VibrantRx (PDP)™

2025 Abridged Formulary

(Partial List of Covered Drugs)
for City of Mesa Basic Medical Plan

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

This abridged formulary was updated on 09/01/2024. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact VibrantRx Member Services at 1-844-826-3451 (TTY users should call 711) 24 hours a day, 365 days a year or visit www.MyVibrantRx.com/mesaaz.

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.

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.

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VibrantRx is a prescription drug plan with a Medicare contract offered by MG Insurance Company. Enrollment in VibrantRx depends on contract renewal.

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VibrantRx 2025 Abridged Formulary

When this drug list (formulary) refers to “we,” “us”, or “our,” it means MG Insurance Company. When it refers to “plan” or “our plan,” it means VibrantRx.

This document includes a partial list of the drugs (formulary) for our plan which is current as of 09/01/2024. For a complete, updated formulary, please contact VibrantRx Member Services. 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 may change on January 1, 2025, and from time to time during the year.

What is the VibrantRx Abridged Formulary?

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

This document is a partial formulary and includes only some of the drugs covered by VibrantRx. For a complete listing of all prescription drugs covered by VibrantRx, please visit our website or call VibrantRx Member Services. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

The VibrantRx formularies include the most commonly used drugs that may be available to you through the additional coverage provided by the City of Mesa. If you are not sure if a drug is covered, please check with VibrantRx Member Services or on our web site at www.MyVibrantRx.com/mesaaz.

Please note: City of Mesa provides additional coverage that may cover prescription drugs not included in your Medicare Part D benefit. There may be instances where your share of the cost may be more or less due to this additional coverage. If you are unsure about your share of the cost for a drug or which drugs may or may not be covered, please call VibrantRx Member Services.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but VibrantRx 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 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 also find information in the section below entitled "How do I request an exception to the VibrantRx 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 we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 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 VibrantRx Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 09/01/2024. To get updated information about the drugs covered by VibrantRx, please contact VibrantRx Member Services. Our contact information appears on the front and back cover pages. If we make mid-year non-maintenance formulary changes, you

will be notified of formulary changes in “Your Monthly Prescription Drug Summary”, also referred to as your Part D Explanation of Benefits (EOB). Formulary changes will appear in the “Formulary Change Notice” within your EOB, or as a separate document if you have no claims activity.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 10. 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 10. 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 I-1. 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?

VibrantRx 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:** VibrantRx requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from VibrantRx before you fill your prescriptions. If you don’t get approval, VibrantRx may not cover the drug.
- **Quantity Limits:** For certain drugs, VibrantRx limits the amount of the drug that VibrantRx will cover. For example, VibrantRx provides 30 tablets in 30 days per prescription for *simvastatin oral tablet 80 mg*. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, VibrantRx 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, VibrantRx may not cover Drug B unless you try Drug A first. If Drug A does not work for you, VibrantRx 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 10. You can also get more information about the restrictions applied to specific covered drugs by visiting our web site at www.MyVibrantRx.com/mesaaz. We have posted online a document that explains 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 VibrantRx 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 VibrantRx formulary?" on page 5 for information about how to request an exception.

What if my drug is not on the Formulary?

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

If you learn that VibrantRx does not cover your drug, you have two options:

- You can ask VibrantRx Member Services for a list of similar drugs that are covered by VibrantRx. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by VibrantRx.

- You can ask VibrantRx 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 VibrantRx Formulary?

You can ask VibrantRx 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 tier, and you would not be able to ask us to provide the drug at a lower cost-sharing tier.
- You can ask us to cover a non-specialty formulary drug at a lower cost-sharing 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, VibrantRx 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, VibrantRx 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 VibrantRx Member Services to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering 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 one month 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 one month 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 31-day emergency supply of that drug while you pursue a formulary exception.

If you experience a change in your setting of care (such as being discharged or admitted to a long term care facility) after your first 90 days of membership in our plan, your physician or pharmacy can request a one-time emergency prescription override. This one-time override will provide you with temporary coverage (up to a 31-day supply) for the applicable drug(s).

For more information

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

If you have questions about VibrantRx, please contact VibrantRx Member Services. 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.

VibrantRx 2025 Abridged Formulary

VibrantRx's Formulary

The abridged formulary that begins on page 10 provides coverage information about some of the drugs covered by VibrantRx. If you have trouble finding your drug in the list, turn to the Index that begins on page I-1.

Remember: This is only a partial list of drugs covered by VibrantRx and may not include all the drugs covered through the additional coverage provided by the City of Mesa. If your prescription is not in this partial formulary, please contact VibrantRx Member Services. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

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

The following abbreviations may be found within the body of this document

COVERAGE NOTES ABBREVIATIONS

ABBREVIATION	DESCRIPTION	EXPLANATION
		Utilization Management Restrictions
PA	Prior Authorization Restriction	You (or your physician) are required to get prior authorization from our plan before you fill your prescription for this drug. Without prior approval, our plan may not cover this drug.
PA BvD	Prior Authorization Restriction for Part B vs Part D Determination	This drug may be eligible for payment under Medicare Part B or Part D. You (or your physician) are required to get prior authorization from our plan to determine that this drug is covered under Medicare Part D before you fill your prescription for this drug. Without prior approval, our plan may not cover this drug.
PA-HRM	Prior Authorization Restriction for High Risk Medications	Medicare has deemed this drug to be potentially harmful for beneficiaries 65 years or older, or a "High Risk Medication." Members age 65 years of age or older are required to get prior authorization from our plan before filling a prescription for this drug. Without prior approval, our plan may not cover this drug.
PA NSO	Prior Authorization Restriction for New Starts Only	If you are a new member, you (or your physician) are required to get prior authorization from our plan before you fill your prescription for this drug. Without prior approval, our plan may not cover this drug.

ABBREVIATION	DESCRIPTION	EXPLANATION
QL	Quantity Limit Restriction	Our plan limits the amount of this drug that is covered per prescription, or within a specific timeframe.
ST	Step Therapy Restriction	Before our plan will provide coverage for this drug, you must first try another drug(s) to treat your medical condition. This drug may only be covered if the other drug(s) does not work for you.
		Other Special Requirements for Coverage
LA	Limited Access Drug	This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-844-826-3451, 24 hours a day, 365 days a year. TTY/TDD users should call 711.
NM	Non-Mail Order Drug	You may be able to receive greater than a 1-month supply of most of the drugs on your formulary via mail order, generally at a reduced cost share. Drugs not available via your mail order benefit are noted with “NM” in the Requirements/Limits column.
NDS	Non-Extended Days Supply	This prescription is limited to a 30 day supply.
EX	Excluded Part D 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 or Medicare out-of-pocket costs. 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.

VibrantRx 2025 Abridged Formulary

Deductible: This plan does not have a deductible.

	Your copayment/coinsurance amount during Initial Coverage Phase		
Tier Number / Name	**Up to 30-day supply at Retail pharmacies**	**Up to 90-day supply at Retail Choice90Rx pharmacies**	**Up to a 90-day supply at Mail Order**
Tier 1: Generic	20% of the cost minimum $5, maximum $50	20% of the cost minimum $10, maximum $100	20% of the cost minimum $10, maximum $100
Tier 2: Preferred Brand	25% of the cost minimum $30, maximum $100	25% of the cost minimum $50, maximum $200	25% of the cost minimum $50, maximum $200
Tier 3: Non-Preferred Brand	40% of the cost minimum $50, maximum $150	40% of the cost minimum $80, maximum $300	40% of the cost minimum $80, maximum $300
Tier 4: Preferred Specialty	20% of the cost minimum $5, maximum $50	*A long-term supply is not available for drugs in Tier 4.*	*A long-term supply is not available for drugs in Tier 4.*
Tier 5: Specialty	25% of the cost minimum $30, maximum $100	*A long-term supply is not available for drugs in Tier 5.*	*A long-term supply is not available for drugs in Tier 5.*

Due to the additional coverage provided by City of Mesa, you have the same copayments or coinsurance that you had during the Initial Coverage Stage. Therefore, you may see no change in your copayment until you qualify for Catastrophic coverage.

After you reach your City of Mesa individual annual prescription drug out-of-pocket maximum of $2,000, the plan pays the full cost of your covered Part D drugs for the rest of the calendar year.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan.

Limitations, copayments, and restrictions may apply.

Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.

The formulary may change at any time. You will receive notice when necessary.

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Analgesics, Miscellaneous		
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	GC; QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	1	GC; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	1	GC; QL (180 per 30 days)
endocet oral tablet 10-325 mg	1	GC; QL (180 per 30 days)
endocet oral tablet 5-325 mg	1	GC; QL (360 per 30 days)
endocet oral tablet 7.5-325 mg	1	GC; QL (240 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	1	GC; QL (2700 per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg	1	GC; QL (180 per 30 days)
hydrocodone-acetaminophen oral tablet 5-325 mg	1	GC; QL (240 per 30 days)
oxycodone oral solution 5 mg/5 ml	1	GC; QL (1300 per 30 days)
oxycodone oral tablet 10 mg, 5 mg	1	GC; QL (180 per 30 days)
oxycodone oral tablet 15 mg, 20 mg, 30 mg	1	GC; QL (120 per 30 days)
oxycodone oral tablet,oral only,ext.rel.12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg	2	GC; QL (60 per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg	1	GC; QL (180 per 30 days)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	1	GC; QL (360 per 30 days)
oxycodone-acetaminophen oral tablet 7.5-325 mg	1	GC; QL (240 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG	2	GC; QL (60 per 30 days)
tramadol oral tablet 50 mg	1	GC; QL (240 per 30 days)
Nonsteroidal Anti-Inflammatory Agents		

Drug Name	Drug Tier	Requirements/Limits
diclofenac sodium oral tablet extended release 24 hr 100 mg	1	GC; QL (60 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 25 mg	1	GC; QL (150 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 50 mg	1	GC; QL (120 per 30 days)
diclofenac sodium oral tablet,delayed release (dr/ec) 75 mg	1	GC; QL (60 per 30 days)
diclofenac sodium topical drops 1.5 %	1	GC; QL (300 per 30 days)
diclofenac sodium topical gel 1 %	1	GC; QL (1000 per 30 days)
diclofenac sodium topical gel 3 %	1	PA; GC; QL (100 per 28 days)
ibu oral tablet 600 mg, 800 mg	1	GC
ibuprofen oral suspension 100 mg/5 ml	1	GC
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	GC
meloxicam oral tablet 15 mg, 7.5 mg	1	GC
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	GC
naproxen oral tablet,delayed release (dr/ec) 375 mg, 500 mg	1	GC
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP 20 MG/GRAM /ACTUATION(2 %)	5	PA; NM; GC; NDS; QL (224 per 28 days)
Anesthetics		
Local Anesthetics		
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	1	PA; GC
lidocaine topical adhesive patch,medicated 5 %	1	PA; GC; QL (90 per 30 days)
lidocaine topical ointment 5 %	1	PA; GC; QL (90 per 30 days)
lidocaine viscous mucous membrane solution 2 %	1	GC

Drug Name	Drug Tier	Requirements/Limits
ZTLIDO TOPICAL ADHESIVE PATCH,MEDICATED 1.8 %	2	PA; GC; QL (90 per 30 days)
Anti-Addiction/Substance Abuse Treatment Agents		
Anti-Addiction/Substance Abuse Treatment Agents		
buprenorphine hcl sublingual tablet 2 mg, 8 mg	1	GC; QL (90 per 30 days)
buprenorphine-naloxone sublingual film 12-3 mg, 8-2 mg	1	GC; QL (60 per 30 days)
buprenorphine-naloxone sublingual film 2-0.5 mg, 4-1 mg	1	GC; QL (30 per 30 days)
buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg	1	GC; QL (90 per 30 days)
CHANTIX CONTINUING MONTH BOX ORAL TABLET 1 MG	2	GC; QL (336 per 365 days)
CHANTIX ORAL TABLET 0.5 MG, 1 MG	2	GC; QL (336 per 365 days)
CHANTIX STARTING MONTH BOX ORAL TABLETS,DOSE PACK 0.5 MG (11)- 1 MG (42)	2	GC
Antianxiety Agents		
Benzodiazepines		
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	1	GC; QL (120 per 30 days)
alprazolam oral tablet 2 mg	1	GC; QL (150 per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	GC; QL (90 per 30 days)
lorazepam oral tablet 2 mg	1	GC; QL (150 per 30 days)
Antibacterials		
Aminoglycosides		
neomycin oral tablet 500 mg	1	GC
tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml	4	PA BvD; NM; GC; NDS
Antibacterials, Miscellaneous		
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	GC
metronidazole oral tablet 250 mg, 500 mg	1	GC
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	1	GC; QL (120 per 30 days)
nitrofurantoin monohyd/m-cryst oral capsule 100 mg	1	GC; QL (60 per 30 days)
Cephalosporins		

Drug Name	Drug Tier	Requirements/Limits
cefdinir oral capsule 300 mg	1	GC
cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	1	GC
cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	1	GC
cefprozil oral tablet 250 mg, 500 mg	1	GC
cefuroxime axetil oral tablet 250 mg, 500 mg	1	GC
cephalexin oral capsule 250 mg, 500 mg	1	GC
cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	1	GC
Macrolides		
azithromycin intravenous recon soln 500 mg	1	GC
azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml	1	GC
azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg	1	GC
clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml	1	GC
clarithromycin oral tablet 250 mg, 500 mg	1	GC
Miscellaneous B-Lactam Antibiotics		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML	5	PA; NM; GC; LA; NDS
meropenem intravenous recon soln 1 gram	1	GC
Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	GC
amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml	1	GC
amoxicillin oral tablet 500 mg, 875 mg	1	GC
amoxicillin oral tablet,chewable 125 mg, 250 mg	1	GC
amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml	1	GC
amoxicillin-pot clavulanate oral tablet 500-125 mg, 875-125 mg	1	GC
amoxicillin-pot clavulanate oral tablet,chewable 200-28.5 mg, 400-57 mg	1	GC
dicloxacillin oral capsule 250 mg, 500 mg	1	GC

Drug Name	Drug Tier	Requirements/Limits
penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml	1	GC
penicillin v potassium oral tablet 250 mg, 500 mg	1	GC
Quinolones		
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	GC
levofloxacin intravenous solution 25 mg/ml	1	GC
levofloxacin oral solution 250 mg/10 ml	1	GC
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	GC
Sulfonamides		
sulfadiazine oral tablet 500 mg	1	GC
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml	1	GC
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	GC
Tetracyclines		
doxy-100 intravenous recon soln 100 mg	1	GC
doxycycline hyclate oral capsule 100 mg, 50 mg	1	GC
doxycycline hyclate oral tablet 100 mg, 20 mg	1	GC
minocycline oral capsule 100 mg, 50 mg, 75 mg	1	GC
Anticancer Agents		
Anticancer Agents		
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG	5	PA NSO; NM; GC; NDS; QL (112 per 28 days)
AFINITOR ORAL TABLET 10 MG	5	PA NSO; NM; GC; NDS; QL (56 per 28 days)
anastrozole oral tablet 1 mg	1	GC
bicalutamide oral tablet 50 mg	1	GC
ELIGARD (3 MONTH) SUBCUTANEOUS SYRINGE 22.5 MG	3	GC
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG	3	GC
ELIGARD (6 MONTH) SUBCUTANEOUS SYRINGE 45 MG	3	GC

Drug Name	Drug Tier	Requirements/Limits
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH)	3	GC
everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg, 7.5 mg	4	PA NSO; NM; GC; NDS; QL (28 per 28 days)
exemestane oral tablet 25 mg	1	GC
hydroxyurea oral capsule 500 mg	1	GC
INLYTA ORAL TABLET 1 MG	5	PA NSO; NM; GC; NDS; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA NSO; NM; GC; NDS; QL (60 per 30 days)
letrozole oral tablet 2.5 mg	1	GC
LEUKERAN ORAL TABLET 2 MG	5	NM; GC; NDS
leuprolide subcutaneous kit 1 mg/0.2 ml	4	NM; GC; NDS
LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG	5	NM; GC; NDS
LUPRON DEPOT (4 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG	5	NM; GC; NDS
LUPRON DEPOT (6 MONTH) INTRAMUSCULAR SYRINGE KIT 45 MG	5	NM; GC; NDS
LYSODREN ORAL TABLET 500 MG	5	NM; GC; NDS
megestrol oral tablet 20 mg, 40 mg	1	PA NSO-HRM; GC; AGE (Max 64 Years)
mercaptopurine oral tablet 50 mg	1	GC
methotrexate sodium injection solution 25 mg/ml	1	PA BvD; GC
methotrexate sodium oral tablet 2.5 mg	1	PA BvD; ST; GC
NEXAVAR ORAL TABLET 200 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA NSO; NM; GC; NDS; QL (21 per 28 days)
PURIXAN ORAL SUSPENSION 20 MG/ML	5	NM; GC; NDS
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG	5	PA NSO; NM; GC; LA; NDS; QL (28 per 28 days)
SOLTAMOX ORAL SOLUTION 20 MG/10 ML	5	NM; GC; NDS
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG	5	PA NSO; NM; GC; NDS; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL ORAL TABLET 20 MG	5	PA NSO; NM; GC; NDS; QL (90 per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA NSO; NM; GC; NDS; QL (84 per 28 days)
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG	5	PA NSO; NM; GC; NDS; QL (30 per 30 days)
tamoxifen oral tablet 10 mg, 20 mg	1	GC
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PA NSO; NM; GC; NDS; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
tretinoin (antineoplastic) oral capsule 10 mg	4	NM; GC; NDS
VOTRIENT ORAL TABLET 200 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
XTANDI ORAL CAPSULE 40 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	5	PA NSO; NM; GC; NDS; QL (60 per 30 days)
ZELBORAF ORAL TABLET 240 MG	5	PA NSO; NM; GC; NDS; QL (240 per 30 days)
ZYTIGA ORAL TABLET 250 MG, 500 MG	5	PA NSO; NM; GC; NDS; QL (120 per 30 days)
Anticonvulsants		
Anticonvulsants		
carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg	1	GC
carbamazepine oral suspension 100 mg/5 ml	1	GC
carbamazepine oral tablet 200 mg	1	GC
carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg	1	GC
carbamazepine oral tablet,chewable 100 mg	1	GC
divalproex oral capsule, delayed rel sprinkle 125 mg	1	GC
divalproex oral tablet extended release 24 hr 250 mg, 500 mg	1	GC

Drug Name	Drug Tier	Requirements/Limits
divalproex oral tablet,delayed release (dr/ec) 125 mg, 250 mg, 500 mg	1	GC
epitol oral tablet 200 mg	1	GC
gabapentin oral capsule 100 mg, 300 mg	1	GC; QL (360 per 30 days)
gabapentin oral capsule 400 mg	1	GC; QL (270 per 30 days)
gabapentin oral solution 250 mg/5 ml	1	GC; QL (2160 per 30 days)
gabapentin oral tablet 600 mg	1	GC; QL (180 per 30 days)
gabapentin oral tablet 800 mg	1	GC; QL (120 per 30 days)
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	GC
lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg	1	GC
levetiracetam oral solution 100 mg/ml	1	GC
levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg	1	GC
levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg	1	GC
oxcarbazepine oral suspension 300 mg/5 ml (60 mg/ml)	1	GC
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	1	GC
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	3	ST; GC
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	5	ST; NM; GC; NDS
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	GC
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG	3	ST; GC; QL (60 per 30 days)
SPRITAM ORAL TABLET FOR SUSPENSION 250 MG, 500 MG, 750 MG	3	ST; GC; QL (120 per 30 days)
topiramate oral capsule, sprinkle 15 mg, 25 mg	1	GC
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	GC
Antidementia Agents		
Antidementia Agents		
donepezil oral tablet 10 mg, 5 mg	1	GC; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
donepezil oral tablet,disintegrating 10 mg, 5 mg	1	GC; QL (30 per 30 days)
galantamine oral capsule,ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg	1	GC; QL (30 per 30 days)
galantamine oral solution 4 mg/ml	1	GC; QL (200 per 30 days)
galantamine oral tablet 12 mg, 4 mg, 8 mg	1	GC; QL (60 per 30 days)
Antidepressants		
Antidepressants		
amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	1	GC
bupropion hcl oral tablet 100 mg, 75 mg	1	GC
bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg	1	GC
bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg	1	GC
citalopram oral solution 10 mg/5 ml	1	GC; QL (600 per 30 days)
citalopram oral tablet 10 mg, 20 mg, 40 mg	1	GC; QL (30 per 30 days)
escitalopram oxalate oral solution 5 mg/5 ml	1	GC
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	GC
fluoxetine oral capsule 10 mg, 20 mg, 40 mg	1	GC
fluoxetine oral solution 20 mg/5 ml (4 mg/ml)	1	GC
sertraline oral concentrate 20 mg/ml	1	GC
sertraline oral tablet 100 mg, 25 mg, 50 mg	1	GC
trazodone oral tablet 100 mg, 150 mg, 300 mg, 50 mg	1	GC
venlafaxine oral capsule,extended release 24hr 150 mg	1	GC; QL (30 per 30 days)
venlafaxine oral capsule,extended release 24hr 37.5 mg, 75 mg	1	GC; QL (90 per 30 days)
venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	GC
Antidiabetic Agents		
Antidiabetic Agents, Miscellaneous		
metformin oral tablet 1,000 mg	1	GC; QL (75 per 30 days)
metformin oral tablet 500 mg	1	GC; QL (150 per 30 days)
metformin oral tablet 850 mg	1	GC; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
metformin oral tablet extended release 24 hr 500 mg	1	GC; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	GC; QL (60 per 30 days)
pioglitazone oral tablet 15 mg, 30 mg, 45 mg	1	GC; QL (30 per 30 days)
TRADJENTA ORAL TABLET 5 MG	2	GC; QL (30 per 30 days)
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML)	2	GC; QL (9 per 30 days)
Insulins		
LANTUS SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	2	GC; QL (30 per 28 days)
LANTUS U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML	2	GC; QL (40 per 28 days)
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML)	1	GC; QL (30 per 28 days)
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30)	1	GC; QL (40 per 28 days)
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30)	1	GC; QL (30 per 28 days)
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML	1	GC; QL (30 per 28 days)
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML	1	GC; QL (40 per 28 days)
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML)	2	GC; QL (18 per 28 days)
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML)	2	GC; QL (13.5 per 28 days)
Sulfonylureas		
glimepiride oral tablet 1 mg, 2 mg	1	GC; QL (30 per 30 days)
glimepiride oral tablet 4 mg	1	GC; QL (60 per 30 days)
glipizide oral tablet 10 mg	1	GC; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
glipizide oral tablet 5 mg	1	GC; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	GC; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg, 5 mg	1	GC; QL (30 per 30 days)
Antifungals		
Antifungals		
clotrimazole-betamethasone topical cream 1-0.05 %	1	GC; QL (90 per 30 days)
fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml	1	GC
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	GC
ketoconazole oral tablet 200 mg	1	GC
ketoconazole topical cream 2 %	1	GC; QL (180 per 30 days)
ketoconazole topical shampoo 2 %	1	GC; QL (360 per 30 days)
nyamyc topical powder 100,000 unit/gram	1	GC; QL (60 per 30 days)
nystatin oral suspension 100,000 unit/ml	1	GC; QL (900 per 30 days)
nystatin oral tablet 500,000 unit	1	GC
nystatin topical cream 100,000 unit/gram	1	GC; QL (60 per 30 days)
nystatin topical ointment 100,000 unit/gram	1	GC; QL (60 per 30 days)
nystatin topical powder 100,000 unit/gram	1	GC; QL (60 per 30 days)
nystop topical powder 100,000 unit/gram	1	GC; QL (60 per 30 days)
terbinafine hcl oral tablet 250 mg	1	GC
Antigout Agents		
Antigout Agents, Other		
allopurinol oral tablet 100 mg, 300 mg	1	GC
probenecid oral tablet 500 mg	1	GC
Antihistamines		
Antihistamines		
hydroxyzine hcl oral solution 10 mg/5 ml	1	GC
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	GC
levocetirizine oral tablet 5 mg	1	GC
Anti-Infectives (Skin And Mucous Membrane)		

Drug Name	Drug Tier	Requirements/Limits
Anti-Infectives (Skin And Mucous Membrane)		
metronidazole vaginal gel 0.75 %	1	GC
terconazole vaginal cream 0.4 %, 0.8 %	1	GC
terconazole vaginal suppository 80 mg	1	GC
Antimigraine Agents		
Antimigraine Agents		
rizatriptan oral tablet 10 mg, 5 mg	1	GC; QL (12 per 30 days)
rizatriptan oral tablet,disintegrating 10 mg, 5 mg	1	GC; QL (12 per 30 days)
sumatriptan succinate oral tablet 100 mg	1	GC; QL (9 per 30 days)
sumatriptan succinate oral tablet 25 mg, 50 mg	1	GC; QL (18 per 30 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	3	GC; QL (4 per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	1	GC; QL (4 per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml	1	GC; QL (4 per 28 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5 ml	1	GC; QL (4 per 28 days)
Antimycobacterials		
Antimycobacterials		
dapsone oral tablet 100 mg, 25 mg	1	GC
isoniazid oral solution 50 mg/5 ml	1	GC
isoniazid oral tablet 100 mg, 300 mg	1	GC
rifampin intravenous recon soln 600 mg	1	GC
rifampin oral capsule 150 mg, 300 mg	1	GC
Antinausea Agents		
Antinausea Agents		
meclizine oral tablet 12.5 mg, 25 mg	1	GC
ondansetron oral tablet,disintegrating 4 mg, 8 mg	1	PA BvD; GC
promethazine oral tablet 12.5 mg, 25 mg, 50 mg	1	PA-HRM; GC; AGE (Max 64 Years)
promethegan rectal suppository 25 mg	1	PA-HRM; GC; AGE (Max 64 Years)
Antiparasite Agents		

Drug Name	Drug Tier	Requirements/Limits
Antiparasite Agents		
atovaquone-proguanil oral tablet 250-100 mg, 62.5-25 mg	1	GC
chloroquine phosphate oral tablet 250 mg	1	GC; QL (50 per 30 days)
chloroquine phosphate oral tablet 500 mg	1	GC; QL (25 per 30 days)
hydroxychloroquine oral tablet 200 mg	1	GC; QL (90 per 30 days)
mefloquine oral tablet 250 mg	1	GC
Antiparkinsonian Agents		
Antiparkinsonian Agents		
benztropine oral tablet 0.5 mg, 1 mg, 2 mg	1	GC
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	1	GC
carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg	1	GC
pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	GC
ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	GC
Antipsychotic Agents		
Antipsychotic Agents		
chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	1	GC
clozapine oral tablet 100 mg	1	GC; QL (270 per 30 days)
clozapine oral tablet 200 mg	1	GC; QL (135 per 30 days)
clozapine oral tablet 25 mg, 50 mg	1	GC; QL (90 per 30 days)
clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 25 mg	1	ST; GC; QL (90 per 30 days)
clozapine oral tablet,disintegrating 150 mg	1	ST; GC; QL (180 per 30 days)
clozapine oral tablet,disintegrating 200 mg	4	ST; NM; GC; NDS; QL (120 per 30 days)
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	1	GC
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	2	GC; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	2	GC; QL (60 per 30 days)
olanzapine intramuscular recon soln 10 mg	1	GC; QL (30 per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	1	GC; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg	1	GC; QL (30 per 30 days)
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	1	GC
PERSERIS ABDOMINAL SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 120 MG, 90 MG	5	NM; GC; NDS; QL (1 per 30 days)
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	GC; QL (90 per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	GC; QL (60 per 30 days)
risperidone oral solution 1 mg/ml	1	GC; QL (480 per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	GC; QL (60 per 30 days)
risperidone oral tablet 4 mg	1	GC; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	1	GC; QL (60 per 30 days)
risperidone oral tablet,disintegrating 3 mg, 4 mg	1	GC; QL (120 per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5	ST; NM; GC; NDS; QL (540 per 30 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	GC; QL (60 per 30 days)
Antivirals (Systemic)		
Antiretrovirals		
abacavir oral solution 20 mg/ml	1	GC
abacavir oral tablet 300 mg	1	GC
COMPLERA ORAL TABLET 200-25-300 MG	5	NM; GC; NDS
EPIVIR HBV ORAL SOLUTION 25 MG/5 ML (5 MG/ML)	3	GC
INTELENCE ORAL TABLET 100 MG, 200 MG	5	NM; GC; NDS
INTELENCE ORAL TABLET 25 MG	3	GC
ISENTRESS HD ORAL TABLET 600 MG	5	NM; GC; NDS
ISENTRESS ORAL POWDER IN PACKET 100 MG	3	GC
ISENTRESS ORAL TABLET 400 MG	5	NM; GC; NDS
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG	3	GC
KALETRA ORAL TABLET 100-25 MG	3	GC; QL (300 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
KALETRA ORAL TABLET 200-50 MG	5	NM; GC; NDS; QL (120 per 30 days)
lamivudine oral solution 10 mg/ml	1	GC
lamivudine oral tablet 100 mg, 150 mg, 300 mg	1	GC
lamivudine-zidovudine oral tablet 150-300 mg	1	GC
lopinavir-ritonavir oral solution 400-100 mg/5 ml	1	GC; QL (480 per 30 days)
nevirapine oral suspension 50 mg/5 ml	1	GC
nevirapine oral tablet 200 mg	1	GC
nevirapine oral tablet extended release 24 hr 100 mg, 400 mg	1	GC
PREZISTA ORAL SUSPENSION 100 MG/ML	5	NM; GC; NDS
PREZISTA ORAL TABLET 150 MG, 600 MG, 800 MG	5	NM; GC; NDS
PREZISTA ORAL TABLET 75 MG	3	GC
SELZENTRY ORAL SOLUTION 20 MG/ML	3	GC
SELZENTRY ORAL TABLET 150 MG, 300 MG, 75 MG	5	NM; GC; NDS
SELZENTRY ORAL TABLET 25 MG	2	GC
STRIBILD ORAL TABLET 150-150-200-300 MG	5	NM; GC; NDS
Antivirals, Miscellaneous		
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION	3	GC; QL (60 per 180 days)
rimantadine oral tablet 100 mg	1	GC
Hcv Antivirals		
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG	5	PA; NM; GC; NDS; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	5	PA; NM; GC; NDS; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	5	PA; NM; GC; NDS; QL (56 per 28 days)
HARVONI ORAL TABLET 90-400 MG	5	PA; NM; GC; NDS; QL (28 per 28 days)
VOSEVI ORAL TABLET 400-100-100 MG	5	PA; NM; GC; NDS; QL (28 per 28 days)
Interferons		

Drug Name	Drug Tier	Requirements/Limits
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML), 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	5	PA NSO; NM; GC; NDS
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML, 6 MILLION UNIT/ML	5	PA NSO; NM; GC; NDS
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML	5	NM; GC; NDS
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML	5	NM; GC; NDS
Nucleosides And Nucleotides		
acyclovir oral capsule 200 mg	1	GC
acyclovir oral suspension 200 mg/5 ml	1	GC
acyclovir oral tablet 400 mg, 800 mg	1	GC
valacyclovir oral tablet 1 gram, 500 mg	1	GC
Blood Products/Modifiers/Volume Expanders		
Anticoagulants		
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
warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	GC
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 15 MG (42)-20 MG (9)	2	GC
XARELTO ORAL TABLET 10 MG, 20 MG	2	GC; QL (30 per 30 days)
XARELTO ORAL TABLET 15 MG, 2.5 MG	2	GC; QL (60 per 30 days)
Blood Formation Modifiers		
CINRYZE INTRAVENOUS RECON SOLN 500 UNIT (5 ML)	5	PA; NM; GC; NDS; QL (20 per 30 days)
DOPTELET (10 TAB PACK) ORAL TABLET 20 MG	5	PA; NM; GC; NDS; QL (60 per 30 days)
DOPTELET (15 TAB PACK) ORAL TABLET 20 MG	5	PA; NM; GC; NDS; QL (60 per 30 days)
DOPTELET (30 TAB PACK) ORAL TABLET 20 MG	5	PA; NM; GC; NDS; QL (60 per 30 days)
FULPHILA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NM; GC; NDS
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT	5	PA; NM; GC; NDS; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
HAEGARDA SUBCUTANEOUS RECON SOLN 3,000 UNIT	5	PA; NM; GC; NDS; QL (20 per 30 days)
LEUKINE INJECTION RECON SOLN 250 MCG	5	NM; GC; NDS
MULPLETA ORAL TABLET 3 MG	5	PA; NM; GC; NDS; QL (7 per 7 days)
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NM; GC; NDS
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML	5	PA; NM; GC; NDS
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; NM; GC; NDS
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NM; GC; NDS
ORLADEYO ORAL CAPSULE 110 MG, 150 MG	5	PA; NM; GC; NDS; QL (30 per 30 days)
PROMACTA ORAL POWDER IN PACKET 12.5 MG	5	PA; NM; GC; NDS; QL (90 per 30 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	5	PA; NM; GC; NDS; QL (180 per 30 days)
PROMACTA ORAL TABLET 12.5 MG	5	PA; NM; GC; NDS; QL (90 per 30 days)
PROMACTA ORAL TABLET 25 MG	5	PA; NM; GC; NDS; QL (30 per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	5	PA; NM; GC; NDS; QL (60 per 30 days)
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	2	PA; GC; QL (12 per 28 days)
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	2	PA; GC; QL (4 per 28 days)
UDENYCA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML	5	PA; NM; GC; NDS
ZARXIO INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML	5	PA; NM; GC; NDS
Hematologic Agents, Miscellaneous		
anagrelide oral capsule 0.5 mg, 1 mg	1	GC
tranexamic acid oral tablet 650 mg	1	GC; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
Platelet-Aggregation Inhibitors		
cilostazol oral tablet 100 mg, 50 mg	1	GC
clopidogrel oral tablet 75 mg	1	GC
Caloric Agents		
Caloric Agents		
CLINIMIX E 5%/D20W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 5 %	3	PA BvD; GC
dextrose 5 % in water (d5w) intravenous piggyback 5 %	1	GC
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	3	PA BvD; GC
NUTRILIPID INTRAVENOUS EMULSION 20 %	3	PA BvD; GC
PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION	3	PA BvD; GC
TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %	3	PA BvD; GC
Cardiovascular Agents		
Alpha-Adrenergic Agents		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	GC
doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	GC
Angiotensin Ii Receptor Antagonists		
losartan oral tablet 100 mg, 25 mg, 50 mg	1	GC
losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	1	GC
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	GC
Angiotensin-Converting Enzyme Inhibitors		
benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	GC
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	GC
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	GC

Drug Name	Drug Tier	Requirements/Limits
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	GC
Antiarrhythmic Agents		
amiodarone oral tablet 200 mg, 400 mg	1	GC
flecainide oral tablet 100 mg, 150 mg, 50 mg	1	GC
pacerone oral tablet 200 mg, 400 mg	1	GC
Beta-Adrenergic Blocking Agents		
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	GC
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	GC
metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg	1	GC
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	GC
Calcium-Channel Blocking Agents		
cartia xt oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	1	GC
diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg	1	GC
diltiazem hcl oral capsule,extended release 24 hr 420 mg	1	GC
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	1	GC
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	GC
dilt-xr oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 mg	1	GC
taztia xt oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	1	GC
tiadylt er oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	1	GC
verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg	1	GC
verapamil oral capsule,ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg	1	GC

Drug Name	Drug Tier	Requirements/Limits
verapamil oral capsule,ext rel. pellets 24 hr 360 mg	3	GC
verapamil oral tablet 120 mg, 40 mg, 80 mg	1	GC
verapamil oral tablet extended release 120 mg, 180 mg, 240 mg	1	GC
Cardiovascular Agents, Miscellaneous		
digitek oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	1	GC
digox oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	1	GC
digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)	1	GC
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml	1	GC; QL (4 per 30 days)
epinephrine injection auto-injector 0.3 mg/0.3 ml	3	GC; QL (4 per 30 days)
hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	GC
Dihydropyridines		
amlodipine oral tablet 10 mg, 2.5 mg, 5 mg	1	GC
amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	1	GC
Diuretics		
furosemide injection solution 10 mg/ml	1	GC
furosemide injection syringe 10 mg/ml	1	GC
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	1	GC
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	GC
hydrochlorothiazide oral capsule 12.5 mg	1	GC
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	GC
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	1	GC
triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg	1	GC
Dyslipidemics		

Drug Name	Drug Tier	Requirements/Limits
atorvastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	GC; QL (30 per 30 days)
fenofibrate oral tablet 160 mg, 54 mg	1	GC
gemfibrozil oral tablet 600 mg	1	GC
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	GC
pravastatin oral tablet 10 mg, 80 mg	1	GC
pravastatin oral tablet 20 mg, 40 mg	1	GC; QL (30 per 30 days)
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	1	GC; QL (30 per 30 days)
Renin-Angiotensin-Aldosterone System Inhibitors		
aliskiren oral tablet 150 mg, 300 mg	1	GC
eplerenone oral tablet 25 mg, 50 mg	1	GC
Vasodilators		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	GC
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	GC
isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg	1	GC
Central Nervous System Agents		
Central Nervous System Agents		
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML	5	PA; NM; GC; NDS; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML	5	PA; NM; GC; NDS; QL (1 per 28 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	5	PA; NM; GC; NDS; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	5	PA; NM; GC; NDS; QL (12 per 28 days)
dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg	1	GC; QL (60 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 5 mg	1	GC; QL (30 per 30 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr 20 mg, 25 mg, 30 mg	1	GC; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	1	GC; QL (60 per 30 days)
glatiramer subcutaneous syringe 20 mg/ml	5	PA; NM; GC; NDS; QL (30 per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	5	PA; NM; GC; NDS; QL (12 per 28 days)
glatopa subcutaneous syringe 20 mg/ml	5	PA; NM; GC; NDS; QL (30 per 30 days)
glatopa subcutaneous syringe 40 mg/ml	5	PA; NM; GC; NDS; QL (12 per 28 days)
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	GC
lithium carbonate oral tablet 300 mg	1	GC
lithium carbonate oral tablet extended release 300 mg, 450 mg	1	GC
methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 40 mg, 50 mg, 60 mg	1	GC; QL (30 per 30 days)
methylphenidate hcl oral capsule, er biphasic 30-70 30 mg	1	GC; QL (60 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg, 20 mg, 40 mg, 60 mg	1	GC; QL (30 per 30 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg	1	GC; QL (60 per 30 days)
methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml	1	GC; QL (900 per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	1	GC; QL (90 per 30 days)
Contraceptives		
Contraceptives		
altavera (28) oral tablet 0.15-0.03 mg	1	GC
apri oral tablet 0.15-0.03 mg	1	GC
aubra eq oral tablet 0.1-20 mg-mcg	1	GC
aviane oral tablet 0.1-20 mg-mcg	1	GC
blisovi 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	GC
blisovi fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	GC

Drug Name	Drug Tier	Requirements/Limits
caziant (28) oral tablet 0.1/.125/.15-25 mg-mcg	1	GC
cyred eq oral tablet 0.15-0.03 mg	1	GC
desogestrel-ethinyl estradiol oral tablet 0.15-0.03 mg	1	GC
emoquette oral tablet 0.15-0.03 mg	1	GC
enpresse oral tablet 50-30 (6)/75-40 (5)/125-30(10)	1	GC
enskyce oral tablet 0.15-0.03 mg	1	GC
estarylla oral tablet 0.25-35 mg-mcg	1	GC
falmina (28) oral tablet 0.1-20 mg-mcg	1	GC
femynor oral tablet 0.25-35 mg-mcg	1	GC
hailey 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	GC
iclevia oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	1	GC; QL (91 per 84 days)
introvale oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	1	GC; QL (91 per 84 days)
isibloom oral tablet 0.15-0.03 mg	1	GC
juleber oral tablet 0.15-0.03 mg	1	GC
junel fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	GC
junel fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	GC
junel fe 24 oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	GC
kurvelo (28) oral tablet 0.15-0.03 mg	1	GC
larin fe 1.5/30 (28) oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	1	GC
larin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	GC
larissia oral tablet 0.1-20 mg-mcg	1	GC
lessina oral tablet 0.1-20 mg-mcg	1	GC
levonest (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	1	GC
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	1	GC

Drug Name	Drug Tier	Requirements/Limits
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	1	GC; QL (91 per 84 days)
levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)	1	GC
levora-28 oral tablet 0.15-0.03 mg	1	GC
lutera (28) oral tablet 0.1-20 mg-mcg	1	GC
marlissa (28) oral tablet 0.15-0.03 mg	1	GC
microgestin fe 1/20 (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	GC
mili oral tablet 0.25-35 mg-mcg	1	GC
norethindrone-e.estradiol-iron oral capsule 1 mg-20 mcg (24)/75 mg (4)	1	GC
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	GC
norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg (28), 0.25-35 mg-mcg	1	GC
nymyo oral tablet 0.25-35 mg-mcg	1	GC
orsythia oral tablet 0.1-20 mg-mcg	1	GC
portia 28 oral tablet 0.15-0.03 mg	1	GC
previfem oral tablet 0.25-35 mg-mcg	1	GC
reclipsen (28) oral tablet 0.15-0.03 mg	1	GC
setlakin oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	1	GC; QL (91 per 84 days)
sprintec (28) oral tablet 0.25-35 mg-mcg	1	GC
sronyx oral tablet 0.1-20 mg-mcg	1	GC
tarina 24 fe oral tablet 1 mg-20 mcg (24)/75 mg (4)	1	GC
tarina fe 1-20 eq (28) oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	GC
tri-estarylla oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	GC
tri-legest fe oral tablet 1-20(5)/1-30(7) /1mg-35mcg (9)	1	GC
tri-lo-estarylla oral tablet 0.18/0.215/0.25 mg-25 mcg	1	GC
tri-lo-sprintec oral tablet 0.18/0.215/0.25 mg-25 mcg	1	GC

Drug Name	Drug Tier	Requirements/Limits
tri-mili oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	GC
tri-nymyo oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	GC
tri-previfem (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	GC
tri-sprintec (28) oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	GC
trivora (28) oral tablet 50-30 (6)/75-40 (5)/125-30(10)	1	GC
tri-vylibra lo oral tablet 0.18/0.215/0.25 mg-25 mcg	1	GC
tri-vylibra oral tablet 0.18/0.215/0.25 mg-35 mcg (28)	1	GC
velivet triphasic regimen (28) oral tablet 0.1/.125/.15-25 mg-mcg	1	GC
vienva oral tablet 0.1-20 mg-mcg	1	GC
vylibra oral tablet 0.25-35 mg-mcg	1	GC
Dental And Oral Agents		
Dental And Oral Agents		
chlorhexidine gluconate mucous membrane mouthwash 0.12 %	1	GC
periogard mucous membrane mouthwash 0.12 %	1	GC
triamcinolone acetonide dental paste 0.1 %	1	GC
Dermatological Agents		
Dermatological Agents, Other		
ammonium lactate topical cream 12 %	1	GC
ammonium lactate topical lotion 12 %	1	GC
fluorouracil topical cream 0.5 %	5	NM; GC; NDS
fluorouracil topical cream 5 %	1	GC
fluorouracil topical solution 2 %, 5 %	1	GC
imiquimod topical cream in packet 5 %	1	GC; QL (24 per 30 days)
Dermatological Antibacterials		
clindamycin phosphate topical solution 1 %	1	GC; QL (180 per 30 days)
clindamycin phosphate topical swab 1 %	1	GC
metronidazole topical cream 0.75 %	1	GC
metronidazole topical gel 0.75 %, 1 %	1	GC

Drug Name	Drug Tier	Requirements/Limits
metronidazole topical lotion 0.75 %	1	GC
Dermatological Anti-Inflammatory Agents		
ala-cort topical cream 1 %	1	GC
clobetasol scalp solution 0.05 %	1	GC
clobetasol topical cream 0.05 %	1	GC
fluocinonide topical cream 0.05 %	1	GC
fluocinonide topical solution 0.05 %	1	GC
hydrocortisone 2.5% cream 2.5 %	1	GC
hydrocortisone topical cream 1 %	1	GC
hydrocortisone topical cream with perineal applicator 2.5 %	1	GC
hydrocortisone topical lotion 2.5 %	1	GC
hydrocortisone topical ointment 1 %, 2.5 %	1	GC
mometasone topical cream 0.1 %	1	GC
mometasone topical ointment 0.1 %	1	GC
mometasone topical solution 0.1 %	1	GC
procto-med hc topical cream with perineal applicator 2.5 %	1	GC
proctosol hc topical cream with perineal applicator 2.5 %	1	GC
proctozone-hc topical cream with perineal applicator 2.5 %	1	GC
triamcinolone acetonide topical cream 0.025 %, 0.1 %, 0.5 %	1	GC
triamcinolone acetonide topical lotion 0.025 %, 0.1 %	1	GC
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	1	GC
Dermatological Retinoids		
adapalene topical cream 0.1 %	1	GC
adapalene topical gel 0.1 %	1	GC
ALTRENO TOPICAL LOTION 0.05 %	3	PA; GC
tretinoin topical cream 0.025 %, 0.05 %, 0.1 %	1	PA; GC
tretinoin topical gel 0.01 %, 0.025 %, 0.05 %	1	PA; GC
Scabicides And Pediculicides		
malathion topical lotion 0.5 %	1	GC
permethrin topical cream 5 %	1	GC

Drug Name	Drug Tier	Requirements/Limits
Devices		
Devices		
BD UF NANO PEN NEEDLE 4MMX32G 32 GAUGE X 5/32"	1	GC
BD VEO INS SYRING 1 ML 6MMX31G 1 ML 31 GAUGE X 15/64"	1	GC
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 1 ML 29 GAUGE X 1/2"	1	GC
PEN NEEDLE, DIABETIC NEEDLE 29 GAUGE X 1/2"	1	GC
Enzyme Replacement/Modifiers		
Enzyme Replacement/Modifiers		
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000-180,000 UNIT, 6,000-19,000 -30,000 UNIT	2	GC
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA BvD; NM; GC; NDS
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000-105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	2	GC
Eye, Ear, Nose, Throat Agents		
Eye, Ear, Nose, Throat Agents, Miscellaneous		
azelastine nasal aerosol,spray 137 mcg (0.1 %)	1	GC; QL (30 per 25 days)
azelastine ophthalmic (eye) drops 0.05 %	1	GC
cromolyn ophthalmic (eye) drops 4 %	1	GC
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	1	GC; QL (30 per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	1	GC; QL (15 per 10 days)
Eye, Ear, Nose, Throat Anti-Infectives Agents		
erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)	1	GC; QL (3.5 per 4 days)

Drug Name	Drug Tier	Requirements/Limits
gentak ophthalmic (eye) ointment 0.3 % (3 mg/gram)	1	GC
gentamicin ophthalmic (eye) drops 0.3 %	1	GC
neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %	1	GC
neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %	1	GC
neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml	1	GC
neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%	1	GC
neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%	1	GC
ofloxacin ophthalmic (eye) drops 0.3 %	1	GC
ofloxacin otic (ear) drops 0.3 %	1	GC
tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %	1	GC
Eye, Ear, Nose, Throat Anti-Inflammatory Agents		
flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)	1	GC; QL (50 per 25 days)
fluticasone propionate nasal spray,suspension 50 mcg/actuation	1	GC; QL (16 per 30 days)
prednisolone acetate ophthalmic (eye) drops,suspension 1 %	3	GC
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 %	2	GC; QL (60 per 30 days)
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION	2	ST; GC; QL (32 per 30 days)
Gastrointestinal Agents		
Antiulcer Agents And Acid Suppressants		
famotidine oral tablet 20 mg, 40 mg	1	GC
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg	1	GC
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	GC; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	GC; QL (60 per 30 days)
Gastrointestinal Agents, Other		
constulose oral solution 10 gram/15 ml	1	GC
dicyclomine oral capsule 10 mg	1	GC
dicyclomine oral solution 10 mg/5 ml	1	GC
dicyclomine oral tablet 20 mg	1	GC
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	PA-HRM; GC; AGE (Max 64 Years)
enulose oral solution 10 gram/15 ml	1	GC
generlac oral solution 10 gram/15 ml	1	GC
lactulose oral solution 10 gram/15 ml	1	GC
loperamide oral capsule 2 mg	1	GC
metoclopramide hcl oral solution 5 mg/5 ml	1	GC
metoclopramide hcl oral tablet 10 mg, 5 mg	1	GC
ursodiol oral capsule 300 mg	1	GC
ursodiol oral tablet 250 mg, 500 mg	1	GC
Laxatives		
gavilyte-c oral recon soln 240-22.72-6.72 - 5.84 gram	1	GC
gavilyte-g oral recon soln 236-22.74-6.74 - 5.86 gram	1	GC
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM	2	GC
Phosphate Binders		
calcium acetate(phosphat bind) oral capsule 667 mg	1	GC
calcium acetate(phosphat bind) oral tablet 667 mg	1	GC
PHOSLYRA ORAL SOLUTION 667 MG (169 MG CALCIUM)/5 ML	3	GC
sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram	4	NM; GC; NDS
sevelamer carbonate oral tablet 800 mg	1	GC
sevelamer hcl oral tablet 400 mg	1	GC
VELPHORO ORAL TABLET,CHEWABLE 500 MG	2	GC
Genitourinary Agents		

Drug Name	Drug Tier	Requirements/Limits
Antispasmodics, Urinary		
oxybutynin chloride oral syrup 5 mg/5 ml	1	GC
oxybutynin chloride oral tablet 5 mg	1	GC
oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg	1	GC
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG	2	GC
Genitourinary Agents, Miscellaneous		
finasteride oral tablet 5 mg	1	GC
tamsulosin oral capsule 0.4 mg	1	GC
Heavy Metal Antagonists		
Heavy Metal Antagonists		
clovique oral capsule 250 mg	4	PA; NM; GC; NDS; QL (240 per 30 days)
deferasirox oral granules in packet 180 mg, 360 mg, 90 mg	4	PA; NM; GC; NDS
deferasirox oral tablet 180 mg, 360 mg	4	PA; NM; GC; NDS
deferasirox oral tablet 90 mg	1	PA; GC
deferasirox oral tablet, dispersible 125 mg	1	PA; GC
deferasirox oral tablet, dispersible 250 mg, 500 mg	4	PA; NM; GC; NDS
deferiprone oral tablet 500 mg	4	PA; NM; GC; NDS
FERRIPROX 1,000 MG TAB(2X/DAY) 1,000 MG	5	PA; NM; GC; NDS
FERRIPROX ORAL SOLUTION 100 MG/ML	5	PA; NM; GC; NDS
FERRIPROX ORAL TABLET 1,000 MG	5	PA; NM; GC; NDS
penicillamine oral capsule 250 mg	4	PA; NM; GC; NDS
penicillamine oral tablet 250 mg	4	PA; NM; GC; NDS
trientine oral capsule 250 mg	4	PA; NM; GC; NDS; QL (240 per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying		
Androgens		
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	1	PA; GC
testosterone enanthate intramuscular oil 200 mg/ml	1	PA; GC; QL (5 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML	2	PA; GC; QL (2 per 28 days)
Estrogens And Antiestrogens		
dotti transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	1	PA-HRM; GC; QL (8 per 28 days); AGE (Max 64 Years)
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	PA-HRM; GC; AGE (Max 64 Years)
estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	1	PA-HRM; GC; QL (8 per 28 days); AGE (Max 64 Years)
estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	1	PA-HRM; GC; QL (4 per 28 days); AGE (Max 64 Years)
estradiol vaginal cream 0.01 % (0.1 mg/gram)	1	GC
estradiol vaginal tablet 10 mcg	1	GC; QL (18 per 28 days)
lyllana transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr	1	PA-HRM; GC; QL (8 per 28 days); AGE (Max 64 Years)
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	2	PA-HRM; GC; AGE (Max 64 Years)
PREMARIN VAGINAL CREAM 0.625 MG/GRAM	2	GC
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14)	2	PA-HRM; GC; AGE (Max 64 Years)
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	2	PA-HRM; GC; AGE (Max 64 Years)
yuvafem vaginal tablet 10 mcg	1	GC; QL (18 per 28 days)
Glucocorticoids/Mineralocorticoids		
prednisolone 15 mg/5 ml soln a/f, d/f 15 mg/5 ml (3 mg/ml)	1	PA BvD; GC
prednisolone oral solution 15 mg/5 ml	1	PA BvD; GC
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	1	PA BvD; GC
prednisone oral solution 5 mg/5 ml	1	PA BvD; GC
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	PA BvD; GC

Drug Name	Drug Tier	Requirements/Limits
prednisone oral tablets,dose pack 10 mg, 10 mg (48 pack), 5 mg, 5 mg (48 pack)	1	GC
Pituitary		
desmopressin nasal spray with pump 10 mcg/spray (0.1 ml)	1	GC
desmopressin oral tablet 0.1 mg, 0.2 mg	1	GC
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	5	PA; NM; GC; NDS
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	5	PA; NM; GC; NDS
ZORBTIVE SUBCUTANEOUS RECON SOLN 8.8 MG	5	PA; NM; GC; NDS
Progestins		
medroxyprogesterone intramuscular suspension 150 mg/ml	1	GC; QL (1 per 84 days)
medroxyprogesterone intramuscular syringe 150 mg/ml	1	GC; QL (1 per 84 days)
medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg	1	GC
progesterone micronized oral capsule 100 mg, 200 mg	1	GC
Thyroid And Antithyroid Agents		
levothyroxine 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
liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg	1	GC
Immunological Agents		
Immunological Agents		
azathioprine oral tablet 50 mg	1	PA BvD; GC
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	1	PA BvD; GC
cyclosporine modified oral solution 100 mg/ml	1	PA BvD; GC

Drug Name	Drug Tier	Requirements/Limits
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML)	5	PA; NM; GC; NDS
ENBREL SUBCUTANEOUS RECON SOLN 25 MG (1 ML)	5	PA; NM; GC; NDS
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML	5	PA; NM; GC; NDS
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)	5	PA; NM; GC; NDS
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML)	5	PA; NM; GC; NDS
gengraf oral capsule 100 mg, 25 mg	1	PA BvD; GC
gengraf oral solution 100 mg/ml	1	PA BvD; GC
HUMIRA PEN CROHNS-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA PEN PSOR-UVEITS-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; NM; GC; NDS
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA(CF) PEN PEDIATRIC UC SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML	5	PA; NM; GC; NDS
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML	5	PA; NM; GC; NDS
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML	5	PA; NM; GC; NDS

Drug Name	Drug Tier	Requirements/Limits
leflunomide oral tablet 10 mg, 20 mg	1	GC
mycophenolate mofetil oral capsule 250 mg	1	PA BvD; GC
mycophenolate mofetil oral suspension for reconstitution 200 mg/ml	4	PA BvD; NM; GC; NDS
mycophenolate mofetil oral tablet 500 mg	1	PA BvD; GC
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG	3	PA BvD; ST; GC
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	1	PA BvD; GC
Vaccines		
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	2	GC
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML	2	GC
BOOSTRIX TDAP INTRAMUSCULAR SUSPENSION 2.5-8-5 LF-MCG-LF/0.5ML	2	GC
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML	2	GC
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML	2	PA BvD; GC
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML	2	PA BvD; GC
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML, 720 ELISA UNIT/0.5 ML	2	GC
MENACTRA (PF) INTRAMUSCULAR SOLUTION 4 MCG/0.5 ML	2	GC
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML	2	GC
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	2	PA BvD; GC
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML	2	PA BvD; GC
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML	2	GC
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5 ML	2	GC

Drug Name	Drug Tier	Requirements/Limits
TYPHIM VI INTRAMUSCULAR SYRINGE 25 MCG/0.5 ML	2	GC
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML, 50 UNIT/ML	2	GC
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML, 50 UNIT/ML	2	GC
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML	2	GC; QL (2 per 365 days)
Inflammatory Bowel Disease Agents		
Inflammatory Bowel Disease Agents		
balsalazide oral capsule 750 mg	1	GC
sulfasalazine oral tablet 500 mg	1	GC
sulfasalazine oral tablet,delayed release (dr/ec) 500 mg	3	GC
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate oral tablet 10 mg	1	GC; QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	GC; QL (4 per 28 days)
calcitriol oral capsule 0.25 mcg, 0.5 mcg	1	GC
calcitriol oral solution 1 mcg/ml	1	GC
ibandronate oral tablet 150 mg	1	GC; QL (1 per 28 days)
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		
buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	GC
ELMIRON ORAL CAPSULE 100 MG	3	GC; QL (90 per 30 days)
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	GC
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	1	GC
pyridostigmine bromide oral syrup 60 mg/5 ml	1	GC
pyridostigmine bromide oral tablet 30 mg, 60 mg	1	GC
Ophthalmic Agents		

Drug Name	Drug Tier	Requirements/Limits
Antiglaucoma Agents		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	2	GC
brimonidine ophthalmic (eye) drops 0.2 %	1	GC
dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml	1	GC
latanoprost ophthalmic (eye) drops 0.005 %	1	GC; QL (2.5 per 25 days)
timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %	1	GC
timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %	3	GC
Replacement Preparations		
Replacement Preparations		
klor-con m10 oral tablet,er particles/crystals 10 meq	1	GC
klor-con m15 oral tablet,er particles/crystals 15 meq	1	GC
klor-con m20 oral tablet,er particles/crystals 20 meq	1	GC
potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml)	1	PA BvD; GC
potassium chloride oral capsule, extended release 10 meq, 8 meq	1	GC
potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml	1	GC
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	1	GC
potassium chloride oral tablet,er particles/crystals 10 meq, 20 meq	1	GC
potassium citrate oral tablet extended release 10 meq (1,080 mg), 15 meq, 5 meq (540 mg)	1	GC
sodium chloride 0.9 % intravenous piggyback	1	GC
Respiratory Tract Agents		
Anti-Inflammatories, Inhaled Corticosteroids		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	1	GC; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION	2	GC; QL (12 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	2	GC; QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	GC; QL (120 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	2	GC; QL (12 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	2	GC; QL (24 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	2	GC; QL (21.2 per 30 days)
Antileukotrienes		
montelukast oral tablet 10 mg	1	GC
montelukast oral tablet,chewable 4 mg, 5 mg	1	GC
zafirlukast oral tablet 10 mg, 20 mg	1	GC
Bronchodilators		
albuterol 5 mg/ml solution 5 mg/ml	1	PA BvD; GC; QL (120 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	1	GC; QL (17 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)	1	GC; QL (13.4 per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)	3	GC; QL (36 per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %)	1	PA BvD; GC; QL (360 per 30 days)
albuterol sulfate inhalation solution for nebulization 2.5 mg/0.5 ml	1	PA BvD; GC; QL (120 per 30 days)
albuterol sulfate oral syrup 2 mg/5 ml	1	GC
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION	2	GC; QL (8 per 30 days)
ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml	1	PA BvD; GC; QL (540 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION	2	GC; QL (4 per 30 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG	2	GC; QL (30 per 30 days)
Respiratory Tract Agents, Other		
acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)	1	PA BvD; GC
cromolyn inhalation solution for nebulization 20 mg/2 ml	1	PA BvD; GC
DALIRESP ORAL TABLET 250 MCG	2	GC; QL (28 per 28 days)
DALIRESP ORAL TABLET 500 MCG	2	GC; QL (30 per 30 days)
XOLAIR SUBCUTANEOUS RECON SOLN 150 MG	5	PA; NM; GC; NDS
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML	5	PA; NM; GC; NDS
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
cyclobenzaprine oral tablet 10 mg, 5 mg	1	PA-HRM; GC; AGE (Max 64 Years)
methocarbamol oral tablet 500 mg, 750 mg	1	PA-HRM; GC; AGE (Max 64 Years)
Sleep Disorder Agents		
Sleep Disorder Agents		
zaleplon oral capsule 10 mg, 5 mg	1	GC; QL (30 per 30 days)
zolpidem oral tablet 10 mg, 5 mg	1	GC; QL (30 per 30 days)
Vasodilating Agents		
Vasodilating Agents		
sildenafil (pulm.hypertension) oral tablet 20 mg	1	PA; GC; QL (90 per 30 days)
TRACLEER ORAL TABLET 125 MG, 62.5 MG	5	PA; NM; GC; LA; NDS; QL (60 per 30 days)
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG	5	PA; NM; GC; NDS; QL (112 per 28 days)

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
Cough and Cold		
1st Gen Antihistamine & Decongestant Combinations		
promethazine vc 5-6.25/5 SYRUP	1	EX
promethazine-phenylephrine 5-6.25/5 SYRUP	1	EX
1st Gen Antihist-Decongest-Anticholinergic Comb		
*respa a.r.*90-8-0.24 TAB ER 12H	1	EX
Antitussives, Non-Narcotic		
benzonatate CAPSULE 100, 150, 200 mg	1	EX
Narcotic Antituss-1st Gen. Antihistamine-Decongest		
promethazine vc-codeine 6.25-5-10 SYRUP	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 30 mL per day)
promethazine-phenyleph-codeine 6.25-5-10 SYRUP	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 30 mL per day)
Narcotic Antitussive-1st Generation Antihistamine		
hydrocodone-chlorpheniramne er 10-8MG/5ML SUS ER 12H	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 10 mL per day)
promethazine-codeine 6.25-10/5 SYRUP	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 30 mL per day)
Narcotic Antitussive-Anticholinergic Comb.		
hydrocodone-homatropine mbr 5-1.5 MG TABLET	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 6 per day)
hydrocodone-homatropine mbr 5-1.5 MG/5 SYRUP	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 30 mL per day)
hydromet 5-1.5 MG/5 SYRUP	1	EX; AGE LIMIT: MUST BE AT LEAST 18 YEARS OLD; QL (Limited to 30 mL per day)

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
Non-Narc Antituss-1st Gen. Antihistamine-Decongest		
bromfed dm 2-30-10/5 SYRUP	1	EX
brompheniramine-pseudoephed-dm 2-30-10/5 SYRUP	1	EX
Non-Narc Antitussive-1st Gen Antihistamine Comb.		
promethazine-dm 6.25-15/5 SYRUP	1	EX
Dermatology - Acne		
Topical Preparations, Antibacterials		
dermazene 1 %-1 % CREAM (G)	1	EX
hydrocortisone-iodoquinol 1 %-1 % CREAM (G)	1	EX
hydrocortisone-iodoquinol-aloe 1.9 %-1 % CREAM PACK	1	EX
silver nitrate SOLUTION 0.005, 0.25, 0.5	1	EX
Dermatology - Antiinfective		
Topical Sulfonamides		
mafenide acetate 50 G PACKET	1	EX
niacinamide-sulfacetamide sod 10 %-4 % CREAM (G)	1	EX
rosula 10 %-5 % MED. PAD	1	EX
sodium sulfacetamide-sulfur 10 %-2 % CREAM (G)	1	EX
sodium sulfacetamide-sulfur 10 %-2 % CLEANSER	1	EX
sodium sulfacetamide-sulfur 10 %-4 % MED. PAD	1	EX
sodium sulfacetamide-sulfur 10%-5%-10% CLEANSER	1	EX; QL (Limited to 1419 per fill)
sodium sulfacetamide-sulfur 10-5%(W/V) LOTION	1	EX

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
sodium sulfacetamide-sulfur 10-5%(W/W) SUSPENSION	1	EX
sodium sulfacetamide-sulfur 10-5%(W/W) CREAM (G)	1	EX
sodium sulfacetamide-sulfur 10-5%(W/W) LOTION	1	EX
sodium sulfacetamide-sulfur 9 %-4 % CLEANSER	1	EX
sodium sulfacetamide-sulfur 9 %-4.5 % KIT	1	EX
sodium sulfacetamide-sulfur 9.8%-4.8% CLEANSER	1	EX
sodium sulfacetamide-sulfur 9.8%-4.8% MED. PAD	1	EX
sodium sulfacetamide-sulfur 9.8%-4.8% CREAM (G)	1	EX
sodium sulfacetamide-sulfur 9.8%-4.8% LOTION	1	EX
sss 10-5 10 %-5 % FOAM	1	EX
sss 10-5 10-5%(W/W) CREAM (G)	1	EX
Dermatology - Miscellaneous		
Antiperspirants		
DRYSOL 0.2 SOLUTION	2	EX
Antiseborrheic Agents		
loutrex CREAM (G)	1	EX
Topical Anti-Inflammatory Steroid-Local Anesthetic		
ANALPRAM HC 2.5%-1% LOTION	2	EX
hydrocortisone-pramoxine hcl 2.5 %-1 % CREAM (G)	1	EX
PRAMOSONE 1 %-1 % CREAM (G)	2	EX; ST REQUIRED
PRAMOSONE 1 %-1 % OINT. (G)	2	EX; ST REQUIRED
PRAMOSONE 2.5 %-1 % OINT. (G)	2	EX
PRAMOSONE 1 %-1 % LOTION	2	EX
PRAMOSONE 2.5 %-1 % LOTION	2	EX
Diabetes		
Blood Sugar Diagnostics		

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
FREESTYLE INSULINX GLUCOSE TEST STRIPS	2	EX; QL: LIMITED TO 200 TEST STRIPS PER 30 DAYS
FREESTYLE LITE GLUCOSE TEST STRIPS	2	EX; QL: LIMITED TO 200 TEST STRIPS PER 30 DAYS
FREESTYLE PRECISION NEO	2	EX; QL: LIMITED TO 200 TEST STRIPS PER 30 DAYS
FREESTYLE GLUCOSE TEST STRIPS	2	EX; QL: LIMITED TO 200 TEST STRIPS PER 30 DAYS
PRECISION XTRA GLUCOSE TEST STRIPS	2	EX; QL: LIMITED TO 200 TEST STRIPS PER 30 DAYS
Diabetic Supplies		
LANCETS	2	EX
DEXCOM G6	2	EX; PA
OMNIPOD CARTRIDGE	2	EX
OMNIPOD DASH 5 PACK POD CARTRIDGE	2	EX
OMNIPOD DASH PDM KIT	2	EX; QL: LIMITED TO 1 IN 365 DAYS
ONETOUCH SURESOFT LANCETS18 GAUGE	2	EX
Endocrine Disorder - Fertility		
Drugs To Treat Impotency		
vardenafil hcl TABLET 2.5MG, 5 MG, 10 MG, 20 MG	1	EX; ST; QL: 1 IN 5 DAYS
vardenafil hcl 10MG TAB RAPDIS	1	EX; ST; QL: 1 IN 5 DAYS
Endocrine Disorder - Thyroid		
Iodine Containing Agents		
sski1 G/ML SOLUTION	1	EX
strong iodine 0.05 SOLUTION	1	EX
Thyroid Hormones		
ARMOUR THYROID TABLET 15 MG, 30 MG, 60 MG, 90 MG, 120 MG, 180 MG, 240 MG, 300 MG	2	EX
nature-throid TABLET 16.25 MG, 32.5 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG,	1	EX

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
113.75 MG, 130 MG , 146.25 MG, 162.5 MG, 195 MG, 260 MG, 325 MG		
np thyroid TABLET 15 MG, 30 MG, 60 MG, 90 MG, 120 MG	1	EX
westhroid TABLET 32.5 MG, 65 MG, 97.5 MG, 130 MG,195 MG	1	EX
wp thyroid TABLET 16.25MG, 32.5MG, 48.75MG, 65 MG, 81.25 MG, 97.5 MG, 113.75 MG, 130 MG	1	EX
Hormonal Deficiency		
Androgen/Estrogen Preps for Female Sexual Dysfunc		
INTRAROSA 6.5 MG INSERT	2	EX; QL (Limited to 1 per day)
Estrogen/Androgen Combinations		
covaryx 1.25-2.5MG TABLET	1	EX
covaryx h.s. 0.625-1.25 TABLET	1	EX
eemt 1.25-2.5MG TABLET	1	EX
*eemt h.s.*0.625-1.25 TABLET	1	EX
estrogen-methyltestosterone 0.625-1.25 TABLET	1	EX
estrogen-methyltestosterone 1.25-2.5MG TABLET	1	EX
Infectious Disease - Bacterial		
Chemotherapeutics, Antibacterial, Misc.		
fosfomycin tromethamine 3 G PACKET	1	EX
hyophen 81.6-0.12 TABLET	1	EX
methenamine mandelate 1 G TABLET	1	EX
methenamine mandelate 500 MG TABLET	1	EX
PHOSPHASAL 81.6-10.8 TABLET	2	EX
URETRON D-S 81.6-10.8 TABLET	2	EX
uro-458 81-0.12MG TABLET	1	EX
urogesic-blue 81.6-.12MG TABLET	1	EX
uro-mp 118-10-36 CAPSULE	1	EX
ustell 120-0.12MG CAPSULE	1	EX

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
Lower Gastrointestinal Disorders - Bowel Inflammat		
Hemorrhoidal Prep, Anti-Infam Steroid/Local Anesth		
ana-lex 2%-2% kit	1	EX
hydrocortisone-pramoxine 1 %-1 % CREAM/APPL	1	EX
hydrocortisone-pramoxine 2.5 %-1 % CREAM/APPL	1	EX
lidocaine-hydrocortisone 0.55%-2.8% GEL W/APPL	1	EX
lidocaine-hydrocortisone 2.5-3%(7G) KIT	1	EX
lidocaine-hydrocortisone 2.5-3%(7G) KIT	1	EX
lidocaine-hydrocortisone 3 %-0.5 % KIT	1	EX
lidocaine-hydrocortisone 3 %-0.5 % CREAM (G)	1	EX
lidocaine-hydrocortisone 3%-1%(7 G) KIT	1	EX
lidocaine-hydrocortisone 3-2.5%(7G) GEL W/APPL	1	EX
PROCTOFOAM-HC 1 %-1 % FOAM	2	EX
Rectal Preparations		
anucort-hc 25 MG SUPP.RECT	1	EX
hydrocortisone acetate SUPP.RECT 25 MG, 30 MG	1	EX
Neoplastic Disease		
Alkylating Agents		
melphalan 2 MG TABLET	1	EX
MYLERAN 2 MG TABLET	5	EX
Antimetabolites		
capecitabine TABLET 150MG, 500MG	4	EX; PA
Pain Management - Analgesics		
Analgesic/Antipyretics, Salicylates		
choline mag trisalicylate 500MG/5ML LIQUID	1	EX

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
diflunisal 500 MG TABLET	1	EX
salsalate TABLET 500 MG, 750 MG	1	EX
Smoking Cessation		
Smoking Deterrent Agents (Ganglionic Stim,Others)		
NICOTINE GUM GUM	0	EX; QL: 9 IN 1 DAYS; AGE LIMIT >= 18 YEARS
NICOTINE LOZENGE	0	EX; QL: 9 IN 1 DAYS; AGE LIMIT >= 18 YEARS
Upper Gastrointestinal Disorders - Spastic Disease		
Belladonna Alkaloids		
ed-spaz 0.125 MG TAB RAPDIS	1	EX
hyoscyamine sulfate 0.125 MG/ML DROPS	1	EX
hyoscyamine sulfate 125MCG/5ML ELIXIR	1	EX
hyoscyamine sulfate 0.125 MG TAB RAPDIS	1	EX
hyoscyamine sulfate 0.125 MG TAB SUBL	1	EX
hyoscyamine sulfate 0.125 MG TABLET	1	EX
hyoscyamine sulfate er 0.375 MG TAB ER 12H	1	EX
hyoscyamine sulfate sr 0.375 MG TAB ER 12H	1	EX
hyosyne 125MCG/5ML ELIXIR	1	EX
hyosyne 0.125MG/ML DROPS	1	EX
oscimin 0.125 MG TABLET	1	EX
oscimin sl 0.125 MG TAB SUBL	1	EX

City of Mesa - 2025 Additional Drug Coverage		
Drug Name	**Drug Tier**	**Requirements/Limits**
oscimin sr 0.375 MG TAB ER 12H	1	EX
Upper Gastrointestinal Disorders - Ulcer Disease		
Anticholinergics,Quaternary Ammonium		
chlordiazepoxide-clidinium 5 MG-2.5MG CAPSUL*E*	1	EX
*propantheline bromide*15MG TABLET	1	EX
Urinary Tract - Functional Disorders		
Urinary Tract Anesthetic/Analgesic Agnt (Azo-Dye)		
phenazopyridine hcl TABLET 100 MG, 200 MG	1	EX
Vitamin And/Or Mineral Deficiency		
Folic Acid Preparations		
folic acid 1 MG TABLET	1	EX

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This abridged formulary was updated on 09/01/2024. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact VibrantRx Member Services at 1-844-826-3451 or, for TTY users, 711, 24 hours a day, 365 days a year or visit www.MyVibrantRx.com/mesaaz.

VibrantRx (PDP)

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www.MyVibrantRx.com/mesaaz

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