BILINGUAL

HealthSun
HEALTH PLANS

FORMULARY
(List of Covered Drugs)

FORMULARIO
(Lista de Medicamentos Cubiertos)

2025

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 25102, Version 11

This formulary was updated on 1/10/2025. 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 1/10/2025. 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. 8 p.m., 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
2025 Formulary List of Covered Drugs

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

HPMS Approved Formulary File Submission 25102, Version 11

This formulary was updated on **01/10/2025**. For more recent information or other questions, please contact HealthSun Health Plans Member Services at 1-877-336-2069 (TTY users should call 1-877-206-0500), from 8am to 8pm, EST., or visit www.healthsun.com. Ours 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 **01/10/2025**. For an updated Drug Lis (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, 2026, 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 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 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of

the drug during the 2025 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 **01/10/2025**. 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 21. 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 113. 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 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 21. 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 4 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 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 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 1-877-486-2048. Or, visit http://www.medicare.gov.

HealthSun Health Plans Formulary

The formulary that begins on page 21 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 113.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ENTRESTO 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 22 includes a column titled, “Drug Tier”. This column indicates what tier each drug is listed under. The table starting on page 7 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 / Mail Order Pharmacy							
HealthSun Plan Name	**Tier 1 30-day supply** (up to a **100-day supply** for some medications)	**Ter 2 30-day supply** (up to a **90-day supply** for some medications)	**Tier 3 30-day supply**	**Insulin Drugs Tier 3 30-day supply**	**Tier 4 30-day supply**	**Tier 5 30-day supply**	**Tier 6 30-day supply**
HealthAdvantage Plan (HMO) Miami-Dade 001	$0	$0	$0	$0	$30	33%	$0
HealthAdvantage Plan (HMO) Broward 012	$0	$0	$5	$5	$30	33%	$0
HealthAdvantage Plan (HMO) Palm Beach 013	$0	$0	$15	$15	$30	33%	$0
HealthAdvantage Plus (HMO) Miami-Dade 017	$0	$0	$10	$10	$30	33%	$0
HealthAdvantage Plus (HMO) Broward 018	$0	$0	$5	$5	$50	33%	$0
HealthAdvantage Plus (HMO) Palm Beach 020	$0	$0	$42	$35	$95	33%	$0
***MediMax (HMO)** Miami-Dade/Broward 006	$0	$0	$25*	$25*	25%*	25%*	$0
***** **MediSun Plus (HMO D-SNP)** Palm Beach 016	$0	$0	$0	$0	$0	$0	$0
***** **MediSun Extra (HMO D-SNP)** Miami-Dade/Broward 019	$0	$0	$0	$0	$0	$0	$0
VitalCare (HMO C-SNP) Miami-Dade/Broward 021	$0	$0	$37	$35	$85	33%	$0
VitalCare (HMO C-SNP) Palm Beach 022	$0	$0	$37	$35	$85	33%	$0

Standard Retail Pharmacy							
HealthSun Plan Name	**Tier 1 30-day supply** (up to a **100-day supply** for some medications)	**Tier 2 30-day supply** (up to a **90-day supply** for some medications)	**Tier 3 30-day supply**	**Insulin Drugs Tier 3 30-day supply**	**Tier 4 30-day supply**	**Tier 5 30-day supply**	**Tier 6 30-day supply**
HealthAdvantage Plan (HMO) Miami-Dade 001	$0	$0	$20	$0	$35	33%	$0
HealthAdvantage Plan (HMO) Broward 012	$0	$0	$20	$5	$35	33%	$0
HealthAdvantage Plan (HMO) Palm Beach 013	$0	$0	$20	$15	$35	33%	$0
HealthAdvantage Plus (HMO) Miami-Dade 017	$0	$0	$10	$10	$35	33%	$0
HealthAdvantage Plus (HMO) Broward 018	$0	$0	$5	$5	$55	33%	$0
HealthAdvantage Plus (HMO) Palm Beach 020	$0	$0	$47	$35	$100	33%	$0
***MediMax (HMO)** Miami-Dade/Broward 006	$0	$0	$25*	$25*	25%*	25%*	$0
***** **MediSun Plus (HMO D-SNP)** Palm Beach 016	$0	$0	$0	$0	$0	$0	$0
***** **MediSun Extra (HMO D-SNP)** Miami-Dade/Broward 019	$0	$0	$0	$0	$0	$0	$0
VitalCare (HMO C-SNP) Miami-Dade/Broward 021	$0	$0	$42	$35	$90	33%	$0
VitalCare (HMO C-SNP) Palm Beach 022	$0	$0	$42	$35	$90	33%	$0

***Members enrolled in HealthSun MediMax (HMO) / PBP 006, MediSun Plus (HMO D-NSP) / PBP 016 or MediSun Extra (HMO D-NSP) / PBP 019** *If you receive "Extra Help", this plan will cover all of your Medicare-covered Part D drugs included on the plan formulary at a $0.00 copay during the Deductible, Initial, and Catastrophic coverage stages.*

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.

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 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 1-877-206-0500), 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 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 2025 - Lista de medicamentos cubiertos

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

HPMS ID: 25102, versión 11

Este formulario se actualizó el **01/10/2025**. 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 1-877-206-0500) 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 desde el **01/10/2025**. 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, los copagos y el coseguro pueden cambiar el 1 de enero de 2025 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 para aplicar estos cambios. Las actualizaciones del Formulario se publican todos los meses en nuestro sitio web:

https://healthsun.com/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 productos biológicos originales 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 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 2025 que estaba cubierto al comienzo del año, nosotros no discontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2025, 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 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 entre en vigencias el **01/10/2025**. 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 la portada posterior.

¿Cómo utilizo el Formulario?

Hay dos formas de encontrar su medicamento dentro del formulario:

Afección médica

El Formulario comienza en la página 21. 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 encuentran en 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 21. 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 113. 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 aparece 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 del 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 el profesional que receta obtengan una autorización previa para determinados medicamentos. Esto significa que necesitará contar con la aprobación de HealthSun Health Plans antes de obtener 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 enfermedad. 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 21. 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 14 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 cuidados 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 1-877-486-2048. O bien, visite http://www.medicare.gov.

Formulario de HealthSun Health Plans

El formulario que comienza en la página 21 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 113.

La primera columna del cuadro menciona el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (por ejemplo, ENTRESTO) y los medicamentos genéricos están en letra cursiva minúscula (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 22 incluye una columna llamada “Nivel de medicamentos”. Esta columna indica en qué nivel se encuentra cada medicamento. La tabla que comienza en la página 17 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 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							
Nombre del plan de HealthSun	**Nivel 1 Suministro para 30 días** (hasta un **suministro para 100 días** para algunos medicamentos)	**Nivel 2 Suministro para 30 días** (hasta un **suministro para 90 días** para algunos medicamentos)	**Nivel 3 Suministro para 30 días**	**Medicamentos de insulina Nivel 3 Suministro para 30 días**	**Nivel 4 Suministro para 30 días**	**Nivel 5 Suministro para 30 días**	**Nivel 6 Suministro para 30 días**
HealthAdvantage Plan (HMO) Miami-Dade 001	$0	$0	$0	$0	$30	33%	$0
HealthAdvantage Plan (HMO) Broward 012	$0	$0	$5	$5	$30	33%	$0
HealthAdvantage Plan (HMO) Palm Beach 013	$0	$0	$15	$15	$30	33%	$0
HealthAdvantage Plus (HMO) Miami-Dade 017	$0	$0	$10	$10	$30	33%	$0
HealthAdvantage Plus (HMO) Broward 018	$0	$0	$5	$5	$50	33%	$0
HealthAdvantage Plus (HMO) Palm Beach 020	$0	$0	$42	$35	$95	33%	$0
***MediMax (HMO)** Miami-Dade/Broward 006	$0	$0	$25*	$25*	25%*	25%*	$0
*** MediSun Plus (HMO D-SNP)** Palm Beach 016	$0	$0	$0	$0	$0	$0	$0
*** MediSun Extra (HMO D-SNP)** Miami-Dade/Broward 019	$0	$0	$0	$0	$0	$0	$0
VitalCare (HMO C-SNP) Miami-Dade/Broward 021	$0	$0	$37	$35	$85	33%	$0
VitalCare (HMO C-SNP) Palm Beach 022	$0	$0	$37	$35	$85	33%	$0

Farmacia minorista estándar							
Nombre del plan de HealthSun	**Nivel 1 Suministro para 30 días** (hasta un **suministro para 100 días** para algunos medicamentos)	**Nivel 2 Suministro para 30 días** (hasta un **suministro para 90 días** para algunos medicamentos)	**Nivel 3 Suministro para 30 días**	**Medicamentos de insulina Nivel 3 Suministro para 30 días**	**Nivel 4 Suministro para 30 días**	**Nivel 5 Suministro para 30 días**	**Nivel 6 Suministro para 30 días**
HealthAdvantage Plan (HMO) Miami-Dade 001	$0	$0	$20	$0	$35	33%	$0
HealthAdvantage Plan (HMO) Broward 012	$0	$0	$20	$5	$35	33%	$0
HealthAdvantage Plan (HMO) Palm Beach 013	$0	$0	$20	$15	$35	33%	$0
HealthAdvantage Plus (HMO) Miami-Dade 017	$0	$0	$10	$10	$35	33%	$0
HealthAdvantage Plus (HMO) Broward 018	$0	$0	$5	$5	$55	33%	$0
HealthAdvantage Plus (HMO) Palm Beach 020	$0	$0	$47	$35	$100	33%	$0
***MediMax (HMO)** Miami-Dade/ Broward 006	$0	$0	$25*	$25*	25%*	25%*	$0
***MediSun Plus (HMO D-SNP)** Palm Beach 016	$0	$0	$0	$0	$0	$0	$0
***MediSun Extra (HMO D-SNP)** Miami-Dade/ Broward 019	$0	$0	$0	$0	$0	$0	$0
VitalCare (HMO C-SNP) Miami-Dade/ Broward 021	$0	$0	$42	$35	$90	33%	$0
VitalCare (HMO C-SNP) Palm Beach 022	$0	$0	$42	$35	$90	33%	$0

**** Miembros inscritos en HealthSun MediMax (HMO)/PBP 006, MediSun Plus (HMO D-SNP) /PBP 016 o MediSun Extra (HMO D-SNP) /PBP 019:*** *Si recibe Ayuda Extra ("Extra Help"), este plan cubrirá todos sus medicamentos de la Parte D cubiertos por Medicare incluidos en el Formulario del plan con un copago de $0.00 durante las etapas de deducible, de cobertura inicial y de cobertura catastrófica.*

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 1-877-206-0500) 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.

SÍMBOLO	NOMBRE	DESCRIPCIÓN DE LA ABREVIATURA
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)

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	2	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	
colchicine-probenecid	1	MO; 100D
diclofenac potassium oral tablet 50 mg	1	MO; 100D
diclofenac sodium er	1	MO; 100D
diclofenac sodium external gel 1 %	2	QL (1000 per 30 days)
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
duramorph	4	
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
fenoprofen calcium oral tablet	2	MO; 90D
fentanyl	2	PA; QL (15 per 30 days); NEDS
fentanyl citrate buccal tablet 200 mcg, 400 mcg, 600 mcg, 800 mcg	5	PA; QL (120 per 30 days); NEDS
flurbiprofen oral tablet 100 mg	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
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 injection solution 2 mg/ml	2	
hydromorphone hcl oral liquid	2	QL (720 per 30 days); NEDS
hydromorphone hcl oral tablet	2	QL (180 per 30 days); NEDS
IBU ORAL TABLET 600 MG, 800 MG	1	MO; 100D
ibuprofen oral suspension	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	5	PA; QL (180 per 30 days); NEDS; HRM
methadone hcl oral solution	3	QL (900 per 30 days); NEDS

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
methadone hcl oral tablet	3	PA; QL (180 per 30 days); NEDS
morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml	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
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 capsule	2	QL (180 per 30 days); NEDS
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
tolmetin sodium oral tablet 600 mg	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	5	PA; QL (120 per 30 days)
abiraterone acetate oral tablet 500 mg	5	PA; QL (60 per 30 days)
AKEEGA	5	PA; QL (60 per 30 days)
ALECENSA	5	PA; QL (240 per 30 days); LA
ALUNBRIG ORAL TABLET 180 MG	5	PA; QL (30 per 30 days); LA
ALUNBRIG ORAL TABLET 30 MG	5	PA; QL (180 per 30 days); LA
ALUNBRIG ORAL TABLET 90 MG	5	PA; QL (60 per 30 days); LA
ALUNBRIG ORAL TABLET THERAPY PACK	5	PA; QL (30 per 180 days); LA
anastrozole oral	2	QL (30 per 30 days); 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)
AYVAKIT	5	PA; QL (30 per 30 days); LA
BALVERSA ORAL TABLET 3 MG	5	PA; QL (90 per 30 days); LA
BALVERSA ORAL TABLET 4 MG	5	PA; QL (60 per 30 days); LA
BALVERSA ORAL TABLET 5 MG	5	PA; QL (30 per 30 days); LA
BAVENCIO	5	PA; LA
BESREMI	5	PA; LA
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); LA
BOSULIF ORAL CAPSULE 50 MG	5	PA; QL (30 per 30 days); LA
BOSULIF ORAL TABLET 100 MG	5	PA; QL (120 per 30 days)
BOSULIF 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); LA
BRUKINSA	5	PA; QL (120 per 30 days); LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CABOMETYX	5	PA; QL (30 per 30 days); LA
CALQUENCE	5	PA; QL (60 per 30 days); LA
CAPRELSA ORAL TABLET 100 MG	5	PA; QL (90 per 30 days); LA
CAPRELSA ORAL TABLET 300 MG	5	PA; QL (30 per 30 days); LA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	5	PA; QL (56 per 28 days); LA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	5	PA; QL (112 per 28 days); LA
COMETRIQ (60 MG DAILY DOSE)	5	PA; QL (84 per 28 days); LA
COPIKTRA	5	PA; QL (60 per 30 days); LA
COTELLIC	5	PA; QL (90 per 30 days); LA
cyclophosphamide intravenous solution 500 mg/2.5ml	5	
cyclophosphamide oral capsule	3	B/D PA
CYRAMZA	5	PA; LA
DARZALEX FASPRO	5	PA
DARZALEX INTRAVENOUS SOLUTION 400 MG/20ML	5	PA; LA
dasatinib	5	PA; QL (30 per 30 days)
DAURISMO ORAL TABLET 100 MG	5	PA; QL (30 per 30 days); LA
DAURISMO ORAL TABLET 25 MG	5	PA; QL (60 per 30 days); LA
ELIGARD	4	PA
ENHERTU	5	PA
ERIVEDGE	5	PA; QL (30 per 30 days); LA
ERLEADA ORAL TABLET 240 MG	5	PA; QL (30 per 30 days); LA
ERLEADA ORAL TABLET 60 MG	5	PA; QL (120 per 30 days); LA
erlotinib hcl oral tablet 100 mg, 150 mg	5	PA; QL (30 per 30 days)
erlotinib hcl oral tablet 25 mg	5	PA; QL (90 per 30 days)
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg	5	PA
everolimus oral tablet soluble	5	PA
exemestane	2	QL (60 per 30 days); MO; 90D
EXKIVITY	5	PA; QL (120 per 30 days); LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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); LA
FRUZAQLA ORAL CAPSULE 5 MG	5	PA; QL (21 per 28 days); LA
GAVRETO	5	PA; QL (120 per 30 days); LA
GAZYVA	5	PA; LA
gefitinib	5	PA; QL (60 per 30 days)
GILOTRIF	5	PA; QL (30 per 30 days); LA
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	4	PA
GLEOSTINE ORAL CAPSULE 100 MG	5	PA
HERCEPTIN HYLECTA	5	B/D PA
hydroxyurea oral	1	
IBRANCE	5	PA; QL (21 per 28 days); LA
ICLUSIG	5	PA; QL (30 per 30 days); LA
IDHIFA ORAL TABLET 100 MG	5	PA; QL (30 per 30 days); LA
IDHIFA ORAL TABLET 50 MG	5	PA; QL (60 per 30 days); LA
imatinib mesylate oral tablet 100 mg	5	PA; QL (90 per 30 days)
imatinib mesylate oral tablet 400 mg	5	PA; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; QL (90 per 30 days); LA
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; QL (30 per 30 days); LA
IMBRUVICA ORAL SUSPENSION	5	PA; QL (216 per 27 days); LA
IMBRUVICA ORAL TABLET 420 MG, 560 MG	5	PA; QL (30 per 30 days); LA
INLYTA ORAL TABLET 1 MG	5	PA; QL (180 per 30 days); LA
INLYTA ORAL TABLET 5 MG	5	PA; QL (120 per 30 days); LA
INQOVI	5	PA; QL (5 per 28 days); LA
INREBIC	5	PA; QL (120 per 30 days); LA
ITOVEBI ORAL TABLET 3 MG	5	PA; QL (56 per 28 days)
ITOVEBI ORAL TABLET 9 MG	5	PA; QL (28 per 28 days)
IWILFIN	5	PA; QL (240 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
JAKAFI	5	PA; QL (60 per 30 days); LA
JAYPIRCA ORAL TABLET 100 MG	5	PA; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	5	PA; QL (30 per 30 days)
KADCYLA	5	PA
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)
KISQALI FEMARA (200 MG DOSE)	5	PA; QL (49 per 28 days)
KISQALI FEMARA (400 MG DOSE)	5	PA; QL (70 per 28 days)
KISQALI FEMARA (600 MG DOSE)	5	PA; QL (91 per 28 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)
lenalidomide oral capsule 10 mg	5	PA; QL (60 per 30 days); LA
lenalidomide oral capsule 15 mg, 2.5 mg, 20 mg, 25 mg	5	PA; QL (30 per 30 days); LA
lenalidomide oral capsule 5 mg	5	PA; QL (150 per 30 days); LA
LENVIMA (10 MG DAILY DOSE)	5	PA; QL (30 per 30 days); LA
LENVIMA (12 MG DAILY DOSE)	5	PA; QL (90 per 30 days); LA
LENVIMA (14 MG DAILY DOSE)	5	PA; QL (60 per 30 days); LA
LENVIMA (18 MG DAILY DOSE)	5	PA; QL (90 per 30 days); LA
LENVIMA (20 MG DAILY DOSE)	5	PA; QL (60 per 30 days); LA
LENVIMA (24 MG DAILY DOSE)	5	PA; QL (90 per 30 days); LA
LENVIMA (4 MG DAILY DOSE)	5	PA; QL (30 per 30 days); LA
LENVIMA (8 MG DAILY DOSE)	5	PA; QL (60 per 30 days); LA
letrozole oral	2	QL (30 per 30 days); MO; 90D
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg	2	
leucovorin calcium oral tablet 5 mg	1	
leuprolide acetate (3 month)	4	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
leuprolide acetate injection	2	PA
LONSURF	5	PA
LORBRENA ORAL TABLET 100 MG	5	PA; QL (30 per 30 days); LA
LORBRENA ORAL TABLET 25 MG	5	PA; QL (90 per 30 days); LA
LUMAKRAS ORAL TABLET 120 MG	5	PA; QL (240 per 30 days); LA
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)	5	PA; QL (1 per 28 days)
LUPRON DEPOT (3-MONTH)	5	PA; QL (1 per 84 days)
LUPRON DEPOT (4-MONTH)	5	PA; QL (1 per 112 days)
LUPRON DEPOT (6-MONTH)	5	PA; QL (1 per 168 days)
LYNPARZA ORAL TABLET	5	PA; QL (120 per 30 days); LA
LYSODREN	5	
LYTGOBI (12 MG DAILY DOSE)	5	PA
LYTGOBI (16 MG DAILY DOSE)	5	PA
LYTGOBI (20 MG DAILY DOSE)	5	PA
MATULANE	5	LA
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); LA
MEKINIST ORAL TABLET 2 MG	5	PA; QL (30 per 30 days); LA
MEKTOVI	5	PA; QL (180 per 30 days); LA
mercaptopurine oral	2	
MESNEX ORAL	5	
NERLYNX	5	PA; QL (180 per 30 days); LA
nilutamide	5	QL (30 per 30 days)
NINLARO	5	PA; QL (3 per 28 days)
NUBEQA	5	PA; QL (120 per 30 days); LA
ODOMZO	5	PA; QL (30 per 30 days); LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
OGSIVEO ORAL TABLET 100 MG, 150 MG	5	PA; QL (60 per 30 days)
OGSIVEO ORAL TABLET 50 MG	5	PA; QL (180 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); LA
ONUREG	5	PA; QL (14 per 28 days); LA
ORGOVYX	5	PA; QL (30 per 28 days); LA
ORSERDU ORAL TABLET 345 MG	5	PA; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	5	PA; QL (90 per 30 days)
oxaliplatin intravenous solution 200 mg/40ml	4	B/D PA
pazopanib hcl	5	PA; QL (120 per 30 days)
PEMAZYRE	5	PA; QL (30 per 30 days); LA
PHESGO	5	PA
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)
POMALYST	5	PA; QL (21 per 28 days); LA
PURIXAN	5	PA
QINLOCK	5	PA; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	5	PA; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5	PA; QL (120 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 (180 per 30 days)
RETEVMO ORAL TABLET 80 MG	5	PA; QL (120 per 30 days)
REZLIDHIA	5	PA; QL (60 per 30 days); LA
RIABNI	5	B/D PA
RITUXAN INTRAVENOUS SOLUTION 100 MG/10ML	5	B/D PA; LA
ROZLYTREK ORAL CAPSULE 100 MG	5	PA; QL (150 per 30 days); LA
ROZLYTREK ORAL CAPSULE 200 MG	5	PA; QL (90 per 30 days); LA
ROZLYTREK ORAL PACKET	5	PA; QL (360 per 30 days); LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
RUBRACA	5	PA; QL (120 per 30 days); LA
RYBREVANT	5	PA
RYDAPT	5	PA; QL (240 per 30 days)
RYLAZE	5	PA
SARCLISA	5	PA
SCEMBLIX ORAL TABLET 100 MG	5	PA; QL (120 per 30 days)
SCEMBLIX ORAL TABLET 20 MG	5	PA; QL (60 per 30 days)
SCEMBLIX ORAL TABLET 40 MG	5	PA; QL (300 per 30 days)
SOLTAMOX	5	MO
sorafenib tosylate	5	PA; QL (120 per 30 days)
STIVARGA	5	PA; QL (84 per 28 days); LA
sunitinib malate	5	PA; QL (30 per 30 days)
TABRECTA	5	PA; QL (120 per 30 days)
TAFINLAR ORAL CAPSULE	5	PA; QL (120 per 30 days); LA
TAFINLAR ORAL TABLET SOLUBLE	5	PA; QL (900 per 30 days)
TAGRISSO	5	PA; QL (30 per 30 days); LA
TALZENNA ORAL CAPSULE 0.1 MG, 0.35 MG	5	PA; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG	5	PA; QL (30 per 30 days); LA
tamoxifen citrate oral	1	MO; 100D
TASIGNA	5	PA; QL (112 per 28 days)
TAZVERIK	5	PA; QL (240 per 30 days); LA
TECENTRIQ	5	PA; LA
TECENTRIQ HYBREZA	5	PA
TECVAYLI	5	PA
TEPMETKO	5	PA; QL (60 per 30 days); LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; QL (30 per 30 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5	PA; QL (60 per 30 days)
TIBSOVO	5	PA; QL (60 per 30 days); LA
toremifene citrate	4	QL (30 per 30 days)
TRELSTAR MIXJECT	4	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
tretinoin oral	5	
TRODELVY	5	PA
TRUQAP	5	PA; QL (64 per 28 days)
TUKYSA	5	PA; QL (120 per 30 days); LA
TURALIO ORAL CAPSULE 125 MG	5	PA; QL (120 per 30 days); LA
VANFLYTA	5	PA; QL (56 per 28 days)
VENCLEXTA ORAL TABLET 10 MG	3	PA; QL (60 per 30 days); LA
VENCLEXTA ORAL TABLET 100 MG	5	PA; QL (180 per 30 days); LA
VENCLEXTA ORAL TABLET 50 MG	5	PA; QL (30 per 30 days); LA
VENCLEXTA STARTING PACK	5	PA; LA
VERZENIO	5	PA; QL (56 per 28 days); LA
VITRAKVI ORAL CAPSULE 100 MG	5	PA; QL (60 per 30 days); LA
VITRAKVI ORAL CAPSULE 25 MG	5	PA; QL (180 per 30 days); LA
VITRAKVI ORAL SOLUTION	5	PA; QL (300 per 30 days); LA
VIZIMPRO	5	PA; QL (30 per 30 days); LA
VONJO	5	PA; QL (120 per 30 days); LA
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); LA
XALKORI ORAL CAPSULE	5	PA; QL (120 per 30 days); LA
XALKORI ORAL CAPSULE SPRINKLE 150 MG	5	PA; QL (180 per 30 days); LA
XALKORI ORAL CAPSULE SPRINKLE 20 MG	5	PA; QL (240 per 30 days); LA
XALKORI ORAL CAPSULE SPRINKLE 50 MG	5	PA; QL (120 per 30 days); LA
XOSPATA	5	PA; QL (90 per 30 days); LA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	5	PA; QL (8 per 28 days); LA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; QL (4 per 28 days); LA
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; QL (8 per 28 days); LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	5	PA; QL (4 per 28 days); LA
XPOVIO (60 MG TWICE WEEKLY)	5	PA; QL (24 per 28 days); LA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	5	PA; QL (8 per 28 days); LA
XPOVIO (80 MG TWICE WEEKLY)	5	PA; QL (32 per 28 days); LA
XTANDI ORAL CAPSULE	5	PA; QL (120 per 30 days); LA
XTANDI ORAL TABLET 40 MG	5	PA; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	5	PA; QL (60 per 30 days)
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); LA
ZEPZELCA	5	PA
ZOLINZA	5	PA; QL (120 per 30 days)
ZYDELIG	5	PA; QL (60 per 30 days); LA
ZYKADIA ORAL TABLET	5	PA; QL (90 per 30 days); LA
BLOOD PRODUCTS AND MODIFIERS / PRODUCTOS SANGUÍNEOS Y MODIFICADORES		
anagrelide hcl	2	MO; 90D
aspirin-dipyridamole er	2	QL (60 per 30 days); MO; 90D
BRILINTA	3	QL (60 per 30 days); MO
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
DROXIA	4	MO
ELIQUIS	3	QL (60 per 30 days); MO
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK	3	QL (74 per 180 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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)
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	5	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
jantoven	1	MO; 100D
LEUKINE INJECTION SOLUTION RECONSTITUTED	5	PA
l-glutamine oral packet	5	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA; QL (1.2 per 28 days)
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML	5	PA
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE	5	PA
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
PROMACTA ORAL PACKET 12.5 MG	5	PA; QL (360 per 30 days); LA
PROMACTA ORAL PACKET 25 MG	5	PA; QL (180 per 30 days); LA
PROMACTA ORAL TABLET 12.5 MG, 25 MG	5	PA; QL (30 per 30 days); LA
PROMACTA ORAL TABLET 50 MG	5	PA; QL (90 per 30 days); LA
PROMACTA ORAL TABLET 75 MG	5	PA; QL (60 per 30 days); LA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 10000 UNIT/ML(1ML), 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA; QL (12 per 28 days)
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	5	PA; QL (12 per 28 days)
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA
TAKHZYRO SUBCUTANEOUS SOLUTION	5	PA; LA
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA
tranexamic acid oral	2	
UDENYCA	5	PA; QL (1.2 per 28 days)
warfarin sodium oral	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
XARELTO ORAL SUSPENSION RECONSTITUTED	3	QL (600 per 30 days); MO
XARELTO ORAL TABLET 10 MG, 20 MG	3	QL (30 per 30 days); MO
XARELTO ORAL TABLET 15 MG, 2.5 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	2	MO; 90D
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, 5-20 mg, 5-40 mg	2	QL (30 per 30 days); MO; 90D
amlodipine besy-benazepril hcl oral capsule 2.5-10 mg, 5-10 mg	1	QL (30 per 30 days); MO; 100D
amlodipine besylate oral	1	MO; 100D
amlodipine besylate-valsartan	2	QL (30 per 30 days); MO; 90D
amlodipine-atorvastatin	2	QL (30 per 30 days); MO; 90D
amlodipine-olmesartan	2	QL (30 per 30 days); MO; 90D
amlodipine-valsartan-hctz	2	QL (30 per 30 days); MO; 90D
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	2	QL (30 per 30 days); MO; 90D
betaxolol hcl oral	1	MO; 100D
bisoprolol fumarate oral	1	MO; 100D
bisoprolol-hydrochlorothiazide	1	MO; 100D
bumetanide injection	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
bumetanide oral	2	MO; 90D
candesartan cilexetil oral tablet 16 mg, 4 mg, 8 mg	2	QL (60 per 30 days); MO; 90D
candesartan cilexetil oral tablet 32 mg	2	QL (30 per 30 days); MO; 90D
candesartan cilexetil-hctz oral tablet 16-12.5 mg	2	QL (60 per 30 days); MO; 90D
candesartan cilexetil-hctz oral tablet 32-12.5 mg, 32-25 mg	2	QL (30 per 30 days); MO; 90D
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 (90 per 30 days); MO; 100D
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	2	QL (4 per 28 days); MO; 90D
clonidine hcl oral	1	MO; 100D
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	PA; QL (60 per 30 days); MO; 100D; HRM
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	PA; QL (60 per 30 days); MO; 100D; HRM
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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
diltiazem hcl er oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	2	MO; 90D
diltiazem hcl oral	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	5	PA; QL (180 per 30 days)
enalapril maleate oral tablet	1	MO; 100D
enalapril-hydrochlorothiazide	1	QL (60 per 30 days); MO; 100D
ENTRESTO ORAL CAPSULE SPRINKLE	3	QL (240 per 30 days); MO
ENTRESTO ORAL TABLET 24-26 MG	3	QL (180 per 30 days); MO
ENTRESTO ORAL TABLET 49-51 MG, 97-103 MG	3	QL (60 per 30 days); MO
eplerenone	2	MO; 90D
ezetimibe	2	QL (30 per 30 days); MO; 90D
ezetimibe-simvastatin	2	PA; QL (30 per 30 days); MO; 90D
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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
fluvastatin sodium	2	QL (60 per 30 days); MO; 90D
fluvastatin sodium er	2	QL (30 per 30 days); MO; 90D
fosinopril sodium	1	MO; 100D
fosinopril sodium-hctz oral tablet 10-12.5 mg	1	QL (60 per 30 days); MO; 100D
fosinopril sodium-hctz oral tablet 20-12.5 mg	1	QL (120 per 30 days); MO; 100D
furosemide injection	1	
furosemide oral tablet	1	MO; 100D
gemfibrozil oral	2	MO; 90D
hydralazine hcl oral	1	MO; 100D
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	1	MO; 100D
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 tablet 100 mg, 200 mg, 300 mg	1	MO; 100D
lisinopril oral	1	MO; 100D
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg	1	QL (30 per 30 days); MO; 100D
lisinopril-hydrochlorothiazide oral tablet 20-12.5 mg	1	QL (120 per 30 days); MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	1	QL (30 per 30 days); MO; 100D
lovastatin oral	1	QL (60 per 30 days); MO; 100D
MATZIM LA	2	MO; 90D
methyldopa oral tablet 500 mg	1	PA; 100D; HRM
metolazone	1	MO; 100D
metoprolol succinate er	1	MO; 100D
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
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	2	MO; 90D
nitroglycerin sublingual	1	MO; 100D
nitroglycerin transdermal patch 24 hour	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
nitroglycerin translingual solution	2	MO; 90D
olmesartan medoxomil oral tablet 20 mg, 40 mg	2	QL (30 per 30 days); MO; 90D
olmesartan medoxomil oral tablet 5 mg	2	QL (60 per 30 days); MO; 90D
olmesartan medoxomil-hctz	2	QL (30 per 30 days); MO; 90D
olmesartan-amlodipine-hctz	2	QL (30 per 30 days); MO; 90D
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	1	QL (60 per 30 days); MO; 100D
quinidine gluconate er	2	MO; 90D
quinidine sulfate oral	1	MO; 100D
ramipril	1	MO; 100D
ranolazine er	2	PA; QL (60 per 30 days); MO; 90D
REPATHA	3	PA; QL (3 per 28 days)
REPATHA PUSHTRONEX SYSTEM	3	PA; QL (3.5 per 28 days)
REPATHA SURECLICK	3	PA; QL (3 per 28 days)
rosuvastatin calcium oral	2	QL (30 per 30 days); MO; 90D
simvastatin oral tablet	1	QL (30 per 30 days); MO; 100D
SOAANZ	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
SORINE	2	MO; 90D
sotalol hcl (af)	2	MO; 90D
sotalol hcl oral	2	MO; 90D
spironolactone oral tablet	1	MO; 100D
spironolactone-hctz	1	MO; 100D
TEGSEDI	5	PA; QL (6 per 28 days); LA
telmisartan oral tablet 20 mg, 40 mg	2	QL (30 per 30 days); MO; 90D
telmisartan oral tablet 80 mg	2	QL (60 per 30 days); MO; 90D
telmisartan-amlodipine	2	QL (30 per 30 days); MO; 90D
telmisartan-hctz oral tablet 40-12.5 mg, 80-25 mg	2	QL (30 per 30 days); MO; 90D
telmisartan-hctz oral tablet 80-12.5 mg	2	QL (60 per 30 days); MO; 90D
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	QL (30 per 30 days); 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	2	QL (60 per 30 days); MO; 90D
valsartan oral tablet 320 mg	2	QL (30 per 30 days); MO; 90D
valsartan oral tablet 40 mg, 80 mg	2	QL (90 per 30 days); MO; 90D
valsartan-hydrochlorothiazide	2	QL (30 per 30 days); MO; 90D
VASCEPA	4	MO
verapamil hcl er	2	MO; 90D
verapamil hcl oral	1	MO; 100D
VERQUVO	4	PA; MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CENTRAL NERVOUS SYSTEM AGENTS / AGENTES DEL SISTEMA NERVIOSO CENTRAL		
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	MO; 100D
amitriptyline hcl oral tablet 25 mg, 50 mg	2	MO; 90D
amoxapine	2	PA; MO; 90D; HRM
amphetamine-dextroamphet er	2	PA; QL (30 per 30 days); MO; 90D
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; 90D
amphetamine-dextroamphetamine oral tablet 30 mg	2	PA; QL (60 per 30 days); MO; 90D
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 174 MG	5	QL (90 per 30 days); MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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)
APTIOM	5	MO
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
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)
AUVELITY	5	PA; QL (60 per 30 days); MO
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT	5	PA; QL (4 per 28 days)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT	5	PA; QL (4 per 28 days)
BAC	2	PA; QL (180 per 30 days); HRM
baclofen oral tablet 10 mg, 15 mg, 5 mg	1	QL (90 per 30 days)
baclofen oral tablet 20 mg	1	QL (120 per 30 days)
benztropine mesylate oral	1	PA; MO; 100D; HRM
BETASERON SUBCUTANEOUS KIT	5	PA; QL (15 per 30 days)
BRIVIACT ORAL SOLUTION	5	QL (600 per 30 days); MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
BRIVIACT ORAL TABLET	5	QL (60 per 30 days); MO
bromocriptine mesylate oral	2	MO; 90D
buprenorphine hcl sublingual tablet sublingual 2 mg	2	QL (240 per 30 days); NEDS
buprenorphine hcl sublingual tablet sublingual 8 mg	2	QL (60 per 30 days); NEDS
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	2	QL (60 per 30 days); 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
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	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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	
chlordiazepoxide hcl	2	QL (120 per 30 days)
chlordiazepoxide-amitriptyline	2	PA; MO; 90D; 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	PA; QL (480 per 30 days); MO; 90D
clobazam oral tablet 10 mg	2	PA; QL (120 per 30 days); MO; 90D
clobazam oral tablet 20 mg	2	PA; QL (60 per 30 days); MO; 90D
clomipramine hcl oral	2	PA; MO; 90D; HRM
clonazepam oral tablet 0.5 mg	1	QL (1200 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
clonazepam oral tablet 1 mg	1	QL (600 per 30 days)
clonazepam oral tablet 2 mg	1	QL (300 per 30 days)
clonazepam oral tablet dispersible 0.125 mg	2	QL (4800 per 30 days)
clonazepam oral tablet dispersible 0.25 mg	2	QL (2400 per 30 days)
clonazepam oral tablet dispersible 0.5 mg	2	QL (1200 per 30 days)
clonazepam oral tablet dispersible 1 mg	2	QL (600 per 30 days)
clonazepam oral tablet dispersible 2 mg	2	QL (300 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	5	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	4	PA; QL (60 per 30 days)
COBENFY STARTER PACK	5	PA
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	2	PA; 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 er oral capsule extended release 24 hour 10 mg, 25 mg, 35 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
dexmethylphenidate hcl er oral capsule extended release 24 hour 15 mg, 30 mg, 40 mg, 5 mg	2	QL (30 per 30 days); MO; 90D
dexmethylphenidate hcl er oral capsule extended release 24 hour 20 mg	1	QL (60 per 30 days); MO; 100D
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg	2	QL (60 per 30 days); MO; 90D
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	2	QL (120 per 30 days); MO; 90D
dextroamphetamine sulfate oral tablet 10 mg	2	QL (180 per 30 days); MO; 90D
dextroamphetamine sulfate oral tablet 5 mg	2	QL (90 per 30 days); MO; 90D
DIACOMIT ORAL CAPSULE 250 MG	5	PA; QL (360 per 30 days); LA
DIACOMIT ORAL CAPSULE 500 MG	5	PA; QL (180 per 30 days); LA
DIACOMIT ORAL PACKET 250 MG	5	PA; QL (360 per 30 days); LA
DIACOMIT ORAL PACKET 500 MG	5	PA; QL (180 per 30 days); LA
DIAZEPAM INTENSOL	2	QL (240 per 30 days)
diazepam oral concentrate	2	QL (240 per 30 days)
diazepam oral solution 5 mg/5ml	2	QL (1200 per 30 days)
diazepam oral tablet 10 mg	1	QL (120 per 30 days)
diazepam oral tablet 2 mg	1	QL (600 per 30 days)
diazepam oral tablet 5 mg	1	QL (240 per 30 days)
diazepam rectal	2	
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	5	PA; QL (14 per 7 days)
dimethyl fumarate oral capsule delayed release 240 mg	5	PA; QL (60 per 30 days)
dimethyl fumarate starter pack oral capsule delayed release therapy pack	5	PA
disulfiram oral	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	4	QL (60 per 30 days); MO
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 30 MG, 40 MG	4	QL (30 per 30 days); MO
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
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; LA
EPITOL	1	MO; 100D
EPRONTIA	4	PA; MO
ergoloid mesylates oral	2	PA; MO; 90D; HRM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ergotamine-caffeine	2	
escitalopram oxalate oral solution	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
estazolam	2	QL (30 per 30 days)
eszopiclone	2	QL (30 per 30 days)
ethosuximide oral	2	MO; 90D
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	4	PA
felbamate oral suspension	4	MO
felbamate oral tablet	2	MO; 90D
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; LA
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	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
FYCOMPA ORAL SUSPENSION	5	PA; QL (720 per 30 days); MO
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	5	PA; QL (30 per 30 days); MO
FYCOMPA ORAL TABLET 2 MG	4	PA; QL (30 per 30 days); MO
gabapentin (once-daily) oral tablet 300 mg	2	QL (30 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 (1080 per 30 days); MO; 100D
gabapentin oral capsule 300 mg	2	QL (360 per 30 days); MO; 90D
gabapentin oral capsule 400 mg	2	QL (270 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
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	5	PA; QL (30 per 30 days)
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	PA; QL (12 per 28 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
GOCOVRI	5	LA
GRALISE ORAL TABLET 450 MG	4	QL (30 per 30 days); MO
GRALISE ORAL TABLET 750 MG, 900 MG	5	QL (60 per 30 days); MO
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)
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)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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)
lacosamide oral solution	2	QL (1200 per 30 days); MO; 90D
lacosamide oral tablet	2	QL (60 per 30 days); MO; 90D
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
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
LIBERVANT	4	QL (10 per 30 days)
lithium	3	MO
lithium carbonate er	1	MO; 100D
lithium carbonate oral	1	MO; 100D
LORAZEPAM INTENSOL	2	QL (150 per 30 days)
lorazepam oral concentrate	2	QL (150 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	PA; 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
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; 90D
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 54 mg	2	PA; QL (30 per 30 days); MO; 90D
methylphenidate hcl er (osm) oral tablet extended release 36 mg	2	PA; QL (60 per 30 days); MO; 90D
methylphenidate hcl er oral tablet extended release 20 mg	2	PA; QL (90 per 30 days); MO; 90D
methylphenidate hcl oral solution 10 mg/5ml	2	PA; QL (900 per 30 days); MO; 90D
methylphenidate hcl oral solution 5 mg/5ml	2	PA; QL (1800 per 30 days); MO; 90D
methylphenidate hcl oral tablet 10 mg, 20 mg	2	PA; QL (90 per 30 days); MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
methylphenidate hcl oral tablet 5 mg	1	PA; QL (90 per 30 days); MO; 100D
methylphenidate hcl oral tablet chewable 10 mg	1	PA; QL (180 per 30 days); MO; 100D
methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg	1	PA; QL (90 per 30 days); MO; 100D
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; 90D
modafinil oral tablet 200 mg	2	PA; QL (60 per 30 days); MO; 90D
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	
naloxone hcl nasal	2	
naltrexone hcl oral	2	
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK	3	
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
NICOTROL	4	
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); LA
NUPLAZID ORAL TABLET 10 MG	5	PA; QL (30 per 30 days); LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
NURTEC	5	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 10 mg, 15 mg, 5 mg	2	MO; 90D
olanzapine oral tablet dispersible 20 mg	2	QL (30 per 30 days); MO; 90D
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
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
perphenazine oral	2	MO; 90D
perphenazine-amitriptyline	2	PA; MO; 90D; HRM
PERSERIS	5	QL (1 per 28 days); MO
phenelzine sulfate oral	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
phenobarbital oral elixir	1	PA; QL (3000 per 30 days); MO; 100D; 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
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; 100D
pregabalin oral capsule 200 mg	1	QL (90 per 30 days); MO; 100D
pregabalin oral capsule 225 mg, 300 mg	1	QL (60 per 30 days); MO; 100D
pregabalin oral solution	1	QL (900 per 30 days); MO; 100D
primidone oral	1	MO; 100D
protriptyline hcl	2	PA; MO; 90D; HRM
pyridostigmine bromide er	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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
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	5	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
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
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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
rufinamide oral tablet 400 mg	5	PA; QL (240 per 30 days); MO
RYTARY	4	ST; MO
SAVELLA	4	PA; QL (60 per 30 days); MO
SAVELLA TITRATION PACK	4	PA
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); LA
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, 250 MG, 500 MG	4	PA; QL (60 per 30 days); MO
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG	4	PA; QL (120 per 30 days); MO
SUBVENITE	1	MO; 100D
sumatriptan succinate oral	2	QL (9 per 30 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PA; QL (60 per 30 days); MO
SYMPAZAN ORAL FILM 5 MG	5	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	5	PA; QL (30 per 30 days)
tetrabenazine oral tablet 12.5 mg	5	PA; QL (240 per 30 days)
tetrabenazine oral tablet 25 mg	5	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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
tiagabine hcl	2	MO; 90D
TIGLUTIK	5	
tizanidine hcl oral	2	
tolcapone	5	PA; QL (180 per 30 days); MO
topiramate oral capsule sprinkle	2	MO; 90D
topiramate oral tablet	1	MO; 100D
tranylcypromine sulfate	2	MO; 90D
trazodone hcl oral	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
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	5	PA; QL (16 per 30 days)
UBRELVY ORAL TABLET 50 MG	5	PA; QL (20 per 30 days)
valproic acid oral capsule	2	MO; 90D
valproic acid oral solution	2	MO; 90D
VALTOCO 10 MG DOSE	4	
VALTOCO 15 MG DOSE	4	
VALTOCO 20 MG DOSE	4	
VALTOCO 5 MG DOSE	4	
varenicline tartrate (starter)	3	PA
varenicline tartrate oral tablet 0.5 mg	3	PA; QL (60 per 30 days)
varenicline tartrate oral tablet 1 mg, 1 mg (56 pack)	3	PA; QL (56 per 28 days)
varenicline tartrate(continue)	3	PA; 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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	2	MO; 90D
venlafaxine hcl er oral tablet extended release 24 hour 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); LA
vigabatrin oral tablet	5	PA; QL (180 per 30 days); LA
VIGADRONE ORAL PACKET	5	PA; QL (150 per 25 days); LA
VIGADRONE ORAL TABLET	5	PA; QL (180 per 30 days)
VIGPODER	5	PA; QL (150 per 25 days)
vilazodone hcl	2	QL (30 per 30 days); MO; 90D
VRAYLAR ORAL CAPSULE	5	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; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ZENZEDI ORAL TABLET 5 MG	2	QL (90 per 30 days); MO; 90D
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	4	PA; MO
zonisamide oral	2	MO; 90D
ZTALMY	5	QL (1100 per 30 days)
ZURZUVAE	5	
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)
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	
alclometasone dipropionate	2	
amcinonide external cream	2	
ammonium lactate external	1	
AMNESTEEM	2	
azelaic acid external	2	
benzoyl peroxide-erythromycin	2	
betamethasone dipropionate aug external cream	2	
betamethasone dipropionate aug external lotion	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
betamethasone dipropionate external cream	2	
betamethasone dipropionate external ointment	2	
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	
CLARAVIS	2	
CLINDACIN ETZ EXTERNAL SWAB	2	
CLINDACIN-P	2	
clindamycin phosphate external gel	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 propionate e	2	QL (120 per 30 days)
clobetasol propionate external cream	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)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CLODAN EXTERNAL SHAMPOO	2	
clotrimazole external cream	1	
clotrimazole external solution	1	
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)
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML	5	PA; QL (8 per 28 days)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	5	PA; QL (1.34 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	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)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	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 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	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	5	
ivermectin external cream	2	
JUBLIA	4	PA
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	5	
metronidazole external	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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)
MYORISAN	2	
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	2	
nystatin-triamcinolone	2	QL (120 per 30 days)
NYSTOP	2	
ORALONE	2	
PANRETIN	5	
PERIOGARD	1	
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	
REGRANEX	5	PA
SANTYL	4	QL (30 per 30 days)
selenium sulfide external lotion	2	
silver sulfadiazine external	2	
SSD (SILVER SULFADIAZINE)	2	
sulfacetamide sodium (acne)	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	2	
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	1	QL (454 per 30 days)
VALCHLOR	5	PA; LA
ZENATANE	2	
ELECTROLYTES / MINERALS / METALS / VITAMINS / ELECTROLITOS / MINERALES / METALES / VITAMINAS		
carglumic acid oral tablet soluble	5	PA; LA
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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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-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 %, 5-0.45 %, 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 intravenous solution 20-0.45 meq/l-%	2	
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
KLOR-CON ORAL TABLET EXTENDED RELEASE	1	MO; 100D
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	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	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
sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %	2	
sodium fluoride oral tablet 2.2 (1 f) mg	2	MO; 90D
sodium fluoride oral tablet chewable 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	QL (90 per 30 days); 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	B/D PA; MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
calcitriol oral solution	2	B/D PA; MO; 90D
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	5	B/D PA; QL (120 per 30 days)
CYCLOSET	4	QL (180 per 30 days); MO
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
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 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
GLUCAGEN HYPOKIT	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
glucagon emergency injection kit	2	
glyburide micronized oral tablet 1.5 mg	2	QL (240 per 30 days); MO; 90D
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	2	QL (120 per 30 days); MO; 90D
GLYXAMBI	3	QL (30 per 30 days); MO
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	3	QL (60 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
JANUVIA	3	QL (30 per 30 days); MO
JARDIANCE	3	QL (30 per 30 days); MO
JENTADUETO	3	QL (60 per 30 days); MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
LOKELMA ORAL PACKET 10 GM	3	QL (34 per 30 days); MO
LOKELMA ORAL PACKET 5 GM	3	QL (90 per 30 days); MO
metformin hcl er (mod) oral tablet extended release 24 hour 1000 mg	4	QL (60 per 30 days); MO
metformin hcl er (mod) oral tablet extended release 24 hour 500 mg	4	QL (120 per 30 days); MO
metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg	4	QL (60 per 30 days); MO
metformin hcl er (osm) oral tablet extended release 24 hour 500 mg	4	QL (120 per 30 days); MO
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	QL (90 per 30 days); MO; 90D
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR	3	PA; QL (2 per 28 days)
nateglinide oral tablet 120 mg	2	QL (90 per 30 days); MO; 90D
nateglinide oral tablet 60 mg	2	QL (180 per 30 days); MO; 90D
NOVOLIN 70/30	3	MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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 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
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/1.5ML	3	PA; QL (1.5 per 28 days)
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)
paricalcitol oral	2	B/D PA; MO; 90D
pioglitazone hcl oral tablet 15 mg	2	QL (90 per 30 days); MO; 90D
pioglitazone hcl oral tablet 30 mg	2	QL (45 per 30 days); MO; 90D
pioglitazone hcl oral tablet 45 mg	2	QL (30 per 30 days); MO; 90D
pioglitazone hcl-glimepiride	2	QL (30 per 30 days); MO; 90D
pioglitazone hcl-metformin hcl	2	QL (90 per 30 days); MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	4	PA; QL (1 per 180 days)
repaglinide oral tablet 0.5 mg	2	QL (960 per 30 days); MO; 90D
repaglinide oral tablet 1 mg	2	QL (480 per 30 days); MO; 90D
repaglinide oral tablet 2 mg	2	QL (240 per 30 days); MO; 90D
risedronate sodium oral tablet 150 mg	2	ST; QL (1 per 28 days); MO; 90D
risedronate sodium oral tablet 30 mg	2	ST; QL (30 per 30 days)
risedronate sodium oral tablet 35 mg	2	ST; QL (4 per 28 days); MO; 90D
risedronate sodium oral tablet 35 mg (12 pack), 35 mg (4 pack)	2	ST; QL (4 per 28 days); MO
risedronate sodium oral tablet 5 mg	2	ST; 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)
sodium polystyrene sulfonate oral powder	1	
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	5	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 600 mcg/2.4ml, 620 mcg/2.48ml	5	PA; QL (3 per 28 days)
tolvaptan oral tablet 15 mg	5	PA; QL (30 per 30 days)
tolvaptan oral tablet 30 mg	5	PA; QL (60 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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
TRESIBA	3	QL (30 per 30 days); MO
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	QL (30 per 30 days); MO
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML	3	QL (18 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	5	QL (240 per 30 days); MO
VELTASSA ORAL PACKET 16.8 GM, 25.2 GM	5	QL (30 per 30 days); MO
VELTASSA ORAL PACKET 8.4 GM	5	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 10-1000 MG, 10-500 MG, 5-500 MG	3	QL (30 per 30 days); MO
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG	3	QL (60 per 30 days); MO
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	5	PA; QL (60 per 30 days); MO
amoxicill-clarithro-lansopraz oral therapy pack	2	
aprepitant oral	2	B/D PA; QL (15 per 30 days)
aprepitant oral capsule 125 mg	4	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 & 125 mg	2	B/D PA; QL (15 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
aprepitant oral capsule 80 mg	2	B/D PA; QL (10 per 30 days)
balsalazide disodium	2	
budesonide er oral tablet extended release 24 hour	4	PA
budesonide oral	2	
budesonide rectal	2	
chlordiazepoxide-clidinium	2	PA; HRM
cimetidine hcl oral solution 300 mg/5ml	2	MO; 90D
cimetidine oral tablet 200 mg	2	
cimetidine oral tablet 300 mg, 400 mg, 800 mg	2	MO; 90D
CLENPIQ	4	
COMPRO	2	
constulose	1	MO; 100D
dexlansoprazole	2	ST; QL (30 per 30 days); MO; 90D
dicyclomine hcl oral capsule	1	
dicyclomine hcl oral solution	2	
dicyclomine hcl oral tablet	1	
diphenoxylate-atropine oral liquid	2	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
dronabinol	2	B/D PA; QL (120 per 30 days)
enulose	2	MO; 90D
esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg	2	QL (30 per 30 days); MO; 90D
famotidine oral tablet 20 mg, 40 mg	1	MO; 100D
fosaprepitant dimeglumine	2	
GATTEX	5	PA; LA
GAVILYTE-C	1	
GAVILYTE-G	1	
GAVILYTE-N WITH FLAVOR PACK	2	
generlac	2	MO; 90D
glycopyrrolate oral tablet 1 mg	1	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
glycopyrrolate oral tablet 2 mg	2	
granisetron hcl oral	2	B/D PA; QL (30 per 30 days)
hydrocortisone ace-pramoxine external cream 1-1 %	1	
hydrocortisone oral	1	
hyoscyamine sulfate oral tablet	2	MO; 90D
hyoscyamine sulfate oral tablet dispersible	2	MO; 90D
hyoscyamine sulfate sublingual	2	MO; 90D
lactulose encephalopathy oral solution 10 gm/15ml	1	MO; 100D
lactulose oral solution	1	MO; 100D
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	1	
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
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	
nizatidine oral capsule	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	
promethazine hcl oral tablet	1	
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
ursodiol oral capsule 300 mg	2	MO; 90D
ursodiol oral tablet	2	MO; 90D
VARUBI (180 MG DOSE)	4	B/D PA; QL (4 per 28 days)
VOWST	5	PA; QL (12 per 30 days)
XERMELO	5	PA; QL (90 per 30 days); LA
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT / TRASTORNO GENÉTICO, ENZIMÁTICO O PROTEICO: REEMPLAZO, MODIFICADORES, TRATAMIENTO		
betaine	5	LA
CREON	3	MO
cromolyn sodium oral	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CYSTAGON	4	PA; LA
GALAFOLD	5	PA; LA
JAVYGTOR	5	PA
miglustat	5	PA; LA
nitisinone	5	PA
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; LA
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
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
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	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER	3	QL (300 per 30 days); MO
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR	3	QL (30 per 30 days); MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
terconazole vaginal cream 0.4 %	1	
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 FE 1/20	1	MO; 100D
AYUNA	1	MO; 100D
AZURETTE	2	MO; 90D
BIJUVA	3	PA; MO; HRM
cabergoline	2	
CAMILA	3	MO
CHARLOTTE 24 FE	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CHATEAL EQ	1	MO; 100D
CLIMARA PRO	4	PA; QL (4 per 28 days); MO; HRM
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 100 MG/ML	2	PA; MO; 90D
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML	2	MO; 90D
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
desmopressin acetate spray	2	MO; 90D
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	2	MO; 90D
desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg	1	MO; 100D
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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
estradiol vaginal	2	MO; 90D
ethynodiol diac-eth estradiol oral tablet 1-50 mg-mcg	1	MO; 100D
etonogestrel-ethinyl estradiol	4	MO
EUTHYROX	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 FE 1/20	1	MO; 100D
HALOETTE	4	MO
HEATHER	3	MO
IMVEXXY MAINTENANCE PACK	3	QL (18 per 28 days); MO
IMVEXXY STARTER PACK	3	QL (18 per 28 days); MO
INCASSIA	3	MO
INCRELEX	5	PA; LA
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
KALLIGA	1	MO; 100D
KARIVA	2	MO; 90D
KELNOR 1/50	1	MO; 100D
KURVELO	1	MO; 100D
lanreotide acetate	5	PA
LARIN 1.5/30	2	MO; 90D
LARIN 1/20	1	MO; 100D
LARIN FE 1/20	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg	1	MO; 100D
LEVORA 0.15/30 (28)	1	MO; 100D
LEVO-T	1	MO; 100D
levothyroxine sodium oral tablet	1	MO; 100D
LEVOXYL	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
LYLEQ	3	MO
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
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 24 FE	1	MO; 100D
MICROGESTIN FE 1/20	1	MO; 100D
mifepristone oral tablet 300 mg	2	PA; LA; 90D
MILI	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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
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	5	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	5	PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE	5	PA; LA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED	5	PA; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
OSPHENA	3	MO
oxandrolone oral tablet 10 mg	2	PA; QL (60 per 30 days)
oxandrolone oral tablet 2.5 mg	2	PA; QL (240 per 30 days)
PIMTREA	2	MO; 90D
PORTIA-28	1	MO; 100D
prednisolone oral solution	2	
prednisolone sodium phosphate oral solution 25 mg/5ml, 6.7 (5 base) mg/5ml	2	
prednisolone sodium phosphate oral tablet dispersible	2	
prednisone oral solution	2	
prednisone oral tablet	1	
prednisone oral tablet therapy pack	1	
PREMARIN ORAL	3	PA; MO; HRM
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
SHAROBEL	3	MO
SIGNIFOR	5	PA; LA
SIMLIYA	2	MO; 90D
SKYLA	3	
SOMATULINE DEPOT	5	PA
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG	5	PA; LA
SPRINTEC 28	2	MO; 90D
SYNAREL	5	PA
SYNTHROID	3	MO
TARINA FE 1/20 EQ	1	MO; 100D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
testosterone cypionate intramuscular solution 100 mg/ml	2	PA; MO; 90D
testosterone cypionate intramuscular solution 200 mg/ml, 200 mg/ml (1 ml)	2	MO; 90D
testosterone enanthate intramuscular solution	2	PA; MO; 90D
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; 90D
testosterone transdermal gel 20.25 mg/1.25gm (1.62%)	2	PA; QL (112.5 per 30 days); MO; 90D
testosterone transdermal gel 25 mg/2.5gm (1%), 50 mg/5gm (1%)	2	PA; QL (300 per 30 days); MO; 90D
testosterone transdermal solution	2	PA; QL (180 per 30 days); MO; 90D
TRI FEMYNOR	2	MO; 90D
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
TRI-LO-SPRINTEC	2	MO; 90D
TRI-MILI	2	MO; 90D
TRI-NYMYO	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
viorele	2	MO; 90D
VOLNEA	2	MO; 90D
VYLIBRA	2	MO; 90D
WYMZYA FE	2	MO; 90D
yuvafem	2	MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
IMMUNOLOGICAL AGENTS / AGENTES INMUNITARIOS		
ABRYSVO	1	
ACTHIB	1	
ACTIMMUNE	5	PA; LA
ADACEL	1	
ARCALYST	5	PA
AREXVY	1	
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG	4	B/D PA
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 5 MG	5	B/D PA
AZASAN	4	B/D PA
azathioprine oral	2	B/D PA; 90D
bcg vaccine injection solution reconstituted	1	
BENLYSTA SUBCUTANEOUS	5	PA
BEXSERO	1	
BIVIGAM INTRAVENOUS SOLUTION 5 GM/50ML	3	PA
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5	1	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
COSENTYX (300 MG DOSE)	5	PA; QL (8 per 28 days); LA
COSENTYX SENSOREADY (300 MG)	5	PA; QL (8 per 28 days); LA
COSENTYX SENSOREADY PEN	5	PA; QL (8 per 28 days); LA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (8 per 28 days); LA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	5	PA; QL (2 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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	
diphtheria-tetanus toxoids dt	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
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE	1	B/D PA
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

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
GENGRAF ORAL SOLUTION	2	B/D PA; 90D
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	1	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE	1	B/D PA
HIBERIX INJECTION	1	
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 PEN-PEDIATRIC UC START SUBCUTANEOUS AUTO-INJECTOR KIT	5	PA; QL (8 per 365 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	1	
IXCHIQ	1	
IXIARO	1	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
JYLAMVO	4	ST
JYNNEOS	1	
kedrab injection solution 1500 unit/10ml	3	
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
leflunomide oral	2	QL (30 per 30 days); MO; 90D
MENACTRA INTRAMUSCULAR SOLUTION	1	
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	
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
MYHIBBIN	5	B/D PA
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 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
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
PEDVAX HIB INTRAMUSCULAR SUSPENSION	1	
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	
PENBRAYA	1	
PENTACEL	1	
PREHEVBRIO	1	B/D PA
PRIORIX	1	
PRIVIGEN INTRAVENOUS SOLUTION 10 GM/100ML, 20 GM/200ML, 5 GM/50ML	5	PA
PROGRAF ORAL PACKET	4	B/D PA
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	1	
QUADRACEL	1	
RABAVERT	1	
RECOMBIVAX HB	1	B/D PA
REZUROCK	5	PA; LA
RINVOQ	5	PA; QL (30 per 30 days)
RINVOQ LQ	5	PA; QL (360 per 30 days)
ROTARIX	1	
ROTATEQ ORAL SOLUTION	1	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	1	
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)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA; QL (6 per 365 days)
STELARA INTRAVENOUS	5	PA; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; QL (1 per 28 days); LA
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA; QL (1 per 28 days)
tacrolimus oral	2	B/D PA; 90D
TDVAX	1	
TENIVAC	1	
TICOVAC	1	
TREMFYA SUBCUTANEOUS SOLUTION AUTO-INJECTOR	5	PA; QL (2 per 28 days)
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	5	PA; QL (2 per 28 days)
TRUMENBA	1	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	1	
TYPHIM VI	1	
VAQTA	1	
VARIVAX	1	
VARIZIG INTRAMUSCULAR SOLUTION	3	
VAXCHORA	1	
XATMEP	4	ST
XELJANZ ORAL SOLUTION	5	PA; QL (240 per 24 days)
XELJANZ ORAL TABLET	5	PA; QL (60 per 30 days)
XELJANZ XR	5	PA; QL (30 per 30 days)
YF-VAX	1	
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
ABELCET	4	B/D PA
acyclovir oral capsule	1	MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
acyclovir oral suspension	2	MO
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-pot clavulanate er	2	
amoxicillin-pot clavulanate oral suspension reconstituted	2	
amoxicillin-pot clavulanate oral tablet	2	
amoxicillin-pot clavulanate oral tablet chewable 400-57 mg	2	
amphotericin b intravenous	2	B/D PA
ampicillin oral capsule 500 mg	1	
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	LA
atazanavir sulfate oral capsule 150 mg, 200 mg	2	QL (60 per 30 days); 90D
atazanavir sulfate oral capsule 300 mg	2	QL (30 per 30 days); 90D
atovaquone oral	2	PA
atovaquone-proguanil hcl	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
azithromycin intravenous	2	
azithromycin oral packet	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	PA
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	
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	2	
cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
cefoxitin sodium intravenous solution reconstituted 2 gm	4	
cefpodoxime proxetil	2	
cefprozil	2	
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	
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	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
COARTEM	4	
colistimethate sodium (cba)	2	
COMPLERA	5	QL (30 per 30 days)
dapsone oral	2	MO; 90D
daptomycin	5	
darunavir oral tablet 600 mg	4	QL (60 per 30 days)
darunavir oral tablet 800 mg	5	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	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	
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)
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	4	QL (30 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
emtricitabine-tenofovir df oral tablet 133-200 mg, 167-250 mg	5	QL (30 per 30 days)
emtricitabine-tenofovir df oral tablet 200-300 mg	2	QL (30 per 30 days); 90D
EMTRIVA ORAL SOLUTION	4	QL (850 per 30 days)
EMVERM	5	
entecavir	2	PA; 90D
EPCLUSA ORAL PACKET 150-37.5 MG	5	PA; QL (30 per 30 days)
EPCLUSA ORAL PACKET 200-50 MG	5	PA; QL (60 per 30 days)
EPCLUSA ORAL TABLET 200-50 MG	5	PA; QL (60 per 30 days)
EPCLUSA ORAL TABLET 400-100 MG	5	PA; QL (30 per 30 days)
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	5	PA
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	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	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	1	
erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml	4	
erythromycin ethylsuccinate oral tablet	2	
erythromycin lactobionate	4	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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)
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)
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED	5	QL (60 per 30 days)
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
imipenem-cilastatin intravenous solution reconstituted 250 mg	2	
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	4	QL (180 per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 25 MG	3	QL (720 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
isoniazid oral	1	MO; 100D
itraconazole oral capsule	2	PA
ivermectin oral	2	PA
JULUCA	5	QL (30 per 30 days)
ketoconazole oral	1	
LAGEVRIO	5	QL (40 per 90 days)
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 solution	2	QL (480 per 30 days); 90D
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	4	QL (120 per 30 days)
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	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
metronidazole intravenous solution 500 mg/100ml	2	
metronidazole oral capsule	2	
metronidazole oral tablet	1	
micafungin sodium	5	
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	5	
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)
nystatin oral tablet	1	
ODEFSEY	5	QL (30 per 30 days)
ofloxacin oral tablet 300 mg, 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)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
PAXLOVID (300/100)	2	QL (30 per 90 days)
penicillin g potassium	2	
penicillin g sodium	2	
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 intravenous solution reconstituted 2.25 (2-0.25) gm, 3-0.375 gm, 3.375 (3-0.375) gm, 4-0.5 gm, 4.5 (4-0.5) gm	2	
posaconazole oral	5	PA; MO
praziquantel oral	4	
PREVYMIS ORAL	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	
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	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ribavirin oral tablet 200 mg	2	
rifabutin	2	
rifampin intravenous	4	
rifampin oral	2	
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)
SELZENTRY ORAL TABLET 25 MG	4	QL (240 per 30 days)
SELZENTRY ORAL TABLET 75 MG	4	QL (60 per 30 days)
SIRTURO	5	PA; LA
sofosbuvir-velpatasvir	5	PA; QL (30 per 30 days)
streptomycin sulfate intramuscular	5	
STRIBILD	5	QL (30 per 30 days)
sulfadiazine oral	4	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet	1	
SUNLENCA ORAL	5	LA
SUNLENCA SUBCUTANEOUS	5	QL (3 per 168 days); MO
SYMTUZA	5	QL (30 per 30 days)
TAZICEF INJECTION SOLUTION RECONSTITUTED 1 GM	2	
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED	2	
TEFLARO	5	
tenofovir disoproxil fumarate	2	QL (30 per 30 days); 90D
terbinafine hcl oral	1	
tetracycline hcl oral capsule	2	
tigecycline	5	
tinidazole oral	2	
TIVICAY ORAL TABLET 10 MG	4	QL (120 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
TIVICAY ORAL TABLET 25 MG, 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	
TRECATOR	4	
trifluridine ophthalmic	2	
trimethoprim oral	1	
TRIUMEQ	5	QL (30 per 30 days)
TRIUMEQ PD	5	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	PA; QL (240 per 30 days)
vancomycin hcl oral capsule 250 mg	4	PA; QL (240 per 30 days)
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml	2	PA; QL (1200 per 30 days)
VIRACEPT ORAL TABLET 250 MG	5	QL (300 per 30 days)
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, 250 MG	5	QL (30 per 30 days)
VIREAD ORAL TABLET 200 MG	4	QL (30 per 30 days)
voriconazole intravenous	4	PA
voriconazole oral suspension reconstituted	5	PA; QL (300 per 30 days)
voriconazole oral tablet 200 mg	4	PA; QL (60 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
voriconazole oral tablet 50 mg	2	PA; QL (120 per 30 days)
XIFAXAN ORAL TABLET 200 MG	4	PA; QL (9 per 3 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; QL (84 per 28 days); MO
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	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
promethazine vc/codeine	6	ED
promethazine-codeine oral solution	6	ED
sodium chloride irrigation solution 0.9 %	1	
OPHTHALMIC AGENTS / AGENTES OFTÁLMICOS		
acetazolamide er	2	MO; 90D
ak-poly-bac	1	
atropine sulfate ophthalmic ointment	3	MO
atropine sulfate ophthalmic solution 1 %	2	MO; 90D
azelastine hcl ophthalmic	2	
bacitracin ophthalmic	2	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
bacitra-neomycin-polymyxin-hc	2	
BESIVANCE	4	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
betaxolol hcl ophthalmic	2	MO; 90D
bimatoprost ophthalmic	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	LA
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	
LOTEMAX OPHTHALMIC OINTMENT	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
LOTEMAX SM	3	
loteprednol etabonate	2	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	MO
methazolamide oral	2	MO; 90D
moxifloxacin hcl (2x day)	2	
moxifloxacin hcl ophthalmic solution	2	
neomycin-bacitracin zn-polymyx	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	
NEO-POLYCIN	2	
NEO-POLYCIN HC	2	
ofloxacin ophthalmic	1	
olopatadine hcl ophthalmic solution 0.2 %	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	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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	
tobramycin ophthalmic	1	
tobramycin-dexamethasone	2	
TOBREX OPHTHALMIC OINTMENT	4	
travoprost (bak free)	2	MO; 90D
VYZULTA	4	MO
XDEMVY	5	LA
XIIDRA	3	QL (60 per 30 days); MO
ZYLET	4	
OTIC AGENTS / AGENTES ÓTICOS		
acetic acid otic	1	
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); LA
ADVAIR HFA	3	QL (12 per 30 days); MO
albuterol sulfate hfa	2	MO; 90D
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml	2	B/D PA; QL (360 per 30 days); MO; 90D

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%	2	B/D PA; MO; 90D
albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml	2	B/D PA; QL (60 per 30 days); MO; 90D
albuterol sulfate oral syrup	1	MO; 100D
albuterol sulfate oral tablet	2	MO; 90D
ambrisentan	5	PA; QL (30 per 30 days); LA
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	3	QL (60 per 30 days); MO
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	2	QL (30 per 25 days)
azelastine-fluticasone	2	QL (23 per 28 days)
bosentan	5	PA; QL (60 per 30 days); LA
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
BRONCHITOL	5	PA; LA
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
carbinoxamine maleate oral solution	2	PA; HRM
CAYSTON	5	PA; LA
cetirizine hcl oral solution	1	
clemastine fumarate oral tablet 2.68 mg	2	PA; HRM
COMBIVENT RESPIMAT	4	QL (8 per 30 days); MO

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
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); LA
flunisolide nasal solution 25 mcg/act (0.025%)	1	QL (75 per 30 days)
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 50 mcg/act	3	QL (60 per 30 days); MO
fluticasone propionate diskus inhalation aerosol powder breath activated 250 mcg/act	3	QL (240 per 30 days); MO
fluticasone propionate hfa inhalation aerosol 110 mcg/act	3	QL (12 per 30 days); MO
fluticasone propionate hfa inhalation aerosol 220 mcg/act	3	QL (24 per 30 days); MO
fluticasone propionate hfa inhalation aerosol 44 mcg/act	3	QL (11 per 30 days); MO
fluticasone propionate nasal	1	QL (16 per 30 days)
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
hydroxyzine hcl oral syrup	1	QL (2880 per 28 days)
hydroxyzine hcl oral tablet 10 mg, 25 mg	1	QL (120 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
hydroxyzine hcl oral tablet 50 mg	1	QL (240 per 30 days)
hydroxyzine pamoate oral	2	QL (120 per 30 days)
ipratropium bromide inhalation	1	B/D PA; MO; 100D
ipratropium bromide nasal	1	QL (30 per 30 days); MO; 100D
ipratropium-albuterol	2	B/D PA; QL (540 per 30 days); MO; 90D
KALYDECO ORAL PACKET	5	PA; QL (56 per 28 days)
KALYDECO ORAL TABLET	5	PA; QL (60 per 30 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	1	QL (30 per 30 days)
mometasone furoate nasal	2	
montelukast sodium oral	2	MO; 90D
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR	5	PA; QL (3 per 28 days); LA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	5	PA; QL (3 per 28 days); LA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	5	PA; QL (0.4 per 28 days); LA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED	5	PA; QL (3 per 28 days); LA
OFEV	5	PA; QL (60 per 30 days)
olopatadine hcl nasal	2	QL (31 per 30 days)
OPSUMIT	5	PA; QL (30 per 30 days); LA
ORKAMBI ORAL PACKET	5	PA; QL (60 per 30 days)
ORKAMBI ORAL TABLET	5	PA; QL (120 per 30 days)
pirfenidone oral tablet 267 mg	5	PA; QL (270 per 30 days)
pirfenidone oral tablet 534 mg, 801 mg	5	PA; QL (90 per 30 days)
promethazine-phenylephrine	2	

You can find information on what the symbols and abbreviations in this table mean by going to page 10 of this document. Usted puede encontrar información del significado de los símbolos y abreviaciones en la página 20 de este documento.

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
PROVENTIL HFA	4	MO
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	5	B/D PA
roflumilast	2	PA; 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 HANDIHALER	3	QL (30 per 30 days); MO
SPIRIVA RESPIMAT	3	QL (4 per 30 days); MO
STIOLTO RESPIMAT	3	QL (4 per 30 days); MO
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG	5	PA; QL (56 per 28 days); LA
SYMDEKO ORAL TABLET THERAPY PACK 50-75 & 75 MG	5	PA; QL (56 per 28 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
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); LA
TRIKAFTA ORAL THERAPY PACK	5	PA; QL (56 per 28 days)
UPTRAVI ORAL	5	PA; QL (60 per 30 days); LA
UPTRAVI TITRATION	5	PA; LA
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); LA

You can find information on what the symbols and abbreviations in this table mean by going to page 10 of this document. Usted puede encontrar información del significado de los símbolos y abreviaciones en la página 20 de este documento.

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML	5	PA; QL (4 per 28 days); LA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML	5	PA; QL (8 per 28 days); LA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	5	PA; QL (4 per 28 days); LA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED	5	PA; QL (8 per 28 days); LA
zafirlukast	2	MO; 90D

You can find information on what the symbols and abbreviations in this table mean by going to page 10 of this document. Usted puede encontrar información del significado de los símbolos y abreviaciones en la página 20 de este documento.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-336-2069** (TTY: **1-877-206-0500**). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-336-2069** (TTY: **1-877-206-0500**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险計劃的任何疑 问。如果您需要此翻译服务，请致电 **1-877-336-2069** (TTY: **1-877-206-0500**)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險計劃可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 **1-877-336-2069** (TTY: **1-877-206-0500**)。我們講粵語的工作人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-877-336-2069** (TTY: **1-877-206-0500**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-877-336-2069** (TTY: **1-877-206-0500**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-877-336-2069** (TTY: **1-877-206-0500**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-336-2069** (TTY: **1-877-206-0500**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-336-2069** (TTY: **1-877-206-0500**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-877-336-2069 (TTY: 1-877-206-0500).** Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالخطة الصحية أو الأدوية. للحصول على مترجم فوري، ما عليك سوى الاتصال بنا على الرقم **1-877-336-2069 (TTY: 1-877-206-0500)** يمكن لشخص يتحدث الإنجليزية أن يساعدك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-336-2069** (TTY: **1-877-206-0500**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-877-336-2069** (TTY: **1-877-206-0500**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È unservizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-877-336-2069** (TTY: **1-877-206-0500**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-877-336-2069** (TTY: **1-877-206-0500**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-877-336-2069** (TTY: **1-877-206-0500**). Ta usługajest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-877-336-2069** (TTY: **1-877-206-0500**) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

HealthSun
HEALTH PLANS

1-877-336-2069 / TTY: 711 | Fax: 305-448-5783
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 25102, Version 11

This formulary was updated on 1/10/2025. 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 1/10/2025. 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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