Preferred Drug List (PDL)

Lista de Medicamentos Preferidos (PDL)

New Mexico Medicaid

Effective Date/Vigencia: 7/1/18

UnitedHealthcare® Community Plan

Introduction

UnitedHealthcare Community Plan is pleased to provide this Preferred Drug List (PDL) to be used when prescribing for patients covered by the pharmacy benefit plan offered by UnitedHealthcare Community Plan. The drugs listed in this PDL are intended to provide sufficient options to treat patients who require treatment with a drug from that pharmacologic or therapeutic class. The drugs listed in the UnitedHealthcare Community Plan PDL have been reviewed and approved by the Pharmacy and Therapeutics Committee. The drugs have been selected to provide the most clinically appropriate and cost-effective medications for patients who have their drug benefit administered through UnitedHealthcare Community Plan. It is also recognized there may be occasions where an unlisted drug is desired for proper medical management of a specific patient. In those infrequent instances, the unlisted medication may be requested through the prior authorization process.

The drugs represented have been reviewed by the Pharmacy and Therapeutics (P&T) Committee and are approved for inclusion. The PDL is reflective of current medical practice as of the date of review.

This edition incorporates drugs added to the PDL since the last edition as well as numerous revisions to the prescribing information based on changes in pharmacotherapy. Comments and suggestions from practicing physicians have also been incorporated to ensure that the UnitedHealthcare Community Plan PDL is reflective of current medical practice.

Notice

The information contained in this PDL and its appendices is provided by UnitedHealthcare Community Plan, solely for the convenience of medical providers. UnitedHealthcare Community Plan does not warrant or assure accuracy of such information nor is it intended to be comprehensive in nature.

This PDL is not intended to be a substitute for the knowledge, expertise, skill and judgment of the medical provider in their choice of prescription drugs. UnitedHealthcare Community Plan assumes no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

National guidelines can be found on the Web sites listed in the Web site section or go to the National Guideline Clearinghouse site at **http://www.guideline.gov.**

Preface

The UnitedHealthcare Community Plan PDL is organized by sections. Each section includes therapeutic groups identified by either a drug class or disease state.

Products are listed by generic name. Brand names are included as a reference to assist in product recognition. Unless exceptions are noted, generally all applicable dosage forms and strengths of the drug cited are included in the PDL. Generics should be considered the first line of prescribing.

The UnitedHealthcare Community Plan PDL covers selected over-the-counter (OTC) products. You are encouraged to prescribe OTC medications when clinically appropriate.

Pharmacy and Therapeutics (P&T) Committee

The P&T Committee includes physicians and pharmacists who are not employees or agents of UnitedHealthcare Community Plan or its affiliates. They must adhere to the Ethics Policy standards of the P&T Committee. UnitedHealthcare Community Plan medical directors and pharmacists also participate in the P&T Committee. The P&T Committee meets quarterly to discuss a variety of issues. Those issues pertaining to pharmaceutical selection and pharmacy program management are communicated quarterly. This newsletter is distributed to all participating physicians who have received the PDL. PDL decisions are also communicated quarterly on the UnitedHealthcare Community Plan internet site.

Outpatient Prescription Drug Benefit-Covered Medications

Medically necessary outpatient prescription drugs are covered when prescribed by a provider licensed to prescribe federal legend drugs or medicines. Some items are covered only with prior authorization. Eligibility for Outpatient Prescription Drug Benefits is based on the individual member's benefit plan.

Product Selection Criteria

The P&T Committee considers clinical information on new-to-market drugs that are typically included in an outpatient pharmacy benefit. The evaluation includes all or part of the following:

- Safety
- Efficacy
- Comparison studies
- Approved indications
- Adverse effects
- Contraindications/Warnings/Precautions
- Pharmacokinetics
- Patient administration/compliance considerations
- Medical outcome and pharmacoeconomic studies

When a new drug is considered for PDL inclusion, it will be reviewed relative to similar drugs currently included in the UnitedHealthcare Community Plan PDL. This review process may result in deletion of drug(s) in a particular therapeutic class in an effort to continually promote the most clinically useful and cost-effective agents.

All the information in the PDL is provided as a reference for drug therapy selection. Specific drug selection for an individual patient rests solely with the prescriber.

PDL Product Descriptions

To assist in understanding which specific strengths and dosage forms are covered on the PDL, examples are noted below. The general principles shown in the examples can then usually be extended to other entries in the book. Any exceptions are noted in the drug list. There may also be a statement associated with a drug list that gives additional information about which specific products or dosage forms are covered.

Products covered include all strengths associated with the dosage form of the cited brand name product.

carvedilol Coreg

All strengths of Coreg would be covered by this listing.

Extended-release and delayed-release products require their own entry.

diltiazem sustained release Cardizem SR

Dosage forms covered will be consistent with the category and use where listed.

Neomycin/polymyxin B/ Hydrocortisone Cortisporin

As listed in the OTIC section, this is limited to the otic solution and suspension. From this entry, the ophthalmic solution and ointment, and the topical cream, cannot be assumed to be on the list unless there are entries for these products in the OPHTHALMIC and DERMATOLOGY sections of the PDL.

When a strength or dosage form is specified, only the specified strength and dosage form is on the PDL. Other strengths/dosage forms of the reference product are not.

citalopram 40mg tabs Celexa tabs

Drug Tiers

The drugs listed in the PDL have different tiers. The tiers are listed in the grid below.

Tier Name	Drug Tier
Tier 1	Generic
Tier 2	Brand

Generic Substitution

The UnitedHealthcare Community Plan PDL **requires** generic substitution on the majority of products when a generic equivalent is available.

Generic substitution is a pharmacy action whereby a generic equivalent is dispensed rather than the brand name product. The PDL indicates generic availability in the "Covered Drug" column.

If a brand name drug is medically necessary, please submit a prior authorization request.

The UnitedHealthcare Community Plan MAC list sets a ceiling price for the reimbursement of certain multisource prescription drugs. This price will typically cover the acquisition of most generics but not branded versions of the same drug. The products selected for inclusion on the MAC list are commonly prescribed and dispensed and have usually gone through the FDA's review and approval process.

An important consideration for generic substitution is the knowledge that all approvals of generic drugs by the FDA since 1984, and many generic approvals prior to 1984, have a showing of bioequivalence between the generic versions and the reference brand product. To gain FDA approval:

1. The generic drug must contain the same active ingredient(s), be the same strength and the same dosage form as the brand name product.
2. The FDA has given the generic an "A" rating compared to the branded product indicating bioequivalence, and has determined the generic is therapeutically equivalent to the reference brand. The ratings of generic drugs are available by referring to the FDA reference, Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).

When the above two criteria are met, a generic can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product. Drug products that have a narrow therapeutic index (NTI) can also be guided by these principles. It is not necessary for the health care provider to approach any one therapeutic class of drug products (e.g., NTI drugs) differently from any other class, when there has been a determination of therapeutic equivalence by the FDA for the drug products under consideration. Also, additional clinical tests or examinations by the physician are not needed when a therapeutically equivalent generic drug product is substituted for the brand name product.

There are now many brand name products that are repackaged or distributed under a generic label. The generic label version should always be considered therapeutically equivalent and substitutable for the source branded product.

Drug Efficacy Study Implementation (DESI) Drugs

Drugs first marketed between 1938 and 1962 were approved as safe but required no showing of effectiveness for FDA approval. Beginning in 1962, all new drugs were required to be both safe and effective before they could be marketed. This legislation also applied retroactively to all drugs approved as safe from 1938-1962. The DESI program was established by the FDA to review the effectiveness of these pre-1962 drugs for their labeled indications, and a determination of "fully effective" was made for most of these products and they remain in the marketplace. A few DESI products remain classified as "less than fully effective" while awaiting final administrative disposition. Also, classified as DESI are many products listed as identical, similar, or related to actual DESI products. UnitedHealthcare Community Plan's PDL does not cover DESI "less than fully effective" drug products.

Plan Exclusions

The following drug categories are excluded from coverage under the outpatient pharmacy benefit and are not part of the UnitedHealthcare

Community Plan PDL.

- DESI drugs
- Antiobesity agents
- Experimental / research drugs
- Cosmetic drugs
- Immunization agents
- Nutritional / diet supplements
- Blood and blood plasma products
- Agents used to promote fertility
- Agents used for erectile dysfunction
- Agents used for cosmetic hair growth
- Drugs from manufacturers that do not participate in the FFS Medicaid Drug Rebate Program
- Diagnostic products
- Medical supplies and DME except as listed: syringes, needles, lancets, alcohol swabs, spacers, preferred diabetes test strips, peak flow meters (Astech, Assess, Peak Air brands, max two per year), vaporizer (limit of one per three years), humidifier (limit of one per three years)

Days Supply Dispensing Limitations

UnitedHealthcare Community Plan members may receive up to a one month supply of a specific medication per prescription order or prescription refill. A medication may be reordered or refilled when ninety percent (90%) of the medication has been utilized for a controlled substance and eighty-five percent (85%) of the medication has been utilized for a non-controlled substance. If a claim is submitted before 90% of the medication has been used for a controlled substance or submitted before 85% of the medication has been used for a non-controlled substance, based on the original day supply submitted on the claim, the claim will reject with a "refill too soon" message. Please call the UnitedHealthcare Community Plan Pharmacy Department at **800-310-6826** with questions or for help with dosage change authorization.

Mandatory Generic Substitution

The UnitedHealthcare Community Plan PDL requires mandatory generic substitution on the vast majority of products when a generic equivalent is available; however, brand name drugs may be covered in certain situations by requesting a prior authorization. The UnitedHealthcare Community Plan PDL prior authorization (PA) list does not include branded items where a generic equivalent is covered.

Prior Authorization of Non-PDL Medications

The drugs in the UnitedHealthcare Community Plan PDL have been selected to provide the most clinically appropriate and cost-effective medications for patients who have their drug benefit administered through UnitedHealthcare Community Plan. It is also recognized that there may be occasions where an unlisted drug is desired for the proper medical management of a specific patient. In those infrequent instances, the prior authorization process reviews requests for unlisted medications the physician may consider medically necessary for patient management.

Requests for these exceptions should be either made in writing by the physician and faxed or called in to:

UnitedHealthcare Community Plan
Pharmacy Services Department
Fax 1-866-940-7328
Phone 1-800-310-6826

A prior authorization request form is available in the UnitedHealthcare Community Plan provider manual and should be used for all prior authorization requests if possible. Appropriate documentation must be provided to support the medical necessity of the non-PDL request. The UnitedHealthcare Pharmacy Department will respond to all requests in accordance with state requirements.

Physicians are requested to adhere to this PDL when prescribing for patients covered by their pharmacy benefit plan offered by UnitedHealthcare

Community Plan. If a pharmacist receives a prescription for a non-PDL drug, the pharmacist should contact the prescribing physician and request that the prescription be changed to a medication included in this PDL. If a PDL alternative is not appropriate, the physician should then be instructed to contact the Plan for a prior authorization.

Please contact the UnitedHealthcare Community Plan Pharmacy Prior Notification Service at **1-800-310-6826** with questions concerning the prior authorization process.

Non-PDL Drugs Five-Day Temporary Supply Overrides

To ensure the use of PDL drugs, all non-PDL drugs should be discussed with the prescribing physician. **If you cannot speak to the physician immediately, and there is an immediate need for the medication, the claim processing system will accept an override to permit a one-time dispensing of a five-day supply of the newly prescribed non-PDL drug.** The pharmacy should submit a claim for a five day supply, with a PA Type of 8 and Prior Authorization number of "00000000120". Please note that non-preferred drugs are available for a five-day supply, however, availability is subject to the benefit design. For assistance, pharmacies may call **1-800-310-6826**.

The pharmacy should contact the physician to discuss a PDL drug or if a prior authorization request is warranted. If the prescribing physician feels a drug is medically necessary, the physician may fax a request for prior authorization to UnitedHealthcare Community Plan at **1-866-940-7328**.

Quantity Limitations (QL)

Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request.

Quantity Limits Based on Efficient Medication Dosing

The Efficient Medication Dosing Program is designed to consolidate medication dosage to the most efficient daily quantity to increase adherence to therapy and also promote the efficient use of health care dollars.

The limits for the program are established based on FDA approval for dosing and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity Limits in the prescription claims processing system will limit the dispensing to consolidate dosing. The pharmacy claims processing system will prompt the pharmacist to request a new prescription order from the physician.

Additions to the QL program drug list will be made from time to time and providers notified accordingly. As always, we recognize that a number of patient-specific variables must be taken into consideration when drug therapy is prescribed and therefore overrides will be available through the medical exception (prior authorization) process. Please contact the UnitedHealthcare Community Plan Pharmacy Prior Notification Service at **1-800-310-6826** with questions.

Controlled Substances

You may fill any FOUR medications from the following classes in a 30-day period:

- benzodiazepines
- sedative hypnotic agents
- barbiturates
- select muscle relaxants

Additional fills will require prior authorization. Medications in these classes may also be subject to individual quantity limits.

Specialty Pharmaceutical Management Program

UnitedHealthcare Community Plan is continuously looking for ways to provide high-quality cost-effective care for Plan members. The Specialty

Pharmaceutical Management Program helps UnitedHealthcare Community Plan to achieve these goals. Injectable medications that are part of this program require plan authorization and are not available through the retail pharmacy network.

To obtain authorization, the provider must submit the appropriate Prior Authorization form to the UnitedHealthcare Community Plan Pharmacy Department via fax at **1-866-940-7328**.

The UnitedHealthcare Pharmacy Department will review and respond to all requests in accordance with state requirements, and if authorized for payment, UnitedHealthcare Community Plan will coordinate the delivery of the product to the member or provider.

Drugs that are part of this program and are on the PDL are identified in this booklet by the designation "SP".

Prior Authorization request forms can be requested by calling the UnitedHealthcare Community Plan Pharmacy Department at **1-800-310-6826**.

Medications Requiring Diagnosis

UnitedHealthcare Community Plan requires that the diagnosis for prescriptions in certain classes match the FDA-approved use or a use supported by current published evidence. Drugs in scope will list "Diagnosis required" in the Requirements and Limits section on the PDL.

The diagnosis will be verified at the point-of-sale by the pharmacy claims processing system. If a matching diagnosis is not found in the medical claim file or on the pharmacy drug claim, the prescription will be rejected at the pharmacy. The pharmacist may then contact the prescriber to verify the diagnosis and submit it on the claim.

If the diagnosis provided still does not match the approved use, prior authorization may be requested through the standard process by faxing a request to **1-866-940-7328**.

Step Therapy (ST)

The following PDL drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the Prior authorization process.

While lower cost PDL alternatives may be appropriate in many instances, other non-PDL alternatives are available with prior authorization (PA).

STEP Drug	First-Line Agent(s)
Amerge	Trial at a minimum dose of 50mg of sumatriptan tablets.
Aricept 23mg	90-day trial of Aricept 10mg daily.
Breo Ellipta	(1) 30 day trial of one inhaled corticosteroid (e.g. Arnuity Ellipta, Asmanex) OR (2) 30 day trial of a long-acting beta2-agonist (e.g. Arcapta, Striverdi) OR 30 day trial of an orally inhaled anticholinergic agent (e.g. Incruse Ellipta, Atrovent, Combivent, Anoro Ellipta).
calcipotriene cream & oint 0.005%	Trial of two medium to high potency topical corticosteroid treatments.
calcitriol 3mcg/gm	Trial of two topical corticosteroids.
DPP4 Inhibitors (Nesina, Kazano, Oseni)	At least a 90-day trial of 1500mg/day of metformin.
Elidel	Minimum age of 2. Trial of one topical corticosteroid.
Eucrisa	Trial of a topical corticosteroid AND one of the following: Elidel or tacrolimus ointment.

STEP Drug	First-Line Agent(s)
fenofibrate	Fill of a statin or 90 days of gemfibrozil within the previous 180 days.
GLP-1 Agonists (Tanzeum, Adlyxin, Trulicity)	At least a 90-day trial of 1500mg/day of metformin.
GLP-1/Insulin Combinations (Soliqua)	Trial of one drug from the following classes: GLP-1 or Basal Insulin.
Optivar	14 day trial of ketotifen within previous 90 days required first.
Ranexa	Trial of one drug from the following classes: beta blockers, calcium channel blockers, long acting nitrates.
Renvela	8-week trial of calcium acetate
SGLT-2 Inhibitors (Steglatro, Segluromet)	At least a 90-day trial of 1500mg/day of metformin.
tacrolimus 0.03%	Minimum age of 2. Trial of one topical corticosteroid.
tacrolimus 0.1%	Minimum age of 16. Trial of one topical corticosteroid.

STEP Drug	First-Line Agent(s)
tolterodine	30 day trial of oxybutynin immediate release. Step Therapy only applies to members less than 65 years of age.
Tretinoin Cream (Tretinoin cream 0.025%, 0.05%, 0.1%, and Avita cream 0.025%)	Trial of Differin OTC Gel 0.1%.
trospium	30 day trial of oxybutynin immediate release. Step Therapy only applies to members less than 65 years of age.
Uloric	8-week trial of up to 600mg of allopurinol required first.
Vancocin	One fill of metronidazole tabs or caps.
Xopenex Respules	30-day trial of Albuterol .083% or .5% respules.

PDL Suggestions

Providers who wish to propose PDL suggestions should forward the information to the UnitedHealthcare Community Plan Director of Pharmacy Services by either mail or fax.

Attn: Director of Pharmacy Services
UnitedHealthcare Community Plan
2 Allegheny Center
Suite 600
Pittsburgh, PA 15212
Fax: **1-866-940-7328**

Providers should furnish adequate documentation, such as clinical studies from the medical literature, in order for the request to be considered for PDL addition. This literature should include information documenting clinical necessity as well as therapeutic advantages over current PDL products. Suggestions received by UnitedHealthcare Community Plan will be reviewed by the Pharmacy and Therapeutics Committee at the subsequent P&T Committee meeting.

Editor

Your comments and suggestions regarding the UnitedHealthcare Community Plan PDL are encouraged. Your input is vital to this PDL's continued success. All responses will be reviewed and considered. Please send your comments to:

UnitedHealthcare Community Plan
2 Allegheny Center
Suite 600
Pittsburgh, PA 15212
Fax: **1-866-940-7328**

Legend

#	Only the dosage forms/strengths of the brand name products noted are on the PDL
OTC	over-the-counter
delayed-rel	delayed-release (also known as enteric coated)
EC	enteric-coated
ext-rel	extended-release (also known as sustained-release)
PA	Prior Authorization required
QL	Quantity Limits apply
ST	Step Therapy, see pages viii - ix for details
SP	Specialty Pharmaceuticals; see page vii for details

Notice

The drug names listed here are the registered and/or unregistered trademarks of third-party pharmaceutical companies unrelated to and unaffiliated with UnitedHealthcare Community Plan. These trademarked brand names are included here for informational purposes only and are not intended to imply or suggest any affiliation between UnitedHealthcare Community Plan and such third-party pharmaceutical companies.

If viewing this PDL via the Internet, please be advised that the PDL is updated periodically and changes may appear prior to their effective date to allow for notification.

Introducción

UnitedHealthcare Community Plan se complace en ofrecer esta Lista de medicamentos preferidos (Preferred Drug List, PDL) que se utilizará al realizar recetas para los pacientes que tienen cobertura del plan de beneficios de farmacia ofrecido por UnitedHealthcare Community Plan. Los medicamentos incluidos en esta PDL tienen como finalidad ofrecer opciones suficientes para tratar a los pacientes que necesitan tratamiento con un medicamento de dicha clase farmacológica o terapéutica. Los medicamentos incluidos en la PDL de UnitedHealthcare Community Plan han sido revisados y aprobados por el Comité de Farmacia y Terapéutica. Los medicamentos se han seleccionado para ofrecer los medicamentos más apropiados desde el punto de vista clínico y más asequibles para los pacientes que tienen su beneficio de medicamentos administrado a través de UnitedHealthcare Community Plan. También se reconoce que puede haber ocasiones en que un medicamento no incluido en la lista se requiere para el control médico adecuado de un paciente específico. En estas instancias poco frecuentes, los medicamentos que no estén incluidos pueden ser requeridos a través del proceso de autorización previa.

Los medicamentos representados han sido revisados por el Comité de Farmacia y Terapéutica (Pharmacy and Therapeutics, P&T) y están aprobados para su inclusión. La PDL refleja la práctica médica actual desde la fecha de la revisión.

Esta edición incorpora medicamentos agregados a la PDL desde la última edición así como numerosas revisiones para la información de prescripción basada en los cambios en la farmacoterapia. También se han incorporado comentarios y sugerencias de médicos practicantes para garantizar que la PDL de UnitedHealthcare Community Plan refleje la práctica médica actual.

Aviso

La información incluida en esta PDL y sus apéndices es provista por UnitedHealthcare Community Plan, exclusivamente para la comodidad de los proveedores médicos. UnitedHealthcare Community Plan no garantiza ni asegura la precisión de dicha información ni pretende ser integral por naturaleza.

Esta PDL no tiene la finalidad de sustituir el conocimiento, la pericia, las habilidades ni el criterio del proveedor médico en su elección de medicamentos recetados.

UnitedHealthcare Community Plan no asume ninguna responsabilidad por las acciones u omisiones de los proveedores médicos sobre la base de la confianza, total o parcial, de la información incluida aquí. El proveedor médico debe consultar la información del producto del fabricante del medicamento o las referencias estándar para obtener información detallada.

Las pautas nacionales pueden encontrarse en los sitios web que se enumeran en la sección del sitio web, o bien, visite el sitio del Centro de Intercambio de Información de Pautas Nacionales en **http://www.guideline.gov.**

Prólogo

La PDL de UnitedHealthcare Community Plan está organizada por secciones. Cada sección incluye grupos terapéuticos identificados por una clase de medicamento o estado de la enfermedad.

Los productos están enumerados por nombre genérico. Las marcas están incluidas como una referencia para ayudarlo a reconocer el producto. A menos que se incluyan excepciones, por lo general todas las formas de dosificación y concentraciones aplicables del medicamento citado están incluidas en la PDL. Los medicamentos genéricos deben ser considerados como medicamentos recetados de primera línea.

La PDL de UnitedHealthcare Community Plan cubre algunos productos de venta libre (over-the-counter, OTC). Lo alentamos a que recete medicamento OTC cuando sea clínicamente apropiado.

Comité de Farmacia y Terapéutica (P&T)

El Comité de P&T incluye médicos y farmacéuticos que no son empleados ni agentes de UnitedHealthcare Community Plan o sus afiliadas. Deben respetar los estándares de la Política sobre ética del Comité de P&T. Los directores médicos de UnitedHealthcare Community Plan y los farmacéuticos también participan en el Comité de P&T. El Comité de P&T se reúne trimestralmente para analizar diversos temas. Los temas pertinentes a la selección farmacéutica y la administración del programa de farmacia se comunican trimestralmente. Este boletín informativo se distribuye a todos los médicos participantes que hayan recibido la PDL. Las decisiones de PDL también son comunicadas trimestralmente en el sitio de Internet de UnitedHealthcare Community Plan.

Beneficio de Medicamentos Recetados Para Pacientes Ambulatorios - Medicamentos Cubiertos

Los medicamentos recetados para pacientes ambulatorios médicamente necesarios están cubiertos cuando son recetados por un proveedor autorizado para recetar medicamentos o fármacos con leyenda federales. Algunos artículos solo se cubren con autorización previa. La elegibilidad para los beneficios de medicamentos recetados para pacientes ambulatorios se basa en el plan de beneficios del miembro individual.

Criterios de Selección de Productos

El Comité de P&T considera la información clínica en los medicamentos nuevos para el mercado que por lo general se incluyen en el beneficio de farmacia para pacientes ambulatorios. La evaluación incluye todo o parte de lo siguiente:

- Seguridad
- Eficacia
- Estudios de comparación
- Indicaciones aprobadas
- Efectos adversos
- Contraindicaciones/Advertencias/ Precauciones
- Farmacocinética
- Administración de pacientes/consideraciones de cumplimiento
- Resultados médicos y estudios farmacoeconómicos

Cuando un medicamento nuevo se considera para su inclusión en la PDL, se revisará en relación a los medicamentos similares que se incluyen actualmente en la PDL de UnitedHealthcare Community Plan. Este proceso de revisión puede derivar en la supresión de medicamentos en una clase terapéutica en particular con el fin de promover continuamente los agentes más económicos y útiles desde el punto de vista clínico.

Toda la información que se incluye en la PDL se proporciona como referencia para la selección de tratamientos con medicamentos. La selección de medicamentos específicos para un paciente individual la realiza exclusivamente el profesional autorizado para recetar medicamentos.

Descripciones de los Productos Incluidos en la PDL

A fin de brindar ayuda para entender qué concentraciones específicas y formas de dosificación están cubiertas en la PDL, a continuación se incluyen ejemplos: Los principios generales que se muestran en los ejemplos generalmente luego pueden extenderse a otras entradas del libro. Las excepciones se indican en la lista de medicamentos. También puede haber una declaración relacionada con una lista de medicamentos que ofrece información adicional acerca de cuáles son los productos específicos o formas de dosificación que se cubren.

Los productos cubiertos incluyen todas las concentraciones asociadas con la forma de dosificación del producto de marca citado.

carvedilol Coreg

Todas las concentraciones de Coreg estarían cubiertas según esta lista.

Los productos de liberación prolongada y de liberación retardada requieren su propia entrada.

diltiazem de liberación Cardizem SR

Las formas de dosificación cubiertas serán consistentes con la categoría y el uso en los casos que se incluyan en la lista.

Neomicina/polimixina B/ Hidrocortisona Cortisporin

Según lo enumerado en la sección de productos ÓTICOS, se limita a la solución y suspensión ótica. En esta entrada, no puede suponerse que la solución oftálmica, el ungüento y la crema tópica estén incluidos en la lista a menos que existan entradas para estos productos en las secciones de productos OFTÁLMICOS y DERMATOLÓGICOS de la PDL.

En los casos en que se especifique la concentración y la forma de dosificación, solo la concentración especificada y la forma de dosificación se encuentran incluidas en la PDL. Otras concentraciones o formas de dosificación del producto de referencia no son.

los comprimidos de citalopram 40 mg Celexa tabs

Niveles de drogas

Los medicamentos enumerados en la PDL tienen niveles diferentes. Los niveles se enumeran en la tabla a continuación.

Nombre del nivel	Nivel del medicamento
Nivel 1	Genérico
Nivel 2	De marca

Sustitución por Genéricos

La PDL de UnitedHealthcare Community Plan **requiere** la sustitución por genéricos en la mayoría de los productos cuando se encuentra disponible un equivalente del medicamento genérico.

La sustitución por genéricos es una medida que toma la farmacia en los casos en que un equivalente de genérico se dispense en lugar del producto de marca. El PDL indica la disponibilidad de genéricos en la columna de “Medicamentos cubiertos”.

Si un medicamento de marca es médicamente necesario, por favor envíe una solicitud de autorización previa.

La lista del Consejo de Apelaciones de Medicare (Medicare Appeals Council, MAC) de UnitedHealthcare Community Plan establece un precio máximo para el reembolso de ciertos medicamentos recetados de múltiples fuentes. Este precio por lo general cubrirá la adquisición de la mayoría de los medicamentos genéricos pero no las versiones de marca del mismo medicamento. Los productos seleccionados para su inclusión en la lista del MAC son recetados y dispensados comúnmente, y por lo general han pasado por el proceso de revisión y aprobación de la Administración de Alimentos y Medicamentos (FDA).

Una consideración importante para la sustitución por genéricos es el conocimiento de que todas las aprobaciones de medicamentos genéricos por parte de la FDA desde el año 1984, y muchas aprobaciones de medicamentos genéricos antes de este año, demuestran una equivalencia biológica entre las versiones genéricas y el producto de marca de referencia. Para obtener la aprobación de la FDA:

1. El medicamento genérico debe incluir los mismos ingredientes activos y tener la misma concentración y forma de dosificación que el producto de marca.
2. La FDA ha otorgado a los medicamentos genéricos la calificación "A" en comparación con los productos de marca que indican la equivalencia biológica; además, ha determinado que, desde el punto de vista terapéutico, el medicamento genérico es equivalente al medicamento de marca. Las calificaciones de los medicamentos genéricos están disponibles al consultar la referencia de la FDA, Productos farmacéuticos aprobados con evaluaciones de equivalencia terapéutica (Libro naranja)

En los casos en que se cumpla con los dos criterios mencionados, un medicamento genérico puede sustituirse con la total expectativa de que el producto sustituido producirá el mismo efecto clínico y tendrá el mismo perfil de seguridad que el producto recetado. Los productos farmacéuticos que tengan un índice terapéutico estrecho (NTI) también pueden ser guiados por estos principios. No es necesario que el proveedor de atención médica se aproxime a cualquier clase terapéutica de los productos farmacéuticos (por ejemplo, medicamentos con NTI) de forma diferente a la de cualquier otra clase, cuando la FDA ha determinado la equivalencia terapéutica de los productos farmacéuticos en cuestión. Además, no es necesario que los médicos realicen pruebas clínicas o exámenes adicionales cuando un producto farmacológico genérico equivalente desde el punto de vista terapéutico se sustituye por el producto de marca.

Actualmente, hay muchos productos de marca que cuentan con un envase nuevo o son distribuidos con etiquetas de medicamento genérico. La versión con etiqueta de medicamento genérico siempre debe considerarse como un equivalente desde el punto de vista terapéutico y sustituible por el producto de marca original.

Medicamentos del Programa Implementación del Estudio Sobre Eficacia de Medicamentos (DESI)

Los medicamentos que se comercializaron por primera vez entre 1938 y 1962 fueron aprobados por ser seguros pero no requerían demostración de eficacia para la aprobación de la FDA. A partir de 1962, todos los medicamentos nuevos debían ser seguros y eficaces antes de que pudieran ser comercializados. Esta legislación también se aplicó de forma retroactiva a todos los medicamentos aprobados por su seguridad entre los años 1938 y 1962. El programa DESI fue establecido por la FDA para revisar la eficacia de estos medicamentos anteriores a 1962 para las indicaciones de sus etiquetas, y se realizó una determinación de eficacia total para la mayoría de estos productos, y permanecen en el mercado. Unos pocos productos del programa DESI permanecen clasificados como "menos que totalmente eficaces" mientras se espera la disposición administrativa final. Además, muchos productos incluidos como idénticos, similares o relacionados con los productos verdaderos del programa DESI están clasificados como DESI. La PDL de UnitedHealthcare Community Plan no cubre los productos farmacéuticos "menos que totalmente eficaces" de DESI.

Exclusiones del Plan

Las siguientes categorías de medicamentos están excluidas de la cobertura conforme al beneficio de farmacia para pacientes ambulatorios y no son parte de la PDL de UnitedHealthcare Community Plan.

- Medicamentos del programa DESI
- Agentes contra la obesidad
- Medicamentos experimentales o en investigación
- Medicamentos usados para fines cosméticos

- Agentes de vacunación
- Suplementos nutricionales/dietéticos
- Productos de sangre o plasma sanguíneo
- Medicamentos usados para promover la fertilidad
- Agentes usados para la disfunción eréctil
- Agentes usados con fines cosméticos para el crecimiento del cabello
- Medicamentos de fabricantes que no participan en el Programa de descuentos en medicamentos de Medicaid de FFS
- Productos de diagnóstico
- Suministros médicos y equipo médico duradero (durable medical equipment, DME) excepto según se menciona: jeringas, agujas, lancetas, toallitas con alcohol, espaciadores, tiras reactivas para medir la glucosa, medidores de flujo máximo (marcas Astech, Assess, Peak Air, máx. dos por año), vaporizador (límite de 1 por cada 3 años), humidificador (límite de 1 por cada 3 años)

Limitaciones en la Provisión de Suministros de Días

Los miembros de UnitedHealthcare Community Plan pueden recibir hasta un suministro de un mes de un medicamento específico por pedido de receta o resurtido de un medicamento recetado. Un medicamento puede volver a pedirse o reponerse cuando se ha utilizado el noventa por ciento (90%) para una sustancia controlada y el ochenta y cinco por ciento (85%) para una sustancia no controlada. Si se presenta una reclamación antes de haberse utilizado el noventa por ciento (90%) para una sustancia controlada u ochenta y cinco por ciento (85%) para una sustancia no controlada, según los días de suministro original presentado en la reclamación, esta será rechazada con un mensaje de "demasiado pronto para una recarga". Por favor llame al Departamento de Farmacias de UnitedHealthcare Community Plan al **800-310-6826** si tiene preguntas o necesita ayuda con una autorización para cambiar la dosis.

Sustitución por Genéricos Obligatoria

La PDL de UnitedHealthcare Community Plan PDL requiere de la sustitución por genéricos obligatoria en gran parte de los productos cuando se encuentra disponible un equivalente genérico; no obstante, los medicamentos de marca pueden estar cubiertos en determinadas situaciones al solicitar una autorización previa. La lista de autorización previa (PA) de la PDL de UnitedHealthcare Community Plan no incluye artículos de marca en los casos en que el equivalente genérico está cubierto.

Autorización Previa de Medicamentos No Incluidos en la PDL

Los medicamentos incluidos en la PDL de UnitedHealthcare Community Plan PDL han sido seleccionados para ofrecer los medicamentos más apropiados desde el punto de vista clínico y más asequibles para los pacientes que tienen su beneficio de medicamentos administrado a través de UnitedHealthcare Community Plan. También se reconoce que puede haber ocasiones en que un medicamento no incluido en la lista se requiere para el control médico adecuado de un paciente específico. En estos casos poco frecuentes, el proceso de autorización previa revisa las solicitudes para los medicamentos no incluidos en la lista que el médico puede considerar médicamente necesario para el control del paciente.

El médico debe realizar las solicitudes de estas excepciones por escrito y enviarlas por fax, o bien, debe llamar a:

UnitedHealthcare Community Plan
Pharmacy Services Department
Fax 1-866-940-7328
Teléfono 1-800-310-6826

En el manual de proveedores de UnitedHealthcare Community Plan se encuentra disponible un formulario de solicitud de autorización previa y, si es posible, debe utilizarse para todas las solicitudes de autorización previa. La documentación correspondiente debe proporcionarse para respaldar la necesidad médica de la solicitud de

medicamentos no incluidos en la PDL. El Servicio de Farmacia de UnitedHealthcare responderá a todas las solicitudes de acuerdo con los requisitos del estado.

Los médicos deben respetar esta PDL al realizar recetas para los pacientes que tienen cobertura mediante su plan de beneficios de farmacia ofrecido por UnitedHealthcare Community Plan. Si un farmacéutico recibe una receta para un medicamento que no está incluido en la PDL, debe comunicarse con el médico que realizó la receta y solicitarle que cambie el medicamento por uno que esté incluido en la PDL. Si una alternativa de la PDL no es adecuada, debe indicarse al médico que se comunique con el plan para solicitar una autorización previa.

Comuníquese con el Servicio de Notificación Previa de Farmacia de UnitedHealthcare Community Plan al **1-800-310-6826** si tiene preguntas relacionadas con el proceso de autorización previa.

Sustituciones de Suministros Temporales de 5 Días de Medicamentos Que No Están Incluidos en la PDL

Para garantizar el uso de medicamentos incluidos en la PDL, debe consultar al médico que realiza la receta acerca de todos los medicamentos que no están incluidos en la PDL. **Si no puede hablar con el médico de inmediato y necesita el medicamento de forma urgente, el sistema de procesamiento de reclamaciones aceptará una sustitución para permitir una provisión por única vez de un suministro de 5 días del medicamento recientemente recetado que no está incluido en la PDL.** La farmacia debe enviar una reclamación para un suministro de 5 días, con el tipo 8 de PA y el número de autorización previa “00000000120”. Tenga en cuenta que los medicamentos no preferidos están disponibles para un suministro de 5 días, no obstante, la disponibilidad está sujeta al esquema de beneficios. Para obtener ayuda, las farmacias pueden llamar al **1-800-310-6826**.

La farmacia debe comunicarse con el médico para analizar el medicamento de la PDL o si se justifica la solicitud de una autorización previa. Si el médico que realiza la receta considera que un medicamento es médicamente necesario, el médico puede enviar por fax una solicitud de autorización previa a UnitedHealthcare Community Plan al **1-866-940-7328**.

Limitaciones de Cantidad (QL)

Las recetas para cantidades mensuales que superen el límite indicado requieren de una solicitud de autorización previa.

Límites de cantidad basados en la dosificación de medicamentos eficaces

El Programa de dosificación de medicamentos eficaces está diseñado para consolidar la dosificación del medicamento a la cantidad diaria más eficaz, para aumentar el seguimiento del tratamiento y también promover el uso eficaz del dinero invertido en la atención médica.

Los límites del programa se establecen conforme a la aprobación de la FDA en cuanto a la dosificación y la disponibilidad de la dosis diaria total con la menor cantidad de comprimidos o cápsulas diarias. Los límites de cantidad en el sistema de procesamiento de reclamaciones de recetas limitará la provisión para consolidar la dosificación. El sistema de procesamiento de reclamaciones de farmacia indicará al farmacéutico que solicite un nuevo pedido de receta del médico.

Las adiciones a la lista de medicamentos del programa de nivel de cantidad (QL) se realizarán de vez en cuando y se notificará a los proveedores al

respecto. Como siempre, reconocemos que deben tenerse en cuenta diversas variables específicas del paciente cuando se indica un tratamiento con medicamentos y, por consiguiente, las sustituciones estarán disponibles a través del proceso de excepción médica (PA). Comuníquese con el Servicio de Notificación Previa de Farmacia de UnitedHealthcare Community Plan al **1-800-310-6826** si tiene preguntas.

Sustancias controladas

Puede surtirse con cualquiera de los CUATRO medicamentos de las siguientes clases en un período de 30 días:

- benzodiazepinas
- agentes sedantes hipnóticos
- barbitúricos
- algunos relajantes musculares.

Los surtidos adicionales requieren de autorización previa. Los medicamentos de estas clases también pueden estar sujetos a los límites de cantidad individuales.

Programa de administración de productos farmacéuticos especiales

UnitedHealthcare Community Plan busca continuamente formas de ofrecer una atención asequible de alta calidad para los miembros del plan. El Programa de administración de productos farmacéuticos especiales ayuda a UnitedHealthcare Community Plan a lograr estos objetivos. Los medicamentos inyectables que forman parte de este programa requieren de la autorización del plan y no están disponibles a través de la red de farmacias minoristas.

Para obtener la autorización, el proveedor debe enviar por fax el formulario de autorización previa correspondiente al Departamento de Farmacia de UnitedHealthcare Community Plan al **1-866-940-7328**.

El Servicio de Farmacia de UnitedHealthcare revisará y responderá a todas las solicitudes de acuerdo con los requisitos del estado, y si se autoriza el pago, UnitedHealthcare Community Plan coordinará la entrega del producto al miembro o proveedor.

Los medicamentos que forman parte de este programa y están incluidos en la PDL están identificados en este folleto mediante la designación “SP”.

Los formularios de solicitud de autorización previa pueden solicitarse llamando al Departamento de Farmacia de UnitedHealthcare Community Plan al **1-800-310-6826**.

Medicamentos que requieren de un diagnóstico

UnitedHealthcare requiere que el diagnóstico de recetas en ciertas clases corresponda al uso aprobado por la FDA o que su uso esté respaldado por evidencias publicadas recientemente. Los fármacos en el alcance enumerarán “Diagnóstico requerido” en la sección Requisitos y límites de la PDL.

Este diagnóstico será verificado en el momento de la venta por el sistema de la farmacia que procesa las solicitudes de venta. Si no se encuentra una correspondencia en el expediente de la solicitud médica o en las solicitudes del medicamento previamente hechas a la farmacia, la receta será rechazada por la farmacia. El farmacéutico pue de después ponerse en contacto con la persona que prescribió ese medicamento para verificar el diagnóstico y aplicarlo a la solicitud.

Si el diagnóstico que se provee aún no corresponde al uso apropiado para el medicamento, se puede solicitar una aprobación previa a través del proceso estándar, enviando una solicitud por fax al número **1-866-940-7328**.

Terapia Escalonada (Step Therapy, ST)

Los siguientes medicamentos de la PDL se cubren rutinariamente solo después de un estudio suficiente de un agente de primera línea indicado que se haya estudiado adecuadamente y se haya desaprobado. Estos medicamentos también pueden solicitarse a través del proceso de autorización previa.

Si bien las alternativas de menor costo que se incluyen en la PDL pueden ser apropiadas en muchos casos, otras alternativas que no se incluyen en la PDL se encuentran disponibles con autorización previa (prior authorization, PA).

Medicamento para TERAPIA ESCALONADA	Agentes de primera línea
Amerge	Estudio con dosis mínima de 50 mg de comprimidos de sumatriptán.
Aricept 23mg	Estudio de 90 días de Aricept de 10 mg diario
Breo Ellipta	(1) Estudio de 30 días de un corticosteroide inhalado (por ejemplo, Arnuity Ellipta, Asmanex) O (2) Estudio de 30 días de un agonista beta2 de acción prolongada (por ejemplo, Arcapta, Striverdi) O estudio de 30 días de un agente anticolinérgico inhalado por vía oral (por ejemplo, Incruse Ellipta, Atrovent, Combivent, Anoro Ellipta).
calcipotriene crema y ungüento 0.005%	Estudio de dos tratamientos con corticosteroides tópicos de potencia media a alta.
calcitriol 3mcg/gm	Estudio de dos corticosteroides tópicos.
Inhibidores de DPP4 (Nesina, Kazano, Oseni)	Estudio de al menos 90 días de 1500 mg/día de metformina.
Elidel	Edad mínima de 2 años. Prueba de un corticosteroide tópico.
Eucrisa	Estudio de un corticosteroide tópico Y uno de los siguientes: Elidel o ungüento de tacrolimus.
fenofibrato	Surtido de una estatina o 90 días de Gemfibrozil dentro de los 180 días previos.
Agonistas GLP-1 (Tanzeum, Adlyxin, Trulicity)	Estudio de por lo menos 90 días de 1500mg/día de metformina.
GLP-1/ Combinaciones de insulina (Soliqua)	Estudio de un medicamento de las siguientes categorías: GLP-1 o insulina basal.
Optivar	Requiere primero un estudio de 14 días de ketotifeno dentro de los 90 días previos.

Medicamento para TERAPIA ESCALONADA	Agentes de primera línea
Ranexa	Estudio de un medicamento de las siguientes categorías: bloqueadores beta, antagonistas del calcio, nitratos de acción prolongada.
Renvela	Estudio de 8 semanas de acetato de calcio.
Inhibidores SGLT-2 (Steglatro, Segluromet)	Estudio de por lo menos 90 días de 1500mg/día de metformina.
tacrolimus 0.03%	Edad mínima de 2 años. Prueba de un corticosteroide tópico.
tacrolimus 0.1%	Edad mínima de 16 años. Prueba de un corticosteroide tópico.
tolterodine	Estudio de 30 días de oxibutinina de liberación inmediata. La terapia escalonada solo se aplica a los miembros menores de 65 años.
Tretinoin Cream (crema Tretinoin 0.025%, 0.05%, 0.1%, y crema Avita 0.025%)	Estudio de Differin Gel 0.1% de venta libre.
trospium	Estudio de 30 días de oxibutinin liberación inmediata. La terapia escalonada solamente se aplica a los miembros menores de 65 años de edad.

Medicamento para TERAPIA ESCALONADA	Agentes de primera línea
Uloric	Primero se requiere un estudio de 8 semanas de hasta 600 mg de alopurinol.
Vancocin	Un surtido de comprimidos o cápsulas de metronidazol.
Xopenex Respules	Estudio de 30 días de Albuterol 0.83% o 0.5% de Respules.

Sugerencias Sobre la PDL

Los proveedores que deseen hacer sugerencias sobre la PDL deben enviar la información por correo o fax al Director de Servicios de Farmacia de UnitedHealthcare Community Plan.

Attn: Director of Pharmacy Services
UnitedHealthcare Community Plan
2 Allegheny Center
Suite 600
Pittsburgh, PA 15212
Fax: **1-866-940-7328**

Los proveedores deben proporcionar la documentación adecuada, como los estudios clínicos de la literatura médica, para que la solicitud sea considerada para la inclusión en la PDL. Esta literatura debe incluir información que documente la necesidad clínica así como las ventajas terapéuticas por sobre los productos actuales incluidos en la PDL. Las sugerencias recibidas por UnitedHealthcare Community Plan serán revisadas por el Comité de Farmacia y Terapéutica en la reunión subsiguiente del comité.

Editor

Se alienta a que realice sus comentarios y sugerencias relacionados con la PDL de UnitedHealthcare Community Plan. Su comentario es muy importante para el éxito continuo de la PDL. Todas las respuestas serán revisadas y tomadas en cuenta. Envíe sus comentarios a:

UnitedHealthcare Community Plan
2 Allegheny Center
Suite 600
Pittsburgh, PA 15212
Fax: **1-866-940-7328**

Leyenda

#	Solo las concentraciones o formas de dosificación de los productos de marca indicados están incluidas en la PDL.
OTC	de venta libre
delayed-rel	liberación ret liberación retardada (también conocido como recubrimiento entérico)
EC	recubrimiento entérico
ext-rel	liberación prolongada (también conocida como liberación sostenida)
PA	Autorización previa requerida
QL	Se aplican límites de cantidad
ST	Terapia escalonada, ver páginas xviii - xx para obtener detalles
SP	Productos farmacéuticos especiales, ver página xvii para obtener detalles

Aviso

La información incluida en este documento es privada. La información no puede ser copiada total o parcialmente sin el permiso escrito de UnitedHealthcare Community Plan. Todos los derechos reservados.

Los nombres de los medicamentos incluidos aquí son marcas comerciales registradas y no registradas de compañías farmacéuticas de terceros no relacionadas ni afiliadas a UnitedHealthcare Community Plan. Estas marcas comerciales registradas se incluyen aquí con fines informativos solamente y no tienen la finalidad de denotar ni sugerir afiliación entre Evercare y dichas compañías farmacéuticas de terceros.

Si ve esta PDL por Internet, tenga en cuenta que la misma se actualiza periódicamente y es posible que se incluyan cambios antes de la fecha de vigencia para permitir su notificación.

Table of Contents

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Antineoplastics & Immunosuppressants				
Antineoplastic Agents				
Alkylating Agents				
altretamine	HEXALEN	brand	2	
busulfan	MYLERAN	brand	2	
chlorambucil	LEUKERAN	brand	2	
cyclophosphamide	CYTOXAN	generic	1	
estramustine phosphate sodium	EMCYT	brand	2	
lomustine	GLEOSTINE	brand	2	
melphalan	ALKERAN	brand	2	
temozolomide	TEMODAR	generic	1	PA, SP
Antimetabolites				
capecitabine	XELODA	generic	1	SP
mercaptopurine	PURINETHOL	generic	1	
thioguanine	TABLOID	brand	2	QL
trifluridine/tipiracil	LONSURF	brand	2	PA, SP
Histone Deacetylase Inhibitors				
panobinostat	FARYDAK	brand	2	PA, SP
vorinostat	ZOLINZA	brand	2	PA, SP
Kinase Inhibitor				
abemaciclib	VERZENIO	brand	2	PA, SP
acalabrutinib	CALQUENCE	brand	2	PA, SP
afatinib	GILOTRIF	brand	2	PA, SP
alectinib	ALECENSA	brand	2	PA, SP
axitinib	INLYTA	brand	2	PA, SP
bosutinib	BOSULIF	brand	2	PA, SP
brigatinib	ALUNBRIG	brand	2	PA, SP
cabozantinib	COMETRIQ CABOMETYX	brand	2	PA, SP
ceritinib	ZYKADIA	brand	2	PA, SP
cobimetinib	COTELLIC	brand	2	PA, SP
crizotinib	XALKORI	brand	2	PA, SP
dabrafenib	TAFINLAR	brand	2	PA, SP
dasatinib	SPRYCEL	brand	2	PA, SP
erlotinib	TARCEVA	brand	2	PA, SP
everolimus	AFINITOR AFINITOR DISPERZ	brand	2	PA, SP

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
gefitinib	IRESSA	brand	2	PA, SP
ibrutinib	IMBRUVICA	brand	2	PA, SP
idelalisib	ZYDELIG	brand	2	PA, SP
imatinib mesylate	GLEEVEC	generic	1	PA, QL, SP
lapatinib ditosylate	TYKERB	brand	2	PA, SP
lenvatinib	LENVIMA	brand	2	PA, SP
midostaurin	RYDAPT	brand	2	PA, SP
nilotinib	TASIGNA	brand	2	PA, SP
palbociclib	IBRANCE	brand	2	PA, SP
pazopanib	VOTRIENT	brand	2	PA, SP
ponatinib	ICLUSIG	brand	2	PA, SP
regorafenib	STIVARGA	brand	2	PA, SP
ruxolitinib	JAKAFI	brand	2	PA, SP
sorafenib	NEXAVAR	brand	2	PA, SP
sunitinib	SUTENT	brand	2	PA, SP
trametinib	MEKINIST	brand	2	PA, SP
vandetanib	CAPRELSA	brand	2	PA, SP
vemurafenib	ZELBORAF	brand	2	PA, SP
Miscellaneous				
leucovorin	LEUCOVOR CA INJ	brand	2	
leucovorin	LEUCOVORIN	generic	1	QL, tabs
mesna	MESNEX	brand	2	SP, tablets
venetoclax	VENCLEXTA	brand	2	PA, SP
Proteasome Inhibitors				
ixazomib	NINLARO	brand	2	PA, SP
Hormonal Antineoplastic Agents				
Androgen Biosynthesis Inhibitors				
abiraterone	ZYTIGA	brand	2	PA, SP
Antiandrogens				
bicalutamide	CASODEX	generic	1	
flutamide	EULEXIN	generic	1	
Antiestrogens				
tamoxifen	NOLVADEX	generic	1	
toremifene	FARESTON	brand	2	
Aromatase Inhibitors				
anastrozole	ARIMIDEX	generic	1	
exemestane	AROMASIN	generic	1	
letrozole	FEMARA	generic	1	

OTC = Over the Counter
PA = Prior Authorization required
QL = Quantity Limit
ST = Step Therapy
SP = Specialty Pharmacy

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Gonadotropin Releasing Hormone Analog				
leuprolide	LUPRON	generic	1	PA, SP
leuprolide	LUPRON DEPOT LUPRON DEPOT 6-MONTH LUPRON DEPOT-PED	brand	2	PA, SP
Progestin				
megestrol acetate	MEGACE	generic	1	
Immunomodulators				
Interferons				
interferon alfa-2b	INTRON A	brand	2	PA, SP
interferon gamma-1b	ACTIMMUNE	brand	2	PA, SP
peginterferon alfa-2b	SYLATRON	brand	2	PA, SP
Miscellaneous				
lenalidomide	REVLIMID	brand	2	PA, SP
pomalidomide	POMALYST	brand	2	PA, SP
thalidomide	THALOMID	brand	2	PA, SP, QL
Immunosuppressants				
Antimetabolites				
azathioprine	IMURAN	generic	1	
mycophenolate mofetil	CELLCEPT	generic	1	
mycophenolate sodium	MYFORTIC	generic	1	
Calcineurin Inhibitors				
cyclosporine	SANDIMMUNE	generic	1	
cyclosporine, modified	GENGRAF NEORAL	generic	1	caps, QL
tacrolimus	HECORIA PROGRAF	generic	1	
Rapamycin Derivative				
sirolimus	RAPAMUNE	generic	1	tabs
sirolimus	RAPAMUNE	brand	2	soln
Other				
everolimus	ZORTRESS	brand	2	
Miscellaneous				
alitretinoin 1% gel	PANRETIN	brand	2	PA
bexarotene caps and topical gel	TARGRETIN	brand	2	PA, SP
cysteamine bitartrate	CYSTAGON	brand	2	SP
etoposide	VEPESID	generic	1	
hydroxyurea	DROXIA	brand	2	

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
hydroxyurea	HYDREA	generic	1	
mitotane	LYSODREN	brand	2	
niraparib	ZEJULA	brand	2	PA, SP
octreotide	SANDOSTATIN	generic	1	SP
olaparib	LYNPARZA	brand	2	PA, SP
pasireotide	SIGNIFOR	brand	2	PA, SP
procarbazine	MATULANE	brand	2	SP
rucaparib	RUBRACA	brand	2	PA, SP
sonidegib	ODOMZO	brand	2	PA, SP
topotecan	HYCAMTIN	brand	2	PA, SP
tretinoin	VESANOID	generic	1	caps, SP
vismodegib	ERIVEDGE	brand	2	PA, SP
Blood Modifiers - Anticoagulants				
Anticoagulants				
apixaban	ELIQUIS	brand	2	QL
betrixaban	BEVYXXA	brand	2	QL
edoxaban	SAVAYSA	brand	2	QL
enoxaparin	LOVENOX	generic	1	QL
heparin	HEPARIN	generic	1	INJ 5000 UNIT/ML, PF INJ 5000 UNIT/0.5ML, INJ 10000 UNIT/ML
rivaroxaban	XARELTO	brand	2	QL
warfarin	COUMADIN	generic	1	
Blood Cell Formation				
darbepoetin alfa	ARANESP	brand	2	PA, SP
epoetin alfa	EPOGEN PROCRIT	brand	2	PA, SP
filgrastim	ZARXIO	brand	2	PA, SP
oprelvekin	NEUMEGA	brand	2	PA, SP
pegfilgrastim	NEULASTA	brand	2	PA, SP
plerixafor	MOZOBIL	brand	2	PA, SP
sargramostim	LEUKINE	brand	2	PA, SP
Platelet Inhibitors				
anagrelide	AGRYLIN	generic	1	
cilostazol	PLETAL	generic	1	
clopidogrel	PLAVIX	generic	1	QL
dipyridamole	PERSANTINE	generic	1	
prasugrel	EFFIENT	generic	1	Diagnosis Required, QL
ticagrelor	BRILINTA	brand	2	Diagnosis Required, QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Miscellaneous				
aminocaproic acid	AMICAR	brand	2	
deferasirox	EXJADE JADENU	brand	2	PA, SP
emicizumab-kxwh	HEMLIBRA	brand	2	PA, SP
pentoxifylline extended-release	TRENTAL	generic	1	
Cardiovascular Agents				
Ace Inhibitors				
benazepril	LOTENSIN	generic	1	
captopril	CAPOTEN	generic	1	
enalapril	VASOTEC	generic	1	
enalapril oral soln	EPANED	brand	2	Members ≥ 8 years of age will require prior authorization.
fosinopril	MONOPRIL	generic	1	QL
lisinopril	ZESTRIL	generic	1	QL
quinapril	ACCUPRIL	generic	1	QL
ramipril	ALTACE	generic	1	
trandolapril	MAVIK	generic	1	
Ace Inhibitor/Diuretic Combinations				
benazepril/ hydrochlorothiazide	LOTENSIN HCT	generic	1	
captopril/ hydrochlorothiazide	CAPOZIDE	generic	1	
enalapril/ hydrochlorothiazide	VASERETIC	generic	1	
fosinopril/ hydrochlorothiazide	MONOPRIL-HCT	generic	1	QL
lisinopril/ hydrochlorothiazide	ZESTORETIC	generic	1	QL
quinapril/ hydrochlorothiazide	ACCURETIC	generic	1	QL
Adrenolytics, Central				
clonidine	CATAPRES	generic	1	tablets
guanfacine	TENEX	generic	1	

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Alpha Blockers				
doxazosin	CARDURA	generic	1	
prazosin	MINIPRESS	generic	1	
terazosin	HYTRIN	generic	1	
Angiotensin II Receptor Blockers (Antagonists)				
losartan	COZAAR	generic	1	QL
Angiotensin II Receptor Blocker Combinations				
losartan/HCTZ	HYZAAR	generic	1	QL
sacubitril/valsartan	ENTRESTO	brand	2	PA, QL
Antiarrhythmics and Cardiac Glycosides				
amiodarone tabs	CORDARONE	generic	1	200 mg and 400 mg
digoxin	LANOXIN	generic	1	
disopyramide	NORPACE	generic	1	
disopyramide extended-release	NORPACE CR	brand	2	
dofetilide	TIKOSYN	generic	1	
flecainide	TAMBOCOR	generic	1	
mexiletine	MEXITIL	generic	1	
propafenone	RYTHMOL	generic	1	IR only
quinidine gluconate extended-release	QUINIDINE GLUCONATE EXT-REL	generic	1	
quinidine sulfate	QUINIDINE SULFATE	generic	1	
quinidine sulfate extended-release	QUINIDINE SULFATE EXT-REL	generic	1	
Beta Blockers and Beta Blocker/Diuretic Combinations				
acebutolol	SECTRAL	generic	1	QL
atenolol	TENORMIN	generic	1	
atenolol/chlorthalidone	TENORETIC	generic	1	
betaxolol	KERLONE	generic	1	
bisoprolol	ZEBETA	generic	1	
bisoprolol/ hydrochlorothiazide	ZIAC	generic	1	
carvedilol	COREG	generic	1	QL
labetalol	TRANDATE	generic	1	
metoprolol	LOPRESSOR	generic	1	25, 50, 100mg tablets
metoprolol succinate	TOPROL XL	generic	1	
propranolol	INDERAL	generic	1	IR only
propranolol ER 24HR	INDERAL LA	generic	1	Diagnosis Required, QL
propranolol/HCTZ	INDERIDE	generic	1	
sotalol	BETAPACE	generic	1	
sotalol AF	BETAPACE AF	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Calcium Channel Blockers				
Dihydropyridines				
amlodipine	NORVASC	generic	1	QL
felodipine extended-release	PLENDIL	generic	1	QL
nicardipine	CARDENE	generic	1	
nifedipine	PROCARDIA	generic	1	
nifedipine extended-release	ADALAT CC PROCARDIA XL	generic	1	QL
nimodipine	NIMOTOP	generic	1	QL
nimodipine oral soln	NYMALIZE	brand	2	
Nondihydropyridines				
diltiazem	CARDIZEM	generic	1	
diltiazem extended-release	CARDIZEM CD	generic	1	QL
diltiazem extended-release	DILACOR XR TIAZAC	generic	1	QL
diltiazem sustained-release	CARDIZEM SR	generic	1	QL
verapamil	CALAN	generic	1	
verapamil extended-release	CALAN SR	generic	1	QL
Diuretics				
amiloride	MIDAMOR	generic	1	
amiloride/ hydrochlorothiazide	MODURETIC	generic	1	
bumetanide	BUMEX	generic	1	
chlorothiazide	DIURIL	generic	1	
chlorothiazide	DIURIL ORAL SUSPENSION	brand	2	QL
chlorthalidone	CHLORTHALIDONE	generic	1	
furosemide	LASIX	generic	1	
hydrochlorothiazide	HYDROCHLOROTHIAZIDE	generic	1	soln, tabs
hydrochlorothiazide	MICROZIDE	generic	1	12.5 mg caps
indapamide	LOZOL	generic	1	
metolazone	ZAROXOLYN	generic	1	
spironolactone	ALDACTONE	generic	1	
spironolactone/ hydrochlorothiazide	ALDACTAZIDE	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
torsemide	DEMADEX	generic	1	
triamterene/ hydrochlorothiazide	DYAZIDE MAXZIDE	generic	1	
Lipid Lowering Agents				
Bile Acid Resin				
cholestyramine	QUESTRAN QUESTRAN-LIGHT	generic	1	Only the bulk products are covered (cans). Individual packets are not covered.
Fibrates				
fenofibrate	LOFIBRA	generic	1	ST
gemfibrozil	LOPID	generic	1	
HMG-CoA Reductase Inhibitors and Combinations				
atorvastatin	LIPITOR	generic	1	
lovastatin	MEVACOR	generic	1	QL
simvastatin	ZOCOR	generic	1	QL
Niacins				
niacin	NIACOR	generic	1	
niacin extended-release	NIASPAN	generic	1	
Miscellaneous				
alirocumab	PRALUENT	brand	2	PA, QL, SP
ezetimibe	ZETIA	generic	1	PA
omega 3 acid ethyl esters	LOVAZA	generic	1	PA
Nitrates				
Oral				
isosorbide dinitrate	ISORDIL	generic	1	
isosorbide dinitrate extended-release	ISOSORBIDE DINITRATE ER	generic	1	
isosorbide mononitrate	ISMO	generic	1	
isosorbide mononitrate extended-release	IMDUR	generic	1	
Sublingual				
isosorbide dinitrate	ISORDIL S.L.	generic	1	
nitroglycerin	NITROLINGUAL	generic	1	
nitroglycerin	NITROSTAT	generic	1	
Transdermal				
nitroglycerin	NITREK NITRO-DUR	generic	1	transdermal, QL
nitroglycerin	NITRO-BID	generic	1	oint

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Potassium-Removing Agents				
patiromer	VELTASSA	brand	2	PA
sodium polystyrene sulfonate	KAYEXALATE	generic	1	susp only
Pulmonary Arterial Hypertension				
ambrisentan	LETAIRIS	brand	2	Diagnosis Required, SP
bosentan	TRACLEER	brand	2	Diagnosis Required, SP
macitentan	OPSUMIT	brand	2	Diagnosis Required, SP
riociguat	ADEMPAS	brand	2	Diagnosis Required, SP
sildenafil	REVATIO	generic	1	Diagnosis Required, SP, tablets
sildenafil	REVATIO SUSPENSION	brand	2	Diagnosis Required, SP, suspension
Miscellaneous				
guanabenz	WYTENSIN	generic	1	
hydralazine	APRESOLINE	generic	1	
methyldopa	ALDOMET	generic	1	
methyldopa/HCTZ	ALDORIL	generic	1	
midodrine	PROAMATINE	generic	1	
minoxidil	LONITEN	generic	1	
ranolazine	RANEXA	brand	2	ST
Central Nervous System				
Alzheimer's Disease				
donepezil	ARICEPT	generic	1	5 mg and 10 mg, QL, Members <18 years of age will require prior authorization.
donepezil	ARICEPT	generic	1	23 mg, ST, Members <18 years of age will require prior authorization.
galantamine	RAZADYNE	generic	1	QL, Members <18 years of age will require prior authorization.
memantine	NAMENDA	generic	1	QL, Members <18 years of age will require prior authorization.
rivastigmine	EXELON	generic	1	QL, Members <18 years of age will require prior authorization.

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Amyotrophic Lateral Sclerosis (ALS)				
riluzole	RILUTEK	generic	1	
Analeptics				
armodafinil	NUVIGIL	generic	1	Diagnosis Required, QL
Analgesics				
Barbiturate Non-Narcotic Analgesics				
butalbital/acetaminophen	PHRENILIN	generic	1	QL
butalbital/acetaminophen	SEDAPAP	generic	1	QL
butalbital/acetaminophen/ caffeine	ESGIC FIORICET ZEBUTAL	generic	1	QL
butalbital/aspirin/caffeine	FIORINAL	generic	1	QL
Non-Narcotic Analgesics				
acetaminophen	TYLENOL	generic	1	OTC
aspirin/acetaminophen/ caffeine	EXCEDRIN MIGRAINE	generic	1	OTC
tramadol	ULTRAM	generic	1	QL
NSAIDS				
diclofenac potassium	CATAFLAM	generic	1	
diclofenac sodium delayed-release	VOLTAREN	generic	1	
diclofenac sodium extended-release	VOLTAREN XR	generic	1	
etodolac	LODINE	generic	1	IR Only
ibuprofen	ADVIL	generic	1	tabs, chew tabs and susp, OTC
ibuprofen	MOTRIN	generic	1	tabs, chew tabs and susp
indomethacin	INDOCIN	generic	1	
ketoprofen	ORUDIS	generic	1	IR only
ketorolac tromethamine	TORADOL	generic	1	QL
meloxicam	MOBIC	generic	1	QL
nabumetone	RELAFEN	generic	1	
naproxen	NAPROSYN	generic	1	
naproxen delayed release	ENTERIC COATED-NAPROSYN	generic	1	
oxaprozin	DAYPRO	generic	1	
piroxicam	FELDENE	generic	1	
sulindac	CLINORIL	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Opioids - Narcotic Analgesics				
butalbital/apap/caff/cod	FIORICET W/CODEINE	generic	1	QL, 50-325-40-30 mg
butalbital/asa/caff/cod	FIORINAL W/CODEINE	generic	1	QL
butorphanol	STADOL	generic	1	nasal spray, QL
codeine sulfate		generic	1	QL
codeine/acetaminophen	TYLENOL W/CODEINE	generic	1	QL
fentanyl transdermal	DURAGESIC	generic	1	PA, QL
hydrocodone/ acetaminophen	LORCET LORTAB LORTAB ELIXIR NORCO VICODIN VICODIN ES	generic	1	QL
hydrocodone ER	ZOHYDRO ER	brand	2	PA
hydromorphone	DILAUDID	generic	1	QL
meperidine	DEMEROL	generic	1	QL
morphine	MSIR	generic	1	QL
morphine	RMS	generic	1	QL
morphine extended-release	MS CONTIN	generic	1	PA, QL
oxycodone	OXYFAST	generic	1	soln, QL
oxycodone	ROXICODONE	generic	1	tabs, QL
oxycodone/ acetaminophen	PERCOCET	generic	1	5/325 mg, 7.5/325 mg, 10/325 mg, QL
oxycodone/aspirin	PERCODAN	generic	1	QL
oxymorphone ER	OXYMORPHONE ER	generic	1	PA, QL, non-crush resistant
Migraine Acute Therapy				
Ergotamine Derivatives				
dihydroergotamine	D.H.E. 45	generic	1	inj, QL
ergotamine/caffeine	CAFERGOT	generic	1	
ergotamine tartrate/ caffeine	MIGERGOT SUPPOSITORIES	brand	2	QL
Selective Serotonin Agonists				
naratriptan	AMERGE	generic	1	ST
rizatriptan	MAXALT/MAXALT MLT	generic	1	QL
sumatriptan	IMITREX	generic	1	QL
sumatriptan	IMITREX 4 MG AND 6 MG INJ	generic	1	4 mg and 6 mg inj

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Migraine Prophylactic Therapy				
amitriptyline	ELAVIL	generic	1	
divalproex sodium cap sprinkle	DEPAKOTE SPRINKLE	generic	1	Members ≥ 8 years of age will require prior authorization.
divalproex sodium delayed-release	DEPAKOTE	generic	1	Minimum age 2
propranolol	INDERAL	generic	1	IR only
verapamil	CALAN	generic	1	
Multiple Sclerosis				
daclizumab	ZINBRYTA	brand	2	Diagnosis Required, QL, SP, ST
dimethyl fumarate	TECFIDERA	brand	2	Diagnosis Required, QL, SP
fingolimod	GILENYA	brand	2	Diagnosis Required, QL, SP
glatiramer acetate	COPAXONE	generic	1	Diagnosis Required, QL, SP
peginterferon beta-1a	PLEGRIDY	brand	2	Diagnosis Required, QL, SP
teriflunomide	AUBAGIO	brand	2	Diagnosis Required, QL, SP
Myasthenia Gravis				
pyridostigmine	MESTINON	generic	1	tabs
pyridostigmine	MESTINON	brand	2	syrup
pyridostigmine extended-release	MESTINON TIMESPAN	generic	1	
Parkinson's Disease				
amantadine	SYMMETREL	generic	1	except tabs
benztropine	COGENTIN	generic	1	
carbidopa/levodopa	SINEMET	generic	1	
carbidopa/levodopa extended-release	SINEMET CR	generic	1	
entacapone	COMTAN	generic	1	
pramipexole	MIRAPEX	generic	1	
ropinirole	REQUIP	generic	1	
selegiline	ELDEPRYL	generic	1	
tolcapone	TASMAR	generic	1	
trihexyphenidyl	ARTANE	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Seizures				
carbamazepine	TEGRETOL	generic	1	
carbamazepine extended-release	CARBATROL TEGRETOL-XR	generic	1	
clobazam	ONFI	brand	2	Diagnosis Required, QL
clonazepam	KLONOPIN	generic	1	tabs
diazepam	DIASTAT ACUDIAL	generic	1	rectal gel, QL
divalproex sodium cap sprinkle	DEPAKOTE SPRINKLE	generic	1	Members ≥ 8 years of age will require prior authorization.
divalproex sodium delayed-release	DEPAKOTE	generic	1	Minimum age 2
ethosuximide	ZARONTIN	generic	1	
exogabine	POTIGA	brand	2	Age Limits Apply
felbamate	FELBATOL	generic	1	
felbamate oral susp	FELBATOL ORAL SUSP	generic	1	Members ≥ 8 years of age will require prior authorization
gabapentin	NEURONTIN	generic	1	caps and tabs only
lacosamide	VIMPAT	brand	2	Age Limits Apply, PA
lamotrigine	LAMICTAL	generic	1	QL
lamotrigine chew dispersable tab	LAMICTAL CD CHEW TAB	generic	1	Members ≥ 8 years of age will require prior authorization.
lamotrigine starter kit	LAMICTAL STARTER KIT	brand	2	
levetiracetam	KEPPRA	generic	1	QL, Maximum age of 9 for solution
methsuximide	CELONTIN	brand	2	
oxcarbazepine	TRILEPTAL	generic	1	QL, Maximum age of 9 for suspension
phenobarbital	PHENOBARBITAL	generic	1	
phenytoin	DILANTIN INFATABS	generic	1	
phenytoin sodium extended	DILANTIN PHENYTEK	generic	1	
pregabalin	LYRICA	brand	2	PA
pregabalin	LYRICA SOLUTION	brand	2	oral solution, PA
primidone	MYSOLINE	generic	1	
rufinamide	BANZEL	brand	2	Diagnosis Required, QL
tiagabine	GABITRIL	generic	1	Age Limits Apply, PA, 2mg & 4mg

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
tiagabine	GABITRIL	brand	2	Age Limits Apply, PA, 12mg & 16mg
topiramate	TOPAMAX	generic	1	QL
topiramate sprinkle caps	TOPAMAX SPRINKLE	generic	1	QL, Members ≥ 8 years of age will require prior authorization.
valproic acid	DEPAKENE	generic	1	
vigabatrin oral solution	SABRIL SOLUTION	brand	2	PA, SP
zonisamide	ZONEGRAN	generic	1	QL
Miscellaneous				
tetrabenazine	XENAZINE	brand	2	Diagnosis Required, SP
valbenazine	INGREZZA	brand	2	PA, QL, SP
Dermatology				
Acne Vulgaris				
Oral				
isotretinoin	ABSORICA AMNESTEEM CLARAVIS MYORISAN ZENTANE	generic	1	PA
Topical				
adapalene gel	DIFFERIN OTC GEL 0.1%	generic	1	
azelaic acid	FINACEA	brand	2	gel
benzoyl peroxide	BENZAC AC	generic	1	
clindamycin	CLEOCIN T	generic	1	gel
clindamycin	CLEOCIN T	generic	1	lotion
clindamycin	CLEOCIN T	generic	1	soln
erythromycin	ERYGEL	generic	1	gel 2%
erythromycin	T-STAT	generic	1	soln
salicylic acid	NEUTROGENA OIL FREE ACNE WASH	generic	1	liquid 2%, OTC
sulfacetamide/sulfur	SULFACET-R	generic	1	lotion
sulfacetamide/sulfur	PLEXION	generic	1	
tretinoin	AVITA RETIN-A	generic	1	cream, ST
Bacterial Infections				
bacitracin	BACITRACIN	generic	1	OTC
gentamicin	GENTAK	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
mupirocin	BACTROBAN	generic	1	ointment, 22 gram tube only
neomycin/polymyxin B/ bacitracin	NEOSPORIN	generic	1	OTC
silver sulfadiazine	SILVADENE	generic	1	
Corticosteroids				
Low Potency				
alclometasone	ACLOVATE	generic	1	0.05% crm/oint
fluocinolone acetonide	DERMA-SMOOTHE OIL/FS	generic	1	oil 0.01%
fluocinolone acetonide	SYNALAR	generic	1	soln/crm 0.01%
hydrocortisone	CORTIZONE	generic	1	crm, oint, lot OTC
hydrocortisone	HYTONE	generic	1	crm 0.5%, 1%, & 2.5%
hydrocortisone	HYTONE	generic	1	lotion 1% & 2.5%
hydrocortisone/aloe	CORTIZONE-10 INTENSIVE HEALING	generic	1	crm 0.5% & 1%, OTC
Medium Potency				
betamethasone val	BETA-VAL	generic	1	crm/oint/lotion 0.1%
fluocinolone acetonide	DERMA-SMOOTHE OIL/FS	generic	1	oil 0.01%
fluocinolone acetonide	SYNALAR	generic	1	crm, oint 0.025%
fluticasone propionate	CUTIVATE	generic	1	crm 0.05%, oint 0.005%
hydrocortisone butyrate	LOCOID	generic	1	crm/oint/soln 0.1%
hydrocortisone valerate	WESTCORT	generic	1	crm 0.2%
mometasone furoate	ELOCON	generic	1	crm/oint/soln 0.1%
prednicarbate	DERMATOP	generic	1	crm0.1%
triamcinolone acetonide	KENALOG	generic	1	crm/lot/oint 0.025%
triamcinolone acetonide	KENALOG	generic	1	crm/oint/lotion 0.1%
High Potency				
betamethasone augmented dip	DIPROLENE	generic	1	lotion 0.05%
betamethasone augmented dip	DIPROLENE AF	generic	1	crm 0.05%
betamethasone dipropionate		generic	1	crm/lotion/oint 0.05%
fluocinonide	LIDEX	generic	1	crm/oint/gel/soln 0.05%
fluocinonide emulsified base	LIDEX E	generic	1	crm 0.05%
triamcinolone acetonide	KENALOG	generic	1	crm 0.5%

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Very High Potency				
betamethasone dip augmented	DIPROLENE	generic	1	gel 0.05%
betamethasone dip augmented	DIPROLENE	generic	1	oint 0.05%
clobetasol propionate	TEMOVATE	generic	1	soln 0.05%
halobetasol	ULTRAVATE	generic	1	cream
Fungal Infections				
ciclopirox	PENLAC SOLUTION 8%	generic	1	
clotrimazole	LOTRIMIN AF	generic	1	OTC
clotrimazole	MYCELEX	generic	1	
clotrimazole with betamethasone	LOTRISONE	generic	1	
ketoconazole	NIZORAL	generic	1	
miconazole	DESENEX	generic	1	2% OTC
miconazole	MICATIN	generic	1	OTC
miconazole	MONISTAT-DERM	generic	1	
nystatin	MYCOSTATIN	generic	1	
terbinafine	LAMISIL AT	generic	1	OTC
tolnaftate	TINACTIN	generic	1	OTC
Psoriasis				
acitretin	SORIATANE	generic	1	oral caps, PA
calcipotriene	DOVONEX	generic	1	crm/oint, ST
calcipotriene	DOVONEX	generic	1	soln
calcitriol	VECTICAL	generic	1	ST
methoxsalen	OXSORALEN-ULTRA	generic	1	
salicylic acid	SCALPICIN	generic	1	liquid 3%
Rosacea				
brimonidine	MIRVASO	brand	2	PA
metronidazole	METROCREAM METROGEL METROLOTION	generic	1	
Scabies and Pediculosis				
crotamiton	EURAX	brand	2	
malathion	OVIDE	generic	1	
permethrin	ELIMITE	generic	1	5%, QL
permethrin	NIX CREME RINSE	generic	1	1%, OTC
pyrethrins/piperonyl butoxide shampoo	RID SHAMPOO	generic	1	4% OTC
spinosad	NATROBA	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Viral Infections				
podofilox	CONDYLOX SOL	generic	1	sol
salicylic acid 17%/ collodion	DUOFILM	generic	1	OTC
Miscellaneous				
aluminum acetate		brand	2	soln/cream, OTC
aluminum chloride topical solution	HYPERCARE 15%	brand	2	
ammonium lactate	LAC-HYDRIN	generic	1	crm 12%, lotion 5% & 12%
ammonium lactate	LACTINOL	generic	1	lotion 10%
becaplermin gel	REGRANEX	brand	2	PA
calamine		brand	2	lotion/ointment, OTC
collagenase oint	SANTYL	brand	2	QL
crisaborole	EUCRISA	brand	2	2% ointment, QL, ST
fluorouracil	EFUDEX	generic	1	
hydrocortisone	PROCTOSOL HC CREAM 2.5% PROCTOZONE CREAM-HC 2.5% ANUSOL HC 2.5%	generic	1	
imiquimod 5% cream	ALDARA	generic	1	
ketoconazole	NIZORAL SHAMPOO	generic	1	shampoo 2%
lidocaine	LIDAMANTEL	generic	1	3% cream
lidocaine	LMX-4	generic	1	4% cream (15 gm tubes), QL
lidocaine	XYLOCAINE	generic	1	jelly 2%
lidocaine patch	LIDODERM	generic	1	Diagnosis Required, QL
lidocaine/prilocaine	EMLA	generic	1	2.5% cream
nitroglycerin	RECTIV	brand	2	Diagnosis Required, 0.4% rectal ointment
pimecrolimus	ELIDEL	brand	2	cream QL, ST; not covered for members less than 2 years of age
selenium sulfide	SELSUN	generic	1	lotion 2.5%
tacrolimus	PROTOPIC 0.03%	generic	2	ointment 0.03%, QL, ST; not covered for members less than 2 years of age
tacrolimus	PROTOPIC 0.1%	generic	2	ointment 0.1%, ST (minimum age 16)

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
urea 10% urea 20%	UREA 10% CREAM UREA 20% CREAM UREA 10% LOTION	brand	2	
urea 40%	UREA 40% LOTION	generic	1	lotion
Ear, Nose & Throat				
Ear				
acetic acid	VOSOL OTIC	generic	1	otic
acetic acid/ aluminum acetate	DOMEBORO OTIC	generic	1	
acetic acid/ hydrocortisone	VOSOL HC OTIC	generic	1	
benzocaine/antipyrine	BENZOTIC	generic	1	
carbamide peroxide	DEBROX	generic	1	6.5%, OTC
ciprofloxacin/ dexamethasone	CIPRODEX	brand	2	Diagnosis Required
neomycin/polymyxin B/ hydrocortisone	CORTISPORIN OTIC	generic	1	otic
ofloxacin	FLOXIN OTIC	generic	1	
Nose				
Antihistamines - First Generation, Sedating				
chlorpheniramine extended-release	CHLOR-TRIMETON ALLERGY	generic	1	12 mg, OTC
chlorpheniramine maleate	CHLOR-TRIMETON SYRUP	generic	1	2 mg/5 ml, OTC
clemastine	CLEMASTINE	generic	1	
cyproheptadine	CYPROHEPTADINE	generic	1	
diphenhydramine		generic	1	
diphenhydramine	BENADRYL	generic		OTC
Antihistamines - Second Generation, Sedating				
cetirizine	ZYRTEC	generic	1	OTC
cetirizine chew tab	ZYRTEC CHEWABLE TABLET	generic	1	OTC, Members ≥ 8 years of age will require prior authorization.
levocetirizine	XYZAL	generic	1	tabs
loratadine	ALAVERT CLARITIN	generic	1	OTC
Antihistamines - Others				
azelastine	ASTELIN	generic	1	spray

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Nasal Steroids				
fluticasone	FLONASE	generic	1	
triamcinolone nasal spray	NASACORT ALLERGY 24 HOUR	brand	2	OTC
Miscellaneous Nasal Decongestants				
oxymetazoline	AFRIN	generic	1	OTC
phenylephrine	NEO-SYNEPHRINE DIMEATAPP DRO DECONGES	generic	1	OTC
Miscellaneous Nasal				
cromolyn sodium	NASALCROM	generic	1	OTC
ipratropium nasal	ATROVENT NASAL SPRAY	generic	1	QL
saline nasal spray 0.65%	OCEAN NASAL SPRAY	generic		OTC
Throat and Mouth				
chlorhexidine gluconate	PERIDEX	generic	1	
lidocaine viscous	XYLOCAINE	generic	1	
pilocarpine	SALAGEN	generic	1	
triamcinolone	KENALOG IN ORABASE	generic	1	paste
Endocrinology				
Adrenal Corticosteroids				
cortisone acetate		generic	1	
dexamethasone	DECADRON	generic	1	
fludrocortisone	FLORINEF	generic	1	
hydrocortisone	CORTEF	generic	1	
methylprednisolone	MEDROL	generic	1	4mg, 8mg, 16mg, 32mg
methylprednisolone	MEDROL	brand	2	2mg
prednisolone				
prednisolone	PRELONE	generic	1	syrup
prednisolone sodium phosphate	ORAPRED PEDIAPRED	generic	1	
prednisone	DELTASONE	generic	1	
Androgens				
testosterone cypionate	DEPO-TESTOSTERONE	generic	1	
testosterone enanthate	DELATESTRYL	generic	1	Vials only. Disposable syringes not covered.
testosterone gel topical tube, packet, and pump bottle	TESTOSTERONE 1% TOPICAL GEL	generic	1	PA

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Diabetes Mellitus				
Glucose Elevating Agents				
glucagon, human recombinant	GLUCAGON	brand	2	QL
Insulin Combinations				
insulin glargine/lixisenatide	SOLIQUA	brand	2	ST
Insulins				
insulin aspart protamine 70%/ insulin aspart 30%	NOVOLOG MIX 70/30	brand	2	QL, vials
insulin glargine	BASAGLAR	brand	2	
insulin glargine 300 unit/ml	TOUJEO SOLOSTAR	brand	2	
insulin human	NOVOLIN R	brand	2	OTC, QL, vials
insulin human	RELION R	brand	2	OTC, QL, vials
insulin isophane	HUMULIN N	brand	2	OTC, QL, vials
insulin isophane human	NOVOLIN N	brand	2	OTC, QL, vials
insulin isophane human	RELION N	brand	2	OTC, QL, vials
insulin isophane human 70%/regular 30%	NOVOLIN 70/30	brand	2	OTC, QL, vials
insulin isophane human 70%/regular 30%	RELION 70/30	brand	2	OTC, QL, vials
insulin isophane/regular	HUMULIN 70/30	brand	2	OTC, QL, vials
insulin lisopro pro/lispro	HUMALOG MIX 50/50	brand	2	QL, vials
insulin lisopro prot/lispro	HUMALOG MIX 75/25	brand	2	QL, vials
insulin lispro	ADMELOG SOLOSTAR	brand	2	PA, QL
insulin lispro	ADMELOG VIALS	brand	2	QL
insulin regular	HUMULIN R	brand	2	OTC, QL, vials
Monitoring - Strips and Kits/Diabetic Supplies				
ONE TOUCH SYSTEMS (ULTRA 2, ULTRAMINI, VERIO, VERIO FLEX, VERIO IQ, VERIO SYNC)		brand	2	QL for insulin dependent or pregnant members: allow testing up to 6 times per day
ONE TOUCH TEST STRIPS (ULTRA, VERIO)		brand	2	QL for non-insulin dependent members: allow twice daily testing
Oral Agents				
acarbose	PRECOSE	generic	1	
alogliptin	NESINA	generic	1	ST
alogliptin/metformin	KAZANO	generic	1	ST

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
alogliptin/pioglitazone	OSENI	generic	1	ST
chlorpropamide	DIABINESE	generic	1	
ertugliflozin	STEGLATRO	brand	2	ST
ertugliflozin/metformin	SEGLUROMET	brand	2	ST
glimepiride	AMARYL	generic	1	
glipizide	GLUCOTROL	generic	1	
glipizide extended-release	GLUCOTROL XL	generic	1	
glyburide	MICRONASE	generic	1	
glyburide, micronized	GLYNASE	generic	1	
metformin	GLUCOPHAGE	generic	1	
metformin ER	GLUCOPHAGE ER	generic	1	
metformin/glyburide	GLUCOVANCE	generic	1	
nateglinide	STARLIX	generic	1	
pioglitazone	ACTOS	generic	1	QL
repaglinide	PRANDIN	generic	1	
tolazamide	TOLINASE	generic	1	
tolbutamide	TOLBUTAMIDE	generic	1	
Miscellaneous Antidiabetic Agents				
albiglutide	TANZEUM	brand	2	ST
dulaglutide	TRULICITY	brand	2	ST
lixisenatide	ADLYXIN	brand	2	ST
pramlintide	SYMLIN	brand	2	PA
Growth Stimulating Agents				
mecasermin	INCRELEX	brand	2	PA, SP
somatropin	ZOMACTON	brand	2	PA, SP
Lipodystropy Agents				
tesamorelin	EGRIFTA	brand	2	Diagnosis Required, SP
Osteoporosis				
abaloparatide inj	TYMLOS	brand	2	PA, SP
alendronate	FOSAMAX	generic	1	QL
calcitonin-salmon	MIACALCIN	generic	1	nasal spray, QL
calcitonin-salmon	FORTICAL	brand	2	nasal spray, QL
etidronate	DIDRONEL	generic	1	
raloxifene	EVISTA	generic	1	
Thyroid Disease				
levothyroxine	LEVOXYL	generic	1	
levothyroxine	SYNTHROID	generic	1	
liothyronine	CYTOMEL	generic	1	
liotrix	THYROLAR	brand	2	
methimazole	TAPAZOLE	generic	1	
propylthiouracil	PROPYLTHIOURACIL	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Miscellaneous				
asfotase alfa	STRENSIQ	brand	2	PA, SP
cabergoline	DOSTINEX	generic	1	
cholic acid	CHOLBAM	brand	2	PA, SP
desmopressin	DDAVP	generic	1	QL
methylergonovine	METHERGINE	generic	1	
mifepristone	KORLYM	brand	2	PA, SP
nitisinone	NITYR	brand	2	Diagnosis Required, SP
pegvisomant	SOMAVERT	brand	2	PA, SP
sapropterin	KUVAN	brand	2	Diagnosis Required, SP
uridine	VISTOGARD	brand	2	
Gastrointestinal				
Constipation/Laxatives				
casanthranol-docusate sodium		generic	1	OTC
docusate calcium plus		generic	1	OTC
docusate potasssium		generic	1	OTC
docusate sodium	COLACE	generic	1	OTC
glycerin	GLYCERIN SUPPOSITORY	generic	1	suppository, OTC
lactulose	ENULOSE	generic	1	
linaclotide	LINZESS	brand	2	Diagnosis Required
magnesium citrate soln	MAGNESIUM CITRATE SOLN	generic	1	
peg 3350/electrolytes	COLYTE	generic	1	
peg 3350/sodium bicarbonate/sodium chloride	TRILYTE	generic	1	
peg 3350/sodium bicarbonate/sodium chloride/potassium chloride	NULYTELY	generic	1	
polyethylene glycol 3350	MIRALAX	generic	1	
sennosides	SENOKOT	generic	1	8.6 mg tab, OTC
Diarrhea				
crofelemer	MYTESI	brand	2	Diagnosis Required, QL
diphenoxylate/atropine	LOMOTIL	generic	1	
loperamide	IMODIUM A-D	generic	1	OTC
loperamide	LOPERAMIDE	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Emesis				
aprepitant	EMEND	generic	1	QL applies to 40 mg, 80 mg and 80-125 mg
dronabinol	MARINOL	generic	1	PA
meclizine	ANTIVERT	generic	1	
metoclopramide	REGLAN	generic	1	
ondansetron	ZOFRAN ZOFRAN ODT	generic	1	QL
prochlorperazine	COMPAZINE	generic	1	
promethazine	PHENERGAN	generic	1	
rolapitant	VARUBI	brand	2	
trimethobenzamide	TIGAN	generic	1	300 mg caps
Gastroesophageal Reflux Disease (Gerd)/Peptic Ulcers				
alginic acid/sodium bicarbonate		brand	2	OTC
alumina/magnesia	MAALOX	generic	1	OTC
alumina/magnesia/ simethicone	MYLANTA	generic	1	OTC
cimetidine	TAGAMET	generic	1	
esomeprazole	NEXIUM 24HR OTC	brand	2	PA
esomeprazole granules	NEXIUM DELAYED RELEASE PACKET	brand	2	Members ≥ 2 years of age will require prior authorization.
famotidine	PEPCID PEPCID AC	generic	1	OTC Pepcid AC 10 mg and 20 mg also covered/ encouraged with written prescription.
lansoprazole	PREVACID	generic	1	
lansoprazole delayed-release	PREVACID SOLUTAB	generic	1	orally disintegrating tabs, Members ≥ 2 years of age will require prior authorization. QL
omeprazole delayed-release	PRILOSEC	generic	1	Capsules only, QL
pantoprazole	PROTONIX	generic	1	
ranitidine	ZANTAC	generic	1	150 mg tabs
ranitidine syrup	ZANTAC	generic	1	
sucralfate	CARAFATE	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
sulcralfate suspension	CARAFATE SUSPENSION	brand	2	suspension, Members 10 years of age up to 65 years of age will require prior authorization.
Gastrointestinal Spasm				
dicyclomine	BENTYL	generic	1	tablets only
glycopyrrolate	ROBINUL	generic	1	
hyoscyamine sulfate	LEVSIN	generic	1	
hyoscyamine sulfate extended-release	LEVSINEX	generic	1	
Inflammatory Bowel Disease				
balsalazide	COLAZAL	generic	1	
budesonide	ENTOCORT EC	generic	1	Diagnosis Required
hydrocortisone	COLOCORT	generic	1	enema
mesalamine	ROWASA	generic	1	enema only
mesalamine extended-release	APRISO DELZICOL	brand	2	
mesalamine supp	CANASA	brand	2	
olsalazine sodium	DIPENTUM	brand	2	
sulfasalazine	AZULFIDINE	generic	1	
sulfasalazine delayed-release	AZULFIDINE EN-TABS	generic	1	
Pancreatic Enzymes				
pancrelipase	CREON CREON 3000 UNIT ZENPEP	brand	2	
Probiotic Supplementation				
acidophilus	ACIDOPHILUS XTRA	brand	2	OTC
acidophilus	ACIDOPHILUS	brand	2	caps and tabs, OTC
acidophilus/bifidus	ACIDOPHILUS/BIFIDUS WAFER	generic	1	OTC
acidophilus/citrus pectin	ACIDOPHILUS/CITRUS PECTIN	generic	1	tabs, OTC
acidophilus/pectin	ACIDOPHILUS/PECTIN	generic	1	caps, OTC

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
probiotics	ALIGN BACID BIOGAIA CULTURELLE DIGESTIVE PROBIOTIC FLORAJEN FLORANEX FLORASTOR LACTINEX PHILLIPS COLON HEALTH RISA-BID RISAQUAD	brand	2	OTC
Miscellaneous				
atropine sulfate	SAL-TROPINE	brand	2	
misoprostol	CYTOTEC	generic	1	
naloxegol	MOVANTIK	brand	2	Diagnosis Required
teduglutide	GATTEX	brand	2	PA, SP
ursodiol	ACTIGALL URSO URSO FORTE	generic	1	
Infectious Diseases				
Anthelmintics				
albendazole	ALBENZA	brand	2	PA
ivermectin	STROMECTOL	generic	1	
praziquantel	BILTRICIDE	brand	2	Diagnosis Required
pyrantel pamoate	REESE'S PINWORM MEDICINE	brand	2	tablets, suspension
pyrantel pamoate	PIN-X	brand	2	chewable tablets, suspension
Antibacterials				
Antituberculosis Agents				
aminosalicyclic acid	PASER	brand	2	
cycloserine	SEROMYCIN	generic	1	
ethambutol	MYAMBUTOL	generic	1	
ethionamide	TRECATOR	brand	2	
isoniazid	ISONIAZID	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
pyrazinamide	PYRAZINAMIDE	generic	1	
rifabutin	MYCOBUTIN	generic	1	
rifampin	RIFADIN	generic	1	
rifapentine	PRIFTIN	brand	2	
Cephalosporins - First Generation				
cefadroxil	DURICEF	generic	1	
cephalexin	KEFLEX	generic	1	tabs are not covered
Cephalosporins - Second Generation				
cefaclor	CECLOR	generic	1	
cefprozil	CEFZIL	generic	1	
cefuroxime axetil	CEFTIN	generic	1	tabs
cefuroxime axetil	CEFTIN	brand	2	suspension
Cephalosporins - Third Generation				
cefdinir	OMNICEF	generic	1	
cefixime	SUPRAX	brand	2	400 mg caps only, QL
Fluoroquinolones				
ciprofloxacin	CIPRO	generic	1	
levofloxacin	LEVAQUIN	generic	1	tablets only
ofloxacin	FLOXIN	generic	1	tabs
Macrolides				
azithromycin	ZITHROMAX	generic	1	QL
clarithromycin	BIAXIN	generic	1	
clarithromycin ER	BIAXIN XL	generic	1	
erythromycin delayed-release	ERYC	generic	1	
erythromycin delayed-release	ERY-TAB	brand	2	
erythromycin ethylsuccinate	E.E.S.	generic	1	
erythromycin stearate	ERYTHROCIN	generic	1	
erythromycin/sulfisoxazole	PEDIAZOLE	generic	1	
fidaxomicin	DIFICID	brand	2	PA
Penicillins				
amoxicillin	AMOXICILLIN CAPSULES AND CHEWABLES	generic	1	Except 500 mg and 875 mg film-coated tabs.
amoxicillin	AMOXIL SUSP	generic	1	suspension
amoxicillin/clavulanate	AUGMENTIN	generic	1	
ampicillin	PRINCIPEN	generic	1	
dicloxacillin	DICLOXACILLIN	generic	1	
penicillin VK	VEETIDS	generic	1	

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Sulfonamides				
sulfamethoxazole/ trimethoprim, DS	BACTRIM BACTRIM DS	generic	1	
Tetracyclines				
doxycycline monohydrate	DOXYCYCLINE MONOHYDRATE	generic	1	50mg & 100mg caps
minocycline	MINOCIN	generic	1	capsules, except 75 mg
Miscellaneous				
vancomycin HCl	VANCOCIN HCL	generic	1	cap, ST
Antifungals				
clotrimazole	MYCELEX	generic	1	troches
fluconazole	DIFLUCAN	generic	1	QL
griseofulvin microsize	GRIFULVIN V	generic	1	
griseofulvin ultramicrosize	GRIS-PEG	generic	1	
itraconazole	SPORANOX	generic	1	caps, PA, QL
itraconazole	SPORANOX	brand	2	soln, PA, QL
ketoconazole	NIZORAL	generic	1	
nystatin	MYCOSTATIN	generic	1	
terbinafine	LAMISIL	generic	1	QL
voriconazole	VFEND	generic	1	PA
Antiprotozoals				
atovaquone	MEPRON	generic	1	PA
benznidazole	BENZNIDAZOLE	brand	2	PA, QL
miltefosine	IMPAVIDO	brand	2	PA
nitazoxanide suspension	ALINIA SUSPENSION	brand	2	Members ≥ 8 years of age will require prior authorization.
nitazoxanide tablet	ALINIA	brand	2	PA
pentamidine isethionate for nebulization	NEBUPENT	brand	2	
Antivirals				
Cytomegalovirus Treatment				
ganciclovir	CYTOVENE	generic	1	
valganciclovir	VALCYTE	generic	1	tabs only
Entry/Fusion Inhibitors				
Hepatitis Treatment				
entecavir	BARACLUDE	generic	1	SP
glecaprevir/pibrentasvir	MAVYRET	brand	2	PA, SP, preferred for Genotypes 1, 2, 3, 4, 5, & 6

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
interferon alfa-2b	INTRON A	brand	2	PA, SP
lamivudine	EPIVIR HBV	generic	1	tabs, SP, QL
lamivudine	EPIVIR HBV	brand	2	solution, SP, QL
peginterferon alfa-2a	PEGASYS	brand	2	PA, SP
peginterferon alfa-2a	PEGASYS PROCLICK	brand	2	PA, SP
ribavirin	REBETOL/COPEGUS	generic	1	200 mg caps and tabs only, SP
Herpes Treatment				
acyclovir	ZOVIRAX	generic	1	caps, tabs, suspension
docosanol	ABREVA OTC CREAM	brand	2	
valacyclovir	VALTREX	generic	1	
Influenza Treatment				
amantadine	SYMMETREL	generic	1	except tabs
oseltamivir	TAMIFLU	generic	1	capsule, QL
oseltamivir	TAMIFLU SUSP	brand	2	Age Limits Apply, QL, susp
rimantadine	FLUMADINE	generic	1	
zanamivir	RELENZA	brand	2	QL
Integrase Inhibitors				
dolutegravir	TIVICAY	brand	2	QL
raltegravir	ISENTRESS	brand	2	QL
raltegravir	ISENTRESS CHEWABLE	brand	2	chewable tablet, QL
raltegravir	ISENTRESS HD	brand	2	QL
raltegravir susp	ISENTRESS SUSP	brand	2	QL
Non-Nucleoside Reverse Transcriptase Inhibitors				
delavirdine	RESCRIPTOR	brand	2	QL
efavirenz	SUSTIVA	brand	2	QL
etravirine	INTELENCE	brand	2	QL
nevirapine	VIRAMUNE	generic	1	QL
nevirapine ER	VIRAMUNE XR	brand	2	QL
rilpivirine	EDURANT	brand	2	QL
Nucleoside Analogues Nucleoside Reverse-Transcriptase Inhibitors/and Combinations				
abacavir	ZIAGEN	generic	1	QL
abacavir/lamivudine	EPZICOM	generic	1	QL
abacavir/lamivudine/ zidovudine	TRIZIVIR	generic	1	QL
didanosine	VIDEX	brand	2	QL
didanosine delayed-release	VIDEX EC	generic	1	QL
emtricitabine	EMTRIVA	brand	2	QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
emtricitabine/rilpivirine/ tenofovir	COMPLERA	brand	2	QL
lamivudine	EPIVIR	generic	1	QL
lamivudine/zidovudine	COMBIVIR	generic	1	QL
stavudine	ZERIT	generic	1	QL
zidovudine	RETROVIR	generic	1	QL
Nucleoside/Nucleotide Reverse-Transcriptase Inhibitor Combination				
bictegravir/emtricitabine/ tenofovir	BIKTARVY	brand	2	QL
efavirenz/emtricitabine/ tenofovir	ATRIPLA	brand	2	QL
emtricitabine/rilpivirine/ tenofovir	ODEFSEY	brand	2	QL
emtricitabine/tenofovir alafenamide	DESCOVY	brand	2	QL
emtricitabine/tenofovir disoproxil	TRUVADA	brand	2	QL
Nucleotide Analogues Nucleotide Reverse-Transcriptase Inhibitor				
tenofovir	VIREAD	brand	2	QL
Protease Inhibitors				
atazanavir	REYATAZ	generic	1	QL
atazanavir	REYATAZ POWDER PACKET	brand	2	Members ≥ 8 years of age will require prior authorization, QL
atazanavir/cobicistat	EVOTAZ	brand	2	QL
darunavir	PREZISTA	brand	2	QL
fosamprenavir	LEXIVA	brand	2	QL
indinavir	CRIXIVAN	brand	2	QL
lopinavir/ritonavir	KALETRA	brand	2	tablets, QL
lopinavir/ritonavir	KALETRA	generic	1	solution, QL
nelfinavir	VIRACEPT	brand	2	QL
ritonavir	NORVIR	brand	2	QL
saquinavir mesylate	INVIRASE	brand	2	QL
tipranavir	APTIVUS	brand	2	QL
Miscellaneous				
abacavir/dolutegravir/ lamivudine	TRIUMEQ	brand	2	QL
cobicistat	TYBOST	brand	2	QL
cobicistat/elvitegravir/ emtricitabine/tenofovir	STRIBILD	brand	2	QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
darunavir/cobicistat	PREZCOBIX	brand	2	QL
dolutegravir/rilpivirine	JULUCA	brand	2	QL
elvitegravir/cobicistat/ emtricitabine/tenofovir alafenamide fumarate	GENVOYA	brand	2	QL
enfuvirtide	FUZEON	brand	2	QL
maraviroc	SELZENTRY	brand	2	QL
Miscellaneous				
bedaquiline	SIRTURO	brand	2	
chloroquine phosphate	ARALEN	generic	1	
clindamycin	CLEOCIN	generic	1	150 mg and 300 mg only
dapsone	DAPSONE	brand	2	
hydroxychloroquine	PLAQUENIL	generic	1	
linezolid	ZYVOX	generic	1	PA
mefloquine	LARIAM	generic	1	
metronidazole	FLAGYL	generic	1	tabs only
neomycin sulfate		brand	2	
nitrofurantoin extended-release	MACROBID	generic	1	
nitrofurantoin macrocrystals	MACRODANTIN	generic	1	
nitrofurantoin susp	FURADANTIN SUSP 25 MG/5 ML	generic	1	Members ≥ 8 years of age will require prior authorization.
palivizumab	SYNAGIS	brand	2	PA, SP
paromomycin	HUMATIN	generic	1	
povidone-iodine		generic	1	OTC
primaquine		generic	1	
pyrimethamine	DARAPRIM	brand	2	PA, SP
trimethoprim	TRIMETHOPRIM	generic	1	tabs only
Musculoskeletal				
Arthritis				
Disease Modifying Anti-Rheumatic Drugs				
adalimumab	HUMIRA	brand	2	PA, SP
anakinra	KINERET	brand	2	PA, SP
apremilast	OTEZLA	brand	2	PA, SP
auranofin	RIDAURA	brand	2	
azathioprine	IMURAN	generic	1	
canakinumab	ILARIS	brand	2	PA, SP

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
certolizumab pegol	CIMZIA	brand	2	PA, SP
etanercept	ENBREL	brand	2	PA, SP
hydroxychloroquine	PLAQUENIL	generic	1	
leflunomide	ARAVA	generic	1	
methotrexate		generic	1	
penicillamine	DEPEN TITRATABLE	brand	2	Diagnosis Required, SP
sarilumab	KEVZARA	brand	2	PA, QL, SP
secukinumab	COSENTYX	brand	2	PA, SP
sulfasalazine	AZULFIDINE	generic	1	
sulfasalazine delayed-release	AZULFIDINE EN-TABS	generic	1	
NSAIDs and Other Analgesics				
acetaminophen	TYLENOL	generic	1	OTC
aspirin	BAYER ECOTRIN	generic	1	OTC
capsaicin	CAPSAGEL CAPZASIN-P CASTIVA	brand	2	OTC, gel, lotion, 0.035% cream
capsaicin		generic	1	OTC, 0.025%, 0.075%, & 0.1% cream
celecoxib	CELEBREX	generic	1	PA, QL
diclofenac 1% gel	VOLTAREN 1% TOPICAL GEL	generic	1	PA
diclofenac potassium	CATAFLAM	generic	1	
diclofenac sodium delayed-release	VOLTAREN	generic	1	
diclofenac sodium extended-release	VOLTAREN XR	generic	1	
etodolac	LODINE	generic	1	IR only
ibuprofen	ADVIL	generic	1	tabs, chew tabs and susp, OTC
ibuprofen	MOTRIN	generic	1	tabs, chew tabs and susp
indomethacin	INDOCIN	generic	1	
ketoprofen	ORUDIS	generic	1	IR only
meloxicam	MOBIC	generic	1	QL
naproxen	NAPROSYN	generic	1	
naproxen delayed release	ENTERIC COATED-NAPROSYN	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
oxaprozin	DAYPRO	generic	1	
piroxicam	FELDENE	generic	1	
salsalate	DISALCID	generic	1	QL
sulindac	CLINORIL	generic	1	
Gout				
allopurinol	ZYLOPRIM	generic	1	
colchicine	MITIGARE	brand	2	
febuxostat	ULORIC	brand	2	ST
probenecid	PROBENECID	generic	1	
Skeletal Muscle Relaxants				
Muscle Spasm				
chlorzoxazone	PARAFON FORTE DSC	generic	1	
cyclobenzaprine	FLEXERIL	generic	1	5mg & 10mg
methocarbamol	ROBAXIN	generic	1	
orphenadrine extended-release	NORFLEX	generic	1	
Spasticity				
baclofen	BACLOFEN	generic	1	
dantrolene	DANTRIUM	generic	1	
diazepam	VALIUM	generic	1	QL
tizanidine	ZANAFLEX	generic	1	tabs only, QL
OB-GYN				
Contraceptives				
Biphasic				
desogestrel/EE	MIRCETTE	generic	1	QL
norethindrone/EE	ORTHO-NOVUM 10/11	generic	1	QL
Emergency Contraception				
levonorgestrel	PLAN B ONE STEP	generic	1	
Extended Cycle				
levonorgestrel/EE	SEASONALE	generic	1	QL
Injectable				
medroxyprogesterone acetate	DEPO-PROVERA	generic	1	QL
Intravaginal				
etonogestrel/EE	NUVARING	brand	2	ring, QL
ortho diaphragm	ORTHO COIL ORTHO FLAT ORTHO FLEX	brand	2	QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Monophasic - 20 mcg Estrogen				
levonorgestrel/EE	ALESSE	generic	1	0.1/20, QL
norethindrone acetate/EE	LOESTRIN 1/20	generic	1	1/20, QL
norethindrone acetate/EE/ iron	LOESTRIN FE 1/20	generic	1	1/20, QL
Monophasic - 30 mcg Estrogen				
desogestrel/EE	ORTHO-CEPT	generic	1	0.15/30, QL
levonorgestrel/EE	NORDETTE	generic	1	0.15/30, QL
norethindrone acetate/EE	LOESTRIN 1.5/30	generic	1	1.5/30, QL
norethindrone acetate/EE/ iron	LOESTRIN FE 1.5/30	generic	1	1.5/30, QL
norgestrel/EE	LO/OVRAL	generic	1	0.3/30, QL
Monophasic - 35 mcg Estrogen				
ethynodiol diacetate/EE	ZOVIA 1/35	generic	1	1/35, QL
norethindrone/EE	BALZIVA	generic	1	0.4/35, QL
norethindrone/EE	MODICON	generic	1	0.5/35, QL
norethindrone/EE	ORTHO-NOVUM 1/35	generic	1	1/35, QL
norgestimate/EE	ORTHO-CYCLEN	generic	1	0.25/35, QL
Monophasic - 50 mcg Estrogen				
ethynodiol diacetate/EE	ZOVIA 1/50	generic	1	1/50, QL
norethindrone/EE	OVCON 50	generic	1	1/50, QL
norethindrone/ME	ORTHO-NOVUM 1/50	generic	1	1/50, QL
norgestrel/EE	OVRAL	generic	1	0.5/50, QL
Progestin				
norethindrone	ORTHO MICRONOR	generic	1	
Transdermal				
norelgestromin/EE	ORTHO EVRA XULANE	generic	1	
Triphasic				
desogestrel/EE	CYCLESSA	generic	1	QL
levonorgestrel/EE	TRIVORA	generic	1	QL
norethindrone acetate/EE/iron	ESTROSTEP FE	generic	1	QL
norethindrone/EE	ORTHO-NOVUM 7/7/7	generic	1	QL
norethindrone/EE	TRI-NORINYL	generic	1	QL
norgestimate/EE	ORTHO TRI-CYCLEN	generic	1	QL
Endometriosis				
danazol	DANOCRINE	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Hormone Therapy/Menopause				
Estrogens - Intravaginal				
estradiol	ESTRADIOL	brand	2	
estrogens, conjugated	PREMARIN	brand	2	crm
yuvafem or estradiol vaginal tablet	VAGIFEM	generic	1	QL
Estrogens - Oral				
estradiol	ESTRACE	generic	1	
estrogens, conjugated	PREMARIN	brand	2	
estropipate	OGEN	generic	1	
Estrogens - Transdermal				
estradiol	CLIMARA	generic	1	QL
Estrogen/Progestin				
estrogens, conjugated/ medroxyprogesterone	PREMPHASE PREMPRO	brand	2	
Progestins				
medroxyprogesterone acetate	PROVERA	generic	1	
norethindrone acetate	AYGESTIN	generic	1	
progesterone micronized cap	PROMETRIUM	generic	1	Diagnosis Required
Ovulation Stimulants				
choriogonadotropin alfa	OVIDREL	brand	2	Diagnosis Required
chorionic gonadotropin	NOVAREL	brand	2	Diagnosis Required
Vaginal Infections				
Oral				
fluconazole	DIFLUCAN	generic	1	QL
metronidazole	FLAGYL	generic	1	tabs
Vaginal				
clotrimazole	GYNE-LOTRIMIN	generic	1	OTC
clindamycin	CLEOCIN	generic	1	crm
metronidazole	METROGEL-VAGINAL METROGEL 1%	generic	1	
miconazole	MONISTAT	generic	1	OTC
miconazole	MONISTAT 3	generic	1	
terconazole	TERAZOL 3/7	generic	1	crm

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Miscellaneous				
conjugated estrogen/ bazedoxifene	DUAVEE	brand	2	
methylergonovine	METHERGINE	generic	1	
tranexamic acid	LYSTEDA	generic	1	PA
Ophthalmic				
Allergy				
azelastine	OPTIVAR	generic	1	ST
cromolyn sodium	CROLOM	generic	1	QL
ketotifen	ALAWAY OTC	generic	1	
naphazoline/glycerin	CLEAR EYES REDNESS RELIEF	generic	1	
naphazoline HCL	VASOCLEAR	generic	1	soln 0.02%
naphazoline/zinc sulfate	VASOCLEAR A	brand	2	OTC
tetrahydrozoline/ zinc sulfate	VISINE-AC	generic	1	
Anti-Inflammatories				
Anti-Infective/Anti-Inflammatory Combinations				
bacitracin/polymyxin/ neomycin/hc	CORTISPORIN	generic	1	ointment
gentamicin/prednisolone acetate	PRED-G	brand	2	
neomycin/polymyxin B/ dexamethasone	MAXITROL	generic	1	
neomycin/polymyxin B/ hydrocortisone	CORTISPORIN	generic	1	suspension
sulfacetamide/pred phos	VASOCIDIN	generic	1	10%/0.25%
tobramycin/ dexamethasone	TOBRADEX	generic	1	
Nonsteroidal				
diclofenac sodium	VOLTAREN	generic	1	
flurbiprofen	OCUFEN	generic	1	
ketorolac	ACULAR/ACULAR LS	generic	1	
Steroidal				
dexamethasone sodium phosphate	DEXASOL	generic	1	
fluorometholone	FML	brand	2	oint 0.1%
fluorometholone	FML FORTE	brand	2	susp 0.25%

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
fluorometholone	FML LIQUIFILM	generic	1	susp 0.1%
prednisolone acetate	PRED FORTE	generic	1	1%
prednisolone acetate	PRED MILD	brand	2	0.12%
prednisolone phosphate	INFLAMASE FORTE	generic	1	1%
Glaucoma				
Beta-Blockers				
carteolol		generic	1	
levobunolol	BETAGAN	generic	1	ophthalmic solution
metipranolol	OPTIPRANOLOL	generic	1	0.3% ophthalmic solution
timolol	TIMOPTIC XE	generic	1	gel forming solution
timolol maleate	TIMOPTIC	generic	1	
Carbonic Anhydrase Inhibitors				
dorzolamide	TRUSOPT	generic	1	
Carbonic Anhydrase Inhibitor/Beta-Blocker Combination				
dorzolamide/ timolol maleate	COSOPT	generic	1	
Cholinesterase Inhibitor				
ecothiophate	PHOSPHOLINE IODINE	brand	2	
Mydriatics				
atropine	ISOPTO ATROPINE	generic	1	
cyclopentolate	CYCLOGYL	generic	1	1%
Oral				
acetazolamide	ACETAZOLAMIDE	generic	1	
acetazolamide extended-release	DIAMOX SEQUELS	generic	1	
methazolamide	NEPTAZANE	generic	1	
Prostaglandins				
latanoprost	XALATAN	generic	1	QL
Topical - Parasympathomimetics				
pilocarpine	ISOPTO CARPINE	generic	1	
pilocarpine	PILOPINE HS GEL	brand	2	
Topical - Sympathomimetics				
brimonidine	ALPHAGAN P	brand	2	0.1%
brimonidine	ALPHAGAN P	generic	1	0.15%
brimonidine	ALPHAGAN	generic	1	0.2%
Immunologic Agents				
lifitegrast	XIIDRA	brand	2	PA

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Infections				
Bacterial				
bacitracin		generic	1	
ciprofloxacin	CILOXAN	generic	1	solution
ciprofloxacin	CILOXAN	brand	2	ointment
erythromycin	ERYTHROMYCIN	generic	1	
gentamicin	GENTAK	generic	1	
neomycin/bacitracin/ polymyxin	NEOSPORIN	generic	1	ointment
neomycin/polymyxin B/ gramicidin	NEOSPORIN	generic	1	solution
ofloxacin	OCUFLOX	generic	1	
polymyxin B/bacitracin	POLYSPORIN	generic	1	
polymyxin B/trimethoprim	POLYTRIM	generic	1	
sulfacetamide	BLEPH-10	generic	1	oint/soln
tobramycin	TOBREX	generic	1	
Viral				
trifluridine	VIROPTIC	generic	1	
Miscellaneous Ophthalmics				
cysteamine 0.44% ophthalmic solution	CYSTARAN	brand	2	Diagnosis Required, SP
sodium chloride hypertonic	MURO 128	generic	1	soln 5%
Psychiatric				
Alcohol Deterrents				
acamprosate	CAMPRAL	brand	2	
disulfiram	ANTABUSE	generic	1	
naltrexone	REVIA	generic	1	
Anxiety				
Benzodiazepines				
alprazolam	GABAZOLAMINE SENTRAZOLAM AM 0.25	brand	2	tab, 0.25 mg & dietary management cap pack
alprazolam	GABAZOLAMINE-0.5			tab, 0.5 mg & dietary management cap pack
alprazolam	XANAX	generic	1	QL, IR only
alprazolam orally disintegrating tab	NIRAVAM	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
alprazolam SR	XANAX XR	generic	1	
chlordiazepoxide	LIBRIUM	generic	1	
clonazepam	KLONOPIN	generic	1	not wafers
clorazepate	TRANXENE T	generic	1	
diazepam	GABAVALE-5	brand	2	tab, 5 mg & dietary management cap pack
diazepam	VALIUM	generic	1	QL
lorazepam	ATIVAN	generic	1	QL
oxazepam	SERAX	generic	1	QL
Miscellaneous				
buspirone	BUSPAR	generic	1	
droperidol inj	INAPSINE	generic	1	
fluvoxamine	LUVOX	generic	1	
fluvoxamine maleate SR	LUVOX CR	generic	1	
hydroxyzine hcl	ATARAX	generic	1	
hydroxyzine pamoate	VISTARIL	generic	1	
meprobamate	EQUANIL MILTOWN	generic	1	
Attention Deficit Hyperactivity Disorder (ADHD) – Diagnosis required				
amphetamine/ dextroamphetamine mixed salts	ADDERALL	generic	1	Age Limits Apply, QL
amphetamine/ dextroamphetamine mixed salts extended-release	ADDERALL XR (BRAND ADDERALL XR IS PREFERRED)	brand	2	Age Limits Apply, QL
atomoxetine	STRATTERA	brand	2	Age Limit Applies, QL
clonidine hcl	KAPVAY	brand	2	
clonidine hcl SR	KAPVAY DOSE PACK	brand	2	
dexmethylphenidate hcl	FOCALIN	generic	1	
dexmethylphenidate hcl SR	FOCALIN XR	brand	2	
dextroamphetamine	DEXEDRINE	generic	1	Age Limits Apply, QL
dextroamphetamine	DEXTROSTAT	generic	1	Age Limits Apply, QL
dextroamphetamine extended-release	DEXEDRINE SPANSULE	generic	1	Age Limits Apply, QL
dextroamphetamine sulfate	PROCENTRA ZENZEDI	generic	1	
guanfacine ER	INTUNIV	generic	1	
lisdexamfetamine	VYVANSE	brand	2	Age Limits Apply, QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
lisdexamfetamine chewable tab	VYVANSE CHEWABLE	brand	2	Diagnosis Required
methamphetamine hcl	DESOXYN	generic	1	
methylphenidate ER	QUILLIVANT XR	brand	2	
methylphenidate extended-release	CONCERTA	generic	1	Age Limits Apply, QL
methylphenidate extended-release	METADATE CD METADATE ER	generic	1	Age Limits Apply, QL
methylphenidate extended-release	RITALIN LA	generic	1	Age Limits Apply, QL
methylphenidate hcl	METHYLIN RITALIN	generic	1	Age Limits Apply, tabs only, QL
methylphenidate hcl ER 24hr		generic	1	Age limits apply, QL, 18mg, 27mg, 36mg, 54mg tablets, Mallinckrodt and Kremers Urban labelers
methylphenidate hcl SA OSM	CONCERTA	generic	1	
methylphenidate TD	DAYTRANA	brand	2	
Bipolar Disorder				
divalproex sodium cap sprinkle	DEPAKOTE SPRINKLE	generic	1	Members ≥ 8 years of age will require prior authorization.
divalproex sodium delayed-release	DEPAKOTE	generic	1	Minimum age 2
lithium carbonate	ESKALITH LITHANE LITHIUM CARBONATE	generic	1	
lithium carbonate extended-release	ESKALITH CR LITHOBID	generic	1	
lithium citrate	CIBALITH-S	generic	1	
Depression				
Monoamine Oxidase Inhibitor (MAOI)				
isocarboxazid	MARPLAN	brand	2	
phenelzine sulfate	NARDIL	generic	1	
selegiline td patch 24HR	EMSAM	brand	2	
tranylcypromine	PARNATE	generic	1	
Selective Serotonin Reuptake Inhibitor (SSRIs)				
citalopram	CELEXA	generic	1	QL
citalopram	SENTRALOPRAM AM-10	brand	2	tab, 10 mg & dietary management cap pack

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
escitalopram	LEXAPRO	generic	1	
fluoxetine	PROZAC	generic	1	10 mg and 20 mg caps and 20 mg soln only
fluoxetine hcl	GABOXETINE SENTRAFLOX AM-10 SENTROXATINE	brand	2	cap, 10 mg & dietary management cap pack
fluoxetine hcl	SARAFEM	brand	2	
fluoxetine hcl delayed-release	PROZAC WEEKLY	generic	1	
paroxetine hcl	PAXIL	generic	1	QL
paroxetine hcl SR	PAXIL CR	generic	1	
paroxetine mesylate tab	PEXEVA	brand	2	
sertraline hcl	ZOLOFT	generic	1	QL
Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)				
desvenlafaxine succinate SR	PRISTIQ	generic	1	
duloxetine hcl	CYMBALTA	generic	1	QL
venlafaxine	EFFEXOR	generic	1	QL
venlafaxine XR	EFFEXOR XR	generic	1	QL
Tricyclic Antidepressants (TCAs)				
amitriptyline hcl	ELAVIL	generic	1	
amitriptyline hcl	SENTRAVIL PM-25	brand	2	tab, 25 mg & diet manage prod cap pack
amoxapine	ASENDIN	generic	1	
clomipramine	ANAFRANIL	generic	1	QL
desipramine hcl	NORPRAMIN PERTOFRANE	generic	1	
doxepin hcl	ADAPIN SINEQUAN	generic	1	
imipramine hcl	TOFRANIL	generic	1	
imipramine pamoate	TOFRANIL-PM	generic	1	
nortriptyline hcl	AVENTYL PAMELOR	generic	1	
protriptyline hcl	VIVACTIL	generic	1	
trimipramine maleate	SURMONTIL	generic	1	
Tricyclic Antidepressant/Phenothiazine combination				
amitriptyline/perphenazine	TRIAVIL	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Miscellaneous Agents				
bupropion	WELLBUTRIN	generic	1	
bupropion extended-release	WELLBUTRIN SR	generic	1	QL
bupropion HBR SR	APLENZIN	brand	2	
bupropion hcl	APPBUTAMONE APPBUTAMONE-D	brand	2	tab 75 mg & dietary management cap pack
bupropion hcl SR	FORFIVO XL	brand	2	
bupropion hcl SR	WELLBUTRIN XL	generic	1	
maprotiline	LUDIOMIL	generic	1	
mirtazapine	REMERON	generic	1	tabs (not soltabs)
mirtazapine orally disintegrating tab	REMERON SOLTAB	generic	1	
nefazodone hcl	SERZONE	brand	2	
trazodone	DESYREL	generic	1	
trazodone hcl	TRAZAMINE	brand	2	tab, 50 mg & dietary management cap pack
vilazodone hcl	VIIBRYD	brand	2	
Insomnia				
Benzodiazepines				
estazolam	PROSOM	generic	1	
flurazepam	DALMANE	generic	1	QL
midazolam hcl	VERSED	generic	1	
quazepam	DORAL	generic	1	
temazepam	RESTORIL	generic	1	QL
triazolam	HALCION	generic	1	QL
Non-Benzodiazepines				
chloral hydrate	CHLORAL HYDRATE	generic	1	
diphenhydramine	NYTOL QUICK CAPS	generic	1	OTC
doxylamine succinate	UNISOM	generic	1	25mg, OTC, QL
eszopiclone	LUNESTA	brand	2	
zaleplon	SONATA	generic	1	QL
zolpidem	AMBIEN	generic	1	QL
zolpidem tartrate	ZOLPIMIST	brand	2	
zolpidem tartrate CR	AMBIEN CR	generic	1	
zolpidem tartrate SL	EDLUAR INTERMEZZO	brand	2	
Narcotic Antagonists				
buprenorphine	SUBUTEX	generic	1	QL
buprenorphine/naloxone	BUNAVAIL	brand	2	QL
buprenorphine/naloxone	SUBOXONE	brand	2	films, QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
buprenorphine/naloxone	SUBOXONE	generic	1	tabs, QL
buprenorphine/naloxone	ZUBSOLV	brand	2	QL
naloxone	NARCAN NASAL SPRAY	brand	2	QL
naloxone	NALOXONE INJ	generic	1	QL, injectable
naltrexone	REVIA	generic	1	
Psychoses – Diagnosis required				
Atypicals				
aripiprazole	ABILIFY TABLETS	generic	1	tablets, QL, Certain daily doses require half tablet dosing: 5 mg once daily – must be dosed as 10 mg tablet, ½ tab once daily 10 mg once daily – must be dosed as 20 mg tablet, ½ tab once daily 15 mg once daily – must be dosed as 30 mg tablet, ½ tab once daily
aripiprazole ER injection	ABILIFY MAINTENA			Age Limit Applies, QL
aripiprazole injection	ARISTADA	brand	2	QL
aripiprazole orally disintegrating tab	ABILIFY DISCMELT	brand	2	
asenapine maleate	SAPHRIS	brand	2	QL
clozapine	CLOZARIL	generic	1	Age Limit Applies, 25mg, 50mg, 100mg only, QL
clozapine orally disintegrating tab	FAZACLO	generic	1	
iloperidone	FANAPT	brand	2	QL
lurasidone hcl	LATUDA	brand	2	QL
olanzapine	ZYPREXA	generic	1	Age Limit Applies, tablets, QL
olanzapine-fluoxetine hcl	SYMBYAX	generic	1	
olanzapine orally disintegrating tab	ZYPREXA ZYDIS	generic	1	Age Limit Applies, QL
olanzapine pamoate	ZYPREXA RELPREVV	brand	2	Diagnosis Required, QL
paliperidone	INVEGA	generic	1	
paliperidone	INVEGA SUSTENNA	brand	2	Age Limit Applies, QL
paliperidone	INVEGA TRINZA	brand	2	Age Limit Applies, QL
quetiapine	SEROQUEL	generic	1	Age Limit Applies, QL
quetiapine fumarate SR	SEROQUEL XR	generic	1	Age Limit Applies, QL

Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
risperidone	RISPERDAL	generic	1	Age Limit Applies, QL
risperidone microspheres	RISPERDAL CONSTA	brand	2	Age Limit Applies, QL
risperidone oral soln	RISPERDAL SOLUTION	generic	1	QL, Members ≥ 8 years of age will require prior authorization.
risperidone orally disintegrating tab	RISPERDAL M-TAB	generic	1	
ziprasidone	GEODON	generic	1	Age Limit Applies, QL
Smoking Cessation				
bupropion (smoking deterrent) ER 12hr	ZYBAN	generic	1	QL
nicotine	NICODERM CQ	generic	1	patches, QL
nicotine inhaler system	NICOTROL INHALER	brand	2	QL
nicotine nasal spray	NICOTROL NASAL	brand	2	QL
nicotine polacrilex gum	NICORETTE OTC	generic	1	QL
nicotine polacrilex lozenge	COMMITT OTC	generic	1	QL
varenicline	CHANTIX	brand	2	QL
Miscellaneous				
carbamazepine SR	EQUETRO	brand	2	
chlorpromazine	THORAZINE	generic	1	
dextromethorphan/ quinidine	NUEDEXTA	brand	2	Diagnosis Required
fluphenazine	PROLIXIN	generic	1	
fluphenazine decanoate	PROLIXIN DECANOATE	generic	1	
haloperidol	HALDOL	generic	1	
haloperidol decanoate	HALDOL DECANOATE	generic	1	
loxapine	LOXITANE	generic	1	
perphenazine	TRILAFON	generic	1	
pimozide	ORAP	generic	1	
prochlorperazine	COMPAZINE COMPRO	generic	1	
thioridazine	MELLARIL	generic	1	
thiothixene	NAVANE	generic	1	
trifluoperazine	STELAZINE	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Respiratory Drugs				
Antitussives, Decongestants, Expectorants and Combinations				
hydrocodone w/homatropine	HYCODAN	generic	1	Age Limits Apply, QL
promethazine w/codeine syrup	PHENERGAN W/ CODEINE	generic	1	Age Limits Apply, QL
promethazine/ phenylephrine/codeine	PHENERGAN VC	generic	1	Age Limits Apply, QL
Asthma/COPD				
Inhalers - Beta Agonists				
albuterol sulfate	VENTOLIN HFA	brand	2	QL
indacaterol	ARCAPTA NEOHALER	brand	2	
olodaterol	STRIVERDI RESPIMAT	brand	2	
Inhalers - Corticosteroids				
beclomethasone	QVAR REDIHALER	brand	2	QL
fluticasone furoate	ARNUITY ELLIPTA	brand	2	QL
mometasone	ASMANEX HFA	brand	2	Patients 8 years and older will require prior authorization
Inhalers - Corticosteroid/Beta Agonist Combinations				
fluticasone/salmeterol	AIRDUO RESPICLICK	generic	1	QL
fluticasone/vilanterol	BREO ELLIPTA	brand	2	ST
Inhalers - Others				
ipratropium/albuterol	COMBIVENT RESPIMAT	brand	2	inhaler
ipratropium HFA	ATROVENT HFA	brand	2	
omalizumab	XOLAIR	brand	2	PA, SP
tiotropium/olodaterol	STIOLTO RESPIMAT	brand	2	QL
umeclidinium inhalation	INCRUSE ELLIPTA	brand	2	
Inhalers for Nebulization				
albuterol	ACCUNEB	generic	1	0.63 mg/3 ml and 1.25 mg /3 ml, Covered for members less than 8 years of age. Members ≥ 8 years of age will require prior authorization.
albuterol	PROVENTIL	generic	1	soln 0.083%, 0.5%
budesonide	PULMICORT RESPULES	generic	1	susp, Members ≥ 5 years of age will require prior authorization. QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
cromolyn	INTAL	generic	1	soln, QL
ipratropium	ATROVENT	generic	1	soln, QL
ipratropium/albuterol	DUONEB	generic	1	soln
levalbuterol HCl	XOPENEX RESPULES	generic	1	QL, ST
Oral Agents - Beta Agonists				
metaproterenol	METAPROTERENOL SYRUP	generic	1	
terbutaline	BRETHINE	generic	1	
Oral Agents - Leukotriene Modifiers				
montelukast	SINGULAIR	generic	1	QL
Oral Agents - Theophylline				
theophylline	THEOPHYLLINE	generic	1	liquid
theophylline extended-release	THEO-24	brand	2	caps
theophylline extended-release	THEOCHRON UNIPHYL	generic	1	tabs
Urological				
Symptomatic Benign Prostatic Hypertrophy				
alfuzosin ER	UROXATRAL	generic	1	
doxazosin	CARDURA	generic	1	
finasteride	PROSCAR	generic	1	
tamsulosin	FLOMAX	generic	1	
terazosin	HYTRIN	generic	1	
Miscellaneous				
bethanechol	URECHOLINE	generic	1	
hyoscyamine, methenamine, phenyl salicylate, sodium phosphate monobasic, methylene blue	UTIRA C	brand	2	
methenamine hippurate	HIPREX UREX	generic	1	
oxybutynin chloride	DITROPAN XL	generic	1	QL
oxybutynin IR	DITROPAN	generic	1	
oxybutynin patch	OXYTROL FOR WOMEN OTC PATCH	brand	2	
pentosan polysulfate sodium	ELMIRON	brand	2	Diagnosis Required, QL
potassium citrate	UROCIT-K	generic	1	
propantheline		generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
phenazopyridine	PYRIDIUM	generic	1	
sodium citrate/citric acid	BICITRA	generic	1	
tolterodine	DETROL	generic	1	ST
trospium	SANCTURA	generic	1	ST
Vitamins and Minerals				
b-complex	B-COMPLEX VITAMIN TAB	generic	1	OTC, QL
calcitriol	ROCALTROL	generic	1	
calcitriol oral soln	ROCALTROL SOLUTION	generic	1	Members ≥ 8 years of age will require prior authorization.
calcium	OS-CAL	generic	1	OTC
calcium carb-vit D w/ minerals	CALTRATE W/D	generic	1	OTC, QL
cholecalciferol	BIO-D DRO-MULSION	generic	1	drops 400 unit/0.03 ml, OTC
cholecalciferol	BIO-D-MULSIO DRO FORTE	generic	1	drops 2000 unit/0.03 ml, OTC
cholecalciferol	D3-50 CAP	brand	2	cap 50000 unit, OTC
cholecalciferol	VITAMIN D 400 UNIT	generic	1	caps & tabs 400 unit, OTC
cholecalciferol	VITAMIN D 2000 UNIT	generic	1	caps & tabs 2000 unit, OTC
cholecalciferol	VITAMIN D 1000 UNIT	generic	1	caps & tabs 1000 unit, OTC
cyanocobalamin	VITAMIN B-12	generic	1	inj
electrolyte	PEDIALYTE	generic	1	soln, oral, OTC
ergocalciferol (D2)	DRISDOL	generic	1	
ferrous sulfate	FEOSOL	generic	1	OTC
fluoride	GEL-KAM LURIDE LURIDE LOZI-TABS PHOS-FLUR PREVIDENT	generic	1	
folic acid	FOLIC ACID	generic	1	
magnesium oxide	MAG-OX	generic	1	OTC
multivitamins/ fluoride/±iron	POLY-VI-FLOR	generic	1	
multivitamins/minerals	CENTRUM	generic	1	OTC
phytonadione	MEPHYTON	brand	2	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
prenat-FE Bis-FE prot succ-FA-CA & omega 3	COMPLETE NATALCARE PAK DHA	brand	2	
prenat-FE Bis-FE prot succ-FA-CA & omega 3	TRUST NATALCARE PAK DHA	brand	2	
prenat-FE Bis-FE prot succ-FA-CA & omega 3	PRUET DHA PAK SETONET PAK	brand	2	
prenat-FE bis-FE prot succ-FA-CA & omega DR	PRUET DHAEC PAK	brand	2	
prenat w/o A w/ fecbn-fegl-DSS-FA & DHA	FOLTABS PAK PLUS DHA RE OB + DHA PAK	brand	2	
prenatal vit w/FE bisglycinate chelate-FA	GENTEX ADE 28-1 MG	brand	2	
prenatal vit w/FE bisglycinate chelate-FA	VINATE AZ EX	brand	2	
prenatal vit w/FE bisglycinate chelate-FA	VINATE II	brand	2	
prenatal vit w/FE polysac cmplx-FA	EDGE OB CHW	brand	2	
prenatal vit w/iron carbonyl-FA	ATABEX PRENATAL	brand	2	
prenatal vitamins w/folic acid	PRENATAL VITAMINS W/ FOLIC ACID MATERNA NESTABS	generic	1	QL
prenatal vit w/o vit a w/fe bisglycinate-fa		brand	2	tab, 32-1 mg
prenatal w/o A w/FE carbonyl-FE gluc-DSS-FA	FOLTABS PRENATAL TRI RX	brand	2	
vitamin A		generic	1	OTC
vitamin ADC/fluoride/±iron drops	TRI-VI-FLOR	generic	1	

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
vitamin B complex/ vitamin C/folic acid	NEPHROCAPS	generic		
vitamin B-1		generic	1	OTC
vitamin B-6		generic	1	OTC
vitamin C		generic	1	OTC
vitamins pediatric	TRI-VI-SOL	generic	1	members <3 years old, OTC
zinc		generic	1	OTC
Potassium				
phosphorus	K-PHOS NEUTRAL	generic	1	tabs
potassium acid phosphate	K-PHOS ORIGINAL	brand	2	
potassium bicarbonate/ potassium citrate effervescent	K-LYTE	generic	1	tabs
potassium chloride extended-release	K-DUR 10 K-DUR 20 KLOR-CON 8 KLOR-CON 10	generic	1	tabs
potassium chloride extended-release	MICRO-K 10	generic	1	caps
potassium chloride	K-LOR	generic	1	powder
potassium chloride	POTASSIUM CHLORIDE	generic	1	liquid
Miscellaneous				
Anaphylaxis				
epinephrine	EPIPEN EPIPEN JR.	generic	1	QL
Antidotes				
acetylcysteine	CETYLEV	brand	2	
succimer	CHEMET	brand	2	QL
Cystic Fibrosis				
acetylcysteine	MUCOMYST	generic	1	
aztreonam	CAYSTON	brand	2	Diagnosis Required, SP
dornase alfa	PULMOZYME	brand	2	Diagnosis Required, SP
ivacaftor	KALYDECO KALYDECO GRANULES	brand	2	PA, SP
lumacaftor/ivacaftor	ORKAMBI	brand	2	PA, SP
sodium chloride for nebulizer	HYPERSAL NEBUSAL	generic	1	
tobramycin neb soln	BETHKIS	brand	2	Diagnosis Required, SP

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
Hereditary Angioedema				
c1 esterase inhibitor, human	BERINERT	brand	2	PA, SP
c1 esterase inhibitor, human	HAEGARDA	brand	2	PA, QL, SP
icatibant	FIRAZYR	brand	2	PA, SP
Hyperphosphatemia				
calcium acetate		generic	1	667 mg tablet only
cinacalcet	SENSIPAR	brand	2	PA
sevelamer	RENVELA	generic	1	ST
Idiopathic Pulmonary Fibrosis (IPF)				
nintedanib	OFEV	brand	2	PA, SP
pirfenidone capsule	ESBRIET	brand	2	PA, SP
Immune Thrombocytopenic Purpura				
eltrombopag	PROMACTA	brand	2	PA, SP
Medical Devices				
insulin syringes				QL
lancets				QL
spacers				QL
Metabolic Modifiers				
carglumic acid	CARBAGLU	brand	2	PA, SP
glycerol phenylbutyrate	RAVICTI	brand	2	PA, SP
sodium phenylbutyrate	BUPHENYL	generic	1	Diagnosis Required, SP
Vaccine				
diphtheria-tetanus tox adsorbed (dt) im	DIP/TET PED INJ	brand	2	QL
hepatitis a vaccine susp	HAVRIX, VAQTA	brand	2	QL
hepatitis b vaccine (recombinant)	ENGERIX-B RECOMBIVAX HB	brand	2	QL
hepatitis b vaccine recombinant adjuvanted	HEPLISAV-B	brand	2	Age Limits Apply, QL
human papillomavirus (hpv) 9-valent recomb vac	GARDASIL 9	brand	2	QL
human papillomavirus (hpv) quadrivalent recombinant vac	GARDASIL	brand	2	QL
influenza virus vaccine recombinant hemagglutinin (ha)	FLUBLOK	brand	2	QL

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Generic Drug Name	Brand Drug Name	Covered Drug	Tier	Requirements & Limits
influenza virus vaccine split	AFLURIA FLUZONE SPLT	brand	2	QL
influenza virus vaccine split high-dose pf	FLUZONE HD PF	brand	2	QL
influenza virus vaccine split pf	AFLURIA PF	brand	2	QL
influenza virus vaccine split quadrivalent	FLUARIX QUAD FLULAVAL QUAD FLUZONE QUAD	brand	2	QL
influenza virus vaccine tiss-cult subunit	FLUCELVAX	brand	2	QL
influenza virus vaccine types a&b surface antigen	FLUVIRIN	brand	2	QL
measles, mumps & rubella virus vaccines for inj	M-M-R II	brand	2	QL
meningococcal (a, c, y, and w-135)	MENOMUNE	brand	2	QL
meningococcal (a, c, y, and w-135) conjugate vaccine	MENACTRA	brand	2	QL
meningococcal (a, c, y, and w-135) oligo conj vac for inj	MENVEO	brand	2	QL
pneumococcal 13-valent conjugate	PREVNAR 13	brand	2	QL
pneumococcal vaccine polyvalent	PNEUMOVAX PNEUMOVAX 23	brand	2	QL
tet tox-diph-acell pertuss ad	ADACEL BOOSTRIX	brand	2	QL
tetanus-diphtheria toxoids (td)	TENIVAC TET/DIP TOX INJ	brand	2	QL
tetanus immune globulin (human)	HYPERTET S/D	brand	2	QL
typhoid vaccine	VIVOTIF BERNA	brand	2	capsules
varicella virus vac live for subcutaneous	VARIVAX	brand	2	QL
zoster vaccine live	ZOSTAVAX	brand	2	QL, Age Limits Apply

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Generic Drug Name	Brand Drug Name Examples
OTC MEDICATIONS	
The following is a list of OTC products on the PDL. Some OTC products are listed on the drug list. OTC products covered are restricted to generics when available. Brand names are provided as reference only.	
Acne	
adapalene gel	DIFFERIN OTC GEL 0.1%
benzoyl peroxide crm, gel, lotion	CLEARASIL
Antifungals	
clotrimazole miconazole crm tolnaftate	MICATIN LOTRIMIN AF TINACTIN
vaginal products	MONISTAT GYNE-LOTRIMIN
Antivirals	
docosanol	ABREVA OTC CREAM
Atopic Dermatitis	
emollients	CETAPHIL CREAM AND LOTION BETACARE CREAM AND LOTION DERMAPHOR OINTMENT E-OINTMENT GLYCERIN TOPICAL
Cough/Cold Allergy	
antihistamines	BENADRYL
nasal sprays	NEO-SYNEPHRINE AFRIN DIMETAPP DRO DECONGES
Diabetes	
alcohol swabs	CURITY ALCOHOL PADS
glucose oral tablets	
insulin (vials only)	HUMULIN NOVOLIN
Earwax Removal Products	
carbamide peroxide	DEBROX

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Generic Drug Name	Brand Drug Name Examples
Family Planning	
condoms-male	KIMONO LIFESTYLES TRUSTEX DUREX FANTASY TROJAN
contraceptive foam	DELFEN
contraceptive gel	GYNOL II
First Aid	
Burow's soln, wet dressings	DOMEBORO
dermatological baths	COLLOIDAL OATMEAL BATHS
hydrocortisone crm, oint	CORTAID
topical antibacterials	NEOSPORIN BACITRACIN
Gastrointestinal	
antacids liquids, chew tabs	MYLANTA LIQUID MAALOX LIQUID TUMS
antidiarrheals	IMODIUM A-D KAOPECTATE
electrolyte rehydrating soln	PEDIALYTE
famotidine	PEPCID AC
laxative enemas	FLEET ENEMA
laxatives	DULCOLAX FLEET PHOSPHO-SODA
probiotics	ALIGN BACID BIOGAIA CULTURELLE DIGESTIVE PROBIOTIC FLORAJEN FLORANEX FLORASTOR LACTINEX PHILLIPS COLON HEALTH RISA-BID RISAQUAD

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Generic Drug Name	Brand Drug Name Examples
psyllium	METAMUCIL
rectal crm, suppositories	PREPARATION H
simethicone	MYLICON
stool softeners	COLACE
sugar+orthophosphoric acid	EMETROL
Insomnia	
doxylamine succinate	UNISOM
Lice Products	
permethrin	NIX
pyrethrins/piperonyl butoxide shampoo	RID SHAMPOO
Motion Sickness	
dimenhydrinate	DRAMAMINE
meclizine	BONINE
Ophthalmics	
allergic conjunctivitis	ALAWAY
artificial tears	HYPOTEARS
decongestants	VISINE MURINE NAPHCON A
Pain	
acetaminophen tabs, liquid, drops, suppositories, chew tabs	TYLENOL
aspirin tabs, EC tabs, chew tabs	BAYER ECOTRIN
aspirin with buffers tabs	
ibuprofen tabs, chew tabs, drops, susp	ADVIL MOTRIN IB
Smoking Cessation Products	
nicotine	COMMIT LOZENGES (QUANTITY LIMIT) NICODERM CQ (QUANTITY LIMIT) NICOTINE GUM (QUANTITY LIMIT) NICOTROL (QUANTITY LIMIT)
Urological	
oxybutynin patch	OXYTROL FOR WOMEN OTC PATCH
Vitamins/Minerals	
b-complex	B-COMPLEX VITAMIN TAB
calcium	CALTRATE CALTRATE W/D OS-CAL TUMS

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Generic Drug Name	Brand Drug Name Examples
iron ferrous fumarate, ferrous gluconate, ferrous sulfate, ferrous bis-glycinate chelate and polysaccharide iron caps	FERGON FEOSOL
magnesium oxide	MAG-OX
vitamin D 400 IU	VITAMIN D 400 IU
vitamins pediatric members <3 years old	VI-DAYLIN POLY-VI-SOL TRI-VI-SOL
vitamins prenatal	STUART PRENATAL
Warts	
salicylic acid 17%/collodion	DUOFILM
Miscellaneous	
fluoride dental rinse	PHOS-FLUR

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Index of Covered Drugs

A

ALL CAPS = Brand-name drug
Lower case = Generic drug

Index of Covered Drugs

B

ALL CAPS = Brand-name drug
Lower case = Generic drug

C

ALL CAPS = Brand-name drug
Lower case = Generic drug

Index of Covered Drugs

ALL CAPS = Brand-name drug

Lower case = Generic drug

D

ALL CAPS = Brand-name drug
Lower case = Generic drug

E

ALL CAPS = Brand-name drug
Lower case = Generic drug

F

G

ALL CAPS = Brand-name drug
Lower case = Generic drug

H

I

ALL CAPS = Brand-name drug
Lower case = Generic drug

J

K

L

ALL CAPS = Brand-name drug
Lower case = Generic drug

Index of Covered Drugs

M

ALL CAPS = Brand-name drug
Lower case = Generic drug

Index of Covered Drugs

ALL CAPS = Brand-name drug
Lower case = Generic drug

N

ALL CAPS = Brand-name drug
Lower case = Generic drug

O

P

ALL CAPS = Brand-name drug
Lower case = Generic drug

Index of Covered Drugs

ALL CAPS = Brand-name drug
Lower case = Generic drug

Q

R

ALL CAPS = Brand-name drug
Lower case = Generic drug

S

ALL CAPS = Brand-name drug
Lower case = Generic drug

T

ALL CAPS = Brand-name drug
Lower case = Generic drug

U

V

ALL CAPS = Brand-name drug
Lower case = Generic drug

ALL CAPS = Brand-name drug
Lower case = Generic drug

“My Medications” worksheet

Take this worksheet with you each time you visit a doctor. Each of your doctors should be aware of every drug you take and you should have a list as well.

Name of Medicine and Strength	Drug Tier	I Take This Medicine For	Directions	Doctor
Example: Lisinopril, 20mg	Tier 1	High blood pressure	One tablet daily	Dr. Johnson