



2024 Formulary/Formulario

(List of Covered Drugs/Lista de Medicamentos Cubiertos)

PBP	Plan Name/Nombre del Plan
070	Freedom VIP Care (HMO C-SNP)
072	Freedom VIP Savings (HMO C-SNP)
099	Freedom VIP Rewards (HMO C-SNP)

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

**LEA ATENTAMENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN
SOBRE LOS MEDICAMENTOS CUBIERTOS POR ESTE PLAN**

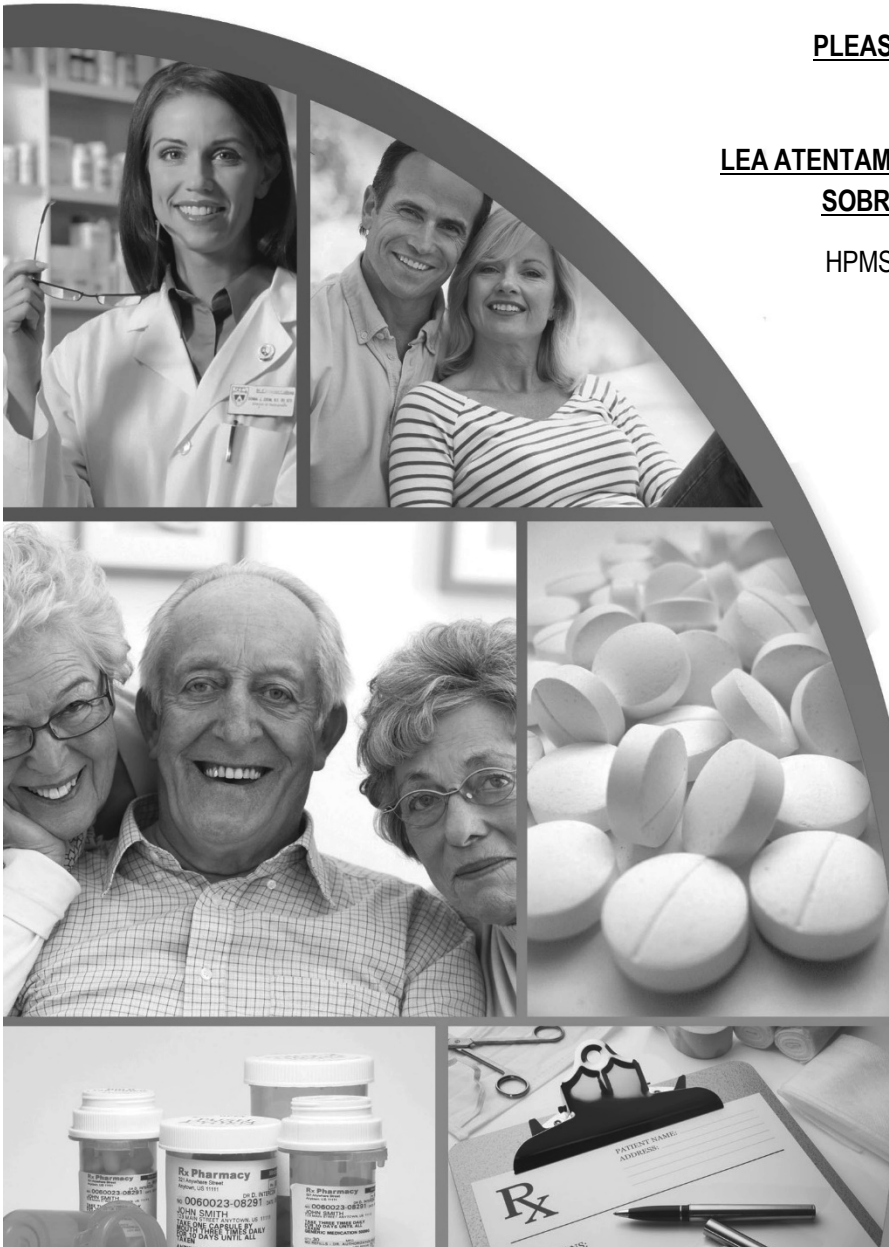
HPMS Approved Formulary File Submission ID24082, Version 15

Presentación de Archivo de Formulario

Aprobado por HPMS ID24082, Versión 15

This formulary was updated on 05/01/2024. For more recent information or other questions, please contact Freedom Health Member Services at 1-800-401-2740 or, for TTY users 711. From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. EST, or visit www.freedomhealth.com.

Este formulario fue actualizado el 05/01/2024. Para información más reciente u otras dudas, comuníquese con el Servicio de Atención al Cliente de Freedom Health al 1-800-401-2740 o 711 para los usuarios de TTY. Del 1 de octubre hasta el 31 de marzo, estamos abiertos los 7 días de la semana de 8 a.m. a 8 p.m. EST. Del 1 de abril hasta el 30 de septiembre, estamos abiertos de lunes a viernes, de 8 a.m. a 8 p.m. EST, o visite www.freedomhealth.com.



Freedom Health, Inc.

2024 Comprehensive Formulary

(List of Covered Drugs)

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

HPMS Approved Formulary File Submission ID24082, Version 15

This formulary was updated on 05/01/2024. For more recent information or other questions, please contact Freedom Health, Inc. Customer/Member Service at 1-800-401-2740 (TTY users should call 711). From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. EST, or visit www.freedomhealth.com.

o **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

o **Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

o **Important Message About What You Pay for Paxlovid** - Our plan covers Paxlovid at no cost to you. Call Member Services for more information.

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 Freedom Health, Inc. When it refers to “plan” or “our plan,” it means Freedom Health, Inc. This document includes a list of the drugs (formulary) for our plan which is current as of 05/01/2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the 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, 2024, and from time to time during the year.

What is the Freedom Health, Inc. Comprehensive Formulary?

A formulary is a list of covered drugs selected by Freedom Health, Inc. 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. Freedom Health, Inc. will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Freedom Health, Inc. network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that 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 the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the Freedom Health, Inc. Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and 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 add a generic drug that is not new to market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or 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, or at the time the member requests a refill of the drug, at which time the member will receive a *one month* 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. 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 Freedom Health, Inc.’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 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 Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 05/01/2024. To get updated information about the drugs covered by Freedom Health, Inc., please contact us. Our contact information appears on the front and back cover pages. In *the event of mid-year non-maintenance formulary changes*, members may be notified by formulary changes posted on our website at www.freedomhealth.com or through written communication such as your monthly Explanation of Benefits (EOB).

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 2. 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 page 1. 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 100. 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?

Freedom Health, Inc. 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 cost less than brand-name drugs.

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:** Freedom Health, Inc. requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Freedom Health, Inc. before you fill your prescriptions. If you don't get approval, Freedom Health, Inc. may not cover the drug.
- **Quantity Limits:** For certain drugs, Freedom Health, Inc. limits the amount of the drug that Freedom Health, Inc. will cover. For example, Freedom Health, Inc. provides 4 tablets per prescription for alendronate. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Freedom Health, Inc. 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, Freedom Health, Inc. may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Freedom Health, Inc. 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 2. 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 Freedom Health, Inc. 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 Freedom Health, Inc.'s formulary?" on page VI for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Freedom Health, Inc. pays for certain OTC drugs. Freedom Health, Inc. will provide these OTC drugs at no cost to you. The cost to Freedom Health, Inc. of these OTC drugs will not count toward your total Part D drug costs (that is, the cost of the OTC drugs does not count for the coverage gap).

OTC Drug Name	Drug Tier	Requirements/ Limits
Gastrointestinal Agents		
<i>Proton Pump Inhibitors</i>		
<i>lansoprazole oral capsule delayed release 15 mg</i>	1	GC
<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	1	GC
<i>omeprazole oral capsule delayed release 20 mg</i>	1	GC
<i>omeprazole oral tablet delayed release 20 mg</i>	1	GC
Respiratory Tract/Pulmonary Agents		
<i>Antihistamines</i>		
<i>cetirizine hcl oral solution 1 mg/ml</i>	1	GC
<i>cetirizine hcl oral tablet 10 mg</i>	1	GC
<i>cetirizine hcl oral tablet chewable 10 mg</i>	1	GC
<i>cetirizine-pseudoephedrine er oral tablet extended release 12-hour 5-120 mg</i>	1	GC
<i>children's loratadine oral syrup 5 mg/5ml</i>	1	GC
<i>fexofenadine hcl oral tablet 180 mg, 60 mg</i>	1	GC
<i>fexofenadine-pseudoephed er oral tablet extended release 12-hour 60-120 mg</i>	1	GC
<i>fexofenadine-pseudoephed er oral tablet extended release 24-hour 180-240 mg</i>	1	GC
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	1	GC
<i>loratadine oral tablet 10 mg</i>	1	GC
<i>loratadine-D 12-hour oral tablet extended release 5-120 mg</i>	1	GC
<i>loratadine-D 24-hour oral tablet extended release 10-240 mg</i>	1	GC

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.

If you learn that Freedom Health, Inc. does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Freedom Health, Inc. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Freedom Health, Inc.
- You can ask Freedom Health, Inc. to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Freedom Health, Inc. Formulary?

You can ask Freedom Health, Inc. 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 cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Freedom Health, Inc. 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.

Generally, Freedom Health, Inc. will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

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 your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to 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 if your ability to get your drugs is limited, 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. 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.

For current members who experience level of care changes, transition supplies will be provided. The pharmacy can contact the Pharmacy Help Desk to request a transition supply. This will allow the provider, pharmacy, and beneficiary time to contact the plan for an exception or appeal. Based on the medical condition of the member, if a level of care change occurs from LTC to home, then a temporary transition of a cumulative 30-day supply will be provided. If a level of care change occurs from home to LTC, then a temporary transition of a cumulative 34-day supply will be provided. Increases in dosing will not be limited by a "refill too soon" edit as the member moves from one level of care to another.

For more information

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

If you have questions about Freedom Health, Inc., 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>.

Freedom Health, Inc.'s Formulary

The formulary that begins on page 2 provides coverage information about the drugs covered by Freedom Health, Inc. If you have trouble finding your drug in the list, turn to the Index that begins on page 100.

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

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

Drug Tier

Tier 1 = Preferred Generic

Tier 2 = Preferred Brand

Tier 3 = Non-Preferred Drug

Tier 4 = Specialty Tier

Tier 5 = Select Diabetic Drugs

Most of the drugs on our formulary are also available by mail order. If you have questions about mail orders, please contact Member Service. Our contact information appears on the front and back cover pages.

The Drug Table below includes a column titled, “Drug Tier.” This column indicates what tier each drug is listed under. The following copayments/coinsurances are associated with the corresponding tiers if you receive the drugs at an in-network pharmacy. These copayments/coinsurances apply during the initial coverage phase. If you receive “Extra Help” refer to your Evidence of Coverage or LIS rider for details about your benefits during the coverage gap and catastrophic coverage.

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PBP	Retail Pharmacy for a 30-day supply in Tier 1	Retail Pharmacy for a 30-day supply in Tier 2	Retail Pharmacy for a 30-day supply in Tier 3	Retail Pharmacy for a 30-day supply in Tier 4	Retail Pharmacy for a 30-day supply in Tier 5
070	\$0	\$15	\$55	33%	\$0
072	\$0	\$20	\$60	33%	\$10
099	\$0	\$30	\$60	33%	\$10
PBP	Mail-Order Pharmacy for a 90- day supply (up to 100-day supply for some medications) in Tier 1	Mail-Order Pharmacy for a 90-day supply in Tier 2	Mail-Order Pharmacy for a 90-day supply in Tier 3	Mail-Order Pharmacy for Tier 4	Mail-Order Pharmacy for a 90-day supply in Tier 5
070	\$0	\$30	\$110	Mail Order Supply Not Available	\$0
072	\$0	\$40	\$120	Mail Order Supply Not Available	\$20
099	\$0	\$60	\$120	Mail Order Supply Not Available	\$20

ED: Excluded Drug. 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. These drugs may not be covered after you reach the Coverage Gap.

LA: Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer/Member Service at 1-800-401-2740. (TTY users should call 711). From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. EST, or visit www.freedomhealth.com.

GC: Gap Coverage. We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

QL: Quantity Limit. For certain drugs, Freedom Health, Inc. limits the amount of the drug that Freedom Health, Inc. will cover. For example, Freedom Health, Inc. provides 4 tablets per prescription for alendronate. This may be in addition to a standard one-month or three-month supply. Also, some drugs are limited to a specified amount “over time”, which means that Freedom Health, Inc will cover the total quantity listed over a specific time (days).

PA: Prior Authorization. Freedom Health, Inc. requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Freedom Health, Inc. before you fill your prescriptions. If you don't get approval, Freedom Health, Inc. may not cover the drug.

ST: Step Therapy. In some cases, Freedom Health, Inc. 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, Freedom Health, Inc. may not cover drug B unless you try Drug A first. If Drug A does not work for you, Freedom Health, Inc. will then cover Drug B.

B/D PA: Prior Authorization for Part B versus Part D. Freedom Health, Inc. requires authorization to determine whether certain drugs are covered by Medicare Part B or Medicare Part D.

NM: Not Mail Order. These are drugs that are not available through mail order.

NEDS: Non-Extended Days' Supply. These are drugs that cannot be obtained for an extended number of days' supply. These can only be filled up to a maximum of 30 days' supply.

OTC: These drugs are covered under your Medicare Prescription Drug Plan with a prescription, and they are also available over-the-counter for purchase without a prescription.

Freedom Health, Inc.
Formulario Completo 2024
(Lista de Medicamentos)

**LEA ATENTAMENTE: ESTE DOCUMENTO CONTIENE INFORMACIÓN
SOBRE LOS MEDICAMENTOS CUBIERTOS POR ESTE PLAN**

Formulario Submitido – Aprobado por HPMS ID24082, Versión 15

Este formulario se actualizó el 05/01/2024. Para obtener información más reciente o si tiene otras preguntas, comuníquese con Servicio a Miembros o el Servicio de Atención al Cliente de Freedom Health, Inc. al 1-800-401-2740 (los usuarios de TTY deben llamar al 711). Del 1 de octubre hasta el 31 de marzo, estamos abiertos los 7 días de la semana, de 8 a.m. a 8 p.m., EST. Del 1 de abril hasta el 30 de septiembre, estamos abiertos de lunes a viernes, de 8 a.m. a 8 p.m., EST, o bien visite www.freedomhealth.com.

o **Mensaje importante acerca del pago de las vacunas** - Nuestro plan cubre la mayoría de las vacunas de la Parte D sin costo para usted. Llame a Servicios para Miembros para obtener más información.

o **Mensaje importante acerca del pago de la insulina** - Usted no pagará más de \$35 por el suministro para un mes de cada producto de insulina cubierto por nuestro plan, sin importar a qué nivel de costos compartidos pertenezca.

o **Mensaje importante acerca del pago de la Paxlovid** - Nuestro plan cubre Paxlovid sin costo para usted. Llame a Servicios para Miembros para obtener más información.

Importante para los miembros existentes: Este formulario se ha modificado desde el año pasado. Consulte este documento para asegurarse de que aún contenga los medicamentos que usted toma.

Cuando esta lista de medicamentos (formulario) se refiere a “nosotros”, “nos” o “nuestro”, significa Freedom Health, Inc. Cuando se hace referencia a “plan” o “nuestro plan”, significa Freedom Health, Inc. Este documento incluye una lista de los medicamentos (formulario) para nuestro plan, que está vigente a partir de 05/01/2024. Para obtener un formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, figura en la tapa y contratapa.

Para poder utilizar su beneficio para medicamentos recetados, por lo general, debe recurrir a farmacias de la red. Los beneficios, el formulario, la red de farmacias, y/o los copagos/coaseguros pueden cambiar a partir del 1° de enero de 2024, y periódicamente durante el año.

¿Qué es el Formulario Completo de Freedom Health, Inc.?

Un formulario es una lista de medicamentos seleccionados por Freedom Health Inc. en consulta con un equipo de proveedores de atención de la salud, que representa las terapias recetadas consideradas como una parte necesaria de un programa de tratamiento de calidad. Freedom Health, Inc. generalmente cubrirá los medicamentos enumerados en nuestro formulario siempre y cuando el medicamento sea médicamente necesario, la receta sea dispensada en una farmacia de la red Freedom Health, Inc. y se cumplan otras normas del plan. Para obtener más información sobre cómo dispensar sus recetas, consulte su Evidencia de Cobertura.

¿Puede cambiar el Formulario (lista de medicamentos)?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos agregar o eliminar medicamentos en la Lista de medicamentos durante el año, moverlos a diferentes niveles de costo compartido o agregar nuevas restricciones. Debemos seguir las reglas de Medicare en la realización de estos cambios.

Cambios que pueden afectarlo este año: En los casos que se detallan a continuación, usted se verá afectado por el cambio en la cobertura durante este año:

- **Nuevos medicamentos genéricos.** Podemos eliminar de inmediato un medicamento de marca en nuestra Lista de medicamentos si lo reemplazamos con un nuevo medicamento genérico que aparecerá en el mismo nivel de participación en los costos o menor y con las mismas restricciones o menos. Además, al agregar el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero moverlo inmediatamente a un nivel de costo compartido diferente o agregar nuevas restricciones. Si actualmente está tomando ese medicamento de marca, es posible que no le informemos con anticipación antes de hacer ese cambio, pero luego le brindaremos información sobre los cambios específicos que hemos realizado.
 - Si realizamos dicho cambio, usted o quien prescribe pueden solicitarnos que hagamos una excepción y seguimos cubriendo el medicamento de marca por usted. El aviso que le proporcionamos también incluirá información sobre los pasos que puede seguir para solicitar una excepción, y puede encontrar información en la siguiente sección titulada "¿Cómo solicito una excepción al Formulario de Freedom Health, Inc.?"

- **Medicamentos retirados del mercado.** Si la Administración de Alimentos y Medicamentos (FDA, por siglos en inglés) considera que un medicamento de nuestro formulario no es seguro o el fabricante del medicamento lo retira del mercado, inmediatamente lo eliminaremos de nuestro formulario y notificaremos a los miembros que toman el medicamento.
- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que estén tomando un medicamento actualmente. Por ejemplo, podemos agregar un medicamento genérico que no es nuevo en el mercado para reemplazar un medicamento de marca que se encuentra actualmente en el formulario, o agregar nuevas restricciones al medicamento de marca o moverlo a un nivel distinto de costo compartido, o ambos. O podemos hacer cambios según las nuevas directrices clínicas. Si eliminamos medicamentos de nuestro formulario, o agregamos una autorización previa, límites de cantidad y/o restricciones de terapia escalonada de un medicamento o cambiamos un medicamento a un nivel de costo compartido más alto, debemos notificar a los miembros afectados el cambio al menos, 30 días antes de que el cambio entre en vigencia o en el momento en que el miembro solicita un reabastecimiento del medicamento, en ese momento el miembro recibirá un suministro de un mes para 30 días del medicamento.
 - Si hacemos estos otros cambios, usted o el emisor de recetas pueden pedirnos que hagamos una excepción y continuemos con la cobertura del medicamento de marca para usted. El aviso que le proporcionaremos también incluirá información sobre cómo solicitar una excepción y también puede encontrar información en la sección que se encuentra a continuación titulada "¿Cómo solicito una excepción al formulario de Freedom Health, Inc.?"

Cambios que no le afectarán si actualmente está tomando el medicamento. Generalmente, si toma un medicamento de nuestro formulario del 2024 que estaba cubierto a principios de año, no interrumpiremos ni reduciremos la cobertura del medicamento durante el año de cobertura del 2024, excepto según lo que se describió anteriormente. Esto significa que estos medicamentos seguirán estando disponibles al mismo costo compartido y sin restricciones nuevas para aquellos miembros que los tomen por el resto del año de cobertura. Este año, no recibirá un aviso directo sobre los cambios que no lo afectan. Sin embargo, el 1 de enero del próximo año, estos cambios podrían afectarlo, y es importante revisar la Lista de medicamentos del nuevo año de beneficios para conocer cualquier cambio en los medicamentos.

El formulario que se adjunta está vigente desde el 1 de mayo de 2024. Para obtener información actualizada sobre los medicamentos que cubre Freedom Health, Inc., comuníquese con nosotros. Nuestra información de contacto figura en la tapa y contratapa. En el caso de cambios a mediados de año en un formulario que no sea de mantenimiento, los miembros pueden ser notificados por medio de cambios en el formulario publicados en nuestro sitio web en www.freedomhealth.com o a través de una comunicación escrita, como la Explicación de beneficios (EOB) mensual.

¿Cómo utilizo el formulario?

Existen dos maneras de encontrar su medicamento dentro del formulario:

Condición médica

El formulario comienza en la página 2. Los medicamentos en este formulario están agrupados en categorías según el tipo de condiciones médicas para las que se utilizan. Por ejemplo, los medicamentos para tratar una condición cardíaca están enumerados en la categoría “Agentes Cardiovasculares”. Si usted sabe para qué se usa su medicamento, busque el nombre de la categoría en la lista que empieza en la página 1. Luego busque su medicamento bajo el nombre de la categoría correspondiente.

Lista en orden alfabético

Si no está seguro en qué categoría buscar, debe buscar su medicamento en el Índice que comienza en la página 100. El Índice brinda una lista alfabética de todos los medicamentos incluidos en este documento. Tanto los medicamentos de marca como los medicamentos genéricos se enumeran en el Índice. Busque en el Índice y encuentre su medicamento. Al lado de su medicamento verá el número de página en la que puede encontrar información de cobertura. Vaya a la página que se enumera en el Índice y encuentre el nombre de su medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Freedom Health, Inc. cubre medicamentos de marca y genéricos. Un medicamento genérico es aquel aprobado por la FDA porque tiene el mismo ingrediente activo que el medicamento de marca. Por lo general, los medicamentos genéricos cuestan menos que los de marca.

¿Existen restricciones para mi cobertura?

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

- **Autorización previa:** Freedom Health, Inc. requiere que usted o su médico obtengan autorización previa para ciertos medicamentos. Esto significa que necesita obtener aprobación de Freedom Health, Inc. antes de poder dispensar su receta. Si no obtiene la aprobación, Freedom Health, Inc. podría no cubrir el medicamento.
- **Límites de cantidad:** Para ciertos medicamentos, Freedom Health, Inc. limita la cantidad del medicamento que Freedom Health, Inc. cubrirá. Por ejemplo, Freedom Health, Inc. proporciona 4 tabletas por receta de alendronato. Esto puede ser adicional a un suministro estándar de un mes o de tres meses.
- **Terapia Escalonada:** En algunos casos, Freedom Health, Inc. requiere que usted pruebe primero ciertos medicamentos para tratar su condición médica antes de cubrir otro medicamento para esa condición. Por ejemplo, si ambos medicamentos A y B tratan su condición médica, Freedom Health, Inc. puede no cubrir el medicamento B a menos que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, Freedom Health, Inc. cubrirá el medicamento B.

Puede averiguar si su medicamento tiene requisitos o límites adicionales consultando el formulario que comienza en la página 2. También puede obtener más información sobre las restricciones aplicadas a medicamentos específicos cubiertos visitando nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y terapia escalonada. También puede pedirnos que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, figura en la tapa y contratapa.

Puede solicitar a Freedom Health, Inc. una excepción a estas restricciones o límites, o solicitar una lista de otros medicamentos similares que puedan tratar su condición médica. Vea la sección “¿Cómo solicito una excepción al formulario de Freedom Health, Inc.?” en la página XVII para obtener información sobre cómo solicitar una excepción.

¿Qué son los medicamentos de venta libre (over-the-counter, OTC)?

Los medicamentos de venta libre (OTC) son medicamentos que normalmente no están cubiertos por un Plan de Medicamentos Recetados de Medicare. Freedom Health, Inc. paga por ciertos medicamentos OTC. Freedom Health, Inc. le proporcionará estos medicamentos OTC sin costo para usted. El costo para Freedom Health, Inc. de estos medicamentos OTC no se tendrá en cuenta para calcular los costos totales por medicamentos de la Parte D (es decir, el costo de los medicamentos OTC no cuenta para la brecha de cobertura).

Nombre del Medicamento	Categoría de Medicamento	Requisitos/ Limitaciones
Agentes Gastrointestinales		
<i>Inhibidores de la Bomba de Protones</i>		
<i>lansoprazole oral capsule delayed release 15 mg</i>	1	GC
<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	1	GC
<i>omeprazole oral capsule delayed release 20 mg</i>	1	GC
<i>omeprazole oral tablet delayed release 20 mg</i>	1	GC
Tracto Respiratorio/Agentes Pulmonares		
<i>Antihistamínicos</i>		
<i>cetirizine hcl oral solution 1 mg/ml</i>	1	GC
<i>cetirizine hcl oral tablet 10 mg</i>	1	GC
<i>cetirizine hcl oral tablet chewable 10 mg</i>	1	GC
<i>cetirizine-pseudoephedrine er oral tablet extended release 12-hour 5-120 mg</i>	1	GC
<i>children's loratadine oral syrup 5 mg/5ml</i>	1	GC
<i>fexofenadine hcl oral tablet 180 mg, 60 mg</i>	1	GC
<i>fexofenadine-pseudoephed er oral tablet extended release 12-hour 60-120 mg</i>	1	GC
<i>fexofenadine-pseudoephed er oral tablet extended release 24-hour 180-240 mg</i>	1	GC
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	1	GC
<i>loratadine oral tablet 10 mg</i>	1	GC
<i>loratadine-D 12-hour oral tablet extended release 5-120 mg</i>	1	GC
<i>loratadine-D 24-hour oral tablet extended release 10-240 mg</i>	1	GC

¿Qué sucede si mi medicamento no se encuentra en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicio a Miembros y consultar si su medicamento está cubierto.

Si Freedom Health, Inc. no cubre su medicamento, usted tiene dos opciones:

- Puede pedir a Servicio a Miembros una lista de medicamentos similares que están cubiertos por Freedom Health, Inc. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por Freedom Health, Inc.
- Puede solicitar que Freedom Health, Inc. haga una excepción y cubra el medicamento. Consulte lo que se describe a continuación para obtener información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al formulario de Freedom Health, Inc.?

Puede solicitar que Freedom Health, Inc. haga una excepción a nuestras reglas de cobertura. Existen varios tipos de excepciones que puede solicitarnos.

- Puede solicitarnos que cubramos un medicamento aunque no esté en nuestro formulario. Si se aprueba, este medicamento estará cubierto a un nivel de distribución de costos predeterminado, y usted no podrá solicitarnos que le suministremos dicho medicamento a un nivel de distribución de costos menor.
- Puede solicitar que cubramos un medicamento del formulario a un nivel de distribución de costos menor, a menos que dicho medicamento se encuentre dentro de los medicamentos especializados. Si se aprueba, esto disminuiría la cantidad que debe pagar por su medicamento.
- Puede pedirnos que eximamos las restricciones o límites de cobertura de su medicamento. Por ejemplo, para ciertos medicamentos, Freedom Health, Inc. limita la cantidad del medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede solicitar que eximamos el límite y que cubramos más.

Por lo general, Freedom Health, Inc. aprobará su solicitud de una excepción únicamente si los medicamentos alternativos incluidos en el formulario del plan, el medicamento de menor nivel de distribución de costos o las restricciones de utilización adicional no son favorables para tratar su condición y/o harán que padezca efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión de cobertura inicial para obtener una excepción al formulario, nivel o restricción de utilización. **Al solicitar una excepción al formulario, nivel o restricción de utilización, deberá enviar una declaración de su emisor de recetas o médico justificando su solicitud.** Por lo general, debemos tomar nuestra decisión dentro de las 72 horas después de obtener la declaración en la que su emisor de recetas realiza la justificación. Puede solicitar una excepción expeditiva (rápida) si usted o su médico creen que su salud corre un riesgo grave al esperar hasta 72 horas por una decisión. Si se le otorga la solicitud de agilización, debemos darle una respuesta dentro de las 24 horas luego de recibir la declaración justificativa del médico o de otro emisor de recetas.

¿Qué hago antes de hablar con mi médico sobre cambiar mis medicamentos o solicitar una excepción?

Como miembro nuevo o miembro que continúa en nuestro plan, podría estar tomando medicamentos que no están en nuestro formulario. O podría estar tomando un medicamento que está en nuestro formulario, pero su capacidad para obtenerlo es limitada. Por ejemplo, puede necesitar una autorización previa de nuestra parte antes de poder dispensar su receta. Deberá hablar con su médico para decidir si debe cambiar a un medicamento adecuado que cubramos o solicitar una excepción al formulario para que cubramos el medicamento que está tomando. Mientras consulta con su médico el curso de acción acorde para usted, podemos cubrir su medicamento en ciertos casos durante los primeros 90 días en los que usted es miembro de nuestro plan.

Para cada uno de sus medicamentos que no está en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, cubriremos un suministro temporal de 30 días. Si su receta se escribe para menos días, permitiremos que los resurtidos proporcionen hasta un suministro máximo de 30 días de medicamentos. Después de su primer suministro de 30 días, no pagaremos estos medicamentos, incluso si ha sido miembro del plan en menos de 90 días.

Si usted es residente de un centro de cuidado a largo plazo y necesita un medicamento que no está en nuestro formulario o si su capacidad para obtener sus medicamentos es limitada, pero ya pasaron los primeros 90 días de membresía en nuestro plan, le cubriremos un suministro de emergencia de 34 días de ese medicamento mientras persigue una excepción al formulario.

Los miembros actuales que experimenten cambios en el nivel de atención recibirán suministros de transición. La farmacia puede comunicarse con la Mesa de Ayuda para Farmacias a fin de solicitar un suministro de transición. Esto dará al proveedor, a la farmacia y al beneficiario tiempo para comunicarse con el plan para solicitar una excepción o realizar una apelación. Según la condición médica del miembro, si ocurre un cambio en el nivel de atención desde el LTC (Cuidado a largo plazo) hasta la casa, entonces se brindará un suministro acumulativo de 30 días de transición temporal. Si ocurre un cambio en el nivel de atención desde la casa hasta el LTC, entonces se brindará un suministro acumulativo de 34 días de transición temporal. Una revisión con una calificación de “recambio demasiado pronto” no limitará los aumentos de dosis a medida que el miembro pasa de un nivel de atención a otro.

Para obtener más información

Para obtener información más detallada sobre su cobertura de medicamentos recetados de Freedom Health, Inc. consulte su Evidencia de Cobertura y otros materiales del plan.

Si tiene alguna pregunta acerca de Freedom Health, Inc., comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, figura en la tapa y contratapa.

Si tiene preguntas generales sobre la cobertura de medicamentos recetados 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 Freedom Health, Inc.

El formulario completo que comienza en la página 2 le brinda información de cobertura acerca de los medicamentos cubiertos por Freedom Health, Inc. Si tiene problemas para encontrar su medicamento en la lista, consulte el Índice que comienza en la página 100.

La primera columna del cuadro enumera el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (p. ej., JANUVIA) y los medicamentos genéricos en letra minúscula y cursiva (p. ej., *lisinopril*).

La información en la columna Requisitos/Límites le indica si Freedom Health, Inc. tiene algunos requisitos especiales para la cobertura de su medicamento.

Nivel del Medicamento

Nivel 1 = Medicamentos Genéricos Preferidos

Nivel 2 = Medicamentos de Marca Preferidos

Nivel 3 = Medicamentos No Preferidos

Nivel 4 = Medicamentos Especializados

Nivel 5 = Medicamentos para Diabéticos Selectos

La mayoría de los medicamentos incluidos en nuestro formulario también están disponibles en pedidos por correo. Si tiene preguntas acerca de los pedidos por correo, comuníquese con Servicio a Miembros. Nuestra información de contacto figura en la tapa y contratapa.

La siguiente Tabla de Medicamentos incluye una columna titulada “Nivel de Medicamentos”. Esta columna indica bajo qué nivel está enumerado cada medicamento. Los siguientes copagos/coseguros se asocian con los niveles correspondientes si recibe los medicamentos en una farmacia de la red. Estos copagos/coseguros se aplican durante la fase inicial de cobertura. Si recibe "Ayuda Adicional" (Extra Help), consulte su Evidencia de Cobertura o el Anexo LIS para obtener más información acerca de sus beneficios durante la etapa sin cobertura y la cobertura catastrófica.

Presentación del Archivo del Formulario Aprobado por el ID24082					
PBP	Farmacia Minorista para un suministro de 30 días en el Nivel 1	Farmacia Minorista para un suministro de 30 días en el Nivel 2	Farmacia Minorista para un suministro de 30 días en el Nivel 3	Farmacia Minorista para un suministro de 30 días en el Nivel 4	Farmacia Minorista para un suministro de 30 días en el Nivel 5
070	\$0	\$15	\$55	33%	\$0
072	\$0	\$20	\$60	33%	\$10
099	\$0	\$30	\$60	33%	\$10
PBP	Farmacia de Pedido por Correo para un suministro de 90 días (máximo un suministro de 100 días para algunos medicamentos) en el Nivel 1	Farmacia de Pedido por Correo para un suministro de 90 días en el Nivel 2	Farmacia de Pedido por Correo para un suministro de 90 días en el Nivel 3	Farmacia de Pedido por Correo para el Nivel 4	Farmacia de Pedido por Correo para un suministro de 90 días en el Nivel 5
070	\$0	\$30	\$110	Suministro de pedidos por correo no disponible	\$0
072	\$0	\$40	\$120	Suministro de pedidos por correo no disponible	\$20
099	\$0	\$60	\$120	Suministro de pedidos por correo no disponible	\$20

ED: Medicamento Excluido (Excluded Drug). Este medicamento recetado generalmente no está cubierto por un Plan de Medicamentos Recetados de Medicare. El monto que usted paga cuando le dispensan una receta de este medicamento no cuenta entre los costos de medicamentos totales (es decir, el monto que paga no lo ayuda a reunir los requisitos para la cobertura catastrófica). Además, si recibe ayuda adicional para pagar sus recetas, no obtendrá ayuda adicional para pagar este medicamento. Estos medicamentos pueden no estar cubiertos después de alcanzar la Etapa sin Cobertura.

LA: Acceso Limitado (Limited Access). Esta receta puede estar disponible solo en ciertas farmacias. Para mayor información, consulte su Directorio de Farmacias o comuníquese con el Servicio de Atención al Cliente o el Servicio a Miembros de Freedom Health, Inc. al 1-800-401-2740 o, para los usuarios de TTY, al 711. Del 1 de octubre hasta el 31 de marzo, estamos abiertos los 7 días de la semana, de 8 a.m. a 8 p.m., EST. Del 1 de abril hasta el 30 de septiembre, estamos abiertos de lunes a viernes, de 8 a.m. a 8 p.m., EST, o bien visite www.freedomhealth.com.

GC: Etapa sin Cobertura (Gap Coverage). Brindamos cobertura adicional de este medicamento recetado en la etapa sin cobertura. Consulte su Evidencia de Cobertura para obtener más información sobre esta cobertura.

QL: Límite de Cantidad (Quantity Limit). Para *ciertos medicamentos*, Freedom Health, Inc. limita *la cantidad del* medicamento que Freedom Health, Inc. cubrirá. Por ejemplo, Freedom Health, Inc. proporciona 4 tabletas por receta de alendronato. Esto puede ser adicional a un suministro estándar de un mes o de tres meses. También, algunos medicamentos se limitan a un monto especificado “durante el tiempo”, lo que significa que Freedom Health, Inc. cubrirá la cantidad total indicada en un tiempo específico (días).

PA: Autorización Previa (Prior Authorization). Freedom Health, Inc. requiere que usted o su médico obtengan autorización previa para ciertos medicamentos. Esto significa que necesita obtener aprobación de Freedom Health, Inc. antes de poder dispensar su receta. Si no obtiene la aprobación, Freedom Health, Inc. podría no cubrir el medicamento.

ST: Terapia Escalonada (Step Therapy). En algunos casos, Freedom Health, Inc. requiere que usted pruebe primero ciertos medicamentos para tratar su condición médica antes de cubrir otro medicamento para esa condición. Por ejemplo, si ambos medicamentos A y B tratan su condición médica, Freedom Health, Inc. puede no cubrir el medicamento B a menos que usted pruebe primero el medicamento A. Si el medicamento A no funciona para usted, Freedom Health, Inc. cubrirá el medicamento B.

B/D PA: Autorización Previa (Prior Authorization) para la Parte B frente a la Parte D. Freedom Health, Inc. requiere autorización para determinar si ciertos medicamentos tienen cobertura de Medicare Parte B o Medicare Parte D.

NM: Pedido No por Correo postal (Not Mail Order). Estos son medicamentos que no están disponibles en nuestras farmacias de envío por correo postal.

NEDS: Suministro de Días no Extendido (Non-Extended Days' Supply). Estos son medicamentos que no se pueden obtener para un suministro extendido de días. Solamente se pueden dispensar recetas hasta por un máximo de 30 días de suministro.

OTC: Estos medicamentos están cubiertos por su plan de medicamentos recetados de Medicare con receta y también están disponibles sin receta para su compra sin receta.

List of Covered Drugs / Lista de Medicamentos

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ANALGESICS AND ANTI-INFLAMMATORY AGENTS		
<i>acetaminophen-codeine #2 oral tablet 300-15 mg</i>	1	QL (180 per 30 days); NEDS; GC
<i>acetaminophen-codeine #3 oral tablet 300-30 mg</i>	1	QL (180 per 30 days); NEDS; GC
<i>acetaminophen-codeine #4 oral tablet 300-60 mg</i>	1	QL (180 per 30 days); NEDS; GC
<i>acetaminophen-codeine oral solution 120-12 mg/5ml</i>	1	QL (900 per 30 days); NEDS; GC
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg</i>	1	QL (180 per 30 days); NEDS; GC
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	GC
<i>buprenorphine transdermal patch weekly 10 mcg/1hr, 15 mcg/1hr, 20 mcg/1hr, 5 mcg/1hr, 7.5 mcg/1hr</i>	3	PA; QL (4 per 28 days); NEDS
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	1	GC
<i>codeine sulfate oral tablet 15 mg, 30 mg, 60 mg</i>	2	QL (180 per 30 days); NEDS
<i>colchicine oral tablet 0.6 mg</i>	2	
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	1	GC
<i>diclofenac potassium oral tablet 50 mg</i>	1	GC
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	1	GC
<i>diclofenac sodium external gel 1 %</i>	3	QL (1000 per 30 days)
<i>diclofenac sodium external solution 1.5 %</i>	2	QL (300 per 30 days)
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	1	GC
<i>diflunisal oral tablet 500 mg</i>	2	
<i>duramorph injection solution 0.5 mg/ml, 1 mg/ml</i>	3	
<i>ec-naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	GC
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	2	QL (180 per 30 days); NEDS
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	1	GC
<i>etodolac oral capsule 200 mg, 300 mg</i>	2	
<i>etodolac oral tablet 400 mg, 500 mg</i>	1	GC
<i>febuxostat oral tablet 40 mg, 80 mg</i>	3	ST
<i>fenoprofen calcium oral tablet 600 mg</i>	1	GC

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

May 2024

DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>fentanyl citrate buccal tablet 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	4	PA; QL (120 per 30 days); NEDS
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr</i>	3	PA; QL (15 per 30 days); NEDS
<i>flurbiprofen oral tablet 100 mg</i>	1	GC
GLYDO EXTERNAL PREFILLED SYRINGE 2 %	1	GC
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	QL (180 per 30 days); NEDS; GC
<i>hydromorphone hcl injection solution 2 mg/ml</i>	3	
<i>hydromorphone hcl oral tablet 2 mg, 4 mg, 8 mg</i>	3	QL (180 per 30 days); NEDS
<i>hydromorphone hcl pf injection solution 10 mg/ml, 50 mg/5ml, 500 mg/50ml</i>	3	
IBU ORAL TABLET 400 MG, 600 MG, 800 MG	1	GC
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	GC
<i>ketoprofen er oral capsule extended release 24 hour 200 mg</i>	1	GC
<i>ketoprofen oral capsule 50 mg</i>	1	GC
<i>ketorolac tromethamine oral tablet 10 mg</i>	2	PA
<i>lidocaine external patch 5 %</i>	3	PA; QL (90 per 30 days)
<i>lidocaine hcl external solution 4 %</i>	1	PA; QL (300 per 30 days); GC
<i>lidocaine hcl urethral/mucosal external gel 2 %</i>	1	GC
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	1	GC
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	1	GC
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	2	QL (30 per 30 days)
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	1	GC
<i>methadone hcl oral solution 10 mg/5ml, 5 mg/5ml</i>	1	QL (900 per 30 days); NEDS; GC
<i>methadone hcl oral tablet 10 mg, 5 mg</i>	1	PA; QL (180 per 30 days); NEDS; GC
<i>morphine sulfate (concentrate) oral solution 10 mg/0.5ml, 100 mg/5ml, 20 mg/ml</i>	1	QL (180 per 30 days); NEDS; GC
<i>morphine sulfate (pf) injection solution 0.5 mg/ml, 1 mg/ml</i>	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	3	PA; QL (30 per 30 days); NEDS
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg</i>	2	PA; QL (60 per 30 days); NEDS
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg, 60 mg</i>	2	PA; QL (90 per 30 days); NEDS
<i>morphine sulfate injection solution 2 mg/ml, 4 mg/ml, 50 mg/ml</i>	2	
<i>morphine sulfate oral solution 10 mg/5ml, 20 mg/5ml</i>	1	QL (900 per 30 days); NEDS; GC
<i>morphine sulfate oral tablet 15 mg, 30 mg</i>	1	QL (180 per 30 days); NEDS; GC
<i>nabumetone oral tablet 500 mg, 750 mg</i>	1	GC
<i>naproxen dr oral tablet delayed release 500 mg</i>	1	GC
<i>naproxen oral suspension 125 mg/5ml</i>	1	GC
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	1	GC
<i>naproxen oral tablet delayed release 375 mg, 500 mg</i>	1	GC
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	GC
<i>oxaprozin oral tablet 600 mg</i>	2	
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg, 40 mg</i>	2	PA; QL (60 per 30 days); NEDS
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 80 mg</i>	3	PA; QL (60 per 30 days); NEDS
<i>oxycodone hcl oral concentrate 10 mg/0.5ml, 100 mg/5ml</i>	3	QL (180 per 30 days); NEDS
<i>oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	2	QL (180 per 30 days); NEDS
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	QL (180 per 30 days); NEDS
<i>piroxicam oral capsule 10 mg, 20 mg</i>	2	
<i>probenecid oral tablet 500 mg</i>	2	
RELAFEN ORAL TABLET 500 MG, 750 MG	1	GC
<i>sulindac oral tablet 150 mg, 200 mg</i>	1	GC
<i>tolmetin sodium oral tablet 600 mg</i>	1	GC
<i>tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	PA; QL (30 per 30 days); NEDS
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg</i>	3	PA; QL (30 per 30 days); NEDS

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>tramadol hcl oral tablet 50 mg</i>	1	QL (240 per 30 days); NEDS; GC
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	1	QL (40 per 5 days); NEDS; GC
ANTINEOPLASTICS		
<i>abiraterone acetate oral tablet 250 mg</i>	4	PA; QL (120 per 30 days); NEDS; NM
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG	4	PA; QL (30 per 30 days); NEDS; NM
ALECENSA ORAL CAPSULE 150 MG	4	PA; QL (240 per 30 days); NEDS; NM; LA
ALUNBRIG ORAL TABLET 180 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
ALUNBRIG ORAL TABLET 30 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
ALUNBRIG ORAL TABLET 90 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	4	PA; QL (30 per 180 days); NEDS; NM; LA
<i>anastrozole oral tablet 1 mg</i>	1	QL (30 per 30 days); GC
AUGTYRO ORAL CAPSULE 40 MG	4	PA; QL (240 per 30 days); NEDS; NM
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
BALVERSA ORAL TABLET 3 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
BALVERSA ORAL TABLET 4 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
BALVERSA ORAL TABLET 5 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML	4	PA; NEDS; NM; LA
BESREMI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 500 MCG/ML	4	PA; NEDS; NM; LA
<i>bexarotene oral capsule 75 mg</i>	4	PA; QL (300 per 30 days); NEDS; NM
<i>bicalutamide oral tablet 50 mg</i>	2	QL (30 per 30 days)
<i>bortezomib intravenous solution reconstituted 3.5 mg</i>	4	PA; NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
BOSULIF ORAL CAPSULE 100 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
BOSULIF ORAL CAPSULE 50 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
BOSULIF ORAL TABLET 100 MG	4	PA; QL (120 per 30 days); NEDS; NM
BOSULIF ORAL TABLET 400 MG, 500 MG	4	PA; QL (30 per 30 days); NEDS; NM
BRAFTOVI ORAL CAPSULE 75 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
BRUKINSA ORAL CAPSULE 80 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
CALQUENCE ORAL CAPSULE 100 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
CALQUENCE ORAL TABLET 100 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
CAPRELSA ORAL TABLET 100 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
CAPRELSA ORAL TABLET 300 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG	4	PA; QL (56 per 28 days); NEDS; NM; LA
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG	4	PA; QL (112 per 28 days); NEDS; NM; LA
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	4	PA; QL (84 per 28 days); NEDS; NM; LA
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
COTELLIC ORAL TABLET 20 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
<i>cyclophosphamide intravenous solution 1 gm/5ml, 2 gm/10ml, 500 mg/2.5ml, 500 mg/ml</i>	4	NEDS; NM
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	2	B/D PA; NM
CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	4	PA; NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
DARZALEX FASPRO SUBCUTANEOUS SOLUTION 1800-30000 MG-UT/15ML	4	PA; NEDS; NM
DARZALEX INTRAVENOUS SOLUTION 400 MG/20ML	4	PA; NEDS; NM; LA
DAURISMO ORAL TABLET 100 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
DAURISMO ORAL TABLET 25 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 7.5 MG	3	PA; NM
EMCYT ORAL CAPSULE 140 MG	4	NEDS; NM
ENHERTU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	4	PA; NEDS; NM
ERIVEDGE ORAL CAPSULE 150 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
<i>erleada oral tablet 240 mg</i>	4	PA; NEDS; NM; LA
ERLEADA ORAL TABLET 60 MG	4	PA; NEDS; NM; LA
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
<i>erlotinib hcl oral tablet 25 mg</i>	4	PA; QL (90 per 30 days); NEDS; NM
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	4	PA; NEDS; NM
<i>everolimus oral tablet soluble 2 mg, 3 mg, 5 mg</i>	4	PA; NEDS; NM
<i>exemestane oral tablet 25 mg</i>	3	QL (60 per 30 days)
EXKIVITY ORAL CAPSULE 40 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
FIRMAGON (240 MG DOSE) SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG/VIAL	4	PA; NEDS; NM
FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG	3	PA; NM
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG	4	PA; QL (21 per 28 days); NEDS; NM
FRUZAQLA ORAL CAPSULE 1 MG	4	PA; QL (84 per 28 days); NEDS; NM; LA
FRUZAQLA ORAL CAPSULE 5 MG	4	PA; QL (21 per 28 days); NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
GAVRETO ORAL CAPSULE 100 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
GAZYVA INTRAVENOUS SOLUTION 1000 MG/40ML	4	PA; NEDS; NM; LA
<i>gefitinib oral tablet 250 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	3	PA; NM
HERCEPTIN HYLECTA SUBCUTANEOUS SOLUTION 600-10000 MG-UNT/5ML	4	B/D PA; NEDS; NM
<i>hydroxyurea oral capsule 500 mg</i>	1	GC
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	4	PA; QL (21 per 28 days); NEDS; NM; LA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG	4	PA; QL (21 per 28 days); NEDS; NM; LA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
IDHIFA ORAL TABLET 100 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
IDHIFA ORAL TABLET 50 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
<i>imatinib mesylate oral tablet 100 mg</i>	4	PA; QL (90 per 30 days); NEDS; NM
<i>imatinib mesylate oral tablet 400 mg</i>	4	PA; QL (60 per 30 days); NEDS; NM
IMBRUVICA ORAL CAPSULE 140 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
IMBRUVICA ORAL CAPSULE 70 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
IMBRUVICA ORAL SUSPENSION 70 MG/ML	4	PA; QL (216 per 27 days); NEDS; NM; LA
IMBRUVICA ORAL TABLET 140 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
INLYTA ORAL TABLET 1 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
INLYTA ORAL TABLET 5 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
INQOVI ORAL TABLET 35-100 MG	4	PA; QL (5 per 28 days); NEDS; NM; LA
INREBIC ORAL CAPSULE 100 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
IWILFIN ORAL TABLET 192 MG	4	PA; QL (240 per 30 days); NEDS; NM
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
JAYPIRCA ORAL TABLET 100 MG	4	PA; QL (60 per 30 days); NEDS; NM
JAYPIRCA ORAL TABLET 50 MG	4	PA; QL (30 per 30 days); NEDS; NM
KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG	4	PA; NEDS; NM
KEYTRUDA INTRAVENOUS SOLUTION 100 MG/4ML	4	PA; NEDS; NM
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; QL (21 per 21 days); NEDS; NM
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; QL (42 per 21 days); NEDS; NM
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; QL (63 per 21 days); NEDS; NM
KISQALI FEMARA (200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	4	PA; QL (49 per 28 days); NEDS; NM
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	4	PA; QL (70 per 28 days); NEDS; NM
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	4	PA; QL (91 per 28 days); NEDS; NM
KRAZATI ORAL TABLET 200 MG	4	PA; QL (180 per 30 days); NEDS; NM
<i>lapatinib ditosylate oral tablet 250 mg</i>	4	PA; QL (180 per 30 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>lenalidomide oral capsule 10 mg</i>	4	PA; QL (60 per 30 days); NEDS; NM; LA
<i>lenalidomide oral capsule 15 mg, 2.5 mg, 20 mg, 25 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM; LA
<i>lenalidomide oral capsule 5 mg</i>	4	PA; QL (150 per 30 days); NEDS; NM; LA
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
<i>letrozole oral tablet 2.5 mg</i>	1	QL (30 per 30 days); GC
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	2	
LEUKERAN ORAL TABLET 2 MG	2	
<i>leuprolide acetate (3 month) intramuscular injectable 22.5 mg</i>	3	PA; NM
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	2	PA; NM
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	4	PA; NEDS; NM
LORBRENA ORAL TABLET 100 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
LORBRENA ORAL TABLET 25 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
LUMAKRAS ORAL TABLET 120 MG	4	PA; QL (240 per 30 days); NEDS; NM; LA

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<i>lumakras oral tablet 320 mg</i>	4	PA; QL (90 per 30 days); NEDS; NM
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG	4	PA; QL (1 per 28 days); NEDS; NM
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 22.5 MG	4	PA; QL (1 per 84 days); NEDS; NM
LYNPARZA ORAL TABLET 100 MG, 150 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
LYSODREN ORAL TABLET 500 MG	4	NEDS; NM
LYTGOBI (12 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	4	PA; NEDS; NM
LYTGOBI (16 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	4	PA; NEDS; NM
LYTGOBI (20 MG DAILY DOSE) ORAL TABLET THERAPY PACK 4 MG	4	PA; NEDS; NM
MATULANE ORAL CAPSULE 50 MG	4	NEDS; NM; LA
<i>megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 800 mg/20ml</i>	2	PA
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	2	PA
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML	4	PA; QL (1200 per 30 days); NEDS; NM
MEKINIST ORAL TABLET 0.5 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
MEKINIST ORAL TABLET 2 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
MEKTOVI ORAL TABLET 15 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
<i>mercaptopurine oral tablet 50 mg</i>	1	GC
MESNEX ORAL TABLET 400 MG	4	NEDS
NERLYNX ORAL TABLET 40 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
<i>nilutamide oral tablet 150 mg</i>	4	QL (30 per 30 days); NEDS
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	4	PA; QL (3 per 28 days); NEDS; NM
NUBEQA ORAL TABLET 300 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA

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ODOMZO ORAL CAPSULE 200 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
OGSIVEO ORAL TABLET 50 MG	4	PA; QL (180 per 30 days); NEDS; NM
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
ONUREG ORAL TABLET 200 MG, 300 MG	4	PA; QL (14 per 28 days); NEDS; NM; LA
ORGOVYX ORAL TABLET 120 MG	4	PA; QL (32 per 30 days); NEDS; NM; LA
ORSERDU ORAL TABLET 345 MG	4	PA; QL (30 per 30 days); NEDS; NM
ORSERDU ORAL TABLET 86 MG	4	PA; QL (90 per 30 days); NEDS; NM
<i>oxaliplatin intravenous solution 200 mg/40ml</i>	3	B/D PA; NM
<i>pazopanib hcl oral tablet 200 mg</i>	4	PA; QL (120 per 30 days); NEDS; NM
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG	4	PA; QL (14 per 21 days); NEDS; NM; LA
<i>pemetrexed disodium intravenous solution reconstituted 100 mg</i>	4	PA; NEDS; NM
<i>pemetrexed disodium intravenous solution reconstituted 1000 mg, 750 mg</i>	4	NEDS; NM
<i>pemetrexed disodium intravenous solution reconstituted 500 mg</i>	3	PA; NM
PHESGO SUBCUTANEOUS SOLUTION 60-60-2000 MG-MG-U/ML, 80-40-2000 MG-MG-U/ML	4	PA; NEDS; NM
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	4	PA; QL (28 per 28 days); NEDS; NM
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	4	PA; QL (56 per 28 days); NEDS; NM
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	4	PA; QL (56 per 28 days); NEDS; NM
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	4	PA; QL (21 per 28 days); NEDS; NM; LA
PURIXAN ORAL SUSPENSION 2000 MG/100ML	4	PA; NEDS; NM

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QINLOCK ORAL TABLET 50 MG	4	PA; QL (90 per 30 days); NEDS; NM
RETEVMO ORAL CAPSULE 40 MG	4	PA; QL (180 per 30 days); NEDS; NM
RETEVMO ORAL CAPSULE 80 MG	4	PA; QL (120 per 30 days); NEDS; NM
REZLIDHIA ORAL CAPSULE 150 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
RIABNI INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML	4	B/D PA; NEDS; NM
RITUXAN INTRAVENOUS SOLUTION 100 MG/10ML	4	B/D PA; NEDS; NM; LA
ROZLYTREK ORAL CAPSULE 100 MG	4	PA; QL (150 per 30 days); NEDS; NM; LA
ROZLYTREK ORAL CAPSULE 200 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
ROZLYTREK ORAL PACKET 50 MG	4	PA; QL (240 per 30 days); NEDS; NM; LA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
RYBREVANT INTRAVENOUS SOLUTION 350 MG/7ML	4	PA; NEDS; NM
RYDAPT ORAL CAPSULE 25 MG	4	PA; QL (240 per 30 days); NEDS; NM
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5ML	4	PA; NEDS; NM
SARCLISA INTRAVENOUS SOLUTION 100 MG/5ML, 500 MG/25ML	4	PA; NEDS; NM
SCEMBLIX ORAL TABLET 20 MG	4	PA; QL (60 per 30 days); NEDS; NM
SCEMBLIX ORAL TABLET 40 MG	4	PA; QL (300 per 30 days); NEDS; NM
SOLTAMOX ORAL SOLUTION 10 MG/5ML	3	
<i>sorafenib tosylate oral tablet 200 mg</i>	4	PA; QL (120 per 30 days); NEDS; NM
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG	4	PA; QL (30 per 30 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
STIVARGA ORAL TABLET 40 MG	4	PA; QL (84 per 28 days); NEDS; NM; LA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG	4	PA; NEDS; NM
TABLOID ORAL TABLET 40 MG	3	
TABRECTA ORAL TABLET 150 MG, 200 MG	4	PA; QL (120 per 30 days); NEDS; NM
TAFINLAR ORAL CAPSULE 50 MG, 75 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
TAFINLAR ORAL TABLET SOLUBLE 10 MG	4	PA; QL (900 per 30 days); NEDS; NM
TAGRISSE ORAL TABLET 40 MG, 80 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
TALZENNA ORAL CAPSULE 0.1 MG, 0.35 MG	4	PA; QL (30 per 30 days); NEDS; NM
TALZENNA ORAL CAPSULE 0.25 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
TALZENNA ORAL CAPSULE 0.5 MG, 0.75 MG, 1 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	1	GC
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	4	PA; QL (112 per 28 days); NEDS; NM
TAZVERIK ORAL TABLET 200 MG	4	PA; QL (240 per 30 days); NEDS; NM; LA
TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML	4	PA; QL (20 per 21 days); NEDS; NM; LA
TECENTRIQ INTRAVENOUS SOLUTION 840 MG/14ML	4	PA; QL (28 per 28 days); NEDS; NM; LA
TECVAYLI SUBCUTANEOUS SOLUTION 153 MG/1.7ML, 30 MG/3ML	4	PA; NEDS; NM
TEPMETKO ORAL TABLET 225 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	4	PA; QL (30 per 30 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
THALOMID ORAL CAPSULE 150 MG, 200 MG	4	PA; QL (60 per 30 days); NEDS; NM
TIBSOVO ORAL TABLET 250 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
<i>toremifene citrate oral tablet 60 mg</i>	3	QL (30 per 30 days); NM
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 3.75 MG	3	PA; NM
<i>tretinoin oral capsule 10 mg</i>	4	NEDS
TRODELVY INTRAVENOUS SOLUTION RECONSTITUTED 180 MG	4	PA; NEDS; NM
TRUQAP ORAL TABLET 160 MG, 200 MG	4	PA; QL (64 per 28 days); NEDS; NM
TRUSELTIQ (100MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 MG	4	PA; QL (21 per 28 days); NEDS; NM; LA
TRUSELTIQ (125MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 100 & 25 MG	4	PA; QL (42 per 28 days); NEDS; NM; LA
TRUSELTIQ (50MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	4	PA; QL (42 per 28 days); NEDS; NM; LA
TRUSELTIQ (75MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 25 MG	4	PA; QL (63 per 28 days); NEDS; NM; LA
TUKYSA ORAL TABLET 150 MG, 50 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
TURALIO ORAL CAPSULE 125 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG	4	PA; QL (56 per 28 days); NEDS; NM
VENCLEXTA ORAL TABLET 10 MG	2	PA; QL (60 per 30 days); NM; LA
VENCLEXTA ORAL TABLET 100 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
VENCLEXTA ORAL TABLET 50 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	4	PA; NEDS; NM; LA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
VITRAKVI ORAL CAPSULE 100 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
VITRAKVI ORAL CAPSULE 25 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
VITRAKVI ORAL SOLUTION 20 MG/ML	4	PA; QL (300 per 30 days); NEDS; NM; LA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
VONJO ORAL CAPSULE 100 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
WELIREG ORAL TABLET 40 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
XALKORI ORAL CAPSULE 200 MG, 250 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
XALKORI ORAL CAPSULE SPRINKLE 150 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
XALKORI ORAL CAPSULE SPRINKLE 20 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
XALKORI ORAL CAPSULE SPRINKLE 50 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
XOSPATA ORAL TABLET 40 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG	4	PA; QL (8 per 28 days); NEDS; NM; LA
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; QL (4 per 28 days); NEDS; NM; LA
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; QL (8 per 28 days); NEDS; NM; LA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG	4	PA; QL (4 per 28 days); NEDS; NM; LA
XPOVIO (60 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; QL (24 per 28 days); NEDS; NM; LA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG	4	PA; QL (8 per 28 days); NEDS; NM; LA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	4	PA; QL (32 per 28 days); NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
XTANDI ORAL CAPSULE 40 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
XTANDI ORAL TABLET 40 MG	4	PA; QL (120 per 30 days); NEDS; NM
XTANDI ORAL TABLET 80 MG	4	PA; QL (60 per 30 days); NEDS; NM
ZEJULA ORAL CAPSULE 100 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
ZEJULA ORAL TABLET 100 MG	4	PA; QL (90 per 30 days); NEDS; NM
ZEJULA ORAL TABLET 200 MG, 300 MG	4	PA; QL (30 per 30 days); NEDS; NM
ZELBORAF ORAL TABLET 240 MG	4	PA; QL (240 per 30 days); NEDS; NM; LA
ZEPZELCA INTRAVENOUS SOLUTION RECONSTITUTED 4 MG	4	PA; NEDS; NM
ZOLINZA ORAL CAPSULE 100 MG	4	PA; QL (120 per 30 days); NEDS; NM
ZYDELIG ORAL TABLET 100 MG, 150 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
ZYKADIA ORAL TABLET 150 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
BLOOD PRODUCTS AND MODIFIERS		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	2	
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	3	QL (60 per 30 days)
BRILINTA ORAL TABLET 60 MG, 90 MG	3	QL (60 per 30 days)
<i>cilostazol oral tablet 100 mg, 50 mg</i>	1	GC
<i>clopidogrel bisulfate oral tablet 75 mg</i>	1	QL (30 per 30 days); GC
<i>dabigatran etexilate mesylate oral capsule 110 mg</i>	3	QL (60 per 30 days)
<i>dabigatran etexilate mesylate oral capsule 150 mg, 75 mg</i>	2	QL (60 per 30 days)
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	3	
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG	2	QL (74 per 180 days)
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	2	QL (60 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ENDARI ORAL PACKET 5 GM	4	NEDS; NM; LA
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 150 mg/ml</i>	3	QL (56 per 28 days)
<i>enoxaparin sodium injection solution prefilled syringe 120 mg/0.8ml, 80 mg/0.8ml</i>	3	QL (44.8 per 28 days)
<i>enoxaparin sodium injection solution prefilled syringe 30 mg/0.3ml</i>	3	QL (16.8 per 28 days)
<i>enoxaparin sodium injection solution prefilled syringe 40 mg/0.4ml</i>	3	QL (22.4 per 28 days)
<i>enoxaparin sodium injection solution prefilled syringe 60 mg/0.6ml</i>	3	QL (33.6 per 28 days)
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml</i>	4	QL (24 per 30 days); NEDS
<i>fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml</i>	3	QL (15 per 30 days)
<i>fondaparinux sodium subcutaneous solution 5 mg/0.4ml</i>	4	QL (12 per 30 days); NEDS
<i>fondaparinux sodium subcutaneous solution 7.5 mg/0.6ml</i>	4	QL (18 per 30 days); NEDS
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	4	PA; QL (1.2 per 28 days); NEDS; NM
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6ML	4	PA; NEDS; NM
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT	4	PA; NEDS; NM; LA
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	2	B/D PA
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml</i>	2	B/D PA
<i>icatibant acetate subcutaneous solution 30 mg/3ml</i>	4	PA; NEDS; NM
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	4	PA; NEDS; NM
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	1	GC
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	4	PA; QL (1.2 per 28 days); NEDS; NM
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML	4	PA; NEDS; NM
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	4	PA; NEDS; NM
<i>pentoxifylline er oral tablet extended release 400 mg</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
PRADAXA ORAL CAPSULE 110 MG	3	QL (60 per 30 days)
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	2	QL (30 per 30 days)
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	2	PA; NM
PROMACTA ORAL PACKET 12.5 MG	4	PA; QL (360 per 30 days); NEDS; NM; LA
PROMACTA ORAL PACKET 25 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
PROMACTA ORAL TABLET 12.5 MG, 25 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
PROMACTA ORAL TABLET 50 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
PROMACTA ORAL TABLET 75 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
RETACRIT INJECTION SOLUTION 10000 UNIT/ML(1ML)	2	PA; NM
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	2	PA; QL (12 per 28 days); NM
RETACRIT INJECTION SOLUTION 40000 UNIT/ML	4	PA; QL (12 per 28 days); NEDS; NM
SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML	4	PA; NEDS; NM
<i>tranexamic acid oral tablet 650 mg</i>	2	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	1	GC
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML	2	QL (600 per 30 days)
XARELTO ORAL TABLET 10 MG, 20 MG	2	QL (30 per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	2	QL (60 per 30 days)
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	2	
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	4	PA; NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CARDIOVASCULAR AGENTS		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	1	GC
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	1	GC
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	3	
<i>amiloride hcl oral tablet 5 mg</i>	1	GC
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	1	GC
<i>amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg</i>	1	GC
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	1	GC
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	GC
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	1	GC
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	1	GC
<i>atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	1	QL (30 per 30 days); GC
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	GC
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	1	GC
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	1	GC
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	1	GC
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	1	GC
<i>bumetanide injection solution 0.25 mg/ml</i>	1	GC
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	GC
<i>candesartan cilexetil oral tablet 16 mg</i>	3	QL (60 per 30 days)
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	1	GC
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	1	GC
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	1	GC
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	1	GC
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	GC
<i>cholestyramine light oral packet 4 gm</i>	2	
<i>cholestyramine light oral powder 4 gm/dose</i>	2	

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<i>cholestyramine oral packet 4 gm</i>	2	
<i>cholestyramine oral powder 4 gm/dose</i>	2	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	1	GC
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	3	QL (4 per 28 days)
<i>colestipol hcl oral tablet 1 gm</i>	1	GC
CORLANOR ORAL SOLUTION 5 MG/5ML	3	PA; QL (560 per 28 days)
CORLANOR ORAL TABLET 5 MG, 7.5 MG	3	PA; QL (60 per 30 days)
DIGOX ORAL TABLET 125 MCG	1	QL (30 per 30 days); GC
DIGOX ORAL TABLET 250 MCG	1	PA; QL (60 per 30 days); GC
<i>digoxin oral solution 0.05 mg/ml</i>	1	GC
<i>digoxin oral tablet 125 mcg</i>	1	QL (30 per 30 days); GC
<i>digoxin oral tablet 250 mcg</i>	1	PA; QL (60 per 30 days); GC
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	1	GC
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	1	GC
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	1	GC
<i>diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	GC
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	1	GC
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	1	GC
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	2	PA
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	3	NM
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	1	GC
<i>droxidopa oral capsule 100 mg</i>	3	PA; QL (90 per 30 days); NM
<i>droxidopa oral capsule 200 mg</i>	3	PA; QL (180 per 30 days); NM
<i>droxidopa oral capsule 300 mg</i>	4	PA; QL (180 per 30 days); NEDS; NM
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	GC
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	1	GC

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ENTRESTO ORAL TABLET 24-26 MG	2	QL (180 per 30 days)
ENTRESTO ORAL TABLET 49-51 MG, 97-103 MG	2	QL (60 per 30 days)
<i>eplerenone oral tablet 25 mg, 50 mg</i>	2	
<i>ethacrynic acid oral tablet 25 mg</i>	3	
<i>ezetimibe oral tablet 10 mg</i>	1	GC
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	2	QL (30 per 30 days)
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	1	GC
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	1	GC
<i>fenofibrate oral capsule 134 mg, 200 mg, 67 mg</i>	1	GC
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	1	GC
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	2	
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	1	GC
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	1	GC
<i>furosemide injection solution 10 mg/ml</i>	1	GC
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	1	GC
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	1	GC
<i>gemfibrozil oral tablet 600 mg</i>	1	GC
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	GC
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	1	GC
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	GC
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	1	GC
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	1	QL (30 per 30 days); GC
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg</i>	1	QL (60 per 30 days); GC
<i>irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg</i>	1	QL (30 per 30 days); GC
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	1	GC
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	1	GC
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	1	GC
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG	4	PA; NEDS; NM; LA
JUXTAPID ORAL CAPSULE 30 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA

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<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	1	GC
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	1	GC
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	GC
<i>losartan potassium oral tablet 100 mg</i>	1	QL (30 per 30 days); GC
<i>losartan potassium oral tablet 25 mg, 50 mg</i>	1	QL (60 per 30 days); GC
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	1	QL (30 per 30 days); GC
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	1	QL (60 per 30 days); GC
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	GC
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	1	GC
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	GC
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	1	GC
<i>metyrosine oral capsule 250 mg</i>	4	NEDS
<i>mexiletine hcl oral capsule 150 mg, 200 mg, 250 mg</i>	1	GC
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	1	GC
MULTAQ ORAL TABLET 400 MG	3	QL (60 per 30 days)
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	1	GC
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	2	
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	3	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	1	GC
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	GC
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	1	GC
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	1	GC
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg</i>	3	QL (30 per 30 days)
<i>olmesartan medoxomil oral tablet 5 mg</i>	3	QL (60 per 30 days)
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	3	QL (30 per 30 days)
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	2	
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	1	GC
<i>pindolol oral tablet 10 mg, 5 mg</i>	1	GC
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML	3	PA; QL (2 per 28 days)
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	1	QL (30 per 30 days); GC
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	1	GC
PREVALITE ORAL PACKET 4 GM	2	
PREVALITE ORAL POWDER 4 GM/DOSE	2	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	3	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	2	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	2	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	1	GC
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	1	GC
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	GC
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	1	GC
<i>quinidine gluconate er oral tablet extended release 324 mg</i>	2	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	1	GC
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	1	GC
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	3	PA
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML	2	PA; QL (3.5 per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	2	PA; QL (3 per 28 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	2	PA; QL (3 per 28 days)
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	1	QL (30 per 30 days); GC
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg</i>	1	QL (30 per 30 days); GC
SORINE ORAL TABLET 120 MG, 160 MG, 240 MG, 80 MG	1	GC
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	1	GC
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	1	GC
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	1	GC
<i>spironolactone-hctz oral tablet 25-25 mg</i>	1	GC
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	1	GC
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	GC
TIADYLT ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG	1	GC
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	1	GC
<i>torseamide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	1	GC
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	1	GC
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	1	GC
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	1	GC
<i>valsartan oral tablet 160 mg</i>	1	QL (60 per 30 days); GC
<i>valsartan oral tablet 320 mg</i>	1	QL (30 per 30 days); GC
<i>valsartan oral tablet 40 mg, 80 mg</i>	1	QL (90 per 30 days); GC
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	1	QL (30 per 30 days); GC
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM	3	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	1	GC
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	1	GC
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	1	GC
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG	3	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CENTRAL NERVOUS SYSTEM AGENTS		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML	4	QL (2.4 per 56 days); NEDS
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 960 MG/3.2ML	4	QL (3.2 per 56 days); NEDS
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	4	QL (1 per 28 days); NEDS
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	4	QL (1 per 28 days); NEDS
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	3	
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	2	PA; QL (1 per 28 days)
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 70 MG/ML	2	PA; QL (2 per 28 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	1	QL (90 per 30 days); GC
<i>amantadine hcl oral capsule 100 mg</i>	2	
<i>amantadine hcl oral tablet 100 mg</i>	2	
<i>amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	GC
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	1	PA; GC
<i>amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg</i>	3	PA; QL (30 per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	2	PA; QL (90 per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	2	PA; QL (60 per 30 days)
<i>apomorphine hcl subcutaneous solution cartridge 30 mg/3ml</i>	4	PA; QL (60 per 30 days); NEDS; NM
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG	4	ST; NEDS
<i>aripiprazole oral solution 1 mg/ml</i>	3	QL (900 per 30 days)
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 5 mg</i>	3	
<i>aripiprazole oral tablet 20 mg, 30 mg</i>	3	QL (30 per 30 days)
<i>aripiprazole oral tablet dispersible 10 mg</i>	3	QL (90 per 30 days)
<i>aripiprazole oral tablet dispersible 15 mg</i>	3	QL (60 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML	4	QL (4.8 per 365 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML	4	QL (3.9 per 60 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML	4	QL (1.6 per 28 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 662 MG/2.4ML	4	QL (2.4 per 28 days); NEDS
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML	4	QL (3.2 per 28 days); NEDS
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	2	PA; QL (30 per 30 days)
<i>armodafinil oral tablet 50 mg</i>	2	PA; QL (60 per 30 days)
<i>asenapine maleate sublingual tablet sublingual 10 mg</i>	3	QL (60 per 30 days)
<i>asenapine maleate sublingual tablet sublingual 2.5 mg</i>	3	QL (240 per 30 days)
<i>asenapine maleate sublingual tablet sublingual 5 mg</i>	3	QL (120 per 30 days)
<i>atomoxetine hcl oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	3	QL (60 per 30 days)
<i>atomoxetine hcl oral capsule 100 mg, 60 mg, 80 mg</i>	3	QL (30 per 30 days)
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG	4	PA; QL (60 per 30 days); NEDS
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML	4	PA; QL (4 per 28 days); NEDS; NM
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML	4	PA; QL (4 per 28 days); NEDS; NM
<i>baclofen oral tablet 10 mg, 5 mg</i>	1	QL (90 per 30 days); GC
<i>baclofen oral tablet 20 mg</i>	1	QL (120 per 30 days); GC
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	PA; GC
BETASERON SUBCUTANEOUS KIT 0.3 MG	4	PA; QL (15 per 30 days); NEDS; NM
BRIVIACT ORAL SOLUTION 10 MG/ML	4	QL (600 per 30 days); NEDS
BRIVIACT ORAL TABLET 10 MG	3	QL (60 per 30 days)
BRIVIACT ORAL TABLET 100 MG, 25 MG, 50 MG, 75 MG	4	QL (60 per 30 days); NEDS
<i>bromocriptine mesylate oral capsule 5 mg</i>	1	GC
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	1	GC
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	1	QL (240 per 30 days); NEDS; GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	1	QL (60 per 30 days); NEDS; GC
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	2	QL (60 per 30 days); NEDS
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg</i>	2	QL (480 per 30 days); NEDS
<i>buprenorphine hcl-naloxone hcl sublingual film 4-1 mg</i>	2	QL (240 per 30 days); NEDS
<i>buprenorphine hcl-naloxone hcl sublingual film 8-2 mg</i>	2	QL (120 per 30 days); NEDS
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg</i>	1	QL (480 per 30 days); NEDS; GC
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 8-2 mg</i>	1	QL (120 per 30 days); NEDS; GC
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	1	QL (60 per 30 days); GC
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg</i>	1	QL (120 per 30 days); GC
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg, 200 mg</i>	1	QL (60 per 30 days); GC
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg</i>	1	QL (90 per 30 days); GC
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 300 mg</i>	1	QL (30 per 30 days); GC
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg</i>	3	QL (30 per 30 days)
<i>bupropion hcl oral tablet 100 mg</i>	1	QL (135 per 30 days); GC
<i>bupropion hcl oral tablet 75 mg</i>	1	QL (180 per 30 days); GC
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	1	GC
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG	4	QL (30 per 30 days); NEDS
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	1	GC
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	2	
<i>carbamazepine oral suspension 100 mg/5ml</i>	1	GC
<i>carbamazepine oral tablet 200 mg</i>	1	GC
<i>carbamazepine oral tablet chewable 100 mg</i>	1	GC
<i>carbidopa oral tablet 25 mg</i>	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	2	
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	1	GC
<i>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</i>	2	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	1	QL (120 per 30 days); GC
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg, 5-12.5 mg</i>	1	PA; GC
<i>chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml</i>	3	
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	2	
<i>chlorzoxazone oral tablet 500 mg</i>	1	PA; GC
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	1	QL (600 per 30 days); GC
<i>citalopram hydrobromide oral tablet 10 mg</i>	1	QL (120 per 30 days); GC
<i>citalopram hydrobromide oral tablet 20 mg</i>	1	QL (60 per 30 days); GC
<i>citalopram hydrobromide oral tablet 40 mg</i>	1	QL (30 per 30 days); GC
<i>clobazam oral suspension 2.5 mg/ml</i>	3	PA; QL (480 per 30 days)
<i>clobazam oral tablet 10 mg</i>	3	PA; QL (120 per 30 days)
<i>clobazam oral tablet 20 mg</i>	3	PA; QL (60 per 30 days)
<i>clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg</i>	3	PA
<i>clonazepam oral tablet 0.5 mg</i>	2	QL (1200 per 30 days)
<i>clonazepam oral tablet 1 mg</i>	2	QL (600 per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	QL (300 per 30 days)
<i>clonazepam oral tablet dispersible 0.125 mg</i>	2	QL (4800 per 30 days)
<i>clonazepam oral tablet dispersible 0.25 mg</i>	2	QL (2400 per 30 days)
<i>clonazepam oral tablet dispersible 0.5 mg</i>	2	QL (1200 per 30 days)
<i>clonazepam oral tablet dispersible 1 mg</i>	2	QL (600 per 30 days)
<i>clonazepam oral tablet dispersible 2 mg</i>	2	QL (300 per 30 days)
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	1	GC
<i>clozapine oral tablet 100 mg</i>	2	QL (270 per 30 days)
<i>clozapine oral tablet 200 mg</i>	2	QL (120 per 30 days)
<i>clozapine oral tablet 25 mg</i>	2	QL (1080 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>clozapine oral tablet 50 mg</i>	2	QL (540 per 30 days)
<i>clozapine oral tablet dispersible 100 mg</i>	2	QL (270 per 30 days)
<i>clozapine oral tablet dispersible 12.5 mg</i>	2	QL (2160 per 30 days)
<i>clozapine oral tablet dispersible 150 mg</i>	2	QL (180 per 30 days)
<i>clozapine oral tablet dispersible 200 mg</i>	4	QL (120 per 30 days); NEDS
<i>clozapine oral tablet dispersible 25 mg</i>	2	QL (1080 per 30 days)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	4	PA; QL (30 per 30 days); NEDS; NM
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	4	PA; QL (12 per 28 days); NEDS; NM
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	1	PA; GC
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	2	PA; QL (60 per 30 days); NM
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	2	
<i>desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	2	PA
<i>desvenlafaxine er oral tablet extended release 24 hour 100 mg, 50 mg</i>	3	QL (30 per 30 days)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	3	
<i>dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	2	QL (60 per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg</i>	2	QL (60 per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	2	QL (120 per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg</i>	1	QL (180 per 30 days); GC
<i>dextroamphetamine sulfate oral tablet 5 mg</i>	1	QL (90 per 30 days); GC
DIACOMIT ORAL CAPSULE 250 MG	4	PA; QL (360 per 30 days); NEDS; NM; LA
DIACOMIT ORAL CAPSULE 500 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA
DIACOMIT ORAL PACKET 250 MG	4	PA; QL (360 per 30 days); NEDS; NM; LA
DIACOMIT ORAL PACKET 500 MG	4	PA; QL (180 per 30 days); NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>diazepam oral solution 5 mg/5ml</i>	1	QL (1200 per 30 days); GC
<i>diazepam oral tablet 10 mg</i>	1	QL (120 per 30 days); GC
<i>diazepam oral tablet 2 mg</i>	1	QL (600 per 30 days); GC
<i>diazepam oral tablet 5 mg</i>	1	QL (240 per 30 days); GC
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	3	
<i>dihydroergotamine mesylate nasal solution 4 mg/ml</i>	4	QL (8 per 28 days); NEDS
DILANTIN ORAL CAPSULE 30 MG	2	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	1	GC
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	1	GC
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	1	GC
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	1	GC
<i>donepezil hcl oral tablet 10 mg, 5 mg</i>	1	QL (30 per 30 days); GC
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	1	QL (30 per 30 days); GC
<i>doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	PA; GC
<i>doxepin hcl oral concentrate 10 mg/ml</i>	1	PA; GC
<i>duloxetine hcl oral capsule delayed release particles 20 mg</i>	1	QL (180 per 30 days); GC
<i>duloxetine hcl oral capsule delayed release particles 30 mg</i>	1	QL (120 per 30 days); GC
<i>duloxetine hcl oral capsule delayed release particles 40 mg</i>	1	QL (90 per 30 days); GC
<i>duloxetine hcl oral capsule delayed release particles 60 mg</i>	1	QL (60 per 30 days); GC
DUOPA ENTERAL SUSPENSION 4.63-20 MG/ML	4	PA; NEDS; NM
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	4	PA; QL (3 per 28 days); NEDS
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML	2	PA; QL (2 per 28 days)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML	2	PA; QL (2 per 28 days)
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	4	PA; QL (30 per 30 days); NEDS
<i>entacapone oral tablet 200 mg</i>	3	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	4	PA; NEDS; NM; LA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
EPITOL ORAL TABLET 200 MG	1	GC
EPRONTIA ORAL SOLUTION 25 MG/ML	3	
<i>ergoloid mesylates oral tablet 1 mg</i>	1	PA; GC
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	1	QL (600 per 30 days); GC
<i>escitalopram oxalate oral tablet 10 mg</i>	1	QL (60 per 30 days); GC
<i>escitalopram oxalate oral tablet 20 mg</i>	1	QL (30 per 30 days); GC
<i>escitalopram oxalate oral tablet 5 mg</i>	1	QL (120 per 30 days); GC
<i>estazolam oral tablet 1 mg, 2 mg</i>	1	QL (30 per 30 days); GC
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	3	QL (30 per 30 days)
<i>ethosuximide oral capsule 250 mg</i>	1	GC
<i>ethosuximide oral solution 250 mg/5ml</i>	1	GC
FANAPT ORAL TABLET 1 MG	4	QL (720 per 30 days); NEDS
FANAPT ORAL TABLET 10 MG, 12 MG	4	QL (60 per 30 days); NEDS
FANAPT ORAL TABLET 2 MG	4	QL (360 per 30 days); NEDS
FANAPT ORAL TABLET 4 MG	4	QL (180 per 30 days); NEDS
FANAPT ORAL TABLET 6 MG	4	QL (120 per 30 days); NEDS
FANAPT ORAL TABLET 8 MG	4	QL (90 per 30 days); NEDS
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	3	
<i>felbamate oral suspension 600 mg/5ml</i>	3	
<i>felbamate oral tablet 400 mg, 600 mg</i>	3	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	3	PA; QL (30 per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	3	PA
<i>fingolimod hcl oral capsule 0.5 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
FINTEPLA ORAL SOLUTION 2.2 MG/ML	4	PA; NEDS; NM; LA
<i>fluoxetine hcl oral capsule 10 mg</i>	1	GC
<i>fluoxetine hcl oral capsule 20 mg</i>	1	QL (120 per 30 days); GC
<i>fluoxetine hcl oral capsule 40 mg</i>	1	QL (60 per 30 days); GC
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	3	QL (4 per 28 days)
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	1	QL (600 per 30 days); GC
<i>fluphenazine decanoate injection solution 25 mg/ml</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>fluphenazine hcl injection solution 2.5 mg/ml</i>	3	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	1	GC
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	1	GC
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	1	GC
<i>flurazepam hcl oral capsule 30 mg</i>	1	QL (30 per 30 days); GC
<i>fluvoxamine maleate oral tablet 100 mg</i>	2	QL (90 per 30 days)
<i>fluvoxamine maleate oral tablet 25 mg, 50 mg</i>	2	
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	4	QL (720 per 30 days); NEDS
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	4	QL (30 per 30 days); NEDS
FYCOMPA ORAL TABLET 2 MG	3	QL (30 per 30 days)
<i>gabapentin oral capsule 100 mg</i>	1	QL (1080 per 30 days); GC
<i>gabapentin oral capsule 300 mg</i>	1	QL (360 per 30 days); GC
<i>gabapentin oral capsule 400 mg</i>	1	QL (270 per 30 days); GC
<i>gabapentin oral solution 250 mg/5ml, 300 mg/6ml</i>	1	QL (2160 per 30 days); GC
<i>gabapentin oral tablet 600 mg</i>	1	QL (180 per 30 days); GC
<i>gabapentin oral tablet 800 mg</i>	1	QL (120 per 30 days); GC
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	3	QL (30 per 30 days)
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	2	QL (60 per 30 days)
<i>gilenya oral capsule 0.25 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	2	PA; QL (30 per 30 days)
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml, 50 mg/ml (1ml)</i>	1	GC
<i>haloperidol lactate injection solution 5 mg/ml</i>	1	GC
<i>haloperidol lactate oral concentrate 10 mg/5ml, 2 mg/ml</i>	1	GC
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	1	GC
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	1	PA; GC
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	3	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML	4	QL (3.5 per 180 days); NEDS
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1560 MG/5ML	4	QL (5 per 180 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML	4	QL (0.75 per 28 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 156 MG/ML	4	QL (1 per 28 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 234 MG/1.5ML	4	QL (1.5 per 28 days); NEDS
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	3	QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML	4	QL (0.5 per 28 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML	4	QL (0.88 per 84 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 410 MG/1.32ML	4	QL (1.32 per 84 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 546 MG/1.75ML	4	QL (1.75 per 84 days); NEDS
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 819 MG/2.63ML	4	QL (2.63 per 84 days); NEDS
<i>lacosamide oral solution 10 mg/ml</i>	3	QL (1200 per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	3	QL (60 per 30 days)
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	3	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	1	GC
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	3	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	3	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg</i>	4	NEDS
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg</i>	3	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg</i>	3	QL (180 per 30 days)
<i>levetiracetam er oral tablet extended release 24 hour 750 mg</i>	3	QL (120 per 30 days)
<i>levetiracetam oral solution 100 mg/ml</i>	1	GC
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	1	GC
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	1	GC
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	1	GC
<i>lithium carbonate oral tablet 300 mg</i>	1	GC
<i>lithium oral solution 8 meq/5ml</i>	2	
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	1	QL (90 per 30 days); GC
<i>lorazepam oral tablet 2 mg</i>	1	QL (150 per 30 days); GC
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
<i>lurasidone hcl oral tablet 120 mg</i>	4	QL (30 per 30 days); NEDS
<i>lurasidone hcl oral tablet 20 mg, 40 mg, 60 mg</i>	3	QL (30 per 30 days)
<i>lurasidone hcl oral tablet 80 mg</i>	3	QL (60 per 30 days)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG	4	QL (30 per 30 days); NEDS
MARPLAN ORAL TABLET 10 MG	2	
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	3	PA; QL (30 per 30 days)
<i>memantine hcl oral solution 2 mg/ml</i>	1	PA; QL (300 per 30 days); GC
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg</i>	1	PA; QL (60 per 30 days); GC
<i>memantine hcl oral tablet 5 mg</i>	1	PA; QL (90 per 30 days); GC
<i>meprobamate oral tablet 200 mg, 400 mg</i>	1	PA; GC
<i>metaxalone oral tablet 800 mg</i>	2	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>methsuximide oral capsule 300 mg</i>	2	
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 60 mg</i>	2	PA; QL (30 per 30 days)
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	1	PA; QL (90 per 30 days); GC
MIGERGOT RECTAL SUPPOSITORY 2-100 MG	4	NEDS
<i>mirtazapine oral tablet 15 mg, 30 mg, 7.5 mg</i>	1	GC
<i>mirtazapine oral tablet 45 mg</i>	1	QL (30 per 30 days); GC
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	1	QL (30 per 30 days); GC
<i>modafinil oral tablet 100 mg</i>	3	PA; QL (30 per 30 days)
<i>modafinil oral tablet 200 mg</i>	3	PA; QL (60 per 30 days)
<i>molindone hcl oral tablet 10 mg, 25 mg, 5 mg</i>	3	
<i>naloxone hcl injection solution 0.4 mg/ml</i>	1	GC
<i>naloxone hcl injection solution prefilled syringe 2 mg/2ml</i>	1	GC
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	3	
<i>naltrexone hcl oral tablet 50 mg</i>	1	GC
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	1	QL (9 per 30 days); GC
NAYZILAM NASAL SOLUTION 5 MG/0.1ML	3	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	2	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR	3	QL (30 per 30 days)
NICOTROL INHALATION INHALER 10 MG	2	
NICOTROL NS NASAL SOLUTION 10 MG/ML	2	QL (120 per 30 days)
<i>nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	1	GC
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	1	GC
NUEDEXTA ORAL CAPSULE 20-10 MG	4	PA; QL (60 per 30 days); NEDS
NUPLAZID ORAL CAPSULE 34 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
NUPLAZID ORAL TABLET 10 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
NURTEC ORAL TABLET DISPERSIBLE 75 MG	4	PA; QL (16 per 30 days); NEDS
<i>olanzapine intramuscular solution reconstituted 10 mg</i>	3	QL (90 per 30 days)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 5 mg, 7.5 mg</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>olanzapine oral tablet 20 mg</i>	1	QL (30 per 30 days); GC
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 5 mg</i>	1	GC
<i>olanzapine oral tablet dispersible 20 mg</i>	1	QL (30 per 30 days); GC
<i>olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg</i>	3	QL (30 per 30 days)
<i>olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg</i>	3	QL (90 per 30 days)
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	1	GC
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	1	QL (120 per 30 days); GC
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	1	GC
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	1	GC
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg</i>	3	QL (30 per 30 days)
<i>paliperidone er oral tablet extended release 24 hour 6 mg</i>	3	QL (60 per 30 days)
<i>paroxetine hcl oral suspension 10 mg/5ml</i>	2	QL (900 per 30 days)
<i>paroxetine hcl oral tablet 10 mg, 40 mg</i>	1	QL (45 per 30 days); GC
<i>paroxetine hcl oral tablet 20 mg</i>	1	QL (30 per 30 days); GC
<i>paroxetine hcl oral tablet 30 mg</i>	1	QL (60 per 30 days); GC
<i>paroxetine mesylate oral capsule 7.5 mg</i>	3	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	2	
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	2	PA
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	4	QL (1 per 28 days); NEDS
<i>phenelzine sulfate oral tablet 15 mg</i>	2	
<i>phenobarbital oral elixir 20 mg/5ml</i>	2	PA; QL (3000 per 30 days)
<i>phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg, 64.8 mg, 97.2 mg</i>	2	PA; QL (120 per 30 days)
<i>phenobarbital oral tablet 16.2 mg, 32.4 mg</i>	2	PA; QL (210 per 30 days)
PHENYTEK ORAL CAPSULE 200 MG, 300 MG	3	
PHENYTOIN INFATABS ORAL TABLET CHEWABLE 50 MG	2	
<i>phenytoin oral suspension 100 mg/4ml, 125 mg/5ml</i>	1	GC
<i>phenytoin oral tablet chewable 50 mg</i>	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	1	GC
<i>pimozide oral tablet 1 mg, 2 mg</i>	2	
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	1	GC
<i>pregabalin oral capsule 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	1	GC
<i>pregabalin oral capsule 200 mg</i>	1	QL (90 per 30 days); GC
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1	QL (60 per 30 days); GC
<i>pregabalin oral solution 20 mg/ml</i>	1	QL (900 per 30 days); GC
<i>primidone oral tablet 125 mg, 250 mg, 50 mg</i>	1	GC
<i>protriptyline hcl oral tablet 10 mg, 5 mg</i>	1	PA; GC
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	3	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	4	NEDS
<i>pyridostigmine bromide oral tablet 30 mg, 60 mg</i>	2	
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg</i>	3	QL (30 per 30 days)
<i>quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg</i>	3	QL (60 per 30 days)
<i>quetiapine fumarate oral tablet 100 mg</i>	1	QL (240 per 30 days); GC
<i>quetiapine fumarate oral tablet 150 mg</i>	1	QL (150 per 30 days); GC
<i>quetiapine fumarate oral tablet 200 mg</i>	1	QL (120 per 30 days); GC
<i>quetiapine fumarate oral tablet 25 mg</i>	1	QL (960 per 30 days); GC
<i>quetiapine fumarate oral tablet 300 mg</i>	1	QL (80 per 30 days); GC
<i>quetiapine fumarate oral tablet 400 mg</i>	1	QL (60 per 30 days); GC
<i>quetiapine fumarate oral tablet 50 mg</i>	1	QL (480 per 30 days); GC
<i>ramelteon oral tablet 8 mg</i>	2	QL (30 per 30 days)
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	2	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG	4	QL (60 per 30 days); NEDS
REXULTI ORAL TABLET 3 MG, 4 MG	4	QL (30 per 30 days); NEDS
<i>riluzole oral tablet 50 mg</i>	2	NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG	3	QL (2 per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 37.5 MG, 50 MG	4	QL (2 per 28 days); NEDS
<i>risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg</i>	3	QL (2 per 28 days)
<i>risperidone microspheres er intramuscular suspension reconstituted er 50 mg</i>	4	QL (2 per 28 days); NEDS
<i>risperidone oral solution 1 mg/ml</i>	1	QL (480 per 30 days); GC
<i>risperidone oral tablet 0.25 mg</i>	1	QL (1920 per 30 days); GC
<i>risperidone oral tablet 0.5 mg</i>	1	QL (960 per 30 days); GC
<i>risperidone oral tablet 1 mg</i>	1	QL (480 per 30 days); GC
<i>risperidone oral tablet 2 mg</i>	1	QL (240 per 30 days); GC
<i>risperidone oral tablet 3 mg, 4 mg</i>	1	QL (120 per 30 days); GC
<i>risperidone oral tablet dispersible 0.25 mg</i>	3	QL (1920 per 30 days)
<i>risperidone oral tablet dispersible 0.5 mg</i>	3	QL (960 per 30 days)
<i>risperidone oral tablet dispersible 1 mg</i>	3	QL (480 per 30 days)
<i>risperidone oral tablet dispersible 2 mg</i>	3	QL (240 per 30 days)
<i>risperidone oral tablet dispersible 3 mg</i>	3	QL (150 per 30 days)
<i>risperidone oral tablet dispersible 4 mg</i>	3	QL (120 per 30 days)
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	3	QL (60 per 30 days)
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	3	QL (30 per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	2	QL (12 per 30 days)
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	2	QL (12 per 30 days)
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	1	GC
ROWEEPRA ORAL TABLET 500 MG	1	GC
<i>rufinamide oral suspension 40 mg/ml</i>	4	PA; QL (2400 per 30 days); NEDS
<i>rufinamide oral tablet 200 mg</i>	3	PA; QL (480 per 30 days)
<i>rufinamide oral tablet 400 mg</i>	3	PA; QL (240 per 30 days)

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SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR	4	QL (30 per 30 days); NEDS
<i>selegiline hcl oral capsule 5 mg</i>	2	
<i>sertraline hcl oral concentrate 20 mg/ml</i>	1	QL (300 per 30 days); GC
<i>sertraline hcl oral tablet 100 mg</i>	1	QL (60 per 30 days); GC
<i>sertraline hcl oral tablet 25 mg</i>	1	QL (240 per 30 days); GC
<i>sertraline hcl oral tablet 50 mg</i>	1	QL (120 per 30 days); GC
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	3	PA; QL (16 per 28 days); NM
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE	4	PA; QL (24 per 28 days); NEDS; NM
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG	3	QL (60 per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 750 MG	3	QL (120 per 30 days)
SUBVENITE ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG	1	GC
SUBVENITE STARTER KIT-BLUE ORAL KIT 35 X 25 MG	3	
SUBVENITE STARTER KIT-GREEN ORAL KIT 84 X 25 MG & 14X100 MG	3	
SUBVENITE STARTER KIT-ORANGE ORAL KIT 42 X 25 MG & 7 X 100 MG	3	
<i>sumatriptan nasal solution 20 mg/lact, 5 mg/lact</i>	3	
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	1	QL (9 per 30 days); GC
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml</i>	3	QL (6 per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	3	QL (6 per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml</i>	3	QL (6 per 30 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	4	PA; QL (60 per 30 days); NEDS
SYMPAZAN ORAL FILM 5 MG	3	PA; QL (30 per 30 days)
<i>tasimelteon oral capsule 20 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG	4	PA; QL (14 per 7 days); NEDS; NM; LA

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TECFIDERA ORAL CAPSULE DELAYED RELEASE 240 MG	4	PA; QL (60 per 30 days); NEDS; NM; LA
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG	4	PA; NEDS; NM; LA
<i>temazepam oral capsule 15 mg, 30 mg</i>	1	QL (30 per 30 days); GC
<i>tetrabenazine oral tablet 12.5 mg</i>	4	PA; QL (240 per 30 days); NEDS; NM
<i>tetrabenazine oral tablet 25 mg</i>	4	PA; QL (120 per 30 days); NEDS; NM
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	1	GC
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	1	GC
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	3	
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	1	GC
<i>tolcapone oral tablet 100 mg</i>	4	PA; QL (180 per 30 days); NEDS
<i>topiramate er oral capsule er 24 hour sprinkle 100 mg, 150 mg, 200 mg, 25 mg, 50 mg</i>	3	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	1	GC
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	GC
<i>tranylcypromine sulfate oral tablet 10 mg</i>	1	GC
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	1	GC
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	1	GC
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	1	PA; GC
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	1	GC
<i>trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg</i>	3	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	3	QL (30 per 30 days)
UBRELVY ORAL TABLET 100 MG	4	PA; QL (16 per 30 days); NEDS
UBRELVY ORAL TABLET 50 MG	4	PA; QL (20 per 30 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML	4	QL (0.28 per 30 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML	4	QL (0.35 per 30 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 150 MG/0.42ML	4	QL (0.42 per 60 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 200 MG/0.56ML	4	QL (0.56 per 60 days); NEDS

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 250 MG/0.7ML	4	QL (0.7 per 60 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 50 MG/0.14ML	4	QL (0.14 per 30 days); NEDS
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 75 MG/0.21ML	4	QL (0.21 per 30 days); NEDS
<i>valproic acid oral capsule 250 mg</i>	1	GC
<i>valproic acid oral solution 250 mg/5ml</i>	1	GC
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML	3	
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML	3	
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML	3	
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML	3	
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	3	PA
<i>varenicline tartrate oral tablet 0.5 mg</i>	3	PA; QL (60 per 30 days)
<i>varenicline tartrate oral tablet 1 mg</i>	3	PA; QL (56 per 28 days)
<i>venlafaxine besylate er oral tablet extended release 24 hour 112.5 mg</i>	3	QL (60 per 30 days)
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg</i>	1	QL (30 per 30 days); GC
<i>venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg</i>	1	QL (180 per 30 days); GC
<i>venlafaxine hcl er oral capsule extended release 24 hour 75 mg</i>	1	QL (90 per 30 days); GC
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg</i>	3	
<i>venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg</i>	3	QL (30 per 30 days)
<i>venlafaxine hcl er oral tablet extended release 24 hour 75 mg</i>	3	QL (90 per 30 days)
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	1	QL (90 per 30 days); GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
VERSACLOZ ORAL SUSPENSION 50 MG/ML	3	QL (600 per 30 days)
<i>vigabatrin oral packet 500 mg</i>	3	PA; QL (180 per 30 days); NM; LA
<i>vigabatrin oral tablet 500 mg</i>	4	PA; QL (180 per 30 days); NEDS; NM; LA
VIGADRONE ORAL PACKET 500 MG	3	PA; QL (180 per 30 days); NM; LA
VIGADRONE ORAL TABLET 500 MG	4	PA; QL (180 per 30 days); NEDS; NM
VIGPODER ORAL PACKET 500 MG	3	PA; QL (180 per 30 days); NM
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	3	QL (30 per 30 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	4	NEDS; NM
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG	4	QL (30 per 30 days); NEDS
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	3	
WAKIX ORAL TABLET 17.8 MG, 4.45 MG	4	PA; QL (60 per 30 days); NEDS; NM
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG	4	QL (56 per 28 days); NEDS
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG	4	QL (56 per 28 days); NEDS
XCOPRI ORAL TABLET 100 MG, 50 MG	4	QL (30 per 30 days); NEDS
XCOPRI ORAL TABLET 150 MG, 200 MG	4	QL (60 per 30 days); NEDS
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG	3	QL (56 per 365 days)
XCOPRI ORAL TABLET THERAPY PACK 14 X 150 MG & 14 X 200 MG, 14 X 50 MG & 14 X 100 MG	4	QL (56 per 365 days); NEDS
ZENZEDI ORAL TABLET 10 MG	1	QL (180 per 30 days); GC
ZENZEDI ORAL TABLET 5 MG	1	QL (90 per 30 days); GC
<i>ziprasidone hcl oral capsule 20 mg</i>	3	QL (240 per 30 days)
<i>ziprasidone hcl oral capsule 40 mg</i>	3	QL (120 per 30 days)
<i>ziprasidone hcl oral capsule 60 mg, 80 mg</i>	3	QL (60 per 30 days)
<i>ziprasidone mesylate intramuscular solution reconstituted 20 mg</i>	3	QL (6 per 3 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	2	QL (9 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	2	QL (9 per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	1	QL (30 per 30 days); GC
ZONISADE ORAL SUSPENSION 100 MG/5ML	4	NEDS
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	1	GC
ZTALMY ORAL SUSPENSION 50 MG/ML	4	QL (1100 per 30 days); NEDS; NM
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG	4	NEDS; NM
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	3	QL (2 per 28 days); NM
DERMATOLOGICAL AGENTS		
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	3	
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	3	
<i>ala-cort external cream 1 %, 2.5 %</i>	1	GC
<i>alclometasone dipropionate external cream 0.05 %</i>	1	GC
<i>alclometasone dipropionate external ointment 0.05 %</i>	1	GC
<i>amcinonide external cream 0.1 %</i>	1	GC
<i>amcinonide external ointment 0.1 %</i>	2	
<i>ammonium lactate external cream 12 %</i>	1	GC
<i>ammonium lactate external lotion 12 %</i>	1	GC
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	3	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	2	
<i>betamethasone dipropionate aug external cream 0.05 %</i>	2	
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	2	
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	2	
<i>betamethasone dipropionate external cream 0.05 %</i>	2	
<i>betamethasone dipropionate external lotion 0.05 %</i>	2	
<i>betamethasone dipropionate external ointment 0.05 %</i>	2	
<i>betamethasone valerate external cream 0.1 %</i>	2	
<i>betamethasone valerate external lotion 0.1 %</i>	2	
<i>betamethasone valerate external ointment 0.1 %</i>	2	
<i>bexarotene external gel 1 %</i>	4	PA; QL (60 per 30 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>calcipotriene external cream 0.005 %</i>	3	QL (120 per 30 days)
<i>calcipotriene external ointment 0.005 %</i>	2	QL (120 per 30 days)
<i>calcipotriene external solution 0.005 %</i>	3	QL (60 per 30 days)
CALCITRENE EXTERNAL OINTMENT 0.005 %	3	QL (120 per 30 days)
<i>cevimeline hcl oral capsule 30 mg</i>	2	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	1	GC
CICLODAN EXTERNAL SOLUTION 8 %	1	GC
<i>ciclopirox external solution 8 %</i>	1	GC
<i>ciclopirox olamine external cream 0.77 %</i>	1	QL (90 per 30 days); GC
<i>ciclopirox olamine external suspension 0.77 %</i>	1	GC
CLARAVIS ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	3	
CLINDACIN-P EXTERNAL SWAB 1 %	1	GC
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-5 %</i>	2	
<i>clindamycin phosphate external lotion 1 %</i>	2	QL (120 per 30 days)
<i>clindamycin phosphate external solution 1 %</i>	2	QL (120 per 30 days)
<i>clindamycin phosphate external swab 1 %</i>	1	GC
CLINPRO 5000 DENTAL PASTE 1.1 %	3	
<i>clobetasol prop emollient base external cream 0.05 %</i>	2	QL (120 per 30 days)
<i>clobetasol propionate e external cream 0.05 %</i>	2	QL (120 per 30 days)
<i>clobetasol propionate external gel 0.05 %</i>	2	QL (60 per 30 days)
<i>clobetasol propionate external ointment 0.05 %</i>	2	QL (120 per 30 days)
<i>clobetasol propionate external solution 0.05 %</i>	2	QL (50 per 30 days)
<i>clotrimazole external cream 1 %</i>	1	GC
<i>clotrimazole external solution 1 %</i>	1	GC
<i>clotrimazole mouth/throat troche 10 mg</i>	1	QL (150 per 30 days); GC
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	2	QL (120 per 30 days)
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	2	
DENTA 5000 PLUS DENTAL CREAM 1.1 %	3	
DENTAGEL DENTAL GEL 1.1 %	3	
<i>desonide external cream 0.05 %</i>	2	
<i>desonide external lotion 0.05 %</i>	2	

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<i>desonide external ointment 0.05 %</i>	2	
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	2	QL (100 per 30 days)
<i>desoximetasone external gel 0.05 %</i>	2	
<i>diclofenac sodium external gel 3 %</i>	3	PA; QL (100 per 30 days)
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML	4	PA; QL (4.56 per 28 days); NEDS; NM
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 MG/2ML	4	PA; QL (8 per 28 days); NEDS; NM
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML	4	PA; QL (1.34 per 28 days); NEDS; NM
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML	4	PA; QL (4.56 per 28 days); NEDS; NM
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML	4	PA; QL (8 per 28 days); NEDS; NM
<i>econazole nitrate external cream 1 %</i>	1	QL (90 per 30 days); GC
<i>ery external pad 2 %</i>	1	GC
<i>erythromycin external gel 2 %</i>	1	GC
<i>erythromycin external solution 2 %</i>	1	GC
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	3	QL (120 per 30 days)
<i>fluocinolone acetonide external ointment 0.025 %</i>	3	QL (120 per 30 days)
<i>fluocinolone acetonide external solution 0.01 %</i>	3	QL (120 per 30 days)
<i>fluocinonide emulsified base external cream 0.05 %</i>	2	QL (240 per 30 days)
<i>fluocinonide external cream 0.1 %</i>	3	QL (120 per 30 days)
<i>fluocinonide external gel 0.05 %</i>	2	QL (240 per 30 days)
<i>fluocinonide external ointment 0.05 %</i>	2	QL (240 per 30 days)
<i>fluocinonide external solution 0.05 %</i>	2	QL (240 per 30 days)
FLUORIDEX DENTAL PASTE 1.1 %	3	
FLUORIDEX ENHANCED WHITENING DENTAL PASTE 1.1 %	3	
FLUORIMAX 5000 DENTAL PASTE 1.1 %	3	
<i>fluorouracil external cream 0.5 %</i>	4	NEDS
<i>fluorouracil external cream 5 %</i>	2	
<i>fluorouracil external solution 2 %, 5 %</i>	2	
<i>fluticasone propionate external cream 0.05 %</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>fluticasone propionate external lotion 0.05 %</i>	3	
<i>fluticasone propionate external ointment 0.005 %</i>	1	GC
<i>gentamicin sulfate external cream 0.1 %</i>	1	QL (30 per 30 days); GC
<i>gentamicin sulfate external ointment 0.1 %</i>	1	QL (30 per 30 days); GC
<i>halobetasol propionate external cream 0.05 %</i>	3	
<i>halobetasol propionate external ointment 0.05 %</i>	3	
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	1	GC
<i>hydrocortisone external cream 1 %, 2.5 %</i>	1	GC
<i>hydrocortisone external ointment 1 %, 2.5 %</i>	1	GC
<i>hydrocortisone valerate external cream 0.2 %</i>	3	
<i>hydrocortisone valerate external ointment 0.2 %</i>	3	
<i>imiquimod external cream 3.75 %, 5 %</i>	3	
<i>imiquimod pump external cream 3.75 %</i>	3	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 35 mg, 40 mg</i>	3	
<i>isotretinoin oral capsule 25 mg</i>	4	NEDS
JUST RIGHT 5000 DENTAL PASTE 1.1 %	3	
<i>ketconazole external cream 2 %</i>	1	QL (120 per 30 days); GC
<i>ketconazole external shampoo 2 %</i>	1	QL (120 per 30 days); GC
KLAYESTA EXTERNAL POWDER 100000 UNIT/GM	1	GC
KOURZEQ MOUTH/THROAT PASTE 0.1 %	1	GC
<i>malathion external lotion 0.5 %</i>	3	
<i>methoxsalen rapid oral capsule 10 mg</i>	4	NEDS; NM
<i>metronidazole external cream 0.75 %</i>	2	
<i>metronidazole external gel 0.75 %, 1 %</i>	2	
<i>metronidazole external lotion 0.75 %</i>	2	
<i>mometasone furoate external cream 0.1 %</i>	1	GC
<i>mometasone furoate external ointment 0.1 %</i>	1	GC
<i>mometasone furoate external solution 0.1 %</i>	1	GC
<i>mupirocin calcium external cream 2 %</i>	3	QL (30 per 30 days)
<i>mupirocin external ointment 2 %</i>	1	QL (120 per 30 days); GC

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MYORISAN ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	3	
NEUAC EXTERNAL GEL 1.2-5 %	2	
<i>nitroglycerin rectal ointment 0.4 %</i>	3	QL (30 per 30 days)
NYAMYC EXTERNAL POWDER 100000 UNIT/GM	1	GC
<i>nystatin external cream 100000 unit/gm</i>	1	GC
<i>nystatin external ointment 100000 unit/gm</i>	1	GC
<i>nystatin external powder 100000 unit/gm</i>	1	GC
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	1	GC
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	2	
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	2	
NYSTOP EXTERNAL POWDER 100000 UNIT/GM	1	GC
ORALONE MOUTH/THROAT PASTE 0.1 %	1	GC
PANRETIN EXTERNAL GEL 0.1 %	4	NEDS; NM
<i>penciclovir external cream 1 %</i>	3	QL (5 per 30 days)
PERIOGARD MOUTH/THROAT SOLUTION 0.12 %	1	GC
<i>permethrin external cream 5 %</i>	2	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	3	
<i>pimecrolimus external cream 1 %</i>	2	PA; QL (100 per 30 days)
<i>podofilox external solution 0.5 %</i>	1	GC
PROCTO-MED HC EXTERNAL CREAM 2.5 %	1	GC
PROCTOSOL HC EXTERNAL CREAM 2.5 %	1	GC
PROCTOZONE-HC EXTERNAL CREAM 2.5 %	1	GC
RECTIV RECTAL OINTMENT 0.4 %	3	QL (30 per 30 days)
REGRANEX EXTERNAL GEL 0.01 %	4	PA; NEDS
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	3	QL (30 per 30 days)
<i>selenium sulfide external lotion 2.5 %</i>	1	GC
<i>sf 5000 plus dental cream 1.1 %</i>	3	
<i>sf dental gel 1.1 %</i>	3	
<i>silver sulfadiazine external cream 1 %</i>	1	GC
<i>sodium fluoride 5000 enamel dental gel 1.1-5 %</i>	3	

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<i>sodium fluoride 5000 plus dental cream 1.1 %</i>	3	
<i>sodium fluoride 5000 ppm dental cream 1.1 %</i>	3	
<i>sodium fluoride 5000 ppm dental gel 1.1 %</i>	3	
<i>sodium fluoride 5000 ppm dental paste 1.1 %</i>	3	
<i>sodium fluoride 5000 sensitive dental gel 1.1-5 %</i>	3	
<i>sodium fluoride dental cream 1.1 %</i>	3	
<i>sodium fluoride dental gel 1.1 %</i>	3	
<i>sodium fluoride mouth/throat solution 0.2 %</i>	3	
SSD (SILVER SULFADIAZINE) EXTERNAL CREAM 1 %	1	GC
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	1	GC
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	3	PA; QL (100 per 30 days)
<i>tazarotene external cream 0.1 %</i>	3	PA
<i>tazarotene external gel 0.05 %, 0.1 %</i>	3	PA
TAZORAC EXTERNAL CREAM 0.05 %	3	PA
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	1	PA; QL (45 per 30 days); GC
<i>tretinoin external gel 0.01 %, 0.025 %</i>	2	PA; QL (45 per 30 days)
<i>tretinoin microsphere external gel 0.04 %, 0.1 %</i>	2	PA; QL (50 per 30 days)
<i>tretinoin microsphere pump external gel 0.04 %, 0.1 %</i>	2	PA; QL (50 per 30 days)
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	1	QL (454 per 30 days); GC
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	1	GC
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	1	GC
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	1	GC
TRIDERM EXTERNAL CREAM 0.1 %, 0.5 %	1	QL (454 per 30 days); GC
VALCHLOR EXTERNAL GEL 0.016 %	4	PA; NEDS; NM; LA
VEREGEN EXTERNAL OINTMENT 15 %	4	NEDS
ZENATANE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG	3	
ELECTROLYTES / MINERALS / METALS / VITAMINS		
<i>carglumic acid oral tablet soluble 200 mg</i>	4	PA; NEDS; NM; LA

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CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %	3	B/D PA
CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	3	B/D PA
CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	3	B/D PA
CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %	3	B/D PA
CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %	3	B/D PA
<i>clinimix eldextrose (8/10) intravenous solution 8 %</i>	3	B/D PA
<i>clinimix eldextrose (8/14) intravenous solution 8 %</i>	3	B/D PA
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	3	B/D PA
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	3	B/D PA
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %	3	B/D PA
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %	3	B/D PA
<i>clinimix/dextrose (6/5) intravenous solution 6 %</i>	3	B/D PA
<i>clinimix/dextrose (8/10) intravenous solution 8 %</i>	3	B/D PA
<i>clinimix/dextrose (8/14) intravenous solution 8 %</i>	3	B/D PA
CLINISOL SF INTRAVENOUS SOLUTION 15 %	3	B/D PA
CLINOLIPID INTRAVENOUS EMULSION 20 %	2	B/D PA
<i>dextrose intravenous solution 10 %</i>	1	GC
<i>dextrose intravenous solution 5 %</i>	2	
<i>dextrose-nacl intravenous solution 10-0.2 %, 5-0.45 %</i>	2	
<i>dextrose-nacl intravenous solution 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.33 %, 5-0.9 %</i>	1	GC
<i>dextrose-sodium chloride intravenous solution 10-0.2 %, 5-0.225 %, 5-0.45 %</i>	2	
<i>dextrose-sodium chloride intravenous solution 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.3 %, 5-0.33 %, 5-0.9 %</i>	1	GC
<i>folic acid oral tablet 1 mg</i>	1	GC; ED

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INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	2	B/D PA
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	2	
ISOLYTE-S INTRAVENOUS SOLUTION	2	
<i>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-%-%</i>	2	
<i>kcl-lactated ringers-d5w intravenous solution 20 meq/l</i>	2	
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	GC
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	1	GC
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	1	GC
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	1	GC
KLOR-CON ORAL PACKET 20 MEQ	1	GC
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	1	GC
<i>levocarnitine oral solution 1 gm/10ml</i>	1	B/D PA; GC
<i>levocarnitine oral tablet 330 mg</i>	2	B/D PA
<i>levocarnitine sf oral solution 1 gm/10ml</i>	1	B/D PA; GC
<i>magnesium sulfate injection solution 50 %, 50 % (10ml syringe)</i>	1	GC
<i>multiple electro type 1 ph 5.5 intravenous solution</i>	2	
<i>multiple electro type 1 ph 7.4 intravenous solution</i>	2	
NUTRILIPID INTRAVENOUS EMULSION 20 %	2	B/D PA
PLASMA-LYTE 148 INTRAVENOUS SOLUTION	2	
PLASMA-LYTE A INTRAVENOUS SOLUTION	2	
PLENAMINE INTRAVENOUS SOLUTION 15 %	3	B/D PA
<i>potassium chloride crys er oral tablet extended release 10 meq, 15 meq, 20 meq</i>	1	GC
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq</i>	1	GC
<i>potassium chloride intravenous solution 10 meq/100ml, 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml, 40 meq/100ml</i>	1	GC
<i>potassium chloride oral packet 20 meq</i>	1	GC
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	1	GC
<i>potassium cl in dextrose 5% intravenous solution 10 meq/l, 20 meq/l</i>	2	
PREMASOL INTRAVENOUS SOLUTION 10 %	3	B/D PA
PROSOL INTRAVENOUS SOLUTION 20 %	3	B/D PA
<i>sodium chloride injection solution 2.5 meq/ml</i>	1	GC
<i>sodium chloride intravenous solution 0.45 %, 3 %, 5 %</i>	1	GC
<i>sodium chloride intravenous solution 0.9 %</i>	2	
<i>sodium fluoride oral tablet 2.2 (1 f) mg</i>	1	GC
<i>sodium fluoride oral tablet chewable 2.2 (1 f) mg</i>	1	GC
TPN ELECTROLYTES INTRAVENOUS CONCENTRATE	2	
TRAVASOL INTRAVENOUS SOLUTION 10 %	3	B/D PA
TROPHAMINE INTRAVENOUS SOLUTION 10 %	3	B/D PA
ENDOCRINE AND METABOLIC DISORDER AGENTS		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	1	QL (90 per 30 days); GC
<i>alendronate sodium oral tablet 10 mg</i>	1	QL (30 per 30 days); GC
<i>alendronate sodium oral tablet 35 mg, 70 mg</i>	1	QL (4 per 28 days); GC
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML	3	PA; QL (2.4 per 30 days)
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML	3	PA; QL (1.2 per 30 days)
<i>calcitonin (salmon) nasal solution 200 unit/lact</i>	2	QL (4 per 30 days)
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	1	B/D PA; GC
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	2	
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	3	B/D PA; QL (60 per 30 days); NM
<i>cinacalcet hcl oral tablet 90 mg</i>	4	B/D PA; QL (120 per 30 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CYCLOSET ORAL TABLET 0.8 MG	3	ST; QL (180 per 30 days)
<i>deferasirox oral tablet 180 mg, 360 mg</i>	4	PA; NEDS; NM
<i>deferasirox oral tablet 90 mg</i>	3	PA; NM
<i>deferasirox oral tablet soluble 125 mg</i>	3	PA; NM
<i>deferasirox oral tablet soluble 250 mg, 500 mg</i>	4	PA; NEDS; NM
<i>deferiprone oral tablet 1000 mg</i>	4	PA; NEDS; NM
<i>deferiprone oral tablet 500 mg</i>	4	PA; NEDS; NM; LA
<i>diazoxide oral suspension 50 mg/ml</i>	4	NEDS
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	3	B/D PA
<i>ergocalciferol oral capsule 1.25 mg (50000 ut)</i>	1	GC
FARXIGA ORAL TABLET 10 MG, 5 MG	5	QL (30 per 30 days); GC
FERRIPROX ORAL TABLET 1000 MG	4	PA; NEDS; NM; LA
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 600 MCG/2.4ML	4	PA; QL (3 per 28 days); NEDS; NM
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT	3	QL (4 per 28 days)
<i>glimepiride oral tablet 1 mg</i>	1	QL (240 per 30 days); GC
<i>glimepiride oral tablet 2 mg</i>	1	QL (120 per 30 days); GC
<i>glimepiride oral tablet 4 mg</i>	1	QL (60 per 30 days); GC
<i>glipizide er oral tablet extended release 24 hour 10 mg</i>	1	QL (60 per 30 days); GC
<i>glipizide er oral tablet extended release 24 hour 2.5 mg</i>	1	QL (240 per 30 days); GC
<i>glipizide er oral tablet extended release 24 hour 5 mg</i>	1	QL (120 per 30 days); GC
<i>glipizide oral tablet 10 mg</i>	1	QL (120 per 30 days); GC
<i>glipizide oral tablet 2.5 mg</i>	1	GC
<i>glipizide oral tablet 5 mg</i>	1	QL (240 per 30 days); GC
<i>glipizide xl oral tablet extended release 24 hour 10 mg</i>	1	QL (60 per 30 days); GC
<i>glipizide xl oral tablet extended release 24 hour 2.5 mg</i>	1	QL (240 per 30 days); GC
<i>glipizide xl oral tablet extended release 24 hour 5 mg</i>	1	QL (120 per 30 days); GC
<i>glipizide-metformin hcl oral tablet 2.5-250 mg</i>	1	QL (240 per 30 days); GC
<i>glipizide-metformin hcl oral tablet 2.5-500 mg, 5-500 mg</i>	1	QL (120 per 30 days); GC
GLUCAGON EMERGENCY INJECTION KIT 1 MG	2	
HUMALOG INJECTION SOLUTION 100 UNIT/ML	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	2	
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	2	
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML	2	
HUMALOG MIX 50/50 SUBCUTANEOUS SUSPENSION (50-50) 100 UNIT/ML	2	
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML	2	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML	2	
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	2	
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	2	OTC
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	2	OTC
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	2	OTC
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	2	OTC
HUMULIN R INJECTION SOLUTION 100 UNIT/ML	2	OTC
<i>ibandronate sodium oral tablet 150 mg</i>	1	QL (1 per 28 days); GC
<i>insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml</i>	5	GC
<i>insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml</i>	5	GC
<i>insulin aspart injection solution 100 unit/ml</i>	5	GC
<i>insulin aspart penfill subcutaneous solution cartridge 100 unit/ml</i>	5	GC
<i>insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml</i>	5	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml</i>	5	GC
<i>insulin lispro injection solution 100 unit/ml</i>	5	GC
<i>insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml</i>	5	GC
<i>insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml</i>	5	GC
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG	3	QL (60 per 30 days)
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG	3	QL (60 per 30 days)
INVOKANA ORAL TABLET 100 MG, 300 MG	3	QL (30 per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	5	QL (60 per 30 days); GC
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG	5	QL (30 per 30 days); GC
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 50-1000 MG, 50-500 MG	5	QL (60 per 30 days); GC
JANUVIA ORAL TABLET 100 MG	5	QL (30 per 30 days); GC
JANUVIA ORAL TABLET 25 MG	5	QL (120 per 30 days); GC
JANUVIA ORAL TABLET 50 MG	5	QL (60 per 30 days); GC
JARDIANCE ORAL TABLET 10 MG, 25 MG	5	QL (30 per 30 days); GC
KERENDIA ORAL TABLET 10 MG, 20 MG	3	QL (30 per 30 days)
<i>lanthanum carbonate oral tablet chewable 1000 mg, 500 mg, 750 mg</i>	3	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	5	GC
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	5	GC
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	5	GC
LOKELMA ORAL PACKET 10 GM, 5 GM	3	
<i>metformin hcl er oral tablet extended release 24 hour 500 mg</i>	1	QL (120 per 30 days); GC
<i>metformin hcl er oral tablet extended release 24 hour 750 mg</i>	1	QL (60 per 30 days); GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>metformin hcl oral tablet 1000 mg</i>	1	QL (60 per 30 days); GC
<i>metformin hcl oral tablet 500 mg</i>	1	QL (150 per 30 days); GC
<i>metformin hcl oral tablet 850 mg</i>	1	QL (90 per 30 days); GC
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	3	QL (90 per 30 days)
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML	2	PA; QL (2 per 28 days)
<i>nateglinide oral tablet 120 mg</i>	1	QL (90 per 30 days); GC
<i>nateglinide oral tablet 60 mg</i>	1	QL (180 per 30 days); GC
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG	4	PA; QL (2 per 28 days); NEDS; NM
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	OTC; GC
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	5	OTC; GC
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	OTC; GC
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	5	OTC; GC
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	1	OTC; GC
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML	5	GC
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML	1	OTC; GC
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	5	OTC; GC
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	5	OTC; GC
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML	1	OTC; GC
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	5	OTC; GC
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML	1	OTC; GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	1	GC
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	1	GC
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	5	GC
NOVOLOG INJECTION SOLUTION 100 UNIT/ML	5	GC
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	5	GC
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	1	GC
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	5	GC
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	5	GC
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML	1	GC
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML	2	PA; QL (1.5 per 28 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML	2	PA; QL (3 per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML	2	PA; QL (3 per 28 days)
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML	2	PA; QL (3 per 28 days)
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	3	B/D PA
<i>pioglitazone hcl oral tablet 15 mg</i>	1	QL (90 per 30 days); GC
<i>pioglitazone hcl oral tablet 30 mg</i>	1	QL (45 per 30 days); GC
<i>pioglitazone hcl oral tablet 45 mg</i>	1	QL (30 per 30 days); GC
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	1	QL (90 per 30 days); GC
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	3	PA; QL (1 per 180 days); NM
<i>repaglinide oral tablet 0.5 mg</i>	2	QL (960 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>repaglinide oral tablet 1 mg</i>	2	QL (480 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	2	QL (240 per 30 days)
<i>rezvoglar kwikpen subcutaneous solution pen-injector 100 unit/ml</i>	5	GC
<i>risedronate sodium oral tablet 150 mg</i>	2	QL (1 per 28 days)
<i>sevelamer carbonate oral packet 0.8 gm</i>	3	QL (540 per 30 days)
<i>sevelamer carbonate oral packet 2.4 gm</i>	3	QL (180 per 30 days)
<i>sevelamer carbonate oral tablet 800 mg</i>	3	QL (540 per 30 days)
<i>sodium polystyrene sulfonate oral powder</i>	1	GC
SPS ORAL SUSPENSION 15 GM/60ML	1	GC
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML	4	PA; QL (11 per 30 days); NEDS
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML	4	PA; QL (6 per 30 days); NEDS
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG	2	QL (60 per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 5-1000 MG	2	QL (60 per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 25-1000 MG	2	QL (30 per 30 days)
<i>teriparatide (recombinant) subcutaneous solution pen-injector 600 mcg/2.4ml, 620 mcg/2.48ml</i>	4	PA; QL (3 per 28 days); NEDS; NM
<i>teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml</i>	4	PA; QL (3 per 28 days); NEDS; NM
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	5	GC
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	5	GC
TRADJENTA ORAL TABLET 5 MG	5	QL (30 per 30 days); GC
<i>trientine hcl oral capsule 250 mg, 500 mg</i>	4	NEDS; NM
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML	2	PA; QL (2 per 28 days)
VELPHORO ORAL TABLET CHEWABLE 500 MG	4	QL (180 per 30 days); NEDS

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	2	PA; QL (9 per 30 days)
<i>vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut)</i>	1	QL (4 per 28 days); GC; ED
<i>vitamin d (ergocalciferol) oral capsule 50000 unit</i>	1	GC
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	4	PA; QL (5.1 per 28 days); NEDS; NM
<i>zoledronic acid intravenous concentrate 4 mg/5ml</i>	2	PA; NM
<i>zoledronic acid intravenous solution 4 mg/100ml</i>	4	PA; NEDS; NM
<i>zoledronic acid intravenous solution 5 mg/100ml</i>	2	PA; NM
GASTROINTESTINAL AGENTS		
<i>alosetron hcl oral tablet 0.5 mg</i>	3	PA; QL (60 per 30 days)
<i>alosetron hcl oral tablet 1 mg</i>	4	PA; QL (60 per 30 days); NEDS
<i>aprepitant oral 80 & 125 mg</i>	2	B/D PA; QL (15 per 30 days)
<i>aprepitant oral capsule 125 mg</i>	2	B/D PA; QL (5 per 30 days)
<i>aprepitant oral capsule 40 mg</i>	2	B/D PA; QL (1 per 28 days)
<i>aprepitant oral capsule 80 & 125 mg</i>	2	B/D PA; QL (15 per 30 days)
<i>aprepitant oral capsule 80 mg</i>	2	B/D PA; QL (10 per 30 days)
<i>balsalazide disodium oral capsule 750 mg</i>	2	
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	4	PA; NEDS
<i>budesonide oral capsule delayed release particles 3 mg</i>	3	
<i>cimetidine hcl oral solution 300 mg/5ml</i>	1	GC
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	1	GC
COMPRO RECTAL SUPPOSITORY 25 MG	1	GC
<i>constulose oral solution 10 gm/15ml</i>	1	GC
<i>dicyclomine hcl oral capsule 10 mg</i>	1	GC
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	1	GC
<i>dicyclomine hcl oral tablet 20 mg</i>	1	GC
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	1	GC
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	1	GC
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	3	B/D PA; QL (120 per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML	3	B/D PA; QL (15 per 30 days)
<i>enulose oral solution 10 gm/15ml</i>	1	GC

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<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	1	QL (30 per 30 days); GC
<i>esomeprazole magnesium oral capsule delayed release 20 mg</i>	1	OTC; GC
<i>esomeprazole magnesium oral capsule delayed release 40 mg</i>	1	ST; QL (30 per 30 days); GC
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	GC
GATTEX SUBCUTANEOUS KIT 5 MG	4	PA; NEDS; NM; LA
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	1	GC
GAVILYTE-N WITH FLAVOR PACK ORAL SOLUTION RECONSTITUTED 420 GM	1	GC
<i>generlac oral solution 10 gm/15ml</i>	1	GC
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	
<i>granisetron hcl oral tablet 1 mg</i>	2	B/D PA; QL (30 per 30 days)
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	1	GC
<i>hydrocortisone rectal enema 100 mg/60ml</i>	1	GC
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	2	
<i>hyoscyamine sulfate oral tablet dispersible 0.125 mg</i>	2	
<i>hyoscyamine sulfate sublingual tablet sublingual 0.125 mg</i>	2	
<i>lactulose encephalopathy oral solution 10 gm/15ml</i>	1	GC
<i>lactulose oral packet 10 gm</i>	4	NEDS
<i>lactulose oral solution 10 gm/15ml, 20 gm/30ml</i>	1	GC
<i>lansoprazole oral capsule delayed release 15 mg</i>	1	OTC; GC
<i>lansoprazole oral capsule delayed release 15 mg</i>	1	GC
<i>lansoprazole oral capsule delayed release 30 mg</i>	1	QL (30 per 30 days); GC
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG	3	QL (30 per 30 days)
<i>loperamide hcl oral capsule 2 mg</i>	1	GC
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	3	QL (60 per 30 days)
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	1	GC
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	3	
<i>mesalamine oral capsule delayed release 400 mg</i>	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>mesalamine oral tablet delayed release 1.2 gm, 800 mg</i>	3	
<i>mesalamine rectal enema 4 gm</i>	1	GC
<i>methscopolamine bromide oral tablet 2.5 mg, 5 mg</i>	2	
<i>metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml</i>	1	GC
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	1	GC
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	2	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	3	QL (30 per 30 days)
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG	4	PA; NEDS; NM; LA
MYTESI ORAL TABLET DELAYED RELEASE 125 MG	4	NEDS; NM
<i>nizatidine oral capsule 150 mg, 300 mg</i>	1	GC
OICALIVA ORAL TABLET 10 MG, 5 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	1	GC
<i>omeprazole oral tablet delayed release 20 mg</i>	1	OTC; GC
<i>ondansetron hcl oral solution 4 mg/5ml</i>	1	B/D PA; QL (450 per 30 days); GC
<i>ondansetron hcl oral tablet 24 mg</i>	1	B/D PA; QL (30 per 30 days); GC
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	B/D PA; QL (90 per 30 days); GC
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	1	B/D PA; QL (90 per 30 days); GC
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	1	GC
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	1	GC
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	1	GC
<i>prochlorperazine rectal suppository 25 mg</i>	1	GC
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	1	GC
<i>promethazine hcl oral syrup 6.25 mg/5ml</i>	1	GC
<i>promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg</i>	1	GC
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	1	PA; GC
PROMETHEGAN RECTAL SUPPOSITORY 12.5 MG, 25 MG, 50 MG	1	PA; GC
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	1	QL (30 per 30 days); GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	3	QL (10 per 28 days)
<i>sucralfate oral tablet 1 gm</i>	1	GC
<i>sulfasalazine oral tablet 500 mg</i>	1	GC
<i>sulfasalazine oral tablet delayed release 500 mg</i>	1	GC
<i>trimethobenzamide hcl oral capsule 300 mg</i>	1	GC
<i>ursodiol oral capsule 300 mg</i>	2	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	2	
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK 2 X 90 MG	3	B/D PA; QL (4 per 28 days); NM
VIBERZI ORAL TABLET 100 MG, 75 MG	4	PA; NEDS
XERMELO ORAL TABLET 250 MG	4	PA; QL (90 per 30 days); NEDS; NM; LA
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
<i>betaine oral powder</i>	4	NEDS; NM; LA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	4	PA; QL (120 per 30 days); NEDS; NM
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT	2	
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	3	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	3	NM; LA
JAVYGTOR ORAL PACKET 100 MG, 500 MG	4	PA; NEDS; NM
JAVYGTOR ORAL TABLET 100 MG	4	PA; NEDS; NM
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	4	PA; NEDS; NM
NITYR ORAL TABLET 10 MG, 2 MG, 5 MG	4	PA; NEDS; NM; LA
PROLASTIN-C INTRAVENOUS SOLUTION 1000 MG/20ML	4	PA; NEDS; NM; LA
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	4	PA; NEDS; NM; LA
RAVICTI ORAL LIQUID 1.1 GM/ML	4	PA; QL (525 per 30 days); NEDS; NM; LA
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	4	PA; NEDS; NM
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	4	PA; NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>sodium phenylbutyrate oral powder 3 gml/tsp</i>	4	PA; NEDS; NM
<i>sodium phenylbutyrate oral tablet 500 mg</i>	4	PA; NEDS; NM
SUCRAID ORAL SOLUTION 8500 UNIT/ML	4	NEDS; NM; LA
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	2	
GENITOURINARY AGENTS		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	1	GC
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	2	
CAVERJECT IMPULSE INTRACAVERNOSAL KIT 10 MCG, 20 MCG	3	QL (6 per 30 days); ED
CAVERJECT INTRACAVERNOSAL SOLUTION RECONSTITUTED 40 MCG	3	QL (6 per 30 days); ED
CIALIS ORAL TABLET 10 MG, 20 MG	2	QL (4 per 30 days); ED
<i>clindamycin phosphate vaginal cream 2 %</i>	3	
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	3	QL (30 per 30 days)
<i>dutasteride oral capsule 0.5 mg</i>	2	QL (30 per 30 days)
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	2	QL (30 per 30 days)
ELMIRON ORAL CAPSULE 100 MG	3	
<i>finasteride oral tablet 5 mg</i>	1	GC
<i>flavoxate hcl oral tablet 100 mg</i>	1	GC
<i>metronidazole vaginal gel 0.75 %</i>	2	
MUSE URETHRAL PELLETT 1000 MCG, 250 MCG, 500 MCG	3	QL (6 per 30 days); ED
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML	3	QL (300 per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	3	QL (30 per 30 days)
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg</i>	1	QL (60 per 30 days); GC
<i>oxybutynin chloride er oral tablet extended release 24 hour 5 mg</i>	1	QL (30 per 30 days); GC
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	1	QL (600 per 30 days); GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>oxybutynin chloride oral tablet 2.5 mg</i>	1	QL (90 per 30 days); GC
<i>oxybutynin chloride oral tablet 5 mg</i>	1	QL (120 per 30 days); GC
<i>penicillamine oral tablet 250 mg</i>	4	NEDS; NM
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	2	
<i>sildenafil citrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	QL (10 per 30 days); GC; ED
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	3	QL (30 per 30 days)
<i>tadalafil oral tablet 10 mg, 20 mg</i>	1	QL (10 per 30 days); GC; ED
<i>tamsulosin hcl oral capsule 0.4 mg</i>	1	GC
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	1	GC
<i>terconazole vaginal suppository 80 mg</i>	1	GC
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	3	QL (30 per 30 days)
VANDEZOLE VAGINAL GEL 0.75 %	2	
<i>vardenafil hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	1	QL (10 per 30 days); GC; ED
VIAGRA ORAL TABLET 100 MG, 25 MG, 50 MG	2	QL (4 per 30 days); ED

HORMONAL AGENTS

AFIRMELLE ORAL TABLET 0.1-20 MG-MCG	1	GC
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	1	GC
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	1	GC
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	1	GC
AMABELZ ORAL TABLET 0.5-0.1 MG	3	PA
APRI ORAL TABLET 0.15-30 MG-MCG	2	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	1	GC
AUBRA EQ ORAL TABLET 0.1-20 MG-MCG	1	GC
AUROVELA 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
AUROVELA 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
AUROVELA 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	GC
AUROVELA FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
AUROVELA FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
AVIANE ORAL TABLET 0.1-20 MG-MCG	1	GC
AYUNA ORAL TABLET 0.15-30 MG-MCG	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
AZURETTE ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	GC
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
BLISOVI FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
<i>cabergoline oral tablet 0.5 mg</i>	2	
CAMILA ORAL TABLET 0.35 MG	1	GC
CHATEAL EQ ORAL TABLET 0.15-30 MG-MCG	1	GC
CYRED EQ ORAL TABLET 0.15-30 MG-MCG	2	
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	2	
DASETTA 1/35 ORAL TABLET 1-35 MG-MCG	1	GC
DASETTA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	GC
DEBLITANE ORAL TABLET 0.35 MG	1	GC
DELYLA ORAL TABLET 0.1-20 MG-MCG	1	GC
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML	3	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML	3	
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 100 MG/ML	1	PA; GC
DEPO-TESTOSTERONE INTRAMUSCULAR SOLUTION 200 MG/ML	1	GC
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	2	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	2	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	3	
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	GC
<i>desogestrel-ethinyl estradiol oral tablet 0.15-30 mg-mcg</i>	2	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	1	GC
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	1	GC
<i>dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)</i>	3	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg</i>	1	GC
DUAVEE ORAL TABLET 0.45-20 MG	3	PA; QL (30 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
EGRIFTA SV SUBCUTANEOUS SOLUTION RECONSTITUTED 2 MG	4	PA; NEDS; NM; LA
ELURYNG VAGINAL RING 0.12-0.015 MG/24HR	3	
EMOQUETTE ORAL TABLET 0.15-30 MG-MCG	2	
ENILLORING VAGINAL RING 0.12-0.015 MG/24HR	3	
ENPRESSE-28 ORAL TABLET 50-30/75-40/ 125-30 MCG	1	GC
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	2	
ERRIN ORAL TABLET 0.35 MG	1	GC
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	1	GC
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	1	GC
<i>estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr</i>	3	PA; QL (8 per 28 days)
<i>estradiol vaginal cream 0.1 mg/gm</i>	3	
<i>estradiol vaginal tablet 10 mcg</i>	3	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	3	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	1	GC
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	3	
EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	GC
FALMINA ORAL TABLET 0.1-20 MG-MCG	1	GC
FEMYNOR ORAL TABLET 0.25-35 MG-MCG	1	GC
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	1	GC
HAILEY 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
HAILEY FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
HAILEY FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
HALOETTE VAGINAL RING 0.12-0.015 MG/24HR	3	
HEATHER ORAL TABLET 0.35 MG	1	GC
HIDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG (21)	3	
INCASSIA ORAL TABLET 0.35 MG	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	4	PA; NEDS; NM; LA
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	2	
JASMIEL ORAL TABLET 3-0.02 MG	1	GC
JENCYCLA ORAL TABLET 0.35 MG	1	GC
JULEBER ORAL TABLET 0.15-30 MG-MCG	2	
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
KALLIGA ORAL TABLET 0.15-30 MG-MCG	2	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	GC
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	1	GC
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	1	GC
KORLYM ORAL TABLET 300 MG	4	PA; NEDS; NM; LA
KURVELO ORAL TABLET 0.15-30 MG-MCG	1	GC
<i>lanreotide acetate subcutaneous solution 120 mg/0.5ml</i>	4	PA; NEDS; NM
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG	1	GC
LESSINA ORAL TABLET 0.1-20 MG-MCG	1	GC
LEVONEST ORAL TABLET 50-30/75-40/ 125-30 MCG	1	GC
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg</i>	1	GC
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	1	GC
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	1	GC
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	1	GC

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<i>levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	GC
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	GC
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	1	GC
LOESTRIN 1.5/30 (21) ORAL TABLET 1.5-30 MG-MCG	1	GC
LOESTRIN 1/20 (21) ORAL TABLET 1-20 MG-MCG	1	GC
LOESTRIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
LOESTRIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
LORYNA ORAL TABLET 3-0.02 MG	1	GC
LO-ZUMANDIMINE ORAL TABLET 3-0.02 MG	1	GC
LUTERA ORAL TABLET 0.1-20 MG-MCG	1	GC
LYLEQ ORAL TABLET 0.35 MG	1	GC
LYZA ORAL TABLET 0.35 MG	1	GC
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	1	GC
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	1	GC
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	1	GC
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	1	GC
<i>megestrol acetate oral suspension 625 mg/5ml</i>	3	PA
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG	3	PA
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	GC
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	1	GC
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	1	GC
<i>methyltestosterone oral capsule 10 mg</i>	4	NEDS
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	1	GC

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MICROGESTIN 24 FE ORAL TABLET 1-20 MG-MCG	1	GC
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	GC
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	GC
<i>mifepristone oral tablet 300 mg</i>	4	PA; NEDS; NM; LA
MILI ORAL TABLET 0.25-35 MG-MCG	1	GC
MILLIPRED ORAL TABLET 5 MG	3	
MONO-LINYAH ORAL TABLET 0.25-35 MG-MCG	1	GC
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	GC
NIKKI ORAL TABLET 3-0.02 MG	1	GC
NORA-BE ORAL TABLET 0.35 MG	1	GC
NORDITROPIN FLEXPOR SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML	4	PA; NEDS; NM
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	GC
<i>norethindrone acetate oral tablet 5 mg</i>	1	GC
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	1	GC
<i>norethindrone oral tablet 0.35 mg</i>	1	GC
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	1	GC
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg</i>	1	GC
NORLYDA ORAL TABLET 0.35 MG	1	GC
NORLYROC ORAL TABLET 0.35 MG	1	GC
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	GC
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	1	GC
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	1	GC
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	GC
NYLIA 1/35 ORAL TABLET 1-35 MG-MCG	1	GC
NYLIA 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	GC

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<i>octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	3	PA; NM
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml</i>	3	PA; NM
<i>octreotide acetate subcutaneous solution prefilled syringe 500 mcg/ml</i>	4	PA; NEDS; NM
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML	4	PA; NEDS; NM; LA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG	3	PA; NM; LA
ORSYTHIA ORAL TABLET 0.1-20 MG-MCG	1	GC
OSPHENA ORAL TABLET 60 MG	3	
<i>oxandrolone oral tablet 10 mg</i>	2	PA; QL (60 per 30 days)
<i>oxandrolone oral tablet 2.5 mg</i>	2	PA; QL (240 per 30 days)
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	GC
PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG	1	GC
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	1	GC
<i>prednicarbate external ointment 0.1 %</i>	1	GC
<i>prednisolone oral solution 15 mg/5ml</i>	1	GC
<i>prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml</i>	1	GC
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg</i>	3	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	2	
<i>prednisone oral solution 5 mg/5ml</i>	1	GC
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	1	GC
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	1	GC
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	PA
PREMARIN VAGINAL CREAM 0.625 MG/GM	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	PA

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>propylthiouracil oral tablet 50 mg</i>	2	
<i>raloxifene hcl oral tablet 60 mg</i>	2	QL (30 per 30 days)
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	2	
SHAROBEL ORAL TABLET 0.35 MG	1	GC
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	4	PA; NEDS; NM; LA
SIMLIYA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	GC
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 90 MG/0.3ML	4	PA; NEDS; NM
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG	4	PA; NEDS; NM; LA
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	1	GC
SRONYX ORAL TABLET 0.1-20 MG-MCG	1	GC
SYNAREL NASAL SOLUTION 2 MG/ML	4	PA; NEDS; NM
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	2	
TAPERDEX 6-DAY ORAL TABLET THERAPY PACK 1.5 MG, 1.5 MG (21)	3	
TARINA FE 1/20 EQ ORAL TABLET 1-20 MG-MCG	1	GC
<i>testosterone cypionate intramuscular solution 100 mg/ml</i>	1	PA; GC
<i>testosterone cypionate intramuscular solution 200 mg/ml, 200 mg/ml (1 ml)</i>	1	GC
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	1	PA; GC
<i>testosterone transdermal gel 1.62 %, 20.25 mg/lact (1.62%), 40.5 mg/2.5gm (1.62%)</i>	3	PA; QL (150 per 30 days)
<i>testosterone transdermal gel 10 mg/lact (2%)</i>	3	PA; QL (120 per 30 days)
<i>testosterone transdermal gel 12.5 mg/lact (1%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)</i>	3	PA; QL (300 per 30 days)
<i>testosterone transdermal gel 20.25 mg/1.25gm (1.62%)</i>	3	PA; QL (112.5 per 30 days)
<i>testosterone transdermal solution 30 mg/lact</i>	3	PA; QL (180 per 30 days)
TRI FEMYNOR ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC
TRI-LINYAH ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC
TRI-NYMYO ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC
TRIVORA (28) ORAL TABLET 50-30/75-40/ 125-30 MCG	1	GC
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	1	GC
<i>tyblume oral tablet chewable 0.1-20 mg-mcg</i>	1	GC
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	1	GC
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	1	GC
VIENVA ORAL TABLET 0.1-20 MG-MCG	1	GC
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	1	GC
VOLNEA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	GC
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	1	GC
WERA ORAL TABLET 0.5-35 MG-MCG	1	GC
YUVAFEM VAGINAL TABLET 10 MCG	3	
ZOVIA 1/35 (28) ORAL TABLET 1-35 MG-MCG	1	GC
IMMUNOLOGICAL AGENTS		
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML	2	
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	2	
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML	4	PA; NEDS; NM; LA
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	4	PA; NEDS; NM
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML	2	
AZASAN ORAL TABLET 100 MG, 75 MG	2	B/D PA; NM
<i>azathioprine oral tablet 100 mg, 75 mg</i>	2	B/D PA; NM
<i>azathioprine oral tablet 50 mg</i>	1	B/D PA; GC; NM
<i>bcg vaccine injection solution reconstituted 50 mg</i>	3	
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	4	PA; NEDS; NM
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	4	PA; NEDS; NM
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	2	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 LF-MCG/0.5	2	
BOOSTRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 5-2.5-18.5 LF-MCG/0.5	2	
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM; LA
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM; LA
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM; LA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM; LA
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	4	PA; QL (2 per 28 days); NEDS; NM
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	1	B/D PA; GC; NM
<i>cyclosporine modified oral solution 100 mg/ml</i>	2	B/D PA; NM
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	2	B/D PA; NM
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	2	
<i>diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml</i>	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML	4	PA; QL (4 per 28 days); NEDS; NM
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML	4	PA; QL (4.08 per 28 days); NEDS; NM
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	4	PA; QL (8 per 28 days); NEDS; NM
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	4	PA; QL (8 per 28 days); NEDS; NM
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML	2	B/D PA
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML	2	B/D PA
ENVARUSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG	3	B/D PA; NM
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg</i>	3	B/D PA; NM
<i>everolimus oral tablet 1 mg</i>	4	B/D PA; NEDS; NM
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML	4	PA; NEDS; NM
GARDASIL 9 INTRAMUSCULAR SUSPENSION	3	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
GENGRAF ORAL CAPSULE 100 MG, 25 MG	1	B/D PA; GC; NM
GENGRAF ORAL SOLUTION 100 MG/ML	2	B/D PA; NM
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 720 EL U/0.5ML	2	
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML	2	B/D PA
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	3	
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML	4	PA; QL (4 per 28 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (2 per 28 days); NEDS; NM
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML	4	PA; QL (2 per 28 days); NEDS; NM
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.4ML, 40 MG/0.8ML	4	PA; QL (4 per 28 days); NEDS; NM
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	4	PA; QL (6 per 365 days); NEDS; NM
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML	4	PA; QL (4 per 365 days); NEDS; NM
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	4	PA; QL (4 per 28 days); NEDS; NM
HUMIRA PEN-PEDIATRIC UC START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (8 per 365 days); NEDS; NM
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML	4	PA; QL (4 per 28 days); NEDS; NM
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	4	PA; QL (12 per 365 days); NEDS; NM
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	4	PA; QL (6 per 365 days); NEDS; NM
HUMIRA-PS/UV/ADOL HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	4	PA; QL (8 per 365 days); NEDS; NM
HUMIRA-PSORIASIS/UEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	4	PA; QL (6 per 365 days); NEDS; NM
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML	2	
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	2	
IPOL INJECTION INJECTABLE	2	
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
IXIARO INTRAMUSCULAR SUSPENSION	2	
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML	2	B/D PA
<i>kedrab injection solution 1500 unit/10ml</i>	2	NM
KINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	3	
<i>leflunomide oral tablet 10 mg, 20 mg</i>	2	QL (30 per 30 days)
MENACTRA INTRAMUSCULAR SOLUTION	2	
MENQUADFI INTRAMUSCULAR SOLUTION	2	
MENVEO INTRAMUSCULAR SOLUTION	2	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	2	
<i>methotrexate oral tablet 2.5 mg</i>	1	GC
<i>methotrexate sodium (pf) injection solution 50 mg/2ml</i>	1	GC; NM
<i>methotrexate sodium oral tablet 2.5 mg</i>	1	GC
M-M-R II INJECTION SOLUTION RECONSTITUTED	2	
<i>mycophenolate mofetil oral capsule 250 mg</i>	2	B/D PA; NM
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	4	B/D PA; NEDS; NM
<i>mycophenolate mofetil oral tablet 500 mg</i>	2	B/D PA; NM
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	3	B/D PA; NM
<i>mycophenolic acid oral tablet delayed release 180 mg, 360 mg</i>	3	B/D PA; NM
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML	4	PA; NEDS; NM
OTEZLA ORAL TABLET 30 MG	4	PA; QL (60 per 30 days); NEDS; NM
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG	4	PA; NEDS; NM
PEDIARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	2	
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	4	NEDS; NM
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML	4	NEDS; NM
PENBRAYA INTRAMUSCULAR SUSPENSION RECONSTITUTED	2	
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	
PREHEVBRIO INTRAMUSCULAR SUSPENSION 10 MCG/ML	3	B/D PA
PRIORIX SUBCUTANEOUS SUSPENSION RECONSTITUTED	2	
PROGRAF ORAL PACKET 0.2 MG, 1 MG	3	B/D PA; NM
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	2	
QUADRACEL INTRAMUSCULAR SUSPENSION , (58 UNT/ML)	3	
QUADRACEL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML	3	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	2	
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 40 MCG/ML, 5 MCG/0.5ML	2	B/D PA
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML	2	B/D PA
REZUROCK ORAL TABLET 200 MG	4	PA; NEDS; NM; LA
RIDAURA ORAL CAPSULE 3 MG	4	NEDS
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG	4	PA; QL (30 per 30 days); NEDS; NM
ROTARIX ORAL SUSPENSION	2	
ROTATEQ ORAL SOLUTION	2	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	2	
<i>sirolimus oral solution 1 mg/ml</i>	4	B/D PA; NEDS; NM
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	3	B/D PA; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML	4	PA; QL (10 per 28 days); NEDS; NM
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	4	PA; QL (6 per 365 days); NEDS; NM
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML	4	PA; QL (1.2 per 56 days); NEDS; NM
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 360 MG/2.4ML	4	PA; QL (2.4 per 56 days); NEDS; NM
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	4	PA; QL (6 per 365 days); NEDS; NM
STELARA INTRAVENOUS SOLUTION 130 MG/26ML	4	PA; NEDS; NM; LA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	4	PA; QL (1 per 28 days); NEDS; NM; LA
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML	4	PA; QL (1 per 28 days); NEDS; NM
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	3	B/D PA; NM
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML	2	
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU, 5-2 LFU (INJECTION)	3	
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML, 2.4 MCG/0.5ML	2	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG	3	ST
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	2	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	2	
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML	2	
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML	2	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML	2	
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	3	NM
XATMEP ORAL SOLUTION 2.5 MG/ML	3	ST; NM
YF-VAX SUBCUTANEOUS INJECTABLE , (2.5 ML IN 1 VIAL, MULTI-DOSE)	2	
INFECTIOUS DISEASE AGENTS		
<i>abacavir sulfate oral solution 20 mg/ml</i>	3	QL (960 per 30 days); NM
<i>abacavir sulfate oral tablet 300 mg</i>	3	QL (60 per 30 days); NM
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	3	QL (30 per 30 days); NM
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	3	B/D PA
<i>acyclovir oral capsule 200 mg</i>	1	GC
<i>acyclovir oral suspension 200 mg/5ml</i>	3	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	1	GC
<i>acyclovir sodium intravenous solution 50 mg/ml</i>	3	B/D PA
<i>adefovir dipivoxil oral tablet 10 mg</i>	3	PA; NM
<i>albendazole oral tablet 200 mg</i>	3	
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1	GC
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	1	GC
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	1	GC
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	1	GC
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	1	GC
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	1	GC
<i>amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg</i>	1	GC
<i>amphotericin b intravenous solution reconstituted 50 mg</i>	3	B/D PA
<i>amphotericin b liposome intravenous suspension reconstituted 50 mg</i>	4	B/D PA; NEDS
<i>ampicillin oral capsule 500 mg</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>ampicillin sodium injection solution reconstituted 1 gm, 125 mg</i>	1	GC
<i>ampicillin sodium intravenous solution reconstituted 1 gm, 10 gm</i>	1	GC
<i>ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	2	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm</i>	2	
<i>ampicillin-sulbactam sodium intravenous solution reconstituted 15 (10-5) gm</i>	3	
APTIVUS ORAL CAPSULE 250 MG	4	QL (120 per 30 days); NEDS; NM
<i>atazanavir sulfate oral capsule 150 mg, 200 mg</i>	3	QL (60 per 30 days); NM
<i>atazanavir sulfate oral capsule 300 mg</i>	3	QL (30 per 30 days); NM
<i>atovaquone oral suspension 750 mg/5ml</i>	3	PA
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	2	
AVYCAZ INTRAVENOUS SOLUTION RECONSTITUTED 2.5 (2-0.5) GM	4	NEDS
<i>azithromycin intravenous solution reconstituted 500 mg</i>	1	GC
<i>azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg</i>	1	GC
<i>aztreonam injection solution reconstituted 1 gm</i>	2	
BARACLUDE ORAL SOLUTION 0.05 MG/ML	4	PA; NEDS; NM
BAXDELA INTRAVENOUS SOLUTION RECONSTITUTED 300 MG	4	NEDS
BAXDELA ORAL TABLET 450 MG	4	NEDS
BICILLIN C-R 900/300 INTRAMUSCULAR SUSPENSION 900000-300000 UNIT/2ML	3	
BICILLIN C-R INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML	3	
BICILLIN L-A INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1200000 UNIT/2ML, 2400000 UNIT/4ML, 600000 UNIT/ML	3	
BIKTARVY ORAL TABLET 30-120-15 MG	4	QL (30 per 30 days); NEDS
BIKTARVY ORAL TABLET 50-200-25 MG	4	QL (30 per 30 days); NEDS; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML	4	QL (4 per 28 days); NEDS
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML	4	QL (6 per 28 days); NEDS
<i>caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg</i>	3	B/D PA
<i>cefaclor er oral tablet extended release 12 hour 500 mg</i>	2	
<i>cefaclor oral capsule 250 mg, 500 mg</i>	1	GC
<i>cefadroxil oral capsule 500 mg</i>	1	GC
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	1	GC
<i>cefadroxil oral tablet 1 gm</i>	1	GC
<i>cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm, 3 gm, 500 mg</i>	3	
<i>cefazolin sodium intravenous solution reconstituted 1 gm</i>	3	
<i>cefdinir oral capsule 300 mg</i>	2	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	2	
<i>cefepime hcl injection solution reconstituted 1 gm</i>	2	
<i>cefepime hcl intravenous solution reconstituted 2 gm</i>	2	
<i>cefixime oral capsule 400 mg</i>	3	
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	2	
<i>cefoxitin sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</i>	1	GC
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	1	GC
<i>ceftazidime injection solution reconstituted 1 gm, 6 gm</i>	2	
<i>ceftazidime intravenous solution reconstituted 2 gm</i>	2	
<i>ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg</i>	1	GC
<i>ceftriaxone sodium intravenous solution reconstituted 10 gm, 2 gm</i>	1	GC
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	1	GC
<i>cefuroxime sodium injection solution reconstituted 750 mg</i>	1	GC

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<i>cefuroxime sodium intravenous solution reconstituted 1.5 gm</i>	1	GC
<i>cephalexin oral capsule 250 mg, 500 mg</i>	1	GC
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	GC
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	1	GC
CIMDUO ORAL TABLET 300-300 MG	4	QL (30 per 30 days); NEDS; NM
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	1	GC
<i>ciprofloxacin in d5w intravenous solution 200 mg/100ml</i>	1	GC
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	GC
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	2	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	1	GC
<i>clindamycin phosphate in d5w intravenous solution 300 mg/50ml, 600 mg/50ml, 900 mg/50ml</i>	2	
<i>clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml</i>	2	
COARTEM ORAL TABLET 20-120 MG	3	
<i>colistimethate sodium (cba) injection solution reconstituted 150 mg</i>	3	
COMPLERA ORAL TABLET 200-25-300 MG	4	QL (30 per 30 days); NEDS; NM
<i>dapsone oral tablet 100 mg, 25 mg</i>	2	
<i>daptomycin intravenous solution reconstituted 350 mg, 500 mg</i>	4	NEDS
<i>darunavir oral tablet 600 mg, 800 mg</i>	4	QL (60 per 30 days); NEDS; NM
DELSTRIGO ORAL TABLET 100-300-300 MG	4	QL (30 per 30 days); NEDS; NM
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	3	
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG	4	QL (30 per 30 days); NEDS; NM
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	1	GC
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML	4	PA; NEDS
DIFICID ORAL TABLET 200 MG	4	PA; NEDS
DOVATO ORAL TABLET 50-300 MG	4	QL (30 per 30 days); NEDS; NM
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>doxycycline hyclate intravenous solution reconstituted 100 mg</i>	3	
<i>doxycycline hyclate oral capsule 100 mg</i>	2	
<i>doxycycline hyclate oral tablet 100 mg</i>	2	
<i>doxycycline hyclate oral tablet 20 mg</i>	1	GC
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg, 75 mg</i>	1	GC
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1	GC
E.E.S. 400 ORAL TABLET 400 MG	3	
EDURANT ORAL TABLET 25 MG	4	QL (30 per 30 days); NEDS; NM
<i>efavirenz oral capsule 200 mg</i>	3	QL (120 per 30 days); NM
<i>efavirenz oral capsule 50 mg</i>	2	QL (360 per 30 days); NM
<i>efavirenz oral tablet 600 mg</i>	3	QL (30 per 30 days); NM
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	3	QL (30 per 30 days); NM
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	4	QL (30 per 30 days); NEDS; NM
<i>emtricitabine oral capsule 200 mg</i>	2	QL (30 per 30 days); NM
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	4	QL (30 per 30 days); NEDS; NM
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	2	QL (30 per 30 days); NM
EMTRIVA ORAL SOLUTION 10 MG/ML	2	QL (850 per 30 days); NM
EMVERM ORAL TABLET CHEWABLE 100 MG	4	NEDS
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	3	PA; NM
EPCLUSA ORAL PACKET 150-37.5 MG	4	PA; QL (30 per 30 days); NEDS; NM
EPCLUSA ORAL PACKET 200-50 MG	4	PA; QL (60 per 30 days); NEDS; NM
EPCLUSA ORAL TABLET 200-50 MG	4	PA; QL (60 per 30 days); NEDS; NM
EPCLUSA ORAL TABLET 400-100 MG	4	PA; QL (30 per 30 days); NEDS; NM
EPIVIR HBV ORAL SOLUTION 5 MG/ML	2	NM
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	4	PA; NEDS

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG	3	PA
<i>ertapenem sodium injection solution reconstituted 1 gm</i>	3	
ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG	2	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	3	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	3	
<i>erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	2	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	3	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	3	
<i>erythromycin lactobionate intravenous solution reconstituted 500 mg</i>	3	
<i>erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg</i>	2	
<i>erythromycin stearate oral tablet 250 mg</i>	3	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	1	GC
<i>etravirine oral tablet 100 mg</i>	4	QL (120 per 30 days); NEDS; NM
<i>etravirine oral tablet 200 mg</i>	4	QL (60 per 30 days); NEDS; NM
EVOTAZ ORAL TABLET 300-150 MG	4	QL (30 per 30 days); NEDS; NM
<i>famciclovir oral tablet 125 mg, 250 mg</i>	2	QL (60 per 30 days)
<i>famciclovir oral tablet 500 mg</i>	2	QL (21 per 7 days)
<i>fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%</i>	1	GC
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	1	GC
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	1	GC
<i>flucytosine oral capsule 250 mg, 500 mg</i>	4	NEDS
<i>fosamprenavir calcium oral tablet 700 mg</i>	3	QL (120 per 30 days); NM
<i>fosfomycin tromethamine oral packet 3 gm</i>	3	
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	4	QL (60 per 30 days); NEDS; NM
<i>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-%</i>	1	GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>gentamicin sulfate injection solution 40 mg/ml</i>	1	GC
GENVOYA ORAL TABLET 150-150-200-10 MG	4	QL (30 per 30 days); NEDS; NM
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	1	GC
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	1	GC
<i>imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg</i>	3	
INTELENCE ORAL TABLET 25 MG	3	QL (480 per 30 days); NM
ISENTRESS HD ORAL TABLET 600 MG	4	QL (60 per 30 days); NEDS; NM
ISENTRESS ORAL PACKET 100 MG	4	QL (180 per 30 days); NEDS; NM
ISENTRESS ORAL TABLET 400 MG	4	QL (120 per 30 days); NEDS; NM
ISENTRESS ORAL TABLET CHEWABLE 100 MG	3	QL (180 per 30 days); NM
ISENTRESS ORAL TABLET CHEWABLE 25 MG	2	QL (720 per 30 days); NM
<i>isoniazid oral syrup 50 mg/5ml</i>	2	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	1	GC
<i>itraconazole oral capsule 100 mg</i>	2	PA
<i>ivermectin oral tablet 3 mg</i>	1	PA; GC
JULUCA ORAL TABLET 50-25 MG	4	QL (30 per 30 days); NEDS; NM
<i>ketoconazole oral tablet 200 mg</i>	1	GC
LAGEVRIO ORAL CAPSULE 200 MG	4	QL (40 per 90 days); NEDS
<i>lamivudine oral solution 10 mg/ml</i>	3	QL (960 per 30 days); NM
<i>lamivudine oral tablet 100 mg</i>	2	NM
<i>lamivudine oral tablet 150 mg</i>	3	QL (60 per 30 days); NM
<i>lamivudine oral tablet 300 mg</i>	3	QL (30 per 30 days); NM
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	2	QL (60 per 30 days); NM
<i>ledipasvir-sofosbuvir oral tablet 90-400 mg</i>	4	PA; QL (28 per 28 days); NEDS; NM
<i>levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml</i>	3	
<i>levofloxacin intravenous solution 25 mg/ml</i>	1	GC
<i>levofloxacin oral solution 25 mg/ml</i>	1	GC
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	1	GC
LEXIVA ORAL SUSPENSION 50 MG/ML	3	QL (1800 per 30 days); NM
<i>linezolid intravenous solution 600 mg/300ml</i>	3	

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<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	4	PA; QL (1800 per 30 days); NEDS
<i>linezolid oral tablet 600 mg</i>	3	PA; QL (56 per 28 days)
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	3	QL (480 per 30 days); NM
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	3	QL (300 per 30 days); NM
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	3	QL (120 per 30 days); NM
<i>maraviroc oral tablet 150 mg, 300 mg</i>	4	QL (120 per 30 days); NEDS; NM
MAVYRET ORAL PACKET 50-20 MG	4	PA; QL (180 per 30 days); NEDS; NM
MAVYRET ORAL TABLET 100-40 MG	4	PA; QL (90 per 30 days); NEDS; NM
<i>mefloquine hcl oral tablet 250 mg</i>	2	
<i>meropenem intravenous solution reconstituted 1 gm, 500 mg</i>	3	
<i>methenamine hippurate oral tablet 1 gm</i>	1	GC
<i>metronidazole intravenous solution 500 mg/100ml</i>	3	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	1	GC
<i>micafungin sodium intravenous solution reconstituted 100 mg, 50 mg</i>	4	NEDS
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	1	GC
<i>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</i>	1	GC
MONDOXYNE NL ORAL CAPSULE 100 MG	1	GC
<i>moxifloxacin hcl in nacl intravenous solution 400 mg/250ml</i>	3	
<i>moxifloxacin hcl intravenous solution 400 mg/250ml</i>	3	
<i>moxifloxacin hcl oral tablet 400 mg</i>	3	
<i>nafcillin sodium injection solution reconstituted 1 gm, 2 gm</i>	3	
<i>nafcillin sodium intravenous solution reconstituted 10 gm</i>	4	NEDS
<i>neomycin sulfate oral tablet 500 mg</i>	1	GC
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	3	QL (30 per 30 days); NM
<i>nevirapine oral suspension 50 mg/5ml</i>	2	QL (1200 per 30 days); NM
<i>nevirapine oral tablet 200 mg</i>	1	QL (60 per 30 days); GC; NM
<i>nitazoxanide oral tablet 500 mg</i>	3	QL (6 per 30 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	1	GC
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	1	GC

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NORVIR ORAL PACKET 100 MG	3	QL (360 per 30 days); NM
NOXAFIL ORAL SUSPENSION 40 MG/ML	4	PA; NEDS
<i>nystatin oral tablet 500000 unit</i>	1	GC
ODEFSEY ORAL TABLET 200-25-25 MG	4	QL (30 per 30 days); NEDS; NM
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	1	GC
<i>oseltamivir phosphate oral capsule 30 mg</i>	2	QL (168 per 365 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	2	QL (84 per 365 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	2	QL (1080 per 365 days)
<i>oxacillin sodium in dextrose intravenous solution 1 gm/50ml</i>	2	
<i>oxacillin sodium in dextrose intravenous solution 2 gm/50ml</i>	3	
<i>oxacillin sodium injection solution reconstituted 1 gm, 2 gm</i>	1	GC
<i>oxacillin sodium intravenous solution reconstituted 10 gm</i>	1	GC
<i>paromomycin sulfate oral capsule 250 mg</i>	2	
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG	4	QL (20 per 90 days); NEDS
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG	4	QL (30 per 90 days); NEDS
<i>penicillin g potassium injection solution reconstituted 20000000 unit, 5000000 unit</i>	3	
<i>penicillin g sodium injection solution reconstituted 5000000 unit</i>	3	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	1	GC
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	1	GC
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	3	B/D PA; NM
<i>pentamidine isethionate injection solution reconstituted 300 mg</i>	3	NM
PFIZERPEN INJECTION SOLUTION RECONSTITUTED 20000000 UNIT	3	
PIFELTRO ORAL TABLET 100 MG	4	QL (30 per 30 days); NEDS; NM

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<i>piperacillin sod-tazobactam intravenous solution reconstituted 13.5 (12-1.5) gm, 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, 40.5 (36-4.5) gm</i>	3	
<i>posaconazole oral suspension 40 mg/ml</i>	4	PA; NEDS
<i>posaconazole oral tablet delayed release 100 mg</i>	4	PA; NEDS
PREVYMIS ORAL TABLET 240 MG, 480 MG	4	QL (30 per 30 days); NEDS; NM
PREZCOBIX ORAL TABLET 800-150 MG	4	QL (30 per 30 days); NEDS; NM
PREZISTA ORAL SUSPENSION 100 MG/ML	4	QL (400 per 30 days); NEDS; NM
PREZISTA ORAL TABLET 150 MG	3	QL (180 per 30 days); NM
PREZISTA ORAL TABLET 75 MG	3	QL (300 per 30 days); NM
PRIFTIN ORAL TABLET 150 MG	3	
PRIMAQUINE PHOSPHATE ORAL TABLET 26.3 (15 BASE) MG	3	
<i>pyrazinamide oral tablet 500 mg</i>	2	
<i>pyrimethamine oral tablet 25 mg</i>	4	NEDS
<i>quinine sulfate oral capsule 324 mg</i>	3	PA
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT	3	QL (60 per 180 days)
RETROVIR INTRAVENOUS SOLUTION 10 MG/ML	3	NM
REYATAZ ORAL PACKET 50 MG	3	QL (240 per 30 days); NM
<i>ribavirin oral capsule 200 mg</i>	1	GC; NM
<i>rifabutin oral capsule 150 mg</i>	3	
<i>rifampin intravenous solution reconstituted 600 mg</i>	3	
<i>rifampin oral capsule 150 mg, 300 mg</i>	2	
<i>rimantadine hcl oral tablet 100 mg</i>	1	GC
<i>ritonavir oral tablet 100 mg</i>	2	QL (360 per 30 days); NM
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG	4	QL (60 per 30 days); NEDS
SELZENTRY ORAL SOLUTION 20 MG/ML	2	QL (1840 per 30 days); NM
SELZENTRY ORAL TABLET 25 MG	2	QL (240 per 30 days); NM
SELZENTRY ORAL TABLET 75 MG	4	QL (60 per 30 days); NEDS; NM
SIRTURO ORAL TABLET 100 MG, 20 MG	4	PA; NEDS; NM; LA

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<i>sofosbuvir-velpatasvir oral tablet 400-100 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM
<i>streptomycin sulfate intramuscular solution reconstituted 1 gm</i>	4	NEDS
STRIBILD ORAL TABLET 150-150-200-300 MG	4	QL (30 per 30 days); NEDS; NM
<i>sulfadiazine oral tablet 500 mg</i>	4	NEDS
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	1	GC
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	1	GC
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG	2	LA
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML	4	QL (3 per 168 days); NEDS
SYMTUZA ORAL TABLET 800-150-200-10 MG	4	QL (30 per 30 days); NEDS; NM
TAZICEF INJECTION SOLUTION RECONSTITUTED 1 GM	2	
TAZICEF INTRAVENOUS SOLUTION RECONSTITUTED 1 GM, 2 GM, 6 GM	2	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	4	NEDS
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	3	QL (30 per 30 days); NM
<i>terbinafine hcl oral tablet 250 mg</i>	1	GC
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	3	
<i>tigecycline intravenous solution reconstituted 50 mg</i>	4	NEDS
<i>tinidazole oral tablet 250 mg, 500 mg</i>	2	
TIVICAY ORAL TABLET 10 MG	3	QL (120 per 30 days); NM
TIVICAY ORAL TABLET 25 MG, 50 MG	4	QL (60 per 30 days); NEDS; NM
TIVICAY PD ORAL TABLET SOLUBLE 5 MG	4	QL (360 per 30 days); NEDS; NM
<i>tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml</i>	2	
TRECTOR ORAL TABLET 250 MG	3	
<i>trifluridine ophthalmic solution 1 %</i>	2	
<i>trimethoprim oral tablet 100 mg</i>	1	GC
TRIUMEQ ORAL TABLET 600-50-300 MG	4	QL (30 per 30 days); NEDS; NM

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TRIUMEQ PD ORAL TABLET SOLUBLE 60-5-30 MG	4	QL (180 per 30 days); NEDS; NM
TRIZIVIR ORAL TABLET 300-150-300 MG	4	QL (60 per 30 days); NEDS; NM
TYBOST ORAL TABLET 150 MG	2	QL (30 per 30 days); NM
<i>valacyclovir hcl oral tablet 1 gm</i>	2	QL (90 per 30 days)
<i>valacyclovir hcl oral tablet 500 mg</i>	2	QL (60 per 30 days)
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	3	NM
<i>valganciclovir hcl oral tablet 450 mg</i>	2	NM
<i>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</i>	2	
<i>vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 500 mg, 750 mg</i>	2	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	3	PA; QL (240 per 30 days)
VIRACEPT ORAL TABLET 250 MG	4	QL (300 per 30 days); NEDS; NM
VIRACEPT ORAL TABLET 625 MG	4	QL (120 per 30 days); NEDS; NM
VIREAD ORAL POWDER 40 MG/GM	2	QL (240 per 30 days); NM
VIREAD ORAL TABLET 150 MG, 250 MG	4	QL (30 per 30 days); NEDS; NM
VIREAD ORAL TABLET 200 MG	3	QL (30 per 30 days); NM
<i>voriconazole intravenous solution reconstituted 200 mg</i>	3	PA
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	4	PA; QL (300 per 30 days); NEDS
<i>voriconazole oral tablet 200 mg</i>	3	PA; QL (60 per 30 days)
<i>voriconazole oral tablet 50 mg</i>	3	PA; QL (120 per 30 days)
XIFAXAN ORAL TABLET 200 MG	3	PA; QL (9 per 3 days)
XIFAXAN ORAL TABLET 550 MG	4	PA; QL (84 per 28 days); NEDS
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG	3	
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG	3	
ZERBAXA INTRAVENOUS SOLUTION RECONSTITUTED 1.5 (1-0.5) GM	4	NEDS
<i>zidovudine oral capsule 100 mg</i>	1	QL (180 per 30 days); GC; NM
<i>zidovudine oral syrup 50 mg/5ml</i>	1	QL (1920 per 30 days); GC; NM
<i>zidovudine oral tablet 300 mg</i>	1	QL (60 per 30 days); GC; NM

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
ZIRGAN OPTHALMIC GEL 0.15 %	3	
MISCELLANEOUS THERAPEUTIC AGENTS		
ALCOHOL SWABS	2	OTC
<i>benzonatate oral capsule 100 mg, 200 mg</i>	2	QL (30 per 10 days); ED
<i>cetirizine-pseudoephedrine oral tablet extended release 12 hour 5-120 mg</i>	1	OTC; GC
<i>fexofenadine-pseudoephedrine oral tablet extended release 12 hour 60-120 mg</i>	1	OTC; GC
<i>fexofenadine-pseudoephedrine oral tablet extended release 24 hour 180-240 mg</i>	1	OTC; GC
GAUZE STERILE PADS 2	1	OTC; GC
INSULIN PEN NEEDLE	1	OTC; QL (200 per 30 days); GC
INSULIN SYRINGE	1	OTC; QL (200 per 30 days); GC
KOSELUGO ORAL CAPSULE 10 MG, 25 MG	4	PA; NEDS; NM
<i>loratadine-pseudoephedrine oral tablet extended release 12 hour 5-120 mg</i>	1	OTC; GC
<i>loratadine-pseudoephedrine oral tablet extended release 24 hour 10-240 mg</i>	1	OTC; GC
<i>sodium chloride irrigation solution 0.9 %</i>	1	GC
OPHTHALMIC AGENTS		
<i>ak-poly-bac ophthalmic ointment 500-10000 unit/gm</i>	2	
ALOCRILOPHthalmic SOLUTION 2 %	3	
ALOMIDE OPTHALMIC SOLUTION 0.1 %	3	
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	2	
<i>atropine sulfate ophthalmic ointment 1 %</i>	2	
<i>atropine sulfate ophthalmic solution 1 %</i>	2	
AZASITE OPTHALMIC SOLUTION 1 %	3	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	2	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	2	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	2	
<i>bepotastine besilate ophthalmic solution 1.5 %</i>	3	
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	2	
BETOPTIC-S OPTHALMIC SUSPENSION 0.25 %	2	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>bimatoprost ophthalmic solution 0.03 %</i>	2	
<i>brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %</i>	1	GC
<i>brinzolamide ophthalmic suspension 1 %</i>	2	
<i>carteolol hcl ophthalmic solution 1 %</i>	1	GC
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	1	GC
<i>cromolyn sodium ophthalmic solution 4 %</i>	1	GC
<i>cyclopentolate hcl ophthalmic solution 1 %</i>	2	
<i>cyclosporine ophthalmic emulsion 0.05 %</i>	3	QL (60 per 30 days)
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	4	NEDS; NM; LA
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	1	GC
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	1	GC
<i>difluprednate ophthalmic emulsion 0.05 %</i>	3	
<i>dorzolamide hcl ophthalmic solution 2 %</i>	1	GC
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	1	GC
<i>dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %</i>	1	GC
<i>epinastine hcl ophthalmic solution 0.05 %</i>	2	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	1	QL (3.5 per 30 days); GC
<i>fluorometholone ophthalmic suspension 0.1 %</i>	2	
<i>gatifloxacin ophthalmic solution 0.5 %</i>	2	
GENTAK OPHTHALMIC OINTMENT 0.3 %	1	GC
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	1	GC
ILEVRO OPHTHALMIC SUSPENSION 0.3 %	3	
IOPIDINE OPHTHALMIC SOLUTION 1 %	3	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	1	GC
LACRISERT OPHTHALMIC INSERT 5 MG	3	QL (60 per 30 days)
<i>latanoprost ophthalmic solution 0.005 %</i>	1	GC
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	1	GC
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	2	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	2	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	2	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	3	

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<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	2	
NATACYN OPHTHALMIC SUSPENSION 5 %	2	
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000</i>	1	GC
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	1	GC
NEO-POLYCIN OPHTHALMIC OINTMENT 3.5-400-10000	1	GC
<i>ofloxacin ophthalmic solution 0.3 %</i>	1	GC
<i>olopatadine hcl ophthalmic solution 0.1 %, 0.2 %</i>	3	
<i>pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %</i>	2	
POLYCIN OPHTHALMIC OINTMENT 500-10000 UNIT/GM	2	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	1	GC
<i>prednisolone acetate ophthalmic suspension 1 %</i>	1	GC
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	2	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	1	GC
RHOPRESSA OPHTHALMIC SOLUTION 0.02 %	3	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	1	GC
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	1	GC
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	2	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	2	
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	1	GC
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 %	3	
<i>tobramycin ophthalmic solution 0.3 %</i>	1	GC
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	2	
TOBREX OPHTHALMIC OINTMENT 0.3 %	3	
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	3	
XIIDRA OPHTHALMIC SOLUTION 5 %	3	QL (60 per 30 days)
OTIC AGENTS		
CIPRO HC OTIC SUSPENSION 0.2-1 %	3	

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>ciprofloxacin hcl otic solution 0.2 %</i>	2	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	3	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML	3	
FLAC OTIC OIL 0.01 %	3	
<i>fluocinolone acetonide otic oil 0.01 %</i>	3	
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	2	
<i>neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1</i>	1	GC
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	1	GC
<i>ofloxacin otic solution 0.3 %</i>	2	
RESPIRATORY TRACT/PULMONARY AGENTS		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	1	B/D PA; GC
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	4	PA; NEDS; NM; LA
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/lact, 108 (90 base) mcg/lact (nda020503), 108 (90 base) mcg/lact (nda020983)</i>	1	GC
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml</i>	1	B/D PA; QL (360 per 30 days); GC
<i>albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%, 2.5 mg/0.5ml</i>	1	B/D PA; QL (60 per 30 days); GC
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	1	GC
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	1	GC
<i>allergy relief childrens 24-hr oral solution 1 mg/ml</i>	1	OTC; GC
ALYQ ORAL TABLET 20 MG	4	PA; QL (60 per 30 days); NEDS; NM
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	4	PA; QL (30 per 30 days); NEDS; NM; LA
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT	2	QL (60 per 30 days)
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	2	QL (30 per 30 days)
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	3	QL (26 per 30 days)

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>azelastine hcl nasal solution 0.1 %, 0.15 %, 137 mcg/spray</i>	2	QL (30 per 25 days)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	4	PA; QL (60 per 30 days); NEDS; NM; LA
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH	2	QL (60 per 30 days)
BREYNA INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT	2	QL (30.9 per 30 days)
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT	2	QL (10.7 per 30 days)
BRONCHITOL INHALATION CAPSULE 40 MG	4	NEDS; NM; LA
<i>budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml</i>	3	B/D PA; QL (120 per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	3	B/D PA; QL (60 per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/lact, 80-4.5 mcg/lact</i>	2	QL (30.6 per 30 days)
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	1	PA; GC
<i>carbinoxamine maleate oral tablet 4 mg</i>	1	PA; GC
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	4	PA; NEDS; NM; LA
<i>cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml</i>	1	OTC; GC
<i>cetirizine hcl oral syrup 1 mg/ml, 5 mg/5ml</i>	1	OTC; GC
<i>cetirizine hcl oral tablet 10 mg</i>	1	OTC; GC
<i>cetirizine hcl oral tablet chewable 10 mg</i>	1	OTC; GC
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG	3	ST
<i>clemastine fumarate oral tablet 2.68 mg</i>	1	PA; GC
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	3	QL (8 per 30 days)
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	1	B/D PA; GC
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	2	PA
<i>cyproheptadine hcl oral tablet 4 mg</i>	1	GC
DALIRESP ORAL TABLET 250 MCG	2	PA; QL (30 per 30 days)
<i>desloratadine oral tablet 5 mg</i>	2	ST
<i>desloratadine oral tablet dispersible 2.5 mg, 5 mg</i>	2	ST

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>epinephrine injection solution 0.3 mg/0.3ml</i>	2	
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	2	QL (2 per 28 days)
<i>fexofenadine hcl oral tablet 180 mg, 60 mg</i>	1	OTC; GC
<i>flunisolide nasal solution 25 mcglact (0.025%)</i>	1	QL (75 per 30 days); GC
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcglact, 50 mcglact</i>	2	QL (60 per 30 days)
<i>fluticasone propionate diskus inhalation aerosol powder breath activated 250 mcglact</i>	2	QL (240 per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 110 mcglact</i>	2	QL (12 per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 220 mcglact</i>	2	QL (24 per 30 days)
<i>fluticasone propionate hfa inhalation aerosol 44 mcglact</i>	2	QL (11 per 30 days)
<i>fluticasone propionate nasal suspension 50 mcglact</i>	1	QL (16 per 30 days); GC
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcglact, 250-50 mcglact, 500-50 mcglact</i>	1	QL (60 per 30 days); GC
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcglact, 232-14 mcglact, 55-14 mcglact</i>	2	QL (1 per 30 days)
<i>hydroxyzine hcl oral tablet 25 mg, 50 mg</i>	1	GC
<i>ipratropium bromide inhalation solution 0.02 %</i>	1	B/D PA; GC
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	1	QL (30 per 30 days); GC
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	1	B/D PA; QL (540 per 30 days); GC
KALYDECO ORAL PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG	4	PA; QL (56 per 28 days); NEDS; NM
KALYDECO ORAL TABLET 150 MG	4	PA; QL (60 per 30 days); NEDS; NM
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml</i>	1	B/D PA; QL (270 per 30 days); GC
<i>levalbuterol hcl inhalation nebulization solution 0.63 mg/3ml</i>	1	B/D PA; QL (540 per 30 days); GC
<i>levalbuterol tartrate inhalation aerosol 45 mcglact</i>	2	QL (45 per 30 days)
<i>levocetirizine oral solution 2.5 mg/5ml</i>	1	QL (300 per 30 days); GC
<i>levocetirizine oral tablet 5 mg</i>	1	QL (30 per 30 days); GC
<i>levocetirizine oral tablet 5 mg, 60 mg</i>	1	OTC; GC
<i>loratadine oral solution 5 mg/5ml</i>	1	OTC; GC

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DRUG NAME / NOMBRE DE MEDICAMENTO	DRUG TIER / NIVEL	REQUIREMENTS / LIMITS REQUISITOS / LIMITACIONES
<i>loratadine oral syrup 5 mg/5ml</i>	1	OTC; GC
<i>loratadine oral tablet 10 mg</i>	1	OTC; GC
<i>mometasone furoate nasal suspension 50 mcg/lact</i>	3	
<i>montelukast sodium oral tablet 10 mg</i>	1	GC
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	1	GC
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML	4	PA; QL (3 per 28 days); NEDS; NM; LA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML	4	PA; QL (3 per 28 days); NEDS; NM; LA
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML	4	PA; QL (0.4 per 28 days); NEDS; NM; LA
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG	4	PA; QL (3 per 28 days); NEDS; NM; LA
OFEV ORAL CAPSULE 100 MG, 150 MG	4	PA; QL (60 per 30 days); NEDS; NM
OPSUMIT ORAL TABLET 10 MG	4	PA; QL (30 per 30 days); NEDS; NM; LA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	3	PA; NM; LA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG	4	PA; NEDS; NM; LA
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG	4	PA; QL (60 per 30 days); NEDS; NM
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	4	PA; QL (120 per 30 days); NEDS; NM
<i>pirfenidone oral tablet 267 mg</i>	4	PA; QL (270 per 30 days); NEDS; NM
<i>pirfenidone oral tablet 534 mg, 801 mg</i>	4	PA; QL (90 per 30 days); NEDS; NM
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML	4	B/D PA; NEDS; NM
<i>roflumilast oral tablet 500 mcg</i>	2	PA; QL (30 per 30 days)
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT	2	QL (60 per 30 days)
<i>sildenafil citrate oral tablet 20 mg</i>	2	PA; QL (360 per 30 days); NM

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SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	2	QL (30 per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	2	QL (4 per 30 days)
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	2	QL (4 per 30 days)
<i>tadalafil (pah) oral tablet 20 mg</i>	4	PA; QL (60 per 30 days); NEDS; NM
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	1	GC
<i>theophylline er oral tablet extended release 12 hour 300 mg</i>	1	GC
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	1	GC
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	4	B/D PA; QL (280 per 28 days); NEDS; NM
TRACLEER ORAL TABLET SOLUBLE 32 MG	4	PA; QL (120 per 30 days); NEDS; NM; LA
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT	2	QL (60 per 30 days)
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG	4	PA; QL (60 per 30 days); NEDS; NM; LA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG	4	PA; NEDS; NM; LA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML	4	PA; QL (270 per 30 days); NEDS; NM
WAL-ZYR ALLERGY CHILDRENS ORAL SOLUTION 1 MG/ML	1	OTC; GC
WIXELA INHUB INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT	1	QL (60 per 30 days); GC
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML	4	PA; QL (8 per 28 days); NEDS; NM; LA
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML	4	PA; QL (4 per 28 days); NEDS; NM; LA
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML	4	PA; QL (8 per 28 days); NEDS; NM; LA

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XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML	4	PA; QL (4 per 28 days); NEDS; NM; LA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	4	PA; QL (8 per 28 days); NEDS; NM; LA
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	1	GC

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irbesartan.....	22	KEYTRUDA.....	9	LENVIMA (10 MG DAILY	
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ISENTRESS.....	85	KISQALI (200 MG DOSE).....	9	LENVIMA (12 MG DAILY	
ISENTRESS HD.....	85	KISQALI (400 MG DOSE).....	9	DOSE).....	10
ISIBLOOM.....	67	KISQALI (600 MG DOSE).....	9	LENVIMA (14 MG DAILY	
ISOLYTE-P IN D5W.....	51	KISQALI FEMARA (200		DOSE).....	10
ISOLYTE-S.....	51	MG DOSE).....	9	LENVIMA (18 MG DAILY	
isoniazid.....	85	KISQALI FEMARA (400		DOSE).....	10
isosorbide dinitrate.....	22	MG DOSE).....	9	LENVIMA (20 MG DAILY	
isosorbide mononitrate.....	22	KISQALI FEMARA (600		DOSE).....	10
isosorbide mononitrate er.....	22	MG DOSE).....	9	LENVIMA (24 MG DAILY	
isotretinoin.....	47	KLAYESTA.....	47	DOSE).....	10
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WEEKLY).....	16		
XPOVIO (40 MG ONCE			
WEEKLY).....	16		

Non-discrimination Notice

Discrimination Is Against the Law

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Freedom Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Freedom Health, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Freedom Health, Inc.:

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

If you need these services, contact the Freedom Health Civil Rights Coordinator.

If you believe that Freedom Health, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Freedom Health Civil Rights Coordinator
P.O. Box 152727
Tampa, FL 33684
Phone: 1-800-401-2740, TTY: 711
Fax: 813-506-6235

You can file a grievance by mail, fax, or phone. If you need help filing a grievance, the Freedom Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

Aviso de no discriminación

La discriminación es contra la ley

Aviso informar a las personas sobre la no discriminación y accesibilidad Requisitos

Freedom Health, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Freedom Health, Inc. no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Freedom Health, Inc.:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
 - Intérpretes de lenguaje de señas capacitados.
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
 - Intérpretes capacitados.
 - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Freedom Health Civil Rights Coordinator.

Si considera que Freedom Health, Inc. no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona:

Freedom Health Civil Rights Coordinator
P.O. Box 152727
Tampa, FL 33684
Teléfono: 1-800-401-2740, TTY: 711
Fax: 813-506-6235

Puede presentar el reclamo por correo postal, fax o correo teléfono. Si necesita ayuda para hacerlo, Freedom Health Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web <https://www.hhs.gov/ocr/complaints/index.html>.

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 1-800-401-2740 (TTY: 711). Someone who speaks English/Language 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 1-800-401-2740 (TTY: 711). 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的任何疑问。如果您需要此翻译服务, 请致电 1-800-401-2740 (TTY: 711)。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 1-800-401-2740 (TTY: 711)。我們講中文的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 1-800-401-2740 (TTY: 711). 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 1-800-401-2740 (TTY: 711). 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 quý vị cần thông dịch viên xin gọi 1-800-401-2740 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-401-2740 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-401-2740 (TTY: 711) 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 1-800-401-2740 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic : إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، لي سعليك سوى الاتصال بنا على (TTY:711) 1-800-401-2740. سيقوم شخص ما يتحدث العربية بمساعدتك. 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 1-800-401-2740 (TTY: 711) 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 1-800-401-2740 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: 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 1-800-401-2740 (TTY: 711). 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 1-800-401-2740 (TTY: 711). 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 1-800-401-2740 (TTY: 711). Ta usługa jest 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。通訳をご用命になるには、**1-800-401-2740 (TTY: 711)**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。

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PBP	Plan Name/Nombre del Plan
070	Freedom VIP Care (HMO C-SNP)
072	Freedom VIP Savings (HMO C-SNP)
099	Freedom VIP Rewards (HMO C-SNP)

Call Toll-Free/Teléfono Gratuito: 1-800-401-2740

TTY: 711

www.freedomhealth.com

Dates/Fechas	Days/Días	Times/Horas
October 1 st to March 31 st Desde el 1 de octubre al 31 de marzo	7 days a week Los 7 días de la semana	8 a.m. to 8 p.m. EST De las 8 a.m. a las 8 p.m. EST
April 1 st to September 30 th Desde el 1 de abril al 30 de septiembre	Monday through Friday De lunes a viernes	8 a.m. to 8 p.m. EST De las 8 a.m. a las 8 p.m. EST

You may enroll in some plans only during specific times of the year.
Contact Freedom Health for more information.

Podrá inscribirse en algunos planes sólo durante fechas específicas del año.
Comuníquese con Freedom Health para más detalles.

This formulary was updated on 05/01/2024. For more recent information or other questions, please contact Freedom Health Member Services at 1-800-401-2740 or, for TTY users 711. From October 1 to March 31, we are open 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we are open Monday through Friday, 8 a.m. to 8 p.m. EST, or visit www.freedomhealth.com.

Este formulario fue actualizado el 05/01/2024. Para información más reciente u otras dudas, comuníquese con el Servicio de Atención al Cliente de Freedom Health al 1-800-401-2740 o 711 para los usuarios de TTY. Del 1 de octubre hasta el 31 de marzo, estamos abiertos los 7 días de la semana de 8 a.m. a 8 p.m. EST. Del 1 de abril hasta el 30 de septiembre, estamos abiertos de lunes a viernes, de 8 a.m. a 8 p.m. EST, o visite www.freedomhealth.com.