BILINGUAL

HealthSun
HEALTH PLANS

# FORMULARY
(List of Covered Drugs)

# FORMULARIO
(Lista de Medicamentos Cubiertos)

2027

MedicareRx
Prescription Drug Coverage

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN. LEA LO SIGUIENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN.

HPMS Approved Formulary ID 27026, Version 9

This formulary was updated on 9/24/2026. For more recent information or other questions, please contact our HealthSun Health Plans Member Services at 1-877-336-2069 / TTY: 711, Monday through Friday from 8 a.m. to 8 p.m. (EST), or visit www.healthsun.com. From October 1 through March 31, we are open seven days a week from 8 a.m. to 8 p.m. (our office will be closed on Thanksgiving and Christmas Day). From April 1 through September 30, we are available Monday through Friday from 8 a.m. to 8 p.m. (our office will be closed on federal holidays). Este formulario se actualizó en 9/24/2026. Para obtener información más reciente o si tiene otras preguntas, comuníquese con HealthSun Health Plans al 1-877-336-2069 / TTY: 711, de lunes a viernes, de 8 a.m. a 8 p.m., o visite www.healthsun.com. Nuestro horario del 1 de octubre al 31 de marzo es de 8 a.m. a 8 p.m., los siete días de la semana (nuestra oficina permanecerá cerrada el Día de Acción de Gracias y Navidad). Desde el 1 de abril hasta el 30 de septiembre, estaremos disponibles de lunes a viernes, de 8 a.m. a 8 p.m. (nuestra oficina permanecerá cerrada los días feriados federales).

# HealthSun Health Plans, Inc.
# 2027 Formulary List of Covered Drugs

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN**

HPMS Approved Formulary File Submission ID **27026**, Version **9**

This formulary was updated on **9/24/2026**. For more recent information or other questions, please contact HealthSun Health Plans Member Services at 1-877-336-2069 (TTY users should call 711), from 8am to 8pm, EST., or visit www.healthsun.com. Our hours of operations during October 1st through March 31st, we are open seven days a week (our office will be closed on Thanksgiving and Christmas Day). From April 1st until September 30th, we are available Monday through Friday from 8am to 8pm (our office will be closed on federal holidays).

**Note to existing members**: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (formulary) refers to "we," "us", or "our," it means HealthSun Health Plans. When it refers to "plan" or "our plan," it means HealthSun Health Plans.

This document includes the Drug List (formulary) for our plan which is current as of **9/24/2026.** *For* an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2028, and from time to time during the year.

## What is the HealthSun Health Plans formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by HealthSun Health Plans in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. HealthSun Health Plans will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a HealthSun Health Plans network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

For a complete listing of all prescription drugs covered by HealthSun Health Plans, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

## Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here:

**https://healthsun.com/plans-coverage/prescription-drug-benefits/**

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

  If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled "How do I request an exception to the *HealthSun Health Plans*' formulary?"

  Some of these drug types may be new to you. For more information, see the section below titled "What are original biological products and how are they related to biosimilars?"

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

  If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the HealthSun Health Plans' formulary?"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2026 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2027 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of **9/24/2026**. To get updated information about the drugs covered by HealthSun Health Plans please contact us. Our contact information appears on the front and back cover pages.

## How do I use the Formulary?

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

**Medical Condition**

The formulary begins on page **23.** The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "cardiovascular agents." If you know what your drug is used for, look for the category name in the list that begins on **23.** Then look under the category name for your drug.

**Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins on page **116.** The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## What are generic drugs?

HealthSun Health Plans covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

## What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, "The 'Drug List' tells which Part D drugs are covered."

## Are there any restrictions on my coverage?

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

- **Prior Authorization:** HealthSun Health Plans requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from HealthSun Health Plans **based on specific criteria** before you fill your prescriptions. If you don't get approval, HealthSun Health Plans may not cover the drug.

- **Quantity Limits:** For certain drugs, HealthSun Health Plans limits the amount of the drug that HealthSun Health Plans will cover. For example, HealthSun Health Plans provides **30 tabs** per prescription for **TRADJENTA**. This may be in addition to a standard one-month or three-month supply.

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page **23.** You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions.

You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask HealthSun Health Plans to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the HealthSun Health Plans' formulary?" on page **5** for information about how to request an exception.

## What if my drug is not on the formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that HealthSun Health Plans does not cover your drug, you have two options:

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

- You can ask HealthSun Health Plans to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the HealthSun Health Plans' formulary?

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

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

- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, HealthSun Health Plans limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

Generally, HealthSun Health Plans will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. ***When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.*** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

## What can I do if my drug is not on the formulary or has a restriction?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first **90** days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary **30-day** supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum **30-day** supply of medication. If coverage is not approved, after your first **30-day** supply, we will not pay for these drugs, even if you have been a member of the plan less than **90** days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first **90** days of membership in our plan, we will cover a **34-day** emergency supply of that drug while you pursue a formulary exception.

HealthSun Health Plans transition process will be maintained with respect to the following: **(1)** the transition of new members into the plan during the annual election period; **(2)** the transition of newly eligible Medicare members from other coverage into our plan; **(3)** the transition of individuals who switch from one Plan to another after the start of the contract year; **(4)** members residing in a Long Term care (LTC) Facility; **(5)** current members affected by negative formulary changes from one contract year to the next contract year; **(6)** members who request an exception but there is a failure to issue a timely decision on the request by the end of the transition period; **(7)** members who remain in the same plan for the new plan year and are on a drug that was the result of an exception that was granted in the previous year; **(8)** current members experiencing a level of care change; **(9)** current members entering the LTC setting from other care settings; and **(10)** current members in a LTC setting requiring an emergency supply of a nonformulary drug.

## For more information

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

If you have questions about HealthSun Health Plans, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 711. Or visit http://www.medicare.gov.

## HealthSun Health Plans formulary

The formulary that begins on the page **23** provides coverage information about the drugs covered by HealthSun Health Plans. If you have trouble finding your drug in the list, turn to the Index that begins on page **116**.

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

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

Certain drugs throughout the formulary will be marked with one or more symbols to indicate their application, such as utilization management restrictions and requirements, mail order availability, drugs limited to a one month supply (even when the drug is on a tier that allows for an extended day supply), excluded Part D drugs covered by the plan, limited access, mail order drugs, tier names, and other coverage information.

The Drug Table starting on page **23** includes a column titled, "**Drug Tier**". This column indicates what tier each drug is listed under. The table starting on page **8** provides the copayments/coinsurances associated with the corresponding tiers if you receive the drug at an in-network pharmacy. These copayments/coinsurances apply during the initial coverage phase. Please refer to your *Evidence of Coverage* for what you pay during the catastrophic coverage stage. If you receive "Extra Help", some information about the costs for Part D prescription drugs may not apply to you. Refer to your *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage.

| Tier | Drug Tier Name |
|---|---|
| 1 | Preferred Generic |
| 2 | Generic |
| 3 | Preferred Brand |
| 4 | Non-Preferred Drug |
| 5 | Specialty Tier |
| 6 | Supplemental Drugs - (enhanced drug coverage) |

## Preferred Retail Pharmacy and Mail Order Pharmacy

**Your cost for a one-month supply (30 days) of a covered Part D drug**

| Preferred Retail Pharmacy and Mail Order Pharmacy | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Plan Name: HealthSun** | **Tier 1*** Preferred Generic | **Tier 2*** Generic | **Tier 3*** Preferred Brand | **Tier 3* Insulin Drugs** | **Tier 4** Non-Preferred Drug | **Tier 5** Specialty Tier | **Tier 6*** Supple-mental Drugs |
| **HealthAdvantage Plan (HMO)** Miami-Dade County H5431-001 | $0 | $0 | $0 | $0 | $30 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Broward County H5431-012 | $0 | $0 | $5 | $5 | $75 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Palm Beach County H5431-013 | $0 | $0 | $10 | $10 | $50 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Miami-Dade County H5431-017 | $0 | $0 | $42 | $35 | $95 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Broward County H5431-018 | $0 | $0 | $42 | $35 | $95 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Palm Beach County H5431-020 | $0 | $0 | $42 | $35 | $95 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Broward & Miami-Dade H5431-021 | $0 | $0 | $37 | $35 | $85 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Palm Beach H5431-022 | $0 | $0 | $37 | $35 | $85 | 33% | $0 |
| **MediMax (HMO)** Broward & Miami-Dade H5431-006 | $0 | $0 | 25% | $35 | $25% | 32% | $0 |
| **MediSun Extra (HMO D-SNP)** Broward, Miami-Dade, & Palm Beach H5431-019 | $0 | $0 | $10 | $10 | $50 | 25% | $0 |
| **MediSun Full Dual Extra (HMO D-SNP)** Broward, Miami-Dade, & Palm Beach H5431-026 | $0 | $0 | $5 | $5 | $50 | 25% | $0 |

* For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is **up to a 100-day supply for some drugs in Tier 1** and **up to a 90-day supply for some drugs in Tier 2, Tier 3, and Tier 6.**

If you receive Extra Help, the amount you pay is determined by your Extra Help low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.

## Standard Retail Pharmacy

**Your cost for a one-month supply (30 days) of a covered Part D drug**

| Standard Retail Pharmacy | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Plan Name: HealthSun** | **Tier 1*** Preferred Generic | **Tier 2*** Generic | **Tier 3*** Preferred Brand | **Tier 3* Insulin Drugs** | **Tier 4** Non-Preferred Drug | **Tier 5** Specialty Tier | **Tier 6*** Supple-mental Drugs |
| **HealthAdvantage Plan (HMO)** Miami-Dade County H5431-001 | $0 | $0 | $10 | $0 | $35 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Broward County H5431-012 | $0 | $0 | $20 | $5 | $80 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Palm Beach County H5431-013 | $0 | $0 | $10 | $10 | $55 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Miami-Dade County H5431-017 | $0 | $0 | $47 | $35 | $100 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Broward County H5431-018 | $0 | $0 | $47 | $35 | $100 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Palm Beach County H5431-020 | $0 | $0 | $47 | $35 | $100 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Broward & Miami-Dade H5431-021 | $0 | $0 | $42 | $35 | $90 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Palm Beach H5431-022 | $0 | $0 | $42 | $35 | $90 | 33% | $0 |
| **MediMax (HMO)** Broward & Miami-Dade H5431-006 | $0 | $0 | 25% | $35 | $25% | 32% | $0 |
| **MediSun Extra (HMO D-SNP)** Broward, Miami-Dade, & Palm Beach H5431-019 | $0 | $0 | $10 | $10 | $50 | 25% | $0 |
| **MediSun Full Dual Extra (HMO D-SNP)** Broward, Miami-Dade, & Palm Beach H5431-026 | $0 | $0 | $5 | $5 | $50 | 25% | $0 |

* For some drugs, you can get a long-term supply (also called an extended supply). A long-term **supply is up to a 100-day supply for some drugs in Tier 1** and **up to a 90-day supply for some drugs in Tier 2, Tier 3, and Tier 6.**

If you receive Extra Help, the amount you pay is determined by your Extra Help low-income subsidy (LIS) coverage. Please refer to your LIS Rider for your specific copayment amount.

Please refer to your plan's *Evidence of Coverage* for details on what you pay at a long-term care pharmacy or at an out-of-network pharmacy when approved by the plan, and what you may pay if you receive Extra Help.

## Abbreviations

| SYMBOL | NAME | ABBREVIATION DESCRIPTION |
|---|---|---|
| **90D** | 90 Day Benefit | This drug is approved for a 90-day supply. |
| **100D** | 100 Day Benefit | This drug is approved for a 100-day supply. |
| **B/D PA** | Part B vs. Part D Prior Authorization Review | This drug may be covered under Medicare Part B or Medicare Part D depending upon the circumstances. |
| **ED** | Enhanced Drug Coverage | Coverage for excluded Medicare Part D Drugs. This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill in a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug. |
| **HRM** | High Risk Medication | PA required for ages 65 or over. |
| **LA** | Limited Access | This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-877-336-2069 (TTY users should call 711), from 8 am to 8 pm, or visit www.HealthSun.com. From October 1st through March 31st, we are open seven days a week (our office will be closed on Thanksgiving and Christmas Day). From April 1st until September 30th, we are available Monday through Friday from 8 am to 8 pm (our office will be closed on federal holidays). |
| **NEDS** | Non-Extended Days Supply | This drug is approved for no more than a 30-day supply. |
| **MO** | Mail-Order | This drug is available at our mail order pharmacies. |
| **PA** | Prior Authorization | You (or your physician) are required to get prior authorization before you fill in your prescription for this drug; without prior approval, we may not cover this drug. |
| **QL** | Quantity Limit | There is a limit on the amount of this drug that is covered per prescription, or within a specific timeframe. Certain drugs marked "QL" for quantity limit will indicate the amount (days' supply or amount dispensed). |
| **ST** | Step Therapy | In some cases, you may be required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. |

# HealthSun Health Plans
# Formulario de 2027 - Lista de medicamentos cubiertos

**LEA LO SIGUIENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN**

HPMS ID: **27026**, Versión **9**

Este formulario se actualizó el **9/24/2026**. Para obtener información más reciente o si tiene otras preguntas, comuníquese con Servicios para Miembros de HealthSun Health Plans al 1-877-336-2069 (los usuarios de TTY deben llamar al 711) de 8 a.m. a 8 p.m. hora del Este, o visite www.healthsun.com. Del 1.º de octubre al 31 de marzo, atendemos los siete días de la semana (nuestra oficina estará cerrada el Día de Acción de Gracias y el día de Navidad). Del 1.º de abril al 30 de septiembre, el horario de atención es de lunes a viernes de 8 a.m. a 8 p.m. (nuestra oficina estará cerrada los días feriados nacionales).

**Nota para los miembros actuales**: Este formulario ha cambiado con respecto al año pasado. Revise este documento para asegurarse de que aún contiene los medicamentos que toma.

Cuando esta Lista de medicamentos (Formulario), menciona "nosotros", "nos" o "nuestro" hace referencia a HealthSun Health Plans. Cuando dice "plan" o "nuestro plan" hace referencia a HealthSun Health Plans.

Este documento incluye la Lista de medicamentos (Formulario) de nuestro plan que está vigente a partir del **9/24/2026**. Para obtener una Lista de medicamentos (Formulario) actualizada, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización de la Lista de medicamentos (Formulario), aparece en la portada y la portada posterior.

Generalmente, debe concurrir a las farmacias de la red para usar el beneficio de medicamentos con receta. Los beneficios, el formulario, la red de farmacias, o los copagos/el coseguro pueden cambiar el 1 de enero de 2028 y periódicamente durante el año.

## ¿Qué es el Formulario de HealthSun Health Plans?

En este documento, los términos Lista de medicamentos y Formulario significan lo mismo. Un Formulario es una Lista de medicamentos cubiertos seleccionados por HealthSun Health Plans con la colaboración de un equipo de proveedores de atención médica, que representa los tratamientos con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Normalmente, HealthSun Health Plans cubrirá los medicamentos incluidos en el formulario, siempre que el medicamento sea médicamente necesario, el medicamento con receta se obtenga en una farmacia de la red de HealthSun Health Plans y se cumpla con otras normas del plan. Para obtener más información sobre cómo obtener sus medicamentos con receta, consulte la Evidencia de cobertura.
Para consultar la lista completa de todos los medicamentos con receta cubiertos por HealthSun Health Plans, visite nuestro sitio web o llámenos. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y en la portada posterior.

## ¿El Formulario puede cambiar?

La mayoría de los cambios en la cobertura de los medicamentos ocurre el 1 de enero, pero nosotros podríamos agregar o quitar medicamentos del Formulario durante el año, moverlos a diferentes niveles de costo compartido o agregar nuevas restricciones. Debemos seguir las normas de Medicare al hacer estos cambios. Las actualizaciones del Formulario se publican todos los meses en nuestro sitio web:

**https://healthsun.com/es/plans-coverage/prescription-drug-benefits/**

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

- **Sustituciones inmediatas de determinadas versiones nuevas de medicamentos de marca y productos biológicos originales.** Podemos eliminar inmediatamente un medicamento de nuestro Formulario si lo reemplazamos con una cierta versión nueva de ese medicamento que aparecerá en el mismo nivel de costo compartido o en un nivel de costo compartido más bajo y con las mismas restricciones o menos. Cuando agregamos una nueva versión de un medicamento a nuestro Formulario, podemos decidir mantener el medicamento de marca o el producto biológico original en nuestro Formulario, pero inmediatamente moverlo a un nivel de costo compartido diferente o agregar nuevas restricciones.

  Podemos aplicar estos cambios inmediatos solo si estamos sumando una nueva versión genérica de un medicamento de marca, o si agregamos ciertas versiones biosimilares de un producto biológico original, que ya estaba en el Formulario (por ejemplo, agregar un biosimilar intercambiable que puede ser sustituido por un producto biológico original por una farmacia sin una receta nueva).

  Si actualmente está tomando el medicamento de marca o el producto biológico original, quizás no le informemos con anticipación que realizaremos un cambio inmediato, pero más adelante le proporcionaremos información sobre los cambios específicos que hemos realizado.

  Si realizamos un cambio, usted o la persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción y sigamos cubriendo para usted el medicamento que se cambiará. Para obtener más información, consulte la sección a continuación titulada "*¿Cómo puedo solicitar una excepción al Formulario de HealthSun Health Plans?*"

  Algunos de estos tipos de medicamentos pueden ser nuevos para usted. Para obtener más información, consulte la sección a continuación titulada *"¿Qué son los productos biológicos originales y cómo se relacionan con los biosimilares?*"

- **Medicamentos retirados del mercado.** Si el fabricante retira un medicamento de la venta o la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA) determina que debe retirarse por razones de seguridad o eficacia, podemos eliminar inmediatamente el medicamento de nuestro Formulario y, luego, notificarles a los miembros que toman el medicamento.

- **Otros cambios.** Podemos hacer otros cambios que afectan a los miembros que actualmente toman un medicamento. Por ejemplo, podemos eliminar un medicamento de marca del Formulario cuando agreguemos un equivalente genérico o eliminar un producto biológico original cuando agregamos un biosimilar. También podemos aplicar nuevas restricciones al medicamento de marca o al producto biológico original, moverlo a un nivel de costo compartido diferente o ambas. Podemos realizar cambios en función de las nuevas pautas clínicas. Si retiramos medicamentos de nuestro Formulario; agregamos autorizaciones previas, restricciones de límite de cantidad o de tratamiento escalonado sobre un medicamento; o pasamos un medicamento a un nivel de costo compartido más alto, debemos notificar a los miembros afectados por el cambio al menos 30 días antes de que entre en vigencia el cambio. Alternativamente, cuando un miembro solicita un resurtido del medicamento, puede recibir un suministro del medicamento para 30 días y un aviso del cambio.

Si realizamos estos otros cambios, usted o la persona autorizada a dar recetas pueden solicitarnos que hagamos una excepción para usted y continuemos la cobertura del medicamento que ha estado tomando. En el aviso que le proporcionamos también incluirá información sobre cómo solicitar una excepción, y usted también puede encontrar información en la sección a continuación titulada *"¿Cómo solicitar que se haga una excepción al Formulario de HealthSun Health Plans?*"

**Cambios que no le afectarán si actualmente está tomando el medicamento.** En general, si usted toma un medicamento de nuestro Formulario para 2026 que estaba cubierto al comienzo del año, nosotros no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2027, excepto como se describe anteriormente. Esto significa que, por el resto del año de cobertura, estos medicamentos continuarán estando disponibles al mismo costo compartido y sin nuevas restricciones para aquellos miembros que estén tomándolos. No recibirá un aviso directo este año sobre cambios que no lo afectan. Sin embargo, dichos cambios los afectarían el 1 de enero del año siguiente, y es importante que verifique el Formulario del nuevo año de beneficios por cualquier cambio en los medicamentos.

El Formulario adjunto está actualizado/vigente a partir del **9/24/2026**. Para recibir información actualizada sobre los medicamentos cubiertos por HealthSun Health Plans comuníquese con nosotros. Nuestra información de contacto aparece en las páginas de la portada y contratapa.

## ¿Cómo utilizo el Formulario?

Hay dos formas de encontrar su medicamento dentro del formulario:

### Afección médica

El Formulario comienza en la página **23**. Los medicamentos de este Formulario están agrupados en categorías según el tipo de afección médica para cuyo tratamiento se los emplea. Por ejemplo, los medicamentos utilizados para tratar una afección cardíaca se enumeran dentro de la categoría "medicamentos cardiovasculares". Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que empieza en la página **23**. Luego, busque su medicamento debajo del nombre de la categoría.

### Listado alfabético

Si no está seguro de qué categoría consultar, debe buscar su medicamento en el Índice que comienza en la página **115**. El Índice proporciona una lista alfabética de todos los medicamentos incluidos en este documento. En el Índice, están tanto los medicamentos de marca como los genéricos. Busque en el Índice y encuentre su medicamento. Junto a su medicamento, verá el número de página donde puede encontrar información acerca de la cobertura. Vaya a la página que figura en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

## ¿Qué son los medicamentos genéricos?

HealthSun Health Plans cubre tanto los medicamentos de marca como los genéricos. Un medicamento genérico está aprobado por la Administración de Drogas y Alimentos (Food and Drug Administration, FDA) dado que se considera que tiene el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos funcionan igual de bien y, suelen costar menos que los de marca. Hay medicamentos genéricos sustitutos disponibles para muchos medicamentos de marca. Normalmente, los medicamentos genéricos pueden sustituir a los medicamentos de marca en la farmacia sin necesidad de obtener una receta nueva, según las leyes estatales.

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

En el Formulario, cuando nos referimos a medicamentos, esto podría significar un medicamento o un producto biológico. Los productos biológicos son medicamentos más complejos que los medicamentos habituales. Dado que los productos biológicos son más complejos que los medicamentos típicos, en lugar de tener una forma genérica, tienen alternativas que se denominan biosimilares. Por lo general, los biosimilares funcionan tan bien como el producto biológico original y pueden costar menos. Existen alternativas biosimilares para algunos productos biológicos originales. Algunos biosimilares son biosimilares intercambiables y, según las leyes estatales, pueden reemplazar al producto biológico original en la farmacia sin necesidad de una nueva receta, al igual que los medicamentos genéricos pueden sustituir a medicamentos de marca.

- Para consultar los tipos de medicamentos, consulte la Evidencia de cobertura, Capítulo 5*,* Sección 3.1, "*La Lista de medicamentos indica qué medicamentos de la Parte D están cubiertos*".

## ¿Hay alguna restricción en mi cobertura?

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

- **Autorización previa:** HealthSun Health Plans exige que usted o la persona autorizada a dar recetas obtengan una autorización previa para determinados medicamentos. Esto significa que necesitará contar con la aprobación de HealthSun Health Plans **sobre la base de criterios específicos** antes de surtir sus medicamentos con receta. Si no consigue la autorización, es posible que HealthSun Health Plans no cubra el medicamento.

- **Límites de cantidad:** Para ciertos medicamentos, HealthSun Health Plans limita la cantidad del medicamento que cubrirá. Por ejemplo, HealthSun Health Plans proporciona **30 comprimidos** por receta de **TRADJENTA**. Esto puede ser complementario a un suministro estándar para un mes o tres meses.

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

Para averiguar si su medicamento tiene requisitos o límites adicionales, consulte el Formulario que empieza en la página **23**. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos en nuestro sitio web. Hemos publicado en línea documentos para explicar nuestras restricciones de autorización previa y de tratamiento escalonado.

También puede solicitarnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparecen en las páginas de la portada y la portada posterior.

Puede pedirle a HealthSun Health Plans que haga una excepción a estas restricciones o límites, o puede solicitarle una lista de otros medicamentos similares que podrían tratar su afección médica. Consulte la sección "*¿Cómo puedo solicitar que se haga una excepción al Formulario de HealthSun Health Plans?*" en la página **15** para obtener información acerca de cómo solicitar una excepción.

## ¿Qué pasa si mi medicamento no está en el Formulario?

Si el medicamento que toma no está incluido en este Formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicios para los miembros y preguntar si su medicamento está cubierto. Para obtener más

información, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.
Si resulta que HealthSun Health Plans no cubre el medicamento que toma, tiene dos alternativas:

- Puede pedir a Servicios para los miembros una lista de medicamentos similares que estén cubiertos por HealthSun Health Plans. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por HealthSun Health Plans.

- Puede solicitar que HealthSun Health Plans que haga una excepción y cubra su medicamento. Consulte a continuación para obtener información sobre cómo solicitar una excepción.

## ¿Cómo puedo solicitar que se haga una excepción al Formulario de HealthSun Health Plans?

Puede solicitar a HealthSun Health Plans que haga una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede solicitarnos que cubramos un medicamento, incluso si no está en nuestro Formulario. Si se aprueba, este medicamento estará cubierto a un nivel de costo compartido predeterminado, y usted no podrá pedirnos que le brindemos el medicamento a un nivel de costo compartido menor.

- Puede pedirnos que no apliquemos una restricción de cobertura, incluidos la autorización previa, el tratamiento escalonado o un límite de cantidad de su medicamento. Por ejemplo, para ciertos medicamentos, HealthSun Health Plans limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que hagamos una excepción al límite y cubramos una cantidad mayor.

- Puede pedirnos que cubramos un medicamento del Formulario a un nivel de costo compartido menor, a menos que el medicamento esté en nuestro nivel de especialidad. Si se aprueba, esto reduciría el monto que usted debe pagar por su medicamento.

Por lo general, HealthSun Health Plans solo aprobará su solicitud de una excepción si los medicamentos alternativos incluidos en el Formulario del plan, o la aplicación de la restricción no fueran tan efectivos para usted o pudieran causarle efectos adversos.

Usted o la persona autorizada a dar recetas deben comunicarse con nosotros para solicitar una excepción al Formulario, incluida una excepción a una restricción de cobertura. **Cuando solicita una excepción, la persona autorizada a dar recetas tendrá que explicar las razones médicas por las que necesita la excepción.** Por lo general, debemos tomar una decisión dentro de las 72 horas a partir de la fecha de haber recibido la declaración que respalda su solicitud por parte de la persona autorizada para dar recetas. Puede pedir una decisión acelerada (rápida) si usted considera, y nosotros estamos de acuerdo, que esperar 72 horas para la toma de la decisión podría perjudicar gravemente su salud. Si aceptamos, o si la persona autorizada a dar recetas pide una decisión rápida, debemos comunicarle nuestra decisión, a más tardar, en un período de 24 horas después de recibir la declaración que respalda su solicitud por parte de la persona autorizada a dar recetas.

## ¿Qué puedo hacer si mi medicamento no está en el Formulario o si tiene una restricción?

Como miembro nuevo o existente de nuestro plan, es posible que esté tomando medicamentos que no están incluidos en nuestro formulario. También es posible que esté tomando un medicamento que está en nuestro Formulario, pero que tiene una restricción de cobertura, como la autorización previa. Debe hablar con la persona autorizada a dar recetas para solicitar una decisión de cobertura para demostrar que cumple con los criterios de aprobación, cambiar a un medicamento alternativo que cubramos o solicitar una excepción al Formulario para que cubramos el medicamento que toma. Mientras usted y su médico determinan el procedimiento adecuado para seguir

su caso, podemos cubrir su medicamento, en ciertos casos, durante los primeros **90** días en que usted sea miembro de nuestro plan.

Para cada uno de los medicamentos que no están en nuestro Formulario o que tienen una restricción de cobertura, cubriremos un suministro temporal de **30 días**. Si su receta está indicada para menos días, permitiremos que realice resurtidos del medicamento por un máximo de hasta **30 días**. Si no se aprueba la cobertura, después del primer suministro para **30** días, no seguiremos pagando estos medicamentos, incluso si ha sido miembro del plan durante menos de **90 días**.

Si es residente de un centro de atención a largo plazo y necesita un medicamento que no está en el Formulario, o si su capacidad para conseguir los medicamentos es limitada, pero ya pasaron los primeros **90 días** de membresía en nuestro plan, cubriremos un suministro de emergencia del medicamento para **34 días** mientras solicita la excepción al formulario.

El proceso de transición a HealthSun Health Plans se mantendrá con respecto a lo siguiente: **(1)** la transición de nuevos miembros al plan durante el período de elección anual; **(2)** la transición de miembros de Medicare recientemente elegibles de otra cobertura a nuestro plan; **(3)** la transición de personas que cambian de plan después del inicio del año del contrato; **(4)** miembros que residen en un centro de cuidado a largo plazo (LTC); **(5)** miembros actuales afectados por cambios en el Formulario que los perjudican de un año de contrato al siguiente año de contrato; **(6)** miembros que solicitan una excepción pero no se emite una decisión oportuna sobre la solicitud antes del final del período de transición; **(7)** miembros que permanecen en el mismo plan para el nuevo año del plan y están tomando un medicamento como resultado de una excepción que se otorgó el año anterior; **(8)** miembros actuales que deben cambiar el nivel de cuidado; **(9)** miembros actuales que ingresan a un entorno de LTC desde otros entornos de cuidado; y **(10)** miembros actuales en un entorno de LTC que requieren un suministro de emergencia de un medicamento que no está en el Formulario.

## Para obtener más información

Para obtener información más detallada sobre la cobertura para medicamentos con receta de HealthSun Health Plans, consulte la Evidencia de cobertura y otra documentación del plan.

Si tiene alguna duda sobre HealthSun Health Plans, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del Formulario, aparece en las páginas de la portada y la portada posterior.

Si tiene preguntas generales sobre su cobertura para medicamentos con receta de Medicare, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 711. O bien, visite http://www.es.medicare.gov/.

## Formulario de HealthSun Health Plans

El formulario que comienza en la página **23** proporciona información de la cobertura de los medicamentos que cubre HealthSun Health Plans. Si tiene dificultad para encontrar el medicamento que toma en la lista, consulte el Índice que comienza en la página **115**

.

La primera columna del cuadro menciona el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (por ejemplo, **ERLEADA**) y los medicamentos genéricos están en letra minúscula y cursiva (por ejemplo, ***simvastatin tab***).

La información en la columna Requisitos/límites indica si HealthSun Health Plans tiene algún requisito especial para la cobertura del medicamento.

Algunos medicamentos en el Formulario estarán marcados con uno o más símbolos para indicar qué condiciones se aplican, como restricciones y requisitos de administración de la utilización, si están disponibles a través del pedido por correo, si están limitados a un suministro de un mes (incluso cuando el medicamento está en un nivel que permite un suministro extendido), si son medicamentos excluidos de la Parte D cubiertos por el plan, si tienen acceso limitado, si son de pedido por correo, el nivel a que pertenecen y otra información de cobertura.
La tabla de medicamentos que comienza en la página **23** incluye una columna llamada "**Nivel de medicamentos**". Esta columna indica en qué nivel se encuentra cada medicamento. La tabla que comienza en la página **18** brinda información sobre los copagos/coseguros asociados con los niveles correspondientes si recibe el medicamento en una farmacia de la red. Estos copagos/coseguros se aplican durante la fase de cobertura inicial.

Consulte su *Evidencia de Cobertura* para saber lo que paga durante la etapa de cobertura catastrófica. Si recibe Ayuda Extra ("Extra Help"), es posible que cierta información sobre los costos de los medicamentos recetados de la Parte D no se aplique a su caso. Consulte su *Cláusula de Evidencia de Cobertura para personas que obtienen ayuda extra para pagar por medicamentos recetados* (también conocida como Cláusula adicional del subsidio por bajos ingresos o "LIS Rider"), donde se explica la cobertura de medicamentos.

| Nivel | Nombre del nivel de medicamentos |
|---|---|
| **1** | Genérico preferido |
| **2** | Genérico |
| **3** | De marca preferida |
| **4** | Medicamento no preferido |
| **5** | Medicamento especializado |
| **6** | Medicamentos complementarios - (mejor cobertura de medicamentos) |

## Farmacia minorista preferida/Farmacia de pedido por correo

**Su costo por un suministro de un mes (30 días) de un medicamento cubierto de la Parte D.**

| Farmacia minorista preferida/Farmacia de pedido por correo | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Nombre del plan: HealthSun** | **Nivel 1*** Medicamentos genéricos preferidos | **Nivel 2*** Medicamentos genéricos | **Nivel 3** Medicamentos de marca preferida | **Nivel 3* Medicamentos de insulina** | **Nivel 4** Medicamentos no preferidos | **Nivel 5** Medicamentos especializados | **Nivel 6*** Medicamentos suplementarios |
| **HealthAdvantage Plan (HMO)** Miami-Dade County H5431-001 | $0 | $0 | $0 | $0 | $30 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Broward County H5431-012 | $0 | $0 | $5 | $5 | $75 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Palm Beach County H5431-013 | $0 | $0 | $10 | $10 | $50 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Miami-Dade County H5431-017 | $0 | $0 | $42 | $35 | $95 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Broward County H5431-018 | $0 | $0 | $42 | $35 | $95 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Palm Beach County H5431-020 | $0 | $0 | $42 | $35 | $95 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Broward, Miami-Dade H5431-021 | $0 | $0 | $37 | $35 | $85 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Palm Beach County H5431-022 | $0 | $0 | $37 | $35 | $85 | 33% | $0 |
| **MediMax (HMO)** Broward & Miami-Dade H5431-006 | $0 | $0 | 25% | $35 | 25% | 32% | $0 |
| **MediSun Extra (HMO D-SNP)** Broward, Miami-Dade, & Palm Beach H5431-019 | $0 | $0 | $10 | $10 | $50 | 25% | $0 |
| **MediSun Full Dual Extra (HMO D-SNP)** Broward, Miami-Dade, & Palm Beach H5431-026 | $0 | $0 | $5 | $5 | $50 | 25% | $0 |

* Para algunos medicamentos, puede obtener un suministro a largo plazo (también llamado suministro extendido). Un suministro a largo plazo es un suministro **para hasta 100 días para algunos medicamentos del Nivel 1** y un suministro **para hasta 90 días para algunos medicamentos del Nivel 2, Nivel 3 y Nivel 6.**

Si recibe Ayuda Extra ("Extra Help"), el monto que paga está determinado por su cobertura del subsidio por bajos ingresos (LIS) de Ayuda Extra ("Extra Help"). Consulte la cláusula adicional del subsidio por bajos ingresos (LIS) para conocer el monto de copago específico.

## Farmacia minorista estándar

**Su costo por un suministro de un mes (30 días) de un medicamento cubierto de la Parte D.**

| Farmacia minorista estándar | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Nombre del plan: HealthSun** | **Nivel 1*** Medicamentos genéricos preferidos | **Nivel 2*** Medicamentos genéricos | **Nivel 3** Medicamentos de marca preferida | **Nivel 3* Medicamentos de insulina** | **Nivel 4** Medicamentos no preferidos | **Nivel 5** Medicamentos especializados | **Nivel 6*** Medicamentos suplementarios |
| **HealthAdvantage Plan (HMO)** Miami-Dade County H5431-001 | $0 | $0 | $10 | $0 | $35 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Broward County H5431-012 | $0 | $0 | $20 | $5 | $80 | 33% | $0 |
| **HealthAdvantage Plan (HMO)** Palm Beach County H5431-013 | $0 | $0 | $10 | $10 | $55 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Miami-Dade County H5431-017 | $0 | $0 | $47 | $35 | $100 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Broward County H5431-018 | $0 | $0 | $47 | $35 | $100 | 33% | $0 |
| **HealthAdvantage Plus (HMO)** Palm Beach County H5431-020 | $0 | $0 | $47 | $35 | $100 | 33% | $0 |

| Farmacia minorista estándar | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Nombre del plan: HealthSun** | **Nivel 1*** Medicamentos genéricos preferidos | **Nivel 2*** Medicamentos genéricos | **Nivel 3** Medicamentos de marca preferida | **Nivel 3* Medicamentos de insulina** | **Nivel 4** Medicamentos no preferidos | **Nivel 5** Medicamentos especializados | **Nivel 6*** Medicamentos suplementarios |
| **VitalCare (HMO C-SNP)** Broward, Miami-Dade H5431-021 | $0 | $0 | $42 | $35 | $90 | 33% | $0 |
| **VitalCare (HMO C-SNP)** Palm Beach County H5431-022 | $0 | $0 | $42 | $35 | $90 | 33% | $0 |
| **MediMax (HMO)** Broward, Miami-Dade H5431-006 | $0 | $0 | 25% | $35 | 25% | 32% | $0 |
| **MediSun Extra (HMO D-SNP)** Broward, Miami-Dade, Palm Beach H5431-019 | $0 | $0 | $10 | $10 | $50 | 25% | $0 |
| **MediSun Full Dual Extra (HMO D-SNP)** Broward, Miami-Dade, Palm Beach H5431-026 | $0 | $0 | $5 | $5 | $50 | 25% | $0 |

***** Para algunos medicamentos, puede obtener un suministro a largo plazo (también llamado suministro extendido). Un suministro a largo plazo es un suministro **para hasta 100 días para algunos medicamentos del Nivel 1** y un suministro **para hasta 90 días para algunos medicamentos del Nivel 2, Nivel 3 y Nivel 6.**

Si recibe Ayuda Adicional, la cantidad que paga está determinada por su cobertura de subsidio por bajos ingresos (LIS) de Ayuda Adicional. Por favor, consulte su Cláusula adicional del subsidio por bajos ingresos o "LIS Rider", para conocer su monto específico de copago.

Consulte *la Evidencia de Cobertura* de su plan para obtener detalles sobre lo que paga en una farmacia de cuidado a largo plazo o en una farmacia fuera de la red cuando lo aprueba el plan.

## Abreviaturas

| SÍMBOLO | NOMBRE | DESCRIPCIÓN DE LA ABREVIATURA |
|---|---|---|
| **90D** | Beneficio de 90 días | Este medicamento está aprobado para un suministro para 90 días. |
| **100D** | Beneficio de 100 días | Este medicamento está aprobado para un suministro para 100 días. |
| **B/D PA** | Revisión de la autorización previa para medicamentos de la Parte B o de la Parte D | Este medicamento puede estar cubierto por Medicare Parte B o Medicare Parte D según las circunstancias. |
| **ED** | Mejor cobertura de medicamentos | Cobertura para medicamentos excluidos de Medicare Parte D. Este medicamento con receta normalmente no está cubierto por un Plan de Medicamentos Recetados de Medicare. El monto que usted paga cuando surte una receta para este medicamento no cuenta para el costo total del medicamento (es decir, el monto que usted paga no lo ayuda a calificar para una cobertura catastrófica). Además, si recibe ayuda extra para pagar sus recetas, no recibirá ninguna ayuda extra para pagar este medicamento. |
| **HRM** | Medicamento de alto riesgo | Se requiere autorización previa (PA) para personas de 65 años o más. |
| **LA** | Acceso limitado | Es posible que esta receta solo esté disponible en determinadas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame a Servicios para Miembros al 1-877-336-2069 (los usuarios de TTY deben llamar al 711) de 8 a.m. a 8 p.m., o visite www.HealthSun.com. Del 1.º de octubre al 31 de marzo, atendemos los siete días de la semana (nuestra oficina estará cerrada el Día de Acción de Gracias y el día de Navidad). Del 1.º de abril al 30 de septiembre, el horario de atención es de lunes a viernes de 8 a.m. a 8 p.m. (nuestra oficina estará cerrada los días feriados nacionales). |
| **NEDS** | Suministro para días no extendidos | Este medicamento está aprobado para un suministro para 30 días como máximo. |
| **MO** | Pedido por correo | Este medicamento está disponible en nuestras farmacias de pedido por correo. |
| **PA** | Autorización previa | Usted (o su médico) debe obtener una autorización previa antes de surtir su receta para este medicamento; es posible que no cubramos este medicamento sin aprobación previa. |
| **QL** | Límite de cantidad | Hay un límite en la cantidad de este medicamento que está cubierta por receta o dentro de un plazo específico. Ciertos medicamentos marcados "QL" por límite de cantidad indicarán la cantidad (días de suministro o cantidad dispensada). |
| **ST** | Terapia escalonada | En algunos casos, se podrá requerir que primero pruebe ciertos medicamentos para tratar su condición médica antes de que cubramos otro medicamento para esa condición. |

**List of Covered Drugs / Lista de Medicamentos**

**Table of Contents (Tabla de contenido)**


**ANALGESICS AND ANTI-INFLAMMATORY AGENTS / AGENTES ANALGÉSICOS Y ANTI-INFLAMATORIOS ..... 23**

**ANTINEOPLASTICS / ANTINEOPLÁSICOS ..... 25**

**BLOOD PRODUCTS AND MODIFIERS / PRODUCTOS SANGUÍNEOS Y MODIFICADORES ..... 34**

**CARDIOVASCULAR AGENTS / AGENTES CARDIOVASCULARES ..... 37**

**CENTRAL NERVOUS SYSTEM AGENTS / AGENTES DEL SISTEMA NERVIOSO CENTRAL ..... 45**

**DERMATOLOGICAL AGENTS / AGENTES DERMATOLÓGICOS ..... 65**

**ELECTROLYTES / MINERALS / METALS / VITAMINS / ELECTROLITOS / MINERALES / METALES / VITAMINAS ..... 69**

**ENDOCRINE AND METABOLIC DISORDER AGENTS / AGENTES DE TRASTORNOS ENDOCRINOS Y METABÓLICOS ..... 72**

**GASTROINTESTINAL AGENTS / AGENTES GASTROINTESTINALES ..... 78**

**GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT / TRASTORNO GENÉTICO, ENZIMÁTICO O PROTEICO: REEMPLAZO, MODIFICADORES, TRATAMIENTO ..... 81**

**GENITOURINARY AGENTS / AGENTES GENITOURINARIOS ..... 81**

**HORMONAL AGENTS / AGENTES HORMONALES ..... 83**

**IMMUNOLOGICAL AGENTS / AGENTES INMUNITARIOS ..... 89**

**INFECTIOUS DISEASE AGENTS / AGENTES DE ENFERMEDADES INFECCIOSAS ..... 96**

**MISCELLANEOUS THERAPEUTIC AGENTS / AGENTES TERAPÉUTICOS VARIOS ..... 107**

**OPHTHALMIC AGENTS / AGENTES OFTÁLMICOS ..... 108**

**OTIC AGENTS / AGENTES ÓTICOS ..... 110**

**RESPIRATORY TRACT/PULMONARY AGENTS / AGENTES PULMONARES/DE LAS VÍAS RESPIRATORIAS ..... 111**

| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| **ANALGESICS AND ANTI-INFLAMMATORY AGENTS / AGENTES ANALGÉSICOS Y ANTI-INFLAMATORIOS** | | |
| *acetaminophen-codeine oral solution* | 2 | QL (900 per 30 days); NEDS |
| *acetaminophen-codeine oral tablet* | 3 | QL (180 per 30 days); NEDS |
| *allopurinol oral tablet 100 mg, 300 mg* | 1 | MO; 100D |
| *buprenorphine transdermal* | 2 | PA; QL (4 per 28 days); NEDS |
| *butorphanol tartrate nasal* | 4 | QL (5 per 30 days); NEDS |
| *celecoxib oral capsule 100 mg, 200 mg, 50 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *celecoxib oral capsule 400 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *colchicine oral capsule* | 3 | |
| *colchicine oral tablet* | 2 | QL (120 per 30 days) |
| *colchicine-probenecid* | 1 | MO; 100D |
| *diclofenac potassium oral tablet 50 mg* | 1 | MO; 100D |
| *diclofenac sodium er* | 1 | MO; 100D |
| *diclofenac sodium external solution 1.5 %* | 4 | QL (300 per 30 days) |
| *diclofenac sodium oral* | 1 | MO; 100D |
| *diclofenac-misoprostol oral tablet delayed release* | 2 | MO; 90D |
| *diflunisal oral* | 2 | MO; 90D |
| ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG | 2 | QL (180 per 30 days); NEDS |
| *etodolac er* | 2 | MO; 90D |
| *etodolac oral* | 1 | MO; 100D |
| *febuxostat* | 2 | ST; MO; 90D |
| *fentanyl* | 4 | PA; QL (15 per 30 days); NEDS |
| *flurbiprofen oral tablet 100 mg* | 1 | MO; 100D |
| GLYDO EXTERNAL PREFILLED SYRINGE | 2 | |
| *hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml* | 2 | QL (2700 per 30 days); NEDS |
| *hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg* | 2 | QL (180 per 30 days); NEDS |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 3 | QL (180 per 30 days); NEDS |
| *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg* | 4 | QL (50 per 10 days); NEDS |
| *hydromorphone hcl oral liquid* | 4 | QL (720 per 30 days); NEDS |
| *hydromorphone hcl oral tablet* | 4 | QL (180 per 30 days); NEDS |
| *ibu oral tablet 600 mg* | 1 | MO; 100D |
| *ibuprofen oral suspension (rx)* | 1 | |
| *ibuprofen oral tablet 400 mg, 600 mg, 800 mg* | 1 | MO; 100D |
| *indomethacin oral capsule 25 mg, 50 mg* | 1 | PA; MO; 100D; HRM |
| *ketoprofen oral capsule 50 mg* | 4 | MO |
| *ketorolac tromethamine oral* | 2 | PA; HRM |
| *lidocaine external ointment 5 %* | 2 | PA; QL (150 per 30 days) |
| *lidocaine external patch 5 %* | 2 | PA; QL (90 per 30 days) |
| *lidocaine hcl external solution* | 2 | PA; QL (300 per 30 days) |
| *lidocaine hcl urethral/mucosal* | 2 | |
| *lidocaine viscous hcl* | 1 | |
| *lidocaine-prilocaine external cream* | 2 | QL (30 per 30 days) |
| *meloxicam oral tablet* | 1 | MO; 100D |
| *meperidine hcl injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml* | 2 | PA; HRM |
| *meperidine hcl oral solution* | 2 | PA; QL (900 per 30 days); NEDS; HRM |
| *meperidine hcl oral tablet 50 mg* | 4 | PA; QL (180 per 30 days); NEDS; HRM |
| *methadone hcl oral solution* | 3 | QL (900 per 30 days); NEDS |
| *methadone hcl oral tablet* | 3 | PA; QL (180 per 30 days); NEDS |
| *morphine sulfate (concentrate) oral solution 100 mg/5ml* | 2 | QL (180 per 30 days); NEDS |
| *morphine sulfate (pf) injection solution 0.5 mg/ml, 1 mg/ml* | 4 | |
| *morphine sulfate er oral tablet extended release 100 mg, 200 mg* | 2 | PA; QL (60 per 30 days); NEDS |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg* | 2 | PA; QL (90 per 30 days); NEDS |
| *morphine sulfate oral solution* | 2 | QL (900 per 30 days); NEDS |
| *morphine sulfate oral tablet 15 mg* | 2 | QL (180 per 30 days); NEDS |
| *morphine sulfate oral tablet 30 mg* | 1 | QL (180 per 30 days); NEDS |
| *nabumetone oral* | 1 | MO; 100D |
| *naproxen dr oral tablet delayed release 500 mg* | 2 | MO; 90D |
| *naproxen oral suspension* | 2 | MO; 90D |
| *naproxen oral tablet* | 1 | MO; 100D |
| *naproxen oral tablet delayed release* | 2 | MO; 90D |
| *naproxen sodium oral tablet 275 mg, 550 mg* | 2 | MO; 90D |
| *oxaprozin oral tablet* | 2 | MO; 90D |
| *oxycodone hcl oral concentrate 100 mg/5ml* | 2 | QL (180 per 30 days); NEDS |
| *oxycodone hcl oral tablet* | 3 | QL (180 per 30 days); NEDS |
| *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg* | 2 | QL (180 per 30 days); NEDS |
| *oxymorphone hcl* | 2 | QL (180 per 30 days); NEDS |
| *pentazocine-naloxone hcl* | 2 | PA; QL (360 per 30 days); NEDS; HRM |
| *piroxicam oral* | 2 | MO; 90D |
| *probenecid oral* | 1 | MO; 100D |
| *sulindac oral* | 1 | MO; 100D |
| *tramadol hcl (er biphasic) oral tablet extended release 24 hour* | 2 | PA; QL (30 per 30 days); NEDS |
| *tramadol hcl er* | 2 | PA; QL (30 per 30 days); NEDS |
| *tramadol hcl oral tablet 50 mg* | 1 | QL (240 per 30 days); NEDS |
| *tramadol-acetaminophen* | 2 | QL (40 per 5 days); NEDS |
| **ANTINEOPLASTICS / ANTINEOPLÁSICOS** | | |
| *abiraterone acetate oral tablet 250 mg* | 4 | PA; QL (120 per 30 days) |
| *abiraterone acetate oral tablet 500 mg* | 5 | PA; QL (60 per 30 days) |
| ABIRTEGA | 3 | PA; QL (120 per 30 days) |
| AKEEGA | 5 | PA; QL (60 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| ALECENSA | 5 | PA; QL (240 per 30 days) |
| ALUNBRIG ORAL TABLET 180 MG | 5 | PA; QL (30 per 30 days) |
| ALUNBRIG ORAL TABLET 30 MG | 5 | PA; QL (180 per 30 days) |
| ALUNBRIG ORAL TABLET 90 MG | 5 | PA; QL (60 per 30 days) |
| ALUNBRIG ORAL TABLET THERAPY PACK | 5 | PA; QL (30 per 180 days) |
| *anastrozole oral* | 2 | MO; 90D |
| AUGTYRO ORAL CAPSULE 160 MG | 5 | PA; QL (60 per 30 days) |
| AUGTYRO ORAL CAPSULE 40 MG | 5 | PA; QL (240 per 30 days) |
| AVMAPKI FAKZYNJA CO-PACK | 5 | PA; QL (66 per 28 days) |
| AYVAKIT | 5 | PA; QL (30 per 30 days) |
| BALVERSA ORAL TABLET 3 MG | 5 | PA; QL (90 per 30 days) |
| BALVERSA ORAL TABLET 4 MG | 5 | PA; QL (60 per 30 days) |
| BALVERSA ORAL TABLET 5 MG | 5 | PA; QL (30 per 30 days) |
| BESREMI | 5 | PA |
| BESREMI PEN | 5 | PA |
| *bexarotene oral* | 5 | PA; QL (300 per 30 days) |
| *bicalutamide* | 2 | QL (30 per 30 days) |
| BOSULIF ORAL CAPSULE 100 MG | 5 | PA; QL (180 per 30 days) |
| BOSULIF ORAL CAPSULE 50 MG | 5 | PA; QL (30 per 30 days) |
| BOSULIF ORAL TABLET 100 MG | 5 | PA; QL (180 per 30 days) |
| BOSULIF ORAL TABLET 500 MG | 5 | PA; QL (30 per 30 days) |
| *bosutinib oral tablet 100 mg* | 4 | PA; QL (180 per 30 days) |
| *bosutinib oral tablet 400 mg, 500 mg* | 5 | PA; QL (30 per 30 days) |
| BRAFTOVI ORAL CAPSULE 75 MG | 5 | PA; QL (180 per 30 days) |
| BRUKINSA ORAL CAPSULE | 5 | PA; QL (120 per 30 days) |
| BRUKINSA ORAL TABLET | 5 | PA; QL (60 per 30 days) |
| CABOMETYX | 5 | PA; QL (30 per 30 days) |
| CALQUENCE ORAL TABLET | 5 | PA; QL (60 per 30 days) |
| CAPRELSA ORAL TABLET 100 MG | 5 | PA; QL (90 per 30 days) |
| CAPRELSA ORAL TABLET 300 MG | 5 | PA; QL (30 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG | 5 | PA; QL (56 per 28 days) |
| COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG | 5 | PA; QL (112 per 28 days) |
| COMETRIQ (60 MG DAILY DOSE) | 5 | PA; QL (84 per 28 days) |
| COPIKTRA | 5 | PA; QL (60 per 30 days) |
| COTELLIC | 5 | PA; QL (90 per 30 days) |
| *cyclophosphamide oral capsule* | 3 | B/D PA |
| DANZITEN | 5 | PA; QL (112 per 28 days) |
| DARZALEX FASPRO | 5 | PA |
| *dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg* | 5 | PA; QL (30 per 30 days) |
| *dasatinib oral tablet 20 mg* | 5 | PA; QL (90 per 30 days) |
| DAURISMO ORAL TABLET 100 MG | 5 | PA; QL (30 per 30 days) |
| DAURISMO ORAL TABLET 25 MG | 5 | PA; QL (60 per 30 days) |
| ELIGARD | 4 | PA |
| ENSACOVE | 5 | PA; QL (60 per 30 days) |
| ERIVEDGE | 5 | PA; QL (30 per 30 days) |
| ERLEADA ORAL TABLET 240 MG | 5 | PA; QL (30 per 30 days) |
| ERLEADA ORAL TABLET 60 MG | 5 | PA; QL (120 per 30 days) |
| *erlotinib hcl oral tablet 100 mg, 150 mg* | 4 | PA; QL (30 per 30 days) |
| *erlotinib hcl oral tablet 25 mg* | 5 | PA; QL (90 per 30 days) |
| EULEXIN | 5 | |
| *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg* | 5 | PA |
| *everolimus oral tablet soluble 2 mg* | 4 | PA |
| *everolimus oral tablet soluble 3 mg, 5 mg* | 5 | PA |
| *exemestane* | 2 | MO; 90D |
| FIRMAGON (240 MG DOSE) | 5 | PA |
| FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG | 4 | PA |
| FOTIVDA | 5 | PA; QL (21 per 28 days) |
| FRUZAQLA ORAL CAPSULE 1 MG | 5 | PA; QL (84 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| FRUZAQLA ORAL CAPSULE 5 MG | 5 | PA; QL (21 per 28 days) |
| GAVRETO | 5 | PA; QL (120 per 30 days) |
| *gefitinib* | 5 | PA; QL (60 per 30 days) |
| GILOTRIF | 5 | PA; QL (30 per 30 days) |
| GOMEKLI ORAL CAPSULE 1 MG | 5 | PA; QL (240 per 30 days) |
| GOMEKLI ORAL CAPSULE 2 MG | 5 | PA; QL (120 per 30 days) |
| GOMEKLI ORAL TABLET SOLUBLE | 5 | PA; QL (240 per 30 days) |
| HERCEPTIN HYLECTA | 5 | B/D PA |
| HERNEXEOS | 5 | PA; QL (90 per 30 days) |
| *hydroxyurea oral* | 1 | |
| HYRNUO | 5 | PA; QL (120 per 30 days) |
| IBRANCE | 5 | PA; QL (21 per 28 days) |
| IBTROZI | 5 | PA; QL (90 per 30 days) |
| ICLUSIG | 5 | PA; QL (30 per 30 days) |
| IDHIFA ORAL TABLET 100 MG | 5 | PA; QL (30 per 30 days) |
| IDHIFA ORAL TABLET 50 MG | 5 | PA; QL (60 per 30 days) |
| *imatinib mesylate oral tablet 100 mg* | 3 | PA; QL (90 per 30 days) |
| *imatinib mesylate oral tablet 400 mg* | 3 | PA; QL (60 per 30 days) |
| IMBRUVICA ORAL CAPSULE 140 MG | 5 | PA; QL (90 per 30 days) |
| IMBRUVICA ORAL CAPSULE 70 MG | 5 | PA; QL (30 per 30 days) |
| IMBRUVICA ORAL SUSPENSION | 5 | PA; QL (216 per 27 days) |
| IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG | 5 | PA; QL (30 per 30 days) |
| *imkeldi* | 5 | PA; QL (280 per 28 days) |
| INLURIYO | 5 | PA; QL (56 per 28 days) |
| INLYTA ORAL TABLET 1 MG | 5 | PA; QL (180 per 30 days) |
| INLYTA ORAL TABLET 5 MG | 5 | PA; QL (120 per 30 days) |
| INQOVI | 5 | PA; QL (5 per 28 days) |
| INREBIC | 5 | PA; QL (120 per 30 days) |
| ITOVEBI ORAL TABLET 3 MG | 5 | PA; QL (56 per 28 days) |
| ITOVEBI ORAL TABLET 9 MG | 5 | PA; QL (28 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| IWILFIN | 5 | PA; QL (240 per 30 days) |
| JAKAFI | 5 | PA; QL (60 per 30 days) |
| JAKAFI XR | 5 | PA; QL (30 per 30 days) |
| JAYPIRCA ORAL TABLET 100 MG | 5 | PA; QL (60 per 30 days) |
| JAYPIRCA ORAL TABLET 50 MG | 5 | PA; QL (30 per 30 days) |
| JIDEYTRO ORAL TABLET 100 MG | 5 | PA; QL (30 per 30 days) |
| JIDEYTRO ORAL TABLET 25 MG | 5 | PA; QL (120 per 30 days) |
| KISQALI (200 MG DOSE) | 5 | PA; QL (21 per 28 days) |
| KISQALI (400 MG DOSE) | 5 | PA; QL (42 per 28 days) |
| KISQALI (600 MG DOSE) | 5 | PA; QL (63 per 28 days) |
| KOMZIFTI | 5 | PA; QL (90 per 30 days) |
| KRAZATI | 5 | PA; QL (180 per 30 days) |
| *lapatinib ditosylate* | 5 | PA; QL (180 per 30 days) |
| LAZCLUZE ORAL TABLET 240 MG | 5 | PA; QL (30 per 30 days) |
| LAZCLUZE ORAL TABLET 80 MG | 5 | PA; QL (60 per 30 days) |
| LEDERLE LEUCOVORIN | 1 | |
| *lenalidomide oral capsule 10 mg* | 5 | PA; QL (60 per 30 days) |
| *lenalidomide oral capsule 15 mg, 2.5 mg, 20 mg, 25 mg* | 5 | PA; QL (30 per 30 days) |
| *lenalidomide oral capsule 5 mg* | 5 | PA; QL (150 per 30 days) |
| LENVIMA (10 MG DAILY DOSE) | 5 | PA; QL (30 per 30 days) |
| LENVIMA (12 MG DAILY DOSE) | 5 | PA; QL (90 per 30 days) |
| LENVIMA (14 MG DAILY DOSE) | 5 | PA; QL (60 per 30 days) |
| LENVIMA (18 MG DAILY DOSE) | 5 | PA; QL (90 per 30 days) |
| LENVIMA (20 MG DAILY DOSE) | 5 | PA; QL (60 per 30 days) |
| LENVIMA (24 MG DAILY DOSE) | 5 | PA; QL (90 per 30 days) |
| LENVIMA (4 MG DAILY DOSE) | 5 | PA; QL (30 per 30 days) |
| LENVIMA (8 MG DAILY DOSE) | 5 | PA; QL (60 per 30 days) |
| *letrozole oral* | 2 | MO; 90D |
| *leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *leucovorin calcium oral tablet 5 mg* | 1 | |
| LEUKERAN | 5 | |
| *leuprolide acetate (3 month)* | 4 | PA |
| *leuprolide acetate injection* | 2 | PA |
| LIFYORLI (125 MG DOSE) | 5 | PA; QL (18 per 28 days) |
| LIFYORLI (150 MG DOSE) | 5 | PA; QL (27 per 28 days) |
| *lomustine* | 4 | PA |
| LONSURF | 5 | PA |
| LORBRENA ORAL TABLET 100 MG | 5 | PA; QL (30 per 30 days) |
| LORBRENA ORAL TABLET 25 MG | 5 | PA; QL (90 per 30 days) |
| LUMAKRAS ORAL TABLET 120 MG | 5 | PA; QL (240 per 30 days) |
| LUMAKRAS ORAL TABLET 240 MG | 5 | PA; QL (120 per 30 days) |
| LUMAKRAS ORAL TABLET 320 MG | 5 | PA; QL (90 per 30 days) |
| LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG | 5 | PA; QL (1 per 28 days) |
| LYNPARZA ORAL TABLET | 5 | PA; QL (120 per 30 days) |
| LYSODREN | 5 | |
| LYTGOBI (12 MG DAILY DOSE) | 5 | PA; QL (84 per 28 days) |
| LYTGOBI (16 MG DAILY DOSE) | 5 | PA; QL (112 per 28 days) |
| LYTGOBI (20 MG DAILY DOSE) | 5 | PA; QL (140 per 28 days) |
| MATULANE | 5 | |
| *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml* | 1 | PA; HRM |
| *megestrol acetate oral tablet* | 1 | PA; HRM |
| MEKINIST ORAL SOLUTION RECONSTITUTED | 5 | PA; QL (1200 per 30 days) |
| MEKINIST ORAL TABLET 0.5 MG | 5 | PA; QL (90 per 30 days) |
| MEKINIST ORAL TABLET 2 MG | 5 | PA; QL (30 per 30 days) |
| MEKTOVI | 5 | PA; QL (180 per 30 days) |
| *mercaptopurine oral suspension* | 5 | PA |
| *mercaptopurine oral tablet* | 2 | |
| *mesna oral* | 4 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| MODEYSO | 5 | PA; QL (20 per 28 days) |
| NERLYNX | 5 | PA; QL (180 per 30 days) |
| *nilotinib hcl* | 5 | PA; QL (112 per 28 days) |
| *nilutamide* | 5 | QL (30 per 30 days) |
| NINLARO | 5 | PA; QL (3 per 28 days) |
| NUBEQA | 5 | PA; QL (120 per 30 days) |
| ODOMZO | 5 | PA; QL (30 per 30 days) |
| OGSIVEO ORAL TABLET 100 MG, 150 MG | 5 | PA; QL (60 per 30 days) |
| OJEMDA ORAL SUSPENSION RECONSTITUTED | 5 | PA; QL (96 per 28 days) |
| OJEMDA ORAL TABLET | 5 | PA; QL (24 per 28 days) |
| OJJAARA | 5 | PA; QL (30 per 30 days) |
| ONUREG | 5 | PA; QL (14 per 28 days) |
| ORGOVYX | 5 | PA; QL (30 per 28 days) |
| ORSERDU ORAL TABLET 345 MG | 5 | PA; QL (30 per 30 days) |
| ORSERDU ORAL TABLET 86 MG | 5 | PA; QL (90 per 30 days) |
| *pazopanib hcl oral tablet 200 mg* | 5 | PA; QL (120 per 30 days) |
| *pazopanib hcl oral tablet 400 mg* | 5 | PA; QL (60 per 30 days) |
| PEMAZYRE | 5 | PA; QL (30 per 30 days) |
| PHESGO | 5 | PA |
| PHYRAGO ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG | 5 | PA; QL (30 per 30 days) |
| PHYRAGO ORAL TABLET 20 MG | 5 | PA; QL (90 per 30 days) |
| PIQRAY (200 MG DAILY DOSE) | 5 | PA; QL (28 per 28 days) |
| PIQRAY (250 MG DAILY DOSE) | 5 | PA; QL (56 per 28 days) |
| PIQRAY (300 MG DAILY DOSE) | 5 | PA; QL (56 per 28 days) |
| *pomalidomide* | 5 | PA; QL (21 per 28 days) |
| POMALYST | 5 | PA; QL (21 per 28 days) |
| QINLOCK | 5 | PA; QL (90 per 30 days) |
| RASONQUE | 5 | PA; QL (60 per 30 days) |
| RETEVMO ORAL TABLET 120 MG, 160 MG | 5 | PA; QL (60 per 30 days) |
| RETEVMO ORAL TABLET 40 MG | 5 | PA; QL (90 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| RETEVMO ORAL TABLET 80 MG | 5 | PA; QL (120 per 30 days) |
| REVUFORJ ORAL TABLET 110 MG | 5 | PA; QL (120 per 30 days) |
| REVUFORJ ORAL TABLET 160 MG | 5 | PA; QL (60 per 30 days) |
| REVUFORJ ORAL TABLET 25 MG | 5 | PA; QL (240 per 30 days) |
| REZLIDHIA | 5 | PA; QL (60 per 30 days) |
| ROMVIMZA | 5 | PA; QL (8 per 28 days) |
| ROZLYTREK ORAL CAPSULE 100 MG | 5 | PA; QL (150 per 30 days) |
| ROZLYTREK ORAL CAPSULE 200 MG | 5 | PA; QL (90 per 30 days) |
| ROZLYTREK ORAL PACKET | 5 | PA; QL (360 per 30 days) |
| RUBRACA | 5 | PA; QL (120 per 30 days) |
| RYDAPT | 5 | PA; QL (240 per 30 days) |
| RYLAZE | 5 | PA |
| SCEMBLIX ORAL TABLET 100 MG | 5 | PA; QL (120 per 30 days) |
| SCEMBLIX ORAL TABLET 20 MG, 40 MG | 5 | PA; QL (60 per 30 days) |
| SOLTAMOX | 5 | MO |
| *sorafenib tosylate* | 5 | PA; QL (120 per 30 days) |
| STIVARGA | 5 | PA; QL (84 per 28 days) |
| *sunitinib malate* | 5 | PA; QL (30 per 30 days) |
| TABLOID | 5 | |
| TABRECTA | 5 | PA; QL (120 per 30 days) |
| TAFINLAR ORAL CAPSULE | 5 | PA; QL (120 per 30 days) |
| TAFINLAR ORAL TABLET SOLUBLE | 5 | PA; QL (900 per 30 days) |
| TAGRISSO | 5 | PA; QL (30 per 30 days) |
| TALZENNA | 5 | PA; QL (30 per 30 days) |
| *tamoxifen citrate oral* | 1 | MO; 100D |
| TECENTRIQ HYBREZA | 5 | PA |
| TECVAYLI | 5 | PA |
| TEPMETKO | 5 | PA; QL (60 per 30 days) |
| THALOMID ORAL CAPSULE 100 MG | 5 | PA; QL (112 per 28 days) |
| THALOMID ORAL CAPSULE 50 MG | 5 | PA; QL (224 per 28 days) |
| TIBSOVO | 5 | PA; QL (60 per 30 days) |

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|---|---|---|
| *toremifene citrate* | 4 | |
| TRELSTAR MIXJECT | 4 | PA |
| *tretinoin oral* | 5 | |
| TRUQAP ORAL TABLET 200 MG | 5 | PA; QL (64 per 28 days) |
| TRUQAP ORAL TABLET THERAPY PACK | 5 | PA; QL (64 per 28 days) |
| TUKYSA | 5 | PA; QL (120 per 30 days) |
| TURALIO ORAL CAPSULE 125 MG | 5 | PA; QL (120 per 30 days) |
| VANFLYTA | 5 | PA; QL (56 per 28 days) |
| VENCLEXTA ORAL TABLET 10 MG | 3 | PA; QL (60 per 30 days) |
| VENCLEXTA ORAL TABLET 100 MG | 5 | PA; QL (180 per 30 days) |
| VENCLEXTA ORAL TABLET 50 MG | 5 | PA; QL (30 per 30 days) |
| VENCLEXTA STARTING PACK | 5 | PA |
| VEPPANU | 5 | PA; QL (30 per 30 days) |
| VERZENIO | 5 | PA; QL (56 per 28 days) |
| VITRAKVI ORAL CAPSULE 100 MG | 5 | PA; QL (60 per 30 days) |
| VITRAKVI ORAL CAPSULE 25 MG | 5 | PA; QL (180 per 30 days) |
| VITRAKVI ORAL SOLUTION | 5 | PA; QL (300 per 30 days) |
| VIZIMPRO | 5 | PA; QL (30 per 30 days) |
| VONJO | 5 | PA; QL (120 per 30 days) |
| VORANIGO ORAL TABLET 10 MG | 5 | PA; QL (60 per 30 days) |
| VORANIGO ORAL TABLET 40 MG | 5 | PA; QL (30 per 30 days) |
| WELIREG | 5 | PA; QL (90 per 30 days) |
| XALKORI ORAL CAPSULE | 5 | PA; QL (120 per 30 days) |
| XALKORI ORAL CAPSULE SPRINKLE 150 MG | 5 | PA; QL (180 per 30 days) |
| XALKORI ORAL CAPSULE SPRINKLE 20 MG | 5 | PA; QL (240 per 30 days) |
| XALKORI ORAL CAPSULE SPRINKLE 50 MG | 5 | PA; QL (120 per 30 days) |
| XOSPATA | 5 | PA; QL (90 per 30 days) |
| XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG | 5 | PA; QL (8 per 28 days) |
| XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG | 5 | PA; QL (16 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG | 5 | PA; QL (4 per 28 days) |
| XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG | 5 | PA; QL (8 per 28 days) |
| XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG | 5 | PA; QL (4 per 28 days) |
| XPOVIO (60 MG TWICE WEEKLY) | 5 | PA; QL (24 per 28 days) |
| XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG | 5 | PA; QL (8 per 28 days) |
| XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 80 MG | 5 | PA; QL (4 per 28 days) |
| XPOVIO (80 MG TWICE WEEKLY) | 5 | PA; QL (32 per 28 days) |
| XTANDI ORAL CAPSULE | 5 | PA; QL (120 per 30 days) |
| XTANDI ORAL TABLET 40 MG | 5 | PA; QL (120 per 30 days) |
| XTANDI ORAL TABLET 80 MG | 5 | PA; QL (60 per 30 days) |
| YULITHIRA | 3 | PA |
| ZEJULA ORAL TABLET 100 MG | 5 | PA; QL (90 per 30 days) |
| ZEJULA ORAL TABLET 200 MG, 300 MG | 5 | PA; QL (30 per 30 days) |
| ZELBORAF | 5 | PA; QL (240 per 30 days) |
| ZENBEXUS | 5 | PA; QL (21 per 28 days) |
| ZOLINZA | 4 | PA; QL (120 per 30 days) |
| ZYDELIG | 5 | PA; QL (60 per 30 days) |
| ZYKADIA ORAL TABLET | 5 | PA; QL (90 per 30 days) |
| **BLOOD PRODUCTS AND MODIFIERS / PRODUCTOS SANGUÍNEOS Y MODIFICADORES** | | |
| *anagrelide hcl* | 2 | MO; 90D |
| *aspirin-dipyridamole er* | 2 | QL (60 per 30 days); MO; 90D |
| *cilostazol* | 2 | MO; 90D |
| *clopidogrel bisulfate oral tablet 75 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *dabigatran etexilate mesylate* | 2 | QL (60 per 30 days); MO; 90D |
| *dipyridamole oral tablet 25 mg, 50 mg* | 1 | PA; MO; 100D; HRM |
| *dipyridamole oral tablet 75 mg* | 2 | PA; MO; 90D; HRM |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| DROXIA | 4 | MO |
| ELIQUIS (1.5 MG PACK) | 3 | MO |
| ELIQUIS (2 MG PACK) | 3 | MO |
| ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK | 3 | QL (74 per 180 days) |
| ELIQUIS ORAL CAPSULE SPRINKLE | 3 | QL (120 per 30 days); MO |
| ELIQUIS ORAL TABLET 2.5 MG | 3 | QL (60 per 30 days); MO |
| ELIQUIS ORAL TABLET 5 MG | 3 | QL (74 per 30 days); MO |
| ELIQUIS ORAL TABLET SOLUBLE | 3 | QL (960 per 30 days); MO |
| *eltrombopag olamine oral packet 12.5 mg* | 5 | PA; QL (360 per 30 days) |
| *eltrombopag olamine oral packet 25 mg* | 5 | PA; QL (180 per 30 days) |
| *eltrombopag olamine oral tablet 12.5 mg, 25 mg* | 5 | PA; QL (30 per 30 days) |
| *eltrombopag olamine oral tablet 50 mg* | 5 | PA; QL (90 per 30 days) |
| *eltrombopag olamine oral tablet 75 mg* | 5 | PA; QL (60 per 30 days) |
| *enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml* | 2 | QL (56 per 28 days) |
| *enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml* | 2 | QL (44.8 per 28 days) |
| *enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml* | 2 | QL (16.8 per 28 days) |
| *enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml* | 2 | QL (22.4 per 28 days) |
| *enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml* | 2 | QL (33.6 per 28 days) |
| *fondaparinux sodium subcutaneous solution 10 mg/0.8ml* | 5 | QL (24 per 30 days) |
| *fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml* | 2 | QL (15 per 30 days) |
| *fondaparinux sodium subcutaneous solution 5 mg/0.4ml* | 5 | QL (12 per 30 days) |
| *fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml* | 5 | QL (18 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML | 4 | |
| FRAGMIN SUBCUTANEOUS SOLUTION 95000 UNIT/3.8ML | 5 | |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 7500 UNIT/0.3ML | 5 | |
| FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 2500 UNIT/0.2ML, 5000 UNIT/0.2ML | 4 | |
| *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml* | 2 | B/D PA |
| *heparin sodium (porcine) injection solution 5000 unit/ml* | 1 | B/D PA |
| *heparin sodium (porcine) pf injection solution 1000 unit/ml* | 2 | B/D PA |
| *icatibant acetate subcutaneous solution prefilled syringe* | 5 | PA; QL (18 per 30 days) |
| *jantoven* | 1 | MO; 100D |
| LEUKINE INJECTION SOLUTION RECONSTITUTED | 5 | PA |
| *l-glutamine oral packet* | 5 | PA |
| NEULASTA ONPRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | PA; QL (1.2 per 28 days) |
| NEULASTA SUBCUTANEOUS SOLUTION 4 MG/0.4ML | 5 | PA; QL (0.8 per 28 days) |
| NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | PA; QL (1.2 per 28 days) |
| *pentoxifylline er* | 1 | MO; 100D |
| *prasugrel hcl* | 2 | QL (30 per 30 days); MO; 90D |
| PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML | 4 | PA |
| PROCRIT INJECTION SOLUTION 20000 UNIT/ML, 40000 UNIT/ML | 5 | PA |
| RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML | 4 | PA; QL (12 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *rivaroxaban oral suspension reconstituted* | 3 | QL (600 per 30 days); MO |
| *rivaroxaban oral tablet* | 3 | QL (60 per 30 days); MO |
| SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | PA; QL (18 per 30 days) |
| TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | PA |
| *ticagrelor* | 2 | QL (60 per 30 days); MO; 90D |
| *tranexamic acid oral* | 2 | |
| UDENYCA | 5 | PA; QL (1.2 per 28 days) |
| UDENYCA ONBODY | 5 | PA; QL (1.2 per 28 days) |
| *warfarin sodium oral* | 1 | MO; 100D |
| XARELTO ORAL TABLET 10 MG, 20 MG | 3 | QL (30 per 30 days); MO |
| XARELTO ORAL TABLET 15 MG | 3 | QL (60 per 30 days); MO |
| XARELTO STARTER PACK | 3 | |
| ZARXIO | 5 | PA |
| **CARDIOVASCULAR AGENTS / AGENTES CARDIOVASCULARES** | | |
| *acebutolol hcl oral* | 1 | MO; 100D |
| *acetazolamide oral* | 2 | MO; 90D |
| *aliskiren fumarate* | 1 | MO; 100D |
| *amiloride hcl oral* | 1 | MO; 100D |
| *amiloride-hydrochlorothiazide* | 1 | MO; 100D |
| *amiodarone hcl oral* | 2 | MO; 90D |
| *amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 5-40 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *amlodipine besy-benazepril hcl oral capsule 2.5-10 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *amlodipine besy-benazepril hcl oral capsule 5-10 mg, 5-20 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *amlodipine besylate oral* | 1 | MO; 100D |
| *amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-320 mg* | 1 | QL (30 per 30 days); MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *amlodipine besylate-valsartan oral tablet 5-160 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *amlodipine-atorvastatin* | 1 | QL (30 per 30 days); MO; 100D |
| *amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-40 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *amlodipine-olmesartan oral tablet 5-20 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *amlodipine-valsartan-hctz oral tablet 5-160-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *atenolol oral* | 1 | MO; 100D |
| *atenolol-chlorthalidone* | 1 | MO; 100D |
| *atorvastatin calcium oral* | 1 | QL (30 per 30 days); MO; 100D |
| *benazepril hcl oral* | 1 | MO; 100D |
| *benazepril-hydrochlorothiazide oral tablet 10-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *benazepril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *benazepril-hydrochlorothiazide oral tablet 5-6.25 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *betaxolol hcl oral* | 1 | MO; 100D |
| *bisoprolol fumarate oral* | 1 | MO; 100D |
| *bisoprolol-hydrochlorothiazide* | 1 | MO; 100D |
| *bumetanide injection* | 2 | |
| *bumetanide oral* | 2 | MO; 90D |
| *candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *candesartan cilexetil oral tablet 32 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *candesartan cilexetil-hctz oral tablet 16-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *captopril oral tablet 100 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *captopril oral tablet 12.5 mg, 25 mg, 50 mg* | 1 | QL (180 per 30 days); MO; 100D |

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|---|---|---|
| *captopril-hydrochlorothiazide* | 2 | QL (60 per 30 days); MO; 90D |
| CARTIA XT | 1 | MO; 100D |
| *carvedilol* | 1 | MO; 100D |
| *carvedilol phosphate er* | 2 | MO; 90D |
| *chlorthalidone oral tablet 25 mg, 50 mg* | 1 | MO; 100D |
| *cholestyramine light* | 2 | MO; 90D |
| *cholestyramine oral* | 2 | MO; 90D |
| *clonidine hcl oral* | 1 | MO; 100D |
| *clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr* | 2 | QL (12 per 28 days); MO; 90D |
| *clonidine transdermal patch weekly 0.3 mg/24hr* | 2 | QL (4 per 28 days); MO; 90D |
| *colesevelam hcl* | 2 | MO; 90D |
| *colestipol hcl* | 2 | MO; 90D |
| CORLANOR ORAL SOLUTION | 4 | PA; QL (560 per 28 days); MO |
| *digox oral tablet 125 mcg* | 1 | QL (30 per 30 days); MO; 100D |
| *digox oral tablet 250 mcg* | 1 | QL (60 per 30 days); MO; 100D |
| *digoxin oral solution* | 2 | MO; 90D |
| *digoxin oral tablet 125 mcg* | 1 | QL (30 per 30 days); MO; 100D |
| *digoxin oral tablet 250 mcg* | 1 | QL (60 per 30 days); MO; 100D |
| *diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg* | 3 | MO |
| *diltiazem hcl er beads oral capsule extended release 24 hour 360 mg, 420 mg* | 2 | MO; 90D |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 300 mg* | 1 | MO; 100D |
| *diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg, 360 mg* | 2 | MO; 90D |
| *diltiazem hcl er oral capsule extended release 12 hour* | 2 | MO; 90D |
| *diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg* | 1 | MO; 100D |

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|---|---|---|
| *diltiazem hcl er oral tablet extended release 24 hour* | 2 | MO; 90D |
| *diltiazem hcl oral tablet* | 1 | MO; 100D |
| *dilt-xr* | 1 | MO; 100D |
| *disopyramide phosphate oral* | 2 | PA; MO; 90D; HRM |
| *dofetilide* | 2 | 90D |
| *doxazosin mesylate oral* | 1 | MO; 100D |
| *droxidopa oral capsule 100 mg* | 2 | PA; QL (90 per 30 days) |
| *droxidopa oral capsule 200 mg, 300 mg* | 4 | PA; QL (180 per 30 days) |
| *enalapril maleate oral tablet* | 1 | MO; 100D |
| *enalapril-hydrochlorothiazide oral tablet 10-25 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *enalapril-hydrochlorothiazide oral tablet 5-12.5 mg* | 1 | QL (120 per 30 days); MO; 100D |
| ENTRESTO ORAL CAPSULE SPRINKLE | 3 | QL (240 per 30 days); MO |
| *eplerenone* | 2 | MO; 90D |
| *ezetimibe oral* | 2 | QL (30 per 30 days); MO; 90D |
| *ezetimibe-simvastatin* | 1 | QL (30 per 30 days); MO; 100D |
| *felodipine er* | 1 | MO; 100D |
| *fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg* | 2 | MO; 90D |
| *fenofibrate oral* | 2 | MO; 90D |
| *fenofibric acid oral capsule delayed release* | 2 | MO; 90D |
| *flecainide acetate* | 2 | MO; 90D |
| *fluvastatin sodium* | 1 | QL (60 per 30 days); MO; 100D |
| *fluvastatin sodium er* | 1 | QL (30 per 30 days); MO; 100D |
| *fosinopril sodium* | 1 | MO; 100D |
| *fosinopril sodium-hctz* | 1 | MO; 100D |
| *furosemide injection* | 1 | |
| *furosemide oral tablet* | 1 | MO; 100D |
| *gemfibrozil oral* | 2 | MO; 90D |
| *hydralazine hcl oral* | 1 | MO; 100D |

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|---|---|---|
| *hydrochlorothiazide oral* | 1 | MO; 100D |
| *icosapent ethyl* | 3 | MO |
| *indapamide oral* | 1 | MO; 100D |
| *irbesartan* | 1 | QL (30 per 30 days); MO; 100D |
| *irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *isosorb dinitrate-hydralazine oral tablet 20-37.5 mg* | 2 | QL (180 per 30 days); MO; 90D |
| *isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg* | 1 | MO; 100D |
| *isosorbide mononitrate* | 3 | MO |
| *isosorbide mononitrate er* | 1 | MO; 100D |
| *isradipine oral capsule 2.5 mg* | 2 | MO; 90D |
| *isradipine oral capsule 5 mg* | 1 | MO; 100D |
| *ivabradine hcl* | 4 | PA; QL (60 per 30 days); MO |
| *labetalol hcl oral* | 1 | MO; 100D |
| *lisinopril oral* | 1 | MO; 100D |
| *lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *lisinopril-hydrochlorothiazide oral tablet 20-25 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *losartan potassium oral tablet 100 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *losartan potassium oral tablet 25 mg, 50 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *losartan potassium-hctz oral tablet 50-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *lovastatin oral* | 1 | QL (60 per 30 days); MO; 100D |
| MATZIM LA | 2 | MO; 90D |
| *methyldopa oral* | 1 | 100D |
| *metolazone* | 1 | MO; 100D |
| *metoprolol succinate er* | 1 | MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg* | 1 | MO; 100D |
| *metoprolol tartrate oral tablet 37.5 mg, 75 mg* | 2 | MO; 90D |
| *metoprolol-hydrochlorothiazide* | 1 | MO; 100D |
| *metyrosine* | 5 | |
| *mexiletine hcl oral* | 2 | MO; 90D |
| *midodrine hcl* | 2 | |
| *minoxidil oral* | 1 | MO; 100D |
| *moexipril hcl* | 1 | MO; 100D |
| MULTAQ | 3 | QL (60 per 30 days); MO |
| *nadolol oral tablet 20 mg, 40 mg, 80 mg* | 2 | MO; 90D |
| *nebivolol hcl* | 2 | MO; 90D |
| NEXLETOL | 3 | PA; QL (30 per 30 days); MO |
| NEXLIZET | 3 | PA; QL (30 per 30 days); MO |
| *niacin (antihyperlipidemic)* | 2 | |
| *niacin er (antihyperlipidemic)* | 2 | MO; 90D |
| *niacor* | 2 | |
| *nicardipine hcl oral* | 2 | MO; 90D |
| *nifedipine er* | 1 | MO; 100D |
| *nifedipine er osmotic release* | 1 | MO; 100D |
| *nimodipine oral capsule* | 2 | |
| *nisoldipine er oral tablet extended release 24 hour 17 mg, 34 mg, 8.5 mg* | 2 | MO; 90D |
| *nitroglycerin sublingual* | 1 | MO; 100D |
| *nitroglycerin transdermal patch 24 hour* | 1 | MO; 100D |
| *nitroglycerin translingual solution* | 2 | MO; 90D |
| *olmesartan medoxomil oral tablet 20 mg, 40 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *olmesartan medoxomil oral tablet 5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *olmesartan medoxomil-hctz oral tablet 20-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *olmesartan medoxomil-hctz oral tablet 40-12.5 mg, 40-25 mg* | 1 | QL (30 per 30 days); MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *olmesartan-amlodipine-hctz oral tablet 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *omega-3-acid ethyl esters* | 2 | MO; 90D |
| *pacerone oral tablet 100 mg, 200 mg, 400 mg* | 2 | MO; 90D |
| *perindopril erbumine* | 1 | MO; 100D |
| *pindolol* | 1 | MO; 100D |
| *pitavastatin calcium* | 3 | QL (30 per 30 days); MO |
| *pravastatin sodium* | 1 | QL (30 per 30 days); MO; 100D |
| *prazosin hcl oral* | 1 | MO; 100D |
| *prevalite* | 2 | MO; 90D |
| *propafenone hcl* | 2 | MO; 90D |
| *propafenone hcl er* | 2 | MO; 90D |
| *propranolol hcl er* | 2 | MO; 90D |
| *propranolol hcl oral solution* | 2 | MO; 90D |
| *propranolol hcl oral tablet* | 1 | MO; 100D |
| *quinapril hcl* | 1 | MO; 100D |
| *quinapril-hydrochlorothiazide oral tablet 10-12.5 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *quinapril-hydrochlorothiazide oral tablet 20-12.5 mg, 20-25 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *quinidine gluconate er* | 2 | MO; 90D |
| *quinidine sulfate oral* | 4 | MO |
| *ramipril* | 1 | MO; 100D |
| *ranolazine er* | 2 | QL (60 per 30 days); MO; 90D |
| REPATHA | 3 | PA; QL (3 per 28 days) |
| REPATHA SURECLICK | 3 | PA; QL (3 per 28 days) |
| *rosuvastatin calcium oral* | 1 | QL (30 per 30 days); MO; 100D |
| *sacubitril-valsartan oral tablet 24-26 mg* | 3 | QL (180 per 30 days); MO |
| *sacubitril-valsartan oral tablet 49-51 mg, 97-103 mg* | 3 | QL (60 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *simvastatin oral tablet* | 1 | QL (30 per 30 days); MO; 100D |
| SOAANZ ORAL TABLET 40 MG | 1 | MO; 100D |
| *sotalol hcl (af)* | 2 | MO; 90D |
| *sotalol hcl oral* | 2 | MO; 90D |
| *spironolactone oral tablet* | 1 | MO; 100D |
| *spironolactone-hctz* | 1 | MO; 100D |
| *telmisartan oral tablet 20 mg, 40 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *telmisartan oral tablet 80 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *telmisartan-amlodipine* | 2 | QL (30 per 30 days); MO; 90D |
| *telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *telmisartan-hctz oral tablet 80-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *terazosin hcl oral* | 1 | MO; 100D |
| TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG | 3 | MO |
| TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 360 MG, 420 MG | 2 | MO; 90D |
| *timolol maleate oral* | 1 | MO; 100D |
| *torsemide oral tablet 10 mg, 100 mg, 20 mg* | 1 | MO; 100D |
| *trandolapril* | 1 | MO; 100D |
| *trandolapril-verapamil hcl er* | 2 | MO; 90D |
| *triamterene-hctz oral capsule 37.5-25 mg* | 1 | MO; 100D |
| *triamterene-hctz oral tablet* | 1 | MO; 100D |
| *valsartan oral tablet 160 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *valsartan oral tablet 320 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *valsartan oral tablet 40 mg, 80 mg* | 1 | QL (90 per 30 days); MO; 100D |
| *valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 80-12.5 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *valsartan-hydrochlorothiazide oral tablet 160-25 mg, 320-12.5 mg, 320-25 mg* | 1 | QL (30 per 30 days); MO; 100D |
| VASCEPA | 4 | MO |
| *verapamil hcl er* | 2 | MO; 90D |
| *verapamil hcl oral* | 1 | MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| VERQUVO | 4 | PA; MO |
| **CENTRAL NERVOUS SYSTEM AGENTS / AGENTES DEL SISTEMA NERVIOSO CENTRAL** | | |
| ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML | 5 | QL (2.4 per 56 days) |
| ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 960 MG/3.2ML | 5 | QL (3.2 per 56 days) |
| ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE | 5 | QL (1 per 28 days); MO |
| ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER | 5 | QL (1 per 28 days); MO |
| *acamprosate calcium* | 2 | MO; 90D |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML | 3 | PA; QL (1 per 28 days); MO |
| AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML | 3 | PA; QL (2 per 28 days); MO |
| *almotriptan malate* | 2 | QL (9 per 30 days) |
| *alprazolam er* | 2 | QL (90 per 30 days) |
| ALPRAZOLAM INTENSOL | 3 | QL (300 per 30 days) |
| *alprazolam oral tablet* | 1 | QL (120 per 30 days) |
| *alprazolam oral tablet dispersible* | 2 | QL (120 per 30 days) |
| *alprazolam xr* | 2 | QL (90 per 30 days) |
| *amantadine hcl oral capsule* | 2 | MO; 90D |
| *amantadine hcl oral solution* | 2 | MO; 90D |
| *amantadine hcl oral tablet* | 2 | MO; 90D |
| *amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 75 mg* | 1 | PA; MO; 100D; HRM |
| *amitriptyline hcl oral tablet 25 mg, 50 mg* | 2 | PA; MO; 90D; HRM |
| *amoxapine* | 2 | PA; MO; 90D; HRM |
| *amphetamine-dextroamphet er* | 2 | PA; QL (30 per 30 days); MO |
| *amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg* | 2 | PA; QL (90 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *amphetamine-dextroamphetamine oral tablet 30 mg* | 2 | PA; QL (60 per 30 days); MO |
| APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 174 MG | 5 | QL (90 per 30 days); MO |
| APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 348 MG | 5 | QL (45 per 30 days); MO |
| APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 522 MG | 5 | QL (30 per 30 days); MO |
| *apomorphine hcl subcutaneous* | 5 | PA; QL (60 per 30 days) |
| *aripiprazole oral solution* | 2 | QL (900 per 30 days); MO; 90D |
| *aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg* | 2 | MO; 90D |
| *aripiprazole oral tablet 20 mg, 30 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *aripiprazole oral tablet dispersible 10 mg* | 2 | QL (90 per 30 days); MO; 90D |
| *aripiprazole oral tablet dispersible 15 mg* | 4 | QL (60 per 30 days); MO |
| ARISTADA INITIO | 5 | QL (4.8 per 365 days) |
| ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML | 5 | QL (3.9 per 56 days); MO |
| ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML | 5 | QL (1.6 per 28 days); MO |
| ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML | 5 | QL (2.4 per 28 days); MO |
| ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML | 5 | QL (3.2 per 28 days); MO |
| *asenapine maleate sublingual tablet sublingual 10 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *asenapine maleate sublingual tablet sublingual 2.5 mg* | 2 | QL (240 per 30 days); MO; 90D |
| *asenapine maleate sublingual tablet sublingual 5 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg* | 2 | QL (30 per 30 days); MO; 90D |
| AUSTEDO | 5 | PA; QL (120 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 6 MG | 5 | PA; QL (60 per 30 days) |
| AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 36 MG, 42 MG, 48 MG | 5 | PA; QL (30 per 30 days) |
| AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG | 5 | PA |
| AUVELITY | 5 | PA; QL (60 per 30 days); MO |
| AUVELITY TITRATION PACK | 4 | PA |
| BAC (BUTALBITAL-ACETAMIN-CAFF) | 2 | PA; QL (180 per 30 days); HRM |
| *baclofen oral tablet* | 1 | |
| *benztropine mesylate oral* | 1 | PA; MO; 100D; HRM |
| BETASERON SUBCUTANEOUS KIT | 5 | PA; QL (15 per 30 days) |
| *brivaracetam oral solution* | 4 | PA; QL (600 per 30 days); MO |
| *brivaracetam oral tablet* | 4 | PA; QL (60 per 30 days); MO |
| *bromocriptine mesylate oral* | 2 | MO; 90D |
| *buprenorphine hcl sublingual* | 2 | NEDS |
| *buprenorphine hcl-naloxone hcl sublingual film 12-3 mg* | 2 | NEDS |
| *buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg* | 2 | QL (480 per 30 days); NEDS |
| *buprenorphine hcl-naloxone hcl sublingual film 4-1 mg* | 2 | QL (240 per 30 days); NEDS |
| *buprenorphine hcl-naloxone hcl sublingual film 8-2 mg* | 2 | QL (120 per 30 days); NEDS |
| *buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg* | 2 | QL (480 per 30 days); NEDS |
| *buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg* | 2 | QL (120 per 30 days); NEDS |
| *bupropion hcl er (smoking det)* | 2 | QL (60 per 30 days) |
| *bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg* | 2 | QL (120 per 30 days); MO; 90D |

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|---|---|---|
| *bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg* | 2 | QL (90 per 30 days); MO; 90D |
| *bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg, 450 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *bupropion hcl oral tablet 100 mg* | 1 | QL (135 per 30 days); MO; 100D |
| *bupropion hcl oral tablet 75 mg* | 1 | QL (180 per 30 days); MO; 100D |
| *buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg* | 1 | |
| *butalbital-acetaminophen oral tablet 50-325 mg* | 2 | PA; QL (180 per 30 days); HRM |
| *butalbital-apap-caffeine oral capsule* | 2 | PA; QL (180 per 30 days); HRM |
| *butalbital-apap-caffeine oral tablet 50-325-40 mg* | 2 | PA; QL (180 per 30 days); HRM |
| BYSANTI | 5 | PA; QL (60 per 30 days); MO |
| BYSANTI TITRATION PACK A | 5 | PA |
| BYSANTI TITRATION PACK B | 5 | PA |
| BYSANTI TITRATION PACK C | 5 | PA |
| CAPLYTA | 5 | QL (30 per 30 days); MO |
| *carbamazepine er* | 2 | MO; 90D |
| *carbamazepine oral suspension* | 2 | MO; 90D |
| *carbamazepine oral tablet* | 2 | MO; 90D |
| *carbamazepine oral tablet chewable* | 1 | MO; 100D |
| *carbidopa oral* | 2 | MO; 90D |
| *carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg* | 2 | MO; 90D |
| *carbidopa-levodopa oral tablet 10-100 mg* | 1 | MO; 100D |
| *carbidopa-levodopa oral tablet 25-100 mg, 25-250 mg* | 2 | MO; 90D |
| *carbidopa-levodopa oral tablet dispersible* | 2 | MO; 90D |
| *carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg* | 2 | MO; 90D |
| *carisoprodol oral* | 2 | |

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|---|---|---|
| *chlordiazepoxide hcl* | 2 | QL (120 per 30 days) |
| *chlordiazepoxide-amitriptyline* | 2 | PA; MO; HRM |
| *chlorpromazine hcl oral concentrate* | 4 | MO |
| *chlorpromazine hcl oral tablet* | 2 | MO; 90D |
| *chlorzoxazone oral tablet 500 mg* | 2 | PA; HRM |
| *citalopram hydrobromide oral solution* | 2 | QL (600 per 30 days); MO; 90D |
| *citalopram hydrobromide oral tablet 10 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *citalopram hydrobromide oral tablet 20 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *citalopram hydrobromide oral tablet 40 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *clobazam oral suspension 2.5 mg/ml* | 2 | PA; QL (480 per 30 days); MO |
| *clobazam oral tablet 10 mg* | 2 | PA; QL (120 per 30 days); MO |
| *clobazam oral tablet 20 mg* | 2 | PA; QL (60 per 30 days); MO |
| *clomipramine hcl oral* | 2 | PA; MO; 90D; HRM |
| *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg* | 2 | QL (90 per 30 days) |
| *clonazepam oral tablet dispersible* | 3 | QL (90 per 30 days) |
| *clonidine hcl er oral tablet extended release 12 hour* | 2 | QL (120 per 30 days); MO; 90D |
| *clorazepate dipotassium* | 2 | |
| *clozapine oral tablet 100 mg* | 2 | QL (270 per 30 days) |
| *clozapine oral tablet 200 mg* | 2 | QL (120 per 30 days) |
| *clozapine oral tablet 25 mg* | 2 | QL (1080 per 30 days) |
| *clozapine oral tablet 50 mg* | 2 | QL (540 per 30 days) |
| *clozapine oral tablet dispersible 100 mg* | 2 | QL (270 per 30 days) |
| *clozapine oral tablet dispersible 12.5 mg* | 2 | QL (2160 per 30 days) |
| *clozapine oral tablet dispersible 150 mg* | 2 | QL (180 per 30 days) |
| *clozapine oral tablet dispersible 200 mg* | 4 | QL (120 per 30 days) |
| *clozapine oral tablet dispersible 25 mg* | 2 | QL (1080 per 30 days) |
| COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG | 5 | PA; QL (60 per 30 days); MO |
| COBENFY ORAL CAPSULE 50-20 MG | 5 | PA; QL (60 per 30 days) |
| COBENFY STARTER PACK | 5 | PA |
| *cyclobenzaprine hcl oral tablet 10 mg* | 2 | PA; QL (90 per 30 days); HRM |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *cyclobenzaprine hcl oral tablet 5 mg* | 2 | PA; QL (180 per 30 days); HRM |
| *dalfampridine er* | 3 | PA; QL (60 per 30 days) |
| *desipramine hcl oral tablet 10 mg, 25 mg* | 1 | PA; MO; 100D; HRM |
| *desipramine hcl oral tablet 100 mg, 150 mg, 50 mg, 75 mg* | 2 | PA; MO; 90D; HRM |
| *desvenlafaxine er* | 2 | QL (30 per 30 days); MO; 90D |
| *desvenlafaxine succinate er* | 2 | MO; 90D |
| *dexmethylphenidate hcl* | 2 | QL (60 per 30 days); MO |
| *dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 25 mg, 35 mg* | 1 | QL (30 per 30 days); MO |
| *dexmethylphenidate hcl er oral capsule extended release 24 hour 15 mg, 30 mg, 40 mg, 5 mg* | 2 | QL (30 per 30 days); MO |
| *dexmethylphenidate hcl er oral capsule extended release 24 hour 20 mg* | 1 | QL (60 per 30 days); MO |
| *dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg* | 2 | QL (60 per 30 days); MO |
| *dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg* | 2 | QL (120 per 30 days); MO |
| *dextroamphetamine sulfate oral tablet 10 mg* | 2 | QL (180 per 30 days); MO |
| *dextroamphetamine sulfate oral tablet 5 mg* | 2 | QL (90 per 30 days); MO |
| DIACOMIT ORAL CAPSULE 250 MG | 5 | PA; QL (360 per 30 days) |
| DIACOMIT ORAL CAPSULE 500 MG | 5 | PA; QL (180 per 30 days) |
| DIACOMIT ORAL PACKET 250 MG | 5 | PA; QL (360 per 30 days) |
| DIACOMIT ORAL PACKET 500 MG | 5 | PA; QL (180 per 30 days) |
| DIAZEPAM INTENSOL | 3 | PA; QL (240 per 30 days); HRM |
| *diazepam oral concentrate* | 3 | PA; QL (240 per 30 days); HRM |
| *diazepam oral solution 5 mg/5ml* | 3 | PA; QL (1200 per 30 days); HRM |
| *diazepam oral tablet 10 mg* | 1 | PA; QL (120 per 30 days); HRM |
| *diazepam oral tablet 2 mg* | 1 | PA; QL (600 per 30 days); HRM |
| *diazepam oral tablet 5 mg* | 1 | PA; QL (240 per 30 days); HRM |
| *diazepam rectal* | 4 | |

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|---|---|---|
| *dihydroergotamine mesylate nasal* | 5 | PA; QL (8 per 28 days) |
| DILANTIN ORAL CAPSULE 30 MG | 4 | PA; MO |
| *dimethyl fumarate oral capsule delayed release 120 mg* | 4 | PA; QL (14 per 7 days) |
| *dimethyl fumarate oral capsule delayed release 240 mg* | 4 | PA; QL (60 per 30 days) |
| *dimethyl fumarate starter pack oral capsule delayed release therapy pack* | 4 | PA |
| *disulfiram oral* | 2 | MO; 90D |
| *divalproex sodium er oral tablet extended release 24 hour* | 2 | MO; 90D |
| *divalproex sodium oral capsule delayed release sprinkle* | 2 | MO; 90D |
| *divalproex sodium oral tablet delayed release 125 mg* | 1 | MO; 100D |
| *divalproex sodium oral tablet delayed release 250 mg, 500 mg* | 2 | MO; 90D |
| *donepezil hcl oral tablet 10 mg, 5 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *donepezil hcl oral tablet 23 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *donepezil hcl oral tablet dispersible* | 2 | QL (30 per 30 days); MO; 90D |
| *doxepin hcl oral capsule* | 2 | PA; MO; 90D; HRM |
| *doxepin hcl oral concentrate* | 2 | PA; MO; 90D; HRM |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 60 MG | 3 | QL (60 per 30 days); MO |
| DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 30 MG, 40 MG | 3 | QL (30 per 30 days); MO |
| *duloxetine hcl oral capsule delayed release particles 120 mg, 80 mg, 90 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *duloxetine hcl oral capsule delayed release particles 20 mg* | 2 | QL (180 per 30 days); MO; 90D |
| *duloxetine hcl oral capsule delayed release particles 30 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *duloxetine hcl oral capsule delayed release particles 40 mg* | 2 | QL (90 per 30 days); MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *duloxetine hcl oral capsule delayed release particles 60 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *eletriptan hydrobromide* | 2 | QL (9 per 30 days) |
| EMSAM | 5 | PA; QL (30 per 30 days); MO |
| *entacapone* | 2 | MO; 90D |
| EPIDIOLEX | 5 | PA |
| *ergotamine-caffeine* | 2 | |
| *escitalopram oxalate oral solution 5 mg/5ml* | 2 | QL (600 per 30 days); MO; 90D |
| *escitalopram oxalate oral tablet 10 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *escitalopram oxalate oral tablet 20 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *escitalopram oxalate oral tablet 5 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *eslicarbazepine acetate oral tablet 200 mg, 400 mg* | 4 | QL (30 per 30 days); MO |
| *eslicarbazepine acetate oral tablet 600 mg, 800 mg* | 4 | QL (60 per 30 days); MO |
| *estazolam* | 2 | QL (30 per 30 days) |
| *eszopiclone* | 2 | QL (30 per 30 days) |
| *ethosuximide oral* | 2 | MO; 90D |
| EXXUA | 5 | PA; QL (30 per 30 days); MO |
| EXXUA TITRATION PACK | 5 | PA; MO |
| FANAPT ORAL TABLET 1 MG | 5 | PA; QL (720 per 30 days); MO |
| FANAPT ORAL TABLET 10 MG, 12 MG | 5 | PA; QL (60 per 30 days); MO |
| FANAPT ORAL TABLET 2 MG | 5 | PA; QL (360 per 30 days); MO |
| FANAPT ORAL TABLET 4 MG | 5 | PA; QL (180 per 30 days); MO |
| FANAPT ORAL TABLET 6 MG | 5 | PA; QL (120 per 30 days); MO |
| FANAPT ORAL TABLET 8 MG | 5 | PA; QL (90 per 30 days); MO |
| FANAPT TITRATION PACK A | 4 | PA |
| FANAPT TITRATION PACK B ORAL TABLET | 4 | PA |
| FANAPT TITRATION PACK C ORAL TABLET | 4 | PA |
| *felbamate oral suspension* | 4 | MO |
| *felbamate oral tablet* | 2 | MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| FETZIMA | 3 | PA; QL (30 per 30 days); MO |
| FETZIMA TITRATION | 3 | PA |
| *fingolimod hcl* | 4 | PA; QL (30 per 30 days) |
| FINTEPLA | 5 | PA |
| *fluoxetine hcl oral capsule 10 mg* | 1 | MO; 100D |
| *fluoxetine hcl oral capsule 20 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *fluoxetine hcl oral capsule 40 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *fluoxetine hcl oral capsule delayed release* | 2 | QL (4 per 28 days); MO; 90D |
| *fluoxetine hcl oral solution* | 2 | QL (600 per 30 days); MO; 90D |
| *fluoxetine hcl oral tablet 10 mg* | 2 | MO; 90D |
| *fluoxetine hcl oral tablet 20 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *fluoxetine hcl oral tablet 60 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *fluphenazine decanoate injection* | 2 | |
| *fluphenazine hcl injection* | 2 | |
| *fluphenazine hcl oral concentrate* | 2 | MO; 90D |
| *fluphenazine hcl oral elixir* | 2 | MO; 90D |
| *fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg* | 1 | MO; 100D |
| *fluphenazine hcl oral tablet 5 mg* | 2 | MO; 90D |
| *flurazepam hcl oral capsule 30 mg* | 2 | QL (30 per 30 days) |
| *fluvoxamine maleate oral tablet 100 mg* | 1 | QL (90 per 30 days); MO; 100D |
| *fluvoxamine maleate oral tablet 25 mg, 50 mg* | 1 | MO; 100D |
| *gabapentin (once-daily) oral tablet 300 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *gabapentin (once-daily) oral tablet 450 mg, 750 mg, 900 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *gabapentin (once-daily) oral tablet 600 mg* | 2 | QL (90 per 30 days); MO; 90D |
| *gabapentin oral capsule 100 mg* | 1 | QL (180 per 30 days); MO; 100D |
| *gabapentin oral capsule 300 mg* | 2 | QL (270 per 30 days); MO; 90D |
| *gabapentin oral capsule 400 mg* | 2 | QL (180 per 30 days); MO; 90D |
| *gabapentin oral solution* | 2 | QL (2160 per 30 days); MO; 90D |
| *gabapentin oral tablet 600 mg* | 2 | QL (180 per 30 days); MO; 90D |
| *gabapentin oral tablet 800 mg* | 2 | QL (120 per 30 days); MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *galantamine hydrobromide er* | 2 | QL (30 per 30 days); MO; 90D |
| *galantamine hydrobromide oral solution* | 2 | QL (200 per 30 days); MO; 90D |
| *galantamine hydrobromide oral tablet* | 2 | QL (60 per 30 days); MO; 90D |
| *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml* | 5 | PA; QL (30 per 30 days) |
| *glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml* | 5 | PA; QL (12 per 28 days) |
| GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML | 4 | PA; QL (30 per 30 days) |
| GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML | 5 | PA; QL (12 per 28 days) |
| GOCOVRI | 5 | |
| *guanfacine hcl er* | 2 | QL (30 per 30 days); MO; 90D |
| *haloperidol decanoate intramuscular* | 2 | |
| *haloperidol lactate injection* | 2 | |
| *haloperidol lactate oral* | 2 | MO; 90D |
| *haloperidol oral tablet 0.5 mg, 1 mg, 2 mg, 5 mg* | 1 | MO; 100D |
| *haloperidol oral tablet 10 mg, 20 mg* | 2 | MO; 90D |
| *imipramine hcl oral tablet 10 mg* | 1 | PA; MO; 100D; HRM |
| *imipramine hcl oral tablet 25 mg, 50 mg* | 2 | PA; MO; 90D; HRM |
| *imipramine pamoate* | 2 | PA; MO; 90D; HRM |
| INGREZZA ORAL CAPSULE 40 MG | 5 | PA; QL (60 per 30 days) |
| INGREZZA ORAL CAPSULE 60 MG, 80 MG | 5 | PA; QL (30 per 30 days) |
| INGREZZA ORAL CAPSULE SPRINKLE 40 MG | 5 | PA; QL (60 per 30 days) |
| INGREZZA ORAL CAPSULE SPRINKLE 60 MG, 80 MG | 5 | PA; QL (30 per 30 days) |
| INGREZZA ORAL CAPSULE THERAPY PACK | 5 | PA; QL (56 per 365 days) |
| INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML | 5 | QL (3.5 per 180 days) |
| INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML | 5 | QL (5 per 180 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML | 5 | QL (0.75 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML | 5 | QL (1 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML | 5 | QL (1.5 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML | 4 | QL (0.25 per 28 days) |
| INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML | 5 | QL (0.5 per 28 days) |
| INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML | 5 | QL (0.88 per 84 days) |
| INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML | 5 | QL (1.32 per 84 days) |
| INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML | 5 | QL (1.75 per 84 days) |
| INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML | 5 | QL (2.63 per 84 days) |
| KESIMPTA | 5 | PA; QL (1.2 per 28 days) |
| KLOXXADO | 4 | |
| *lacosamide oral solution* | 2 | QL (1200 per 30 days); MO |
| *lacosamide oral tablet* | 2 | QL (60 per 30 days); MO |
| LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG | 4 | PA |
| LAMICTAL XR ORAL KIT 50 & 100 & 200 MG | 5 | PA |
| *lamotrigine oral tablet* | 1 | MO; 100D |
| *lamotrigine oral tablet chewable 25 mg* | 1 | MO; 100D |
| *lamotrigine oral tablet chewable 5 mg* | 2 | MO; 90D |
| *lamotrigine oral tablet dispersible* | 2 | MO; 90D |
| *lamotrigine starter kit-blue* | 2 | |
| *lamotrigine starter kit-green* | 5 | |
| *lamotrigine starter kit-orange* | 2 | |
| *levetiracetam er oral tablet extended release 24 hour 500 mg* | 2 | QL (180 per 30 days); MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *levetiracetam er oral tablet extended release 24 hour 750 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *levetiracetam oral solution* | 2 | MO; 90D |
| *levetiracetam oral tablet* | 1 | MO; 100D |
| *levetiracetam oral tablet disintegrating soluble 250 mg* | 4 | PA; QL (360 per 30 days); MO |
| *levetiracetam oral tablet disintegrating soluble 500 mg* | 4 | PA; QL (180 per 30 days); MO |
| *lithium* | 3 | MO |
| *lithium carbonate er* | 1 | MO; 100D |
| *lithium carbonate oral* | 1 | MO; 100D |
| LORAZEPAM INTENSOL | 3 | QL (150 per 30 days) |
| *lorazepam oral concentrate 1 mg/0.5ml* | 2 | QL (150 per 30 days) |
| *lorazepam oral concentrate 2 mg/ml* | 3 | QL (150 per 30 days) |
| *lorazepam oral tablet 0.5 mg* | 1 | QL (120 per 30 days) |
| *lorazepam oral tablet 1 mg* | 1 | QL (90 per 30 days) |
| *lorazepam oral tablet 2 mg* | 1 | QL (150 per 30 days) |
| *loxapine succinate oral capsule 10 mg, 25 mg, 5 mg* | 2 | MO; 90D |
| *loxapine succinate oral capsule 50 mg* | 1 | MO; 100D |
| *lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg* | 4 | QL (30 per 30 days); MO |
| *lurasidone hcl oral tablet 80 mg* | 4 | QL (60 per 30 days); MO |
| LYBALVI | 5 | QL (30 per 30 days); MO |
| MARPLAN | 4 | MO |
| *memantine hcl er* | 2 | PA; QL (30 per 30 days); MO; 90D |
| *memantine hcl oral tablet 10 mg* | 2 | PA; QL (60 per 30 days); MO; 90D |
| *memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg* | 2 | PA; QL (60 per 30 days) |
| *memantine hcl oral tablet 5 mg* | 2 | PA; QL (90 per 30 days); MO; 90D |
| *meprobamate* | 2 | PA; HRM |
| *methocarbamol oral tablet 500 mg, 750 mg* | 2 | |
| *methsuximide* | 2 | MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 40 mg, 50 mg, 60 mg* | 2 | PA; QL (30 per 30 days); MO |
| *methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg* | 2 | PA; QL (30 per 30 days); MO |
| *methylphenidate hcl er (osm) oral tablet extended release 36 mg* | 2 | PA; QL (60 per 30 days); MO |
| *methylphenidate hcl er oral tablet extended release 20 mg* | 2 | PA; QL (90 per 30 days); MO |
| *methylphenidate hcl oral solution 10 mg/5ml* | 2 | PA; QL (900 per 30 days); MO |
| *methylphenidate hcl oral solution 5 mg/5ml* | 2 | PA; QL (1800 per 30 days); MO |
| *methylphenidate hcl oral tablet 10 mg, 20 mg* | 2 | PA; QL (90 per 30 days); MO |
| *methylphenidate hcl oral tablet 5 mg* | 1 | PA; QL (90 per 30 days); MO |
| *methylphenidate hcl oral tablet chewable 10 mg* | 1 | PA; QL (180 per 30 days); MO |
| *methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg* | 1 | PA; QL (90 per 30 days); MO |
| MIGERGOT | 5 | |
| *mirtazapine oral tablet 15 mg, 30 mg, 7.5 mg* | 1 | MO; 100D |
| *mirtazapine oral tablet 45 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *mirtazapine oral tablet dispersible* | 2 | QL (30 per 30 days); MO; 90D |
| *modafinil oral tablet 100 mg* | 2 | PA; QL (30 per 30 days); MO |
| *modafinil oral tablet 200 mg* | 2 | PA; QL (60 per 30 days); MO |
| *molindone hcl* | 2 | MO; 90D |
| *naloxone hcl injection solution 0.4 mg/ml* | 1 | |
| *naloxone hcl injection solution cartridge* | 2 | |
| *naloxone hcl injection solution prefilled syringe* | 2 | |
| *naltrexone hcl oral* | 2 | |
| NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR | 3 | MO |
| NAYZILAM | 4 | PA |
| *nefazodone hcl* | 2 | MO; 90D |
| NEUPRO | 4 | QL (30 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| NICOTROL NS | 4 | QL (120 per 30 days) |
| *nortriptyline hcl oral capsule* | 1 | MO; 100D |
| *nortriptyline hcl oral solution* | 2 | MO; 90D |
| NUEDEXTA | 5 | PA; QL (60 per 30 days); MO |
| NUPLAZID ORAL CAPSULE | 5 | PA; QL (30 per 30 days) |
| NUPLAZID ORAL TABLET 10 MG | 5 | PA; QL (30 per 30 days) |
| NURTEC | 3 | PA; QL (16 per 30 days) |
| *olanzapine intramuscular* | 2 | QL (90 per 30 days) |
| *olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 5 mg, 7.5 mg* | 2 | MO; 90D |
| *olanzapine oral tablet 20 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *olanzapine oral tablet dispersible* | 2 | QL (30 per 30 days); MO; 90D |
| *olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg* | 4 | QL (30 per 30 days); MO |
| *olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg* | 4 | QL (90 per 30 days); MO |
| OPIPZA ORAL FILM 10 MG, 5 MG | 5 | PA; QL (90 per 30 days); MO |
| OPIPZA ORAL FILM 2 MG | 5 | PA; QL (30 per 30 days); MO |
| *orphenadrine citrate er* | 2 | |
| *oxazepam* | 2 | QL (120 per 30 days) |
| *oxcarbazepine oral suspension* | 2 | MO; 90D |
| *oxcarbazepine oral tablet 150 mg, 600 mg* | 2 | MO; 90D |
| *oxcarbazepine oral tablet 300 mg* | 1 | MO; 100D |
| *paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *paliperidone er oral tablet extended release 24 hour 6 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *paliperidone er oral tablet extended release 24 hour 9 mg* | 4 | QL (30 per 30 days); MO |
| *paroxetine hcl er oral tablet extended release 24 hour 12.5 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *paroxetine hcl er oral tablet extended release 24 hour 25 mg, 37.5 mg* | 2 | QL (60 per 30 days); MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *paroxetine hcl oral suspension* | 2 | QL (900 per 30 days); MO; 90D |
| *paroxetine hcl oral tablet 10 mg, 40 mg* | 1 | QL (45 per 30 days); MO; 100D |
| *paroxetine hcl oral tablet 20 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *paroxetine hcl oral tablet 30 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *paroxetine mesylate* | 2 | MO; 90D |
| *perampanel oral suspension* | 5 | PA; QL (720 per 30 days); MO |
| *perampanel oral tablet* | 4 | PA; QL (30 per 30 days); MO |
| *perphenazine oral* | 2 | MO; 90D |
| *perphenazine-amitriptyline* | 2 | PA; MO; 90D; HRM |
| *phenelzine sulfate oral* | 2 | MO; 90D |
| *phenobarbital oral elixir* | 3 | PA; QL (3000 per 30 days); MO; HRM |
| *phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg, 64.8 mg, 97.2 mg* | 3 | PA; QL (120 per 30 days); MO; HRM |
| *phenobarbital oral tablet 16.2 mg, 32.4 mg* | 3 | PA; QL (210 per 30 days); MO; HRM |
| PHENYTEK | 4 | MO |
| PHENYTOIN INFATABS | 1 | MO; 100D |
| *phenytoin oral* | 1 | MO; 100D |
| *phenytoin sodium extended* | 1 | MO; 100D |
| *pimozide* | 2 | MO; 90D |
| *pramipexole dihydrochloride* | 2 | MO; 90D |
| *pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 2.25 mg, 3 mg, 4.5 mg* | 2 | MO; 90D |
| *pramipexole dihydrochloride er oral tablet extended release 24 hour 3.75 mg* | 1 | MO; 100D |
| *pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg, 75 mg* | 1 | MO |
| *pregabalin oral capsule 200 mg* | 1 | QL (90 per 30 days); MO |
| *pregabalin oral capsule 225 mg, 300 mg* | 1 | QL (60 per 30 days); MO |
| *pregabalin oral solution* | 1 | QL (900 per 30 days); MO |

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|---|---|---|
| *primidone oral* | 1 | MO; 100D |
| *protriptyline hcl* | 2 | PA; MO; 90D; HRM |
| *pyridostigmine bromide er oral tablet extended release* | 2 | |
| *pyridostigmine bromide oral tablet 60 mg* | 1 | |
| *quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *quetiapine fumarate oral tablet 100 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *quetiapine fumarate oral tablet 150 mg* | 1 | QL (150 per 30 days); MO; 100D |
| *quetiapine fumarate oral tablet 200 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *quetiapine fumarate oral tablet 25 mg* | 1 | QL (960 per 30 days); MO; 100D |
| *quetiapine fumarate oral tablet 300 mg* | 1 | QL (80 per 30 days); MO; 100D |
| *quetiapine fumarate oral tablet 400 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *quetiapine fumarate oral tablet 50 mg* | 1 | QL (480 per 30 days); MO; 100D |
| RALDESY | 4 | QL (1800 per 30 days); MO |
| *ramelteon* | 2 | QL (30 per 30 days) |
| *rasagiline mesylate oral* | 2 | MO; 90D |
| REXULTI | 5 | QL (30 per 30 days); MO |
| *riluzole* | 2 | 90D |
| *risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg* | 2 | QL (2 per 28 days) |
| *risperidone microspheres er intramuscular suspension reconstituted er 50 mg* | 4 | QL (2 per 28 days) |
| *risperidone oral solution* | 2 | QL (480 per 30 days); MO; 90D |
| *risperidone oral tablet 0.25 mg* | 2 | QL (1920 per 30 days); MO; 90D |
| *risperidone oral tablet 0.5 mg* | 2 | QL (960 per 30 days); MO; 90D |
| *risperidone oral tablet 1 mg* | 2 | QL (480 per 30 days); MO; 90D |
| *risperidone oral tablet 2 mg* | 2 | QL (240 per 30 days); MO; 90D |
| *risperidone oral tablet 3 mg, 4 mg* | 2 | QL (120 per 30 days); MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *risperidone oral tablet dispersible 0.25 mg* | 2 | QL (1920 per 30 days); MO; 90D |
| *risperidone oral tablet dispersible 0.5 mg* | 2 | QL (960 per 30 days); MO; 90D |
| *risperidone oral tablet dispersible 1 mg* | 2 | QL (480 per 30 days); MO; 90D |
| *risperidone oral tablet dispersible 2 mg* | 2 | QL (240 per 30 days); MO; 90D |
| *risperidone oral tablet dispersible 3 mg* | 2 | QL (150 per 30 days); MO; 90D |
| *risperidone oral tablet dispersible 4 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *rivastigmine* | 2 | QL (30 per 30 days); MO; 90D |
| *rivastigmine tartrate* | 2 | QL (60 per 30 days); MO; 90D |
| *ropinirole hcl* | 2 | MO; 90D |
| *ropinirole hcl er* | 2 | MO; 90D |
| ROWEEPRA ORAL TABLET 500 MG | 1 | MO; 100D |
| *rufinamide oral suspension* | 5 | PA; QL (2400 per 30 days); MO |
| *rufinamide oral tablet 200 mg* | 4 | PA; QL (480 per 30 days); MO |
| *rufinamide oral tablet 400 mg* | 5 | PA; QL (240 per 30 days); MO |
| RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG | 5 | QL (2 per 28 days) |
| SECUADO | 5 | QL (30 per 30 days); MO |
| *selegiline hcl oral* | 2 | MO; 90D |
| *sertraline hcl oral concentrate* | 2 | QL (300 per 30 days); MO; 90D |
| *sertraline hcl oral tablet 100 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *sertraline hcl oral tablet 25 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *sertraline hcl oral tablet 50 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *sodium oxybate* | 5 | PA; QL (540 per 30 days) |
| SPRAVATO (56 MG DOSE) | 4 | PA; QL (16 per 28 days) |
| SPRAVATO (84 MG DOSE) | 5 | PA; QL (24 per 28 days) |
| SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG | 4 | PA; QL (60 per 30 days); MO |
| SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG | 5 | PA; QL (120 per 30 days); MO |
| SUBVENITE ORAL SUSPENSION | 5 | MO |
| SUBVENITE ORAL TABLET | 4 | MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *sumatriptan succinate oral* | 2 | QL (9 per 30 days) |
| *sumatriptan succinate subcutaneous solution 6 mg/0.5ml* | 4 | QL (6 per 30 days) |
| SYMPAZAN ORAL FILM 10 MG | 4 | PA; QL (60 per 30 days); MO |
| SYMPAZAN ORAL FILM 20 MG | 5 | PA; QL (60 per 30 days); MO |
| SYMPAZAN ORAL FILM 5 MG | 4 | PA; QL (30 per 30 days); MO |
| TEGLUTIK | 5 | |
| *temazepam oral capsule 15 mg, 30 mg* | 1 | QL (30 per 30 days) |
| *temazepam oral capsule 22.5 mg, 7.5 mg* | 2 | QL (30 per 30 days) |
| *teriflunomide* | 4 | PA; QL (30 per 30 days) |
| *tetrabenazine oral tablet 12.5 mg* | 4 | PA; QL (240 per 30 days) |
| *tetrabenazine oral tablet 25 mg* | 4 | PA; QL (120 per 30 days) |
| *thioridazine hcl oral tablet 10 mg* | 2 | MO; 90D |
| *thioridazine hcl oral tablet 100 mg, 25 mg, 50 mg* | 1 | MO; 100D |
| *thiothixene oral capsule 1 mg, 10 mg* | 2 | MO; 90D |
| *thiothixene oral capsule 2 mg, 5 mg* | 1 | MO; 100D |
| *tiagabine hcl* | 2 | MO; 90D |
| TIGLUTIK | 5 | |
| *tizanidine hcl oral capsule 2 mg, 4 mg, 6 mg* | 2 | |
| *tizanidine hcl oral tablet* | 2 | |
| *tolcapone* | 4 | PA; QL (180 per 30 days); MO |
| *topiramate oral capsule sprinkle* | 2 | MO; 90D |
| *topiramate oral solution* | 4 | MO |
| *topiramate oral tablet* | 1 | MO; 100D |
| *tranylcypromine sulfate* | 2 | MO; 90D |
| *trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg* | 1 | MO; 100D |
| *triazolam* | 2 | QL (30 per 30 days) |
| *trifluoperazine hcl oral tablet 1 mg, 2 mg, 5 mg* | 1 | MO; 100D |
| *trifluoperazine hcl oral tablet 10 mg* | 2 | MO; 90D |
| *trihexyphenidyl hcl oral solution* | 2 | PA; MO; 90D; HRM |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *trihexyphenidyl hcl oral tablet* | 1 | MO; 100D |
| *trimipramine maleate oral* | 2 | MO; 90D |
| TRINTELLIX | 4 | QL (30 per 30 days); MO |
| UBRELVY ORAL TABLET 100 MG | 3 | PA; QL (16 per 30 days) |
| UBRELVY ORAL TABLET 50 MG | 3 | PA; QL (20 per 30 days) |
| *valproic acid oral capsule* | 2 | MO; 90D |
| *valproic acid oral solution* | 2 | MO; 90D |
| VALTOCO 10 MG DOSE | 5 | QL (10 per 30 days) |
| VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML | 5 | QL (10 per 30 days) |
| VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML | 5 | QL (10 per 30 days) |
| VALTOCO 5 MG DOSE | 5 | QL (10 per 30 days) |
| *varenicline tartrate (starter)* | 3 | |
| *varenicline tartrate oral tablet 0.5 mg* | 3 | QL (60 per 30 days) |
| *varenicline tartrate oral tablet 1 mg* | 3 | QL (56 per 28 days) |
| *varenicline tartrate(continue)* | 3 | QL (56 per 28 days) |
| *venlafaxine besylate er* | 4 | QL (60 per 30 days); MO |
| *venlafaxine hcl* | 1 | QL (90 per 30 days); MO; 100D |
| *venlafaxine hcl er oral capsule extended release 24 hour 150 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg* | 1 | QL (180 per 30 days); MO; 100D |
| *venlafaxine hcl er oral capsule extended release 24 hour 75 mg* | 1 | QL (90 per 30 days); MO; 100D |
| *venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 225 mg, 37.5 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *venlafaxine hcl er oral tablet extended release 24 hour 75 mg* | 2 | QL (90 per 30 days); MO; 90D |
| VERSACLOZ | 4 | QL (600 per 30 days) |
| *vigabatrin oral packet* | 5 | PA; QL (150 per 25 days) |
| *vigabatrin oral tablet* | 5 | PA; QL (180 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| VIGADRONE ORAL PACKET | 5 | PA; QL (150 per 25 days) |
| VIGADRONE ORAL TABLET | 5 | PA; QL (180 per 30 days) |
| *vilazodone hcl* | 2 | QL (30 per 30 days); MO; 90D |
| VRAYLAR ORAL CAPSULE | 3 | QL (30 per 30 days); MO |
| XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG | 5 | PA; QL (56 per 28 days); MO |
| XCOPRI (350 MG DAILY DOSE) | 5 | PA; QL (56 per 28 days); MO |
| XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG | 5 | PA; QL (30 per 30 days); MO |
| XCOPRI ORAL TABLET 150 MG, 200 MG | 5 | PA; QL (60 per 30 days); MO |
| XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG | 4 | PA; QL (56 per 365 days) |
| XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG | 5 | PA; QL (56 per 365 days) |
| *zaleplon oral capsule 10 mg* | 2 | QL (60 per 30 days) |
| *zaleplon oral capsule 5 mg* | 2 | QL (30 per 30 days) |
| ZENZEDI ORAL TABLET 10 MG | 2 | QL (180 per 30 days); MO |
| ZENZEDI ORAL TABLET 5 MG | 2 | QL (90 per 30 days); MO |
| *ziprasidone hcl oral capsule 20 mg* | 2 | QL (240 per 30 days); MO; 90D |
| *ziprasidone hcl oral capsule 40 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *ziprasidone hcl oral capsule 60 mg, 80 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *ziprasidone mesylate* | 4 | QL (6 per 3 days) |
| *zolpidem tartrate er* | 2 | QL (30 per 30 days) |
| *zolpidem tartrate oral tablet* | 2 | QL (30 per 30 days) |
| ZONISADE | 5 | PA; MO |
| *zonisamide oral* | 2 | MO; 90D |
| ZTALMY | 5 | PA; QL (1100 per 30 days) |
| ZURZUVAE | 5 | PA |
| ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG | 4 | QL (2 per 28 days) |
| ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 405 MG | 5 | QL (2 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| **DERMATOLOGICAL AGENTS / AGENTES DERMATOLÓGICOS** | | |
| ACCUTANE | 2 | |
| *acitretin oral capsule 10 mg, 25 mg* | 2 | PA |
| *acitretin oral capsule 17.5 mg* | 4 | PA |
| *acyclovir external ointment* | 2 | PA; QL (30 per 30 days) |
| *ala-cort external cream 1 % (rx)* | 1 | |
| *alclometasone dipropionate* | 2 | |
| *ammonium lactate external (rx)* | 1 | |
| AMNESTEEM | 2 | |
| *azelaic acid external* | 2 | |
| *benzoyl peroxide-erythromycin* | 2 | |
| *betamethasone dipropionate aug external cream* | 2 | |
| *betamethasone dipropionate aug external lotion* | 2 | |
| *betamethasone dipropionate external cream* | 2 | |
| *betamethasone dipropionate external ointment* | 2 | QL (45 per 30 days) |
| *betamethasone valerate external cream* | 1 | |
| *betamethasone valerate external lotion* | 1 | |
| *betamethasone valerate external ointment* | 1 | |
| *bexarotene external* | 5 | PA; QL (60 per 30 days) |
| *calcipotriene external cream* | 2 | QL (120 per 30 days) |
| *calcipotriene external ointment* | 2 | QL (120 per 30 days) |
| *calcipotriene external solution* | 2 | QL (60 per 30 days) |
| CALCITRENE | 2 | QL (120 per 30 days) |
| *cevimeline hcl* | 2 | MO; 90D |
| *chlorhexidine gluconate mouth/throat* | 1 | |
| CICLODAN EXTERNAL SOLUTION | 2 | |
| *ciclopirox external* | 2 | |
| *ciclopirox olamine external cream* | 1 | QL (90 per 30 days) |
| *ciclopirox olamine external suspension* | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| CLARAVIS | 2 | |
| CLINDACIN ETZ EXTERNAL SWAB | 2 | |
| CLINDACIN-P | 2 | |
| *clindamycin phos (once-daily)* | 2 | |
| *clindamycin phos (twice-daily)* | 2 | |
| *clindamycin phosphate external lotion* | 2 | QL (120 per 30 days) |
| *clindamycin phosphate external solution* | 2 | QL (120 per 30 days) |
| *clindamycin phosphate external swab* | 2 | |
| *clobetasol prop emollient base* | 2 | QL (120 per 30 days) |
| *clobetasol propionate e* | 2 | QL (120 per 30 days) |
| *clobetasol propionate external cream 0.05 %* | 2 | QL (120 per 30 days) |
| *clobetasol propionate external gel* | 2 | QL (60 per 30 days) |
| *clobetasol propionate external lotion* | 4 | |
| *clobetasol propionate external ointment* | 2 | QL (120 per 30 days) |
| *clobetasol propionate external shampoo* | 2 | |
| *clobetasol propionate external solution* | 2 | QL (50 per 30 days) |
| CLODAN EXTERNAL SHAMPOO | 2 | |
| *clotrimazole external cream (rx)* | 1 | |
| *clotrimazole external solution (rx)* | 1 | QL (60 per 30 days) |
| *clotrimazole mouth/throat troche* | 1 | QL (150 per 30 days) |
| *clotrimazole-betamethasone* | 2 | QL (120 per 30 days) |
| *desonide external cream* | 2 | |
| *desonide external lotion* | 2 | |
| *desonide external ointment* | 2 | |
| *desoximetasone external cream* | 2 | QL (100 per 30 days) |
| *desoximetasone external liquid* | 2 | |
| *desoximetasone external ointment 0.25 %* | 2 | |
| *diclofenac sodium external gel 3 %* | 2 | PA; QL (100 per 30 days) |
| DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML | 5 | PA; QL (4.56 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML | 5 | PA; QL (8 per 28 days) |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML | 5 | PA; QL (4.56 per 28 days) |
| DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML | 5 | PA; QL (8 per 28 days) |
| *econazole nitrate external cream* | 2 | QL (90 per 30 days) |
| *erythromycin external gel* | 2 | |
| *erythromycin external solution* | 1 | |
| EUCRISA | 4 | |
| *fluocinolone acetonide body* | 2 | QL (120 per 30 days) |
| *fluocinolone acetonide external* | 2 | QL (120 per 30 days) |
| *fluocinolone acetonide scalp* | 2 | QL (120 per 30 days) |
| *fluocinonide emulsified base* | 2 | QL (240 per 30 days) |
| *fluocinonide external gel* | 2 | QL (240 per 30 days) |
| *fluocinonide external ointment* | 2 | QL (240 per 30 days) |
| *fluocinonide external solution* | 2 | QL (240 per 30 days) |
| *fluorouracil external cream 5 %* | 2 | QL (40 per 28 days) |
| *fluorouracil external solution 2 %* | 3 | QL (10 per 28 days) |
| *fluorouracil external solution 5 %* | 2 | QL (10 per 28 days) |
| *fluticasone propionate external cream* | 2 | |
| *fluticasone propionate external ointment* | 2 | |
| *gentamicin sulfate external* | 2 | QL (30 per 30 days) |
| *halobetasol propionate external cream* | 2 | |
| *halobetasol propionate external ointment* | 2 | |
| *hydrocortisone (perianal) external cream 1 %* | 2 | |
| *hydrocortisone (perianal) external cream 2.5 %* | 1 | |
| *hydrocortisone butyrate external lotion* | 2 | |
| *hydrocortisone butyrate external ointment* | 2 | |
| *hydrocortisone butyrate external solution* | 2 | |
| *hydrocortisone external cream 1 %, 2.5 % (rx)* | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *hydrocortisone external lotion 2.5 %* | 1 | |
| *hydrocortisone external ointment 1 %, 2.5 % (rx)* | 1 | |
| *hydrocortisone valerate* | 2 | |
| *imiquimod external cream 5 %* | 2 | QL (24 per 28 days) |
| *isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 35 mg, 40 mg* | 2 | |
| *isotretinoin oral capsule 25 mg* | 4 | |
| *ivermectin external cream* | 2 | |
| *ketoconazole external cream* | 2 | QL (120 per 30 days) |
| *ketoconazole external shampoo 2 %* | 1 | QL (120 per 30 days) |
| KLAYESTA | 2 | |
| KOURZEQ | 2 | |
| *malathion external* | 4 | |
| *methoxsalen rapid* | 4 | |
| *metronidazole external* | 2 | |
| *mometasone furoate external cream* | 1 | |
| *mometasone furoate external ointment* | 1 | |
| *mupirocin calcium* | 2 | QL (30 per 30 days) |
| *mupirocin external* | 2 | QL (120 per 30 days) |
| *naftifine hcl external cream* | 2 | |
| *nitroglycerin rectal* | 2 | QL (30 per 30 days) |
| NYAMYC | 2 | |
| *nystatin external cream* | 1 | |
| *nystatin external ointment* | 1 | |
| *nystatin external powder* | 2 | |
| *nystatin mouth/throat suspension 100000 unit/ml* | 2 | |
| *nystatin-triamcinolone* | 2 | QL (120 per 30 days) |
| NYSTOP | 2 | |
| ORALONE | 2 | |
| PANRETIN | 5 | |
| PERIOGARD | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *permethrin external cream* | 2 | |
| *pilocarpine hcl oral* | 2 | MO; 90D |
| *pimecrolimus* | 4 | PA; QL (100 per 30 days) |
| *podofilox external* | 2 | |
| PROCTO-MED HC EXTERNAL | 2 | |
| PROCTOSOL HC EXTERNAL | 2 | |
| PROCTOZONE-HC EXTERNAL | 2 | |
| SANTYL | 4 | QL (30 per 30 days) |
| *selenium sulfide external lotion* | 2 | |
| *silver sulfadiazine external* | 2 | |
| SSD (SILVER SULFADIAZINE) | 2 | |
| *sulfacetamide sodium (acne)* | 2 | |
| *tacrolimus external ointment* | 2 | PA; QL (100 per 30 days) |
| *tazarotene external cream 0.05 %* | 4 | PA |
| *tazarotene external cream 0.1 %* | 2 | PA |
| *tazarotene external gel* | 2 | PA |
| *tretinoin external* | 2 | PA; QL (45 per 30 days) |
| *triamcinolone acetonide external aerosol solution* | 4 | |
| *triamcinolone acetonide external cream* | 1 | QL (454 per 30 days) |
| *triamcinolone acetonide external lotion 0.025 %* | 1 | |
| *triamcinolone acetonide external lotion 0.1 %* | 2 | |
| *triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %* | 1 | |
| *triamcinolone acetonide mouth/throat* | 2 | |
| TRIDERM EXTERNAL CREAM 0.5 % | 1 | QL (454 per 30 days) |
| VALCHLOR | 5 | PA |
| ZENATANE | 2 | |
| **ELECTROLYTES / MINERALS / METALS / VITAMINS / ELECTROLITOS / MINERALES / METALES / VITAMINAS** | | |
| AMINOSYN II INTRAVENOUS SOLUTION 15 % | 2 | B/D PA |
| *carglumic acid oral tablet soluble* | 5 | PA |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| CLINIMIX E/DEXTROSE (2.75/5) | 4 | B/D PA |
| CLINIMIX E/DEXTROSE (4.25/10) | 4 | B/D PA |
| CLINIMIX E/DEXTROSE (4.25/5) | 4 | B/D PA |
| CLINIMIX E/DEXTROSE (5/15) | 4 | B/D PA |
| CLINIMIX E/DEXTROSE (5/20) | 4 | B/D PA |
| *clinimix e/dextrose (8/10)* | 4 | B/D PA |
| *clinimix e/dextrose (8/14)* | 4 | B/D PA |
| CLINIMIX/DEXTROSE (4.25/10) | 4 | B/D PA |
| CLINIMIX/DEXTROSE (4.25/5) | 4 | B/D PA |
| CLINIMIX/DEXTROSE (5/15) | 4 | B/D PA |
| CLINIMIX/DEXTROSE (5/20) | 4 | B/D PA |
| *clinimix/dextrose (6/5)* | 4 | B/D PA |
| *clinimix/dextrose (8/10)* | 4 | B/D PA |
| *clinimix/dextrose (8/14)* | 4 | B/D PA |
| CLINISOL SF | 2 | B/D PA |
| CLINOLIPID | 2 | B/D PA |
| *dextrose intravenous solution 10 %, 5 %* | 2 | |
| *dextrose-nacl intravenous solution 5-0.9 %* | 2 | |
| *dextrose-sodium chloride intravenous solution 10-0.2 %* | 3 | |
| *dextrose-sodium chloride intravenous solution 10-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.3 %, 5-0.33 %, 5-0.45 %, 5-0.9 %* | 2 | |
| *folic acid oral tablet 1 mg* | 6 | ED |
| INTRALIPID INTRAVENOUS EMULSION 20 % | 2 | B/D PA |
| ISOLYTE-P IN D5W | 4 | |
| ISOLYTE-S | 4 | |
| *kcl (0.149%) in nacl* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.225 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%* | 2 | |
| *kcl-lactated ringers-d5w* | 3 | |
| KLOR-CON 10 | 1 | MO; 100D |
| KLOR-CON M10 | 1 | MO; 100D |
| KLOR-CON M15 | 1 | MO; 100D |
| KLOR-CON M20 | 1 | MO; 100D |
| KLOR-CON ORAL PACKET 20 MEQ | 2 | MO; 90D |
| *levocarnitine oral solution* | 2 | B/D PA; MO; 90D |
| *levocarnitine oral tablet* | 3 | B/D PA; MO |
| *levocarnitine sf* | 2 | B/D PA; MO; 90D |
| *magnesium sulfate injection solution 50 %, 50 % (10ml syringe)* | 2 | |
| *multiple electro type 1 ph 5.5* | 2 | |
| *multiple electro type 1 ph 7.4* | 2 | |
| NUTRILIPID | 2 | B/D PA |
| PLENAMINE | 2 | B/D PA |
| *potassium chloride crys er* | 1 | MO; 100D |
| *potassium chloride er* | 1 | MO; 100D |
| *potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%* | 2 | |
| *potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml* | 2 | |
| *potassium chloride oral packet 20 meq* | 2 | MO; 90D |
| *potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)* | 2 | MO; 90D |
| *potassium cl in dextrose 5% intravenous solution 10 meq/l, 20 meq/l* | 2 | |
| PREMASOL INTRAVENOUS SOLUTION 10 % | 4 | B/D PA |
| PROSOL | 4 | B/D PA |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %* | 2 | |
| *sodium fluoride oral tablet 2.2 (1 f) mg* | 2 | MO; 90D |
| TPN ELECTROLYTES INTRAVENOUS CONCENTRATE | 3 | |
| TRAVASOL | 4 | B/D PA |
| TROPHAMINE INTRAVENOUS SOLUTION 10 % | 4 | B/D PA |
| **ENDOCRINE AND METABOLIC DISORDER AGENTS / AGENTES DE TRASTORNOS ENDOCRINOS Y METABÓLICOS** | | |
| *acarbose oral* | 2 | MO; 90D |
| *alendronate sodium oral solution* | 2 | QL (300 per 28 days); MO; 90D |
| *alendronate sodium oral tablet 10 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *alendronate sodium oral tablet 35 mg, 70 mg* | 1 | QL (4 per 28 days); MO; 100D |
| *calcitonin (salmon) nasal* | 2 | QL (4 per 30 days); MO; 90D |
| *calcitriol oral capsule* | 1 | MO; 100D |
| *calcitriol oral solution* | 2 | MO; 90D |
| *calcium acetate (phos binder) oral capsule* | 3 | MO |
| *cinacalcet hcl oral tablet 30 mg* | 2 | B/D PA; QL (60 per 30 days); 90D |
| *cinacalcet hcl oral tablet 60 mg* | 4 | B/D PA; QL (60 per 30 days) |
| *cinacalcet hcl oral tablet 90 mg* | 4 | B/D PA; QL (120 per 30 days) |
| *dapagliflozin base-metformin er oral tablet extended release 24 hour 10-1000 mg, 10-500 mg, 5-500 mg* | 3 | QL (30 per 30 days); MO |
| *dapagliflozin base-metformin er oral tablet extended release 24 hour 5-1000 mg* | 3 | QL (60 per 30 days); MO |
| *dapagliflozin* | 1 | QL (30 per 30 days); MO; 100D |
| *deferasirox oral tablet 90 mg* | 3 | PA |
| *deferasirox oral tablet soluble 125 mg* | 4 | PA |
| *deferasirox oral tablet soluble 250 mg, 500 mg* | 5 | PA |
| *diazoxide oral* | 2 | MO; 90D |
| *doxercalciferol oral* | 2 | B/D PA; MO; 90D |
| FARXIGA | 3 | QL (30 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| FIASP FLEXTOUCH | 3 | MO |
| FIASP INJECTION | 3 | MO |
| FIASP PENFILL | 3 | MO |
| FIASP PUMPCART | 3 | MO |
| *glimepiride oral tablet 1 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *glimepiride oral tablet 2 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *glimepiride oral tablet 4 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *glipizide er oral tablet extended release 24 hour 10 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *glipizide er oral tablet extended release 24 hour 2.5 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *glipizide er oral tablet extended release 24 hour 5 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *glipizide oral tablet 10 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *glipizide oral tablet 15 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *glipizide oral tablet 2.5 mg* | 1 | MO; 100D |
| *glipizide oral tablet 5 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *glipizide-metformin hcl oral tablet 2.5-250 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *glucagon emergency injection solution reconstituted 1 mg* | 2 | |
| *glyburide micronized oral tablet 3 mg* | 2 | QL (120 per 30 days); MO; 90D |
| *glyburide micronized oral tablet 6 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *glyburide oral tablet 1.25 mg* | 1 | QL (480 per 30 days); MO; 100D |
| *glyburide oral tablet 2.5 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *glyburide oral tablet 5 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *glyburide-metformin oral tablet 1.25-250 mg* | 1 | QL (240 per 30 days); MO; 100D |
| *glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg* | 1 | QL (120 per 30 days); MO; 100D |
| GLYXAMBI | 3 | QL (30 per 30 days); MO |
| GVOKE HYPOPEN 1-PACK | 4 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| GVOKE HYPOPEN 2-PACK | 4 | |
| GVOKE KIT | 4 | |
| GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML | 4 | |
| *ibandronate sodium oral* | 2 | QL (1 per 28 days); MO; 90D |
| *insulin asp prot & asp flexpen* | 3 | MO |
| *insulin aspart flexpen* | 3 | MO |
| *insulin aspart injection* | 3 | MO |
| *insulin aspart penfill* | 3 | MO |
| *insulin aspart prot & aspart* | 3 | MO |
| INVOKAMET | 4 | QL (60 per 30 days); MO |
| INVOKAMET XR | 4 | QL (60 per 30 days); MO |
| INVOKANA | 4 | QL (30 per 30 days); MO |
| JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG | 3 | QL (30 per 30 days); MO |
| JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG | 3 | QL (60 per 30 days); MO |
| JARDIANCE | 3 | QL (30 per 30 days); MO |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG | 3 | QL (60 per 30 days); MO |
| JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 5-1000 MG | 3 | QL (30 per 30 days); MO |
| KERENDIA | 3 | QL (30 per 30 days); MO |
| KIONEX COMBINATION | 2 | |
| LANTUS | 3 | QL (30 per 30 days); MO |
| LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR | 3 | QL (30 per 30 days); MO |
| *linagliptin-metformin hcl* | 3 | QL (60 per 30 days); MO |
| *liraglutide* | 3 | PA; QL (9 per 30 days) |
| LOKELMA ORAL PACKET 10 GM | 3 | QL (34 per 30 days); MO |
| LOKELMA ORAL PACKET 5 GM | 3 | QL (90 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *metformin hcl er oral tablet extended release 24 hour 500 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *metformin hcl er oral tablet extended release 24 hour 750 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *metformin hcl oral tablet 1000 mg* | 1 | QL (60 per 30 days); MO; 100D |
| *metformin hcl oral tablet 500 mg* | 1 | QL (150 per 30 days); MO; 100D |
| *metformin hcl oral tablet 850 mg* | 1 | QL (90 per 30 days); MO; 100D |
| *miglitol* | 2 | MO; 90D |
| MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR | 3 | PA; QL (2 per 28 days) |
| *nateglinide* | 1 | MO; 100D |
| NOVOLIN 70/30 | 3 | MO |
| NOVOLIN 70/30 FLEXPEN | 3 | MO |
| NOVOLIN 70/30 FLEXPEN RELION | 3 | MO |
| NOVOLIN 70/30 RELION | 3 | MO |
| NOVOLIN N | 3 | MO |
| NOVOLIN N FLEXPEN | 3 | MO |
| NOVOLIN N FLEXPEN RELION | 3 | MO |
| NOVOLIN N RELION | 3 | MO |
| NOVOLIN R | 3 | MO |
| NOVOLIN R FLEXPEN | 3 | MO |
| NOVOLIN R FLEXPEN RELION | 3 | MO |
| NOVOLIN R RELION | 3 | MO |
| NOVOLOG 70/30 FLEXPEN RELION | 3 | MO |
| NOVOLOG FLEXPEN RELION | 3 | MO |
| NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR | 3 | MO |
| NOVOLOG INJECTION | 3 | MO |
| NOVOLOG MIX 70/30 | 3 | MO |
| NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR | 3 | MO |
| NOVOLOG MIX 70/30 RELION | 3 | MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE | 3 | MO |
| NOVOLOG RELION INJECTION | 3 | MO |
| OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML | 3 | PA; QL (3 per 28 days) |
| OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML | 3 | PA; QL (3 per 28 days) |
| OZEMPIC (2 MG/DOSE) | 3 | PA; QL (3 per 28 days) |
| OZEMPIC ORAL TABLET 1.5 MG | 3 | PA; QL (60 per 365 days) |
| OZEMPIC ORAL TABLET 4 MG, 9 MG | 3 | PA; QL (30 per 30 days) |
| *paricalcitol oral* | 2 | B/D PA; MO; 90D |
| *pioglitazone hcl oral tablet 15 mg* | 1 | QL (90 per 30 days); MO; 100D |
| *pioglitazone hcl oral tablet 30 mg* | 1 | QL (45 per 30 days); MO; 100D |
| *pioglitazone hcl oral tablet 45 mg* | 1 | QL (30 per 30 days); MO; 100D |
| *pioglitazone hcl-glimepiride* | 1 | QL (30 per 30 days); MO; 100D |
| *pioglitazone hcl-metformin hcl* | 1 | QL (90 per 30 days); MO; 100D |
| PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 4 | PA; QL (1 per 180 days) |
| *repaglinide* | 1 | MO; 100D |
| *risedronate sodium oral tablet 150 mg* | 2 | QL (1 per 28 days); MO; 90D |
| *risedronate sodium oral tablet 30 mg* | 2 | QL (30 per 30 days) |
| *risedronate sodium oral tablet 35 mg* | 2 | QL (4 per 28 days); MO; 90D |
| *risedronate sodium oral tablet 35 mg (12 pack), 35 mg (4 pack)* | 2 | QL (4 per 28 days); MO |
| *risedronate sodium oral tablet 5 mg* | 2 | QL (30 per 30 days); MO; 90D |
| RYBELSUS ORAL TABLET 14 MG, 7 MG | 3 | PA; QL (30 per 30 days) |
| RYBELSUS ORAL TABLET 3 MG | 3 | PA; QL (60 per 365 days) |
| *sevelamer carbonate oral tablet* | 3 | QL (540 per 30 days); MO |
| *sitagliptin phos-metformin hcl* | 1 | QL (60 per 30 days); MO; 100D |
| *sitagliptin phosphate* | 1 | QL (30 per 30 days); MO; 100D |
| *sodium polystyrene sulfonate combination* | 2 | |
| *sodium polystyrene sulfonate oral powder* | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| SOLIQUA | 3 | QL (15 per 25 days); MO |
| SPS (SODIUM POLYSTYRENE SULF) | 2 | |
| SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR | 5 | PA; QL (11 per 30 days); MO |
| SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR | 4 | PA; QL (6 per 30 days); MO |
| SYNJARDY | 3 | QL (60 per 30 days); MO |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG | 3 | QL (60 per 30 days); MO |
| SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG | 3 | QL (30 per 30 days); MO |
| *teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml* | 4 | PA; QL (2.24 per 28 days) |
| *tolvaptan oral tablet* | 5 | PA; QL (120 per 30 days) |
| TOUJEO MAX SOLOSTAR | 3 | QL (12 per 30 days); MO |
| TOUJEO SOLOSTAR | 3 | QL (13.5 per 30 days); MO |
| TRADJENTA | 3 | QL (30 per 30 days); MO |
| *trientine hcl* | 5 | PA |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 25-5-1000 MG | 3 | QL (30 per 30 days); MO |
| TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-2.5-1000 MG, 5-2.5-1000 MG | 3 | QL (60 per 30 days); MO |
| TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR | 3 | PA; QL (2 per 28 days) |
| TYMLOS | 5 | PA; QL (1.56 per 28 days) |
| VELTASSA ORAL PACKET 1 GM | 4 | QL (240 per 30 days); MO |
| VELTASSA ORAL PACKET 16.8 GM, 25.2 GM | 4 | QL (30 per 30 days); MO |
| VELTASSA ORAL PACKET 8.4 GM | 4 | QL (90 per 30 days); MO |
| *vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit* | 6 | ED |
| XGEVA | 5 | PA; QL (5.1 per 28 days) |
| XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG | 3 | QL (60 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| **GASTROINTESTINAL AGENTS / AGENTES GASTROINTESTINALES** | | |
| *alosetron hcl oral tablet 0.5 mg* | 2 | PA; QL (60 per 30 days); MO; 90D |
| *alosetron hcl oral tablet 1 mg* | 4 | PA; QL (60 per 30 days); MO |
| *amoxicill-clarithro-lansopraz oral therapy pack* | 2 | |
| *aprepitant oral capsule 125 mg* | 5 | B/D PA; QL (5 per 30 days) |
| *aprepitant oral capsule 40 mg* | 2 | B/D PA; QL (1 per 28 days) |
| *aprepitant oral capsule 80 mg* | 4 | B/D PA; QL (10 per 30 days) |
| *aprepitant oral capsule therapy pack* | 2 | B/D PA; QL (15 per 30 days) |
| *balsalazide disodium* | 2 | |
| *bis subcit-metronid-tetracyc* | 4 | |
| *bismuth/metronidaz/tetracyclin* | 4 | |
| *budesonide er oral tablet extended release 24 hour* | 5 | PA |
| *budesonide oral* | 2 | |
| *budesonide rectal* | 2 | |
| *chlordiazepoxide-clidinium* | 2 | PA; HRM |
| *cimetidine oral tablet 200 mg (rx)* | 2 | |
| *cimetidine oral tablet 300 mg, 400 mg, 800 mg* | 2 | MO; 90D |
| CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM - GM/175ML | 4 | |
| COMPRO | 2 | |
| *constulose* | 1 | MO; 100D |
| *dexlansoprazole* | 2 | QL (30 per 30 days); MO; 90D |
| *dicyclomine hcl oral capsule* | 1 | PA; HRM |
| *dicyclomine hcl oral solution 10 mg/5ml* | 4 | PA; HRM |
| *dicyclomine hcl oral tablet 20 mg* | 1 | PA; HRM |
| *diphenoxylate-atropine oral liquid* | 2 | |
| *diphenoxylate-atropine oral tablet 2.5-0.025 mg* | 1 | |
| *dronabinol oral capsule* | 2 | B/D PA; QL (120 per 30 days) |
| *enulose* | 1 | MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *esomeprazole magnesium oral capsule delayed release (rx)* | 2 | QL (30 per 30 days); MO; 90D |
| *famotidine oral tablet 20 mg, 40 mg (rx)* | 1 | MO; 100D |
| *fosaprepitant dimeglumine* | 2 | |
| GAVILYTE-C | 1 | |
| GAVILYTE-G | 1 | |
| GAVILYTE-N WITH FLAVOR PACK | 2 | |
| *generlac* | 1 | MO; 100D |
| *glycopyrrolate oral tablet 1 mg* | 1 | |
| *glycopyrrolate oral tablet 2 mg* | 2 | |
| *granisetron hcl oral* | 4 | B/D PA; QL (30 per 30 days) |
| *hydrocortisone ace-pramoxine external cream 1-1 %* | 1 | |
| *hydrocortisone oral* | 1 | |
| *hydrocortisone rectal enema* | 3 | |
| *hyoscyamine sulfate oral tablet* | 3 | MO |
| *hyoscyamine sulfate oral tablet dispersible* | 3 | MO |
| *hyoscyamine sulfate sublingual* | 3 | MO |
| *lactulose encephalopathy oral solution 10 gm/15ml* | 1 | MO; 100D |
| *lactulose oral solution* | 1 | MO; 100D |
| *lansoprazole oral capsule delayed release 15 mg (rx)* | 2 | MO; 90D |
| *lansoprazole oral capsule delayed release 30 mg* | 2 | QL (30 per 30 days); MO; 90D |
| LINZESS | 3 | QL (30 per 30 days); MO |
| *loperamide hcl oral capsule* | 1 | |
| *lubiprostone* | 2 | QL (60 per 30 days); MO; 90D |
| *meclizine hcl oral tablet 12.5 mg, 25 mg (rx)* | 1 | PA; HRM |
| *mesalamine er oral capsule extended release 24 hour* | 2 | MO; 90D |
| *mesalamine oral capsule delayed release* | 2 | MO; 90D |
| *mesalamine oral tablet delayed release 1.2 gm* | 2 | MO; 90D |

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|---|---|---|
| *mesalamine oral tablet delayed release 800 mg* | 2 | |
| *mesalamine rectal* | 2 | |
| *methscopolamine bromide oral* | 2 | |
| *metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml* | 1 | |
| *metoclopramide hcl oral tablet* | 1 | |
| *misoprostol oral tablet 100 mcg* | 1 | MO; 100D |
| *misoprostol oral tablet 200 mcg* | 2 | MO; 90D |
| MOVANTIK | 4 | QL (30 per 30 days) |
| MYTESI | 5 | |
| *na sulfate-k sulfate-mg sulf* | 3 | |
| *nizatidine oral capsule* | 1 | MO; 100D |
| *omeprazole oral capsule delayed release 10 mg, 40 mg* | 2 | MO; 90D |
| *ondansetron hcl oral solution* | 2 | B/D PA; QL (450 per 30 days) |
| *ondansetron hcl oral tablet 24 mg* | 2 | B/D PA; QL (30 per 30 days) |
| *ondansetron hcl oral tablet 4 mg, 8 mg* | 2 | B/D PA; QL (90 per 30 days) |
| *ondansetron oral tablet dispersible 16 mg* | 2 | B/D PA; QL (30 per 30 days) |
| *ondansetron oral tablet dispersible 4 mg, 8 mg* | 2 | B/D PA; QL (90 per 30 days) |
| *pantoprazole sodium oral tablet delayed release* | 2 | MO; 90D |
| *peg 3350-kcl-na bicarb-nacl* | 2 | |
| *peg-3350/electrolytes* | 1 | |
| *prochlorperazine* | 2 | |
| *prochlorperazine maleate oral* | 1 | MO; 100D |
| *promethazine hcl oral solution* | 2 | PA; HRM |
| *promethazine hcl oral tablet* | 1 | PA; HRM |
| PROMETHEGAN | 2 | PA; HRM |
| *scopolamine* | 2 | QL (10 per 28 days) |
| *sucralfate oral suspension* | 4 | MO |
| *sucralfate oral tablet* | 1 | MO; 100D |
| *sulfasalazine oral* | 1 | MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *ursodiol oral capsule 300 mg* | 2 | MO; 90D |
| *ursodiol oral tablet* | 2 | MO; 90D |
| VARUBI (180 MG DOSE) | 5 | B/D PA; QL (4 per 28 days) |
| VELSIPITY | 5 | PA; QL (30 per 30 days) |
| VOWST | 5 | PA |
| XERMELO | 5 | PA; QL (90 per 30 days) |
| **GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT / TRASTORNO GENÉTICO, ENZIMÁTICO O PROTEICO: REEMPLAZO, MODIFICADORES, TRATAMIENTO** | | |
| *betaine* | 4 | |
| CREON | 3 | MO |
| *cromolyn sodium oral* | 2 | MO; 90D |
| CYSTAGON | 4 | PA |
| GALAFOLD | 5 | PA |
| JAVYGTOR | 5 | PA |
| *miglustat* | 5 | PA |
| *nitisinone* | 5 | PA |
| PROLASTIN-C INTRAVENOUS SOLUTION | 5 | PA |
| REVCOVI | 5 | PA |
| *sapropterin dihydrochloride oral packet* | 5 | PA |
| *sapropterin dihydrochloride oral tablet* | 5 | PA |
| *sodium phenylbutyrate oral powder 3 gm/tsp* | 5 | PA |
| *sodium phenylbutyrate oral tablet* | 5 | PA |
| YARGESA | 5 | PA |
| ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT | 3 | MO |
| **GENITOURINARY AGENTS / AGENTES GENITOURINARIOS** | | |
| *alfuzosin hcl er* | 1 | MO; 100D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *bethanechol chloride oral* | 1 | |
| *clindamycin phosphate vaginal* | 2 | |
| *darifenacin hydrobromide er* | 2 | QL (30 per 30 days); MO; 90D |
| *dutasteride oral* | 2 | QL (30 per 30 days); MO; 90D |
| *dutasteride-tamsulosin hcl* | 2 | QL (30 per 30 days); MO; 90D |
| FILSPARI ORAL TABLET 200 MG | 5 | PA; QL (30 per 30 days) |
| FILSPARI ORAL TABLET 400 MG | 5 | PA; QL (60 per 30 days) |
| *finasteride oral tablet 5 mg* | 1 | MO; 100D |
| GEMTESA | 4 | QL (30 per 30 days); MO |
| LITHOSTAT | 4 | MO |
| *metronidazole vaginal* | 2 | |
| *miconazole 3 vaginal suppository* | 2 | |
| *mirabegron er oral tablet extended release 24 hour* | 3 | QL (30 per 30 days); MO |
| *oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg* | 2 | QL (60 per 30 days); MO; 90D |
| *oxybutynin chloride er oral tablet extended release 24 hour 5 mg* | 2 | QL (30 per 30 days); MO; 90D |
| *oxybutynin chloride oral solution* | 1 | QL (600 per 30 days); MO; 100D |
| *oxybutynin chloride oral tablet 2.5 mg* | 1 | QL (90 per 30 days); MO; 100D |
| *oxybutynin chloride oral tablet 5 mg* | 1 | QL (120 per 30 days); MO; 100D |
| *penicillamine oral tablet* | 5 | |
| *potassium citrate er* | 2 | |
| *sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg* | 6 | QL (6 per 30 days); ED |
| *silodosin* | 2 | MO; 90D |
| *solifenacin succinate* | 2 | QL (30 per 30 days); MO; 90D |
| *tadalafil oral tablet 10 mg, 20 mg* | 6 | QL (6 per 30 days); ED |
| *tadalafil oral tablet 5 mg* | 4 | PA; QL (30 per 30 days); MO |
| *tamsulosin hcl* | 2 | MO; 90D |
| TARPEYO | 5 | PA; QL (120 per 30 days) |
| *terconazole vaginal cream 0.4 %* | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *terconazole vaginal suppository* | 2 | |
| *tolterodine tartrate er* | 2 | QL (30 per 30 days); MO; 90D |
| VANDAZOLE | 2 | |
| **HORMONAL AGENTS / AGENTES HORMONALES** | | |
| ALTAVERA | 1 | MO; 100D |
| APRI | 1 | MO; 100D |
| AUROVELA 1.5/30 | 2 | MO; 90D |
| AUROVELA 1/20 | 1 | MO; 100D |
| AUROVELA 24 FE | 1 | MO; 100D |
| AUROVELA FE 1/20 | 1 | MO; 100D |
| AYUNA | 1 | MO; 100D |
| AZURETTE | 2 | MO; 90D |
| BIJUVA | 3 | PA; MO; HRM |
| BLISOVI 24 FE | 1 | MO; 100D |
| BLISOVI FE 1/20 | 1 | MO; 100D |
| *cabergoline* | 2 | |
| CAMILA | 3 | MO |
| CHARLOTTE 24 FE | 2 | MO; 90D |
| CHATEAL EQ | 1 | MO; 100D |
| CLIMARA PRO | 4 | PA; QL (4 per 28 days); MO; HRM |
| CRYSELLE | 1 | MO; 100D |
| CRYSELLE-28 | 1 | MO; 100D |
| CYRED EQ | 1 | MO; 100D |
| *danazol oral* | 2 | |
| DEBLITANE | 3 | MO |
| DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE | 3 | |
| DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION | 2 | MO |
| *desmopressin ace spray refrig* | 2 | MO; 90D |
| *desmopressin acetate oral tablet 0.1 mg* | 2 | MO; 90D |
| *desmopressin acetate oral tablet 0.2 mg* | 1 | MO; 100D |

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|---|---|---|
| *desmopressin acetate spray* | 2 | MO; 90D |
| *desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)* | 2 | MO; 90D |
| *dexamethasone oral elixir* | 1 | |
| *dexamethasone oral tablet* | 1 | |
| *drospirenone-ethinyl estradiol oral tablet 3-0.02 mg* | 2 | MO; 90D |
| ELINEST | 1 | MO; 100D |
| ELURYNG | 3 | MO |
| EMZAHH | 3 | MO |
| ENILLORING | 4 | MO |
| ENSKYCE ORAL TABLET 0.15-30 MG-MCG | 1 | MO; 100D |
| ERRIN | 3 | MO |
| ESTARYLLA | 2 | MO; 90D |
| *estradiol oral* | 1 | MO; 100D |
| *estradiol vaginal cream 0.01 %* | 2 | MO; 90D |
| *estradiol vaginal tablet* | 2 | MO; 90D |
| *estrogens conjugated* | 3 | MO |
| *ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg* | 1 | MO; 100D |
| *etonogestrel-ethinyl estradiol* | 4 | MO |
| FEIRZA 1/20 | 1 | MO; 100D |
| FINZALA | 2 | MO; 90D |
| *fludrocortisone acetate oral* | 1 | MO; 100D |
| GALLIFREY | 2 | MO; 90D |
| HAILEY 1.5/30 | 2 | MO; 90D |
| HAILEY 24 FE | 1 | MO; 100D |
| HAILEY FE 1/20 | 1 | MO; 100D |
| HEATHER | 3 | MO |
| IMVEXXY MAINTENANCE PACK | 3 | QL (18 per 28 days); MO |
| IMVEXXY STARTER PACK | 3 | QL (18 per 28 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| INCASSIA | 3 | MO |
| INCRELEX | 5 | PA |
| ISIBLOOM | 1 | MO; 100D |
| JASMIEL | 2 | MO; 90D |
| JENCYCLA | 3 | MO |
| JULEBER | 1 | MO; 100D |
| JUNEL 1.5/30 | 2 | MO; 90D |
| JUNEL 1/20 | 1 | MO; 100D |
| JUNEL FE 1/20 | 1 | MO; 100D |
| JUNEL FE 24 | 1 | MO; 100D |
| KALLIGA | 1 | MO; 100D |
| KARIVA | 2 | MO; 90D |
| KURVELO | 1 | MO; 100D |
| LARIN 1.5/30 | 2 | MO; 90D |
| LARIN 1/20 | 1 | MO; 100D |
| LARIN 24 FE | 1 | MO; 100D |
| LARIN FE 1/20 | 1 | MO; 100D |
| *levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg* | 1 | MO; 100D |
| LEVORA 0.15/30 (28) | 1 | MO; 100D |
| *levothyroxine sodium oral tablet* | 1 | MO; 100D |
| LEVOXYL | 1 | MO; 100D |
| *liomny* | 1 | MO; 100D |
| *liothyronine sodium oral* | 1 | MO; 100D |
| LOESTRIN 1.5/30 (21) | 2 | MO; 90D |
| LOESTRIN 1/20 (21) | 1 | MO; 100D |
| LOESTRIN FE 1/20 | 1 | MO; 100D |
| LORYNA | 2 | MO; 90D |
| LOW-OGESTREL | 1 | MO; 100D |
| LO-ZUMANDIMINE | 2 | MO; 90D |
| LUIZZA 1.5/30 | 2 | MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| LUIZZA 1/20 | 1 | 100D |
| LYLEQ | 3 | MO |
| LYLLANA | 1 | QL (8 per 28 days); MO; 100D |
| LYZA | 3 | MO |
| *marlissa* | 1 | MO; 100D |
| *medroxyprogesterone acetate intramuscular* | 2 | |
| *medroxyprogesterone acetate oral tablet 10 mg, 5 mg* | 1 | MO; 100D |
| *medroxyprogesterone acetate oral tablet 2.5 mg* | 2 | MO; 90D |
| *megestrol acetate oral suspension 625 mg/5ml* | 2 | PA; MO; 90D; HRM |
| MELEYA | 3 | MO |
| *methimazole oral* | 1 | MO; 100D |
| *methylprednisolone oral* | 1 | |
| *methyltestosterone oral* | 5 | MO |
| MIBELAS 24 FE | 2 | MO; 90D |
| MICROGESTIN 1.5/30 | 2 | MO; 90D |
| MICROGESTIN 1/20 | 1 | MO; 100D |
| MICROGESTIN FE 1/20 | 1 | MO; 100D |
| *mifepristone oral tablet 300 mg* | 5 | PA |
| MILI | 2 | MO; 90D |
| MONO-LINYAH | 2 | MO; 90D |
| NEXPLANON | 3 | |
| NIKKI | 2 | MO; 90D |
| NORA-BE | 3 | MO |
| NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR | 5 | PA |
| *norelgestromin-eth estradiol* | 3 | MO |
| *norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg* | 1 | MO; 100D |
| *norethin ace-eth estrad-fe oral tablet chewable* | 2 | MO; 90D |
| *norethindrone acetate oral* | 2 | MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *norethindrone acet-ethinyl est oral tablet 1.5-30 mg-mcg* | 2 | MO; 90D |
| *norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg* | 1 | MO; 100D |
| *norethindrone oral* | 3 | MO |
| *norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg* | 2 | MO; 90D |
| *norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg* | 2 | MO; 90D |
| *norgestim-eth estrad triphasic* | 2 | MO; 90D |
| NORLYROC | 3 | MO |
| *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml* | 2 | PA; 90D |
| *octreotide acetate injection solution 500 mcg/ml* | 4 | PA |
| *octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml* | 2 | PA; 90D |
| *octreotide acetate subcutaneous solution prefilled syringe 500 mcg/ml* | 4 | PA |
| OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE | 5 | PA |
| OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED | 5 | PA |
| ORQUIDEA | 3 | MO |
| OSPHENA | 3 | MO |
| PIMTREA | 2 | MO; 90D |
| PORTIA-28 | 1 | MO; 100D |
| *prednisolone oral solution* | 2 | |
| *prednisolone sodium phosphate oral solution 25 mg/5ml, 5 mg/5ml* | 2 | |
| *prednisone oral solution* | 2 | |
| *prednisone oral tablet* | 1 | |
| *prednisone oral tablet therapy pack* | 1 | |
| PREMARIN ORAL | 3 | MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| PREMARIN VAGINAL | 3 | MO |
| *progesterone oral* | 2 | MO; 90D |
| *propylthiouracil oral* | 1 | MO; 100D |
| *raloxifene hcl* | 2 | QL (30 per 30 days); MO; 90D |
| RECLIPSEN | 1 | MO; 100D |
| REZDIFFRA | 5 | PA; QL (30 per 30 days) |
| SHAROBEL | 3 | MO |
| SIGNIFOR | 5 | PA |
| SIMLIYA | 2 | MO; 90D |
| SKYLA | 3 | |
| SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG | 5 | PA |
| SPRINTEC 28 | 2 | MO; 90D |
| SYNAREL | 5 | PA |
| SYNTHROID | 3 | MO |
| TARINA 24 FE | 1 | MO; 100D |
| TARINA FE 1/20 EQ | 1 | MO; 100D |
| *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)* | 2 | MO |
| *testosterone enanthate intramuscular solution* | 2 | MO |
| *testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%), 40.5 mg/2.5gm (1.62%)* | 2 | PA; QL (150 per 30 days); MO |
| *testosterone transdermal gel 20.25 mg/1.25gm (1.62%)* | 2 | PA; QL (112.5 per 30 days); MO |
| *testosterone transdermal gel 25 mg/2.5gm (1%), 50 mg/5gm (1%)* | 2 | PA; QL (300 per 30 days); MO |
| *testosterone transdermal solution* | 2 | PA; QL (180 per 30 days); MO |
| TRI-ESTARYLLA | 2 | MO; 90D |
| TRI-LINYAH | 2 | MO; 90D |
| TRI-LO-ESTARYLLA | 2 | MO; 90D |
| TRI-LO-MARZIA | 2 | MO; 90D |
| TRI-LO-MILI | 2 | MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| TRI-LO-SPRINTEC | 2 | MO; 90D |
| TRI-MILI | 2 | MO; 90D |
| TRI-SPRINTEC | 2 | MO; 90D |
| TRI-VYLIBRA | 2 | MO; 90D |
| TRI-VYLIBRA LO | 2 | MO; 90D |
| TURQOZ | 1 | MO; 100D |
| UNITHROID | 1 | MO; 100D |
| VALTYA 1/50 | 1 | MO; 100D |
| VESTURA | 2 | MO; 90D |
| *viorele* | 2 | MO; 90D |
| VOLNEA | 2 | MO; 90D |
| VYLIBRA | 2 | MO; 90D |
| WYMZYA FE | 2 | MO; 90D |
| XELRIA FE | 2 | MO; 90D |
| *yuvafem* | 2 | MO; 90D |
| **IMMUNOLOGICAL AGENTS / AGENTES INMUNITARIOS** | | |
| ABRYSVO | 1 | QL (1 per 365 days) |
| ACTHIB | 1 | |
| ACTIMMUNE | 5 | PA |
| ADACEL | 1 | |
| ARCALYST | 5 | PA |
| AREXVY | 1 | QL (1 per 365 days) |
| AZASAN | 4 | B/D PA |
| *azathioprine oral* | 2 | B/D PA; 90D |
| *bcg vaccine injection solution reconstituted* | 1 | |
| BENLYSTA SUBCUTANEOUS | 5 | PA |
| BEXSERO | 1 | |
| BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML | 5 | PA; QL (2 per 28 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 320 MG/2ML | 5 | PA; QL (4 per 28 days) |
| BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML | 5 | PA; QL (2 per 28 days) |
| BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 320 MG/2ML | 5 | PA; QL (4 per 28 days) |
| BIVIGAM INTRAVENOUS SOLUTION 5 GM/50ML | 5 | PA |
| BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 1 | |
| COSENTYX (300 MG DOSE) | 5 | PA; QL (8 per 28 days) |
| COSENTYX SENSOREADY (300 MG) | 5 | PA; QL (8 per 28 days) |
| COSENTYX SENSOREADY PEN | 5 | PA; QL (8 per 28 days) |
| COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML | 5 | PA; QL (8 per 28 days) |
| COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML | 5 | PA; QL (2 per 28 days) |
| COSENTYX UNOREADY | 5 | PA; QL (8 per 28 days) |
| *cyclosporine modified oral capsule 100 mg, 50 mg* | 2 | B/D PA; 90D |
| *cyclosporine modified oral capsule 25 mg* | 1 | B/D PA; 100D |
| *cyclosporine modified oral solution* | 2 | B/D PA; 90D |
| *cyclosporine oral capsule 100 mg* | 2 | B/D PA; 90D |
| *cyclosporine oral capsule 25 mg* | 1 | B/D PA; 100D |
| DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5 | 1 | |
| ENBREL MINI | 5 | PA; QL (8 per 28 days) |
| ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML | 5 | PA; QL (4 per 28 days) |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML | 5 | PA; QL (4.08 per 28 days) |
| ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML | 5 | PA; QL (8 per 28 days) |
| ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR | 5 | PA; QL (8 per 28 days) |
| ENGERIX-B INJECTION SUSPENSION 20 MCG/ML | 1 | B/D PA |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE | 1 | B/D PA |
| ENTYVIO PEN | 5 | PA; QL (1.36 per 28 days) |
| ENVARSUS XR | 4 | B/D PA |
| *everolimus oral tablet 0.25 mg* | 2 | B/D PA; 90D |
| *everolimus oral tablet 0.5 mg, 1 mg* | 5 | B/D PA |
| *everolimus oral tablet 0.75 mg* | 4 | B/D PA |
| FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 GM/200ML | 5 | PA |
| GAMMAGARD INJECTION SOLUTION 1 GM/10ML | 4 | PA |
| GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML | 5 | PA |
| GAMMAGARD S/D LESS IGA | 5 | PA |
| GAMMAKED INJECTION SOLUTION 1 GM/10ML | 5 | PA |
| GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML | 5 | PA |
| GAMUNEX-C INJECTION SOLUTION 1 GM/10ML | 5 | PA |
| GARDASIL 9 | 1 | |
| GENGRAF ORAL CAPSULE 100 MG | 2 | B/D PA; 90D |
| GENGRAF ORAL CAPSULE 25 MG | 1 | B/D PA; 100D |
| HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML | 5 | PA; QL (2.4 per 28 days) |
| HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.8ML | 5 | PA; QL (4.8 per 28 days) |
| HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML | 5 | PA; QL (2.4 per 28 days) |
| HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.8ML | 5 | PA; QL (4.8 per 28 days) |
| HAVRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 1 | |
| HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE | 1 | B/D PA |
| HIBERIX INJECTION | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML | 5 | PA; QL (4 per 28 days) |
| HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 5 | PA; QL (2 per 28 days) |
| HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML | 5 | PA; QL (2 per 28 days) |
| HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML, 40 MG/0.8ML | 5 | PA; QL (4 per 28 days) |
| HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML | 5 | PA; QL (6 per 365 days) |
| HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT | 5 | PA; QL (6 per 365 days) |
| IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED | 1 | |
| INFANRIX | 1 | |
| IPOL INJECTION SUSPENSION | 1 | |
| IXIARO | 1 | |
| JYLAMVO | 4 | ST |
| JYNNEOS | 1 | |
| *kedrab injection solution 1500 unit/10ml* | 3 | |
| KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | PA; QL (18.76 per 28 days) |
| KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 1 | |
| *leflunomide oral* | 2 | QL (30 per 30 days); MO; 90D |
| MENQUADFI INTRAMUSCULAR SOLUTION | 1 | |
| MENVEO | 1 | |
| *methotrexate sodium (pf) injection solution 50 mg/2ml* | 1 | |
| *methotrexate sodium injection solution 50 mg/2ml* | 1 | |
| *methotrexate sodium oral* | 1 | |
| M-M-R II INJECTION | 1 | |
| MRESVIA | 1 | QL (0.5 per 365 days) |

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|---|---|---|
| *mycophenolate mofetil oral capsule* | 2 | B/D PA; 90D |
| *mycophenolate mofetil oral suspension reconstituted* | 4 | B/D PA |
| *mycophenolate mofetil oral tablet* | 2 | B/D PA; 90D |
| *mycophenolate sodium* | 2 | B/D PA; 90D |
| *mycophenolic acid oral tablet delayed release 180 mg, 360 mg* | 2 | B/D PA; 90D |
| OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML | 4 | PA |
| OCTAGAM INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML | 5 | PA |
| OTEZLA ORAL TABLET | 5 | PA; QL (60 per 30 days) |
| OTEZLA ORAL TABLET THERAPY PACK | 5 | PA |
| OTEZLA XR | 5 | PA; QL (30 per 30 days) |
| OTEZLA/OTEZLA XR INITIATION PK | 5 | PA |
| PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 1 | |
| PEDVAXHIB | 1 | |
| PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML | 5 | |
| PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | |
| PENBRAYA | 1 | |
| *penmenvy* | 1 | |
| PENTACEL | 1 | |
| PRIORIX | 1 | |
| PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML | 5 | PA |
| PRIVIGEN INTRAVENOUS SOLUTION 5 GM/50ML | 4 | PA |
| PROGRAF ORAL PACKET | 4 | B/D PA |
| PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED | 1 | |
| QUADRACEL | 1 | |

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|---|---|---|
| RABAVERT | 1 | |
| RECOMBIVAX HB | 1 | B/D PA |
| REZUROCK | 5 | PA; QL (30 per 30 days) |
| RINVOQ | 5 | PA; QL (30 per 30 days) |
| RINVOQ LQ | 5 | PA; QL (360 per 30 days) |
| ROTARIX ORAL SUSPENSION | 1 | |
| ROTATEQ ORAL SOLUTION | 1 | |
| SELARSDI INTRAVENOUS | 5 | PA |
| SELARSDI SUBCUTANEOUS SOLUTION | 3 | PA; QL (0.5 per 28 days) |
| SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML | 3 | PA; QL (0.5 per 28 days) |
| SELARSDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML | 5 | PA; QL (1 per 28 days) |
| SHINGRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 1 | |
| SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML | 1 | |
| SIMLANDI (1 PEN) | 5 | PA; QL (4 per 28 days) |
| SIMLANDI (1 SYRINGE) | 5 | PA; QL (4 per 28 days) |
| SIMLANDI (2 PEN) | 5 | PA; QL (4 per 28 days) |
| SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML | 5 | PA; QL (2 per 28 days) |
| SIMLANDI (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML | 5 | PA; QL (4 per 28 days) |
| *sirolimus oral solution* | 4 | B/D PA |
| *sirolimus oral tablet* | 2 | B/D PA; 90D |
| SKYRIZI INTRAVENOUS | 5 | PA; QL (10 per 28 days) |
| SKYRIZI PEN | 5 | PA; QL (6 per 365 days) |
| SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML | 5 | PA; QL (1.2 per 56 days) |
| SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML | 5 | PA; QL (2.4 per 56 days) |

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|---|---|---|
| SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML | 5 | PA; QL (6 per 365 days) |
| SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 55 MG/0.37ML | 5 | PA; QL (2.22 per 365 days) |
| *tacrolimus oral* | 2 | B/D PA; 90D |
| TENIVAC | 1 | |
| TICOVAC | 1 | |
| *tofacitinib citrate er* | 5 | PA; QL (30 per 30 days) |
| *tofacitinib citrate oral solution* | 4 | PA; QL (240 per 24 days) |
| *tofacitinib citrate oral tablet* | 5 | PA; QL (60 per 30 days) |
| TREMFYA ONE-PRESS SUBCUTANEOUS SOLUTION PEN-INJECTOR | 5 | PA; QL (2 per 28 days) |
| TREMFYA PEN | 5 | PA; QL (2 per 28 days) |
| TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE | 5 | PA; QL (2 per 28 days) |
| TREMFYA-CD/UC INDUCTION | 5 | PA; QL (4 per 28 days) |
| TRUMENBA | 1 | |
| TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 1 | |
| TYENNE SUBCUTANEOUS | 5 | PA; QL (3.6 per 28 days) |
| TYPHIM VI | 1 | |
| VAQTA | 1 | |
| VARIVAX INJECTION | 1 | |
| VARIZIG INTRAMUSCULAR SOLUTION | 3 | |
| VAXCHORA | 1 | PA |
| VIMKUNYA | 1 | |
| VIVOTIF | 1 | |
| XATMEP | 4 | ST |
| YESINTEK INTRAVENOUS | 5 | PA |
| YESINTEK SUBCUTANEOUS SOLUTION | 3 | PA; QL (0.5 per 28 days) |
| YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML | 3 | PA; QL (0.5 per 28 days) |

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|---|---|---|
| YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML | 5 | PA; QL (1 per 28 days) |
| YF-VAX SUBCUTANEOUS SUSPENSION RECONSTITUTED | 1 | |
| ZYMFENTRA (2 PEN) | 5 | PA; QL (2 per 28 days) |
| ZYMFENTRA (2 SYRINGE) | 5 | PA; QL (2 per 28 days) |
| **INFECTIOUS DISEASE AGENTS / AGENTES DE ENFERMEDADES INFECCIOSAS** | | |
| *abacavir sulfate oral solution* | 2 | QL (960 per 30 days); 90D |
| *abacavir sulfate oral tablet* | 2 | QL (60 per 30 days); 90D |
| *abacavir sulfate-lamivudine* | 2 | QL (30 per 30 days); 90D |
| *acyclovir oral capsule* | 1 | MO |
| *acyclovir oral suspension 200 mg/5ml* | 2 | MO |
| *acyclovir oral suspension 400 mg/10ml, 800 mg/20ml* | 2 | |
| *acyclovir oral tablet* | 1 | MO |
| *acyclovir sodium intravenous solution* | 2 | B/D PA |
| *adefovir dipivoxil* | 2 | PA; 90D |
| *albendazole oral* | 4 | |
| *amikacin sulfate injection solution 500 mg/2ml* | 2 | |
| *amoxicillin oral capsule* | 1 | |
| *amoxicillin oral suspension reconstituted* | 1 | |
| *amoxicillin oral tablet* | 1 | |
| *amoxicillin oral tablet chewable 125 mg, 250 mg* | 1 | |
| *amoxicillin trihydrate oral* | 1 | |
| *amoxicillin-pot clavulanate er* | 2 | |
| *amoxicillin-pot clavulanate oral suspension reconstituted* | 2 | |
| *amoxicillin-pot clavulanate oral tablet* | 2 | |
| *amphotericin b intravenous* | 2 | B/D PA |
| *amphotericin b liposome* | 5 | B/D PA |
| *ampicillin oral capsule 500 mg* | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *ampicillin sodium injection solution reconstituted 1 gm, 125 mg* | 2 | |
| *ampicillin sodium intravenous solution reconstituted 1 gm, 10 gm* | 2 | |
| *ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm* | 2 | |
| *ampicillin-sulbactam sodium intravenous* | 2 | |
| APTIVUS ORAL CAPSULE | 5 | QL (120 per 30 days) |
| ARIKAYCE | 5 | |
| *atazanavir sulfate oral capsule 150 mg, 200 mg* | 4 | QL (60 per 30 days) |
| *atazanavir sulfate oral capsule 300 mg* | 4 | QL (30 per 30 days) |
| *atovaquone oral* | 2 | PA |
| *atovaquone-proguanil hcl* | 2 | |
| *azithromycin intravenous* | 2 | |
| *azithromycin oral suspension reconstituted* | 2 | |
| *azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack)* | 1 | |
| *azithromycin oral tablet 600 mg* | 2 | |
| *aztreonam injection solution reconstituted 1 gm* | 2 | |
| BARACLUDE ORAL SOLUTION | 5 | |
| BICILLIN C-R | 4 | |
| BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE | 4 | |
| BIKTARVY ORAL TABLET 30-120-15 MG | 5 | QL (30 per 30 days); MO |
| BIKTARVY ORAL TABLET 50-200-25 MG | 5 | QL (30 per 30 days) |
| CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML | 5 | QL (4 per 28 days) |
| CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML | 5 | QL (6 per 28 days) |
| *caspofungin acetate* | 4 | B/D PA |
| *cefaclor er* | 3 | |
| *cefaclor oral capsule* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *cefadroxil* | 2 | |
| *cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 3 gm, 500 mg* | 2 | |
| *cefazolin sodium intravenous solution reconstituted 1 gm* | 2 | |
| *cefdinir* | 2 | |
| *cefepime hcl injection solution reconstituted 1 gm* | 2 | |
| *cefepime hcl intravenous solution reconstituted 2 gm* | 2 | |
| *cefixime oral capsule* | 2 | |
| *cefixime oral suspension reconstituted* | 2 | |
| *cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm* | 2 | |
| *cefoxitin sodium intravenous solution reconstituted 2 gm* | 4 | |
| *cefpodoxime proxetil* | 2 | |
| *cefprozil* | 2 | |
| *ceftaroline fosamil* | 5 | |
| *ceftazidime injection solution reconstituted 1 gm, 6 gm* | 2 | |
| *ceftazidime intravenous* | 2 | |
| *ceftriaxone sodium in dextrose* | 2 | |
| *ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg* | 2 | |
| *ceftriaxone sodium intravenous* | 2 | |
| *cefuroxime axetil oral tablet* | 2 | |
| *cefuroxime sodium injection solution reconstituted 750 mg* | 2 | |
| *cefuroxime sodium intravenous solution reconstituted 1.5 gm* | 2 | |
| *cephalexin oral capsule 250 mg, 500 mg* | 1 | |
| *cephalexin oral suspension reconstituted* | 2 | |
| *cephalexin oral tablet* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *chloroquine phosphate oral* | 1 | MO; 100D |
| CIMDUO | 5 | QL (30 per 30 days) |
| *ciprofloxacin hcl oral tablet 250 mg, 500 mg* | 1 | |
| *ciprofloxacin hcl oral tablet 750 mg* | 2 | |
| *ciprofloxacin in d5w intravenous solution 200 mg/100ml* | 2 | |
| *clarithromycin er* | 2 | |
| *clarithromycin oral* | 2 | |
| *clindamycin hcl oral* | 1 | |
| *clindamycin palmitate hcl* | 2 | |
| *clindamycin phosphate in d5w* | 2 | |
| *clindamycin phosphate injection solution 600 mg/4ml* | 2 | |
| COARTEM | 4 | |
| *colistimethate sodium (cba)* | 2 | |
| CRESEMBA ORAL | 5 | PA |
| *dapsone oral* | 2 | MO; 90D |
| *daptomycin* | 4 | |
| *darunavir* | 4 | QL (60 per 30 days) |
| DELSTRIGO | 5 | QL (30 per 30 days) |
| DESCOVY | 5 | QL (30 per 30 days) |
| *dicloxacillin sodium* | 2 | |
| DIFICID | 5 | PA |
| DOVATO | 5 | QL (30 per 30 days) |
| DOXY 100 | 2 | |
| *doxycycline hyclate intravenous* | 2 | |
| *doxycycline hyclate oral capsule 100 mg, 50 mg* | 2 | |
| *doxycycline hyclate oral tablet 100 mg* | 2 | |
| *doxycycline hyclate oral tablet 20 mg* | 1 | |
| *doxycycline hyclate oral tablet delayed release 200 mg, 50 mg* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *doxycycline monohydrate oral capsule 100 mg* | 2 | |
| *doxycycline monohydrate oral capsule 50 mg* | 1 | |
| *doxycycline monohydrate oral suspension reconstituted* | 2 | |
| *doxycycline monohydrate oral tablet* | 2 | |
| E.E.S. 400 ORAL TABLET | 2 | |
| EDURANT | 5 | QL (30 per 30 days) |
| EDURANT PED | 5 | QL (180 per 30 days) |
| *efavirenz oral tablet* | 4 | QL (30 per 30 days) |
| *efavirenz-emtricitab-tenofo df* | 4 | QL (30 per 30 days) |
| *efavirenz-lamivudine-tenofovir* | 4 | QL (30 per 30 days) |
| *emtricitabine* | 2 | QL (30 per 30 days); 90D |
| *emtricitabine-tenofovir df oral tablet 100-150 mg, 167-250 mg* | 4 | QL (30 per 30 days) |
| *emtricitabine-tenofovir df oral tablet 133-200 mg* | 5 | QL (30 per 30 days) |
| *emtricitabine-tenofovir df oral tablet 200-300 mg* | 2 | QL (30 per 30 days); 90D |
| *emtricitab-rilpivir-tenofov df* | 5 | QL (30 per 30 days) |
| EMTRIVA ORAL SOLUTION | 4 | QL (850 per 30 days) |
| EMVERM | 5 | |
| *entecavir* | 2 | 90D |
| ERAXIS | 4 | PA |
| *ertapenem sodium* | 2 | |
| ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 500 MG | 2 | |
| ERY-TAB ORAL TABLET DELAYED RELEASE 333 MG | 3 | |
| *erythromycin base oral capsule delayed release particles* | 2 | |
| *erythromycin base oral tablet 250 mg* | 2 | |
| *erythromycin base oral tablet delayed release 250 mg, 500 mg* | 2 | |
| *erythromycin base oral tablet delayed release 333 mg* | 3 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml* | 1 | |
| *erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml* | 4 | |
| *erythromycin ethylsuccinate oral tablet* | 2 | |
| *erythromycin oral tablet delayed release 250 mg, 500 mg* | 2 | |
| *erythromycin oral tablet delayed release 333 mg* | 3 | |
| *ethambutol hcl oral tablet 100 mg* | 2 | |
| *ethambutol hcl oral tablet 400 mg* | 1 | |
| *etravirine oral tablet 100 mg* | 4 | QL (120 per 30 days) |
| *etravirine oral tablet 200 mg* | 4 | QL (60 per 30 days) |
| EVOTAZ | 5 | QL (30 per 30 days) |
| *famciclovir oral tablet 125 mg, 250 mg* | 2 | QL (60 per 30 days) |
| *famciclovir oral tablet 500 mg* | 2 | QL (21 per 7 days) |
| *fidaxomicin* | 5 | PA |
| *fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%* | 2 | |
| *fluconazole oral* | 2 | |
| *flucytosine oral* | 5 | |
| *fosamprenavir calcium* | 4 | QL (120 per 30 days) |
| *fosfomycin tromethamine* | 4 | |
| *gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%, 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%* | 2 | |
| *gentamicin sulfate injection solution 40 mg/ml* | 2 | |
| GENVOYA | 5 | QL (30 per 30 days) |
| *griseofulvin microsize oral suspension* | 2 | |
| *hydroxychloroquine sulfate oral tablet 200 mg* | 1 | MO; 100D |
| IDVYNSO | 5 | QL (30 per 30 days); MO |
| *imipenem-cilastatin intravenous solution reconstituted 250 mg* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| IMPAVIDO | 5 | |
| INTELENCE ORAL TABLET 25 MG | 4 | QL (480 per 30 days) |
| ISENTRESS HD | 5 | QL (60 per 30 days) |
| ISENTRESS ORAL PACKET | 3 | QL (180 per 30 days) |
| ISENTRESS ORAL TABLET | 5 | QL (120 per 30 days) |
| ISENTRESS ORAL TABLET CHEWABLE 100 MG | 5 | QL (180 per 30 days) |
| ISENTRESS ORAL TABLET CHEWABLE 25 MG | 3 | QL (720 per 30 days) |
| *isoniazid oral* | 1 | MO; 100D |
| *itraconazole oral capsule* | 2 | PA |
| *ivermectin oral* | 2 | |
| JULUCA | 5 | QL (30 per 30 days) |
| KALETRA ORAL SOLUTION | 4 | QL (480 per 30 days) |
| *ketoconazole oral* | 1 | |
| *lamivudine oral solution* | 2 | QL (960 per 30 days); 90D |
| *lamivudine oral tablet 100 mg* | 2 | 90D |
| *lamivudine oral tablet 150 mg* | 2 | QL (60 per 30 days); 90D |
| *lamivudine oral tablet 300 mg* | 2 | QL (30 per 30 days); 90D |
| *lamivudine-zidovudine* | 2 | QL (60 per 30 days); 90D |
| *levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml* | 2 | |
| *levofloxacin intravenous* | 2 | |
| *levofloxacin oral solution* | 2 | |
| *levofloxacin oral tablet* | 1 | |
| *linezolid in sodium chloride* | 2 | |
| *linezolid intravenous solution 600 mg/300ml* | 2 | |
| *linezolid oral suspension reconstituted* | 5 | PA; QL (1800 per 30 days) |
| *linezolid oral tablet* | 4 | PA; QL (56 per 28 days) |
| LIVTENCITY | 5 | PA |
| *lopinavir-ritonavir oral tablet 100-25 mg* | 4 | QL (300 per 30 days) |
| *lopinavir-ritonavir oral tablet 200-50 mg* | 4 | QL (120 per 30 days) |
| *maraviroc* | 3 | QL (120 per 30 days) |

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|---|---|---|
| MAVYRET ORAL PACKET | 5 | PA; QL (180 per 30 days) |
| MAVYRET ORAL TABLET | 5 | PA; QL (90 per 30 days) |
| *mefloquine hcl* | 2 | MO; 90D |
| *meropenem intravenous solution reconstituted 1 gm, 500 mg* | 2 | |
| *methenamine hippurate* | 2 | |
| *metronidazole intravenous solution 500 mg/100ml* | 2 | |
| *metronidazole oral capsule* | 2 | |
| *metronidazole oral tablet* | 1 | |
| *micafungin sodium* | 4 | |
| *minocycline hcl oral capsule 100 mg, 75 mg* | 2 | |
| *minocycline hcl oral capsule 50 mg* | 1 | |
| *minocycline hcl oral tablet* | 2 | |
| MONDOXYNE NL ORAL CAPSULE 100 MG | 2 | |
| *moxifloxacin hcl in nacl* | 2 | |
| *moxifloxacin hcl oral* | 4 | |
| *nafcillin sodium injection solution reconstituted 1 gm, 2 gm* | 4 | |
| *nafcillin sodium intravenous solution reconstituted 10 gm* | 4 | |
| *neomycin sulfate oral* | 2 | |
| *nevirapine er oral tablet extended release 24 hour 400 mg* | 2 | QL (30 per 30 days); 90D |
| *nevirapine oral suspension* | 2 | QL (1200 per 30 days); 90D |
| *nevirapine oral tablet* | 2 | QL (60 per 30 days); 90D |
| *nitazoxanide oral* | 4 | QL (6 per 30 days) |
| *nitrofurantoin macrocrystal oral* | 2 | |
| *nitrofurantoin monohyd macro* | 2 | |
| NORVIR ORAL PACKET | 4 | QL (360 per 30 days) |
| NUZYRA | 5 | |
| *nystatin oral tablet* | 1 | |
| ODEFSEY | 5 | QL (30 per 30 days) |

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|---|---|---|
| *ofloxacin oral tablet 400 mg* | 2 | |
| *oseltamivir phosphate oral capsule 30 mg* | 2 | QL (168 per 365 days) |
| *oseltamivir phosphate oral capsule 45 mg, 75 mg* | 2 | QL (84 per 365 days) |
| *oseltamivir phosphate oral suspension reconstituted* | 2 | QL (1080 per 365 days) |
| PAXLOVID (150/100) | 2 | QL (20 per 90 days) |
| PAXLOVID (300/100 & 150/100) | 2 | QL (11 per 90 days) |
| PAXLOVID (300/100) | 2 | QL (30 per 90 days) |
| *penicillin g potassium* | 2 | |
| *penicillin g sodium* | 5 | |
| *penicillin v potassium oral solution reconstituted* | 2 | |
| *penicillin v potassium oral tablet* | 1 | |
| *pentamidine isethionate inhalation* | 2 | B/D PA |
| *pentamidine isethionate injection* | 2 | |
| PFIZERPEN INJECTION SOLUTION RECONSTITUTED 20000000 UNIT | 2 | |
| PIFELTRO | 5 | QL (30 per 30 days) |
| *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3-0.375 gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm* | 2 | |
| *posaconazole oral* | 5 | PA; MO |
| *praziquantel oral* | 4 | |
| *pretomanid* | 4 | PA |
| PREVYMIS ORAL PACKET | 5 | PA; QL (120 per 30 days) |
| PREVYMIS ORAL TABLET | 5 | PA; QL (30 per 30 days) |
| PREZCOBIX | 5 | QL (30 per 30 days) |
| PREZISTA ORAL SUSPENSION | 5 | QL (400 per 30 days) |
| PREZISTA ORAL TABLET 150 MG | 4 | QL (180 per 30 days) |
| PREZISTA ORAL TABLET 75 MG | 4 | QL (300 per 30 days) |
| PRIFTIN | 4 | |
| *primaquine phosphate oral tablet 26.3 (15 base) mg* | 4 | |

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|---|---|---|
| *pyrazinamide oral* | 2 | |
| *pyrimethamine oral* | 5 | PA |
| *quinine sulfate oral* | 2 | PA |
| RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT | 4 | QL (60 per 180 days) |
| RETROVIR INTRAVENOUS | 4 | |
| REYATAZ ORAL PACKET | 4 | QL (240 per 30 days) |
| *ribavirin oral capsule* | 2 | |
| *ribavirin oral tablet 200 mg* | 2 | |
| *rifabutin* | 2 | |
| *rifampin intravenous* | 4 | |
| *rifampin oral* | 2 | |
| *rifapentine* | 4 | |
| *rilpivirine hcl* | 5 | QL (30 per 30 days) |
| *rimantadine hcl* | 2 | |
| *ritonavir* | 2 | QL (360 per 30 days); 90D |
| RUKOBIA | 5 | QL (60 per 30 days); MO |
| SELZENTRY ORAL SOLUTION | 3 | QL (1840 per 30 days) |
| SIRTURO | 5 | PA |
| *sofosbuvir-velpatasvir* | 5 | PA; QL (30 per 30 days) |
| *streptomycin sulfate intramuscular* | 5 | |
| STRIBILD | 5 | QL (30 per 30 days) |
| *sulfadiazine oral* | 5 | |
| *sulfamethoxazole-trimethoprim oral* | 1 | |
| SUNLENCA ORAL TABLET | 5 | QL (10 per 365 days) |
| SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG | 5 | QL (8 per 365 days) |
| SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG | 5 | QL (10 per 365 days) |
| SUNLENCA SUBCUTANEOUS | 5 | QL (3 per 168 days); MO |
| SYMTUZA | 5 | QL (30 per 30 days) |

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|---|---|---|
| TAZICEF INJECTION SOLUTION RECONSTITUTED 1 GM | 2 | |
| TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED 2 GM, 6 GM | 2 | |
| *tenofovir disoproxil fumarate* | 2 | QL (30 per 30 days); 90D |
| *terbinafine hcl oral* | 1 | |
| *tetracycline hcl oral capsule* | 2 | |
| *tigecycline* | 4 | |
| *tinidazole oral* | 2 | |
| TIVICAY ORAL TABLET 50 MG | 5 | QL (60 per 30 days) |
| TIVICAY PD | 5 | QL (360 per 30 days) |
| *tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml* | 2 | |
| *trifluridine ophthalmic* | 2 | |
| *trimethoprim oral* | 1 | |
| TRIUMEQ | 5 | QL (30 per 30 days) |
| TRIUMEQ PD | 4 | QL (180 per 30 days) |
| TYBOST | 3 | QL (30 per 30 days) |
| *valacyclovir hcl oral tablet 1 gm* | 2 | QL (90 per 30 days) |
| *valacyclovir hcl oral tablet 500 mg* | 2 | QL (60 per 30 days) |
| *valganciclovir hcl oral solution reconstituted* | 4 | |
| *valganciclovir hcl oral tablet* | 3 | |
| *vancomycin hcl intravenous solution 1000 mg/200ml, 1250 mg/250ml, 1500 mg/300ml, 1750 mg/350ml, 2000 mg/400ml, 500 mg/100ml, 750 mg/150ml* | 3 | |
| *vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 100 gm, 500 mg, 750 mg* | 2 | |
| *vancomycin hcl oral capsule 125 mg* | 2 | QL (120 per 30 days) |
| *vancomycin hcl oral capsule 250 mg* | 4 | QL (240 per 30 days) |
| *vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml* | 2 | QL (1200 per 30 days) |
| VIRACEPT ORAL TABLET 250 MG | 5 | QL (300 per 30 days) |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| VIRACEPT ORAL TABLET 625 MG | 5 | QL (120 per 30 days) |
| VIREAD ORAL POWDER | 3 | QL (240 per 30 days) |
| VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG | 5 | QL (30 per 30 days) |
| *voriconazole intravenous solution reconstituted* | 4 | PA |
| *voriconazole oral suspension reconstituted* | 4 | PA; QL (300 per 30 days) |
| *voriconazole oral tablet 200 mg* | 4 | PA; QL (60 per 30 days) |
| *voriconazole oral tablet 50 mg* | 2 | PA; QL (120 per 30 days) |
| VOSEVI | 5 | PA; QL (30 per 30 days) |
| XIFAXAN ORAL TABLET 200 MG | 3 | PA; QL (9 per 3 days) |
| XIFAXAN ORAL TABLET 550 MG | 3 | PA; QL (84 per 28 days); MO |
| XOCOVA | 4 | QL (7 per 60 days) |
| *zidovudine oral capsule* | 2 | QL (180 per 30 days); 90D |
| *zidovudine oral syrup* | 2 | QL (1920 per 30 days); 90D |
| *zidovudine oral tablet* | 2 | QL (60 per 30 days); 90D |
| ZIRGAN | 3 | |
| **MISCELLANEOUS THERAPEUTIC AGENTS / AGENTES TERAPÉUTICOS VARIOS** | | |
| ALCOHOL SWABS | 2 | MO |
| *benzonatate oral capsule 100 mg, 200 mg* | 6 | QL (30 per 10 days); ED |
| GAUZE STERILE PADS 2 | 2 | MO |
| *hydrocodone bit-homatrop mbr* | 6 | ED |
| IGALMI SUBLINGUAL FILM 120 MCG | 5 | QL (30 per 30 days) |
| IGALMI SUBLINGUAL FILM 180 MCG | 4 | QL (30 per 30 days) |
| INSULIN PEN NEEDLE | 2 | QL (200 per 30 days); MO |
| INSULIN SYRINGE | 2 | QL (200 per 30 days); MO |
| KOSELUGO | 5 | PA |
| OMNIPOD 5 DEXG7G6 INTRO GEN 5 | 4 | PA |
| OMNIPOD 5 DEXG7G6 PODS GEN 5 | 4 | PA |
| OMNIPOD 5 LIBRE INTRO | 4 | PA |
| OMNIPOD 5 LIBRE PODS | 4 | PA |
| OMNIPOD DASH INTRO (GEN 4) | 4 | PA |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| OMNIPOD DASH PODS (GEN 4) | 4 | PA |
| *promethazine-codeine* | 6 | ED |
| *promethazine-dm oral syrup 6.25-15 mg/5ml* | 6 | ED |
| *sodium chloride irrigation solution 0.9 %* | 1 | |
| WEGOVY ORAL TABLET 1.5 MG | 3 | PA; QL (60 per 365 days) |
| WEGOVY ORAL TABLET 25 MG, 4 MG, 9 MG | 3 | PA; QL (30 per 30 days) |
| WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML | 3 | PA; QL (2 per 28 days) |
| WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML | 3 | PA; QL (3 per 28 days) |
| **OPHTHALMIC AGENTS / AGENTES OFTÁLMICOS** | | |
| *acetazolamide er* | 2 | MO; 90D |
| *atropine sulfate ophthalmic solution 1 %* | 2 | MO; 90D |
| *azelastine hcl ophthalmic* | 2 | |
| *bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm* | 1 | |
| *bacitra-neomycin-polymyxin-hc* | 2 | |
| *besifloxacin hcl* | 4 | |
| *betaxolol hcl ophthalmic* | 2 | MO; 90D |
| *bimatoprost ophthalmic solution 0.01 %* | 3 | MO |
| *bimatoprost ophthalmic solution 0.03 %* | 2 | MO; 90D |
| *brimonidine tartrate ophthalmic* | 2 | MO; 90D |
| *brimonidine tartrate-timolol* | 2 | MO; 90D |
| *brinzolamide* | 2 | MO; 90D |
| *bromfenac sodium ophthalmic solution 0.07 %, 0.075 %* | 2 | |
| *carteolol hcl* | 1 | MO; 100D |
| *ciprofloxacin hcl ophthalmic* | 1 | |
| *cromolyn sodium ophthalmic* | 1 | |
| *cyclopentolate hcl ophthalmic solution 1 %* | 2 | MO; 90D |
| CYSTARAN | 5 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *dexamethasone sodium phosphate ophthalmic* | 2 | |
| *diclofenac sodium ophthalmic* | 1 | |
| *difluprednate* | 2 | |
| *dorzolamide hcl ophthalmic* | 1 | MO; 100D |
| *dorzolamide hcl-timolol mal* | 1 | MO; 100D |
| *dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %* | 1 | MO; 100D |
| *erythromycin ophthalmic* | 1 | QL (3.5 per 30 days) |
| *fluorometholone ophthalmic* | 2 | |
| *flurbiprofen sodium* | 2 | |
| FML FORTE | 4 | |
| *gatifloxacin ophthalmic* | 2 | |
| *gentamicin sulfate ophthalmic solution* | 1 | |
| ILEVRO | 3 | |
| *ketorolac tromethamine ophthalmic* | 2 | |
| *latanoprost ophthalmic* | 1 | MO; 100D |
| *levobunolol hcl ophthalmic solution 0.5 %* | 1 | MO; 100D |
| *levofloxacin ophthalmic* | 2 | |
| *loteprednol etabonate* | 2 | |
| *loteprednol-tobramycin* | 4 | |
| LUMIGAN OPHTHALMIC SOLUTION 0.01 % | 3 | MO |
| *methazolamide oral* | 2 | MO; 90D |
| *moxifloxacin hcl (2x day)* | 2 | |
| *moxifloxacin hcl ophthalmic solution* | 2 | |
| NATACYN | 4 | |
| *neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000* | 2 | |
| *neomycin-polymyxin-dexameth* | 1 | |
| *neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025* | 2 | |
| *neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1* | 2 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *ofloxacin ophthalmic* | 1 | |
| *olopatadine hcl ophthalmic solution 0.2 % (rx)* | 2 | |
| OXERVATE | 5 | PA |
| *pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %* | 2 | MO; 90D |
| POLYCIN | 1 | |
| *polymyxin b-trimethoprim* | 1 | |
| *prednisolone acetate ophthalmic* | 2 | |
| *prednisolone sodium phosphate ophthalmic* | 3 | |
| *proparacaine hcl ophthalmic* | 1 | |
| RESTASIS | 3 | QL (60 per 30 days); MO |
| RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % | 3 | QL (5.5 per 28 days); MO |
| RHOPRESSA | 3 | MO |
| ROCKLATAN | 3 | MO |
| SIMBRINZA | 4 | MO |
| *sulfacetamide sodium ophthalmic solution* | 1 | |
| *sulfacetamide-prednisolone ophthalmic solution* | 2 | |
| *timolol maleate (once-daily)* | 1 | MO; 100D |
| *timolol maleate ophthalmic gel forming solution* | 2 | MO; 90D |
| *timolol maleate ophthalmic solution* | 1 | MO; 100D |
| TOBRADEX OPHTHALMIC OINTMENT | 4 | |
| TOBRADEX ST | 4 | |
| *tobramycin ophthalmic* | 1 | |
| *tobramycin-dexamethasone* | 2 | |
| TOBREX OPHTHALMIC OINTMENT | 4 | |
| *travoprost (bak free)* | 2 | MO; 90D |
| VYZULTA | 4 | MO |
| XDEMVY | 5 | PA |
| XIIDRA | 3 | QL (60 per 30 days); MO |
| **OTIC AGENTS / AGENTES ÓTICOS** | | |
| *acetic acid otic* | 1 | |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *ciprofloxacin hcl otic* | 2 | |
| *ciprofloxacin-dexamethasone* | 2 | |
| FLAC | 2 | |
| *fluocinolone acetonide otic* | 2 | |
| *hydrocortisone-acetic acid* | 2 | |
| *neomycin-polymyxin-hc otic* | 2 | |
| *ofloxacin otic* | 2 | |
| **RESPIRATORY TRACT/PULMONARY AGENTS / AGENTES PULMONARES/DE LAS VÍAS RESPIRATORIAS** | | |
| *acetylcysteine inhalation* | 2 | B/D PA |
| ADEMPAS | 5 | PA; QL (90 per 30 days) |
| *albuterol sulfate hfa* | 2 | MO; 90D |
| *albuterol sulfate inhalation* | 2 | B/D PA; MO; 90D |
| *albuterol sulfate oral syrup* | 1 | MO; 100D |
| *albuterol sulfate oral tablet* | 2 | MO; 90D |
| ALYQ | 4 | PA; QL (60 per 30 days) |
| *ambrisentan oral tablet 10 mg* | 5 | PA; QL (30 per 30 days) |
| *ambrisentan oral tablet 5 mg* | 4 | PA; QL (30 per 30 days) |
| *arformoterol tartrate* | 4 | B/D PA; QL (120 per 30 days); MO |
| ARNUITY ELLIPTA | 3 | QL (30 per 30 days); MO |
| ATROVENT HFA | 3 | QL (26 per 30 days); MO |
| *azelastine hcl nasal solution 0.1 %, 137 mcg/spray* | 2 | QL (30 per 25 days) |
| *azelastine-fluticasone* | 2 | QL (23 per 28 days) |
| *bosentan oral tablet* | 5 | PA; QL (60 per 30 days) |
| BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH | 3 | QL (60 per 30 days); MO |
| *breyna* | 3 | QL (30.9 per 30 days); MO |
| BREZTRI AEROSPHERE | 3 | QL (10.7 per 30 days); MO |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml* | 2 | B/D PA; QL (120 per 30 days); MO; 90D |
| *budesonide inhalation suspension 1 mg/2ml* | 2 | B/D PA; QL (60 per 30 days); MO; 90D |
| *budesonide-formoterol fumarate* | 3 | QL (30.6 per 30 days); MO |
| CAYSTON | 5 | PA |
| *cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml (rx)* | 1 | |
| *clemastine fumarate oral tablet 2.68 mg* | 2 | PA; HRM |
| COMBIVENT RESPIMAT | 4 | QL (8 per 30 days); MO |
| *cromolyn sodium inhalation* | 2 | B/D PA; MO; 90D |
| *cyproheptadine hcl oral syrup* | 1 | PA; HRM |
| *cyproheptadine hcl oral tablet* | 1 | |
| DULERA | 4 | QL (13 per 30 days); MO |
| *epinephrine injection solution 0.3 mg/0.3ml* | 2 | QL (2 per 28 days) |
| *epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml* | 2 | QL (2 per 28 days) |
| FASENRA PEN | 5 | PA; QL (1 per 28 days) |
| FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML | 5 | PA; QL (0.5 per 28 days) |
| FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML | 5 | PA; QL (1 per 28 days) |
| *flunisolide nasal solution 25 mcg/act (0.025%)* | 1 | QL (75 per 30 days) |
| *fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act* | 3 | QL (60 per 30 days); MO |
| *fluticasone propionate nasal (rx)* | 1 | QL (16 per 30 days) |
| *fluticasone-salmeterol inhalation aerosol* | 3 | QL (12 per 30 days); MO |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (60 per 30 days); MO; 90D |
| *fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act* | 2 | QL (1 per 30 days); MO; 90D |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *hydroxyzine hcl oral syrup* | 3 | PA; HRM |
| *hydroxyzine hcl oral tablet* | 1 | PA; HRM |
| *hydroxyzine pamoate oral capsule 100 mg* | 3 | PA; HRM |
| *hydroxyzine pamoate oral capsule 25 mg, 50 mg* | 2 | PA; HRM |
| *ipratropium bromide hfa* | 3 | QL (26 per 30 days); MO |
| *ipratropium bromide inhalation* | 1 | B/D PA; MO; 100D |
| *ipratropium bromide nasal* | 1 | MO; 100D |
| *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml* | 2 | B/D PA; QL (540 per 30 days); MO; 90D |
| KALYDECO ORAL PACKET | 5 | PA; QL (56 per 28 days) |
| *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml* | 2 | B/D PA; QL (270 per 30 days); MO; 90D |
| *levalbuterol hcl inhalation nebulization solution 0.63 mg/3ml* | 2 | B/D PA; QL (540 per 30 days); MO; 90D |
| *levalbuterol tartrate* | 2 | QL (45 per 30 days); MO; 90D |
| *levocetirizine dihydrochloride oral tablet (rx)* | 1 | |
| *macitentan* | 5 | PA; QL (30 per 30 days) |
| *mometasone furoate nasal (rx)* | 2 | |
| *montelukast sodium oral* | 2 | MO; 90D |
| *nintedanib esylate* | 5 | PA; QL (60 per 30 days) |
| NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR | 5 | PA; QL (3 per 28 days) |
| NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML | 5 | PA; QL (3 per 28 days) |
| NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML | 5 | PA; QL (0.4 per 28 days) |
| NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED | 5 | PA; QL (3 per 28 days) |
| OFEV | 5 | PA; QL (60 per 30 days) |
| *olopatadine hcl nasal* | 2 | QL (31 per 30 days) |
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG | 4 | PA |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG | 5 | PA |
| ORKAMBI ORAL PACKET | 5 | PA; QL (60 per 30 days) |
| *pirfenidone oral tablet 267 mg* | 3 | PA; QL (270 per 30 days) |
| *pirfenidone oral tablet 534 mg* | 5 | PA; QL (90 per 30 days) |
| *pirfenidone oral tablet 801 mg* | 3 | PA; QL (90 per 30 days) |
| PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML | 5 | B/D PA |
| *roflumilast* | 2 | QL (30 per 30 days); MO; 90D |
| SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT | 3 | QL (60 per 30 days); MO |
| *sildenafil citrate oral tablet 20 mg* | 2 | PA; QL (360 per 30 days); 90D |
| SPIRIVA RESPIMAT | 3 | QL (4 per 30 days); MO |
| STIOLTO RESPIMAT | 3 | QL (4 per 30 days); MO |
| SYMDEKO | 5 | PA; QL (56 per 28 days) |
| *tadalafil (pah)* | 4 | PA; QL (60 per 30 days) |
| *theophylline er oral tablet extended release 12 hour 300 mg* | 1 | MO; 100D |
| *theophylline er oral tablet extended release 24 hour* | 1 | MO; 100D |
| *theophylline oral* | 2 | MO; 90D |
| *tiotropium bromide* | 3 | QL (30 per 30 days); MO |
| TOBI PODHALER | 5 | QL (224 per 28 days) |
| *tobramycin inhalation nebulization solution 300 mg/5ml* | 5 | B/D PA; QL (280 per 28 days) |
| TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT | 3 | QL (60 per 30 days); MO |
| TRIKAFTA ORAL TABLET THERAPY PACK | 5 | PA; QL (84 per 28 days) |
| TRIKAFTA ORAL THERAPY PACK | 5 | PA; QL (56 per 28 days) |
| *umeclidinium-vilanterol* | 3 | QL (60 per 30 days); MO |
| WINREVAIR | 5 | PA |

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| DRUG NAME / NOMBRE DE MEDICAMENTO | DRUG TIER / NIVEL | REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES |
|---|---|---|
| *wixela inhub inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act* | 2 | QL (60 per 30 days); MO; 90D |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML | 5 | PA; QL (8 per 28 days) |
| XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML | 5 | PA; QL (4 per 28 days) |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML | 5 | PA; QL (8 per 28 days) |
| XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML | 5 | PA; QL (4 per 28 days) |
| XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED | 5 | PA; QL (8 per 28 days) |
| *zafirlukast* | 2 | MO; 90D |

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# Index / Índice


**A**

*abacavir sulfate* ..... 96
*abacavir sulfate-lamivudine* ..... 96
ABILIFY ASIMTUFII ..... 45
ABILIFY MAINTENA ..... 45
*abiraterone acetate* ..... 25
ABIRTEGA ..... 25
ABRYSVO ..... 89
*acamprosate calcium* ... 45
*acarbose* ..... 72
ACCUTANE ..... 65
*acebutolol hcl* ..... 37
*acetaminophen-codeine* ..... 23
*acetazolamide* ..... 37
*acetazolamide er* ..... 108
*acetic acid* ..... 110
*acetylcysteine* ..... 111
*acitretin* ..... 65
ACTHIB ..... 89
ACTIMMUNE ..... 89
*acyclovir* ..... 65, 96
*acyclovir sodium* ..... 96
ADACEL ..... 89
*adefovir dipivoxil* ..... 96
ADEMPAS ..... 111
AIMOVIG ..... 45
AKEEGA ..... 25
*ala-cort* ..... 65
*albendazole* ..... 96
*albuterol sulfate* ..... 111
*albuterol sulfate hfa* ..... 111
*alclometasone dipropionate* ..... 65
ALCOHOL SWABS ..... 107
ALECENSA ..... 26
*alendronate sodium* ..... 72
*alfuzosin hcl er* ..... 81
*aliskiren fumarate* ..... 37
*allopurinol* ..... 23
*almotriptan malate* ..... 45
*alosetron hcl* ..... 78
*alprazolam* ..... 45
*alprazolam er* ..... 45
ALPRAZOLAM INTENSOL . 45
*alprazolam xr* ..... 45
ALTAVERA ..... 83
ALUNBRIG ..... 26
ALYQ ..... 111
*amantadine hcl* ..... 45
*ambrisentan* ..... 111
*amikacin sulfate* ..... 96
*amiloride hcl* ..... 37
*amiloride-hydrochlorothiazide* .... 37
AMINOSYN II ..... 69
*amiodarone hcl* ..... 37
*amitriptyline hcl* ..... 45
*amlodipine besy-benazepril hcl* ..... 37
*amlodipine besylate* ..... 37
*amlodipine besylate-valsartan* ..... 37, 38
*amlodipine-atorvastatin* . 38
*amlodipine-olmesartan* .. 38
*amlodipine-valsartan-hctz* ..... 38
*ammonium lactate* ..... 65
AMNESTEEM ..... 65
*amoxapine* ..... 45
*amoxicill-clarithro-lansopraz* ..... 78
*amoxicillin* ..... 96
*amoxicillin trihydrate* ..... 96
*amoxicillin-pot clavulanate* ..... 96
*amoxicillin-pot clavulanate er* ..... 96
*amphetamine-dextroamphet er* ..... 45
*amphetamine-dextroamphetamine* . 45, 46
*amphotericin b* ..... 96
*amphotericin b liposome* ..... 96
*ampicillin* ..... 96
*ampicillin sodium* ..... 97
*ampicillin-sulbactam sodium* ..... 97
*anagrelide hcl* ..... 34
*anastrozole* ..... 26
APLENZIN ..... 46
*apomorphine hcl* ..... 46
*aprepitant* ..... 78
APRI ..... 83
APTIVUS ..... 97
ARCALYST ..... 89
AREXVY ..... 89
*arformoterol tartrate* ..... 111
ARIKAYCE ..... 97
*aripiprazole* ..... 46
ARISTADA ..... 46
ARISTADA INITIO ..... 46
ARNUITY ELLIPTA ..... 111
*asenapine maleate* ..... 46
*aspirin-dipyridamole er* ... 34
*atazanavir sulfate* ..... 97
*atenolol* ..... 38
*atenolol-chlorthalidone* .. 38
*atomoxetine hcl* ..... 46
*atorvastatin calcium* ..... 38
*atovaquone* ..... 97
*atovaquone-proguanil hcl* ..... 97
*atropine sulfate* ..... 108
ATROVENT HFA ..... 111
AUGTYRO ..... 26
AUROVELA 1.5/30 ..... 83
AUROVELA 1/20 ..... 83
AUROVELA 24 FE ..... 83
AUROVELA FE 1/20 ..... 83
AUSTEDO ..... 46
AUSTEDO XR ..... 47
AUSTEDO XR PATIENT TITRATION ..... 47
AUVELITY ..... 47
AUVELITY TITRATION PACK ..... 47
AVMAPKI FAKZYNJA CO-PACK ..... 26
AYUNA ..... 83
AYVAKIT ..... 26
AZASAN ..... 89
*azathioprine* ..... 89
*azelaic acid* ..... 65
*azelastine hcl* ..... 108, 111

*azelastine-fluticasone* ... 111
*azithromycin* ..... 97
*aztreonam* ..... 97
AZURETTE ..... 83
**B**
BAC (BUTALBITAL-ACETAMIN-CAFF) ..... 47
*bacitracin-polymyxin b* 108
*bacitra-neomycin-polymyxin-hc* ..... 108
*baclofen* ..... 47
*balsalazide disodium* ..... 78
BALVERSA ..... 26
BARACLUDE ..... 97
*bcg vaccine* ..... 89
*benazepril hcl* ..... 38
*benazepril-hydrochlorothiazide* .... 38
BENLYSTA ..... 89
*benzonatate* ..... 107
*benzoyl peroxide-erythromycin* ..... 65
*benztropine mesylate* ..... 47
*besifloxacin hcl* ..... 108
BESREMI ..... 26
BESREMI PEN ..... 26
*betaine* ..... 81
*betamethasone dipropionate* ..... 65
*betamethasone dipropionate aug* ..... 65
*betamethasone valerate* ..... 65
BETASERON ..... 47
*betaxolol hcl* ..... 38, 108
*bethanechol chloride* .... 82
*bexarotene* ..... 26, 65
BEXSERO ..... 89
*bicalutamide* ..... 26
BICILLIN C-R ..... 97
BICILLIN L-A ..... 97
BIJUVA ..... 83
BIKTARVY ..... 97
*bimatoprost* ..... 108
BIMZELX ..... 89, 90
*bis subcit-metronid-tetracyc* ..... 78
*bismuth/metronidaz/tetracyclin* ..... 78
*bisoprolol fumarate* ..... 38
*bisoprolol-hydrochlorothiazide* .... 38
BIVIGAM ..... 90
BLISOVI 24 FE ..... 83
BLISOVI FE 1/20 ..... 83
BOOSTRIX ..... 90
*bosentan* ..... 111
BOSULIF ..... 26
*bosutinib* ..... 26
BRAFTOVI ..... 26
BREO ELLIPTA ..... 111
*breyna* ..... 111
BREZTRI AEROSPHERE ..... 111
*brimonidine tartrate* ..... 108
*brimonidine tartrate-timolol* ..... 108
*brinzolamide* ..... 108
*brivaracetam* ..... 47
*bromfenac sodium* ..... 108
*bromocriptine mesylate* . 47
BRUKINSA ..... 26
*budesonide* ..... 78, 112
*budesonide er* ..... 78
*budesonide-formoterol fumarate* ..... 112
*bumetanide* ..... 38
*buprenorphine* ..... 23
*buprenorphine hcl* ..... 47
*buprenorphine hcl-naloxone hcl* ..... 47
*bupropion hcl* ..... 48
*bupropion hcl er (smoking det)* ..... 47
*bupropion hcl er (sr)* . 47, 48
*bupropion hcl er (xl)* ..... 48
*buspirone hcl* ..... 48
*butalbital-acetaminophen* ..... 48
*butalbital-apap-caffeine* 48
*butorphanol tartrate* ..... 23
BYSANTI ..... 48
BYSANTI TITRATION PACK A ..... 48
BYSANTI TITRATION PACK B ..... 48
BYSANTI TITRATION PACK C ..... 48
**C**
CABENUVA ..... 97
*cabergoline* ..... 83
CABOMETYX ..... 26
*calcipotriene* ..... 65
*calcitonin (salmon)* ..... 72
CALCITRENE ..... 65
*calcitriol* ..... 72
*calcium acetate (phos binder)* ..... 72
CALQUENCE ..... 26
CAMILA ..... 83
*candesartan cilexetil* ..... 38
*candesartan cilexetil-hctz* ..... 38
CAPLYTA ..... 48
CAPRELSA ..... 26
*captopril* ..... 38
*captopril-hydrochlorothiazide* .... 39
*carbamazepine* ..... 48
*carbamazepine er* ..... 48
*carbidopa* ..... 48
*carbidopa-levodopa* ..... 48
*carbidopa-levodopa er* . 48
*carbidopa-levodopa-entacapone* ..... 48
*carglumic acid* ..... 69
*carisoprodol* ..... 48
*carteolol hcl* ..... 108
CARTIA XT ..... 39
*carvedilol* ..... 39
*carvedilol phosphate er* . 39
*caspofungin acetate* ..... 97
CAYSTON ..... 112
*cefaclor* ..... 97
*cefaclor er* ..... 97
*cefadroxil* ..... 98
*cefazolin sodium* ..... 98
*cefdinir* ..... 98
*cefepime hcl* ..... 98
*cefixime* ..... 98
*cefoxitin sodium* ..... 98
*cefpodoxime proxetil* ..... 98
*cefprozil* ..... 98
*ceftaroline fosamil* ..... 98

*ceftazidime* ..... 98
*ceftriaxone sodium* ..... 98
*ceftriaxone sodium in dextrose* ..... 98
*cefuroxime axetil* ..... 98
*cefuroxime sodium* ..... 98
*celecoxib* ..... 23
*cephalexin* ..... 98
*cetirizine hcl* ..... 112
*cevimeline hcl* ..... 65
CHARLOTTE 24 FE ..... 83
CHATEAL EQ ..... 83
*chlordiazepoxide hcl* ..... 49
*chlordiazepoxide-amitriptyline* ..... 49
*chlordiazepoxide-clidinium* ..... 78
*chlorhexidine gluconate* 65
*chloroquine phosphate* . 99
*chlorpromazine hcl* ..... 49
*chlorthalidone* ..... 39
*chlorzoxazone* ..... 49
*cholestyramine* ..... 39
*cholestyramine light* ..... 39
CICLODAN ..... 65
*ciclopirox* ..... 65
*ciclopirox olamine* ..... 65
*cilostazol* ..... 34
CIMDUO ..... 99
*cimetidine* ..... 78
*cinacalcet hcl* ..... 72
*ciprofloxacin hcl* .... 99, 108, 111
*ciprofloxacin in d5w* ..... 99
*ciprofloxacin-dexamethasone* ..... 111
*citalopram hydrobromide* ..... 49
CLARAVIS ..... 66
*clarithromycin* ..... 99
*clarithromycin er* ..... 99
*clemastine fumarate* .... 112
CLENPIQ ..... 78
CLIMARA PRO ..... 83
CLINDACIN ETZ ..... 66
CLINDACIN-P ..... 66
*clindamycin hcl* ..... 99
*clindamycin palmitate hcl* ..... 99
*clindamycin phos (once-daily)* ..... 66
*clindamycin phos (twice-daily)* ..... 66
*clindamycin phosphate* 66, 82, 99
*clindamycin phosphate in d5w* ..... 99
CLINIMIX E/DEXTROSE (2.75/5) ..... 70
CLINIMIX E/DEXTROSE (4.25/10) ..... 70
CLINIMIX E/DEXTROSE (4.25/5) ..... 70
CLINIMIX E/DEXTROSE (5/15) ..... 70
CLINIMIX E/DEXTROSE (5/20) ..... 70
*clinimix e/dextrose (8/10)* 70
*clinimix e/dextrose (8/14)* 70
CLINIMIX/DEXTROSE (4.25/10) ..... 70
CLINIMIX/DEXTROSE (4.25/5) ..... 70
CLINIMIX/DEXTROSE (5/15) ..... 70
CLINIMIX/DEXTROSE (5/20) ..... 70
*clinimix/dextrose (6/5)* .... 70
*clinimix/dextrose (8/10)* .. 70
*clinimix/dextrose (8/14)* .. 70
CLINISOL SF ..... 70
CLINOLIPID ..... 70
*clobazam* ..... 49
*clobetasol prop emollient base* ..... 66
*clobetasol propionate* ... 66
*clobetasol propionate e* 66
CLODAN ..... 66
*clomipramine hcl* ..... 49
*clonazepam* ..... 49
*clonidine* ..... 39
*clonidine hcl* ..... 39
*clonidine hcl er* ..... 49
*clopidogrel bisulfate* ..... 34
*clorazepate dipotassium* 49
*clotrimazole* ..... 66
*clotrimazole-betamethasone* ..... 66
*clozapine* ..... 49
COARTEM ..... 99
COBENFY ..... 49
COBENFY STARTER PACK 49
*colchicine* ..... 23
*colchicine-probenecid* .. 23
*colesevelam hcl* ..... 39
*colestipol hcl* ..... 39
*colistimethate sodium (cba)* ..... 99
COMBIVENT RESPIMAT .. 112
COMETRIQ (100 MG DAILY DOSE) ..... 27
COMETRIQ (140 MG DAILY DOSE) ..... 27
COMETRIQ (60 MG DAILY DOSE) ..... 27
COMPRO ..... 78
*constulose* ..... 78
COPIKTRA ..... 27
CORLANOR ..... 39
COSENTYX ..... 90
COSENTYX (300 MG DOSE) ..... 90
COSENTYX SENSOREADY (300 MG) ..... 90
COSENTYX SENSOREADY PEN ..... 90
COSENTYX UNOREADY ... 90
COTELLIC ..... 27
CREON ..... 81
CRESEMBA ..... 99
*cromolyn sodium* .... 81, 108, 112
CRYSELLE ..... 83
CRYSELLE-28 ..... 83
*cyclobenzaprine hcl* . 49, 50
*cyclopentolate hcl* ..... 108
*cyclophosphamide* ..... 27
*cyclosporine* ..... 90
*cyclosporine modified* .... 90
*cyproheptadine hcl* ..... 112
CYRED EQ ..... 83
CYSTAGON ..... 81
CYSTARAN ..... 108

**D**
*dabigatran etexilate mesylate* ..... 34
*dalfampridine er* ..... 50
*danazol* ..... 83
DANZITEN ..... 27
*dapagliflozin base-metformin er* ..... 72
*dapagliflozin* ..... 72
*dapsone* ..... 99
DAPTACEL ..... 90
*daptomycin* ..... 99
*darifenacin hydrobromide er* ..... 82
*darunavir* ..... 99
DARZALEX FASPRO ..... 27
*dasatinib* ..... 27
DAURISMO ..... 27
DEBLITANE ..... 83
*deferasirox* ..... 72
DELSTRIGO ..... 99
DEPO-SUBQ PROVERA 104 ..... 83
DEPO-TESTOSTERONE ..... 83
DESCOVY ..... 99
*desipramine hcl* ..... 50
*desmopressin ace spray refrig* ..... 83
*desmopressin acetate* ... 83
*desmopressin acetate spray* ..... 84
*desogestrel-ethinyl estradiol* ..... 84
*desonide* ..... 66
*desoximetasone* ..... 66
*desvenlafaxine er* ..... 50
*desvenlafaxine succinate er* ..... 50
*dexamethasone* ..... 84
*dexamethasone sodium phosphate* ..... 109
*dexlansoprazole* ..... 78
*dexmethylphenidate hcl* 50
*dexmethylphenidate hcl er* ..... 50
*dextroamphetamine sulfate* ..... 50
*dextroamphetamine sulfate er* ..... 50
*dextrose* ..... 70
*dextrose-nacl* ..... 70
*dextrose-sodium chloride* ..... 70
DIACOMIT ..... 50
*diazepam* ..... 50
DIAZEPAM INTENSOL ..... 50
*diazoxide* ..... 72
*diclofenac potassium* ..... 23
*diclofenac sodium* ... 23, 66, 109
*diclofenac sodium er* ..... 23
*diclofenac-misoprostol* ... 23
*dicloxacillin sodium* ..... 99
*dicyclomine hcl* ..... 78
DIFICID ..... 99
*diflunisal* ..... 23
*difluprednate* ..... 109
*digox* ..... 39
*digoxin* ..... 39
*dihydroergotamine mesylate* ..... 51
DILANTIN ..... 51
*diltiazem hcl* ..... 40
*diltiazem hcl er* ..... 39, 40
*diltiazem hcl er beads* .... 39
*diltiazem hcl er coated beads* ..... 39
*dilt-xr* ..... 40
*dimethyl fumarate* ..... 51
*dimethyl fumarate starter pack* ..... 51
*diphenoxylate-atropine* . 78
*dipyridamole* ..... 34
*disopyramide phosphate* ..... 40
*disulfiram* ..... 51
*divalproex sodium* ..... 51
*divalproex sodium er* ..... 51
*dofetilide* ..... 40
*donepezil hcl* ..... 51
*dorzolamide hcl* ..... 109
*dorzolamide hcl-timolol mal* ..... 109
*dorzolamide hcl-timolol mal pf* ..... 109
DOVATO ..... 99
*doxazosin mesylate* ..... 40
*doxepin hcl* ..... 51
*doxercalciferol* ..... 72
DOXY 100 ..... 99
*doxycycline hyclate* ..... 99
*doxycycline monohydrate* ..... 100
DRIZALMA SPRINKLE ..... 51
*dronabinol* ..... 78
*drospirenone-ethinyl estradiol* ..... 84
DROXIA ..... 35
*droxidopa* ..... 40
DULERA ..... 112
*duloxetine hcl* ..... 51, 52
DUPIXENT ..... 66, 67
*dutasteride* ..... 82
*dutasteride-tamsulosin hcl* ..... 82

**E**
E.E.S. 400 ..... 100
*econazole nitrate* ..... 67
EDURANT ..... 100
EDURANT PED ..... 100
*efavirenz* ..... 100
*efavirenz-emtricitab-tenofo df* ..... 100
*efavirenz-lamivudine-tenofovir* ..... 100
*eletriptan hydrobromide* 52
ELIGARD ..... 27
ELINEST ..... 84
ELIQUIS ..... 35
ELIQUIS (1.5 MG PACK) ... 35
ELIQUIS (2 MG PACK) ..... 35
ELIQUIS DVT/PE STARTER PACK ..... 35
*eltrombopag olamine* .... 35
ELURYNG ..... 84
EMSAM ..... 52
*emtricitabine* ..... 100
*emtricitabine-tenofovir df* ..... 100
*emtricitab-rilpivir-tenofov df* ..... 100
EMTRIVA ..... 100
EMVERM ..... 100

EMZAHH ..... 84
*enalapril maleate* ..... 40
*enalapril-hydrochlorothiazide* .... 40
ENBREL ..... 90
ENBREL MINI ..... 90
ENBREL SURECLICK ..... 90
ENDOCET ..... 23
ENGERIX-B ..... 90, 91
ENILLORING ..... 84
*enoxaparin sodium* ..... 35
ENSACOVE ..... 27
ENSKYCE ..... 84
*entacapone* ..... 52
*entecavir* ..... 100
ENTRESTO ..... 40
ENTYVIO PEN ..... 91
*enulose* ..... 78
ENVARSUS XR ..... 91
EPIDIOLEX ..... 52
*epinephrine* ..... 112
*eplerenone* ..... 40
ERAXIS ..... 100
*ergotamine-caffeine* ..... 52
ERIVEDGE ..... 27
ERLEADA ..... 27
*erlotinib hcl* ..... 27
ERRIN ..... 84
*ertapenem sodium* ..... 100
ERY-TAB ..... 100
*erythromycin* ... 67, 101, 109
*erythromycin base* ..... 100
*erythromycin ethylsuccinate* ..... 101
*escitalopram oxalate* ..... 52
*eslicarbazepine acetate* 52
*esomeprazole magnesium* ..... 79
ESTARYLLA ..... 84
*estazolam* ..... 52
*estradiol* ..... 84
*estrogens conjugated* .... 84
*eszopiclone* ..... 52
*ethambutol hcl* ..... 101
*ethosuximide* ..... 52
*ethynodiol diac-eth estradiol* ..... 84
*etodolac* ..... 23
*etodolac er* ..... 23
*etonogestrel-ethinyl estradiol* ..... 84
*etravirine* ..... 101
EUCRISA ..... 67
EULEXIN ..... 27
*everolimus* ..... 27, 91
EVOTAZ ..... 101
*exemestane* ..... 27
EXXUA ..... 52
EXXUA TITRATION PACK .. 52
*ezetimibe* ..... 40
*ezetimibe-simvastatin* ..... 40

**F**

*famciclovir* ..... 101
*famotidine* ..... 79
FANAPT ..... 52
FANAPT TITRATION PACK A ..... 52
FANAPT TITRATION PACK B ..... 52
FANAPT TITRATION PACK C ..... 52
FARXIGA ..... 72
FASENRA ..... 112
FASENRA PEN ..... 112
*febuxostat* ..... 23
FEIRZA 1/20 ..... 84
*felbamate* ..... 52
*felodipine er* ..... 40
*fenofibrate* ..... 40
*fenofibrate micronized* ... 40
*fenofibric acid* ..... 40
*fentanyl* ..... 23
FETZIMA ..... 53
FETZIMA TITRATION ..... 53
FIASP ..... 73
FIASP FLEXTOUCH ..... 73
FIASP PENFILL ..... 73
FIASP PUMPCART ..... 73
*fidaxomicin* ..... 101
FILSPARI ..... 82
*finasteride* ..... 82
*fingolimod hcl* ..... 53
FINTEPLA ..... 53
FINZALA ..... 84
FIRMAGON ..... 27
FIRMAGON (240 MG DOSE) ..... 27
FLAC ..... 111
FLEBOGAMMA DIF ..... 91
*flecainide acetate* ..... 40
*fluconazole* ..... 101
*fluconazole in sodium chloride* ..... 101
*flucytosine* ..... 101
*fludrocortisone acetate* . 84
*flunisolide* ..... 112
*fluocinolone acetonide* 67, 111
*fluocinolone acetonide body* ..... 67
*fluocinolone acetonide scalp* ..... 67
*fluocinonide* ..... 67
*fluocinonide emulsified base* ..... 67
*fluorometholone* ..... 109
*fluorouracil* ..... 67
*fluoxetine hcl* ..... 53
*fluphenazine decanoate* ..... 53
*fluphenazine hcl* ..... 53
*flurazepam hcl* ..... 53
*flurbiprofen* ..... 23
*flurbiprofen sodium* ..... 109
*fluticasone furoate-vilanterol* ..... 112
*fluticasone propionate* .. 67, 112
*fluticasone-salmeterol* .. 112
*fluvastatin sodium* ..... 40
*fluvastatin sodium er* ..... 40
*fluvoxamine maleate* ..... 53
FML FORTE ..... 109
*folic acid* ..... 70
*fondaparinux sodium* ..... 35
*fosamprenavir calcium* 101
*fosaprepitant dimeglumine* ..... 79
*fosfomycin tromethamine* ..... 101
*fosinopril sodium* ..... 40
*fosinopril sodium-hctz* ..... 40
FOTIVDA ..... 27

FRAGMIN ..... 36
FRUZAQLA ..... 27, 28
*furosemide* ..... 40
**G**
*gabapentin* ..... 53
*gabapentin (once-daily)* 53
GALAFOLD ..... 81
*galantamine hydrobromide* ..... 54
*galantamine hydrobromide er* ..... 54
GALLIFREY ..... 84
GAMMAGARD ..... 91
GAMMAGARD S/D LESS IGA ..... 91
GAMMAKED ..... 91
GAMMAPLEX ..... 91
GAMUNEX-C ..... 91
GARDASIL 9 ..... 91
*gatifloxacin* ..... 109
GAUZE STERILE PADS 2 .. 107
GAVILYTE-C ..... 79
GAVILYTE-G ..... 79
GAVILYTE-N WITH FLAVOR PACK ..... 79
GAVRETO ..... 28
*gefitinib* ..... 28
*gemfibrozil* ..... 40
GEMTESA ..... 82
*generlac* ..... 79
GENGRAF ..... 91
*gentamicin in saline* ..... 101
*gentamicin sulfate* . 67, 101, 109
GENVOYA ..... 101
GILOTRIF ..... 28
*glatiramer acetate* ..... 54
GLATOPA ..... 54
*glimepiride* ..... 73
*glipizide* ..... 73
*glipizide er* ..... 73
*glipizide-metformin hcl* ... 73
*glucagon emergency* .... 73
*glyburide* ..... 73
*glyburide micronized* ..... 73
*glyburide-metformin* ..... 73
*glycopyrrolate* ..... 79
GLYDO ..... 23
GLYXAMBI ..... 73
GOCOVRI ..... 54
GOMEKLI ..... 28
*granisetron hcl* ..... 79
*griseofulvin microsize* .... 101
*guanfacine hcl er* ..... 54
GVOKE HYPOPEN 1-PACK ..... 73
GVOKE HYPOPEN 2-PACK ..... 74
GVOKE KIT ..... 74
GVOKE PFS ..... 74
**H**
HADLIMA ..... 91
HADLIMA PUSHTOUCH .... 91
HAILEY 1.5/30 ..... 84
HAILEY 24 FE ..... 84
HAILEY FE 1/20 ..... 84
*halobetasol propionate* . 67
*haloperidol* ..... 54
*haloperidol decanoate* . 54
*haloperidol lactate* ..... 54
HAVRIX ..... 91
HEATHER ..... 84
*heparin sodium (porcine)* ..... 36
*heparin sodium (porcine) pf* ..... 36
HEPLISAV-B ..... 91
HERCEPTIN HYLECTA ..... 28
HERNEXEOS ..... 28
HIBERIX ..... 91
HUMIRA (2 PEN) ..... 92
HUMIRA (2 SYRINGE) ..... 92
HUMIRA-CD/UC/HS STARTER ..... 92
HUMIRA-PSORIASIS/UVEIT STARTER ..... 92
*hydralazine hcl* ..... 40
*hydrochlorothiazide* ..... 41
*hydrocodone bit-homatrop mbr* ..... 107
*hydrocodone-acetaminophen* .... 23, 24
*hydrocodone-ibuprofen* 24
*hydrocortisone* .... 67, 68, 79
*hydrocortisone (perianal)* ..... 67
*hydrocortisone ace-pramoxine* ..... 79
*hydrocortisone butyrate* . 67
*hydrocortisone valerate* . 68
*hydrocortisone-acetic acid* ..... 111
*hydromorphone hcl* ..... 24
*hydroxychloroquine sulfate* ..... 101
*hydroxyurea* ..... 28
*hydroxyzine hcl* ..... 113
*hydroxyzine pamoate* .. 113
*hyoscyamine sulfate* ..... 79
HYRNUO ..... 28
**I**
*ibandronate sodium* ..... 74
IBRANCE ..... 28
IBTROZI ..... 28
*ibu* ..... 24
*ibuprofen* ..... 24
*icatibant acetate* ..... 36
ICLUSIG ..... 28
*icosapent ethyl* ..... 41
IDHIFA ..... 28
IDVYNSO ..... 101
IGALMI ..... 107
ILEVRO ..... 109
*imatinib mesylate* ..... 28
IMBRUVICA ..... 28
*imipenem-cilastatin* ..... 101
*imipramine hcl* ..... 54
*imipramine pamoate* ..... 54
*imiquimod* ..... 68
*imkeldi* ..... 28
IMOVAX RABIES ..... 92
IMPAVIDO ..... 102
IMVEXXY MAINTENANCE PACK ..... 84
IMVEXXY STARTER PACK .. 84
INCASSIA ..... 85
INCRELEX ..... 85
*indapamide* ..... 41
*indomethacin* ..... 24
INFANRIX ..... 92
INGREZZA ..... 54
INLURIYO ..... 28
INLYTA ..... 28
INQOVI ..... 28

INREBIC ..... 28
*insulin asp prot & asp flexpen* ..... 74
*insulin aspart* ..... 74
*insulin aspart flexpen* ..... 74
*insulin aspart penfill* ..... 74
*insulin aspart prot & aspart* ..... 74
INSULIN PEN NEEDLE ..... 107
INSULIN SYRINGE ..... 107
INTELENCE ..... 102
INTRALIPID ..... 70
INVEGA HAFYERA ..... 54
INVEGA SUSTENNA .... 54, 55
INVEGA TRINZA ..... 55
INVOKAMET ..... 74
INVOKAMET XR ..... 74
INVOKANA ..... 74
IPOL ..... 92
*ipratropium bromide* .... 113
*ipratropium bromide hfa* ..... 113
*ipratropium-albuterol* ... 113
*irbesartan* ..... 41
*irbesartan-hydrochlorothiazide* .... 41
ISENTRESS ..... 102
ISENTRESS HD ..... 102
ISIBLOOM ..... 85
ISOLYTE-P IN D5W ..... 70
ISOLYTE-S ..... 70
*isoniazid* ..... 102
*isosorb dinitrate-hydralazine* ..... 41
*isosorbide dinitrate* ..... 41
*isosorbide mononitrate* .. 41
*isosorbide mononitrate er* ..... 41
*isotretinoin* ..... 68
*isradipine* ..... 41
ITOVEBI ..... 28
*itraconazole* ..... 102
*ivabradine hcl* ..... 41
*ivermectin* ..... 68, 102
IWILFIN ..... 29
IXIARO ..... 92

**J**

JAKAFI ..... 29
JAKAFI XR ..... 29
*jantoven* ..... 36
JANUMET XR ..... 74
JARDIANCE ..... 74
JASMIEL ..... 85
JAVYGTOR ..... 81
JAYPIRCA ..... 29
JENCYCLA ..... 85
JENTADUETO XR ..... 74
JIDEYTRO ..... 29
JULEBER ..... 85
JULUCA ..... 102
JUNEL 1.5/30 ..... 85
JUNEL 1/20 ..... 85
JUNEL FE 1/20 ..... 85
JUNEL FE 24 ..... 85
JYLAMVO ..... 92
JYNNEOS ..... 92

**K**

KALETRA ..... 102
KALLIGA ..... 85
KALYDECO ..... 113
KARIVA ..... 85
*kcl (0.149%) in nacl* ..... 70
*kcl in dextrose-nacl* ..... 71
*kcl-lactated ringers-d5w* 71
*kedrab* ..... 92
KERENDIA ..... 74
KESIMPTA ..... 55
*ketoconazole* ..... 68, 102
*ketoprofen* ..... 24
*ketorolac tromethamine* 24, 109
KINERET ..... 92
KINRIX ..... 92
KIONEX ..... 74
KISQALI (200 MG DOSE) .. 29
KISQALI (400 MG DOSE) .. 29
KISQALI (600 MG DOSE) .. 29
KLAYESTA ..... 68
KLOR-CON ..... 71
KLOR-CON 10 ..... 71
KLOR-CON M10 ..... 71
KLOR-CON M15 ..... 71
KLOR-CON M20 ..... 71
KLOXXADO ..... 55
KOMZIFTI ..... 29
KOSELUGO ..... 107
KOURZEQ ..... 68
KRAZATI ..... 29
KURVELO ..... 85

**L**

*labetalol hcl* ..... 41
*lacosamide* ..... 55
*lactulose* ..... 79
*lactulose encephalopathy* ..... 79
LAMICTAL XR ..... 55
*lamivudine* ..... 102
*lamivudine-zidovudine* . 102
*lamotrigine* ..... 55
*lamotrigine starter kit-blue* ..... 55
*lamotrigine starter kit-green* ..... 55
*lamotrigine starter kit-orange* ..... 55
*lansoprazole* ..... 79
LANTUS ..... 74
LANTUS SOLOSTAR ..... 74
*lapatinib ditosylate* ..... 29
LARIN 1.5/30 ..... 85
LARIN 1/20 ..... 85
LARIN 24 FE ..... 85
LARIN FE 1/20 ..... 85
*latanoprost* ..... 109
LAZCLUZE ..... 29
LEDERLE LEUCOVORIN .... 29
*leflunomide* ..... 92
*lenalidomide* ..... 29
LENVIMA (10 MG DAILY DOSE) ..... 29
LENVIMA (12 MG DAILY DOSE) ..... 29
LENVIMA (14 MG DAILY DOSE) ..... 29
LENVIMA (18 MG DAILY DOSE) ..... 29
LENVIMA (20 MG DAILY DOSE) ..... 29
LENVIMA (24 MG DAILY DOSE) ..... 29
LENVIMA (4 MG DAILY DOSE) ..... 29
LENVIMA (8 MG DAILY DOSE) ..... 29

*letrozole* ..... 29
*leucovorin calcium* ... 29, 30
LEUKERAN ..... 30
LEUKINE ..... 36
*leuprolide acetate* ..... 30
*leuprolide acetate (3 month)* ..... 30
*levalbuterol hcl* ..... 113
*levalbuterol tartrate* ..... 113
*levetiracetam* ..... 56
*levetiracetam er* ..... 55, 56
*levobunolol hcl* ..... 109
*levocarnitine* ..... 71
*levocarnitine sf* ..... 71
*levocetirizine dihydrochloride* ..... 113
*levofloxacin* ..... 102, 109
*levofloxacin in d5w* ..... 102
*levonorgestrel-ethinyl estrad* ..... 85
LEVORA 0.15/30 (28) ..... 85
*levothyroxine sodium* ..... 85
LEVOXYL ..... 85
*l-glutamine* ..... 36
*lidocaine* ..... 24
*lidocaine hcl* ..... 24
*lidocaine hcl urethral/mucosal* ..... 24
*lidocaine viscous hcl* ..... 24
*lidocaine-prilocaine* ..... 24
LIFYORLI (125 MG DOSE) . 30
LIFYORLI (150 MG DOSE) . 30
*linagliptin-metformin hcl* . 74
*linezolid* ..... 102
*linezolid in sodium chloride* ..... 102
LINZESS ..... 79
*liomny* ..... 85
*liothyronine sodium* ..... 85
*liraglutide* ..... 74
*lisinopril* ..... 41
*lisinopril-hydrochlorothiazide* .... 41
*lithium* ..... 56
*lithium carbonate* ..... 56
*lithium carbonate er* ..... 56
LITHOSTAT ..... 82
LIVTENCITY ..... 102
LOESTRIN 1.5/30 (21) ..... 85
LOESTRIN 1/20 (21) ..... 85
LOESTRIN FE 1/20 ..... 85
LOKELMA ..... 74
*lomustine* ..... 30
LONSURF ..... 30
*loperamide hcl* ..... 79
*lopinavir-ritonavir* ..... 102
*lorazepam* ..... 56
LORAZEPAM INTENSOL .... 56
LORBRENA ..... 30
LORYNA ..... 85
*losartan potassium* ..... 41
*losartan potassium-hctz* . 41
*loteprednol etabonate* 109
*loteprednol-tobramycin* 109
*lovastatin* ..... 41
LOW-OGESTREL ..... 85
*loxapine succinate* ..... 56
LO-ZUMANDIMINE ..... 85
*lubiprostone* ..... 79
LUIZZA 1.5/30 ..... 85
LUIZZA 1/20 ..... 86
LUMAKRAS ..... 30
LUMIGAN ..... 109
LUPRON DEPOT (1-MONTH) ..... 30
*lurasidone hcl* ..... 56
LYBALVI ..... 56
LYLEQ ..... 86
LYLLANA ..... 86
LYNPARZA ..... 30
LYSODREN ..... 30
LYTGOBI (12 MG DAILY DOSE) ..... 30
LYTGOBI (16 MG DAILY DOSE) ..... 30
LYTGOBI (20 MG DAILY DOSE) ..... 30
LYZA ..... 86

**M**

*macitentan* ..... 113
*magnesium sulfate* ..... 71
*malathion* ..... 68
*maraviroc* ..... 102
*marlissa* ..... 86
MARPLAN ..... 56
MATULANE ..... 30
MATZIM LA ..... 41
MAVYRET ..... 103
*meclizine hcl* ..... 79
*medroxyprogesterone acetate* ..... 86
*mefloquine hcl* ..... 103
*megestrol acetate* .... 30, 86
MEKINIST ..... 30
MEKTOVI ..... 30
MELEYA ..... 86
*meloxicam* ..... 24
*memantine hcl* ..... 56
*memantine hcl er* ..... 56
MENQUADFI ..... 92
MENVEO ..... 92
*meperidine hcl* ..... 24
*meprobamate* ..... 56
*mercaptopurine* ..... 30
*meropenem* ..... 103
*mesalamine* ..... 79, 80
*mesalamine er* ..... 79
*mesna* ..... 30
*metformin hcl* ..... 75
*metformin hcl er* ..... 75
*methadone hcl* ..... 24
*methazolamide* ..... 109
*methenamine hippurate* ..... 103
*methimazole* ..... 86
*methocarbamol* ..... 56
*methotrexate sodium* ..... 92
*methotrexate sodium (pf)* ..... 92
*methoxsalen rapid* ..... 68
*methscopolamine bromide* ..... 80
*methsuximide* ..... 56
*methyldopa* ..... 41
*methylphenidate hcl* ..... 57
*methylphenidate hcl er* .. 57
*methylphenidate hcl er (cd)* ..... 57
*methylphenidate hcl er (osm)* ..... 57
*methylprednisolone* ..... 86
*methyltestosterone* ..... 86
*metoclopramide hcl* ..... 80
*metolazone* ..... 41

*metoprolol succinate er* . 41
*metoprolol tartrate* ..... 42
*metoprolol-hydrochlorothiazide* .... 42
*metronidazole* ... 68, 82, 103
*metyrosine* ..... 42
*mexiletine hcl* ..... 42
MIBELAS 24 FE ..... 86
*micafungin sodium* ..... 103
*miconazole 3* ..... 82
MICROGESTIN 1.5/30 ..... 86
MICROGESTIN 1/20 ..... 86
MICROGESTIN FE 1/20 ..... 86
*midodrine hcl* ..... 42
*mifepristone* ..... 86
MIGERGOT ..... 57
*miglitol* ..... 75
*miglustat* ..... 81
MILI ..... 86
*minocycline hcl* ..... 103
*minoxidil* ..... 42
*mirabegron er* ..... 82
*mirtazapine* ..... 57
*misoprostol* ..... 80
M-M-R II ..... 92
*modafinil* ..... 57
MODEYSO ..... 31
*moexipril hcl* ..... 42
*molindone hcl* ..... 57
*mometasone furoate* .... 68, 113
MONDOXYNE NL ..... 103
MONO-LINYAH ..... 86
*montelukast sodium* ..... 113
*morphine sulfate* ..... 25
*morphine sulfate (concentrate)* ..... 24
*morphine sulfate (pf)* ..... 24
*morphine sulfate er* ... 24, 25
MOUNJARO ..... 75
MOVANTIK ..... 80
*moxifloxacin hcl* .... 103, 109
*moxifloxacin hcl (2x day)* ..... 109
*moxifloxacin hcl in nacl* 103
MRESVIA ..... 92
MULTAQ ..... 42
*multiple electro type 1 ph 5.5* ..... 71
*multiple electro type 1 ph 7.4* ..... 71
*mupirocin* ..... 68
*mupirocin calcium* ..... 68
*mycophenolate mofetil* . 93
*mycophenolate sodium* . 93
*mycophenolic acid* ..... 93
MYTESI ..... 80

**N**

*na sulfate-k sulfate-mg sulf* ..... 80
*nabumetone* ..... 25
*nadolol* ..... 42
*nafcillin sodium* ..... 103
*naftifine hcl* ..... 68
*naloxone hcl* ..... 57
*naltrexone hcl* ..... 57
NAMZARIC ..... 57
*naproxen* ..... 25
*naproxen dr* ..... 25
*naproxen sodium* ..... 25
NATACYN ..... 109
*nateglinide* ..... 75
NAYZILAM ..... 57
*nebivolol hcl* ..... 42
*nefazodone hcl* ..... 57
*neomycin sulfate* ..... 103
*neomycin-bacitracin zn-polymyx* ..... 109
*neomycin-polymyxin-dexameth* ..... 109
*neomycin-polymyxin-gramicidin* ..... 109
*neomycin-polymyxin-hc* ..... 109, 111
NERLYNX ..... 31
NEULASTA ..... 36
NEULASTA ONPRO ..... 36
NEUPRO ..... 57
*nevirapine* ..... 103
*nevirapine er* ..... 103
NEXLETOL ..... 42
NEXLIZET ..... 42
NEXPLANON ..... 86
*niacin (antihyperlipidemic)* ..... 42
*niacin er (antihyperlipidemic)* .... 42
*niacor* ..... 42
*nicardipine hcl* ..... 42
NICOTROL NS ..... 58
*nifedipine er* ..... 42
*nifedipine er osmotic release* ..... 42
NIKKI ..... 86
*nilotinib hcl* ..... 31
*nilutamide* ..... 31
*nimodipine* ..... 42
NINLARO ..... 31
*nintedanib esylate* ..... 113
*nisoldipine er* ..... 42
*nitazoxanide* ..... 103
*nitisinone* ..... 81
*nitrofurantoin macrocrystal* ..... 103
*nitrofurantoin monohyd macro* ..... 103
*nitroglycerin* ..... 42, 68
*nizatidine* ..... 80
NORA-BE ..... 86
NORDITROPIN FLEXPRO ... 86
*norelgestromin-eth estradiol* ..... 86
*norethin ace-eth estrad-fe* ..... 86
*norethindrone* ..... 87
*norethindrone acetate* .. 86
*norethindrone acet-ethinyl est* ..... 87
*norethin-eth estradiol-fe* . 87
*norgestimate-eth estradiol* ..... 87
*norgestim-eth estrad triphasic* ..... 87
NORLYROC ..... 87
*nortriptyline hcl* ..... 58
NORVIR ..... 103
NOVOLIN 70/30 ..... 75
NOVOLIN 70/30 FLEXPEN 75
NOVOLIN 70/30 FLEXPEN RELION ..... 75
NOVOLIN 70/30 RELION .. 75
NOVOLIN N ..... 75
NOVOLIN N FLEXPEN ..... 75

NOVOLIN N FLEXPEN RELION ..... 75
NOVOLIN N RELION..... 75
NOVOLIN R ..... 75
NOVOLIN R FLEXPEN ..... 75
NOVOLIN R FLEXPEN RELION ..... 75
NOVOLIN R RELION ..... 75
NOVOLOG..... 75
NOVOLOG 70/30 FLEXPEN RELION ..... 75
NOVOLOG FLEXPEN..... 75
NOVOLOG FLEXPEN RELION ..... 75
NOVOLOG MIX 70/30 ..... 75
NOVOLOG MIX 70/30 FLEXPEN ..... 75
NOVOLOG MIX 70/30 RELION ..... 75
NOVOLOG PENFILL ..... 76
NOVOLOG RELION ..... 76
NUBEQA ..... 31
NUCALA ..... 113
NUEDEXTA ..... 58
NUPLAZID ..... 58
NURTEC ..... 58
NUTRILIPID ..... 71
NUZYRA ..... 103
NYAMYC ..... 68
*nystatin* ..... 68, 103
*nystatin-triamcinolone* .... 68
NYSTOP..... 68
**O**
OCTAGAM..... 93
*octreotide acetate* ..... 87
ODEFSEY..... 103
ODOMZO ..... 31
OFEV..... 113
*ofloxacin* ..... 104, 110, 111
OGSIVEO..... 31
OJEMDA..... 31
OJJAARA ..... 31
*olanzapine*..... 58
*olanzapine-fluoxetine hcl* ..... 58
*olmesartan medoxomil* .. 42
*olmesartan medoxomil-hctz* ..... 42
*olmesartan-amlodipine-hctz* ..... 43
*olopatadine hcl* .... 110, 113
*omega-3-acid ethyl esters* ..... 43
*omeprazole* ..... 80
OMNIPOD 5 DEXG7G6 INTRO GEN 5..... 107
OMNIPOD 5 DEXG7G6 PODS GEN 5 ..... 107
OMNIPOD 5 LIBRE INTRO ..... 107
OMNIPOD 5 LIBRE PODS 107
OMNIPOD DASH INTRO (GEN 4) ..... 107
OMNIPOD DASH PODS (GEN 4) ..... 108
OMNITROPE ..... 87
*ondansetron* ..... 80
*ondansetron hcl*..... 80
ONUREG..... 31
OPIPZA..... 58
ORALONE..... 68
ORENITRAM..... 113, 114
ORGOVYX..... 31
ORKAMBI..... 114
*orphenadrine citrate er*.. 58
ORQUIDEA ..... 87
ORSERDU..... 31
*oseltamivir phosphate* .. 104
OSPHENA ..... 87
OTEZLA..... 93
OTEZLA XR ..... 93
OTEZLA/OTEZLA XR INITIATION PK..... 93
*oxaprozin* ..... 25
*oxazepam* ..... 58
*oxcarbazepine*..... 58
OXERVATE..... 110
*oxybutynin chloride* ..... 82
*oxybutynin chloride er*.... 82
*oxycodone hcl*..... 25
*oxycodone-acetaminophen* ..... 25
*oxymorphone hcl*..... 25
OZEMPIC ..... 76
OZEMPIC (0.25 OR 0.5 MG/DOSE)..... 76
OZEMPIC (1 MG/DOSE) .. 76
OZEMPIC (2 MG/DOSE) .. 76
**P**
*pacerone*..... 43
*paliperidone er*..... 58
PANRETIN..... 68
*pantoprazole sodium* ..... 80
*paricalcitol*..... 76
*paroxetine hcl* ..... 59
*paroxetine hcl er*..... 58
*paroxetine mesylate*..... 59
PAXLOVID (150/100) ..... 104
PAXLOVID (300/100 & 150/100)..... 104
PAXLOVID (300/100) ..... 104
*pazopanib hcl*..... 31
PEDIARIX..... 93
PEDVAXHIB..... 93
*peg 3350-kcl-na bicarb-nacl*..... 80
*peg-3350/electrolytes* .... 80
PEGASYS..... 93
PEMAZYRE ..... 31
PENBRAYA..... 93
*penicillamine* ..... 82
*penicillin g potassium* ... 104
*penicillin g sodium* ..... 104
*penicillin v potassium*.... 104
*penmenvy* ..... 93
PENTACEL..... 93
*pentamidine isethionate* ..... 104
*pentazocine-naloxone hcl* ..... 25
*pentoxifylline er* ..... 36
*perampanel* ..... 59
*perindopril erbumine* ..... 43
PERIOGARD ..... 68
*permethrin* ..... 69
*perphenazine* ..... 59
*perphenazine-amitriptyline* ..... 59
PFIZERPEN..... 104
*phenelzine sulfate*..... 59
*phenobarbital* ..... 59
PHENYTEK ..... 59
*phenytoin*..... 59
PHENYTOIN INFATABS ..... 59

*phenytoin sodium extended* ..... 59
PHESGO ..... 31
PHYRAGO ..... 31
PIFELTRO ..... 104
*pilocarpine hcl* ..... 69, 110
*pimecrolimus* ..... 69
*pimozide* ..... 59
PIMTREA ..... 87
*pindolol* ..... 43
*pioglitazone hcl* ..... 76
*pioglitazone hcl-glimepiride* ..... 76
*pioglitazone hcl-metformin hcl* ..... 76
*piperacillin sod-tazobactam* ..... 104
PIQRAY (200 MG DAILY DOSE) ..... 31
PIQRAY (250 MG DAILY DOSE) ..... 31
PIQRAY (300 MG DAILY DOSE) ..... 31
*pirfenidone* ..... 114
*piroxicam* ..... 25
*pitavastatin calcium* ..... 43
PLENAMINE ..... 71
*podofilox* ..... 69
POLYCIN ..... 110
*polymyxin b-trimethoprim* ..... 110
*pomalidomide* ..... 31
POMALYST ..... 31
PORTIA-28 ..... 87
*posaconazole* ..... 104
*potassium chloride* ..... 71
*potassium chloride crys er* ..... 71
*potassium chloride er* ..... 71
*potassium chloride in nacl* ..... 71
*potassium citrate er* ..... 82
*potassium cl in dextrose 5%* ..... 71
*pramipexole dihydrochloride* ..... 59
*pramipexole dihydrochloride er* ..... 59
*prasugrel hcl* ..... 36
*pravastatin sodium* ..... 43
*praziquantel* ..... 104
*prazosin hcl* ..... 43
*prednisolone* ..... 87
*prednisolone acetate* .. 110
*prednisolone sodium phosphate* ..... 87, 110
*prednisone* ..... 87
*pregabalin* ..... 59
PREMARIN ..... 87, 88
PREMASOL ..... 71
*pretomanid* ..... 104
*prevalite* ..... 43
PREVYMIS ..... 104
PREZCOBIX ..... 104
PREZISTA ..... 104
PRIFTIN ..... 104
*primaquine phosphate* 104
*primidone* ..... 60
PRIORIX ..... 93
PRIVIGEN ..... 93
*probenecid* ..... 25
*prochlorperazine* ..... 80
*prochlorperazine maleate* ..... 80
PROCRIT ..... 36
PROCTO-MED HC ..... 69
PROCTOSOL HC ..... 69
PROCTOZONE-HC ..... 69
*progesterone* ..... 88
PROGRAF ..... 93
PROLASTIN-C ..... 81
PROLIA ..... 76
*promethazine hcl* ..... 80
*promethazine-codeine* 108
*promethazine-dm* ..... 108
PROMETHEGAN ..... 80
*propafenone hcl* ..... 43
*propafenone hcl er* ..... 43
*proparacaine hcl* ..... 110
*propranolol hcl* ..... 43
*propranolol hcl er* ..... 43
*propylthiouracil* ..... 88
PROQUAD ..... 93
PROSOL ..... 71
*protriptyline hcl* ..... 60
PULMOZYME ..... 114
*pyrazinamide* ..... 105
*pyridostigmine bromide* . 60
*pyridostigmine bromide er* ..... 60
*pyrimethamine* ..... 105

**Q**

QINLOCK ..... 31
QUADRACEL ..... 93
*quetiapine fumarate* ..... 60
*quetiapine fumarate er* .. 60
*quinapril hcl* ..... 43
*quinapril-hydrochlorothiazide* .... 43
*quinidine gluconate er* ... 43
*quinidine sulfate* ..... 43
*quinine sulfate* ..... 105

**R**

RABAVERT ..... 94
RALDESY ..... 60
*raloxifene hcl* ..... 88
*ramelteon* ..... 60
*ramipril* ..... 43
*ranolazine er* ..... 43
*rasagiline mesylate* ..... 60
RASONQUE ..... 31
RECLIPSEN ..... 88
RECOMBIVAX HB ..... 94
RELENZA DISKHALER ..... 105
*repaglinide* ..... 76
REPATHA ..... 43
REPATHA SURECLICK ..... 43
RESTASIS ..... 110
RESTASIS MULTIDOSE ..... 110
RETACRIT ..... 36
RETEVMO ..... 31, 32
RETROVIR ..... 105
REVCOVI ..... 81
REVUFORJ ..... 32
REXULTI ..... 60
REYATAZ ..... 105
REZDIFFRA ..... 88
REZLIDHIA ..... 32
REZUROCK ..... 94
RHOPRESSA ..... 110
*ribavirin* ..... 105
*rifabutin* ..... 105
*rifampin* ..... 105
*rifapentine* ..... 105

*rilpivirine hcl* ..... 105
*riluzole* ..... 60
*rimantadine hcl* ..... 105
RINVOQ ..... 94
RINVOQ LQ ..... 94
*risedronate sodium* ..... 76
*risperidone* ..... 60, 61
*risperidone microspheres er* ..... 60
*ritonavir* ..... 105
*rivaroxaban* ..... 37
*rivastigmine* ..... 61
*rivastigmine tartrate* ..... 61
ROCKLATAN ..... 110
*roflumilast* ..... 114
ROMVIMZA ..... 32
*ropinirole hcl* ..... 61
*ropinirole hcl er* ..... 61
*rosuvastatin calcium* ..... 43
ROTARIX ..... 94
ROTATEQ ..... 94
ROWEEPRA ..... 61
ROZLYTREK ..... 32
RUBRACA ..... 32
*rufinamide* ..... 61
RUKOBIA ..... 105
RYBELSUS ..... 76
RYDAPT ..... 32
RYKINDO ..... 61
RYLAZE ..... 32

**S**

*sacubitril-valsartan* ..... 43
SAJAZIR ..... 37
SANTYL ..... 69
*sapropterin dihydrochloride* ..... 81
SCEMBLIX ..... 32
*scopolamine* ..... 80
SECUADO ..... 61
SELARSDI ..... 94
*selegiline hcl* ..... 61
*selenium sulfide* ..... 69
SELZENTRY ..... 105
SEREVENT DISKUS ..... 114
*sertraline hcl* ..... 61
*sevelamer carbonate* ..... 76
SHAROBEL ..... 88
SHINGRIX ..... 94
SIGNIFOR ..... 88
*sildenafil citrate* ..... 82, 114
*silodosin* ..... 82
*silver sulfadiazine* ..... 69
SIMBRINZA ..... 110
SIMLANDI (1 PEN) ..... 94
SIMLANDI (1 SYRINGE) ..... 94
SIMLANDI (2 PEN) ..... 94
SIMLANDI (2 SYRINGE) ..... 94
SIMLIYA ..... 88
*simvastatin* ..... 44
*sirolimus* ..... 94
SIRTURO ..... 105
*sitagliptin phos-metformin hcl* ..... 76
*sitagliptin phosphate* ..... 76
SKYLA ..... 88
SKYRIZI ..... 94, 95
SKYRIZI PEN ..... 94
SOAANZ ..... 44
*sodium chloride* ..... 72, 108
*sodium fluoride* ..... 72
*sodium oxybate* ..... 61
*sodium phenylbutyrate* ..... 81
*sodium polystyrene sulfonate* ..... 76
*sofosbuvir-velpatasvir* ..... 105
*solifenacin succinate* ..... 82
SOLIQUA ..... 77
SOLTAMOX ..... 32
SOMAVERT ..... 88
*sorafenib tosylate* ..... 32
*sotalol hcl* ..... 44
*sotalol hcl (af)* ..... 44
SPIRIVA RESPIMAT ..... 114
*spironolactone* ..... 44
*spironolactone-hctz* ..... 44
SPRAVATO (56 MG DOSE) ..... 61
SPRAVATO (84 MG DOSE) ..... 61
SPRINTEC 28 ..... 88
SPRITAM ..... 61
SPS (SODIUM POLYSTYRENE SULF) ..... 77
SSD (SILVER SULFADIAZINE) ..... 69
STIOLTO RESPIMAT ..... 114
STIVARGA ..... 32
*streptomycin sulfate* ..... 105
STRIBILD ..... 105
SUBVENITE ..... 61
*sucralfate* ..... 80
*sulfacetamide sodium* ..... 110
*sulfacetamide sodium (acne)* ..... 69
*sulfacetamide-prednisolone* ..... 110
*sulfadiazine* ..... 105
*sulfamethoxazole-trimethoprim* ..... 105
*sulfasalazine* ..... 80
*sulindac* ..... 25
*sumatriptan succinate* ..... 62
*sunitinib malate* ..... 32
SUNLENCA ..... 105
SYMDEKO ..... 114
SYMLINPEN 120 ..... 77
SYMLINPEN 60 ..... 77
SYMPAZAN ..... 62
SYMTUZA ..... 105
SYNAREL ..... 88
SYNJARDY ..... 77
SYNJARDY XR ..... 77
SYNTHROID ..... 88

**T**

TABLOID ..... 32
TABRECTA ..... 32
*tacrolimus* ..... 69, 95
*tadalafil* ..... 82
*tadalafil (pah)* ..... 114
TAFINLAR ..... 32
TAGRISSO ..... 32
TAKHZYRO ..... 37
TALZENNA ..... 32
*tamoxifen citrate* ..... 32
*tamsulosin hcl* ..... 82
TARINA 24 FE ..... 88
TARINA FE 1/20 EQ ..... 88
TARPEYO ..... 82
*tazarotene* ..... 69
TAZICEF ..... 106
TECENTRIQ HYBREZA ..... 32
TECVAYLI ..... 32
TEGLUTIK ..... 62
*telmisartan* ..... 44

*telmisartan-amlodipine* .. 44
*telmisartan-hctz* ..... 44
*temazepam* ..... 62
TENIVAC ..... 95
*tenofovir disoproxil fumarate* ..... 106
TEPMETKO ..... 32
*terazosin hcl* ..... 44
*terbinafine hcl* ..... 106
*terconazole* ..... 82, 83
*teriflunomide* ..... 62
*teriparatide* ..... 77
*testosterone* ..... 88
*testosterone cypionate* .. 88
*testosterone enanthate* . 88
*tetrabenazine* ..... 62
*tetracycline hcl* ..... 106
THALOMID ..... 32
*theophylline* ..... 114
*theophylline er* ..... 114
*thioridazine hcl* ..... 62
*thiothixene* ..... 62
TIADYLT ER ..... 44
*tiagabine hcl* ..... 62
TIBSOVO ..... 32
*ticagrelor* ..... 37
TICOVAC ..... 95
*tigecycline* ..... 106
TIGLUTIK ..... 62
*timolol maleate* ..... 44, 110
*timolol maleate (once-daily)* ..... 110
*tinidazole* ..... 106
*tiotropium bromide* ..... 114
TIVICAY ..... 106
TIVICAY PD ..... 106
*tizanidine hcl* ..... 62
TOBI PODHALER ..... 114
TOBRADEX ..... 110
TOBRADEX ST ..... 110
*tobramycin* ..... 110, 114
*tobramycin sulfate* ..... 106
*tobramycin-dexamethasone* ..... 110
TOBREX ..... 110
*tofacitinib citrate* ..... 95
*tofacitinib citrate er* ..... 95
*tolcapone* ..... 62
*tolterodine tartrate er* ..... 83
*tolvaptan* ..... 77
*topiramate* ..... 62
*toremifene citrate* ..... 33
*torsemide* ..... 44
TOUJEO MAX SOLOSTAR. 77
TOUJEO SOLOSTAR ..... 77
TPN ELECTROLYTES ..... 72
TRADJENTA ..... 77
*tramadol hcl* ..... 25
*tramadol hcl (er biphasic)* ..... 25
*tramadol hcl er* ..... 25
*tramadol-acetaminophen* ..... 25
*trandolapril* ..... 44
*trandolapril-verapamil hcl er* ..... 44
*tranexamic acid* ..... 37
*tranylcypromine sulfate* .. 62
TRAVASOL ..... 72
*travoprost (bak free)* .... 110
*trazodone hcl* ..... 62
TRELEGY ELLIPTA ..... 114
TRELSTAR MIXJECT ..... 33
TREMFYA ..... 95
TREMFYA ONE-PRESS ..... 95
TREMFYA PEN ..... 95
TREMFYA-CD/UC INDUCTION ..... 95
*tretinoin* ..... 33, 69
*triamcinolone acetonide* 69
*triamterene-hctz* ..... 44
*triazolam* ..... 62
TRIDERM ..... 69
*trientine hcl* ..... 77
TRI-ESTARYLLA ..... 88
*trifluoperazine hcl* ..... 62
*trifluridine* ..... 106
*trihexyphenidyl hcl* .... 62, 63
TRIJARDY XR ..... 77
TRIKAFTA ..... 114
TRI-LINYAH ..... 88
TRI-LO-ESTARYLLA ..... 88
TRI-LO-MARZIA ..... 88
TRI-LO-MILI ..... 88
TRI-LO-SPRINTEC ..... 89
*trimethoprim* ..... 106
TRI-MILI ..... 89
*trimipramine maleate* ..... 63
TRINTELLIX ..... 63
TRI-SPRINTEC ..... 89
TRIUMEQ ..... 106
TRIUMEQ PD ..... 106
TRI-VYLIBRA ..... 89
TRI-VYLIBRA LO ..... 89
TROPHAMINE ..... 72
TRULICITY ..... 77
TRUMENBA ..... 95
TRUQAP ..... 33
TUKYSA ..... 33
TURALIO ..... 33
TURQOZ ..... 89
TWINRIX ..... 95
TYBOST ..... 106
TYENNE ..... 95
TYMLOS ..... 77
TYPHIM VI ..... 95

**U**

UBRELVY ..... 63
UDENYCA ..... 37
UDENYCA ONBODY ..... 37
*umeclidinium-vilanterol* 114
UNITHROID ..... 89
*ursodiol* ..... 81

**V**

*valacyclovir hcl* ..... 106
VALCHLOR ..... 69
*valganciclovir hcl* ..... 106
*valproic acid* ..... 63
*valsartan* ..... 44
*valsartan-hydrochlorothiazide* .... 44
VALTOCO 10 MG DOSE .. 63
VALTOCO 15 MG DOSE .. 63
VALTOCO 20 MG DOSE .. 63
VALTOCO 5 MG DOSE .... 63
VALTYA 1/50 ..... 89
*vancomycin hcl* ..... 106
VANDAZOLE ..... 83
VANFLYTA ..... 33
VAQTA ..... 95
*varenicline tartrate* ..... 63
*varenicline tartrate (starter)* ..... 63

*varenicline tartrate(continue)* ..... 63
VARIVAX ..... 95
VARIZIG ..... 95
VARUBI (180 MG DOSE) .. 81
VASCEPA ..... 44
VAXCHORA ..... 95
VELSIPITY ..... 81
VELTASSA ..... 77
VENCLEXTA ..... 33
VENCLEXTA STARTING PACK ..... 33
*venlafaxine besylate er* .. 63
*venlafaxine hcl* ..... 63
*venlafaxine hcl er* ..... 63
VEPPANU ..... 33
*verapamil hcl* ..... 44
*verapamil hcl er* ..... 44
VERQUVO ..... 45
VERSACLOZ ..... 63
VERZENIO ..... 33
VESTURA ..... 89
*vigabatrin* ..... 63
VIGADRONE ..... 64
*vilazodone hcl* ..... 64
VIMKUNYA ..... 95
*viorele* ..... 89
VIRACEPT ..... 106, 107
VIREAD ..... 107
*vitamin d (ergocalciferol)* ..... 77
VITRAKVI ..... 33
VIVOTIF ..... 95
VIZIMPRO ..... 33
VOLNEA ..... 89
VONJO ..... 33
VORANIGO ..... 33
*voriconazole* ..... 107
VOSEVI ..... 107
VOWST ..... 81
VRAYLAR ..... 64
VYLIBRA ..... 89
VYZULTA ..... 110

**W**

*warfarin sodium* ..... 37
WEGOVY ..... 108
WELIREG ..... 33
WINREVAIR ..... 114
*wixela inhub* ..... 115
WYMZYA FE ..... 89

**X**

XALKORI ..... 33
XARELTO ..... 37
XARELTO STARTER PACK . 37
XATMEP ..... 95
XCOPRI ..... 64
XCOPRI (250 MG DAILY DOSE) ..... 64
XCOPRI (350 MG DAILY DOSE) ..... 64
XDEMVY ..... 110
XELRIA FE ..... 89
XERMELO ..... 81
XGEVA ..... 77
XIFAXAN ..... 107
XIGDUO XR ..... 77
XIIDRA ..... 110
XOCOVA ..... 107
XOLAIR ..... 115
XOSPATA ..... 33
XPOVIO (100 MG ONCE WEEKLY) ..... 33
XPOVIO (40 MG ONCE WEEKLY) ..... 33, 34
XPOVIO (40 MG TWICE WEEKLY) ..... 34
XPOVIO (60 MG ONCE WEEKLY) ..... 34
XPOVIO (60 MG TWICE WEEKLY) ..... 34
XPOVIO (80 MG ONCE WEEKLY) ..... 34
XPOVIO (80 MG TWICE WEEKLY) ..... 34
XTANDI ..... 34

**Y**

YARGESA ..... 81
YESINTEK ..... 95, 96
YF-VAX ..... 96
YULITHIRA ..... 34
*yuvafem* ..... 89

**Z**

*zafirlukast* ..... 115
*zaleplon* ..... 64
ZARXIO ..... 37
ZEJULA ..... 34
ZELBORAF ..... 34
ZENATANE ..... 69
ZENBEXUS ..... 34
ZENPEP ..... 81
ZENZEDI ..... 64
*zidovudine* ..... 107
*ziprasidone hcl* ..... 64
*ziprasidone mesylate* ..... 64
ZIRGAN ..... 107
ZOLINZA ..... 34
*zolpidem tartrate* ..... 64
*zolpidem tartrate er* ..... 64
ZONISADE ..... 64
*zonisamide* ..... 64
ZTALMY ..... 64
ZURZUVAE ..... 64
ZYDELIG ..... 34
ZYKADIA ..... 34
ZYMFENTRA (2 PEN) ..... 96
ZYMFENTRA (2 SYRINGE) . 96
ZYPREXA RELPREVV ..... 64

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

**English** – ATTENTION: If you need help in your language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-877-336-2069** (TTY: **1-877-206-0500**). Hours of operation are 8 a.m. to 8 p.m. local time, seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

**Español (Spanish)** – ATENCIÓN: Si necesita ayuda en su idioma, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono indicado anteriormente. El horario de atención es de 8 a.m. a 8 p.m. hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.º de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.º de abril hasta el 30 de septiembre.

**العربية (Arabic)** – تنبيه: إذا كنت تحتاج إلى المساعدة بلغتك، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل على رقم الهاتف المذكور أعلاه. ساعات العمل من الساعة 8 صباحًا حتى الساعة 8 مساءً على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بدايةً من 1 أكتوبر حتى 31 مارس، ومن الاثنين حتى الجمعة (ما عدا أيام العطلات) من 1 أبريل حتى 30 سبتمبر.

**简体中文 (Chinese Simplified)** – 注意：如果您在您的语言方面需要帮助，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务，以可访问的格式提供信息。请拨打上面列出的电话号码。营业时间：10 月 1 日至 3 月 31 日，每周七天（感恩节和圣诞节除外），4 月 1 日至 9 月 30 日，周一至周五（节假日除外），当地时间上午 8 时至晚上 8 时。

**繁體中文 (Chinese Traditional)** – 注意：如果您在您的語言方面需要協助，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打上面列出的電話號碼。營業時間：10 月 1 日至 3 月 31 日，每週七天（感恩節和耶誕節除外），4 月 1 日至 9 月 30 日，週一至週五（節假日除外），當地時間上午 8 時至晚上 8 時。

**Français (French)** – ATTENTION : Si vous avez besoin d'aide dans votre langue, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone mentionné ci-dessus. Les heures d'ouverture sont de 8h à 20h, heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

**Deutsch (German)** – ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die oben aufgeführte Telefonnummer an. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

**Kreyòl Ayisyen (Haitian Creole)** – ATANSYON: Si w bezwen èd nan lang ou, sèvis asistans lenguistik gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma ki aksesib disponib tou san w p ap peye. Rele nimewo telefòn yo bay anwo a. Orè fonksyònman yo se 8 a.m. rive 8 p.m., sèt jou sou sèt (eksepte Jou Thanksgiving ak Nwèl) soti 1ye Oktòb rive 31 Mas, ak Lendi pou rive Vandredi (eksepte jou ferye) soti 1ye Avril rive 30 Septanm.

**Italiano (Italian)** –ATTENZIONE: se hai bisogno di supporto nella tua lingua, sono disponibili servizi di assistenza linguistica gratuita. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiama il numero di telefono riportato sopra. Il servizio è attivo dalle 8.00 alle 20.00 ora locale, sette giorni su sette (eccetto il Giorno del Ringraziamento e Natale) dal 1° ottobre al 31 marzo, e dal lunedì al venerdì (eccetto i giorni festivi) dal 1° aprile al 30 settembre.

**한국어(Korean)** – 주의: 귀하의 언어로 도움이 필요하신 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 위의 전화 번호로 전화해 주십시오. 운영 시간은 현지 시간 오전 8시부터 오후 8시까지이며 10월 1일부터 3월 31일까지는 주 7일(추수 감사절과 성탄절은 제외) 내내, 4월 1일부터 9월 30일까지는 월요일부터 금요일까지(휴일은 제외)입니다.

**ພາສາລາວ (Laotian)** – ເອົາໃຈໃສ່: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ນອກຈາກນີ້ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມໃນການໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທລະສັບທີ່ລະບຸໄວ້ຂ້າງເທິງ. ເວລາເຮັດວຽກແມ່ນ 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ ຕາມເວລາໃນທ້ອງຖິ່ນ, ເຈັດມື້ຕໍ່ອາທິດ (ຍົກເວັ້ນວັນຂອບໃຈພະເຈົ້າ ແລະ ວັນຄຣິດສມາດ) ຕັ້ງແຕ່ວັນທີ 1 ຕຸລາ ຫາ ວັນທີ 31 ມີນາ, ແລະ ວັນຈັນ ເຖິງ ວັນສຸກ (ຍົກເວັ້ນວັນພັກ) ຕັ້ງແຕ່ວັນທີ 1 ເມສາ ຫາ 30 ກັນຍາ.

**Polski (Polish)** – UWAGA: Jeśli potrzebujesz pomocy w swoim języku, możesz skorzystać z bezpłatnych usług pomocy językowej. Dostępne są również nieodpłatnie odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach. Zadzwoń pod numer telefonu podany powyżej. Czynne od 8:00 rano do 8:00 wieczorem czasu lokalnego, siedem dni w tygodniu (oprócz Święta Dziękczynienia i Bożego Narodzenia) od 1 października do 31 marca oraz od poniedziałku do piątku (oprócz świąt) od 1 kwietnia do 30 września.

**Português (Portuguese)** – ATENÇÃO: Se necessita de ajuda no seu idioma, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone acima indicado. Horário de expediente: das 8h às 20h, (hora local), sete dias por semana (exceto Dia de Ação de Graças e Natal) de 1 de outubro até 31 de março, e de segunda a sexta-feira (exceto feriados) de 1 de abril até 30 de setembro.

**Русский (Russian)** – ВНИМАНИЕ: Если вам нужна помощь на вашем языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по вышеуказанному номеру телефона. Часы работы: с 08:00 до 20:00 в любой день недели (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

**Tagalog (Tagalog)** – PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono na nakalista sa itaas. Ang mga oras ng opisina ay 8 a.m. hanggang 8 p.m., lokal na oras, pitong araw sa isang linggo (maliban sa Thanksgiving at Pasko) mula Oktubre 1 hanggang Marso 31, at Lunes hanggang Biyernes (maliban sa mga holiday) mula Abril 1 hanggang Setyembre 30.

**ภาษาไทย (Thai)** – หมายเหตุ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ เรามีบริการช่วยเหลือด้านภาษาฟรีสำหรับคุณ นอกจากนี้ยังมีความช่วยเหลือและบริการเสริมที่เหมาะสม เพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายอีกด้วย โทรไปยังหมายเลขโทรศัพท์ที่ระบุไว้ด้านบน เวลาทำการคือ 08.00 น. ถึง 20.00 น. ตามเวลาท้องถิ่น เจ็ดวันต่อสัปดาห์ (ยกเว้นวันขอบคุณพระเจ้าและวันคริสต์มาส) ตั้งแต่วันที่ 1 ตุลาคม ถึง 31 มีนาคม และวันจันทร์ถึงวันศุกร์ (ยกเว้นวันหยุด) ตั้งแต่วันที่ 1 เมษายน ถึง 30 กันยายน

**Українська (Ukrainian)** – УВАГА. Якщо вам потрібна допомога рідною мовою, ви можете скористатися безкоштовними послугами мовної підтримки. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також можна отримати безкоштовно. Зателефонуйте за вказаним вище номером. Графік роботи: з 08:00 до 20:00 за місцевим часом, без вихідних (крім Дня подяки й Різдва) з 1 жовтня по 31 березня й із понеділка по п’ятницю (крім святкових днів) з 1 квітня по 30 вересня.

**Tiếng Việt (Vietnamese)** – CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại nêu trên. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ địa phương, bảy ngày một tuần (trừ Lễ Tạ ơn và Giáng sinh) từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

HealthSun
HEALTH PLANS

**1-877-336-2069 / TTY: 711**
**11430 NW 20th Street, Suite 300, Miami, FL 33172**
**HealthSun.com**

MedicareRx
Prescription Drug Coverage

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN.
LEA LO SIGUIENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN ACERCA DE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN.

HPMS Approved Formulary ID 27026, Version 9

This formulary was updated on 9/24/2026. For more recent information or other questions, please contact our HealthSun Health Plans Member Services at 1-877-336-2069 / TTY: 711, Monday through Friday from 8 a.m. to 8 p.m. (EST), or visit www.healthsun.com. From October 1 through March 31, we are open seven days a week from 8 a.m. to 8 p.m. (our office will be closed on Thanksgiving and Christmas Day). From April 1through September 30, we are available Monday through Friday from 8 a.m. to 8 p.m. (our office will be closed on federal holidays). Este formulario se actualizó en 9/24/2026. Para obtener información más reciente o si tiene otras preguntas, comuníquese con HealthSun Health Plans al 1-877-336-2069 / TTY: 711, de lunes a viernes, de 8 a.m. a 8 p.m., o visite www.healthsun.com. Nuestro horario del 1 de octubre al 31 de marzo es de 8 a.m. a 8 p.m., los siete días de la semana (nuestra oficina permanecerá cerrada el Día de Acción de Gracias y Navidad). Desde el 1 de abril hasta el 30 de septiembre, estaremos disponibles de lunes a viernes, de 8 a.m. a 8 p.m. (nuestra oficina permanecerá cerrada los días feriados federales).

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