 mg 102
Diltiazem Hcl Coated Beads Cap Er 24hr 180 mg 102
diltiazem hcl coated beads cap er 24hr 240 mg 102
Diltiazem Hcl Coated Beads Cap Er 24hr 240 mg 102
diltiazem hcl coated beads cap er 24hr 300 mg 102
Diltiazem Hcl Coated Beads Cap Er 24hr 300 mg 102
diltiazem hcl coated beads cap er 24hr 360 mg 102
diltiazem hcl extended release beads cap er 24hr 120 mg 102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg 102
diltiazem hcl extended release beads cap er 24hr 180 mg 102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg 102
diltiazem hcl extended release beads cap er 24hr 240 mg 102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg 102
diltiazem hcl extended release beads cap er 24hr 300 mg 102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg 102
diltiazem hcl extended release beads cap er 24hr 360 mg 102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg 102
diltiazem hcl extended release beads cap er 24hr 420 mg 102
Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg 102
diltiazem hcl tab 120 mg 103
diltiazem hcl tab 30 mg 102
diltiazem hcl tab 60 mg 102
diltiazem hcl tab 90 mg 102
DILT-XR
see Diltiazem Hcl Cap Er 24hr 120 mg 101
see Diltiazem Hcl Cap Er 24hr 180 mg 102
see Diltiazem Hcl Cap Er 24hr 240 mg 102
dimethyl fumarate capsule delayed release 120 mg 154
dimethyl fumarate capsule delayed release 240 mg 154
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg 154
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml 71
diphenoxylate w/ atropine tab 2.5-0.025 mg . 71
dipyridamole tab 25 mg 135
dipyridamole tab 50 mg 135
dipyridamole tab 75 mg 135
disopyramide phosphate cap 100 mg 53
disopyramide phosphate cap 150 mg 53
disulfiram tab 250 mg 151
disulfiram tab 500 mg 151
divalproex sodium cap delayed release sprinkle 125 mg 62
divalproex sodium tab delayed release 125 mg 63
divalproex sodium tab delayed release 250 mg 63
divalproex sodium tab delayed release 500 mg 63
divalproex sodium tab er 24 hr 250 mg 63
divalproex sodium tab er 24 hr 500 mg 63
dofetilide cap 125 mcg (0.125 mg) 54
dofetilide cap 250 mcg (0.25 mg) 54
dofetilide cap 500 mcg (0.5 mg) 54
DOLISHALE

see Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg 110
dolutegravir sodium
see TIVICAY PD TAB 5MG 98
see TIVICAY TAB 50MG 98
dolutegravir sodium-lamivudine
see DOVATO TAB 50-300MG 96
donepezil hydrochloride orally disintegrating tab 10 mg 152
donepezil hydrochloride orally disintegrating tab 5 mg 152
donepezil hydrochloride tab 10 mg 152
donepezil hydrochloride tab 23 mg 152
donepezil hydrochloride tab 5 mg 152
DOPTELET SPR CAP 10MG 136
DOPTELET TAB 20MG 136
dorzolamide hcl ophth soln 2% 149
dorzolamide hcl-timolol maleate ophth soln 2-0.5% 147
dorzolamide hcl-timolol maleate pf ophth soln 2-0.5% 147
DOTTI
see Estradiol Td Patch Twice Weekly 0.025 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.0375 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.05 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.075 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.1 mg/24hr 130
DOVATO TAB 50-300MG 96
doxazosin mesylate tab 1 mg 77
doxazosin mesylate tab 2 mg 77
doxazosin mesylate tab 4 mg 77
doxazosin mesylate tab 8 mg 77
doxepin hcl (sleep) tab 3 mg (base equiv) 137
doxepin hcl (sleep) tab 6 mg (base equiv) 137
doxepin hcl cap 10 mg 66
doxepin hcl cap 100 mg 66
doxepin hcl cap 150 mg 66
doxepin hcl cap 25 mg 66
doxepin hcl cap 50 mg 66
doxepin hcl cap 75 mg 66
doxepin hcl conc 10 mg/ml 66
doxercalciferol cap 0.5 mcg 128
doxercalciferol cap 1 mcg 128
doxercalciferol cap 2.5 mcg 128
doxycycline (rosacea)
see ORACEA CAP 40MG 125
doxycycline hyclate cap 100 mg 158
doxycycline hyclate cap 50 mg 158
doxycycline hyclate tab 100 mg 158
doxycycline monohydrate cap 100 mg 158
Doxycycline Monohydrate Cap 100 mg 158
doxycycline monohydrate cap 50 mg 158
doxycycline monohydrate for susp 25 mg/5ml 158
doxycycline monohydrate tab 100 mg 158
Doxycycline Monohydrate Tab 100 mg 159
doxycycline monohydrate tab 150 mg 159
doxycycline monohydrate tab 50 mg 158
doxycycline monohydrate tab 75 mg 158
doxylamine-pyridoxine tab delayed release 10-10 mg 72
dronabinol cap 10 mg 72
dronabinol cap 2.5 mg 72
dronabinol cap 5 mg 72
dronedarone hcl
see MULTAQ TAB 400MG 54
drospirenone-ethinyl estradiol tab 3-0.02 mg 108
Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 108
drospirenone-ethinyl estradiol tab 3-0.03 mg 108
Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg 109
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg 108
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg 108
Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg 108
droxidopa cap 100 mg 164
droxidopa cap 200 mg 164
droxidopa cap 300 mg 164
DUAVEE TAB 0.45-20 129
dulaglutide
see TRULICITY INJ 0.75/0.5 69
see TRULICITY INJ 1.5/0.5 69
see TRULICITY INJ 3/0.5 69
see TRULICITY INJ 4.5/0.5 69
duloxetine hcl enteric coated pellets cap 20 mg (base eq) 65
duloxetine hcl enteric coated pellets cap 30 mg (base eq) 65

duloxetine hcl enteric coated pellets cap 40 mg (base eq) 65
duloxetine hcl enteric coated pellets cap 60 mg (base eq) 65
DUREX MIS REALFEEL 139
dust mite mixed allergen extract
see ODACTRA SUB 38
dutasteride cap 0.5 mg 134
dutasteride-tamsulosin hcl cap 0.5-0.4 mg 134
E
E.E.S. 400
see Erythromycin Ethylsuccinate Tab 400 mg 139
EASIVENT MIS 140
EASIVENT MIS MASK LG 140
EASIVENT MIS MASK MED 140
EASIVENT MIS MASK SM 140
econazole nitrate cream 1% 120
edaravone
see RADICAVA ORS SUS 105/5ML 147
see RADICAVA ORS SUS STARTER 147
efavirenz tab 600 mg 96
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg 97
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg 97
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg 97
elafibranor
see IQIRVO TAB 80MG 133
elagolix sodium
see ORILISSA TAB 150MG 127
see ORILISSA TAB 200MG 127
elagolix sodium-estradiol-norethindrone acetate
see ORIAHNN CAP 130
eletriptan hydrobromide tab 20 mg (base equivalent) 142
eletriptan hydrobromide tab 40 mg (base equivalent) 142
eliglustat tartrate
see CERDELGA CAP 84MG 135
ELINEST
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg 114
ELIQUIS CAP 0.15MG 57
ELIQUIS ST P TAB 5MG 57
ELIQUIS TAB 0.5MG 58
ELIQUIS TAB 1.5MG 58
ELIQUIS TAB 2.5MG 58
ELIQUIS TAB 2MG 58
ELIQUIS TAB 5MG 58
ELITE-OB
see Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg 146
ELIXOPHYLLIN
see Theophylline Elixir 80 mg/15ml 57
ELLA TAB 30MG 115
eltrombopag choline
see ALVAIZ TAB 18MG 136
see ALVAIZ TAB 36MG 136
see ALVAIZ TAB 54MG 136
see ALVAIZ TAB 9MG 136
eltrombopag olamine powder pack for susp 12.5 mg (base eq) 136
eltrombopag olamine powder pack for susp 25 mg (base equiv) 137
eltrombopag olamine tab 12.5 mg (base equiv) 137
eltrombopag olamine tab 25 mg (base equiv) 137
eltrombopag olamine tab 50 mg (base equiv) 137
eltrombopag olamine tab 75 mg (base equiv) 137
ELURYNG
see Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr 115
eluxadoline
see VIBERZI TAB 100MG 133
see VIBERZI TAB 75MG 133
elvitegravir-cobicistat-emtricitabine-tenofovir alafenamide
see GENVOYA TAB 97
EMBECTA INSULIN PEN NEEDLES - OTC 140
EMBECTA INSULIN SYRINGE - OTC 140
EMBECTA INSULIN SYRINGE - RX 140
EMFLAZA SUS 22.75/ML 116
empagliflozin
see JARDIANCE TAB 10MG 70
see JARDIANCE TAB 25MG 70
empagliflozin-linagliptin
see GLYXAMBI TAB 10-5 MG 67
see GLYXAMBI TAB 25-5 MG 67

empagliflozin-linagliptin-metformin
see TRIJARDY XR TAB 68
empagliflozin-metformin hcl
see SYNJARDY TAB 67
see SYNJARDY TAB 12.5-500 67
see SYNJARDY TAB 5-1000MG 67
see SYNJARDY TAB 5-500MG 67
see SYNJARDY XR TAB 67
see SYNJARDY XR TAB 10-1000 67
see SYNJARDY XR TAB 25-1000 68
see SYNJARDY XR TAB 5-1000MG 67
emtricitabine caps 200 mg 97
emtricitabine-rilpivirine-tenofovir alafenamide fumarate
see ODEFSEY TAB 97
emtricitabine-rilpivirine-tenofovir df tab 200-25-300 mg 97
emtricitabine-tenofovir alafenamide fumarate
see DESCOVY TAB 120-15MG 96
see DESCOVY TAB 200/25MG 96
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg 97
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg 97
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg 97
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg 97
EMVERM CHW 100MG 50
EMZAHH
see Norethindrone Tab 0.35 mg 115
enalapril maleate & hydrochlorothiazide tab 10-25 mg 79
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg 79
enalapril maleate oral soln 1 mg/ml 76
enalapril maleate tab 10 mg 76
enalapril maleate tab 2.5 mg 76
enalapril maleate tab 20 mg 76
enalapril maleate tab 5 mg 76
ENCARE SUP 100MG 163
encorafenib
see BRAFTOVI CAP 75MG 85
ENDOCET
see Oxycodone W/ Acetaminophen Tab 10-325 mg 47
see Oxycodone W/ Acetaminophen Tab 2.5-325 mg 47
see Oxycodone W/ Acetaminophen Tab 5-325 mg 47
see Oxycodone W/ Acetaminophen Tab 7.5-325 mg 47
ENILLORING
see Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr 115
ENSKYCE
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
ENSTILAR AER 122
entacapone tab 200 mg 90
entecavir tab 0.5 mg 98
entecavir tab 1 mg 98
entrectinib
see ROZLYTREK CAP 100MG 88
see ROZLYTREK CAP 200MG 89
see ROZLYTREK PAK 50MG 89
ENULOSE
see Lactulose (Encephalopathy) Solution 10 gm/15ml 132
enzalutamide
see XTANDI CAP 40MG 83
see XTANDI TAB 40MG 84
see XTANDI TAB 80MG 84
EPCLUSA PAK 150-37.5 98
EPCLUSA PAK 200-50MG 98
EPCLUSA TAB 200-50MG 98
EPCLUSA TAB 400-100 98
epinastine hcl ophth soln 0.05% 149
epinephrine (anaphylaxis)
see AUVI-Q INJ 0.15MG 163
see AUVI-Q INJ 0.1MG 163
see AUVI-Q INJ 0.3MG 163
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000) 164
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000) 164
eplerenone tab 25 mg 80
eplerenone tab 50 mg 80
EQ NICOTINE
see Nicotine Td Patch 24hr 14 mg/24hr 157
see Nicotine Td Patch 24hr 21 mg/24hr 157
EQ NICOTINE LOZENGES
see Nicotine Polacrilex Lozenge 4 mg 156

EQ NICOTINE POLACRILEX
see Nicotine Polacrilex Gum 2 mg 155
see Nicotine Polacrilex Gum 4 mg 156
see Nicotine Polacrilex Lozenge 2 mg 156
see Nicotine Polacrilex Lozenge 4 mg 156
EQ NICOTINE STEP 3
see Nicotine Td Patch 24hr 7 mg/24hr 157
ergocalciferol cap 1.25 mg (50000 unit) 164
ergotamine w/ caffeine tab 1-100 mg 141
ERIVEDGE CAP 150MG 83
ERLEADA TAB 240MG 83
ERLEADA TAB 60MG 83
erlotinib hcl tab 100 mg (base equivalent) 82
erlotinib hcl tab 150 mg (base equivalent) 83
erlotinib hcl tab 25 mg (base equivalent) 82
ERRIN
see Norethindrone Tab 0.35 mg 115
ERY
see Erythromycin Pads 2% 119
erythromycin ethylsuccinate for susp 200 mg/5ml 139
erythromycin ethylsuccinate for susp 400 mg/5ml 139
Erythromycin Ethylsuccinate Tab 400 mg 139
erythromycin gel 2% 119
erythromycin ophth oint 5 mg/gm 148
Erythromycin Pads 2% 119
erythromycin soln 2% 119
erythromycin tab 250 mg 139
erythromycin tab 500 mg 139
erythromycin tab delayed release 250 mg 139
erythromycin tab delayed release 333 mg 139
erythromycin tab delayed release 500 mg 139
erythromycin w/ delayed release particles cap 250 mg 139
escitalopram oxalate soln 5 mg/5ml (base equiv) 63
escitalopram oxalate tab 10 mg (base equiv) . 64
escitalopram oxalate tab 20 mg (base equiv) . 64
escitalopram oxalate tab 5 mg (base equiv) ... 64
eslicarbazepine acetate tab 200 mg 59
eslicarbazepine acetate tab 400 mg 59
eslicarbazepine acetate tab 600 mg 59
eslicarbazepine acetate tab 800 mg 59
esomeprazole magnesium cap delayed release 20 mg (base eq) 161
esomeprazole magnesium cap delayed release 40 mg (base eq) 161
esomeprazole magnesium for delayed release susp pack 2.5 mg 161
esomeprazole magnesium for delayed release susp packet 10 mg 161
esomeprazole magnesium for delayed release susp packet 20 mg 161
esomeprazole magnesium for delayed release susp packet 40 mg 161
esomeprazole magnesium for delayed release susp packet 5 mg 161
ESTARYLLA
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg 114
estazolam tab 1 mg 137
estazolam tab 2 mg 137
estradiol & norethindrone acetate
see COMBIPATCH DIS 129
estradiol & norethindrone acetate tab 0.5-0.1 mg 129
Estradiol & Norethindrone Acetate Tab 0.5-0.1 mg 129
estradiol & norethindrone acetate tab 1-0.5 mg 129
Estradiol & Norethindrone Acetate Tab 1-0.5 mg 130
estradiol gel 0.06% (0.75 mg/1.25 gm metered-dose pump) 130
estradiol tab 0.5 mg 130
estradiol tab 1 mg 130
estradiol tab 2 mg 130
estradiol td gel 0.25 mg/0.25gm (0.1%) 130
estradiol td gel 0.5 mg/0.5gm (0.1%) 130
estradiol td gel 0.75 mg/0.75gm (0.1%) 130
estradiol td gel 1 mg/gm (0.1%) 130
estradiol td gel 1.25 mg/1.25gm (0.1%) 130
estradiol td patch twice weekly 0.025 mg/24hr 131
Estradiol Td Patch Twice Weekly 0.025 mg/24hr 131
estradiol td patch twice weekly 0.0375 mg/24hr 131
Estradiol Td Patch Twice Weekly 0.0375 mg/24hr 131
estradiol td patch twice weekly 0.05 mg/24hr 131

Estradiol Td Patch Twice Weekly 0.05 mg/24hr 131
estradiol td patch twice weekly 0.075 mg/24hr 131
Estradiol Td Patch Twice Weekly 0.075 mg/24hr 131
estradiol td patch twice weekly 0.1 mg/24hr 130
Estradiol Td Patch Twice Weekly 0.1 mg/24hr 130, 131
estradiol td patch weekly 0.025 mg/24hr 131
estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr) 131
estradiol td patch weekly 0.05 mg/24hr 131
estradiol td patch weekly 0.06 mg/24hr 131
estradiol td patch weekly 0.075 mg/24hr 131
estradiol td patch weekly 0.1 mg/24hr 131
estradiol vaginal
see IMVEXXY MAIN SUP 10MCG 163
see IMVEXXY MAIN SUP 4MCG 163
see IMVEXXY STRT SUP 10MCG 163
see IMVEXXY STRT SUP 4MCG 163
see VAGIFEM TAB 10MCG 163
estradiol vaginal cream 0.01% 163
estradiol valerate-dienogest
see NATAZIA TAB 111
estradiol-progesterone
see BIJUVA CAP 0.5-100 129
see BIJUVA CAP 1-100MG 129
estrogens, conjugated tab 0.3 mg 131
estrogens, conjugated tab 0.45 mg 131
estrogens, conjugated tab 0.625 mg 131
estrogens, conjugated tab 0.9 mg 131
estrogens, conjugated tab 1.25 mg 131
eszopiclone tab 1 mg 137
eszopiclone tab 2 mg 137
eszopiclone tab 3 mg 137
ethacrynic acid tab 25 mg 126
ethambutol hcl tab 100 mg 81
ethambutol hcl tab 400 mg 81
ethosuximide cap 250 mg 62
ethosuximide soln 250 mg/5ml 62
Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg 109
Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-50 mcg 109
etodolac cap 200 mg 40
etodolac cap 300 mg 40
etodolac tab 400 mg 40
etodolac tab 500 mg 40
etodolac tab er 24hr 400 mg 40
etodolac tab er 24hr 500 mg 40
etodolac tab er 24hr 600 mg 40
etonogestrel-ethinyl estradiol va ring 0.12-0.015 mg/24hr 115
Etonogestrel-Ethinyl Estradiol Va Ring 0.12-0.015 mg/24hr 115
etoposide cap 50 mg 90
etrasimod arginine
see VELSIPITY TAB 2MG 132
etravirine tab 100 mg 97
etravirine tab 200 mg 97
EUCRISA OIN 2% 124
everolimus tab 0.25 mg 144
everolimus tab 0.5 mg 144
everolimus tab 0.75 mg 144
everolimus tab 1 mg 144
everolimus tab 10 mg 86
Everolimus Tab 10 mg 86
everolimus tab 2.5 mg 85
Everolimus Tab 2.5 mg 85
everolimus tab 5 mg 86
Everolimus Tab 5 mg 86
everolimus tab 7.5 mg 86
Everolimus Tab 7.5 mg 86
everolimus tab for oral susp 2 mg 86
everolimus tab for oral susp 3 mg 86
everolimus tab for oral susp 5 mg 86
exemestane tab 25 mg 83
ezetimibe tab 10 mg 75
ezetimibe-simvastatin tab 10-10 mg 73
ezetimibe-simvastatin tab 10-20 mg 73
ezetimibe-simvastatin tab 10-40 mg 73
ezetimibe-simvastatin tab 10-80 mg 74
F
FA-8
see Folic Acid Cap 0.8 mg 135
FALMINA
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110
famciclovir tab 125 mg 99
famciclovir tab 250 mg 99
famciclovir tab 500 mg 99
famotidine for susp 40 mg/5ml 161
famotidine tab 20 mg 161

famotidine tab 40 mg 161
FC2 FEMALE MIS CONDOM 139
febuxostat tab 40 mg 134
febuxostat tab 80 mg 134
FEIRZA 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 113
FEIRZA 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
felbamate susp 600 mg/5ml 62
felbamate tab 400 mg 62
felbamate tab 600 mg 62
felodipine tab er 24hr 10 mg 103
felodipine tab er 24hr 2.5 mg 103
felodipine tab er 24hr 5 mg 103
fenofibrate cap 150 mg 74
fenofibrate micronized cap 134 mg 74
fenofibrate micronized cap 200 mg 74
fenofibrate micronized cap 43 mg 74
fenofibrate micronized cap 67 mg 74
fenofibrate tab 145 mg 74
fenofibrate tab 160 mg 74
fenofibrate tab 48 mg 74
fenofibrate tab 54 mg 74
fenofibric acid tab 105 mg 74
fenofibric acid tab 35 mg 74
fentanyl td patch 72hr 100 mcg/hr 42
fentanyl td patch 72hr 12 mcg/hr 42
fentanyl td patch 72hr 25 mcg/hr 42
fentanyl td patch 72hr 37.5 mcg/hr 42
fentanyl td patch 72hr 50 mcg/hr 42
fentanyl td patch 72hr 62.5 mcg/hr 42
fentanyl td patch 72hr 75 mcg/hr 42
fentanyl td patch 72hr 87.5 mcg/hr 42
ferric citrate
see AURYXIA TAB 210MG 133
ferric citrate tab 1 gm (210 mg ferric iron) 133
fesoterodine fumarate tab er 24hr 4 mg 162
fesoterodine fumarate tab er 24hr 8 mg 162
FIASP FLEX INJ TOUCH 69
FIASP INJ 100/ML 69
FIASP PENFIL INJ U-100 69
fidaxomicin tab 200 mg 139
FILSPARI TAB 200MG 133
FILSPARI TAB 400MG 133
FINACEA AER 15% 124
finasteride tab 1 mg 124
finasteride tab 5 mg 134
finerenone
see KERENDIA TAB 10MG 129
see KERENDIA TAB 20MG 129
see KERENDIA TAB 40MG 129
fingolimod hcl cap 0.5 mg (base equiv) 154
FINZALA
see Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24) 113
flavoxate hcl tab 100 mg 163
flecainide acetate tab 100 mg 53
flecainide acetate tab 150 mg 53
flecainide acetate tab 50 mg 53
FLEXICHAMBER MIS 141
FLEXICHAMBER MIS MASK LRG 141
FLEXICHAMBER MIS MASK SM 141
flibanserin
see ADDYI TAB 100MG 153
fluconazole for susp 10 mg/ml 72
fluconazole for susp 40 mg/ml 72
fluconazole tab 100 mg 72
fluconazole tab 150 mg 72
fluconazole tab 200 mg 72
fluconazole tab 50 mg 72
flucytosine cap 250 mg 72
fludrocortisone acetate tab 0.1 mg 117
flunisolide nasal soln 25 mcg/act (0.025%) 147
fluocinolone acetonide (otic) oil 0.01% 150
fluocinolone acetonide cream 0.01% 122
fluocinolone acetonide cream 0.025% 122
fluocinolone acetonide oil 0.01% (body oil) 123
fluocinolone acetonide oil 0.01% (scalp oil) 123
fluocinolone acetonide oint 0.025% 123
fluocinolone acetonide soln 0.01% 123
fluocinonide cream 0.05% 123
fluocinonide emulsified base cream 0.05% 123
fluocinonide gel 0.05% 123
fluocinonide oint 0.05% 123
fluocinonide soln 0.05% 123
fluorometholone ophth susp 0.1% 149
fluorouracil cream 5% 121
fluorouracil soln 2% 121
fluorouracil soln 5% 121
fluoxetine hcl cap 10 mg 64
fluoxetine hcl cap 20 mg 64
fluoxetine hcl cap 40 mg 64

fluoxetine hcl cap delayed release 90 mg 64
fluoxetine hcl solution 20 mg/5ml 64
fluoxetine hcl tab 10 mg 64
fluoxetine hcl tab 20 mg 64
fluphenazine hcl elixir 2.5 mg/5ml 95
fluphenazine hcl oral conc 5 mg/ml 95
fluphenazine hcl tab 1 mg 95
fluphenazine hcl tab 10 mg 95
fluphenazine hcl tab 2.5 mg 95
fluphenazine hcl tab 5 mg 95
flurbiprofen sodium ophth soln 0.03% 149
flurbiprofen tab 100 mg 40
flurbiprofen tab 50 mg 40
fluticasone furoate aerosol powder breath activ 100 mcg/act 55
fluticasone furoate aerosol powder breath activ 200 mcg/act 55
fluticasone furoate aerosol powder breath activ 50 mcg/act 55
fluticasone furoate-vilanterol
see BREO ELLIPTA INH 100-25 56
see BREO ELLIPTA INH 200-25 56
see BREO ELLIPTA INH 50-25MCG 56
fluticasone propionate (nasal)
see XHANCE MIS 93MCG 147
fluticasone propionate cream 0.05% 123
fluticasone propionate hfa inhal aer 110 mcg/act 55
fluticasone propionate hfa inhal aer 220 mcg/act 55
fluticasone propionate hfa inhal aero 44 mcg/act 55
fluticasone propionate lotion 0.05% 123
fluticasone propionate nasal susp 50 mcg/act 147
fluticasone propionate oint 0.005% 123
fluticasone-salmeterol aer powder ba 100-50 mcg/act 56
Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act 56
fluticasone-salmeterol aer powder ba 250-50 mcg/act 56
Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act 56
fluticasone-salmeterol aer powder ba 500-50 mcg/act 56
Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act 56
fluticasone-umeclidinium-vilanterol
see TRELEGY AER 100MCG 57
see TRELEGY AER 200MCG 57
fluvastatin sodium cap 20 mg (base equivalent) 75
fluvastatin sodium cap 40 mg (base equivalent) 75
fluvastatin sodium tab er 24 hr 80 mg (base equivalent) 75
fluvoxamine maleate cap er 24hr 100 mg 64
fluvoxamine maleate cap er 24hr 150 mg 64
fluvoxamine maleate tab 100 mg 64
fluvoxamine maleate tab 25 mg 64
fluvoxamine maleate tab 50 mg 64
FOLATE
see Folic Acid Tab 400 mcg 135
folic acid cap 0.8 mg 135
Folic Acid Cap 0.8 mg 135
folic acid tab 1 mg 135
folic acid tab 400 mcg 135
Folic Acid Tab 400 mcg 135, 136
folic acid tab 800 mcg 136
Folic Acid Tab 800 mcg 136
formoterol fumarate soln nebu 20 mcg/2ml ... 56
fosamprenavir calcium tab 700 mg (base equiv) 97
fosfomycin tromethamine powd pack 3 gm (base equivalent) 51
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg 79
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg 79
fosinopril sodium tab 10 mg 76
fosinopril sodium tab 20 mg 76
fosinopril sodium tab 40 mg 76
FOUNDAYO TAB 0.8MG 31
FOUNDAYO TAB 14.5MG 32
FOUNDAYO TAB 17.2MG 32
FOUNDAYO TAB 2.5MG 31
FOUNDAYO TAB 5.5MG 32
FOUNDAYO TAB 9MG 32
frovatriptan succinate tab 2.5 mg (base equivalent) 142
furosemide oral soln 10 mg/ml 126
furosemide oral soln 8 mg/ml 126

furosemide tab 20 mg 126
furosemide tab 40 mg 126
furosemide tab 80 mg 126
FYAVOLV
see Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg 130
see Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg 130
G
gabapentin (once-daily)
see GRALISE TAB 300MG 155
see GRALISE TAB 450MG 155
see GRALISE TAB 600MG 155
see GRALISE TAB 750MG 155
see GRALISE TAB 900MG 155
gabapentin (once-daily) tab 300 mg 155
gabapentin (once-daily) tab 450 mg 155
gabapentin (once-daily) tab 600 mg 155
gabapentin (once-daily) tab 750 mg 155
gabapentin (once-daily) tab 900 mg 155
gabapentin cap 100 mg 59
gabapentin cap 200 mg 59
gabapentin cap 300 mg 59
gabapentin cap 400 mg 59
gabapentin oral soln 250 mg/5ml 59
gabapentin tab 600 mg 59
gabapentin tab 800 mg 59
GALAFOLD CAP 123MG 128
galantamine hydrobromide cap er 24hr 16 mg 152
galantamine hydrobromide cap er 24hr 24 mg 152
galantamine hydrobromide cap er 24hr 8 mg 152
galantamine hydrobromide oral soln 4 mg/ml 152
galantamine hydrobromide tab 12 mg 152
galantamine hydrobromide tab 4 mg 152
galantamine hydrobromide tab 8 mg 152
GALBRIELA
see Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg 111
GALLIFREY
see Norethindrone Acetate Tab 5 mg 151
gatifloxacin ophth soln 0.5% 148
GAVILYTE-C
see Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm 138
GAVILYTE-G
see Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm 138
GAVILYTE-N/FLAVOR PACK
see Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm 138
GAVRETO CAP 100MG 86
gefitinib tab 250 mg 83
gemfibrozil tab 600 mg 74
GEMMILY
see Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24) 113
GEMTESA TAB 75MG 162
GENGRAF
see Cyclosporine Modified Cap 100 mg 144
see Cyclosporine Modified Cap 25 mg 144
gentamicin sulfate cream 0.1% 120
gentamicin sulfate oint 0.1% 120
gentamicin sulfate ophth soln 0.3% 148
GENVOYA TAB 97
gilteritinib fumarate
see XOSPATA TAB 40MG 90
GLARGIN YFGN INJ 100U/ML 69
GLARGIN YFGN SOL 100U/ML 69
glecaprevir-pibrentasvir
see MAVYRET PAK 50-20MG 99
see MAVYRET TAB 100-40MG 99
GLEOSTINE CAP 40MG 82
glimepiride tab 1 mg 70
glimepiride tab 2 mg 70
glimepiride tab 4 mg 70
glipizide tab 10 mg 71
glipizide tab 15 mg 71
glipizide tab 5 mg 71
glipizide tab er 24hr 10 mg 71
glipizide tab er 24hr 2.5 mg 71
glipizide tab er 24hr 5 mg 71
glipizide-metformin hcl tab 2.5-250 mg 67
glipizide-metformin hcl tab 2.5-500 mg 67
glipizide-metformin hcl tab 5-500 mg 67
glucagon
see BAQSIMI ONE POW 3MG/DOSE 68
see BAQSIMI TWO POW 3MG/DOSE 68
see GVOKE HYPO 1 INJ 0.5/.1ML 68
see GVOKE HYPO 1 INJ 1/0.2ML 68

see GVOKE HYPO 2 INJ 0.5/.1ML 68
see GVOKE HYPO 2 INJ 1/0.2ML 68
see GVOKE KIT SOL 1/0.2ML 68
see GVOKE PFS INJ 1/0.2ML 68
glucagon for inj 1 mg 68
glyburide tab 1.25 mg 71
glyburide tab 2.5 mg 71
glyburide tab 5 mg 71
glyburide-metformin tab 1.25-250 mg 67
glyburide-metformin tab 2.5-500 mg 67
glyburide-metformin tab 5-500 mg 67
glycerol phenylbutyrate liquid 1.1 gm/ml 128
glycopyrrolate oral soln 1 mg/5ml 160
glycopyrrolate tab 1 mg 160
glycopyrrolate tab 2 mg 160
GLYXAMBI TAB 10-5 MG 67
GLYXAMBI TAB 25-5 MG 67
GNP FOLIC ACID
see Folic Acid Tab 400 mcg 136
GNP NICOTINE TRANSDERMAL
see Nicotine Td Patch 24hr 14 mg/24hr 157
see Nicotine Td Patch 24hr 21 mg/24hr 157
see Nicotine Td Patch 24hr 7 mg/24hr 157
GOMEKLI CAP 1MG 86
GOMEKLI CAP 2MG 86
GOMEKLI TAB 1MG 86
GOODSENSE NICOTINE
see Nicotine Polacrilex Lozenge 2 mg 156
see Nicotine Polacrilex Lozenge 4 mg 157
GOODSENSE NICOTINE POLACR
see Nicotine Polacrilex Gum 2 mg 155
see Nicotine Polacrilex Gum 4 mg 156
see Nicotine Polacrilex Lozenge 4 mg 157
GRALISE TAB 300MG 155
GRALISE TAB 450MG 155
GRALISE TAB 600MG 155
GRALISE TAB 750MG 155
GRALISE TAB 900MG 155
granisetron
see SANCUSO DIS 3.1MG 72
granisetron hcl tab 1 mg 71
grass mixed pollens allergen extract
see ORALAIR SUB 300 IR 38
GRASTEK SUB 2800BAU 38
griseofulvin microsize susp 125 mg/5ml 72
griseofulvin microsize tab 500 mg 72
griseofulvin ultramicrosize tab 125 mg 72
griseofulvin ultramicrosize tab 165 mg 72
griseofulvin ultramicrosize tab 250 mg 72
guanfacine hcl tab 1 mg 78
guanfacine hcl tab 2 mg 78
guanfacine hcl tab er 24hr 1 mg (base equiv) . 33
guanfacine hcl tab er 24hr 2 mg (base equiv) . 33
guanfacine hcl tab er 24hr 3 mg (base equiv) . 33
guanfacine hcl tab er 24hr 4 mg (base equiv) . 33
GVOKE HYPO 1 INJ 0.5/.1ML 68
GVOKE HYPO 1 INJ 1/0.2ML 68
GVOKE HYPO 2 INJ 0.5/.1ML 68
GVOKE HYPO 2 INJ 1/0.2ML 68
GVOKE KIT SOL 1/0.2ML 68
GVOKE PFS INJ 1/0.2ML 68
GYNOL II GEL 3% 163
H
HAILEY 1.5/30
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
HAILEY 24 FE
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113
HAILEY FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 113
HAILEY FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
halcinonide soln 0.1% 123
halobetasol propionate
see BRYHALI LOT 0.01% 122
halobetasol propionate cream 0.05% 123
halobetasol propionate foam 0.05% 123
halobetasol propionate oint 0.05% 123
haloperidol lactate oral conc 2 mg/ml 94
haloperidol tab 0.5 mg 94
haloperidol tab 1 mg 94
haloperidol tab 10 mg 94
haloperidol tab 2 mg 94
haloperidol tab 20 mg 94
haloperidol tab 5 mg 94
HARVONI PAK 98
HARVONI PAK 45-200MG 98
HARVONI TAB 45-200MG 99
HARVONI TAB 90-400MG 99
HEATHER
see Norethindrone Tab 0.35 mg 115

HIDEX 6-DAY
see Dexamethasone Tab Therapy Pack 1.5 mg (21) 116
HOLD CHAMBER MIS ADLT LG 141
HOLD CHAMBER MIS MEDIUM 141
HOLD CHAMBER MIS SMALL 141
HUMULIN R INJ U-500KWP 69
hydralazine hcl tab 10 mg 80
hydralazine hcl tab 100 mg 80
hydralazine hcl tab 25 mg 80
hydralazine hcl tab 50 mg 80
hydrochlorothiazide cap 12.5 mg 127
hydrochlorothiazide tab 12.5 mg 127
hydrochlorothiazide tab 25 mg 127
hydrochlorothiazide tab 50 mg 127
hydrocod polst-chlorphen polst er susp 10-8 mg/5ml 118
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml 117
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg 117
hydrocodone bitartrate cap er 12hr 10 mg 42
hydrocodone bitartrate cap er 12hr 15 mg 42
hydrocodone bitartrate cap er 12hr 20 mg 42
hydrocodone bitartrate cap er 12hr 30 mg 42
hydrocodone bitartrate cap er 12hr 40 mg 42
hydrocodone bitartrate cap er 12hr 50 mg 42
hydrocodone bitartrate tab er 24hr deter 100 mg 42
hydrocodone bitartrate tab er 24hr deter 120 mg 42
hydrocodone bitartrate tab er 24hr deter 20 mg 42
hydrocodone bitartrate tab er 24hr deter 30 mg 42
hydrocodone bitartrate tab er 24hr deter 40 mg 42
hydrocodone bitartrate tab er 24hr deter 60 mg 42
hydrocodone bitartrate tab er 24hr deter 80 mg 42
hydrocodone-acetaminophen soln 10-300 mg/15ml 46
hydrocodone-acetaminophen soln 7.5-325 mg/15ml 46
hydrocodone-acetaminophen tab 10-300 mg . 46
hydrocodone-acetaminophen tab 10-325 mg . 46
hydrocodone-acetaminophen tab 2.5-325 mg 46
hydrocodone-acetaminophen tab 5-300 mg ... 46
hydrocodone-acetaminophen tab 5-325 mg ... 46
hydrocodone-acetaminophen tab 7.5-300 mg 46
hydrocodone-acetaminophen tab 7.5-325 mg 46
hydrocodone-ibuprofen tab 10-200 mg 47
hydrocodone-ibuprofen tab 5-200 mg 46
hydrocodone-ibuprofen tab 7.5-200 mg 46
hydrocortisone acetate (intrarectal)
see CORTIFOAM AER 90MG 49
hydrocortisone acetate cream 2.5% 123
hydrocortisone acetate w/ pramoxine
see PROCTOFOAM AER HC 1% 49
hydrocortisone acetate w/ pramoxine perianal cream 1-1% 49
hydrocortisone butyrate cream 0.1% 123
hydrocortisone butyrate oint 0.1% 123
hydrocortisone butyrate soln 0.1% 123
hydrocortisone cream 1% 123
Hydrocortisone Cream 1% 123
hydrocortisone cream 2.5% 123
hydrocortisone enema 100 mg/60ml 49
hydrocortisone lotion 2.5% 123
hydrocortisone oint 1% 123
hydrocortisone oint 2.5% 123
hydrocortisone perianal cream 1% 49
Hydrocortisone Perianal Cream 1% 49
hydrocortisone perianal cream 2.5% 49
Hydrocortisone Perianal Cream 2.5% 49
Hydrocortisone Soln 2.5% 123
hydrocortisone tab 10 mg 116
hydrocortisone tab 20 mg 116
hydrocortisone tab 5 mg 116
hydrocortisone valerate cream 0.2% 123
hydrocortisone valerate oint 0.2% 123
hydrocortisone w/ acetic acid otic soln 1-2% 150
hydromorphone hcl liqd 1 mg/ml 42
hydromorphone hcl tab 2 mg 43
hydromorphone hcl tab 4 mg 43
hydromorphone hcl tab 8 mg 43
hydromorphone hcl tab er 24hr 12 mg 43
hydromorphone hcl tab er 24hr 16 mg 43
hydromorphone hcl tab er 24hr 32 mg 43
hydromorphone hcl tab er 24hr 8 mg 43
hydroxychloroquine sulfate tab 100 mg 81
hydroxychloroquine sulfate tab 200 mg 81
hydroxychloroquine sulfate tab 300 mg 81

hydroxychloroquine sulfate tab 400 mg 81
hydroxyurea (sickle cell disease)
see SIKLOS TAB 1000MG 135
see SIKLOS TAB 100MG 135
hydroxyurea cap 500 mg 90
hydroxyzine hcl syrup 10 mg/5ml 52
hydroxyzine hcl tab 10 mg 52
hydroxyzine hcl tab 25 mg 52
hydroxyzine hcl tab 50 mg 52
hydroxyzine pamoate cap 100 mg 52
hydroxyzine pamoate cap 25 mg 52
hydroxyzine pamoate cap 50 mg 52
hyoscyamine sulfate elixir 0.125 mg/5ml 160
Hyoscyamine Sulfate Elixir 0.125 mg/5ml 160
hyoscyamine sulfate sl tab 0.125 mg 160
hyoscyamine sulfate soln 0.125 mg/ml 161
Hyoscyamine Sulfate Soln 0.125 mg/ml 161
hyoscyamine sulfate tab 0.125 mg 161
hyoscyamine sulfate tab disint 0.125 mg 161
HYOSYNE
see Hyoscyamine Sulfate Elixir 0.125 mg/5ml 160
see Hyoscyamine Sulfate Soln 0.125 mg/ml 161
I
ibandronate sodium tab 150 mg (base equivalent) 127
IBRANCE CAP 125MG 86
IBRANCE TAB 100MG 86
IBRANCE TAB 125MG 86
IBRANCE TAB 75MG 86
IBTROZI CAP 200MG 86
IBU
see Ibuprofen Tab 400 mg 40
see Ibuprofen Tab 600 mg 40
see Ibuprofen Tab 800 mg 40
ibuprofen susp 100 mg/5ml 40
ibuprofen tab 400 mg 40
Ibuprofen Tab 400 mg 40
ibuprofen tab 600 mg 40
Ibuprofen Tab 600 mg 40
ibuprofen tab 800 mg 40
Ibuprofen Tab 800 mg 40
ibuprofen-famotidine tab 800-26.6 mg 40
ICLEVIA
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg 109
icosapent ethyl
see VASCEPA CAP 0.5GM 74
see VASCEPA CAP 1GM 74
icotrokinra hcl
see ICOTYDE TAB 200MG 121
ICOTYDE TAB 200MG 121
ILEVRO DRO 0.3% OP 149
imatinib mesylate tab 100 mg (base equivalent) 86
imatinib mesylate tab 400 mg (base equivalent) 87
imipramine hcl tab 10 mg 66
imipramine hcl tab 25 mg 66
imipramine hcl tab 50 mg 66
imipramine pamoate cap 100 mg 66
imipramine pamoate cap 125 mg 66
imipramine pamoate cap 150 mg 66
imipramine pamoate cap 75 mg 66
imiquimod cream 3.75% 124
imiquimod cream 5% 124
IMITREX INJ 4MG/0.5 142
IMITREX INJ 6MG/0.5 142
IMVEXXY MAIN SUP 10MCG 163
IMVEXXY MAIN SUP 4MCG 163
IMVEXXY STRT SUP 10MCG 163
IMVEXXY STRT SUP 4MCG 163
INBRIJA CAP 42MG 91
INCASSIA
see Norethindrone Tab 0.35 mg 115
indapamide tab 1.25 mg 127
indapamide tab 2.5 mg 127
indomethacin cap 25 mg 40
indomethacin cap 50 mg 40
indomethacin cap er 75 mg 40
indomethacin suppos 50 mg 40
indomethacin susp 25 mg/5ml 40
INGREZZA CAP 40-80MG 153
INGREZZA CAP 40MG 153
INGREZZA CAP 60MG 153
INGREZZA CAP 80MG 154
INLYTA TAB 1MG 82
INLYTA TAB 5MG 82
INSPIREASE MIS DD SYST 141
insulin aspart
see NOVOLOG INJ 100/ML 70
see NOVOLOG INJ FLEXPEN 70
see NOVOLOG INJ PENFILL 70
insulin aspart (with niacinamide)

see FIASP FLEX INJ TOUCH 69
see FIASP INJ 100/ML 69
see FIASP PENFIL INJ U-100 69
insulin aspart protamine & aspart (human)
see NOVOLOG MIX INJ 70/30 70
see NOVOLOG MIX INJ FLEXPEN 70
insulin degludec
see TRESIBA FLEX INJ 100UNIT 70
see TRESIBA FLEX INJ 200UNIT 70
see TRESIBA INJ 100UNIT 70
insulin degludec-liraglutide
see XULTOPHY INJ 100/3.6 68
insulin glargine
see LANTUS INJ 100/ML 69
see LANTUS SOLOS INJ 100/ML 70
see TOUJEO MAX INJ 300/ML 70
see TOUJEO SOLO INJ 300/ML 70
insulin glargine-lixisenatide
see SOLIQUA INJ 100/33 67
insulin icodec-abae
see AWIQLI FLEX INJ 700UNIT 69
insulin nph (human) (isophane)
see NOVOLIN N INJ 100 UNIT 70
see NOVOLIN N INJ U-100 70
insulin nph isophane & reg (human)
see NOVOLIN INJ 70/30 70
see NOVOLIN INJ 70/30 FP 70
insulin pen needle
see BD INSULIN PEN NEEDLES - OTC 139
see EMBECTA INSULIN PEN NEEDLES - OTC 140
insulin regular (human)
see AFREZZA POW 12 UNIT 69
see AFREZZA POW 4-8 UNIT 69
see AFREZZA POW 4-8-12 69
see AFREZZA POW 4UNIT 69
see AFREZZA POW 8 UNIT 69
see AFREZZA POW 8-12UNIT 69
see HUMULIN R INJ U-500KWP 69
see NOVOLIN R INJ 100 UNIT 70
see NOVOLIN R INJ U-100 70
insulin syringe/needle u-100
see BD INSULIN SYRINGE - RX 139
see EMBECTA INSULIN SYRINGE - OTC 140
insulin syringe/needle u-500
see EMBECTA INSULIN SYRINGE - RX 140
insulin syringes (disposable)
see BD INSULIN SYRINGE - OTC 139
INTRAROSA SUP 6.5MG 163
INTROVALE
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg 109
ipratropium bromide hfa inhal aerosol 17 mcg/act 54
ipratropium bromide inhal soln 0.02% 54
ipratropium bromide nasal soln 0.03% (21 mcg/spray) 147
ipratropium bromide nasal soln 0.06% (42 mcg/spray) 147
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml 56
IQIRVO TAB 80MG 133
irbesartan tab 150 mg 77
irbesartan tab 300 mg 77
irbesartan tab 75 mg 77
irbesartan-hydrochlorothiazide tab 150-12.5 mg 79
irbesartan-hydrochlorothiazide tab 300-12.5 mg 79
ISENTRESS CHW 100MG 97
ISENTRESS CHW 25MG 97
ISENTRESS HD TAB 600MG 97
ISENTRESS POW 100MG 97
ISENTRESS TAB 400MG 97
ISIBLOOM
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
isoniazid syrup 50 mg/5ml 81
isoniazid tab 100 mg 81
isoniazid tab 300 mg 81
isosorbide dinitrate tab 10 mg 51
isosorbide dinitrate tab 20 mg 51
isosorbide dinitrate tab 30 mg 51
isosorbide dinitrate tab 5 mg 51
isosorbide dinitrate-hydralazine hcl tab 20-37.5 mg 104
isosorbide mononitrate tab 10 mg 51
isosorbide mononitrate tab 20 mg 51
isosorbide mononitrate tab er 24hr 120 mg 51
isosorbide mononitrate tab er 24hr 30 mg 51
isosorbide mononitrate tab er 24hr 60 mg 51
isotretinoin cap 10 mg 119
Isotretinoin Cap 10 mg 119
isotretinoin cap 20 mg 119
Isotretinoin Cap 20 mg 119

isotretinoin cap 30 mg 119
Isotretinoin Cap 30 mg 119
isotretinoin cap 40 mg 119
Isotretinoin Cap 40 mg 119
isradipine cap 2.5 mg 103
isradipine cap 5 mg 103
itraconazole cap 100 mg 72
itraconazole oral soln 10 mg/ml 72
ivabradine hcl tab 5 mg (base equiv) 106
ivabradine hcl tab 7.5 mg (base equiv) 106
ivacaftor
see KALYDECO PAK 25MG 158
see KALYDECO PAK 50MG 158
see KALYDECO PAK 75MG 158
see KALYDECO TAB 150MG 158
ivermectin cream 1% 124
ivermectin tab 3 mg 50
ivermectin tab 6 mg 50
ixazomib citrate
see NINLARO CAP 2.3MG 88
see NINLARO CAP 3MG 88
see NINLARO CAP 4MG 88

J

JAIMIESS
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) 109
JAKAFI TAB 10MG 87
JAKAFI TAB 15MG 87
JAKAFI TAB 20MG 87
JAKAFI TAB 25MG 87
JAKAFI TAB 5MG 87
JAKAFI XR TAB 11MG 87
JAKAFI XR TAB 22MG 87
JAKAFI XR TAB 33MG 87
JAKAFI XR TAB 44MG 87
JAKAFI XR TAB 55MG 87
JARDIANCE TAB 10MG 70
JARDIANCE TAB 25MG 70
JASCAYD TAB 18MG 158
JASCAYD TAB 9MG 158
JASMIEL
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 108
JAVYGTOR
see Sapropterin Dihydrochloride Powder Packet 100 mg 128
see Sapropterin Dihydrochloride Powder Packet 500 mg 128
see Sapropterin Dihydrochloride Tab 100 mg 129
JAYTHARI
see Deflazacort Susp 22.75 mg/ml 116
see Deflazacort Tab 18 mg 116
see Deflazacort Tab 30 mg 116
see Deflazacort Tab 36 mg 116
see Deflazacort Tab 6 mg 116
JENCYCLA
see Norethindrone Tab 0.35 mg 115
JINTELI
see Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg 130
JOLESSA
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg 109
JOYEAUX
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21) 110
JULEBER
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
JUNEL 1.5/30
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
JUNEL 1/20
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 111
JUNEL FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 113
JUNEL FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
JUNEL FE 24
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113

K

KAITLIB FE
see Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg 111
KALLIGA
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
KALYDECO PAK 25MG 158

KALYDECO PAK 50MG 158
KALYDECO PAK 75MG 158
KALYDECO TAB 150MG 158
KARIVA
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 108
KELNOR 1/35
see Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg 109
KERENDIA TAB 10MG 129
KERENDIA TAB 20MG 129
KERENDIA TAB 40MG 129
ketoconazole cream 2% 120
ketoconazole shampoo 2% 120
ketoconazole tab 200 mg 72
ketorolac tromethamine ophth soln 0.4% 149
ketorolac tromethamine ophth soln 0.5% 149
ketorolac tromethamine tab 10 mg 40
KIONEX
see Sodium Polystyrene Sulfonate Susp 15 gm/60ml 145
KISQALI TAB 200DOSE 87
KISQALI TAB 400DOSE 87
KISQALI TAB 600DOSE 87
KLAYESTA
see Nystatin Topical Powder 100000 unit/gm 121
KLOR-CON
see Potassium Chloride Powder Packet 20 meq 143
KLOR-CON 10
see Potassium Chloride Tab Er 10 meq 143
KLOR-CON 8
see Potassium Chloride Tab Er 8 meq (600 mg) 143
KLOR-CON M10
see Potassium Chloride Microencapsulated Crys Er Tab 10 meq 143
KLOR-CON M15
see Potassium Chloride Microencapsulated Crys Er Tab 15 meq 143
KLOR-CON M20
see Potassium Chloride Microencapsulated Crys Er Tab 20 meq 143
KLS QUIT2
see Nicotine Polacrilex Gum 2 mg 155
see Nicotine Polacrilex Lozenge 2 mg 156
KLS QUIT4
see Nicotine Polacrilex Gum 4 mg 156
see Nicotine Polacrilex Lozenge 4 mg 157
KOSELUGO CAP 10MG 87
KOSELUGO CAP 25MG 87
KOSELUGO CAP 5MG 87
KOSELUGO CAP 7.5MG 87
KOURZEQ
see Triamcinolone Acetonide Dental Paste 0.1% 145
KP FOLIC ACID
see Folic Acid Tab 800 mcg 136
KRAZATI TAB 200MG 87
KRISTALOSE
see Lactulose Oral Crystal Packet 10 gm 138
see Lactulose Oral Crystal Packet 20 gm 138
KURVELO
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
KYMBEE
see Deflazacort Susp 22.75 mg/ml 116
see Deflazacort Tab 18 mg 116
see Deflazacort Tab 30 mg 116
see Deflazacort Tab 36 mg 116
see Deflazacort Tab 6 mg 116

L

labetalol hcl tab 100 mg 100
labetalol hcl tab 200 mg 100
labetalol hcl tab 300 mg 100
labetalol hcl tab 400 mg 100
lacosamide oral solution 10 mg/ml 59
lacosamide tab 100 mg 59
lacosamide tab 150 mg 59
lacosamide tab 200 mg 60
lacosamide tab 50 mg 59
lactic acid (ammonium lactate) cream 12% 124
lactic acid (ammonium lactate) lotion 12% 124
lactic acid-citric acid-potassium bitartrate
see PHEXX GEL 163
lactulose (encephalopathy) solution 10 gm/15ml 132
Lactulose (Encephalopathy) Solution 10 gm/15ml 132
lactulose oral crystal packet 10 gm 138
Lactulose Oral Crystal Packet 10 gm 138
lactulose oral crystal packet 20 gm 138
Lactulose Oral Crystal Packet 20 gm 138

lactulose solution 10 gm/15ml 138
Lactulose Solution 10 gm/15ml 138
LAGEVRIO CAP 200MG 99
lamivudine oral soln 10 mg/ml 97
lamivudine tab 100 mg (hbv) 99
lamivudine tab 150 mg 97
lamivudine tab 300 mg 97
lamivudine-tenofovir disoproxil fumarate
see CIMDUO TAB 300-300 96
lamivudine-zidovudine tab 150-300 mg 97
lamotrigine orally disintegrating tab 100 mg . 60
lamotrigine orally disintegrating tab 200 mg . 60
lamotrigine orally disintegrating tab 25 mg 60
lamotrigine orally disintegrating tab 50 mg 60
lamotrigine tab 100 mg 60
Lamotrigine Tab 100 mg 60
lamotrigine tab 150 mg 60
Lamotrigine Tab 150 mg 60
lamotrigine tab 200 mg 60
Lamotrigine Tab 200 mg 60
lamotrigine tab 25 mg 60
Lamotrigine Tab 25 mg 60
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit 60
Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit 60
lamotrigine tab 35 x 25 mg starter kit 60
Lamotrigine Tab 35 X 25 mg Starter Kit 60
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit 60
Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit 60
lamotrigine tab chewable dispersible 25 mg ... 60
lamotrigine tab chewable dispersible 5 mg 60
lamotrigine tab disint 21 x 25 mg & 7 x 50 mg titration kit 60
lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit 60
lamotrigine tab disint 42 x 50mg & 14 x 100mg titration kit 60
lamotrigine tab er 24hr 100 mg 60
lamotrigine tab er 24hr 200 mg 60
lamotrigine tab er 24hr 25 mg 60
lamotrigine tab er 24hr 250 mg 60
lamotrigine tab er 24hr 300 mg 60
lamotrigine tab er 24hr 50 mg 60
LANOXIN TAB 0.0625MG 104
lansoprazole cap delayed release 15 mg 161
lansoprazole cap delayed release 30 mg 161
LANTUS INJ 100/ML 69
LANTUS SOLOS INJ 100/ML 70
lapatinib ditosylate tab 250 mg (base equiv) .. 87
LARIN 1.5/30
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
LARIN 1/20
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 112
LARIN 24 FE
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113
LARIN FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 113
LARIN FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
larotrectinib sulfate
see VITRAKVI CAP 100MG 89
see VITRAKVI CAP 25MG 89
see VITRAKVI SOL 20MG/ML 90
latanoprost ophth soln 0.005% 150
LEDERLE LEUCOVORIN
see Leucovorin Calcium Tab 5 mg 90
ledipasvir-sofosbuvir
see HARVONI PAK 98
see HARVONI PAK 45-200MG 98
see HARVONI TAB 45-200MG 99
see HARVONI TAB 90-400MG 99
leflunomide tab 10 mg 41
leflunomide tab 20 mg 41
lenacapavir sodium
see YEZTUGO TAB 300MG 98
lenalidomide cap 10 mg 144
lenalidomide cap 15 mg 144
lenalidomide cap 20 mg 144
lenalidomide cap 25 mg 144
lenalidomide cap 5 mg 144
lenalidomide caps 2.5 mg 144
lenvatinib mesylate
see LENVIMA CAP 10 MG 82
see LENVIMA CAP 12MG 82
see LENVIMA CAP 14 MG 82
see LENVIMA CAP 18 MG 82

see LENVIMA CAP 20 MG 82
see LENVIMA CAP 24 MG 82
see LENVIMA CAP 4MG 82
see LENVIMA CAP 8 MG 82
LENVIMA CAP 10 MG 82
LENVIMA CAP 12MG 82
LENVIMA CAP 14 MG 82
LENVIMA CAP 18 MG 82
LENVIMA CAP 20 MG 82
LENVIMA CAP 24 MG 82
LENVIMA CAP 4MG 82
LENVIMA CAP 8 MG 82
LESSINA
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110
letrozole tab 2.5 mg 83
leucovorin calcium tab 10 mg 90
leucovorin calcium tab 15 mg 90
leucovorin calcium tab 25 mg 90
leucovorin calcium tab 5 mg 90
Leucovorin Calcium Tab 5 mg 90
levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv) 56
levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv) 56
levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv) 56
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv) 56
levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv) 57
levamlodipine maleate tab 2.5 mg 103
levamlodipine maleate tab 5 mg 103
levetiracetam oral soln 100 mg/ml 60
levetiracetam tab 1000 mg 60
levetiracetam tab 250 mg 60
levetiracetam tab 500 mg 60
Levetiracetam Tab 500 mg 60
levetiracetam tab 750 mg 60
levetiracetam tab disintegrating soluble 250 mg 61
levetiracetam tab disintegrating soluble 500 mg 61
levetiracetam tab er 24hr 500 mg 61
levetiracetam tab er 24hr 750 mg 61
levobunolol hcl ophth soln 0.5% 147
levocarnitine oral soln 1 gm/10ml (10%) 128
levocarnitine tab 330 mg 128
levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml) 73
levocetirizine dihydrochloride tab 5 mg 73
levodopa
see INBRIJA CAP 42MG 91
levofloxacin ophth soln 0.5% 148
levofloxacin ophth soln 1.5% 148
levofloxacin oral soln 25 mg/ml 131
levofloxacin tab 250 mg 131
levofloxacin tab 500 mg 132
levofloxacin tab 750 mg 132
LEVONEST
see Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg 110
Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg 109
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg 109
Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg 109
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg 109
Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 109, 110
Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
Levonorgestrel Tab 1.5 mg 115
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg 110
Levonorgestrel-Eth Estra Tab 0.05-30/0.075-40/0.125-30mg-Mcg 110
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg 110
Levonorgestrel-Ethinyl Estradiol (Continuous) Tab 90-20 mcg 110
levonorgestrel-ethinyl estradiol-fe tab 0.1 mg-20 mcg (21) 110
Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21) 110
Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7) 109
Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) 109
levothyroxine sodium
see SYNTHROID TAB 100MCG 160
see SYNTHROID TAB 112MCG 160

see SYNTHROID TAB 125MCG 160
see SYNTHROID TAB 137MCG 160
see SYNTHROID TAB 150MCG 160
see SYNTHROID TAB 175MCG 160
see SYNTHROID TAB 200MCG 160
see SYNTHROID TAB 25MCG 160
see SYNTHROID TAB 300MCG 160
see SYNTHROID TAB 50MCG 160
see SYNTHROID TAB 75MCG 160
see SYNTHROID TAB 88MCG 160
levothyroxine sodium tab 100 mcg 159
Levothyroxine Sodium Tab 100 mcg 159
levothyroxine sodium tab 112 mcg 159
Levothyroxine Sodium Tab 112 mcg 159
levothyroxine sodium tab 125 mcg 159
Levothyroxine Sodium Tab 125 mcg 159
levothyroxine sodium tab 137 mcg 159
Levothyroxine Sodium Tab 137 mcg 159
levothyroxine sodium tab 150 mcg 159
Levothyroxine Sodium Tab 150 mcg 160
levothyroxine sodium tab 175 mcg 160
Levothyroxine Sodium Tab 175 mcg 160
levothyroxine sodium tab 200 mcg 160
Levothyroxine Sodium Tab 200 mcg 160
levothyroxine sodium tab 25 mcg 159
Levothyroxine Sodium Tab 25 mcg 159
levothyroxine sodium tab 300 mcg 160
Levothyroxine Sodium Tab 300 mcg 160
levothyroxine sodium tab 50 mcg 159
Levothyroxine Sodium Tab 50 mcg 159
levothyroxine sodium tab 75 mcg 159
Levothyroxine Sodium Tab 75 mcg 159
levothyroxine sodium tab 88 mcg 159
Levothyroxine Sodium Tab 88 mcg 159
LEVOXYL
see Levothyroxine Sodium Tab 100 mcg 159
see Levothyroxine Sodium Tab 112 mcg 159
see Levothyroxine Sodium Tab 125 mcg 159
see Levothyroxine Sodium Tab 137 mcg 159
see Levothyroxine Sodium Tab 150 mcg 160
see Levothyroxine Sodium Tab 175 mcg 160
see Levothyroxine Sodium Tab 200 mcg 160
see Levothyroxine Sodium Tab 25 mcg 159
see Levothyroxine Sodium Tab 50 mcg 159
see Levothyroxine Sodium Tab 75 mcg 159
see Levothyroxine Sodium Tab 88 mcg 159
lidocaine hcl soln 4% 124
lidocaine hcl viscous soln 2% 145
lidocaine oint 5% 124
lidocaine patch 5% 124
Lidocaine Patch 5% 124
lidocaine-prilocaine cream 2.5-2.5% 124
LIDOCAN
see Lidocaine Patch 5% 124
linaclotide
see LINZESS CAP 145MCG 133
see LINZESS CAP 290MCG 133
see LINZESS CAP 72MCG 133
linezolid for susp 100 mg/5ml 51
linezolid tab 600 mg 51
LINZESS CAP 145MCG 133
LINZESS CAP 290MCG 133
LINZESS CAP 72MCG 133
LIOMNY
see Liothyronine Sodium Tab 25 mcg 160
see Liothyronine Sodium Tab 5 mcg 160
see Liothyronine Sodium Tab 50 mcg 160
liothyronine sodium tab 25 mcg 160
Liothyronine Sodium Tab 25 mcg 160
liothyronine sodium tab 5 mcg 160
Liothyronine Sodium Tab 5 mcg 160
liothyronine sodium tab 50 mcg 160
Liothyronine Sodium Tab 50 mcg 160
liraglutide soln pen-injector 18 mg/3ml (6 mg/ml) 69
lisdexamfetamine dimesylate cap 10 mg 30
lisdexamfetamine dimesylate cap 20 mg 30
lisdexamfetamine dimesylate cap 30 mg 30
lisdexamfetamine dimesylate cap 40 mg 30
lisdexamfetamine dimesylate cap 50 mg 30
lisdexamfetamine dimesylate cap 60 mg 30
lisdexamfetamine dimesylate cap 70 mg 30
lisdexamfetamine dimesylate chew tab 10 mg 30
lisdexamfetamine dimesylate chew tab 20 mg 30
lisdexamfetamine dimesylate chew tab 30 mg 30
lisdexamfetamine dimesylate chew tab 40 mg 31
lisdexamfetamine dimesylate chew tab 50 mg 31
lisdexamfetamine dimesylate chew tab 60 mg 31
lisinopril & hydrochlorothiazide tab 10-12.5 mg 79
lisinopril & hydrochlorothiazide tab 20-12.5 mg 79
lisinopril & hydrochlorothiazide tab 20-25 mg 79
lisinopril tab 10 mg 76

lisinopril tab 2.5 mg 76
lisinopril tab 20 mg 76
lisinopril tab 30 mg 76
lisinopril tab 40 mg 76
lisinopril tab 5 mg 76
LITFULO CAP 50MG 124
lithium carbonate
see LITHOBID TAB 300MG 93
lithium carbonate cap 150 mg 93
lithium carbonate cap 300 mg 93
lithium carbonate cap 600 mg 93
lithium carbonate tab 300 mg 93
lithium carbonate tab er 300 mg 93
lithium carbonate tab er 450 mg 93
lithium oral solution 8 meq/5ml 93
LITHOBID TAB 300MG 93
LO LOESTRIN TAB 1-10-10 110
LOESTRIN 1.5/30-21
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
LOESTRIN 1/20-21
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 112
LOESTRIN FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 113
LOESTRIN FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
lofexidine hcl tab 0.18 mg (base equivalent) 151
LOJAIMIESS
see Levonorg-Eth Est Tab 0.1-0.02mg(84) & Eth Est Tab 0.01mg(7) 109
LOMAIRA
see Phentermine Hcl Tab 8 mg 31
lomustine
see GLEOSTINE CAP 40MG 82
lomustine cap 10 mg 82
lomustine cap 100 mg 82
lomustine cap 40 mg 82
LONSURF TAB 15-6.14 84
LONSURF TAB 20-8.19 84
loperamide hcl cap 2 mg 71
lopinavir-ritonavir tab 100-25 mg 97
lopinavir-ritonavir tab 200-50 mg 97
LOPRESSOR TAB 12.5MG 100
lorazepam conc 2 mg/ml 53
lorazepam tab 0.5 mg 53
lorazepam tab 1 mg 53
lorazepam tab 2 mg 53
LORYNA
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 108
losartan potassium & hydrochlorothiazide tab 100-12.5 mg 79
losartan potassium & hydrochlorothiazide tab 100-25 mg 79
losartan potassium & hydrochlorothiazide tab 50-12.5 mg 79
losartan potassium tab 100 mg 77
losartan potassium tab 25 mg 77
losartan potassium tab 50 mg 77
loteprednol etabonate ophth gel 0.5% 149
loteprednol etabonate ophth susp 0.2% 149
loteprednol etabonate ophth susp 0.5% 149
loteprednol etabonate-tobramycin ophth susp 0.5-0.3% 149
lotilaner
see XDEMVY DRO 0.25% 148
lovastatin tab 10 mg 75
lovastatin tab 20 mg 75
lovastatin tab 40 mg 75
LOW-OGESTREL
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg 115
loxapine succinate cap 10 mg 94
loxapine succinate cap 25 mg 94
loxapine succinate cap 5 mg 94
loxapine succinate cap 50 mg 94
LO-ZUMANDIMINE
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 108
lubiprostone cap 24 mcg 132
lubiprostone cap 8 mcg 132
LUIZZA 1.5/30
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
LUIZZA 1/20
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 112
LUMAKRAS TAB 120MG 87
LUMAKRAS TAB 240MG 87
LUMAKRAS TAB 320MG 88
LUMRYZ PAK 6GM 152

LUMRYZ PAK 7.5GM 152
LUMRYZ PAK 9GM 152
LUMRYZ PAK STARTER 152
LUMRYZ PKG 4.5GM 152
lurasidone hcl tab 120 mg 93
lurasidone hcl tab 20 mg 93
lurasidone hcl tab 40 mg 93
lurasidone hcl tab 60 mg 93
lurasidone hcl tab 80 mg 93
LUTERA
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110
LYLEQ
see Norethindrone Tab 0.35 mg 115
LYLLANA
see Estradiol Td Patch Twice Weekly 0.025 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.0375 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.05 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.075 mg/24hr 131
see Estradiol Td Patch Twice Weekly 0.1 mg/24hr 131
LYNPARZA TAB 100MG 88
LYNPARZA TAB 150MG 88
LYZA
see Norethindrone Tab 0.35 mg 115

M

macitentan
see OPSUMIT TAB 10MG 106
macitentan tab 10 mg 106
macitentan-tadalafil
see OPSYNVI TAB 10-20MG 104
see OPSYNVI TAB 10-40MG 104
malathion lotion 0.5% 125
MALE MIS CONDOM 139
maraviroc tab 150 mg 97
maraviroc tab 300 mg 97
MARLISSA
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
mavacamten
see CAMZYOS CAP 10MG 104
see CAMZYOS CAP 15MG 104
see CAMZYOS CAP 2.5MG 104
see CAMZYOS CAP 5MG 104
MAVYRET PAK 50-20MG 99
MAVYRET TAB 100-40MG 99
MAYZENT PAK STARTER 154
MAYZENT TAB 0.25MG 154
MAYZENT TAB 1MG 154
MAYZENT TAB 2MG 154
mebendazole
see EMVERM CHW 100MG 50
meclizine hcl tab 12.5 mg 72
meclizine hcl tab 25 mg 72
meclizine hcl tab 50 mg 72
meclofenamate sodium cap 100 mg 40
meclofenamate sodium cap 50 mg 40
MEDROL TAB 2MG 116
medroxyprogesterone acetate tab 10 mg 151
medroxyprogesterone acetate tab 2.5 mg 151
medroxyprogesterone acetate tab 5 mg 151
mefenamic acid cap 250 mg 40
mefloquine hcl tab 250 mg 81
megestrol acetate susp 40 mg/ml 83
megestrol acetate susp 625 mg/5ml 151
megestrol acetate tab 20 mg 83
megestrol acetate tab 40 mg 83
MEKINIST SOL 0.05/ML 88
MEKINIST TAB 0.5MG 88
MEKINIST TAB 2MG 88
MEKTOVI TAB 15MG 88
MELEYA
see Norethindrone Tab 0.35 mg 115
meloxicam susp 7.5 mg/5ml 40
meloxicam tab 15 mg 40
meloxicam tab 7.5 mg 40
memantine hcl cap er 24hr 14 mg 152
memantine hcl cap er 24hr 21 mg 152
memantine hcl cap er 24hr 28 mg 152
memantine hcl cap er 24hr 7 mg 152
memantine hcl oral solution 2 mg/ml 152
memantine hcl tab 10 mg 152
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack 152
memantine hcl tab 5 mg 152
memantine hcl-donepezil hcl
see NAMZARIC CAP 14-10MG 153
see NAMZARIC CAP 21-10MG 153
see NAMZARIC CAP 28-10MG 153
see NAMZARIC CAP 7-10MG 152

memantine hcl-donepezil hcl cap er 24hr 14-10 mg 152
memantine hcl-donepezil hcl cap er 24hr 21-10 mg 152
memantine hcl-donepezil hcl cap er 24hr 28-10 mg 152
meperidine hcl oral soln 50 mg/5ml 43
meperidine hcl tab 50 mg 43
meprobamate tab 200 mg 52
meprobamate tab 400 mg 52
mercaptopurine susp 2000 mg/100ml (20 mg/ml) 82
mercaptopurine tab 50 mg 82
mesalamine cap dr 400 mg 132
mesalamine cap er 24hr 0.375 gm 132
mesalamine cap er 250 mg 132
mesalamine cap er 500 mg 132
mesalamine enema 4 gm 132
mesalamine suppos 1000 mg 132
mesalamine tab delayed release 1.2 gm 132
mesalamine tab delayed release 800 mg 132
mesna tab 400 mg 90
metaxalone tab 800 mg 146
metformin hcl oral soln 500 mg/5ml 68
metformin hcl tab 1000 mg 68
metformin hcl tab 500 mg 68
metformin hcl tab 850 mg 68
metformin hcl tab er 24hr 500 mg 68
metformin hcl tab er 24hr 750 mg 68
methadone hcl conc 10 mg/ml 43
Methadone Hcl Conc 10 mg/ml 43
methadone hcl soln 10 mg/5ml 43
methadone hcl soln 5 mg/5ml 43
methadone hcl tab 10 mg 43
methadone hcl tab 5 mg 43
methadone hcl tab for oral susp 40 mg 43
Methadone Hcl Tab For Oral Susp 40 mg 43
METHADONE HYDROCHLORIDE I
see Methadone Hcl Conc 10 mg/ml 43
METHADOSE
see Methadone Hcl Tab For Oral Susp 40 mg 43
methamphetamine hcl tab 5 mg 31
methazolamide tab 25 mg 126
methazolamide tab 50 mg 126
methenamine hippurate tab 1 gm 51
methenamine mandelate tab 0.5 gm 51
METHERGINE
see Methylergonovine Maleate Tab 0.2 mg 150
methimazole tab 10 mg 159
methimazole tab 5 mg 159
METHITEST
see Methyltestosterone Oral Tab 10 mg 49
methocarbamol tab 1000 mg 146
Methocarbamol Tab 1000 mg 146
methocarbamol tab 500 mg 146
methocarbamol tab 750 mg 146
methotrexate sodium tab 2.5 mg (base equiv) 82
methoxsalen rapid cap 10 mg 121
methscopolamine bromide tab 2.5 mg 161
methscopolamine bromide tab 5 mg 161
methsuximide cap 300 mg 62
methyldopa tab 250 mg 78
methyldopa tab 500 mg 78
methylergonovine maleate tab 0.2 mg 150
Methylergonovine Maleate Tab 0.2 mg 150
methylphenidate hcl cap er 10 mg (cd) 34
methylphenidate hcl cap er 20 mg (cd) 35
methylphenidate hcl cap er 24hr 10 mg (la) 35
methylphenidate hcl cap er 24hr 10 mg (xr) 35
methylphenidate hcl cap er 24hr 15 mg (xr) 35
methylphenidate hcl cap er 24hr 20 mg (la) 35
methylphenidate hcl cap er 24hr 20 mg (xr) 35
methylphenidate hcl cap er 24hr 30 mg (la) 35
methylphenidate hcl cap er 24hr 30 mg (xr) 35
methylphenidate hcl cap er 24hr 40 mg (la) 35
methylphenidate hcl cap er 24hr 40 mg (xr) 35
methylphenidate hcl cap er 24hr 50 mg (xr) 35
methylphenidate hcl cap er 24hr 60 mg (la) 36
methylphenidate hcl cap er 24hr 60 mg (xr) 36
methylphenidate hcl cap er 30 mg (cd) 36
methylphenidate hcl cap er 40 mg (cd) 36
methylphenidate hcl cap er 50 mg (cd) 36
methylphenidate hcl cap er 60 mg (cd) 36
methylphenidate hcl chew tab 10 mg 36
methylphenidate hcl chew tab 2.5 mg 36
methylphenidate hcl chew tab 5 mg 36
methylphenidate hcl soln 10 mg/5ml 36
methylphenidate hcl soln 5 mg/5ml 36
methylphenidate hcl tab 10 mg 37
methylphenidate hcl tab 20 mg 37
methylphenidate hcl tab 5 mg 37
methylphenidate hcl tab er 10 mg 37
methylphenidate hcl tab er 20 mg 37
methylphenidate hcl tab er 24hr 18 mg 37

methylphenidate hcl tab er 24hr 27 mg 37
methylphenidate hcl tab er 24hr 36 mg 37
methylphenidate hcl tab er 24hr 54 mg 37
methylphenidate hcl tab er osmotic release (osm) 18 mg 37
methylphenidate hcl tab er osmotic release (osm) 27 mg 37
methylphenidate hcl tab er osmotic release (osm) 36 mg 38
methylphenidate hcl tab er osmotic release (osm) 54 mg 38
methylphenidate hcl tab er osmotic release (osm) 72 mg 38
methylphenidate td patch 10 mg/9hr 38
methylphenidate td patch 15 mg/9hr 38
methylphenidate td patch 20 mg/9hr 38
methylphenidate td patch 30 mg/9hr 38
methylprednisolone
see MEDROL TAB 2MG 116
methylprednisolone tab 16 mg 116
methylprednisolone tab 32 mg 117
methylprednisolone tab 4 mg 116
methylprednisolone tab 8 mg 116
methylprednisolone tab therapy pack 4 mg (21) 117
methyltestosterone cap 10 mg 49
Methyltestosterone Oral Tab 10 mg 49
metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv) 132
metoclopramide hcl tab 10 mg (base equivalent) 132
metoclopramide hcl tab 5 mg (base equivalent) 132
metolazone tab 10 mg 127
metolazone tab 2.5 mg 127
metolazone tab 5 mg 127
metoprolol & hydrochlorothiazide tab 100-25 mg 79
metoprolol & hydrochlorothiazide tab 100-50 mg 79
metoprolol & hydrochlorothiazide tab 50-25 mg 79
metoprolol succinate tab er 24hr 100 mg (tartrate equiv) 100
metoprolol succinate tab er 24hr 200 mg (tartrate equiv) 100
metoprolol succinate tab er 24hr 25 mg (tartrate equiv) 100
metoprolol succinate tab er 24hr 50 mg (tartrate equiv) 100
metoprolol tartrate
see LOPRESSOR TAB 12.5MG 100
metoprolol tartrate tab 100 mg 100
metoprolol tartrate tab 12.5 mg 100
metoprolol tartrate tab 25 mg 100
metoprolol tartrate tab 37.5 mg 100
metoprolol tartrate tab 50 mg 100
metoprolol tartrate tab 75 mg 100
metronidazole cap 375 mg 50
metronidazole cream 0.75% 124
metronidazole gel 0.75% 125
metronidazole gel 1% 125
metronidazole lotion 0.75% 125
metronidazole tab 250 mg 50
metronidazole tab 500 mg 50
metronidazole vaginal gel 0.75% 163
metyrosine cap 250 mg 77
mexiletine hcl cap 150 mg 53
mexiletine hcl cap 200 mg 53
mexiletine hcl cap 250 mg 53
MIBELAS 24 FE
see Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24) 113
MICONAZOLE 3
see Miconazole Nitrate Vaginal Suppos 200 mg 163
Miconazole Nitrate Vaginal Suppos 200 mg 163
MICROCHAMBER MIS 141
MICROGESTIN 1.5/30
see Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
MICROGESTIN 1/20
see Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 112
MICROGESTIN FE 1.5/30
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 113
MICROGESTIN FE 1/20
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
MICROSPACER MIS 141
midazolam (anticonvulsant)
see NAYZILAM SPR 5MG 59

midazolam hcl syrup 2 mg/ml (base equivalent) 137
midodrine hcl tab 10 mg 164
midodrine hcl tab 2.5 mg 164
midodrine hcl tab 5 mg 164
midostaurin
see RYDAPT CAP 25MG 89
mifepristone tab 200 mg 129
mifepristone tab 300 mg 68
migalastat hcl
see GALAFOLD CAP 123MG 128
miglitol tab 100 mg 66
miglitol tab 25 mg 66
miglitol tab 50 mg 66
miglustat cap 100 mg 135
Miglustat Cap 100 mg 135
MILI
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg 114
milnacipran hcl tab 100 mg 153
milnacipran hcl tab 12.5 mg 153
milnacipran hcl tab 12.5 mg (5) & 25 mg (8) & 50 mg (42) pak 153
milnacipran hcl tab 25 mg 153
milnacipran hcl tab 50 mg 153
MILOPHENE
see Clomiphene Citrate Tab 50 mg 127
MIMVEY
see Estradiol & Norethindrone Acetate Tab 1-0.5 mg 130
minocycline hcl cap 100 mg 159
minocycline hcl cap 50 mg 159
minocycline hcl cap 75 mg 159
minocycline hcl tab 100 mg 159
minocycline hcl tab 50 mg 159
minocycline hcl tab 75 mg 159
minoxidil tab 10 mg 80
minoxidil tab 2.5 mg 80
MINZOYA
see Levonorgestrel-Ethinyl Estradiol-Fe Tab 0.1 mg-20 mcg (21) 110
mirabegron granules for oral extended release susp 8 mg/ml 162
mirabegron tab er 24 hr 25 mg 162
mirabegron tab er 24 hr 50 mg 162
mirdametinib
see GOMEKLI CAP 1MG 86
see GOMEKLI CAP 2MG 86
see GOMEKLI TAB 1MG 86
mirtazapine orally disintegrating tab 15 mg ... 63
mirtazapine orally disintegrating tab 30 mg ... 63
mirtazapine orally disintegrating tab 45 mg ... 63
mirtazapine tab 15 mg 63
mirtazapine tab 30 mg 63
mirtazapine tab 45 mg 63
mirtazapine tab 7.5 mg 63
misoprostol tab 100 mcg 162
misoprostol tab 200 mcg 162
modafinil tab 100 mg 38
modafinil tab 200 mg 38
moexipril hcl tab 15 mg 76
moexipril hcl tab 7.5 mg 76
molindone hcl tab 10 mg 95
molindone hcl tab 25 mg 95
molindone hcl tab 5 mg 95
molnupiravir
see LAGEVRIO CAP 200MG 99
mometasone furoate (inhalation)
see ASMANEX HFA AER 100 MCG 54
see ASMANEX HFA AER 200 MCG 54
see ASMANEX HFA AER 50MCG 54
mometasone furoate cream 0.1% 123
mometasone furoate nasal susp 50 mcg/act 147
mometasone furoate oint 0.1% 123
mometasone furoate solution 0.1% (lotion) .. 123
MONDOXYNE NL
see Doxycycline Monohydrate Cap 100 mg 158
MONO-LINYAH
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg 114
monomethyl fumarate
see BAFIERTAM CAP 95MG 154
montelukast sodium chew tab 4 mg (base equiv) 54
montelukast sodium chew tab 5 mg (base equiv) 54
montelukast sodium oral granules packet 4 mg (base equiv) 54
montelukast sodium tab 10 mg (base equiv) .. 54
morphine sulfate beads cap er 24hr 120 mg ... 43
morphine sulfate beads cap er 24hr 30 mg 43
morphine sulfate beads cap er 24hr 45 mg 43
morphine sulfate beads cap er 24hr 60 mg 43
morphine sulfate beads cap er 24hr 75 mg 43

morphine sulfate beads cap er 24hr 90 mg 43
morphine sulfate oral soln 10 mg/5ml 43
morphine sulfate oral soln 100 mg/5ml (20 mg/ml) 43
morphine sulfate oral soln 20 mg/5ml 43
morphine sulfate tab 15 mg 44
morphine sulfate tab 30 mg 44
morphine sulfate tab er 100 mg 44
morphine sulfate tab er 15 mg 44
morphine sulfate tab er 200 mg 44
morphine sulfate tab er 30 mg 44
morphine sulfate tab er 60 mg 44
MOUNJARO INJ 10MG/0.5 69
MOUNJARO INJ 12.5/0.5 69
MOUNJARO INJ 15MG/0.5 69
MOUNJARO INJ 2.5/0.5 69
MOUNJARO INJ 5MG/0.5 69
MOUNJARO INJ 7.5/0.5 69
MOVANTIK TAB 12.5MG 133
MOVANTIK TAB 25MG 133
moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily) 148
moxifloxacin hcl ophth soln 0.5% (base equiv) 148
moxifloxacin hcl tab 400 mg (base equiv) 132
MULTAQ TAB 400MG 54
mupirocin oint 2% 120
mycophenolate mofetil cap 250 mg 144
mycophenolate mofetil for oral susp 200 mg/ml 144
mycophenolate mofetil tab 500 mg 144
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv) 144
mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv) 144
MYFEMBREE TAB 130

N

nabumetone tab 500 mg 40
nabumetone tab 750 mg 40
nadolol tab 20 mg 101
nadolol tab 40 mg 101
nadolol tab 80 mg 101
nafarelin acetate
see SYNAREL SOL 2MG/ML 127
naftifine hcl cream 1% 121
naftifine hcl cream 2% 121
naftifine hcl gel 2% 121
naldemedine tosylate
see SYMPROIC TAB 0.2MG 133
naloxegol oxalate
see MOVANTIK TAB 12.5MG 133
see MOVANTIK TAB 25MG 133
naltrexone hcl tab 50 mg 71
NAMZARIC CAP 14-10MG 153
NAMZARIC CAP 21-10MG 153
NAMZARIC CAP 28-10MG 153
NAMZARIC CAP 7-10MG 152
naproxen sodium tab 275 mg 40
naproxen sodium tab 550 mg 40
naproxen tab 250 mg 40
naproxen tab 375 mg 40
naproxen tab 500 mg 40
naproxen tab ec 375 mg 40
naproxen tab ec 500 mg 41
naratriptan hcl tab 1 mg (base equiv) 142
naratriptan hcl tab 2.5 mg (base equiv) 142
NATAZIA TAB 111
nateglinide tab 120 mg 70
nateglinide tab 60 mg 70
NATESTO GEL 5.5MG 49
NAYZILAM SPR 5MG 59
nebivolol hcl tab 10 mg (base equivalent) 100
nebivolol hcl tab 2.5 mg (base equivalent) 100
nebivolol hcl tab 20 mg (base equivalent) 101
nebivolol hcl tab 5 mg (base equivalent) 100
NECON 0.5/35-28
see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg 111
nefazodone hcl tab 100 mg 64
nefazodone hcl tab 150 mg 64
nefazodone hcl tab 200 mg 64
nefazodone hcl tab 250 mg 64
nefazodone hcl tab 50 mg 64
nelfinavir mesylate
see VIRACEPT TAB 250MG 98
see VIRACEPT TAB 625MG 98
neomycin sulfate tab 500 mg 38
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin 148
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml 148
neomycin-polymyxin-dexamethasone ophth oint 0.1% 149

neomycin-polymyxin-dexamethasone ophth susp 0.1% 149
neomycin-polymyxin-hc ophth susp 149
neomycin-polymyxin-hc otic soln 1% 150
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1% 150
nepafenac
see ILEVRO DRO 0.3% OP 149
nerandomilast
see JASCAYD TAB 18MG 158
see JASCAYD TAB 9MG 158
NEUAC
see Clindamycin Phosph-Benzoyl Peroxide (Refrig) Gel 1.2 (1)-5% 118
NEUPRO DIS 1MG/24HR 91
NEUPRO DIS 2MG/24HR 91
NEUPRO DIS 3MG/24HR 91
NEUPRO DIS 4MG/24HR 91
NEUPRO DIS 6MG/24HR 92
NEUPRO DIS 8MG/24HR 92
nevirapine susp 50 mg/5ml 97
nevirapine tab 200 mg 97
nevirapine tab er 24hr 400 mg 97
NEXLETOL TAB 180MG 73
NEXLIZET TAB 180/10MG 74
niacin tab er 1000 mg (antihyperlipidemic) 75
niacin tab er 500 mg (antihyperlipidemic) 75
niacin tab er 750 mg (antihyperlipidemic) 75
nicardipine hcl cap 20 mg 103
nicardipine hcl cap 30 mg 103
NICORELIEF
see Nicotine Polacrilex Gum 2 mg 156
nicotine
see NICOTROL NS SPR 10MG/ML 157
NICOTINE MINI LOZENGE
see Nicotine Polacrilex Lozenge 2 mg 156
nicotine polacrilex gum 2 mg 155
Nicotine Polacrilex Gum 2 mg 155, 156
nicotine polacrilex gum 4 mg 156
Nicotine Polacrilex Gum 4 mg 156
nicotine polacrilex lozenge 2 mg 156
Nicotine Polacrilex Lozenge 2 mg 156
nicotine polacrilex lozenge 4 mg 156
Nicotine Polacrilex Lozenge 4 mg 156, 157
NICOTINE STEP 1
see Nicotine Td Patch 24hr 21 mg/24hr 157
NICOTINE STEP 3
see Nicotine Td Patch 24hr 7 mg/24hr 157
nicotine td patch 24hr 14 mg/24hr 157
Nicotine Td Patch 24hr 14 mg/24hr 157
nicotine td patch 24hr 21 mg/24hr 157
Nicotine Td Patch 24hr 21 mg/24hr 157
nicotine td patch 24hr 7 mg/24hr 157
Nicotine Td Patch 24hr 7 mg/24hr 157
NICOTINE TRANSDERMAL SYST
see Nicotine Td Patch 24hr 14 mg/24hr 157
see Nicotine Td Patch 24hr 21 mg/24hr 157
see Nicotine Td Patch 24hr 7 mg/24hr 157
NICOTROL NS SPR 10MG/ML 157
nifedipine cap 10 mg 103
nifedipine cap 20 mg 103
nifedipine tab er 24hr 30 mg 103
nifedipine tab er 24hr 60 mg 103
nifedipine tab er 24hr 90 mg 103
nifedipine tab er 24hr osmotic release 30 mg 103
nifedipine tab er 24hr osmotic release 60 mg 103
nifedipine tab er 24hr osmotic release 90 mg 103
NIKKI
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 108
nilotinib hcl cap 150 mg (base equivalent) 88
nilotinib hcl cap 200 mg (base equivalent) 88
nilotinib hcl cap 50 mg (base equivalent) 88
nilutamide tab 150 mg 83
nimodipine cap 30 mg 103
nimodipine oral soln 60 mg/20ml (3 mg/ml) 103
NINLARO CAP 2.3MG 88
NINLARO CAP 3MG 88
NINLARO CAP 4MG 88
nintedanib esylate
see OFEV CAP 100MG 158
see OFEV CAP 150MG 158
nintedanib esylate cap 100 mg (base equivalent) 158
nintedanib esylate cap 150 mg (base equivalent) 158
niraparib tosylate
see ZEJULA TAB 100MG 90
see ZEJULA TAB 200MG 90
see ZEJULA TAB 300MG 90
nirmatrelvir-ritonavir
see PAXLOVID PAK 98
see PAXLOVID TAB 150-100 98
see PAXLOVID TAB 300-100 98

nisoldipine tab er 24hr 17 mg 103
nisoldipine tab er 24hr 34 mg 103
nisoldipine tab er 24hr 8.5 mg 103
nitazoxanide tab 500 mg 50
nitisinone
see ORFADIN CAP 10MG 128
see ORFADIN CAP 20MG 128
see ORFADIN CAP 2MG 128
see ORFADIN CAP 5MG 128
see ORFADIN SUS 4MG/ML 128
nitisinone cap 10 mg 128
nitisinone cap 2 mg 128
nitisinone cap 20 mg 128
nitisinone cap 5 mg 128
NITRO-BID
see Nitroglycerin Oint 2% 51
nitrofurantoin macrocrystalline cap 100 mg ... 51
nitrofurantoin macrocrystalline cap 25 mg 51
nitrofurantoin macrocrystalline cap 50 mg 51
nitrofurantoin monohydrate macrocrystalline cap 100 mg 51
nitrofurantoin susp 25 mg/5ml 51
nitroglycerin oint 0.4% 50
nitroglycerin oint 2% 51
Nitroglycerin Oint 2% 51
nitroglycerin sl tab 0.3 mg 51
nitroglycerin sl tab 0.4 mg 51
nitroglycerin sl tab 0.6 mg 51
nitroglycerin td patch 24hr 0.1 mg/hr 52
nitroglycerin td patch 24hr 0.2 mg/hr 52
nitroglycerin td patch 24hr 0.4 mg/hr 52
nitroglycerin td patch 24hr 0.6 mg/hr 52
nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray) 52
nizatidine cap 150 mg 161
nizatidine cap 300 mg 161
nonoxynol-9
see ENCARE SUP 100MG 163
see GYNOL II GEL 3% 163
see TODAY SPONGE MIS 163
see VCF VAGINAL GEL CONTRACE 163
see VCF VAGINAL MIS CONTRACP 163
NORA-BE
see Norethindrone Tab 0.35 mg 115
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr 115
Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr 115
Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg 111
Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg 111
Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg 111
Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg 111
Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.8 mg-25 mcg 111
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg 111
Norethindrone Ace & Ethinyl Estradiol Tab 1 mg-20 mcg 111, 112
Norethindrone Ace & Ethinyl Estradiol Tab 1.5 mg-30 mcg 112
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1.5 mg-30 mcg 112, 113
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24) 113
Norethindrone Ace-Eth Estradiol-Fe Chew Tab 1 mg-20 mcg (24) 113
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24) 113
Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24) 113
Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113
norethindrone acetate tab 5 mg 151
Norethindrone Acetate Tab 5 mg 151
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg 130
Norethindrone Acetate-Ethinyl Estradiol Tab 0.5 mg-2.5 mcg 130
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg 130
Norethindrone Acetate-Ethinyl Estradiol Tab 1 mg-5 mcg 130
norethindrone acetate-ethinyl estradiol-fe fum (biphasic)
see LO LOESTRIN TAB 1-10-10 110
Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg 111

norethindrone tab 0.35 mg 115
Norethindrone Tab 0.35 mg 115
Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg 113, 114
Norethindrone-Eth Estradiol Tab 0.5-35/1-35/0.5-35 mg-Mcg 114
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg 114
Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg 114
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg 114
Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg 114
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg 114
Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg 114
Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg 114, 115
NORLYROC
see Norethindrone Tab 0.35 mg 115
NORTREL 0.5/35 (28)
see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg 111
NORTREL 1/35
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg 111
NORTREL 7/7/7
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg 113
nortriptyline hcl cap 10 mg 66
nortriptyline hcl cap 25 mg 66
nortriptyline hcl cap 50 mg 66
nortriptyline hcl cap 75 mg 66
nortriptyline hcl soln 10 mg/5ml 66
NOVOLIN INJ 70/30 70
NOVOLIN INJ 70/30 FP 70
NOVOLIN N INJ 100 UNIT 70
NOVOLIN N INJ U-100 70
NOVOLIN R INJ 100 UNIT 70
NOVOLIN R INJ U-100 70
NOVOLOG INJ 100/ML 70
NOVOLOG INJ FLEXPEN 70
NOVOLOG INJ PENFILL 70
NOVOLOG MIX INJ 70/30 70
NOVOLOG MIX INJ FLEXPEN 70
NUBEQA TAB 300MG 83
NURTEC TAB 75MG ODT 141
NYLIA 1/35
see Norethindrone & Ethinyl Estradiol Tab 1 mg-35 mcg 111
NYLIA 7/7/7
see Norethindrone-Eth Estradiol Tab 0.5-35/0.75-35/1-35 mg-Mcg 114
nystatin cream 100000 unit/gm 121
nystatin oint 100000 unit/gm 121
nystatin susp 100000 unit/ml 145
nystatin tab 500000 unit 72
nystatin topical powder 100000 unit/gm 121
Nystatin Topical Powder 100000 unit/gm 121
nystatin-triamcinolone cream 100000-0.1 unit/gm-% 121
nystatin-triamcinolone oint 100000-0.1 unit/gm-% 121
NYSTOP
see Nystatin Topical Powder 100000 unit/gm 121

O

ODACTRA SUB 38
ODEFSEY TAB 97
ODOMZO CAP 200MG 83
OFEV CAP 100MG 158
OFEV CAP 150MG 158
ofloxacin ophth soln 0.3% 148
ofloxacin otic soln 0.3% 150
ofloxacin tab 400 mg 132
olanzapine orally disintegrating tab 10 mg 94
olanzapine orally disintegrating tab 15 mg 94
olanzapine orally disintegrating tab 20 mg 94
olanzapine orally disintegrating tab 5 mg 94
olanzapine tab 10 mg 94
olanzapine tab 15 mg 94
olanzapine tab 2.5 mg 94
olanzapine tab 20 mg 94
olanzapine tab 5 mg 94
olanzapine tab 7.5 mg 94
olanzapine-fluoxetine hcl cap 12-25 mg 153
olanzapine-fluoxetine hcl cap 12-50 mg 153
olanzapine-fluoxetine hcl cap 3-25 mg 153
olanzapine-fluoxetine hcl cap 6-25 mg 153
olanzapine-fluoxetine hcl cap 6-50 mg 153
olaparib
see LYNPARZA TAB 100MG 88

see LYNPARZA TAB 150MG 88
olmesartan medoxomil tab 20 mg 77
olmesartan medoxomil tab 40 mg 77
olmesartan medoxomil tab 5 mg 77
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg 79
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg 79
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg 80
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg 80
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg 80
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg 80
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg 80
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg 80
olodaterol hcl
see STRIVERDI AER 2.5MCG 57
olopatadine hcl nasal soln 0.6% 146
olopatadine hcl ophth soln 0.2% (base equivalent) 149
omega-3-acid ethyl esters cap 1 gm 74
omeprazole cap delayed release 10 mg 161
omeprazole cap delayed release 20 mg 161
omeprazole cap delayed release 40 mg 161
ondansetron hcl oral soln 4 mg/5ml 71
ondansetron hcl tab 24 mg 71
ondansetron hcl tab 4 mg 71
ondansetron hcl tab 8 mg 71
ondansetron orally disintegrating tab 4 mg 71
ondansetron orally disintegrating tab 8 mg 71
OPSUMIT TAB 10MG 106
OPSYNVI TAB 10-20MG 104
OPSYNVI TAB 10-40MG 104
OPTICHAMBER MIS DIA LG 141
OPTICHAMBER MIS DIA MD 141
OPTICHAMBER MIS DIA SM 141
OPTICHAMBER MIS DIAMOND 141
OPTION 2
see Levonorgestrel Tab 1.5 mg 115
OPZELURA CRE 1.5% 124
ORACEA CAP 40MG 125
ORALAIR SUB 300 IR 38
ORALONE DENTAL PASTE
see Triamcinolone Acetonide Dental Paste 0.1% 145
ORENITRAM TAB 0.125MG 105
ORENITRAM TAB 0.25MG 105
ORENITRAM TAB 1MG 105
ORENITRAM TAB 2.5MG 105
ORENITRAM TAB 5MG 105
ORENITRAM TAB MONTH 1 105
ORENITRAM TAB MONTH 2 105
ORENITRAM TAB MONTH 3 105
ORFADIN CAP 10MG 128
ORFADIN CAP 20MG 128
ORFADIN CAP 2MG 128
ORFADIN CAP 5MG 128
ORFADIN SUS 4MG/ML 128
orforglipron calcium (weight management)
see FOUNDAYO TAB 0.8MG 31
see FOUNDAYO TAB 14.5MG 32
see FOUNDAYO TAB 17.2MG 32
see FOUNDAYO TAB 2.5MG 31
see FOUNDAYO TAB 5.5MG 32
see FOUNDAYO TAB 9MG 32
ORIAHNN CAP 130
ORILISSA TAB 150MG 127
ORILISSA TAB 200MG 127
ORLADEYO CAP 110MG 134
ORLADEYO CAP 150MG 134
ORLADEYO PAK 108MG 134
ORLADEYO PAK 132MG 134
ORLADEYO PAK 72MG 134
ORLADEYO PAK 96MG 134
orlistat cap 120 mg 32
ORMALVI
see Dichlorphenamide Tab 50 mg 126
orphenadrine citrate tab er 12hr 100 mg 146
ORQUIDEA
see Norethindrone Tab 0.35 mg 115
oseltamivir phosphate cap 30 mg (base equiv) 99
oseltamivir phosphate cap 45 mg (base equiv) 99
oseltamivir phosphate cap 75 mg (base equiv) 99
oseltamivir phosphate for susp 6 mg/ml (base equiv) 99
osimertinib mesylate
see TAGRISSO TAB 40MG 83
see TAGRISSO TAB 80MG 83
OTEZLA TAB 10/20 41

OTEZLA TAB 10/20/30 41
OTEZLA TAB 20MG 41
OTEZLA TAB 30MG 41
OTEZLA XR TAB 75MG 41
OTEZLA/XR TAB 28 DAY 41
oxaprozin cap 300 mg 41
oxaprozin tab 600 mg 41
oxazepam cap 10 mg 53
oxazepam cap 15 mg 53
oxazepam cap 30 mg 53
oxcarbazepine
see OXTELLAR XR TAB 150MG 61
see OXTELLAR XR TAB 300MG 61
see OXTELLAR XR TAB 600MG 61
oxcarbazepine susp 300 mg/5ml (60 mg/ml) .. 61
oxcarbazepine tab 150 mg 61
oxcarbazepine tab 300 mg 61
oxcarbazepine tab 600 mg 61
oxcarbazepine tab er 24hr 150 mg 61
oxcarbazepine tab er 24hr 300 mg 61
oxcarbazepine tab er 24hr 600 mg 61
oxiconazole nitrate cream 1% 121
OXTELLAR XR TAB 150MG 61
OXTELLAR XR TAB 300MG 61
OXTELLAR XR TAB 600MG 61
oxybutynin chloride solution 5 mg/5ml 162
oxybutynin chloride tab 2.5 mg 162
oxybutynin chloride tab 5 mg 162
oxybutynin chloride tab er 24hr 10 mg 162
oxybutynin chloride tab er 24hr 15 mg 162
oxybutynin chloride tab er 24hr 5 mg 162
oxycodone hcl cap 5 mg 44
oxycodone hcl conc 100 mg/5ml (20 mg/ml) .. 44
oxycodone hcl soln 5 mg/5ml 44
oxycodone hcl tab 10 mg 44
oxycodone hcl tab 15 mg 44
oxycodone hcl tab 20 mg 44
oxycodone hcl tab 30 mg 44
oxycodone hcl tab 5 mg 44
oxycodone w/ acetaminophen tab 10-325 mg 47
Oxycodone W/ Acetaminophen Tab 10-325 mg47
oxycodone w/ acetaminophen tab 2.5-325 mg
..... 47
Oxycodone W/ Acetaminophen Tab 2.5-325 mg
..... 47
oxycodone w/ acetaminophen tab 5-325 mg .. 47
Oxycodone W/ Acetaminophen Tab 5-325 mg . 47
oxycodone w/ acetaminophen tab 7.5-325 mg
..... 47
Oxycodone W/ Acetaminophen Tab 7.5-325 mg
..... 47
oxymetazoline hcl cream 1% 125
oxymorphone hcl tab 10 mg 44
oxymorphone hcl tab 5 mg 44
ozanimod hcl
see ZEPOSIA 7DAY CAP STR PACK 154
see ZEPOSIA CAP 0.92MG 154
see ZEPOSIA CAP STR KIT 155
OZEMPIC INJ 2MG/3ML 69
OZEMPIC INJ 4MG/3ML 69
OZEMPIC INJ 8MG/3ML 69
OZEMPIC TAB 1.5MG 69
OZEMPIC TAB 4MG 69
OZEMPIC TAB 9MG 69
P
PACERONE
see Amiodarone Hcl Tab 100 mg 16, 53
see Amiodarone Hcl Tab 200 mg 53
palbociclib
see IBRANCE CAP 125MG 86
see IBRANCE TAB 100MG 86
see IBRANCE TAB 125MG 86
see IBRANCE TAB 75MG 86
paliperidone tab er 24hr 1.5 mg 93
paliperidone tab er 24hr 3 mg 93
paliperidone tab er 24hr 6 mg 93
paliperidone tab er 24hr 9 mg 93
pancrelipase (lipase-protease-amylase)
see CREON CAP 12000UNT 125
see CREON CAP 24000UNT 125
see CREON CAP 3000UNIT 125
see CREON CAP 36000UNT 125
see CREON CAP 6000UNIT 125
see VIOKACE TAB 10440 125
see VIOKACE TAB 20880 125
see ZENPEP CAP 10000UNT 125
see ZENPEP CAP 15000UNT 125
see ZENPEP CAP 20000UNT 125
see ZENPEP CAP 25000UNT 125
see ZENPEP CAP 3000UNIT 125
see ZENPEP CAP 40000UNT 126
see ZENPEP CAP 5000UNIT 125
see ZENPEP CAP 60000UNT 126

pantoprazole sodium ec tab 20 mg (base equiv) 161
pantoprazole sodium ec tab 40 mg (base equiv) 162
paricalcitol cap 1 mcg 128
paricalcitol cap 2 mcg 128
paricalcitol cap 4 mcg 128
paroxetine hcl oral susp 10 mg/5ml (base equiv) 64
paroxetine hcl tab 10 mg 64
paroxetine hcl tab 20 mg 64
paroxetine hcl tab 30 mg 64
paroxetine hcl tab 40 mg 64
paroxetine hcl tab er 24hr 12.5 mg 64
paroxetine hcl tab er 24hr 25 mg 64
paroxetine hcl tab er 24hr 37.5 mg 64
patiromer sorbitex calcium
see VELTASSA POW 16.8GM 145
see VELTASSA POW 1GM 145
see VELTASSA POW 25.2GM 145
see VELTASSA POW 8.4GM 145
PAXLOVID PAK 98
PAXLOVID TAB 150-100 98
PAXLOVID TAB 300-100 98
pazopanib hcl tab 200 mg (base equiv) 88
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm 138
Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 236 gm 138
Peg 3350-Kcl-Na Bicarb-Nacl-Na Sulfate For Soln 240 gm 138
peg 3350-kcl-sod bicarb-nacl for soln 420 gm 138
Peg 3350-Kcl-Sod Bicarb-Nacl For Soln 420 gm 138
penciclovir cream 1% 121
penicillamine cap 250 mg 143
penicillamine tab 250 mg 143
penicillin v potassium for soln 125 mg/5ml ... 151
penicillin v potassium for soln 250 mg/5ml ... 151
penicillin v potassium tab 250 mg 151
penicillin v potassium tab 500 mg 151
pentamidine isethionate for nebulization soln 300 mg 50
pentazocine w/ naloxone hcl tab 50-0.5 mg 48
pentoxifylline tab er 400 mg 134
perampanel susp 0.5 mg/ml 58
perampanel tab 10 mg 58
perampanel tab 12 mg 58
perampanel tab 2 mg 58
perampanel tab 4 mg 58
perampanel tab 6 mg 58
perampanel tab 8 mg 58
perindopril erbumine tab 2 mg 76
perindopril erbumine tab 4 mg 76
perindopril erbumine tab 8 mg 76
permethrin cream 5% 125
perphenazine tab 16 mg 95
perphenazine tab 2 mg 95
perphenazine tab 4 mg 95
perphenazine tab 8 mg 95
perphenazine-amitriptyline tab 2-10 mg 153
perphenazine-amitriptyline tab 2-25 mg 153
perphenazine-amitriptyline tab 4-10 mg 153
perphenazine-amitriptyline tab 4-25 mg 153
perphenazine-amitriptyline tab 4-50 mg 153
pexidartinib hcl
see TURALIO CAP 125MG 89
PHEBURANE MIS 483/GM 128
phendimetrazine tartrate tab 35 mg 31
phenelzine sulfate tab 15 mg 63
phenobarbital elixir 20 mg/5ml 137
phenobarbital tab 100 mg 137
phenobarbital tab 15 mg 137
phenobarbital tab 16.2 mg 137
phenobarbital tab 30 mg 137
phenobarbital tab 32.4 mg 137
phenobarbital tab 60 mg 137
phenobarbital tab 64.8 mg 137
phenobarbital tab 97.2 mg 137
phenoxybenzamine hcl cap 10 mg 77
phentermine hcl cap 15 mg 31
phentermine hcl cap 30 mg 31
phentermine hcl cap 37.5 mg 31
phentermine hcl tab 37.5 mg 31
Phentermine Hcl Tab 8 mg 31
phentermine hcl-topiramate
see QSYMIA CAP 11.25-69 31
see QSYMIA CAP 15-92MG 31
see QSYMIA CAP 3.75-23 31
see QSYMIA CAP 7.5-46MG 31
phentermine hcl-topiramate cap er 24hr 11.25-69 mg 31
phentermine hcl-topiramate cap er 24hr 15-92 mg 31

phentermine hcl-topiramate cap er 24hr 3.75-23 mg 31
phentermine hcl-topiramate cap er 24hr 7.5-46 mg 31
phenylephrine hcl ophth soln 10% 147
phenylephrine hcl ophth soln 2.5% 147
PHENYTEK
see Phenytoin Sodium Extended Cap 200 mg 62
see Phenytoin Sodium Extended Cap 300 mg 62
phenytoin chew tab 50 mg 62
phenytoin sodium extended cap 100 mg 62
phenytoin sodium extended cap 200 mg 62
Phenytoin Sodium Extended Cap 200 mg 62
phenytoin sodium extended cap 300 mg 62
Phenytoin Sodium Extended Cap 300 mg 62
phenytoin susp 125 mg/5ml 62
PHEXX GEL 163
PHILITH
see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg 111
PHOSPHO-TRIN K500
see Potassium Phosphate Monobasic Tab 500 mg 143
phytonadione tab 5 mg 164
pilocarpine hcl ophth soln 1% 148
pilocarpine hcl ophth soln 1.25% 148
pilocarpine hcl ophth soln 2% 148
pilocarpine hcl ophth soln 4% 148
pilocarpine hcl tab 5 mg 145
pilocarpine hcl tab 7.5 mg 145
pimecrolimus cream 1% 124
pimozide tab 1 mg 155
pimozide tab 2 mg 155
PIMTREA
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 108
pindolol tab 10 mg 101
pindolol tab 5 mg 101
pioglitazone hcl tab 15 mg (base equiv) 70
pioglitazone hcl tab 30 mg (base equiv) 70
pioglitazone hcl tab 45 mg (base equiv) 70
pioglitazone hcl-glimepiride tab 30-2 mg 67
pioglitazone hcl-glimepiride tab 30-4 mg 67
pioglitazone hcl-metformin hcl tab 15-500 mg 67
pioglitazone hcl-metformin hcl tab 15-850 mg 67
PIQRAY 200MG TAB DOSE 88
PIQRAY 250MG TAB DOSE 88
PIQRAY 300MG TAB DOSE 88
pirfenidone cap 267 mg 158
pirfenidone tab 267 mg 158
pirfenidone tab 534 mg 158
pirfenidone tab 801 mg 158
piroxicam cap 10 mg 41
piroxicam cap 20 mg 41
pitavastatin calcium tab 1 mg 75
pitavastatin calcium tab 2 mg 75
pitavastatin calcium tab 4 mg 75
pitolisant hcl
see WAKIX TAB 17.8MG 33
see WAKIX TAB 4.45MG 33
PNV-DHA
see Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg 145
PNV-SELECT
see Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg 146
POCKET CHAMB MIS 141
POCKET SPACE MIS 141
podofilox gel 0.5% 124
podofilox soln 0.5% 124
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1% 148
pomalidomide
see POMALYST CAP 1MG 84
see POMALYST CAP 2MG 84
see POMALYST CAP 3MG 84
see POMALYST CAP 4MG 84
pomalidomide cap 1 mg 84
pomalidomide cap 2 mg 84
pomalidomide cap 3 mg 84
pomalidomide cap 4 mg 84
POMALYST CAP 1MG 84
POMALYST CAP 2MG 84
POMALYST CAP 3MG 84
POMALYST CAP 4MG 84
PORTIA-28
see Levonorgestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 110
posaconazole susp 40 mg/ml 72
potassium chloride cap er 10 meq 143
potassium chloride cap er 8 meq 143

potassium chloride microencapsulated crys er tab 10 meq 143
Potassium Chloride Microencapsulated Crys Er Tab 10 meq 143
potassium chloride microencapsulated crys er tab 15 meq 143
Potassium Chloride Microencapsulated Crys Er Tab 15 meq 143
potassium chloride microencapsulated crys er tab 20 meq 143
Potassium Chloride Microencapsulated Crys Er Tab 20 meq 143
potassium chloride oral soln 10% (20 meq/15ml) 143
potassium chloride oral soln 20% (40 meq/15ml) 143
potassium chloride powder packet 20 meq 143
Potassium Chloride Powder Packet 20 meq 143
potassium chloride tab er 10 meq 143
Potassium Chloride Tab Er 10 meq 143
potassium chloride tab er 15 meq 143
potassium chloride tab er 20 meq (1500 mg) 143
potassium chloride tab er 8 meq (600 mg) 143
Potassium Chloride Tab Er 8 meq (600 mg) 143
potassium citrate tab er 10 meq (1080 mg) 133
potassium citrate tab er 15 meq (1620 mg) 133
potassium citrate tab er 5 meq (540 mg) 133
potassium iodide oral soln 1 gm/ml 118
Potassium Phosphate Monobasic Tab 500 mg 143
pralsetinib
see GAVRETO CAP 100MG 86
pramipexole dihydrochloride tab 0.125 mg 92
pramipexole dihydrochloride tab 0.25 mg 92
pramipexole dihydrochloride tab 0.5 mg 92
pramipexole dihydrochloride tab 0.75 mg 92
pramipexole dihydrochloride tab 1 mg 92
pramipexole dihydrochloride tab 1.5 mg 92
pramipexole dihydrochloride tab er 24hr 0.375 mg 92
pramipexole dihydrochloride tab er 24hr 0.75 mg 92
pramipexole dihydrochloride tab er 24hr 1.5 mg 92
pramipexole dihydrochloride tab er 24hr 2.25 mg 92
pramipexole dihydrochloride tab er 24hr 3 mg 92
pramipexole dihydrochloride tab er 24hr 3.75 mg 92
pramipexole dihydrochloride tab er 24hr 4.5 mg 92
prasterone vaginal
see INTRAROSA SUP 6.5MG 163
prasugrel hcl tab 10 mg (base equiv) 135
prasugrel hcl tab 5 mg (base equiv) 135
pravastatin sodium tab 10 mg 75
pravastatin sodium tab 20 mg 75
pravastatin sodium tab 40 mg 75
pravastatin sodium tab 80 mg 75
praziquantel tab 600 mg 50
prazosin hcl cap 1 mg 78
prazosin hcl cap 2 mg 78
prazosin hcl cap 5 mg 78
PRED SOD PHO SOL 1% OP 149
prednisolone acetate ophth susp 1% 149
prednisolone sod phos orally disintegr tab 10 mg (base eq) 117
prednisolone sod phos orally disintegr tab 15 mg (base eq) 117
prednisolone sod phos orally disintegr tab 30 mg (base eq) 117
prednisolone sod phosphate oral soln 15 mg/5ml (base equiv) 117
prednisolone sod phosphate oral soln 5 mg/5ml (base equiv) 117
prednisolone sodium phosphate oral soln 25 mg/5ml (base eq) 117
prednisolone soln 15 mg/5ml 117
prednisolone tab 5 mg 117
prednisone oral soln 5 mg/5ml 117
prednisone tab 1 mg 117
prednisone tab 10 mg 117
prednisone tab 2.5 mg 117
prednisone tab 20 mg 117
prednisone tab 5 mg 117
prednisone tab 50 mg 117
prednisone tab delayed release 1 mg 117
prednisone tab delayed release 2 mg 117
prednisone tab delayed release 5 mg 117
prednisone tab therapy pack 10 mg (21) 117
prednisone tab therapy pack 10 mg (48) 117
prednisone tab therapy pack 5 mg (21) 117
prednisone tab therapy pack 5 mg (48) 117
pregabalin cap 100 mg 61

pregabalin cap 150 mg 61
pregabalin cap 200 mg 61
pregabalin cap 225 mg 61
pregabalin cap 25 mg 61
pregabalin cap 300 mg 61
pregabalin cap 50 mg 61
pregabalin cap 75 mg 61
pregabalin soln 20 mg/ml 61
pregabalin tab er 24hr 165 mg 155
pregabalin tab er 24hr 330 mg 155
pregabalin tab er 24hr 82.5 mg 155
PREMPHASE TAB 130
PREMPRO TAB 130
PREMPRO TAB 0.3-1.5 130
PREMPRO TAB 0.45-1.5 130
PREMPRO TAB 0.625-5 130
Prenat W/o A W/fefum-Methfol-Fa-Dha Cap 27-0.6-0.4-300 mg 145
Prenatal Vit W/ Fe Fum-Methylfolate-Fa Tab 27-0.6-0.4 mg 146
Prenatal Vit W/ Iron Carbonyl-Fa Tab 50-1.25 mg 146
PREVALITE
see Cholestyramine Light Powder 4 gm/dose 74
see Cholestyramine Light Powder Packets 4 gm 74
PREZCOBIX TAB 800-150 97
primaquine phosphate tab 26.3 mg (15 mg base) 81
primidone tab 250 mg 61
primidone tab 50 mg 61
probenecid tab 500 mg 134
PROCENTRA
see Dextroamphetamine Sulfate Oral Solution 5 mg/5ml 28
prochlorperazine maleate tab 10 mg (base equivalent) 95
prochlorperazine maleate tab 5 mg (base equivalent) 95
prochlorperazine suppos 25 mg 95
Prochlorperazine Suppos 25 mg 95
PROCTOCORT
see Hydrocortisone Perianal Cream 1% 49
PROCTOFOAM AER HC 1% 49
PROCTO-MED HC
see Hydrocortisone Perianal Cream 2.5% 49
PROCTOSOL HC
see Hydrocortisone Perianal Cream 2.5% 49
PROCTOZONE-HC
see Hydrocortisone Perianal Cream 2.5% 49
progesterone (vaginal)
see CRINONE GEL 4% VAG 163
see CRINONE GEL 8% VAG 163
progesterone cap 100 mg 151
progesterone cap 200 mg 151
progesterone vaginal insert 100 mg 163
promethazine & phenylephrine syrup 6.25-5 mg/5ml 118
promethazine hcl oral soln 6.25 mg/5ml 73
promethazine hcl suppos 12.5 mg 73
Promethazine Hcl Suppos 12.5 mg 73
promethazine hcl suppos 25 mg 73
Promethazine Hcl Suppos 25 mg 73
Promethazine Hcl Suppos 50 mg 73
promethazine hcl tab 12.5 mg 73
promethazine hcl tab 25 mg 73
promethazine hcl tab 50 mg 73
promethazine w/ codeine syrup 6.25-10 mg/5ml 118
promethazine-dm syrup 6.25-15 mg/5ml 118
PROMETHEGAN
see Promethazine Hcl Suppos 12.5 mg 73
see Promethazine Hcl Suppos 25 mg 73
see Promethazine Hcl Suppos 50 mg 73
propafenone hcl cap er 12hr 225 mg 53
propafenone hcl cap er 12hr 325 mg 53
propafenone hcl cap er 12hr 425 mg 53
propafenone hcl tab 150 mg 53
propafenone hcl tab 225 mg 53
propafenone hcl tab 300 mg 53
propranolol hcl cap er 24hr 120 mg 101
propranolol hcl cap er 24hr 160 mg 101
propranolol hcl cap er 24hr 60 mg 101
propranolol hcl cap er 24hr 80 mg 101
propranolol hcl oral soln 20 mg/5ml 101
propranolol hcl oral soln 40 mg/5ml 101
propranolol hcl tab 10 mg 101
propranolol hcl tab 20 mg 101
propranolol hcl tab 40 mg 101
propranolol hcl tab 60 mg 101
propranolol hcl tab 80 mg 101
propylthiouracil tab 50 mg 159
protriptyline hcl tab 10 mg 66

protriptyline hcl tab 5 mg 66
prucalopride succinate tab 1 mg (base equivalent) 132
prucalopride succinate tab 2 mg (base equivalent) 132
PRURADIK
see Crotamiton Lotion 10% 125
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml 118
PULMICORT INH 180MCG 55
PULMICORT INH 90MCG 55
PYQUVI
see Deflazacort Susp 22.75 mg/ml 116
pyrazinamide tab 500 mg 81
pyridostigmine bromide oral soln 60 mg/5ml . 81
pyridostigmine bromide tab 60 mg 81
pyridostigmine bromide tab er 180 mg 81
pyrimethamine tab 25 mg 81
Q
QC FOLIC ACID
see Folic Acid Tab 800 mcg 136
QELBREE CAP 100MG ER 33
QELBREE CAP 150MG ER 33
QELBREE CAP 200MG ER 33
QSYMIA CAP 11.25-69 31
QSYMIA CAP 15-92MG 31
QSYMIA CAP 3.75-23 31
QSYMIA CAP 7.5-46MG 31
quetiapine fumarate tab 100 mg 94
quetiapine fumarate tab 150 mg 94
quetiapine fumarate tab 200 mg 95
quetiapine fumarate tab 25 mg 94
quetiapine fumarate tab 300 mg 95
quetiapine fumarate tab 400 mg 95
quetiapine fumarate tab 50 mg 94
quetiapine fumarate tab er 24hr 150 mg 95
quetiapine fumarate tab er 24hr 200 mg 95
quetiapine fumarate tab er 24hr 300 mg 95
quetiapine fumarate tab er 24hr 400 mg 95
quetiapine fumarate tab er 24hr 50 mg 95
quinapril hcl tab 10 mg 76
quinapril hcl tab 20 mg 76
quinapril hcl tab 40 mg 76
quinapril hcl tab 5 mg 76
quinapril-hydrochlorothiazide tab 10-12.5 mg 80
quinidine gluconate tab er 324 mg 53
quinine sulfate cap 324 mg 81
QULIPTA TAB 10MG 141
QULIPTA TAB 30MG 141
QULIPTA TAB 60MG 141
QUVIVIQ TAB 25MG 138
QUVIVIQ TAB 50MG 138
R
rabeprazole sodium ec tab 20 mg 162
RADICAVA ORS SUS 105/5ML 147
RADICAVA ORS SUS STARTER 147
RAGWITEK SUB 38
raloxifene hcl tab 60 mg 127
raltegravir potassium
see ISENTRESS CHW 100MG 97
see ISENTRESS CHW 25MG 97
see ISENTRESS HD TAB 600MG 97
see ISENTRESS POW 100MG 97
see ISENTRESS TAB 400MG 97
ramelteon tab 8 mg 138
ramipril cap 1.25 mg 76
ramipril cap 10 mg 76
ramipril cap 2.5 mg 76
ramipril cap 5 mg 76
ranitidine hcl tab 150 mg 161
ranitidine hcl tab 300 mg 161
ranolazine tab er 12hr 1000 mg 51
ranolazine tab er 12hr 500 mg 51
rasagiline mesylate tab 0.5 mg (base equiv) ... 92
rasagiline mesylate tab 1 mg (base equiv) 92
RECLIPSEN
see Desogestrel & Ethinyl Estradiol Tab 0.15 mg-30 mcg 108
regorafenib
see STIVARGA TAB 40MG 89
RELENZA MIS DISKHALE 99
relugolix-estradiol-norethindrone acetate
see MYFEMBREE TAB 130
repaglinide tab 0.5 mg 70
repaglinide tab 1 mg 70
repaglinide tab 2 mg 70
repotrectinib
see AUGTYRO CAP 160MG 84
see AUGTYRO CAP 40MG 84
RESTASIS EMU 0.05% OP 148
RESTASIS MUL EMU 0.05% OP 148
RETEVMO TAB 120MG 88
RETEVMO TAB 160MG 88
RETEVMO TAB 40MG 88

RETEVMO TAB 80MG 88
revefenacin
see YUPELRI NEB 175/3ML 54
ribavirin cap 200 mg 99
ribavirin tab 200 mg 99
ribociclib succinate
see KISQALI TAB 200DOSE 87
see KISQALI TAB 400DOSE 87
see KISQALI TAB 600DOSE 87
rifabutin cap 150 mg 81
rifampin cap 150 mg 81
rifampin cap 300 mg 81
rifapentine tab 150 mg 81
rifaximin
see XIFAXAN TAB 550MG 50
rilpivirine hcl tab 25 mg (base equivalent) 97
riluzole tab 50 mg 147
rimantadine hydrochloride tab 100 mg 99
rimegepant sulfate
see NURTEC TAB 75MG ODT 141
RINVOQ LQ SOL 1MG/ML 39
RINVOQ TAB 15MG ER 39
RINVOQ TAB 30MG ER 39
RINVOQ TAB 45MG ER 39
riociguat
see ADEMPAS TAB 0.5MG 106
see ADEMPAS TAB 1.5MG 106
see ADEMPAS TAB 1MG 106
see ADEMPAS TAB 2.5MG 106
see ADEMPAS TAB 2MG 106
risedronate sodium tab 150 mg 127
risedronate sodium tab 30 mg 127
risedronate sodium tab 35 mg 127
risedronate sodium tab 5 mg 127
risedronate sodium tab delayed release 35 mg 127
risperidone orally disintegrating tab 0.25 mg . 93
risperidone orally disintegrating tab 0.5 mg ... 93
risperidone orally disintegrating tab 1 mg 93
risperidone orally disintegrating tab 2 mg 93
risperidone orally disintegrating tab 3 mg 93
risperidone orally disintegrating tab 4 mg 93
risperidone soln 1 mg/ml 93
risperidone tab 0.25 mg 93
risperidone tab 0.5 mg 93
risperidone tab 1 mg 93
risperidone tab 2 mg 94
risperidone tab 3 mg 94
risperidone tab 4 mg 94
RITEFLO MIS 141
ritlecitinib tosylate
see LITFULO CAP 50MG 124
ritonavir tab 100 mg 97
rivaroxaban
see XARELTO STAR TAB 15/20MG 58
see XARELTO SUS 1MG/ML 58
see XARELTO TAB 10MG 58
see XARELTO TAB 15MG 58
see XARELTO TAB 2.5MG 58
see XARELTO TAB 20MG 58
rivaroxaban for susp 1 mg/ml 58
rivaroxaban tab 2.5 mg 58
rivastigmine tartrate cap 1.5 mg (base equivalent) 153
rivastigmine tartrate cap 3 mg (base equivalent) 153
rivastigmine tartrate cap 4.5 mg (base equivalent) 153
rivastigmine tartrate cap 6 mg (base equivalent) 153
rivastigmine td patch 24hr 13.3 mg/24hr 153
rivastigmine td patch 24hr 4.6 mg/24hr 153
rivastigmine td patch 24hr 9.5 mg/24hr 153
RIVELSA
see Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg 109
rizatriptan benzoate oral disintegrating tab 10 mg (base eq) 142
rizatriptan benzoate oral disintegrating tab 5 mg (base eq) 142
rizatriptan benzoate tab 10 mg (base equivalent) 142
rizatriptan benzoate tab 5 mg (base equivalent) 142
roflumilast (topical)
see ZORYVE CRE 0.05% 124
see ZORYVE CRE 0.15% 124
see ZORYVE CRE 0.3% 124
see ZORYVE MIS 0.3% 124
roflumilast tab 250 mcg 54
roflumilast tab 500 mcg 54
ropinirole hydrochloride tab 0.25 mg 92
ropinirole hydrochloride tab 0.5 mg 92
ropinirole hydrochloride tab 1 mg 92

ropinirole hydrochloride tab 2 mg 92
ropinirole hydrochloride tab 3 mg 92
ropinirole hydrochloride tab 4 mg 92
ropinirole hydrochloride tab 5 mg 92
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent) 92
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent) 92
ropinirole hydrochloride tab er 24hr 4 mg (base equivalent) 92
ropinirole hydrochloride tab er 24hr 6 mg (base equivalent) 92
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent) 92
rosuvastatin calcium tab 10 mg 75
rosuvastatin calcium tab 20 mg 75
rosuvastatin calcium tab 40 mg 75
rosuvastatin calcium tab 5 mg 75
ROSYRAH
see Levonor-Eth Est Tab 0.15-0.02/0.025/0.03 mg &eth Est 0.01 mg 109
rotigotine
see NEUPRO DIS 1MG/24HR 91
see NEUPRO DIS 2MG/24HR 91
see NEUPRO DIS 3MG/24HR 91
see NEUPRO DIS 4MG/24HR 91
see NEUPRO DIS 6MG/24HR 92
see NEUPRO DIS 8MG/24HR 92
ROWEEPRA
see Levetiracetam Tab 500 mg 60
ROZLYTREK CAP 100MG 88
ROZLYTREK CAP 200MG 89
ROZLYTREK PAK 50MG 89
rufinamide susp 40 mg/ml 61
rufinamide tab 200 mg 61
rufinamide tab 400 mg 61
ruxolitinib phosphate
see JAKAFI TAB 10MG 87
see JAKAFI TAB 15MG 87
see JAKAFI TAB 20MG 87
see JAKAFI TAB 25MG 87
see JAKAFI TAB 5MG 87
see JAKAFI XR TAB 11MG 87
see JAKAFI XR TAB 22MG 87
see JAKAFI XR TAB 33MG 87
see JAKAFI XR TAB 44MG 87
see JAKAFI XR TAB 55MG 87
ruxolitinib phosphate (topical)
see OPZELURA CRE 1.5% 124
RYBELSUS TAB 14MG 69
RYBELSUS TAB 3MG 69
RYBELSUS TAB 7MG 69
RYDAPT CAP 25MG 89
RYTARY CAP 145MG 92
RYTARY CAP 195MG 92
RYTARY CAP 245MG 92
RYTARY CAP 95MG 92
RYVENT
see Carbinoxamine Maleate Tab 6 mg 73
S
sacubitril-valsartan tab 24-26 mg 104
sacubitril-valsartan tab 49-51 mg 104
sacubitril-valsartan tab 97-103 mg 104
salmeterol xinafoate
see SEREVENT DIS AER 50MCG 57
salsalate tab 750 mg 42
SANCUSO DIS 3.1MG 72
sapropterin dihydrochloride powder packet 100 mg 128
Sapropterin Dihydrochloride Powder Packet 100 mg 128
sapropterin dihydrochloride powder packet 500 mg 128
Sapropterin Dihydrochloride Powder Packet 500 mg 128
sapropterin dihydrochloride tab 100 mg 128
Sapropterin Dihydrochloride Tab 100 mg 129
saxagliptin hcl tab 2.5 mg (base equiv) 68
saxagliptin hcl tab 5 mg (base equiv) 68
saxagliptin-metformin hcl tab er 24hr 2.5-1000 mg 67
saxagliptin-metformin hcl tab er 24hr 5-1000 mg 67
saxagliptin-metformin hcl tab er 24hr 5-500 mg 67
SCEMBLIX TAB 100MG 89
SCEMBLIX TAB 20MG 89
SCEMBLIX TAB 40MG 89
scopolamine td patch 72hr 1 mg/3days 72
segesterone acetate-ethinyl estradiol
see ANNOVERA MIS 115
selegiline hcl cap 5 mg 92
selegiline hcl tab 5 mg 92
selenium sulfide lotion 2.5% 121

selexipag
see UPTRAVI PACK TAB 200/800 106
see UPTRAVI TAB 1000MCG 106
see UPTRAVI TAB 100MCG 106
see UPTRAVI TAB 1200MCG 106
see UPTRAVI TAB 1400MCG 106
see UPTRAVI TAB 150MCG 106
see UPTRAVI TAB 1600MCG 106
see UPTRAVI TAB 200MCG 106
see UPTRAVI TAB 400MCG 106
see UPTRAVI TAB 600MCG 106
see UPTRAVI TAB 800MCG 106
selpercatinib
see RETEVMO TAB 120MG 88
see RETEVMO TAB 160MG 88
see RETEVMO TAB 40MG 88
see RETEVMO TAB 80MG 88
selumetinib sulfate
see KOSELUGO CAP 10MG 87
see KOSELUGO CAP 25MG 87
see KOSELUGO CAP 5MG 87
see KOSELUGO CAP 7.5MG 87
semaglutide
see OZEMPIC INJ 2MG/3ML 69
see OZEMPIC INJ 4MG/3ML 69
see OZEMPIC INJ 8MG/3ML 69
see OZEMPIC TAB 1.5MG 69
see OZEMPIC TAB 4MG 69
see OZEMPIC TAB 9MG 69
see RYBELSUS TAB 14MG 69
see RYBELSUS TAB 3MG 69
see RYBELSUS TAB 7MG 69
semaglutide (weight management)
see WEGOVY TAB 1.5MG 32
see WEGOVY TAB 25MG 32
see WEGOVY TAB 4MG 32
see WEGOVY TAB 9MG 32
serdexmethylphenidate chloride-dexmethylphenidate hcl
see AZSTARYS CAP 26.1-5.2 33
see AZSTARYS CAP 39.2-7.8 33
see AZSTARYS CAP 52.3-10. 33
SEREVENT DIS AER 50MCG 57
sertraline hcl cap 150 mg 64
sertraline hcl cap 200 mg 64
sertraline hcl oral concentrate for solution 20 mg/ml 64
sertraline hcl tab 100 mg 64
sertraline hcl tab 25 mg 64
sertraline hcl tab 50 mg 64
SETLAKIN
see Levonorgestrel & Ethinyl Estradiol (91-Day) Tab 0.15-0.03 mg 109
sevelamer carbonate packet 0.8 gm 133
sevelamer carbonate packet 2.4 gm 133
sevelamer carbonate tab 800 mg 133
sevelamer hcl tab 400 mg 133
sevelamer hcl tab 800 mg 133
SHAROBEL
see Norethindrone Tab 0.35 mg 115
short ragweed pollen allergen extract
see RAGWITEK SUB 38
SIKLOS TAB 1000MG 135
SIKLOS TAB 100MG 135
sildenafil citrate for suspension 10 mg/ml 106
sildenafil citrate tab 100 mg 104
sildenafil citrate tab 20 mg 106
sildenafil citrate tab 25 mg 104
sildenafil citrate tab 50 mg 104
silodosin cap 4 mg 134
silodosin cap 8 mg 134
silver sulfadiazine cream 1% 122
Silver Sulfadiazine Cream 1% 122
SIMBRINZA SUS 1-0.2% 148
SIMLIYA
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 108
SIMPESSE
see Levonorg-Eth Est Tab 0.15-0.03mg(84) & Eth Est Tab 0.01mg(7) 109
simvastatin tab 10 mg 75
simvastatin tab 20 mg 75
simvastatin tab 40 mg 75
simvastatin tab 5 mg 75
simvastatin tab 80 mg 75
siponimod fumarate
see MAYZENT PAK STARTER 154
see MAYZENT TAB 0.25MG 154
see MAYZENT TAB 1MG 154
see MAYZENT TAB 2MG 154
sirolimus oral soln 1 mg/ml 144
sirolimus tab 0.5 mg 144
sirolimus tab 1 mg 144
sirolimus tab 2 mg 144

SIRTURO TAB 100MG 81
SIRTURO TAB 20MG 81
sitagliptin
see ZITUVIO TAB 100MG 69
see ZITUVIO TAB 25MG 69
see ZITUVIO TAB 50MG 69
sitagliptin free base-metformin hcl
see ZITUVIMET TAB 50-1000 68
see ZITUVIMET TAB 50-500MG 68
see ZITUVIMET XR TAB 100-1000 68
see ZITUVIMET XR TAB 50-1000 68
see ZITUVIMET XR TAB 50-500MG 68
sitagliptin phosphate tab 100 mg (base equiv) 68
sitagliptin phosphate tab 25 mg (base equiv) . 68
sitagliptin phosphate tab 50 mg (base equiv) . 68
sitagliptin phosphate-metformin hcl tab 50-1000 mg 67
sitagliptin phosphate-metformin hcl tab 50-500 mg 67
sitagliptin phosphate-metformin hcl tab er 24hr 100-1000 mg 67
sitagliptin phosphate-metformin hcl tab er 24hr 50-1000 mg 67
sitagliptin phosphate-metformin hcl tab er 24hr 50-500 mg 67
SM NICOTINE
see Nicotine Polacrilex Lozenge 2 mg 156
SM NICOTINE POLACRILEX
see Nicotine Polacrilex Lozenge 4 mg 157
sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml 138
sodium chloride soln nebu 0.9% 118
sodium chloride soln nebu 10% 118
sodium chloride soln nebu 3% 118
sodium chloride soln nebu 7% 118
sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf) 142
sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf) 142
sodium fluoride chew tab 1 mg f (from 2.2 mg naf) 143
sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf) 143
sodium fluoride tab 0.5 mg f (from 1.1 mg naf) 143
sodium fluoride tab 1 mg f (from 2.2 mg naf) 143
sodium oxybate
see LUMRYZ PAK 6GM 152
see LUMRYZ PAK 7.5GM 152
see LUMRYZ PAK 9GM 152
see LUMRYZ PAK STARTER 152
see LUMRYZ PKG 4.5GM 152
sodium oxybate oral solution 500 mg/ml 152
sodium phenylbutyrate
see PHEBURANE MIS 483/GM 128
sodium phenylbutyrate oral powder 3 gm/teaspoonful 129
sodium phenylbutyrate tab 500 mg 129
sodium picosulfate-magnesium oxide-anhydrous citric acid
see CLENPIQ SOL 138
sodium polystyrene sulfonate powder 145
Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml 145
sodium polystyrene sulfonate susp 15 gm/60ml 145
Sodium Polystyrene Sulfonate Susp 15 gm/60ml 145
sofosbuvir
see SOVALDI PAK 150MG 99
see SOVALDI PAK 200MG 99
see SOVALDI TAB 200MG 99
see SOVALDI TAB 400MG 99
sofosbuvir-velpatasvir
see EPCLUSA PAK 150-37.5 98
see EPCLUSA PAK 200-50MG 98
see EPCLUSA TAB 200-50MG 98
see EPCLUSA TAB 400-100 98
sofosbuvir-velpatasvir-voxilaprevir
see VOSEVI TAB 99
solifenacin succinate tab 10 mg 162
solifenacin succinate tab 5 mg 162
SOLIQUA INJ 100/33 67
solriamfetol hcl
see SUNOSI TAB 150MG 33
see SUNOSI TAB 75MG 33
sonidegib phosphate
see ODOMZO CAP 200MG 83
sorafenib tosylate tab 200 mg (base equivalent) 89
sotalol hcl (afib/afl) tab 120 mg 101
sotalol hcl (afib/afl) tab 160 mg 101
sotalol hcl (afib/afl) tab 80 mg 101
sotalol hcl tab 120 mg 101

sotalol hcl tab 160 mg 101
sotalol hcl tab 240 mg 101
sotalol hcl tab 80 mg 101
sotorasib
see LUMAKRAS TAB 120MG 87
see LUMAKRAS TAB 240MG 87
see LUMAKRAS TAB 320MG 88
SOTYKTU TAB 6MG 121
SOVALDI PAK 150MG 99
SOVALDI PAK 200MG 99
SOVALDI TAB 200MG 99
SOVALDI TAB 400MG 99
spacer/aerosol-holding chamber supplies - masks
see FLEXICHAMBER MIS MASK LRG 141
see FLEXICHAMBER MIS MASK SM 141
spacer/aerosol-holding chambers
see AERCHMBR PLS MIS LRG MASK 140
see AERCHMBR PLS MIS MED MASK 140
see AERCHMBR PLS MIS SM MASK 140
see AERCHMBR Z- MIS STAT PLS 140
see AEROCHAMBER MIS CHAMBER 140
see AEROCHAMBER MIS MV 140
see AEROCHAMBER MIS PLUS 140
see AEROVENT MIS PLUS 140
see BREATHE EASE MIS LG MASK 140
see BREATHE EASE MIS MED MASK 140
see BREATHE EASE MIS SM MASK 140
see COMPACT SPAC MIS CHAMBER 140
see COMPACT SPAC MIS LG MASK 140
see COMPACT SPAC MIS MD MASK 140
see COMPACT SPAC MIS SM MASK 140
see EASIVENT MIS 140
see EASIVENT MIS MASK LG 140
see EASIVENT MIS MASK MED 140
see EASIVENT MIS MASK SM 140
see FLEXICHAMBER MIS 141
see HOLD CHAMBER MIS ADLT LG 141
see HOLD CHAMBER MIS MEDIUM 141
see HOLD CHAMBER MIS SMALL 141
see INSPIREASE MIS DD SYST 141
see MICROCHAMBER MIS 141
see MICROSPACER MIS 141
see OPTICHAMBER MIS DIA LG 141
see OPTICHAMBER MIS DIA MD 141
see OPTICHAMBER MIS DIA SM 141
see OPTICHAMBER MIS DIAMOND 141
see POCKET CHAMB MIS 141
see POCKET SPACE MIS 141
see RITEFLO MIS 141
sparsentan
see FILSPARI TAB 200MG 133
see FILSPARI TAB 400MG 133
spinosad susp 0.9% 125
SPIRIVA CAP HANDIHLR 54
SPIRIVA RESP AER 1.25MCG 54
SPIRIVA RESP AER 2.5MCG 54
spironolactone & hydrochlorothiazide tab 25-25 mg 126
spironolactone susp 25 mg/5ml 126
spironolactone tab 100 mg 126
spironolactone tab 25 mg 126
spironolactone tab 50 mg 126
SPRINTEC 28
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg 114
SPS
see Sodium Polystyrene Sulfonate Rectal Susp 30 gm/120ml 145
see Sodium Polystyrene Sulfonate Susp 15 gm/60ml 145
SSD
see Silver Sulfadiazine Cream 1% 122
STIOLTO AER 2.5-2.5 57
STIVARGA TAB 40MG 89
STRIVERDI AER 2.5MCG 57
SUBVENITE
see Lamotrigine Tab 100 mg 60
see Lamotrigine Tab 150 mg 60
see Lamotrigine Tab 200 mg 60
see Lamotrigine Tab 25 mg 60
SUBVENITE STARTER KIT/BLU
see Lamotrigine Tab 35 X 25 mg Starter Kit .. 60
SUBVENITE STARTER KIT/GRE
see Lamotrigine Tab 84 X 25 mg & 14 X 100 mg Starter Kit 60
SUBVENITE STARTER KIT/ORA
see Lamotrigine Tab 25 mg (42) & 100 mg (7) Starter Kit 60
sucralfate tab 1 gm 161
sulconazole nitrate cream 1% 121
sulconazole nitrate solution 1% 121
sulfacetamide sodium lotion 10% (acne) 119
sulfacetamide sodium ophth soln 10% 148

sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)% 149
sulfadiazine tab 500 mg 158
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml 50
Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml 50
sulfamethoxazole-trimethoprim tab 400-80 mg 50
sulfamethoxazole-trimethoprim tab 800-160 mg 50
sulfasalazine tab 500 mg 132
sulfasalazine tab delayed release 500 mg 132
SULFATRIM PEDIATRIC
see Sulfamethoxazole-Trimethoprim Susp 200-40 mg/5ml 50
sulindac tab 150 mg 41
sulindac tab 200 mg 41
sumatriptan
see TOSYMRA SOL 10MG 142
sumatriptan nasal spray 20 mg/act 142
sumatriptan nasal spray 5 mg/act 142
sumatriptan succinate
see IMITREX INJ 4MG/0.5 142
see IMITREX INJ 6MG/0.5 142
see ZEMBRACE SYM INJ 3/0.5ML 142
sumatriptan succinate inj 6 mg/0.5ml 142
sumatriptan succinate solution auto-injector 6 mg/0.5ml 142
sumatriptan succinate tab 100 mg 142
sumatriptan succinate tab 25 mg 142
sumatriptan succinate tab 50 mg 142
sunitinib malate cap 12.5 mg (base equivalent) 89
sunitinib malate cap 25 mg (base equivalent) 89
sunitinib malate cap 37.5 mg (base equivalent) 89
sunitinib malate cap 50 mg (base equivalent) 89
SUNOSI TAB 150MG 33
SUNOSI TAB 75MG 33
suvorexant
see BELSOMRA TAB 10MG 138
see BELSOMRA TAB 15MG 138
see BELSOMRA TAB 20MG 138
see BELSOMRA TAB 5MG 138
SYEDA
see Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg 109
SYMPROIC TAB 0.2MG 133
SYMTUZA TAB 98
SYNAREL SOL 2MG/ML 127
SYNJARDY TAB 67
SYNJARDY TAB 12.5-500 67
SYNJARDY TAB 5-1000MG 67
SYNJARDY TAB 5-500MG 67
SYNJARDY XR TAB 67
SYNJARDY XR TAB 10-1000 67
SYNJARDY XR TAB 25-1000 68
SYNJARDY XR TAB 5-1000MG 67
SYNTHROID TAB 100MCG 160
SYNTHROID TAB 112MCG 160
SYNTHROID TAB 125MCG 160
SYNTHROID TAB 137MCG 160
SYNTHROID TAB 150MCG 160
SYNTHROID TAB 175MCG 160
SYNTHROID TAB 200MCG 160
SYNTHROID TAB 25MCG 160
SYNTHROID TAB 300MCG 160
SYNTHROID TAB 50MCG 160
SYNTHROID TAB 75MCG 160
SYNTHROID TAB 88MCG 160
T
tacrolimus cap 0.5 mg 145
tacrolimus cap 1 mg 145
tacrolimus cap 5 mg 145
tacrolimus cap er 24hr 0.5 mg 145
tacrolimus cap er 24hr 1 mg 145
tacrolimus cap er 24hr 5 mg 145
tacrolimus oint 0.03% 124
tacrolimus oint 0.1% 124
tadalafil (pulmonary hypertension)
see TADLIQ SUS 20MG/5ML 106
tadalafil tab 10 mg 105
tadalafil tab 2.5 mg 104
tadalafil tab 20 mg 105
tadalafil tab 20 mg (pah) 106
Tadalafil Tab 20 mg (Pah) 106
tadalafil tab 5 mg 104
TADLIQ SUS 20MG/5ML 106
tafamidis
see VYNDAMAX CAP 61MG 106
TAFINLAR CAP 50MG 89
TAFINLAR CAP 75MG 89

TAFINLAR TAB 10MG 89
tafluprost preservative free (pf) ophth soln 0.0015% 150
TAGRISSO TAB 40MG 83
TAGRISSO TAB 80MG 83
taletrectinib adipate
see IBTROZI CAP 200MG 86
TALICIA CAP 162
tamoxifen citrate tab 10 mg (base equivalent) 83
tamoxifen citrate tab 20 mg (base equivalent) 83
tamsulosin hcl cap 0.4 mg 134
TANLOR
see Methocarbamol Tab 1000 mg 146
tapentadol hcl tab 100 mg 44
tapentadol hcl tab 50 mg 44
tapentadol hcl tab 75 mg 44
tapinarof
see VTAMA CRE 1% 121
TARINA 24 FE
see Norethindrone Ace-Ethinyl Estradiol-Fe Tab 1 mg-20 mcg (24) 113
TARINA FE 1/20 EQ
see Norethindrone Ace & Ethinyl Estradiol-Fe Tab 1 mg-20 mcg 112
tasimelteon capsule 20 mg 138
TAYSOFY
see Norethindrone Ace-Ethinyl Estradiol-Fe Cap 1 mg-20 mcg (24) 113
tazarotene cream 0.05% 121
tazarotene cream 0.1% 121
tazarotene gel 0.05% 121
tazarotene gel 0.1% 121
telmisartan tab 20 mg 77
telmisartan tab 40 mg 77
telmisartan tab 80 mg 77
telmisartan-amlodipine tab 40-10 mg 80
telmisartan-amlodipine tab 40-5 mg 80
telmisartan-amlodipine tab 80-10 mg 80
telmisartan-amlodipine tab 80-5 mg 80
telmisartan-hydrochlorothiazide tab 40-12.5 mg 80
telmisartan-hydrochlorothiazide tab 80-12.5 mg 80
telmisartan-hydrochlorothiazide tab 80-25 mg 80
temazepam cap 15 mg 137
temazepam cap 22.5 mg 137
temazepam cap 30 mg 137
temazepam cap 7.5 mg 137
temozolomide cap 100 mg 82
temozolomide cap 140 mg 82
temozolomide cap 180 mg 82
temozolomide cap 20 mg 82
temozolomide cap 250 mg 82
temozolomide cap 5 mg 82
TENCON
see Butalbital-Acetaminophen Tab 50-325 mg 41
tenofovir disoproxil fumarate tab 300 mg 98
terazosin hcl cap 1 mg (base equivalent) 78
terazosin hcl cap 10 mg (base equivalent) 78
terazosin hcl cap 2 mg (base equivalent) 78
terazosin hcl cap 5 mg (base equivalent) 78
terbinafine hcl tab 250 mg 72
terbutaline sulfate tab 2.5 mg 57
terbutaline sulfate tab 5 mg 57
terconazole vaginal cream 0.4% 163
terconazole vaginal cream 0.8% 163
terconazole vaginal suppos 80 mg 163
teriflunomide tab 14 mg 154
teriflunomide tab 7 mg 154
testosterone
see NATESTO GEL 5.5MG 49
testosterone td gel 12.5 mg/act (1%) 49
testosterone td gel 20.25 mg/1.25gm (1.62%) 49
testosterone td gel 20.25 mg/act (1.62%) 49
testosterone td gel 25 mg/2.5gm (1%) 49
testosterone td gel 40.5 mg/2.5gm (1.62%) 49
testosterone td gel 50 mg/5gm (1%) 49
testosterone td soln 30 mg/act 49
tetrabenazine tab 12.5 mg 154
tetrabenazine tab 25 mg 154
tetracycline hcl cap 250 mg 159
tetracycline hcl cap 500 mg 159
TEXACORT
see Hydrocortisone Soln 2.5% 123
thalidomide
see THALOMID CAP 100MG 144
see THALOMID CAP 50MG 144
THALOMID CAP 100MG 144
THALOMID CAP 50MG 144
theophylline elixir 80 mg/15ml 57
Theophylline Elixir 80 mg/15ml 57
theophylline soln 80 mg/15ml 57

theophylline tab er 12hr 100 mg 57
theophylline tab er 12hr 200 mg 57
theophylline tab er 12hr 300 mg 57
theophylline tab er 12hr 450 mg 57
theophylline tab er 24hr 400 mg 57
theophylline tab er 24hr 600 mg 57
thioridazine hcl tab 10 mg 95
thioridazine hcl tab 100 mg 95
thioridazine hcl tab 25 mg 95
thioridazine hcl tab 50 mg 95
thiothixene cap 1 mg 96
thiothixene cap 10 mg 96
thiothixene cap 2 mg 96
thiothixene cap 5 mg 96
THRIVE
see Nicotine Polacrilex Gum 2 mg 156
TIADYLT ER
see Diltiazem Hcl Extended Release Beads Cap Er 24hr 120 mg 102
see Diltiazem Hcl Extended Release Beads Cap Er 24hr 180 mg 102
see Diltiazem Hcl Extended Release Beads Cap Er 24hr 240 mg 102
see Diltiazem Hcl Extended Release Beads Cap Er 24hr 300 mg 102
see Diltiazem Hcl Extended Release Beads Cap Er 24hr 360 mg 102
see Diltiazem Hcl Extended Release Beads Cap Er 24hr 420 mg 102
tiagabine hcl tab 12 mg 62
tiagabine hcl tab 16 mg 62
tiagabine hcl tab 2 mg 62
tiagabine hcl tab 4 mg 62
ticagrelor tab 60 mg 135
ticagrelor tab 90 mg 135
TILIA FE
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg 111
timolol maleate ophth gel forming soln 0.25% 147
timolol maleate ophth gel forming soln 0.5% 147
timolol maleate ophth soln 0.25% 147
timolol maleate ophth soln 0.5% 147
timolol maleate ophth soln 0.5% (once-daily) 147
timolol maleate preservative free ophth soln 0.25% 147
timolol maleate preservative free ophth soln 0.5% 147
timolol maleate tab 10 mg 101
timolol maleate tab 20 mg 101
timolol maleate tab 5 mg 101
timolol ophth soln 0.5% 147
timothy grass pollen allergen extract
see GRASTEK SUB 2800BAU 38
tinidazole tab 250 mg 50
tinidazole tab 500 mg 50
tiopronin tab 100 mg 134
tiopronin tab delayed release 100 mg 134
Tiopronin Tab Delayed Release 100 mg 134
tiopronin tab delayed release 300 mg 134
Tiopronin Tab Delayed Release 300 mg 134
tiotropium bromide
see SPIRIVA CAP HANDIHLR 54
see SPIRIVA RESP AER 1.25MCG 54
see SPIRIVA RESP AER 2.5MCG 54
tiotropium bromide-olodaterol hcl
see STIOLTO AER 2.5-2.5 57
tipranavir
see APTIVUS CAP 250MG 96
tirzepatide
see MOUNJARO INJ 10MG/0.5 69
see MOUNJARO INJ 12.5/0.5 69
see MOUNJARO INJ 15MG/0.5 69
see MOUNJARO INJ 2.5/0.5 69
see MOUNJARO INJ 5MG/0.5 69
see MOUNJARO INJ 7.5/0.5 69
TIVICAY PD TAB 5MG 98
TIVICAY TAB 50MG 98
tizanidine hcl cap 2 mg (base equivalent) 146
tizanidine hcl cap 4 mg (base equivalent) 146
tizanidine hcl cap 6 mg (base equivalent) 146
tizanidine hcl cap 8 mg (base equivalent) 146
tizanidine hcl tab 2 mg (base equivalent) 146
tizanidine hcl tab 4 mg (base equivalent) 146
TOBRADEX OIN 0.3-0.1% 149
tobramycin (ophth)
see TOBREX OIN 0.3% OP 148
tobramycin nebu soln 300 mg/4ml 38
tobramycin nebu soln 300 mg/5ml 39
tobramycin ophth soln 0.3% 148
tobramycin-dexamethasone
see TOBRADEX OIN 0.3-0.1% 149

tobramycin-dexamethasone ophth susp 0.3-0.1% 149
TOBREX OIN 0.3% OP 148
TODAY SPONGE MIS 163
tofacitinib citrate oral soln 1 mg/ml (base equivalent) 39
tofacitinib citrate tab 10 mg (base equivalent) 39
tofacitinib citrate tab 5 mg (base equivalent) . 39
tofacitinib citrate tab er 24hr 11 mg (base equivalent) 39
tofacitinib citrate tab er 24hr 22 mg (base equivalent) 39
tolcapone tab 100 mg 90
tolmetin sodium tab 600 mg 41
tolterodine tartrate cap er 24hr 2 mg 162
tolterodine tartrate cap er 24hr 4 mg 162
tolterodine tartrate tab 1 mg 162
tolterodine tartrate tab 2 mg 162
tolvaptan (hyponatremia) tab 15 mg 129
tolvaptan (hyponatremia) tab 30 mg 129
tolvaptan tab 15 mg 129
tolvaptan tab 30 mg 129
tolvaptan tab therapy pack 15 mg 129
tolvaptan tab therapy pack 30 & 15 mg 129
tolvaptan tab therapy pack 45 & 15 mg 129
tolvaptan tab therapy pack 60 & 30 mg 129
tolvaptan tab therapy pack 90 & 30 mg 129
topiramate cap er 24hr 100 mg 61
topiramate cap er 24hr 200 mg 61
topiramate cap er 24hr 25 mg 61
topiramate cap er 24hr 50 mg 61
topiramate oral soln 25 mg/ml 61
topiramate sprinkle cap 15 mg 61
topiramate sprinkle cap 25 mg 61
topiramate sprinkle cap 50 mg 61
topiramate tab 100 mg 61
topiramate tab 200 mg 61
topiramate tab 25 mg 61
topiramate tab 50 mg 61
toremifene citrate tab 60 mg (base equivalent) 83
TORPENZ
see Everolimus Tab 10 mg 86
see Everolimus Tab 2.5 mg 85
see Everolimus Tab 5 mg 86
see Everolimus Tab 7.5 mg 86
torsemide tab 10 mg 126
torsemide tab 100 mg 126
torsemide tab 20 mg 126
torsemide tab 5 mg 126
TOSYMRA SOL 10MG 142
TOUJEO MAX INJ 300/ML 70
TOUJEO SOLO INJ 300/ML 70
tramadol hcl oral soln 5 mg/ml 44
tramadol hcl tab 50 mg 44
tramadol hcl tab er 24hr 100 mg 44
tramadol hcl tab er 24hr 200 mg 44
tramadol hcl tab er 24hr 300 mg 45
tramadol hcl tab er 24hr biphasic release 200 mg 45
tramadol hcl tab er 24hr biphasic release 300 mg 45
tramadol-acetaminophen tab 37.5-325 mg 48
trametinib dimethyl sulfoxide
see MEKINIST SOL 0.05/ML 88
see MEKINIST TAB 0.5MG 88
see MEKINIST TAB 2MG 88
trandolapril tab 1 mg 76
trandolapril tab 2 mg 76
trandolapril tab 4 mg 76
trandolapril-verapamil hcl tab er 1-240 mg 80
trandolapril-verapamil hcl tab er 2-180 mg 80
trandolapril-verapamil hcl tab er 2-240 mg 80
trandolapril-verapamil hcl tab er 4-240 mg 80
tranexamic acid tab 650 mg 137
tranylcypromine sulfate tab 10 mg 63
travoprost ophth soln 0.004% (benzalkonium free) (bak free) 150
trazodone hcl tab 100 mg 64
trazodone hcl tab 150 mg 64
trazodone hcl tab 25 mg 64
trazodone hcl tab 300 mg 64
trazodone hcl tab 50 mg 64
trazodone hcl tab 75 mg 64
TRELEGY AER 100MCG 57
TRELEGY AER 200MCG 57
treprostinil
see TYVASO DPI POW 16-32-48 105
see TYVASO DPI POW 16MCG 105
see TYVASO DPI POW 32MCG 105
see TYVASO DPI POW 48-80MCG 105
see TYVASO DPI POW 48MCG 105
see TYVASO DPI POW 64MCG 105
see TYVASO DPI POW 80MCG 105

see TYVASO DPI POW INST KIT 105
see TYVASO DPI POW MAIN KIT 105
see TYVASO RF KT SOL 0.6MG/ML 105
see TYVASO SOL 0.6MG/ML 105
see TYVASO ST KT SOL 0.6MG/ML 105
treprostinil diolamine
see ORENITRAM TAB 0.125MG 105
see ORENITRAM TAB 0.25MG 105
see ORENITRAM TAB 1MG 105
see ORENITRAM TAB 2.5MG 105
see ORENITRAM TAB 5MG 105
see ORENITRAM TAB MONTH 1 105
see ORENITRAM TAB MONTH 2 105
see ORENITRAM TAB MONTH 3 105
treprostinil sodium
see YUTREPIA CAP 106MCG 105
see YUTREPIA CAP 26.5MCG 105
see YUTREPIA CAP 53MCG 105
see YUTREPIA CAP 79.5MCG 105
TRESIBA FLEX INJ 100UNIT 70
TRESIBA FLEX INJ 200UNIT 70
TRESIBA INJ 100UNIT 70
tretinoin cap 10 mg 90
tretinoin cream 0.025% 120
tretinoin cream 0.05% 119
tretinoin cream 0.1% 119
tretinoin gel 0.01% 120
tretinoin gel 0.025% 120
tretinoin gel 0.05% 120
tretinoin microsphere gel 0.04% 120
tretinoin microsphere gel 0.08% 120
tretinoin microsphere gel 0.1% 120
TREZIX
see Acetaminophen-Caffeine-Dihydrocodeine Cap 320.5-30-16 mg 45
triamcinolone acetonide cream 0.025% 123
triamcinolone acetonide cream 0.1% 123
triamcinolone acetonide cream 0.5% 123
Triamcinolone Acetonide Cream 0.5% 123
triamcinolone acetonide dental paste 0.1% .. 145
Triamcinolone Acetonide Dental Paste 0.1% .. 145
triamcinolone acetonide lotion 0.025% 123
triamcinolone acetonide lotion 0.1% 123
triamcinolone acetonide oint 0.025% 123
triamcinolone acetonide oint 0.1% 123
triamcinolone acetonide oint 0.5% 123
triamterene & hydrochlorothiazide cap 37.5-25 mg 126
triamterene & hydrochlorothiazide tab 37.5-25 mg 126
triamterene & hydrochlorothiazide tab 75-50 mg 126
triamterene cap 100 mg 126
triamterene cap 50 mg 126
triazolam tab 0.125 mg 137
triazolam tab 0.25 mg 137
TRIDACAINE III
see Lidocaine Patch 5% 124
TRIDERM
see Triamcinolone Acetonide Cream 0.5% .. 123
trientine hcl cap 250 mg 143
TRI-ESTARYLLA
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg 114
trifarotene
see AKLIEF CRE 0.005% 118
trifluoperazine hcl tab 1 mg (base equivalent) 95
trifluoperazine hcl tab 10 mg (base equivalent) 96
trifluoperazine hcl tab 2 mg (base equivalent) 95
trifluoperazine hcl tab 5 mg (base equivalent) 96
trifluridine ophth soln 1% 148
trifluridine-tipiracil
see LONSURF TAB 15-6.14 84
see LONSURF TAB 20-8.19 84
trihexyphenidyl hcl oral soln 0.4 mg/ml 90
trihexyphenidyl hcl tab 2 mg 90
trihexyphenidyl hcl tab 5 mg 90
TRIJARDY XR TAB 68
TRI-LEGEST FE
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg 111
TRI-LINYAH
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg 114
TRI-LO-ESTARYLLA
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg 114
TRI-LO-MARZIA
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg 114
TRI-LO-MILI

see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg 114
TRI-LO-SPRINTEC
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg 114
trimethobenzamide hcl cap 300 mg 72
trimethoprim tab 100 mg 50
TRI-MILI
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg 114
trimipramine maleate cap 100 mg 66
trimipramine maleate cap 25 mg 66
trimipramine maleate cap 50 mg 66
TRINTELLIX TAB 10MG 65
TRINTELLIX TAB 20MG 65
TRINTELLIX TAB 5MG 64
TRI-SPRINTEC
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg 114
TRIUMEQ PD TAB 98
TRIUMEQ TAB 98
TRI-VYLIBRA
see Norgestimate-Eth Estrad Tab 0.18-35/0.215-35/0.25-35 mg-Mcg 114
TRI-VYLIBRA LO
see Norgestimate-Eth Estrad Tab 0.18-25/0.215-25/0.25-25 mg-Mcg 114
tropicamide ophth soln 0.5% 147
tropicamide ophth soln 1% 147
trospium chloride cap er 24hr 60 mg 162
trospium chloride tab 20 mg 162
TRULICITY INJ 0.75/0.5 69
TRULICITY INJ 1.5/0.5 69
TRULICITY INJ 3/0.5 69
TRULICITY INJ 4.5/0.5 69
TRUQAP PAK 160MG 89
TRUQAP PAK 200MG 89
TRUQAP TAB 200MG 89
TRUSTEX MIS FLAVORS 139
TURALIO CAP 125MG 89
TURQOZ
see Norgestrel & Ethinyl Estradiol Tab 0.3 mg-30 mcg 115
TYDEMY
see Drospirenone-Ethinyl Estrad-Levomefolate Tab 3-0.03-0.451 mg 108
TYVASO DPI POW 16-32-48 105
TYVASO DPI POW 16MCG 105
TYVASO DPI POW 32MCG 105
TYVASO DPI POW 48-80MCG 105
TYVASO DPI POW 48MCG 105
TYVASO DPI POW 64MCG 105
TYVASO DPI POW 80MCG 105
TYVASO DPI POW INST KIT 105
TYVASO DPI POW MAIN KIT 105
TYVASO RF KT SOL 0.6MG/ML 105
TYVASO SOL 0.6MG/ML 105
TYVASO ST KT SOL 0.6MG/ML 105
U
UBRELVY TAB 100MG 141
UBRELVY TAB 50MG 141
ubrogepant
see UBRELVY TAB 100MG 141
see UBRELVY TAB 50MG 141
UCERIS TAB 9MG 117
ulipristal acetate
see ELLA TAB 30MG 115
ultrasound - gel 125
umeclidinium-vilanterol
see ANORO ELLIPT AER 62.5-25 55
UNITHROID
see Levothyroxine Sodium Tab 100 mcg 159
see Levothyroxine Sodium Tab 112 mcg 159
see Levothyroxine Sodium Tab 125 mcg 159
see Levothyroxine Sodium Tab 137 mcg 159
see Levothyroxine Sodium Tab 150 mcg 160
see Levothyroxine Sodium Tab 175 mcg 160
see Levothyroxine Sodium Tab 200 mcg 160
see Levothyroxine Sodium Tab 25 mcg 159
see Levothyroxine Sodium Tab 300 mcg 160
see Levothyroxine Sodium Tab 50 mcg 159
see Levothyroxine Sodium Tab 75 mcg 159
see Levothyroxine Sodium Tab 88 mcg 159
upadacitinib
see RINVOQ LQ SOL 1MG/ML 39
see RINVOQ TAB 15MG ER 39
see RINVOQ TAB 30MG ER 39
see RINVOQ TAB 45MG ER 39
UPTRAVI PACK TAB 200/800 106
UPTRAVI TAB 1000MCG 106
UPTRAVI TAB 100MCG 106
UPTRAVI TAB 1200MCG 106
UPTRAVI TAB 1400MCG 106
UPTRAVI TAB 150MCG 106

UPTRAVI TAB 1600MCG 106
UPTRAVI TAB 200MCG 106
UPTRAVI TAB 400MCG 106
UPTRAVI TAB 600MCG 106
UPTRAVI TAB 800MCG 106
uridine triacetate (emergency treatment)
see VISTOGARD PAK 10GM 71
ursodiol cap 300 mg 132
ursodiol tab 250 mg 132
ursodiol tab 500 mg 132
V
VAGIFEM TAB 10MCG 163
valacyclovir hcl tab 1 gm 99
valacyclovir hcl tab 500 mg 99
valbenazine tosylate
see INGREZZA CAP 40-80MG 153
see INGREZZA CAP 40MG 153
see INGREZZA CAP 60MG 153
see INGREZZA CAP 80MG 154
valganciclovir hcl for soln 50 mg/ml (base equiv) 98
valganciclovir hcl tab 450 mg (base equivalent) 98
valproate sodium oral soln 250 mg/5ml (base equiv) 63
valproic acid cap 250 mg 63
valsartan oral soln 4 mg/ml 77
valsartan tab 160 mg 77
valsartan tab 320 mg 77
valsartan tab 40 mg 77
valsartan tab 80 mg 77
valsartan-hydrochlorothiazide tab 160-12.5 mg 80
valsartan-hydrochlorothiazide tab 160-25 mg 80
valsartan-hydrochlorothiazide tab 320-12.5 mg 80
valsartan-hydrochlorothiazide tab 320-25 mg 80
valsartan-hydrochlorothiazide tab 80-12.5 mg 80
VALTOCO SPR 10MG 59
VALTOCO SPR 15MG 59
VALTOCO SPR 20MG 59
VALTOCO SPR 5MG 59
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 109
vancomycin hcl cap 125 mg (base equivalent) 50
vancomycin hcl cap 250 mg (base equivalent) 50
vancomycin hcl for oral soln 25 mg/ml (base equivalent) 50
vancomycin hcl for oral soln 50 mg/ml (base equivalent) 50
VANRAFIA TAB 0.75MG 133
vardenafil hcl orally disintegrating tab 10 mg 105
vardenafil hcl tab 10 mg 105
vardenafil hcl tab 2.5 mg 105
vardenafil hcl tab 20 mg 105
vardenafil hcl tab 5 mg 105
varenicline tartrate tab 0.5 mg (base equiv) . 158
varenicline tartrate tab 1 mg (base equiv) 158
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack 158
VASCEPA CAP 0.5GM 74
VASCEPA CAP 1GM 74
VCF VAGINAL GEL CONTRACE 163
VCF VAGINAL MIS CONTRACP 163
VELIVET
see Desogest-Ethin Est Tab 0.1-0.025/0.125-0.025/0.15-0.025mg-Mg 108
VELSIPITY TAB 2MG 132
VELTASSA POW 16.8GM 145
VELTASSA POW 1GM 145
VELTASSA POW 25.2GM 145
VELTASSA POW 8.4GM 145
venlafaxine hcl cap er 24hr 150 mg (base equivalent) 65
venlafaxine hcl cap er 24hr 37.5 mg (base equivalent) 65
venlafaxine hcl cap er 24hr 75 mg (base equivalent) 65
venlafaxine hcl tab 100 mg (base equivalent) . 65
venlafaxine hcl tab 25 mg (base equivalent) ... 65
venlafaxine hcl tab 37.5 mg (base equivalent) 65
venlafaxine hcl tab 50 mg (base equivalent) ... 65
venlafaxine hcl tab 75 mg (base equivalent) ... 65
venlafaxine hcl tab er 24hr 225 mg (base equivalent) 65
VENXXIVA
see Tiopronin Tab Delayed Release 100 mg 134
see Tiopronin Tab Delayed Release 300 mg 134

verapamil hcl cap er 24hr 100 mg 103
verapamil hcl cap er 24hr 120 mg 103
verapamil hcl cap er 24hr 180 mg 103
verapamil hcl cap er 24hr 200 mg 103
verapamil hcl cap er 24hr 240 mg 103
verapamil hcl cap er 24hr 300 mg 103
verapamil hcl cap er 24hr 360 mg 103
verapamil hcl tab 120 mg 103
verapamil hcl tab 40 mg 103
verapamil hcl tab 80 mg 103
verapamil hcl tab er 120 mg 103
verapamil hcl tab er 180 mg 103
verapamil hcl tab er 240 mg 103
vericiguat
see VERQUVO TAB 10MG 107
see VERQUVO TAB 2.5MG 106
see VERQUVO TAB 5MG 107
VERQUVO TAB 10MG 107
VERQUVO TAB 2.5MG 106
VERQUVO TAB 5MG 107
VESTURA
see Drospirenone-Ethinyl Estradiol Tab 3-0.02 mg 108
VEVYE DRO 0.1% 148
vibegron
see GEMTESA TAB 75MG 162
VIBERZI TAB 100MG 133
VIBERZI TAB 75MG 133
VIENVA
see Levonorgestrel & Ethinyl Estradiol Tab 0.1 mg-20 mcg 110
vigabatrin powd pack 500 mg 62
Vigabatrin Powd Pack 500 mg 62
vigabatrin tab 500 mg 62
Vigabatrin Tab 500 mg 62
VIGADRONE
see Vigabatrin Powd Pack 500 mg 62
see Vigabatrin Tab 500 mg 62
vilazodone hcl tab 10 mg 65
vilazodone hcl tab 20 mg 65
vilazodone hcl tab 40 mg 65
viloxazine hcl (adhd)
see QELBREE CAP 100MG ER 33
see QELBREE CAP 150MG ER 33
see QELBREE CAP 200MG ER 33
VIOKACE TAB 10440 125
VIOKACE TAB 20880 125
VIORELE
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 108
VIRACEPT TAB 250MG 98
VIRACEPT TAB 625MG 98
vismodegib
see ERIVEDGE CAP 150MG 83
VISTOGARD PAK 10GM 71
VITRAKVI CAP 100MG 89
VITRAKVI CAP 25MG 89
VITRAKVI SOL 20MG/ML 90
VOLNEA
see Desogest-Eth Estrad & Eth Estrad Tab 0.15-0.02/0.01 mg(21/5) 108
voriconazole for susp 40 mg/ml 72
voriconazole tab 200 mg 73
voriconazole tab 50 mg 72
vortioxetine hbr
see TRINTELLIX TAB 10MG 65
see TRINTELLIX TAB 20MG 65
see TRINTELLIX TAB 5MG 64
VOSEVI TAB 99
VRAYLAR CAP 0.5MG 93
VRAYLAR CAP 0.75MG 93
VRAYLAR CAP 1.5MG 93
VRAYLAR CAP 3MG 93
VRAYLAR CAP 4.5MG 93
VRAYLAR CAP 6MG 93
VTAMA CRE 1% 121
VYFEMLA
see Norethindrone & Ethinyl Estradiol Tab 0.4 mg-35 mcg 111
VYLIBRA
see Norgestimate & Ethinyl Estradiol Tab 0.25 mg-35 mcg 114
VYNDAMAX CAP 61MG 106
W
WAKIX TAB 17.8MG 33
WAKIX TAB 4.45MG 33
warfarin sodium tab 1 mg 57
warfarin sodium tab 10 mg 57
warfarin sodium tab 2 mg 57
warfarin sodium tab 2.5 mg 57
warfarin sodium tab 3 mg 57
warfarin sodium tab 4 mg 57
warfarin sodium tab 5 mg 57
warfarin sodium tab 6 mg 57

warfarin sodium tab 7.5 mg 57
WEGOVY TAB 1.5MG 32
WEGOVY TAB 25MG 32
WEGOVY TAB 4MG 32
WEGOVY TAB 9MG 32
WERA
see Norethindrone & Ethinyl Estradiol Tab 0.5 mg-35 mcg 111
WINLEVI CRE 1% 120
WIXELA INHUB
see Fluticasone-Salmeterol Aer Powder Ba 100-50 mcg/act 56
see Fluticasone-Salmeterol Aer Powder Ba 250-50 mcg/act 56
see Fluticasone-Salmeterol Aer Powder Ba 500-50 mcg/act 56
WYMZYA FE
see Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg 111
X
XARAH FE
see Norethindrone Ac-Ethinyl Estrad-Fe Tab 1-20/1-30/1-35 mg-Mcg 111
XARELTO STAR TAB 15/20MG 58
XARELTO SUS 1MG/ML 58
XARELTO TAB 10MG 58
XARELTO TAB 15MG 58
XARELTO TAB 2.5MG 58
XARELTO TAB 20MG 58
XCOPRI PAK 100-150 62
XCOPRI PAK 12.5-25 62
XCOPRI PAK 150-200 62
XCOPRI PAK 50-100MG 62
XCOPRI TAB 100MG 62
XCOPRI TAB 150MG 62
XCOPRI TAB 200MG 62
XCOPRI TAB 25MG 62
XCOPRI TAB 50MG 62
XDEMVY DRO 0.25% 148
XELRIA FE
see Norethindrone & Ethinyl Estradiol-Fe Chew Tab 0.4 mg-35 mcg 111
XHANCE MIS 93MCG 147
XIFAXAN TAB 550MG 50
XIGDUO XR TAB 2.5-1000 68
XOSPATA TAB 40MG 90
XTANDI CAP 40MG 83
XTANDI TAB 40MG 84
XTANDI TAB 80MG 84
XULANE
see Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr 115
XULTOPHY INJ 100/3.6 68
XYWAV SOL 0.5GM/ML 152
Y
YARGESA
see Miglustat Cap 100 mg 135
YEZTUGO TAB 300MG 98
YL FOLIC ACID
see Folic Acid Tab 400 mcg 136
YONSA TAB 125MG 84
YULITHIRA
see Everolimus Tab 10 mg 86
see Everolimus Tab 2.5 mg 85
see Everolimus Tab 5 mg 86
see Everolimus Tab 7.5 mg 86
YUPELRI NEB 175/3ML 54
YUTREPIA CAP 106MCG 105
YUTREPIA CAP 26.5MCG 105
YUTREPIA CAP 53MCG 105
YUTREPIA CAP 79.5MCG 105
Z
ZAFEMY
see Norelgestromin-Ethinyl Estradiol Td Ptwk 150-35 mcg/24hr 115
zafirlukast tab 10 mg 54
zafirlukast tab 20 mg 54
zaleplon cap 10 mg 137
zaleplon cap 5 mg 137
zanamivir
see RELENZA MIS DISKHALE 99
zanubrutinib
see BRUKINSA CAP 80MG 85
see BRUKINSA TAB 160MG 85
ZEJULA TAB 100MG 90
ZEJULA TAB 200MG 90
ZEJULA TAB 300MG 90
ZELVYSIA
see Sapropterin Dihydrochloride Powder Packet 100 mg 128
see Sapropterin Dihydrochloride Powder Packet 500 mg 128
ZEMBRACE SYM INJ 3/0.5ML 142
ZENATANE

see Isotretinoin Cap 10 mg 119
see Isotretinoin Cap 20 mg 119
see Isotretinoin Cap 30 mg 119
see Isotretinoin Cap 40 mg 119
ZENPEP CAP 10000UNT 125
ZENPEP CAP 15000UNT 125
ZENPEP CAP 20000UNT 125
ZENPEP CAP 25000UNT 125
ZENPEP CAP 3000UNIT 125
ZENPEP CAP 40000UNT 126
ZENPEP CAP 5000UNIT 125
ZENPEP CAP 60000UNT 126
ZENZEDI
see Dextroamphetamine Sulfate Tab 10 mg . 29
see Dextroamphetamine Sulfate Tab 15 mg . 29
see Dextroamphetamine Sulfate Tab 2.5 mg 28
see Dextroamphetamine Sulfate Tab 20 mg . 29
see Dextroamphetamine Sulfate Tab 30 mg . 30
see Dextroamphetamine Sulfate Tab 5 mg ... 29
see Dextroamphetamine Sulfate Tab 7.5 mg 29
ZEPOSIA 7DAY CAP STR PACK 154
ZEPOSIA CAP 0.92MG 154
ZEPOSIA CAP STR KIT 155
zidovudine cap 100 mg 98
zidovudine syrup 10 mg/ml 98
zidovudine tab 300 mg 98
ziprasidone hcl cap 20 mg 93
ziprasidone hcl cap 40 mg 93
ziprasidone hcl cap 60 mg 93
ziprasidone hcl cap 80 mg 93
ZITUVIMET TAB 50-1000 68
ZITUVIMET TAB 50-500MG 68
ZITUVIMET XR TAB 100-1000 68
ZITUVIMET XR TAB 50-1000 68
ZITUVIMET XR TAB 50-500MG 68
ZITUVIO TAB 100MG 69
ZITUVIO TAB 25MG 69
ZITUVIO TAB 50MG 69
zolmitriptan nasal spray 5 mg/spray unit 142
zolmitriptan orally disintegrating tab 2.5 mg 142
zolmitriptan orally disintegrating tab 5 mg .. 142
zolmitriptan tab 2.5 mg 142
zolmitriptan tab 5 mg 142
zolpidem tartrate tab 10 mg 138
zolpidem tartrate tab 5 mg 138
zolpidem tartrate tab er 12.5 mg 138
zolpidem tartrate tab er 6.25 mg 138
zonisamide cap 100 mg 62
zonisamide cap 25 mg 61
zonisamide cap 50 mg 61
ZORYVE CRE 0.05% 124
ZORYVE CRE 0.15% 124
ZORYVE CRE 0.3% 124
ZORYVE MIS 0.3% 124
ZOVIA 1/35
see Ethynodiol Diacetate & Ethinyl Estradiol Tab 1 mg-35 mcg 109
ZUBSOLV SUB 0.7-0.18 48
ZUBSOLV SUB 1.4-0.36 48
ZUBSOLV SUB 11.4-2.9 49
ZUBSOLV SUB 2.9-0.71 48
ZUBSOLV SUB 5.7-1.4 49
ZUBSOLV SUB 8.6-2.1 49
ZUMANDIMINE
see Drospirenone-Ethinyl Estradiol Tab 3-0.03 mg 109
zuranolone
see ZURZUVAE CAP 20MG 63
see ZURZUVAE CAP 25MG 63
see ZURZUVAE CAP 30MG 63
ZURZUVAE CAP 20MG 63
ZURZUVAE CAP 25MG 63
ZURZUVAE CAP 30MG 63
ZYKADIA TAB 150MG 90

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