Express Scripts Medicare (PDP)
2015 Formulary (List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS COVERED BY THIS PLAN

Version Number: Formulary ID Number: 15058, v6

This formulary was updated on 08/06/2014. For more recent information or other questions, please contact **Express Scripts Medicare®** (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week. You can also visit us on the Web at **www.Express-Scripts.com**.

Note to current members: This formulary has changed since last year. Please review this document to understand your plan's drug coverage.

When this drug list (formulary) refers to "we," "us" or "our," it means *Express Scripts Insurance Company* or *Medco Containment Life Insurance Company.* When it refers to "plan" or "our plan," it means *Express Scripts Medicare.*

This document includes the list of the covered drugs (formulary) for our plan, which is current as of August 6, 2014. For more recent information, please contact us. Our contact information, along with the date we last updated the formulary, appears above and on the back cover.

You must use network pharmacies to fill your prescriptions to get the most from your benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2016, and from time to time during the year.

This information is available for free in other languages. Please call Express Scripts Medicare Customer Service at the numbers on the back of your member ID card for additional information. Customer Service is available 24 hours a day, 7 days a week.

Esta información está disponible sin cargo en otros idiomas. Llame al Servicio al cliente de Express Scripts Medicare a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio al cliente está disponible las 24 horas del día, los 7 días de la semana.

This document is available in braille. Please contact Customer Service if you need plan information in another format.

What is the Express Scripts Medicare formulary?

The list of drugs covered by the plan is also known as the "formulary." It contains a list of highly utilized Medicare Part D drugs selected by Express Scripts Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare's standard formulary rules. **Your specific plan may provide coverage of additional drugs that are not listed in this formulary, and your plan may have different plan rules and coverage.** For more information on your plan's specific drug coverage, please review your other plan materials, visit us on the Web at **www.Express-Scripts.com** or contact Customer Service.

Express Scripts Medicare will generally cover a drug as long as the drug is medically necessary, the prescription is filled at an Express Scripts Medicare network pharmacy and other plan rules are followed. For more information on how to fill your prescriptions, please review your other plan materials.

Can my drug coverage change?

Generally, if you are taking a drug covered by your plan in 2015, Express Scripts Medicare will not discontinue or reduce coverage of the drug during the 2015 coverage year, except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our plan's coverage, will not affect members who are currently taking the drug. It will remain available at the same copayment or coinsurance amount for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If Express Scripts Medicare removes drugs from your plan's coverage, adds prior authorization, quantity limits, and/or step therapy restrictions on a drug, or moves a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective. If the Food and Drug Administration (FDA) determines that a drug we cover is unsafe, or if the drug's manufacturer removes the drug from the market, we will immediately stop covering the drug and provide notice to members who are taking the drug. This enclosed formulary is current as of the date indicated on the front cover. **To get updated information about the drugs covered, please visit us on the Web or contact our Customer Service department using the information provided on the front and back covers of this formulary.** If there are any additional changes made to this plan's drug coverage that affect you and are not mentioned above, you will be notified in writing of these changes within a reasonable period of time after the changes take effect.

How do I use the formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular, Hypertension/Lipids."

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 62. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the "Drug Name" column of the list.

What are generic drugs?

Both brand-name drugs and generic drugs are covered under this plan. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the drugs may not be covered. These drugs are noted with "PA" next to them in the formulary.

  Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the plan is limited. The plan may limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. These drugs are noted with "QL" next to them in the formulary.

- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. These drugs are noted with "ST" next to them in the formulary.

You may be able to find out if your drug has any additional requirements or limits by looking in the drug list that begins on page 1. Note: This drug list includes all possible restrictions and limits on coverage. **The requirements and limits may not apply to your plan's specific coverage.** To confirm whether a particular drug is covered, visit us on the Web at **www.Express-Scripts.com** or contact Customer Service.

You can ask us to make an exception to these restrictions or limits. See the section "How do I request an exception to the formulary?" on the following page for information about how to request an exception.

What if my drug is not listed on this formulary?

If your drug is not included in this list of covered drugs, you should first contact Customer Service and ask if your drug is covered.

If you learn that your drug is not covered, you have two options:

- You can ask our Customer Service department for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.

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

You should talk to your doctor to decide if you should switch to an appropriate drug that the plan covers or request an exception so that the plan will cover the drug you are taking.

How do I request an exception to the formulary?

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

- You can request coverage of a drug that is not currently covered by this plan. If approved, the drug will be covered at a pre-determined cost-sharing level, and you will not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to cover a formulary drug at a lower cost-sharing level. If your drug is contained in our Non-Preferred Brand Drug tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand Drug tier instead. If approved, this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Express Scripts Medicare limits the amount of the drug it will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

You should contact us to ask for an initial coverage decision for an exception, utilization restriction exception or to ask the plan to cover a drug that is not currently covered. **When you are requesting an exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

Generally, your request for an exception will only be approved if the alternative drugs that are covered, the lower-tiered drugs or the additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

How do I request an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. To start an appeal, you, your doctor or your representative must contact us.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

For more information about the appeals process, you may contact Customer Service using the information provided on the front and back covers of this document.

Can I get a temporary transition supply while I wait for an exception decision?

As a new or continuing member in our plan, you may be taking drugs that are not covered from one year to the next. Or, you may be taking a drug that is covered but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request an exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, or while you wait for a coverage decision from us, we may cover a temporary transition supply of your drug in certain cases during the first 90 days that you are enrolled in the plan or at the start of a new coverage year.

For each of your drugs that has restrictions or limitations, we will cover a temporary transition supply when you go to a network pharmacy. This temporary transition supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 98-day transition supply, consistent with the dispensing increment (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that has restrictions or limitations but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency transition supply of that drug (unless you have a prescription written for fewer days) while you pursue an exception.

Other times when we will cover a temporary 31-day transition supply (or less, if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

Other coverage that your plan may provide

Your plan **may** also cover categories of "excluded" drugs that are not normally covered by a Medicare prescription drug plan and are not listed in the formulary. **Drugs in the following categories may be covered subject to the rules and limitations of your specific plan:**

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used to promote fertility
- Prescription drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs, such as CAVERJECT®, CIALIS®, EDEX®, LEVITRA®, MUSE® and VIAGRA®, when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR®, XELODA®)
- Non-prescription drugs, also known as over-the-counter (OTC) drugs.

Please contact Customer Service for additional information about your plan's specific drug coverage and your cost-sharing amount. **Please note:** Costs for excluded drugs not normally covered by a Medicare prescription drug plan will not count toward your Medicare prescription drug yearly deductible (if applicable), total drug costs or yearly out-of-pocket expenses.

Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by this plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 62.

The "Drug Name" column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., CRESTOR®) and generic drugs are listed in lowercase italics (e.g., *atorvastatin*). The information in the "Requirements/Limits" column tells you if there are any special requirements for coverage of that particular drug.

If you are not sure whether your drug is covered, please visit our website or contact Customer Service using the information provided on the front and back covers of this formulary.

Your Costs

The amount you pay for a covered drug will depend on:

- **Your coverage stage.** Your plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.
- **The drug tier for your drug.** Each covered drug is in one of three drug tiers. Each tier may have a different cost-sharing amount. The "Drug Tiers" chart on the following page explains what types of drugs are included in each tier and shows how costs may change with each tier.

Your other plan materials have more information about your plan's coverage stages and list the specific cost-sharing amounts for each tier.

Drug Tiers

Tier	Includes	Helpful tips
Tier 1: **Generic Drugs**	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	Use Tier 1 drugs for the lowest cost-sharing amount.
Tier 2: **Preferred Brand Drugs**	This tier includes mostly brand-name drugs as well as some generic drugs.	Drugs in this tier will generally have lower cost-sharing amounts than non-preferred brand drugs.
Tier 3: **Non-Preferred Brand Drugs**	This tier includes non-preferred brand-name drugs as well as some generic drugs.	Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you.

If you qualify for Extra Help

If you qualify for Extra Help from Medicare to help pay for your prescription drugs, your cost-sharing amounts may be lower than your plan's standard benefit. Members who qualify for Extra Help will receive a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Low Income Rider" or "LIS Rider"). Please read it to find out what your costs are. You can also contact Customer Service with any questions using the information listed on the front and back covers of this formulary.

For more information

For more detailed information about your Medicare prescription drug coverage and your plan's specific costs, please review your other plan materials.

If you need additional information on network pharmacies or if you have any other questions, please contact our Customer Service department using the information provided on the front and back covers of this formulary.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or visit http://www.medicare.gov.

Below is a list of abbreviations that may appear on the following pages in the "Requirements/Limits" column that tells you if there are any special requirements for coverage of your drug.

Note: The following drug list includes all possible restrictions and limitations. **Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list.** To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at **www.Express-Scripts.com**.

List of abbreviations

LA: Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, contact Customer Service using the information provided on the front and back covers of this formulary.

MO: Mail-Order Drug. This prescription drug is available through our home delivery service, as well as through our retail network pharmacies. Consider using home delivery for your long-term (maintenance) medications, such as high blood pressure medications. Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.

PA: Prior Authorization. The plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don't get approval, we may not cover this drug.

QL: Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

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

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	2	PA; MO
AMBISOME	2	PA; MO
amphotericin b	1	PA; MO
CANCIDAS	2	PA; MO
clotrimazole mucous membrane	1	MO
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	2	MO
fluconazole	1	MO
fluconazole in dextrose(iso-o) intravenous piggyback 400 mg/200 ml	1	
flucytosine	1	MO
griseofulvin microsize	1	MO
griseofulvin ultramicrosize	1	MO
itraconazole	1	MO; QL (120 per 30 days)
ketoconazole oral	1	MO
LAMISIL ORAL GRANULES IN PACKET	2	MO
MYCAMINE	2	MO
NOXAFIL ORAL	2	MO
nystatin oral suspension	1	MO
nystatin oral tablet	1	MO
SPORANOX ORAL SOLUTION	2	MO
terbinafine oral	1	MO
voriconazole	1	MO
ANTIVIRALS		
abacavir	1	MO
abacavir-lamivudine-zidovudine	1	MO
acyclovir oral	1	MO
acyclovir sodium intravenous solution	1	PA
adefovir	1	MO
amantadine hcl oral	1	MO
APTIVUS ORAL CAPSULE	2	MO
APTIVUS ORAL SOLUTION	2	
ATRIPLA	2	MO
BARACLUDE	2	MO
cidofovir	1	PA; MO
COMPLERA	2	MO
CRIXIVAN	2	MO
didanosine	1	MO
EDURANT	2	MO
EMTRIVA	2	MO
EPIVIR ORAL SOLUTION	2	MO
EPIVIR HBV ORAL SOLUTION	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
EPZICOM	2	MO
famciclovir	1	MO
foscarnet	1	PA; MO
FUZEON	2	MO
ganciclovir sodium	1	MO
INTELENCE ORAL TABLET 100 MG, 200 MG	2	MO
INTELENCE ORAL TABLET 25 MG	2	
INVIRASE	2	MO
ISENTRESS ORAL POWDER IN PACKET	2	
ISENTRESS ORAL TABLET	2	MO
ISENTRESS ORAL TABLET,CHEWABLE	2	MO
KALETRA	2	MO
lamivudine	1	MO
lamivudine-zidovudine	1	MO
LEXIVA	2	MO
MODERIBA	1	MO
MODERIBA DOSE PACK ORAL TABLETS,DOSE PACK 400 MG (7)-400 MG (7), 600 MG (7)- 600 MG (7)	1	MO
nevirapine	1	MO
NORVIR	2	MO
OLYSIO	2	PA; MO
PREZISTA ORAL SUSPENSION	2	MO
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	2	MO
REBETOL ORAL SOLUTION	2	MO
RELENZA DISKHALER	2	MO; QL (60 per 180 days)
RESCRIPTOR	2	MO
RETROVIR INTRAVENOUS	2	
REYATAZ	2	MO
RIBAPAK DOSE PACK ORAL TABLETS,DOSE PACK 400-400 MG (28)-MG (28), 600-400 MG (28)-MG (28), 600-600 MG (28)-MG (28)	1	MO
RIBASPHERE ORAL CAPSULE	1	MO
RIBASPHERE ORAL TABLET 200 MG, 600 MG	1	MO
RIBASPHERE ORAL TABLET 400 MG	1	
ribavirin	1	MO
rimantadine	1	MO
SELZENTRY	2	MO
SOVALDI	2	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
stavudine	1	MO
STRIBILD	2	MO
SUSTIVA	2	MO
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML	2	MO; LA
TAMIFLU ORAL CAPSULE 30 MG	2	MO; QL (84 per 180 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG	2	MO; QL (42 per 180 days)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	2	MO; QL (600 per 180 days)
TIVICAY	2	MO
TRUVADA	2	MO
TYZEKA	2	MO
valacyclovir	1	MO; QL (30 per 30 days)
VALCYTE	2	MO
VICTRELIS	2	MO
VIDEX 2 GRAM PEDIATRIC	2	MO
VIRACEPT	2	MO
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	2	MO
VIRAZOLE	2	MO
VIREAD	2	MO
ZIAGEN ORAL SOLUTION	2	MO
zidovudine	1	MO
CEPHALOSPORINS		
cefaclor	1	MO
cefadroxil	1	MO
cefazolin injection recon soln 1 gram	1	MO
cefazolin injection recon soln 10 gram, 500 mg	1	
cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml	1	MO
cefdinir	1	MO
cefditoren pivoxil oral tablet 200 mg	1	
cefepime	1	MO
cefotaxime injection recon soln 1 gram, 2 gram, 500 mg	1	
cefotaxime injection recon soln 10 gram	1	MO
cefotetan	1	
cefoxitin intravenous recon soln 1 gram	1	MO
cefoxitin intravenous recon soln 10 gram, 2 gram	1	
cefoxitin in dextrose, iso-osm	1	
cefpodoxime	1	MO
cefprozil	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ceftazidime injection recon soln 1 gram, 6 gram	1	
ceftazidime injection recon soln 2 gram	1	MO
ceftriaxone injection recon soln 10 gram	1	
ceftriaxone injection recon soln 250 mg, 500 mg	1	MO
ceftriaxone intravenous	1	MO
cefuroxime axetil	1	MO
cefuroxime sodium injection	1	MO
cefuroxime sodium intravenous	1	
cephalexin	1	MO
FORTAZ INJECTION RECON SOLN 6 GRAM	2	
FORTAZ INTRAVENOUS RECON SOLN 1 GRAM	2	
SUPRAX ORAL CAPSULE	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTIO N 100 MG/5 ML, 200 MG/5 ML	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTIO N 500 MG/5 ML	3	
SUPRAX ORAL TABLET	3	MO
TEFLARO	2	MO
ERYTHROMYCINS / OTHER MACROLIDES		
azithromycin	1	MO
clarithromycin	1	MO
E.E.S. 400	1	MO
E.E.S. GRANULES	2	MO
ERY-TAB ORAL TABLET,DELAYE D RELEASE (DR/EC) 250 MG, 333 MG	1	MO
ERY-TAB ORAL TABLET,DELAYE D RELEASE (DR/EC) 500 MG	2	MO
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	2	
ERYTHROCIN (AS STEARATE)	1	MO
erythromycin oral tablet	1	MO
erythromycin ethylsuccinate oral	1	MO
erythromycin-sulfisoxazole	1	MO
ZMAX	2	MO

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Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS ANTIINFECTIVES		
ALBENZA	2	MO
ALINIA	2	MO
amikacin injection solution 500 mg/2 ml	1	MO
atovaquone	1	MO
atovaquone-proguanil	1	MO
AZACTAM IN DEXTROSE (ISO-OSM)	2	
aztreonam injection recon soln 1 gram	1	MO
BACIIM	1	
bacitracin intramuscular	1	MO
BETHKIS	2	PA; MO; QL (224 per 28 days)
BILTRICIDE	2	MO
CAPASTAT	3	
CAYSTON	2	MO; LA; QL (84 per 28 days)
chloramphenicol sod succinate	1	
chloroquine phosphate oral	1	MO
clindamycin hcl	1	MO
clindamycin in dextrose 5 %	1	MO
CLINDAMYCIN PEDIATRIC	1	

Drug Name	Drug Tier	Requirements /Limits
clindamycin phosphate intravenous solution 600 mg/4 ml	1	MO
COARTEM	2	MO
colistin (colistimethate na)	1	MO
CUBICIN	2	MO
dapsone	2	MO
DARAPRIM	2	MO
ethambutol	1	MO
gentamicin injection solution 40 mg/ml	1	MO
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 70 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml, 90 mg/100 ml	1	
gentamicin sulfate (pf) intravenous solution 80 mg/8 ml	1	
hydroxychloroquine oral	1	MO
imipenem-cilastatin	1	MO
INVANZ INJECTION	3	MO
isoniazid injection	1	
isoniazid oral	1	MO
KETEK	2	MO
mefloquine	1	MO

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Drug Name	Drug Tier	Requirements /Limits
meropenem intravenous recon soln 500 mg	1	MO
metronidazole oral capsule	1	
metronidazole oral tablet	1	MO
metronidazole in nacl (iso-os)	1	MO
NEBUPENT	2	PA; MO; QL (6 per 28 days)
neomycin	1	MO
paromomycin	1	MO
PASER	2	MO
PENTAM	3	MO
polymyxin b sulfate	1	MO
PRIFTIN	2	MO
primaquine	2	MO
pyrazinamide	1	MO
quinine sulfate	1	MO
rifabutin	1	MO
rifampin	1	MO
SIRTURO	2	MO; LA
streptomycin intramuscular	2	MO
STROMECTOL	2	MO
SYNERCID	2	
tinidazole	1	MO
tobramycin in 0.225 % nacl	1	PA; MO; QL (280 per 28 days)
tobramycin in 0.9 % nacl intravenous piggyback 80 mg/100 ml	1	MO
tobramycin sulfate injection solution	1	MO
TRECATOR	2	MO
TYGACIL	2	MO
XIFAXAN	2	MO
ZYVOX INTRAVENOUS PARENTERAL SOLUTION 600 MG/300 ML	2	MO
ZYVOX ORAL	2	MO
PENICILLINS		
amoxicillin	1	MO
amoxicillin-pot clavulanate	1	MO
ampicillin	1	MO
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	1	MO
ampicillin-sulbactam injection recon soln 15 gram	1	
ampicillin-sulbactam injection recon soln 3 gram	1	MO
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	MO

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Drug Name	Drug Tier	Requirements /Limits
BICILLIN C-R	2	MO
BICILLIN L-A	2	MO
dicloxacillin	1	MO
nafcillin injection recon soln 1 gram, 10 gram	1	MO
nafcillin in dextrose iso-osm intravenous piggyback 1 gram/50 ml	1	
oxacillin injection recon soln 10 gram	1	MO
oxacillin intravenous recon soln 2 gram	1	
oxacillin in dextrose(iso-osm)	1	
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	2	
penicillin g potassium injection recon soln 5 million unit	1	MO
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	1	MO
penicillin g sodium	1	MO
penicillin v potassium	1	MO
PFIZERPEN-G INJECTION RECON SOLN 5 MILLION UNIT	1	
piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram	1	MO
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	2	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 3.375 GRAM/50 ML	2	MO
QUINOLONES		
ciprofloxacin intravenous solution 400 mg/40 ml	1	
ciprofloxacin oral suspension,microcapsule recon	1	
ciprofloxacin oral tablet	1	MO
ciprofloxacin (mixture)	1	MO
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	1	MO
levofloxacin intravenous	1	MO
levofloxacin oral	1	MO

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Drug Name	Drug Tier	Requirements /Limits
levofloxacin in d5w intravenous piggyback 500 mg/100 ml	1	
moxifloxacin	1	MO
ofloxacin oral	1	MO
SULFA'S / RELATED AGENTS		
sulfadiazine oral	1	MO
sulfamethoxazole-trimethoprim	1	MO
TETRACYCLINES		
demeclocycline	2	MO
doxycycline hyclate intravenous	1	
doxycycline hyclate oral	1	MO
doxycycline monohydrate oral capsule 150 mg, 75 mg	1	MO
doxycycline monohydrate oral suspension for reconstitution	1	MO
doxycycline monohydrate oral tablet 150 mg, 50 mg, 75 mg	1	MO
minocycline oral	1	MO
tetracycline	1	MO
VIBRAMYCIN ORAL SYRUP	2	MO
URINARY TRACT AGENTS		
MACRODANTIN ORAL CAPSULE 25 MG	2	MO
methenamine hippurate	1	MO
nitrofurantoin oral	1	MO
nitrofurantoin macrocrystal oral capsule 50 mg	1	MO
nitrofurantoin monohyd/m-cryst	1	MO
PRIMSOL	3	MO
trimethoprim	1	MO
VANCOMYCIN		
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg	1	MO
vancomycin oral	1	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
amifostine crystalline	1	MO
dexrazoxane intravenous recon soln 250 mg	1	
ELITEK INTRAVENOUS RECON SOLN 1.5 MG	2	
FUSILEV	2	MO
KEPIVANCE	2	

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Drug Name	Drug Tier	Requirements /Limits
leucovorin calcium injection recon soln 100 mg, 350 mg	1	MO
leucovorin calcium oral	1	MO
mesna	1	MO
MESNEX ORAL	2	MO
XGEVA	2	MO
ZINECARD INTRAVENOUS RECON SOLN 250 MG	2	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ABRAXANE	2	MO
AFINITOR ORAL TABLET 10 MG	2	PA; MO; QL (60 per 30 days)
AFINITOR ORAL TABLET 2.5 MG, 5 MG, 7.5 MG	2	PA; MO
AFINITOR DISPERZ	2	PA; MO
ALIMTA INTRAVENOUS RECON SOLN 500 MG	2	MO
anastrozole	1	MO
ARRANON	2	
ARZERRA INTRAVENOUS SOLUTION 100 MG/5 ML	2	PA; MO
AVASTIN	2	MO
azacitidine	1	MO
azathioprine	1	PA; MO
bicalutamide	1	MO
BICNU	3	MO
bleomycin injection recon soln 30 unit	1	MO
BOSULIF ORAL TABLET 100 MG	2	PA; MO
BOSULIF ORAL TABLET 500 MG	2	PA; MO; QL (30 per 30 days)
BUSULFEX	2	
CAPRELSA ORAL TABLET 100 MG	2	MO; LA
CAPRELSA ORAL TABLET 300 MG	2	MO; LA; QL (30 per 30 days)
carboplatin intravenous solution	1	MO
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	2	PA; MO
CELLCEPT INTRAVENOUS	2	PA
cisplatin	1	MO
cladribine	1	MO
CLOLAR	2	MO
COMETRIQ	2	PA; MO
cyclophosphamide oral capsule	2	PA
cyclophosphamide oral tablet	1	PA; MO
cyclosporine intravenous	1	PA

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Drug Name	Drug Tier	Requirements /Limits
cyclosporine oral	1	PA; MO
cyclosporine modified	1	PA; MO
cytarabine	1	MO
cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)	1	MO
dacarbazine intravenous recon soln 200 mg	1	MO
daunorubicin intravenous solution	1	
decitabine	1	MO
DOCEFREZ	2	
docetaxel intravenous solution 80 mg/4 ml (20 mg/ml)	1	MO
docetaxel intravenous solution 80 mg/8 ml (10 mg/ml)	1	
doxorubicin intravenous solution 50 mg/25 ml	1	MO
DROXIA	2	MO
ELLENCE INTRAVENOUS SOLUTION 200 MG/100 ML	3	MO
ELOXATIN INTRAVENOUS SOLUTION 100 MG/20 ML	2	MO
EMCYT	2	MO
epirubicin intravenous solution 50 mg/25 ml	1	MO
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML	2	MO
ERIVEDGE	2	PA; MO; QL (30 per 30 days)
ERWINAZE	2	
ETOPOPHOS	3	MO
etoposide intravenous	1	MO
exemestane	1	MO
FARESTON	2	MO
FASLODEX	2	MO
FIRMAGON KIT W DILUENT SYRINGE	2	MO
fludarabine intravenous recon soln	1	MO
fluorouracil intravenous solution 2.5 gram/50 ml	1	MO
flutamide	1	MO
FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	2	MO
gemcitabine intravenous recon soln 1 gram	1	MO

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Drug Name	Drug Tier	Requirements /Limits
GENGRAF	1	PA; MO
GILOTRIF ORAL TABLET 20 MG	2	PA; MO; QL (60 per 30 days)
GILOTRIF ORAL TABLET 30 MG	2	PA; MO; QL (40 per 30 days)
GILOTRIF ORAL TABLET 40 MG	2	PA; MO; QL (30 per 30 days)
GLEEVEC ORAL TABLET 100 MG	2	PA; MO
GLEEVEC ORAL TABLET 400 MG	2	PA; MO; QL (60 per 30 days)
HALAVEN	2	MO
HERCEPTIN	2	MO
HEXALEN	2	MO
hydroxyurea	1	MO
idarubicin	1	
ifosfamide intravenous recon soln 1 gram	1	MO
IMBRUVICA	2	PA; MO; QL (120 per 30 days)
INLYTA ORAL TABLET 1 MG	2	PA; MO
INLYTA ORAL TABLET 5 MG	2	PA; MO; QL (120 per 30 days)
irinotecan intravenous solution 100 mg/5 ml	1	MO
ISTODAX	2	MO
IXEMPRA INTRAVENOUS RECON SOLN 45 MG	2	MO
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	2	PA; MO
JAKAFI ORAL TABLET 25 MG	2	PA; MO; QL (60 per 30 days)
JEVTANA	2	MO
KADCYLA INTRAVENOUS RECON SOLN 100 MG	2	MO
letrozole	1	MO
LEUKERAN	2	MO
leuprolide	1	MO
lomustine	2	MO
LUPRON DEPOT	2	PA; MO
LUPRON DEPOT (3 MONTH)	2	PA; MO
LUPRON DEPOT (4 MONTH)	2	PA; MO
LUPRON DEPOT (6 MONTH)	2	PA; MO
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	2	PA; MO
LYSODREN	2	MO
MATULANE	2	MO
MEGACE ES	2	MO

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Drug Name	Drug Tier	Requirements /Limits
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	1	MO
megestrol oral tablet	1	MO
MEKINIST ORAL TABLET 0.5 MG	2	PA; MO; QL (120 per 30 days)
MEKINIST ORAL TABLET 2 MG	2	PA; MO; QL (30 per 30 days)
melphalan	1	
mercaptopurine	1	MO
methotrexate sodium oral	1	PA; MO
methotrexate sodium (pf) injection recon soln	3	PA
methotrexate sodium (pf) injection solution	1	PA; MO
mitomycin intravenous recon soln 20 mg	1	MO
mitoxantrone	1	MO
MUSTARGEN	3	MO
mycophenolate mofetil	1	PA; MO
mycophenolate sodium	1	PA; MO
NEORAL	2	PA; MO
NEXAVAR	2	PA; MO; LA
NILANDRON	2	MO
NIPENT	2	MO
NULOJIX	2	PA; MO

Drug Name	Drug Tier	Requirements /Limits
octreotide acetate injection solution	1	MO
ONCASPAR	2	MO
oxaliplatin intravenous solution 100 mg/20 ml	1	MO
paclitaxel	1	MO
PERJETA	2	MO
POMALYST	2	MO
PROGRAF INTRAVENOUS	2	PA; MO
RAPAMUNE ORAL SOLUTION	2	PA; MO
RAPAMUNE ORAL TABLET 1 MG, 2 MG	2	PA; MO
REVLIMID	2	PA; MO; LA
RHEUMATREX	3	PA; MO
RITUXAN	2	PA; MO
SANDIMMUNE	2	PA; MO
SANDOSTATIN LAR DEPOT	2	MO
SIGNIFOR	2	PA; MO
SIMULECT INTRAVENOUS RECON SOLN 20 MG	2	PA; MO
sirolimus	1	PA; MO
SOLTAMOX	2	MO
SPRYCEL ORAL TABLET 100 MG, 20 MG, 50 MG, 80 MG	2	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
SPRYCEL ORAL TABLET 140 MG	2	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 70 MG	2	PA; MO; QL (60 per 30 days)
STIVARGA	2	PA; MO; QL (84 per 28 days)
SUTENT ORAL CAPSULE 12.5 MG	2	PA; MO
SUTENT ORAL CAPSULE 25 MG	2	PA; MO; QL (60 per 30 days)
SUTENT ORAL CAPSULE 50 MG	2	PA; MO; QL (30 per 30 days)
SYLVANT INTRAVENOUS RECON SOLN 100 MG	2	MO
SYNRIBO	2	MO
TABLOID	2	MO
tacrolimus	1	PA; MO
TAFINLAR ORAL CAPSULE 50 MG	2	PA; MO; QL (180 per 30 days)
TAFINLAR ORAL CAPSULE 75 MG	2	PA; MO; QL (120 per 30 days)
tamoxifen	1	MO
TARCEVA ORAL TABLET 100 MG, 25 MG	2	PA; MO
TARCEVA ORAL TABLET 150 MG	2	PA; MO; QL (30 per 30 days)
TARGRETIN	2	MO
TASIGNA ORAL CAPSULE 150 MG	2	PA; MO
TASIGNA ORAL CAPSULE 200 MG	2	PA; MO; QL (112 per 28 days)
THALOMID	2	PA; MO
TOPOSAR	1	MO
topotecan intravenous recon soln	1	MO
TORISEL	2	MO
TREANDA INTRAVENOUS RECON SOLN 100 MG	2	MO
TRELSTAR	2	MO
TRELSTAR DEPOT	2	
TRELSTAR LA	2	
tretinoin (chemotherapy)	1	MO
TRISENOX	2	MO
TYKERB	2	PA; MO; LA; QL (180 per 30 days)
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)	2	PA; MO
VELCADE	2	MO

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Drug Name	Drug Tier	Requirements /Limits
vinblastine intravenous solution	1	MO
vincristine intravenous solution 1 mg/ml	1	MO
vinorelbine intravenous solution 50 mg/5 ml	1	MO
VOTRIENT	2	PA; MO; QL (120 per 30 days)
XALKORI ORAL CAPSULE 200 MG	2	PA; MO
XALKORI ORAL CAPSULE 250 MG	2	PA; MO; QL (60 per 30 days)
XTANDI	2	PA; MO; QL (120 per 30 days)
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	2	MO
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	2	MO
ZANOSAR	3	MO
ZELBORAF	2	PA; MO; QL (240 per 30 days)
ZOLINZA	2	MO
ZORTRESS	2	PA; MO
ZYKADIA	2	PA; MO; QL (150 per 30 days)
ZYTIGA	2	PA; MO; QL (120 per 30 days)

AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH

ANTICONVULSANTS

APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	3	MO
APTIOM ORAL TABLET 600 MG	2	MO
BANZEL	2	MO
carbamazepine	1	MO
CELONTIN	2	MO
clonazepam	1	PA; MO
diazepam rectal	1	PA; MO
DILANTIN	2	MO
divalproex	1	MO
EPITOL	1	MO
ethosuximide	1	MO
felbamate	1	MO
fosphenytoin injection solution 100 mg pe/2 ml	1	MO
FYCOMPA	2	MO
gabapentin oral capsule	1	MO
gabapentin oral solution 250 mg/5 ml	1	MO

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Drug Name	Drug Tier	Requirements /Limits
gabapentin oral tablet	1	MO
GABITRIL ORAL TABLET 12 MG, 16 MG	2	MO
lamotrigine oral tablet	1	MO
lamotrigine oral tablet extended release 24hr	1	MO
lamotrigine oral tablet, chewable dispersible	1	MO
levetiracetam intravenous	1	MO
levetiracetam oral solution 100 mg/ml	1	MO
levetiracetam oral tablet	1	MO
levetiracetam oral tablet extended release 24 hr	1	MO
LYRICA	2	PA; MO
ONFI	2	PA; MO
oxcarbazepine	1	MO
PEGANONE	2	MO
phenobarbital	1	MO
phenytoin oral suspension 125 mg/5 ml	1	MO
phenytoin oral tablet,chewable	1	MO
phenytoin sodium intravenous solution	1	MO
phenytoin sodium extended	1	MO
POTIGA	2	MO
primidone	1	MO
SABRIL	2	MO; LA
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG	2	MO
tiagabine	1	MO
topiramate oral capsule, sprinkle	1	MO
topiramate oral tablet	1	MO
valproate sodium	1	MO
valproic acid	1	MO
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	MO
VIMPAT INTRAVENOUS	2	
VIMPAT ORAL	2	MO
zonisamide	1	MO
ANTIPARKINSONISM AGENTS		
APOKYN	2	MO; LA
AZILECT	2	MO
benztropine	1	MO
bromocriptine	1	MO
carbidopa	1	MO
carbidopa-levodopa	1	MO

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Drug Name	Drug Tier	Requirements /Limits
carbidopa-levodopa-entacapone	1	MO
entacapone	1	MO
NEUPRO	3	MO
pramipexole	1	MO
ropinirole	1	MO
selegiline hcl	1	MO
TASMAR	2	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
CAFERGOT	2	MO
dihydroergotamine injection	1	MO
MIGERGOT	1	MO
naratriptan	1	MO; QL (18 per 28 days)
RELPAX	2	MO; QL (18 per 28 days)
rizatriptan	1	MO; QL (36 per 28 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation	1	MO; QL (18 per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	1	MO; QL (36 per 28 days)
sumatriptan succinate oral	1	MO; QL (18 per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	1	MO; QL (16 per 28 days)
sumatriptan succinate subcutaneous solution	1	MO; QL (16 per 28 days)
zolmitriptan	1	MO; QL (18 per 28 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
AMPYRA	2	PA; MO; LA
AUBAGIO	2	PA; MO
COPAXONE SUBCUTANEOUS SYRINGE	2	PA; MO; QL (12 per 28 days)
COPAXONE SUBCUTANEOUS SYRINGE KIT	2	PA; MO; QL (30 per 30 days)
donepezil	1	MO
EXELON TRANSDERMAL	2	MO
galantamine	1	MO
GILENYA	2	PA; MO
NAMENDA	2	PA; MO
NAMENDA TITRATION PAK	2	PA; MO
NAMENDA XR	2	PA; MO
NUEDEXTA	2	MO
rivastigmine tartrate	1	MO
TECFIDERA	2	PA; MO
TYSABRI	2	PA; MO; LA
XENAZINE	2	PA; MO; LA
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
baclofen	1	MO

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Drug Name	Drug Tier	Requirements /Limits
cyclobenzaprine	1	PA; MO
dantrolene	1	MO
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	2	PA; MO
LIORESAL INTRATHECAL SOLUTION 50 MCG/ML	2	PA
MESTINON ORAL SYRUP	2	MO
MESTINON TIMESPAN	2	MO
pyridostigmine bromide	1	MO
tizanidine	1	MO
NARCOTIC ANALGESICS		
acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml	1	QL (4500 per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	1	MO; QL (360 per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	1	MO; QL (180 per 30 days)
BUPRENEX	2	MO; QL (267 per 30 days)
buprenorphine injection syringe	1	QL (267 per 30 days)
buprenorphine sublingual tablet, sublingual 2 mg	1	MO; QL (300 per 30 days)
buprenorphine sublingual tablet, sublingual 8 mg	1	MO; QL (75 per 30 days)
BUTRANS	2	MO; QL (4 per 28 days)
codeine sulfate oral tablet	1	MO; QL (180 per 30 days)
DURAMORPH (PF) INJECTION SOLUTION 0.5 MG/ML	1	MO; QL (4000 per 30 days)
DURAMORPH (PF) INJECTION SOLUTION 1 MG/ML	1	QL (2000 per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	1	MO; QL (360 per 30 days)
ENDODAN	1	MO; QL (360 per 30 days)
fentanyl citrate buccal lozenge on a handle 1,200 mcg	1	PA; MO; QL (39 per 30 days)
fentanyl citrate buccal lozenge on a handle 1,600 mcg	1	PA; MO; QL (29 per 30 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	1	PA; MO; QL (120 per 30 days)
fentanyl citrate buccal lozenge on a handle 400 mcg	1	PA; MO; QL (116 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
fentanyl citrate buccal lozenge on a handle 600 mcg	1	PA; MO; QL (77 per 30 days)
fentanyl citrate buccal lozenge on a handle 800 mcg	1	PA; MO; QL (58 per 30 days)
fentanyl patches transdermal patch 72 hour 100 mcg/hr	1	MO; QL (9 per 30 days)
fentanyl patches transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	MO; QL (10 per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	1	MO; QL (5550 per 30 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	1	MO; QL (360 per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	1	MO; QL (50 per 30 days)
hydromorphone oral liquid	1	MO; QL (300 per 30 days)
hydromorphone oral tablet	1	MO; QL (180 per 30 days)
hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 8 mg	1	MO; QL (60 per 30 days)
hydromorphone (pf) injection solution 10 mg/ml	2	MO; QL (120 per 30 days)
ibuprofen-oxycodone	1	MO; QL (28 per 30 days)
levorphanol tartrate	1	MO; QL (120 per 30 days)
LORCET (HYDROCODONE)	1	QL (360 per 30 days)
LORCET HD	1	MO; QL (360 per 30 days)
LORCET PLUS	1	QL (360 per 30 days)
LORTAB 10-325	1	MO; QL (360 per 30 days)
LORTAB 5-325	1	MO; QL (360 per 30 days)
LORTAB 7.5-325	1	MO; QL (360 per 30 days)
methadone injection	1	QL (160 per 30 days)
methadone oral solution 10 mg/5 ml	1	MO; QL (600 per 30 days)
methadone oral solution 5 mg/5 ml	1	MO; QL (1200 per 30 days)
methadone oral tablet 10 mg	1	MO; QL (120 per 30 days)
methadone oral tablet 5 mg	1	MO; QL (240 per 30 days)
morphine intravenous syringe 2 mg/ml	1	QL (1000 per 30 days)
morphine intravenous syringe 4 mg/ml	1	QL (500 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
morphine oral capsule, er multiphase 24 hr 120 mg	1	MO; QL (50 per 30 days)
morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg	1	MO; QL (60 per 30 days)
morphine oral capsule,extend.release pellets 10 mg, 20 mg, 30 mg, 50 mg, 60 mg	1	MO; QL (90 per 30 days)
morphine oral capsule,extend.release pellets 100 mg	1	MO; QL (60 per 30 days)
morphine oral capsule,extend.release pellets 80 mg	1	MO; QL (75 per 30 days)
morphine oral solution	1	MO; QL (900 per 30 days)
morphine oral tablet	1	MO; QL (180 per 30 days)
morphine oral tablet extended release 100 mg	1	MO; QL (60 per 30 days)
morphine oral tablet extended release 15 mg, 30 mg	1	MO; QL (120 per 30 days)
morphine oral tablet extended release 200 mg	1	MO; QL (30 per 30 days)
morphine oral tablet extended release 60 mg	1	MO; QL (100 per 30 days)
morphine concentrate oral solution	1	MO; QL (300 per 30 days)
oxycodone oral capsule	1	MO; QL (360 per 30 days)
oxycodone oral concentrate	1	MO; QL (180 per 30 days)
oxycodone oral solution	1	MO; QL (1200 per 30 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg	1	MO; QL (180 per 30 days)
oxycodone oral tablet 30 mg	1	MO; QL (134 per 30 days)
oxycodone oral tablet 5 mg	1	MO; QL (360 per 30 days)
oxycodone-acetaminophen	1	MO; QL (360 per 30 days)
oxycodone-aspirin	1	MO; QL (360 per 30 days)
OXYCONTIN ORAL TABLET EXTENDED RELEASE 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG	2	MO; QL (90 per 30 days)
OXYCONTIN ORAL TABLET EXTENDED RELEASE 12 HR 60 MG	2	MO; QL (67 per 30 days)
OXYCONTIN ORAL TABLET EXTENDED RELEASE 12 HR 80 MG	2	MO; QL (50 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
oxymorphone oral tablet 10 mg	1	MO; QL (200 per 30 days)
oxymorphone oral tablet 5 mg	1	MO; QL (180 per 30 days)
oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg	1	MO; QL (90 per 30 days)
oxymorphone oral tablet extended release 12 hr 30 mg	1	MO; QL (67 per 30 days)
oxymorphone oral tablet extended release 12 hr 40 mg	1	MO; QL (50 per 30 days)
REPREXAIN	1	MO; QL (50 per 30 days)
VICODIN	1	MO; QL (360 per 30 days)
VICODIN ES	1	MO; QL (360 per 30 days)
VICODIN HP	1	MO; QL (360 per 30 days)
ZAMICET	1	MO; QL (5550 per 30 days)
NON-NARCOTIC ANALGESICS		
buprenorphine-naloxone sublingual tablet, sublingual 2-0.5 mg	1	PA; MO; QL (360 per 30 days)
buprenorphine-naloxone sublingual tablet, sublingual 8-2 mg	1	PA; MO; QL (90 per 30 days)
butorphanol tartrate injection solution 1 mg/ml	1	MO; QL (720 per 30 days)
butorphanol tartrate injection solution 2 mg/ml	1	MO; QL (360 per 30 days)
butorphanol tartrate nasal	1	MO; QL (40 per 30 days)
CELEBREX	2	MO
diclofenac potassium	1	MO
diclofenac sodium oral	1	MO
diclofenac sodium topical drops	1	MO
diclofenac-misoprostol	1	MO
diflunisal	1	MO
etodolac	1	MO
fenoprofen oral tablet	1	MO
FLECTOR	3	PA; MO; QL (60 per 30 days)
flurbiprofen	1	MO
ibuprofen oral suspension	1	MO
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	MO
ketoprofen	1	MO
meclofenamate oral	1	MO
mefenamic acid	1	MO
meloxicam oral suspension	1	MO

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Drug Name	Drug Tier	Requirements /Limits
meloxicam oral tablet 15 mg	1	MO
meloxicam oral tablet 7.5 mg	1	MO; QL (30 per 30 days)
nabumetone	1	MO
nalbuphine injection solution 10 mg/ml	1	MO; QL (200 per 30 days)
nalbuphine injection solution 20 mg/ml	1	MO; QL (100 per 30 days)
naloxone injection syringe 1 mg/ml	1	MO
naltrexone	1	MO
naproxen	1	MO
naproxen sodium oral tablet 275 mg, 550 mg	1	MO
oxaprozin	1	MO
piroxicam	1	MO
SUBOXONE SUBLINGUAL FILM 12-3 MG	2	PA; MO; QL (50 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 4-1 MG, 8-2 MG	2	PA; MO; QL (90 per 30 days)
sulindac oral	1	MO
tolmetin	1	MO
tramadol oral tablet	1	MO; QL (240 per 30 days)
tramadol oral tablet extended release 24 hr 100 mg, 200 mg	2	MO; QL (30 per 30 days)
tramadol oral tablet, er multiphase 24 hr 300 mg	2	MO; QL (30 per 30 days)
tramadol-acetaminophen	1	MO; QL (240 per 30 days)
VOLTAREN GEL	2	MO
ZUBSOLV	2	PA; MO; QL (90 per 30 days)
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY INTRAMUSCULAR	2	MO
ABILIFY ORAL SOLUTION	2	MO
ABILIFY ORAL TABLET 10 MG	2	MO; QL (90 per 30 days)
ABILIFY ORAL TABLET 15 MG, 20 MG	2	MO; QL (60 per 30 days)
ABILIFY ORAL TABLET 2 MG	2	MO; QL (450 per 30 days)
ABILIFY ORAL TABLET 30 MG	2	MO; QL (30 per 30 days)
ABILIFY ORAL TABLET 5 MG	2	MO; QL (180 per 30 days)
ABILIFY DISCMELT ORAL TABLET,DISINTEGRATING 10 MG	2	MO; QL (90 per 30 days)
ABILIFY DISCMELT ORAL TABLET,DISINTEGRATING 15 MG	2	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG	2	MO
alprazolam oral tablet	1	MO
amitriptyline	1	PA; MO
amoxapine	1	MO
AMPHETAMINE SALT COMBO ORAL TABLET 20 MG, 7.5 MG	1	MO
BRINTELLIX ORAL TABLET 10 MG	2	MO; QL (60 per 30 days)
BRINTELLIX ORAL TABLET 20 MG	2	MO; QL (30 per 30 days)
BRINTELLIX ORAL TABLET 5 MG	2	MO; QL (120 per 30 days)
bupropion hcl oral tablet	1	MO
bupropion hcl oral tablet extended release 100 mg	1	MO; QL (120 per 30 days)
bupropion hcl oral tablet extended release 150 mg	1	MO; QL (90 per 30 days)
bupropion hcl oral tablet extended release 200 mg	1	MO; QL (60 per 30 days)
bupropion hcl oral tablet extended release 24 hr 150 mg	1	MO; QL (90 per 30 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	1	MO; QL (60 per 30 days)
buspirone	1	MO
chlorpromazine	1	MO
citalopram oral solution	1	MO
citalopram oral tablet 10 mg	1	MO; QL (120 per 30 days)
citalopram oral tablet 20 mg	1	MO; QL (60 per 30 days)
citalopram oral tablet 40 mg	1	MO; QL (30 per 30 days)
clomipramine	1	PA; MO
clonidine hcl oral tablet extended release 12 hr	1	MO
clorazepate dipotassium	1	PA; MO
clozapine oral tablet	1	
desipramine oral	1	MO
dexmethylphenidate	1	MO
dextroamphetamine oral capsule, extended release	1	MO
dextroamphetamine oral tablet	1	MO
dextroamphetamine-amphetamine	1	MO
diazepam oral solution 5 mg/5 ml	1	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
diazepam oral tablet	1	PA; MO
DIAZEPAM INTENSOL	1	PA; MO
doxepin oral	1	PA; MO
duloxetine oral capsule,delayed release(dr/ec) 20 mg	1	MO; QL (180 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg	1	MO; QL (120 per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 60 mg	1	MO; QL (60 per 30 days)
EMSAM	3	MO
ergoloid	1	MO
escitalopram oxalate oral solution	1	MO
escitalopram oxalate oral tablet 10 mg	1	MO; QL (60 per 30 days)
escitalopram oxalate oral tablet 20 mg	1	MO; QL (30 per 30 days)
escitalopram oxalate oral tablet 5 mg	1	MO; QL (120 per 30 days)
eszopiclone	1	ST; MO; QL (30 per 30 days)
FANAPT ORAL TABLET 1 MG	3	MO; QL (720 per 30 days)
FANAPT ORAL TABLET 10 MG, 8 MG	3	MO; QL (90 per 30 days)
FANAPT ORAL TABLET 12 MG	3	MO; QL (60 per 30 days)
FANAPT ORAL TABLET 2 MG	3	MO; QL (360 per 30 days)
FANAPT ORAL TABLET 4 MG	3	MO; QL (180 per 30 days)
FANAPT ORAL TABLET 6 MG	3	MO; QL (120 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	3	QL (8 per 28 days)
FAZACLO ORAL TABLET,DISINTEGRATING 150 MG, 200 MG	3	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	2	ST; MO; QL (28 per 28 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG	2	ST; MO; QL (30 per 30 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	2	ST; MO; QL (180 per 30 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 40 MG	2	ST; MO; QL (90 per 30 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 80 MG	2	ST; MO; QL (45 per 30 days)
fluoxetine oral capsule 10 mg	1	MO; QL (240 per 30 days)
fluoxetine oral capsule 20 mg	1	MO
fluoxetine oral capsule 40 mg	1	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
fluoxetine oral capsule,delayed release(dr/ec)	1	MO; QL (4 per 28 days)
fluoxetine oral solution	1	MO
fluoxetine oral tablet 10 mg	1	MO; QL (240 per 30 days)
fluoxetine oral tablet 20 mg	1	MO
fluphenazine decanoate	1	MO
fluphenazine hcl	1	MO
fluvoxamine oral capsule,extended release 24hr 100 mg	1	MO; QL (90 per 30 days)
fluvoxamine oral capsule,extended release 24hr 150 mg	1	MO; QL (60 per 30 days)
fluvoxamine oral tablet 100 mg	1	MO; QL (90 per 30 days)
fluvoxamine oral tablet 25 mg	1	MO; QL (360 per 30 days)
fluvoxamine oral tablet 50 mg	1	MO; QL (180 per 30 days)
FORFIVO XL	3	MO; QL (30 per 30 days)
GEODON INTRAMUSCULAR	3	MO
guanidine	1	MO
haloperidol	1	MO
haloperidol decanoate	1	MO
haloperidol lactate	1	MO

Drug Name	Drug Tier	Requirements /Limits
imipramine hcl	1	PA; MO
imipramine pamoate	2	PA; MO
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 1.5 MG	3	MO; QL (240 per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG	3	MO; QL (120 per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	3	MO; QL (60 per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 9 MG	3	MO; QL (41 per 30 days)
INVEGA SUSTENNA	2	MO
LATUDA ORAL TABLET 120 MG	2	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 20 MG	2	MO; QL (240 per 30 days)
LATUDA ORAL TABLET 40 MG	2	MO; QL (120 per 30 days)
LATUDA ORAL TABLET 60 MG, 80 MG	2	MO; QL (60 per 30 days)
lithium carbonate	1	MO
lithium citrate	1	MO

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Drug Name	Drug Tier	Requirements /Limits
lorazepam oral tablet	1	PA; MO
LORAZEPAM INTENSOL	1	PA; MO
loxapine succinate	1	MO
maprotiline	1	MO
MARPLAN	2	MO
METADATE ER	1	MO
methamphetamine	1	MO
methylphenidate oral capsule, er biphasic 30-70 10 mg, 50 mg, 60 mg	1	MO
methylphenidate oral capsule,er biphasic 50-50	1	MO
methylphenidate oral solution	1	MO
methylphenidate oral tablet	1	MO
methylphenidate oral tablet extended release	1	MO
methylphenidate oral tablet extended release 24hr	1	MO
mirtazapine	1	MO
modafinil	1	PA; MO
nefazodone	1	MO
nortriptyline	1	MO
olanzapine intramuscular	1	MO
olanzapine oral tablet 10 mg	1	MO; QL (60 per 30 days)
olanzapine oral tablet 15 mg, 20 mg	1	MO; QL (30 per 30 days)
olanzapine oral tablet 2.5 mg	1	MO; QL (240 per 30 days)
olanzapine oral tablet 5 mg	1	MO; QL (120 per 30 days)
olanzapine oral tablet 7.5 mg	1	MO; QL (81 per 30 days)
olanzapine oral tablet,disintegrating 10 mg	1	MO; QL (60 per 30 days)
olanzapine oral tablet,disintegrating 15 mg, 20 mg	1	MO; QL (30 per 30 days)
olanzapine oral tablet,disintegrating 5 mg	1	MO; QL (120 per 30 days)
olanzapine-fluoxetine	1	MO
ORAP	2	MO
oxazepam	1	PA; MO
paroxetine hcl oral tablet 10 mg	1	MO; QL (180 per 30 days)
paroxetine hcl oral tablet 20 mg	1	MO; QL (90 per 30 days)
paroxetine hcl oral tablet 30 mg	1	MO; QL (60 per 30 days)
paroxetine hcl oral tablet 40 mg	1	MO; QL (45 per 30 days)
paroxetine hcl oral tablet extended release 24 hr 12.5 mg	1	MO; QL (180 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
paroxetine hcl oral tablet extended release 24 hr 25 mg	1	MO; QL (90 per 30 days)
paroxetine hcl oral tablet extended release 24 hr 37.5 mg	1	MO; QL (60 per 30 days)
PAXIL ORAL SUSPENSION	2	MO
perphenazine	1	MO
phenelzine	1	MO
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	2	ST; MO; QL (120 per 30 days)
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR 50 MG	2	ST; MO; QL (240 per 30 days)
PROCENTRA	1	MO
protriptyline	1	MO
quetiapine oral tablet 100 mg	1	MO; QL (240 per 30 days)
quetiapine oral tablet 200 mg	1	MO; QL (120 per 30 days)
quetiapine oral tablet 25 mg	1	MO; QL (902 per 30 days)
quetiapine oral tablet 300 mg	1	MO; QL (81 per 30 days)
quetiapine oral tablet 400 mg	1	MO; QL (60 per 30 days)
quetiapine oral tablet 50 mg	1	MO; QL (480 per 30 days)
RISPERDAL CONSTA	2	MO
risperidone oral solution	1	MO; QL (480 per 30 days)
risperidone oral tablet 0.25 mg	1	MO; QL (1920 per 30 days)
risperidone oral tablet 0.5 mg	1	MO; QL (960 per 30 days)
risperidone oral tablet 1 mg	1	MO; QL (480 per 30 days)
risperidone oral tablet 2 mg	1	MO; QL (240 per 30 days)
risperidone oral tablet 3 mg	1	MO; QL (161 per 30 days)
risperidone oral tablet 4 mg	1	MO; QL (120 per 30 days)
risperidone oral tablet,disintegrating 0.25 mg	1	MO; QL (1920 per 30 days)
risperidone oral tablet,disintegrating 0.5 mg	1	MO; QL (960 per 30 days)
risperidone oral tablet,disintegrating 1 mg	1	MO; QL (480 per 30 days)
risperidone oral tablet,disintegrating 2 mg	1	MO; QL (240 per 30 days)
risperidone oral tablet,disintegrating 3 mg	1	MO; QL (161 per 30 days)
risperidone oral tablet,disintegrating 4 mg	1	MO; QL (120 per 30 days)
ROZEREM	2	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
SAPHRIS SUBLINGUAL TABLET, SUBLINGUAL 10 MG	2	MO; QL (60 per 30 days)
SAPHRIS SUBLINGUAL TABLET, SUBLINGUAL 5 MG	2	MO; QL (120 per 30 days)
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET, SUBLINGUAL 10 MG	2	MO; QL (60 per 30 days)
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET, SUBLINGUAL 5 MG	2	MO; QL (120 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	2	MO; QL (161 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 200 MG	2	MO; QL (120 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	2	MO; QL (81 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 400 MG	2	MO; QL (60 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 50 MG	2	MO; QL (480 per 30 days)
sertraline oral concentrate	1	MO
sertraline oral tablet 100 mg	1	MO; QL (60 per 30 days)
sertraline oral tablet 25 mg	1	MO; QL (240 per 30 days)
sertraline oral tablet 50 mg	1	MO; QL (120 per 30 days)
STRATTERA	2	MO
SURMONTIL	3	PA; MO
temazepam	1	PA; MO
thioridazine	1	MO
thiothixene	1	MO
tranylcypromine	1	MO
trazodone	1	MO
trifluoperazine	1	MO
venlafaxine oral capsule,extended release 24hr 150 mg	1	MO; QL (60 per 30 days)
venlafaxine oral capsule,extended release 24hr 37.5 mg	1	MO; QL (180 per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	1	MO; QL (90 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
venlafaxine oral tablet 100 mg, 75 mg	1	MO; QL (90 per 30 days)
venlafaxine oral tablet 25 mg	1	MO; QL (270 per 30 days)
venlafaxine oral tablet 37.5 mg	1	MO; QL (180 per 30 days)
venlafaxine oral tablet 50 mg	1	MO; QL (150 per 30 days)
VERSACLOZ	2	LA
VIIBRYD ORAL TABLET 10 MG	2	MO; QL (120 per 30 days)
VIIBRYD ORAL TABLET 20 MG	2	MO; QL (60 per 30 days)
VIIBRYD ORAL TABLET 40 MG	2	MO; QL (30 per 30 days)
VIIBRYD ORAL TABLETS,DOSE PACK	2	MO; QL (30 per 30 days)
XYREM	2	MO; LA
zaleplon oral capsule 10 mg	1	MO; QL (60 per 30 days)
zaleplon oral capsule 5 mg	1	MO; QL (30 per 30 days)
ZENZEDI ORAL TABLET 10 MG, 5 MG	1	MO
ZENZEDI ORAL TABLET 15 MG, 20 MG, 30 MG	3	
ZENZEDI ORAL TABLET 2.5 MG, 7.5 MG	3	MO
ziprasidone hcl oral capsule 20 mg	1	MO; QL (240 per 30 days)
ziprasidone hcl oral capsule 40 mg	1	MO; QL (120 per 30 days)
ziprasidone hcl oral capsule 60 mg	1	MO; QL (80 per 30 days)
ziprasidone hcl oral capsule 80 mg	1	MO; QL (60 per 30 days)
zolpidem	1	ST; MO; QL (30 per 30 days)
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
amiodarone intravenous solution	1	PA; MO
amiodarone oral tablet 200 mg, 400 mg	1	MO
flecainide	1	MO
mexiletine	1	MO
PACERONE	1	MO
procainamide injection solution 100 mg/ml	1	MO
procainamide injection solution 500 mg/ml	1	
propafenone	1	MO
quinidine gluconate	1	MO
quinidine sulfate	1	MO
SORINE ORAL TABLET 120 MG, 160 MG, 80 MG	1	MO
SORINE ORAL TABLET 240 MG	1	

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Drug Name	Drug Tier	Requirements /Limits
sotalol oral tablet 160 mg, 240 mg, 80 mg	1	MO
SOTALOL AF ORAL TABLET 120 MG	1	MO
TIKOSYN	2	MO
ANTIHYPERTENSIVE THERAPY		
acebutolol oral	1	MO
AFEDITAB CR	1	MO
amiloride	1	MO
amiloride-hydrochlorothiazide	1	MO
amlodipine	1	MO
amlodipine-benazepril	1	MO
atenolol	1	MO
atenolol-chlorthalidone	1	MO
AZOR	2	ST; MO
benazepril	1	MO
benazepril-hydrochlorothiazide	1	MO
BENICAR	2	ST; MO
BENICAR HCT	2	ST; MO
betaxolol oral	1	MO
BIDIL	2	MO
bisoprolol fumarate	1	MO
bisoprolol-hydrochlorothiazide	1	MO
bumetanide	1	MO
BYSTOLIC	2	MO

Drug Name	Drug Tier	Requirements /Limits
candesartan	1	MO
candesartan-hydrochlorothiazid	1	MO
captopril	1	MO
captopril-hydrochlorothiazide	1	MO
CARTIA XT	1	MO
carvedilol	1	MO
chlorothiazide	1	MO
chlorothiazide sodium	1	MO
chlorthalidone	1	MO
clonidine	1	MO; QL (4 per 28 days)
clonidine hcl oral tablet	1	MO
CLORPRES ORAL TABLET 0.1-15 MG	1	MO
COREG CR	2	MO
DEMSER	2	MO
DIBENZYLINE	3	MO
DILT-XR	1	MO
diltiazem hcl intravenous	1	
diltiazem hcl oral capsule, extended release 180 mg, 360 mg, 420 mg	1	MO
diltiazem hcl oral capsule,extended release 12 hr	1	MO

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Drug Name	Drug Tier	Requirements /Limits
diltiazem hcl oral capsule,extended release 24hr 120 mg, 240 mg, 300 mg	1	MO
diltiazem hcl oral tablet	1	MO
doxazosin oral tablet 1 mg, 2 mg, 4 mg	1	MO; QL (30 per 30 days)
doxazosin oral tablet 8 mg	1	MO; QL (60 per 30 days)
EDARBI	3	ST; MO
EDARBYCLOR	3	ST; MO
EDECRIN	2	MO
enalapril maleate	1	MO
enalapril-hydrochlorothiazide	1	MO
eplerenone	1	MO
eprosartan	1	MO
felodipine	1	MO
fosinopril	1	MO
fosinopril-hydrochlorothiazide	1	MO
furosemide injection solution	1	MO
furosemide oral	1	MO
hydralazine	1	MO
hydrochlorothiazide	1	MO
indapamide	1	MO
irbesartan	1	MO
irbesartan-hydrochlorothiazide	1	MO
isradipine	1	MO

Drug Name	Drug Tier	Requirements /Limits
labetalol intravenous solution	1	MO
labetalol oral	1	MO
lisinopril	1	MO
lisinopril-hydrochlorothiazide	1	MO
losartan	1	MO
losartan-hydrochlorothiazide	1	MO
MATZIM LA	1	MO
methyclothiazide	1	MO
methyldopa	1	MO
metolazone	1	MO
metoprolol succinate	1	MO
metoprolol ta-hydrochlorothiaz	1	MO
metoprolol tartrate intravenous solution	1	MO
metoprolol tartrate oral	1	MO
minoxidil oral	1	MO
moexipril	1	MO
moexipril-hydrochlorothiazide	1	MO
nadolol	1	MO
nadolol-bendroflumethiazide	1	MO
nicardipine	1	MO
NIFEDICAL XL	1	MO
nifedipine oral tablet extended release 24hr	1	MO

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Drug Name	Drug Tier	Requirements /Limits
nimodipine	1	MO
nisoldipine	1	MO
perindopril erbumine	1	MO
pindolol	1	MO
prazosin	1	MO
propranolol intravenous	1	
propranolol oral	1	MO
propranolol-hydrochlorothiazid	1	MO
quinapril	1	MO
quinapril-hydrochlorothiazide	1	MO
ramipril	1	MO
REMODULIN	2	PA; MO; LA
spironolacton-hydrochlorothiaz	1	MO
spironolactone	1	MO
TAZTIA XT	1	MO
telmisartan	1	MO
telmisartan-amlodipine	1	MO
telmisartan-hydrochlorothiazid	1	MO
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	MO; QL (30 per 30 days)
terazosin oral capsule 10 mg	1	MO; QL (60 per 30 days)
timolol maleate oral	1	MO

Drug Name	Drug Tier	Requirements /Limits
torsemide intravenous solution 20 mg/2 ml (10 mg/ml)	1	
torsemide oral	1	MO
trandolapril	1	MO
triamterene-hydrochlorothiazid	1	MO
TRIBENZOR	2	ST; MO
valsartan-hydrochlorothiazide	1	MO
verapamil intravenous solution	1	MO
verapamil oral	1	MO
CARDIAC GLYCOSIDES		
digoxin oral	1	MO
LANOXIN ORAL TABLET 187.5 MCG	2	
LANOXIN ORAL TABLET 62.5 MCG	2	MO
COAGULATION THERAPY		
AGGRENOX	2	MO
BRILINTA	2	MO
cilostazol	1	MO
clopidogrel	1	MO
dipyridamole oral	1	MO
EFFIENT	2	MO
ELIQUIS	2	MO
enoxaparin	1	MO
fondaparinux	1	MO

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Drug Name	Drug Tier	Requirements /Limits
heparin (porcine) injection solution	1	MO
heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml)	1	
heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/500 ml (50 unit/ml)	1	MO
heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml	1	
JANTOVEN	1	MO
pentoxifylline	1	MO
PRADAXA	2	MO
PROMACTA	2	PA; MO; LA
tranexamic acid intravenous	1	MO
warfarin	1	MO
XARELTO	2	MO
LIPID/CHOLESTEROL LOWERING AGENTS		
amlodipine-atorvastatin	1	MO; QL (30 per 30 days)
atorvastatin	1	MO; QL (30 per 30 days)
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	1	MO
colestipol oral granules	1	MO
colestipol oral tablet	1	MO
CRESTOR	2	MO; QL (30 per 30 days)
fenofibrate oral tablet	1	MO
fenofibrate micronized	1	MO
fenofibrate nanocrystallized	1	MO
fenofibric acid (choline)	1	MO
fluvastatin oral capsule 20 mg	1	MO; QL (30 per 30 days)
fluvastatin oral capsule 40 mg	1	MO; QL (60 per 30 days)
gemfibrozil oral	1	MO
JUXTAPID	2	MO; LA
KYNAMRO	2	MO; LA
LIPOFEN	3	MO
lovastatin oral tablet 10 mg	1	MO; QL (30 per 30 days)
lovastatin oral tablet 20 mg, 40 mg	1	MO; QL (60 per 30 days)
niacin oral tablet extended release 24 hr	1	MO
omega-3 acid ethyl esters	1	MO
pravastatin	1	MO; QL (30 per 30 days)
PREVALITE ORAL POWDER	1	MO

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Drug Name	Drug Tier	Requirements /Limits
simvastatin	1	MO; QL (30 per 30 days)
VASCEPA	2	MO
WELCHOL	2	MO
ZETIA	2	MO
MISCELLANEOUS CARDIOVASCULAR AGENTS		
RANEXA	2	MO
VECAMYL	2	
NITRATES		
isosorbide dinitrate	1	MO
isosorbide mononitrate	1	MO
NITRO-BID	1	MO
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR	2	MO
nitroglycerin intravenous	1	PA
nitroglycerin transdermal	1	MO
nitroglycerin translingual spray,non-aerosol	1	MO
NITROSTAT	2	MO
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
acitretin	1	MO
calcipotriene	1	MO
calcipotriene-betamethasone	1	MO
calcitriol topical	1	MO
selenium sulfide topical suspension	1	MO
BURN THERAPY		
silver sulfadiazine	1	MO
SSD	1	MO
MISCELLANEOUS DERMATOLOGICALS		
8-MOP	2	MO
ammonium lactate	1	MO
CARAC	2	MO
CONDYLOX TOPICAL GEL	2	MO
diclofenac sodium topical gel	1	MO
fluorouracil topical	1	MO
imiquimod	1	MO
methoxsalen rapid	1	
PANRETIN	2	MO
podofilox	1	MO
PROTOPIC	2	PA; MO
PRUDOXIN	1	MO
REGRANEX	2	MO; QL (15 per 30 days)
UVADEX	3	
ZYCLARA	2	MO
THERAPY FOR ACNE		
adapalene	1	PA; MO
AMNESTEEM	1	MO

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Drug Name	Drug Tier	Requirements /Limits
AVITA TOPICAL CREAM	1	PA; MO
AZELEX	2	MO
CLARAVIS	1	MO
clindamycin phosphate topical	1	MO
clindamycin-benzoyl peroxide topical gel	1	MO
ERY PADS	1	MO
erythromycin with ethanol topical gel	1	MO
erythromycin with ethanol topical solution	1	MO
erythromycin-benzoyl peroxide	1	MO
metronidazole topical cream	1	MO
metronidazole topical gel	1	MO
metronidazole topical lotion	1	MO
MYORISAN	1	
TAZORAC	2	PA; MO
tretinoin topical	1	PA; MO
ZENATANE	1	MO
TOPICAL ANESTHETICS		
lidocaine topical adhesive patch,medicated	1	PA; MO
lidocaine topical ointment	1	MO
lidocaine (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)	1	MO
lidocaine hcl injection solution 20 mg/ml (2 %)	1	MO
lidocaine hcl mucous membrane gel	1	MO
lidocaine hcl mucous membrane jelly in applicator	1	MO
lidocaine hcl mucous membrane solution 2 %	1	
lidocaine hcl mucous membrane solution 4 %	1	MO
lidocaine-prilocaine topical cream	1	MO
TOPICAL ANTIBACTERIALS		
ALTABAX	2	MO
gentamicin topical	1	MO
mafenide acetate	1	MO
mupirocin	1	MO
mupirocin calcium	1	MO
sulfacetamide sodium (acne)	1	MO
SULFAMYLON TOPICAL CREAM	2	MO
TOPICAL ANTIFUNGALS		
ciclopirox	1	MO
clotrimazole topical	1	MO

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Drug Name	Drug Tier	Requirements /Limits
clotrimazole-betamethasone	1	MO
econazole topical	1	MO
ketoconazole topical	1	MO
KETODAN KIT	1	MO
NAFTIN	2	MO
NYAMYC	1	MO
nystatin topical	1	MO
nystatin-triamcinolone	1	MO
NYSTOP	1	MO
PEDI-DRI	1	MO
TOPICAL ANTIVIRALS		
acyclovir topical	1	MO
DENAVIR	2	MO
XERESE	3	MO
ZOVIRAX TOPICAL CREAM	3	MO
TOPICAL CORTICOSTEROIDS		
ALA-CORT	1	MO
alclometasone	1	MO
amcinonide	1	MO
APEXICON E	1	MO
betamethasone dipropionate	1	MO
betamethasone valerate	1	MO
betamethasone, augmented	1	MO
CAPEX	2	MO
clobetasol topical foam	1	MO
clobetasol topical gel	1	MO
clobetasol topical lotion	1	MO
clobetasol topical ointment	1	MO
clobetasol topical shampoo	1	MO
clobetasol topical solution	1	MO
clobetasol-emollient topical cream	1	MO
CORDRAN TAPE LARGE ROLL	2	MO
desonide	1	MO
desoximetasone	1	MO
diflorasone	1	MO
fluocinolone	1	MO
fluocinonide topical cream 0.1 %	1	MO
fluocinonide topical gel	1	MO
fluocinonide topical ointment	1	MO
fluocinonide topical solution	1	MO
FLUOCINONIDE-E	1	MO
fluticasone topical	1	MO
halobetasol propionate	1	MO

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Drug Name	Drug Tier	Requirements /Limits
hydrocortisone topical cream 1 %, 2.5 %	1	MO
hydrocortisone topical lotion 2.5 %	1	MO
hydrocortisone topical ointment 1 %, 2.5 %	1	MO
hydrocortisone butyr-emollient	1	MO
hydrocortisone butyrate topical ointment	1	MO
hydrocortisone butyrate topical solution	1	MO
hydrocortisone valerate	1	MO
mometasone	1	MO
PANDEL	2	MO
prednicarbate	1	MO
triamcinolone acetonide topical	1	MO
TRIDERM	1	MO
TOPICAL ENZYMES		
SANTYL	2	MO
TOPICAL SCABICIDES / PEDICULICIDES		
EURAX	3	MO
lindane	1	MO
malathion	1	MO
permethrin topical cream	1	MO

Drug Name	Drug Tier	Requirements /Limits
SKLICE	2	MO
spinosad	1	MO
ULESFIA	3	MO
DIAGNOSTICS / MISCELLANEOUS AGENTS		
IRRIGATING SOLUTIONS		
lactated ringers irrigation	1	MO
neomycin-polymyxin b gu	1	MO
ringers irrigation	1	MO
MISCELLANEOUS AGENTS		
acamprosate	1	MO
ADAGEN	2	MO
alendronate oral tablet 40 mg	1	MO; QL (30 per 30 days)
anagrelide	1	MO
ARALAST NP INTRAVENOUS RECON SOLN 500 MG	2	MO; LA
CARBAGLU	2	MO; LA
cevimeline	1	MO
CHEMET	2	MO
CLINIMIX 4.25%/D5W SULFIT FREE	2	PA
d10 % & 0.45 % sodium chloride	1	
d2.5 %-0.45 % sodium chloride	1	

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Drug Name	Drug Tier	Requirements /Limits
d5 % and 0.9 % sodium chloride	1	MO
d5 %-0.45 % sodium chloride	1	MO
dextrose 10 % & 0.2 % nacl	1	
dextrose 10 % in water (d10w)	1	MO
dextrose 5 % in water (d5w) intravenous parenteral solution	1	MO
dextrose 5 %-lactated ringers	1	MO
dextrose 5%-0.2 % sod chloride	1	
dextrose 5%-0.3 % sod.chloride	1	
disulfiram	1	MO
etidronate disodium	1	MO
EXJADE	2	MO; LA
FERRIPROX	2	MO
INCRELEX	2	MO; LA
KIONEX ORAL POWDER	1	MO
levocarnitine intravenous	1	MO
levocarnitine oral tablet	1	MO
levocarnitine (with sugar)	1	MO
midodrine	1	MO
ORFADIN	2	MO; LA
pilocarpine hcl oral	1	MO
PROLASTIN-C	2	MO; LA
RAVICTI	2	MO
RENVELA ORAL TABLET	3	MO
riluzole	1	MO
sodium chloride irrigation	1	MO
sodium chloride 0.9 % intravenous parenteral solution	1	MO
sodium phenylbutyrate	1	MO
SODIUM POLYSTYRENE (SORB FREE)	1	
SYPRINE	2	MO
THIOLA	2	MO
water for irrigation, sterile	1	MO
zoledronic acid-mannitol-water intravenous solution	1	PA; MO
SMOKING DETERRENTS		
BUPROBAN	1	MO
CHANTIX	2	MO
CHANTIX CONTINUING MONTH BOX	2	MO
CHANTIX CONTINUING MONTH PAK	2	

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Drug Name	Drug Tier	Requirements /Limits
CHANTIX STARTING MONTH BOX	2	MO
CHANTIX STARTING MONTH PAK	2	
NICOTROL	3	MO
NICOTROL NS	3	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
azelastine nasal aerosol,spray	1	MO; QL (60 per 30 days)
azelastine nasal spray,non-aerosol	1	MO
BACTROBAN NASAL	2	MO
chlorhexidine gluconate mucous membrane	1	MO
ipratropium bromide nasal	1	MO; QL (30 per 30 days)
PERIOGARD	1	MO
triamcinolone acetonide dental	1	MO
TYZINE NASAL DROPS 0.05 %	2	MO
MISCELLANEOUS OTIC PREPARATIONS		
ACETASOL HC	1	MO
acetic acid otic	1	MO
fluocinolone acetonide oil	1	MO
hydrocortisone-acetic acid	1	MO
ofloxacin otic	1	MO
OTIC STEROID / ANTIBIOTIC		
CIPRODEX	2	MO
COLY-MYCIN S	2	MO
CORTISPORIN-TC	2	MO
neomycin-polymyxin-hc otic	1	MO
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
A-HYDROCORT	1	MO
cortisone	1	MO
DEPO-MEDROL	2	MO
dexamethasone oral elixir	1	MO
dexamethasone oral tablet	1	MO
DEXAMETHASONE INTENSOL	1	MO
dexamethasone sodium phosphate injection	1	MO
fludrocortisone	1	MO
hydrocortisone oral	1	MO
methylprednisolone oral tablet	1	PA; MO
methylprednisolone oral tablets,dose pack	1	MO
methylprednisolone acetate	1	MO

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Drug Name	Drug Tier	Requirements /Limits
methylprednisolone sodium succ injection recon soln 125 mg	1	MO
methylprednisolone sodium succ injection recon soln 40 mg	1	
MILLIPRED ORAL TABLET	1	PA; MO
prednisolone sodium phosphate oral solution 15 mg/5 ml, 5 mg base/5 ml (6.7 mg/5 ml)	1	MO
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml)	1	
prednisone oral solution	1	MO
prednisone oral tablet	1	PA; MO
PREDNISONE INTENSOL	1	MO
SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML	2	MO
SOLU-MEDROL INTRAVENOUS RECON SOLN 2 GRAM	2	
SOLU-MEDROL (PF) INJECTION	2	MO
SOLU-MEDROL (PF) INTRAVENOUS RECON SOLN 500 MG/4 ML	2	MO
triamcinolone acetonide injection suspension 10 mg/ml	1	MO
triamcinolone acetonide injection suspension 40 mg/ml	1	
VERIPRED 20	1	MO
ANTITHYROID AGENTS		
methimazole	1	MO
propylthiouracil	1	MO
DIABETES THERAPY		
acarbose oral tablet 100 mg	1	MO; QL (90 per 30 days)
acarbose oral tablet 25 mg	1	MO; QL (360 per 30 days)
acarbose oral tablet 50 mg	1	MO; QL (180 per 30 days)
ALCOHOL PADS	1	
BYDUREON SUBCUTANEOUS SUSPENSION,EXTENDED REL RECON	2	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/0.04 ML	2	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/0.02 ML	2	PA; MO; QL (1.2 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
CYCLOSET	3	MO; QL (180 per 30 days)
gauze pads 2 x 2	2	
glimepiride oral tablet 1 mg	1	MO; QL (240 per 30 days)
glimepiride oral tablet 2 mg	1	MO; QL (120 per 30 days)
glimepiride oral tablet 4 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet 10 mg	1	MO; QL (120 per 30 days)
glipizide oral tablet 5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	MO; QL (60 per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg	1	MO; QL (240 per 30 days)
glipizide oral tablet extended release 24hr 5 mg	1	MO; QL (120 per 30 days)
glipizide-metformin oral tablet 2.5-250 mg	1	MO; QL (240 per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	MO; QL (120 per 30 days)
GLUCAGEN	2	
GLUCAGEN HYPOKIT	2	MO
GLUCAGON EMERGENCY	2	MO
HUMALOG	2	MO
HUMALOG KWIKPEN	2	MO
HUMALOG MIX 50-50	2	MO
HUMALOG MIX 50-50 KWIKPEN	2	MO
HUMALOG MIX 75-25	2	MO
HUMALOG MIX 75-25 KWIKPEN	2	MO
HUMULIN 70/30	2	MO
HUMULIN 70/30 KWIKPEN	2	MO
HUMULIN 70/30 PEN	2	MO
HUMULIN N	2	MO
HUMULIN N KWIKPEN	2	MO
HUMULIN N PEN	2	MO
HUMULIN R	2	MO
HUMULIN R U-500 "CONCENTRATED "	2	MO
insulin pen needle	2	MO
insulin syringe (disp) u-100 0.3 ml	2	MO
insulin syringe (disp) u-100 1 ml	2	
insulin syringe (disp) u-100 1/2 ml	2	MO
INVOKANA	2	MO; QL (30 per 30 days)
JANUMET	2	MO; QL (60 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	2	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	2	MO; QL (60 per 30 days)
JANUVIA	2	MO; QL (30 per 30 days)
JENTADUETO	3	ST; MO; QL (60 per 30 days)
KAZANO	3	ST; MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	2	MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	2	MO; QL (30 per 30 days)
LANTUS	2	MO
LANTUS SOLOSTAR	2	MO
LEVEMIR	2	MO
LEVEMIR FLEXPEN	2	MO
LEVEMIR FLEXTOUCH	2	MO
metformin oral tablet 1,000 mg	1	MO; QL (75 per 30 days)
metformin oral tablet 500 mg	1	MO; QL (150 per 30 days)
metformin oral tablet 850 mg	1	MO; QL (90 per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	MO; QL (120 per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	MO; QL (75 per 30 days)
metformin oral tablet extended release 24hr 1,000 mg	1	MO; QL (75 per 30 days)
nateglinide oral tablet 120 mg	1	MO; QL (90 per 30 days)
nateglinide oral tablet 60 mg	1	MO; QL (180 per 30 days)
needles, insulin disp.,safety	2	
NESINA	3	ST; MO; QL (30 per 30 days)
NOVOLOG	2	MO
NOVOLOG FLEXPEN	2	MO
NOVOLOG MIX 70-30	2	MO
NOVOLOG MIX 70-30 FLEXPEN	2	MO
NOVOLOG PENFILL	2	MO
ONGLYZA	2	MO; QL (30 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
pioglitazone	1	MO; QL (30 per 30 days)
pioglitazone-glimepiride	1	MO; QL (30 per 30 days)
pioglitazone-metformin	1	MO; QL (90 per 30 days)
PROGLYCEM	2	MO
repaglinide oral tablet 0.5 mg	1	MO; QL (960 per 30 days)
repaglinide oral tablet 1 mg	1	MO; QL (480 per 30 days)
repaglinide oral tablet 2 mg	1	MO; QL (240 per 30 days)
RIOMET	2	MO; QL (765 per 30 days)
SYMLINPEN 120	2	PA; MO; QL (18.9 per 30 days)
SYMLINPEN 60	2	PA; MO; QL (10.5 per 30 days)
tolazamide oral tablet 250 mg	1	MO; QL (120 per 30 days)
tolazamide oral tablet 500 mg	1	MO; QL (60 per 30 days)
tolbutamide	1	MO; QL (180 per 30 days)
TRADJENTA	3	ST; MO; QL (30 per 30 days)
VGO 20	2	MO
VGO 30	2	MO
VGO 40	2	MO

Drug Name	Drug Tier	Requirements /Limits
VICTOZA 2-PAK	2	PA; MO; QL (9 per 30 days)
VICTOZA 3-PAK	2	PA; MO; QL (9 per 30 days)
MISCELLANEOUS HORMONES		
ALDURAZYME	2	MO
ANADROL-50	2	PA; MO
ANDRODERM	2	PA; MO
ANDROGEL	2	PA; MO
ANDROXY	2	MO
AXIRON	3	PA; MO
cabergoline	1	MO; QL (16 per 28 days)
calcitonin (salmon)	1	MO
calcitriol intravenous	1	MO
calcitriol oral	1	MO
CEREZYME	2	MO
chorionic gonadotropin, human	1	PA; MO
danazol oral	1	MO
desmopressin injection	1	MO
desmopressin nasal spray,non-aerosol	1	MO
desmopressin oral	1	MO
doxercalciferol intravenous	1	
doxercalciferol oral	1	MO
ELAPRASE	2	MO

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Drug Name	Drug Tier	Requirements /Limits
FABRAZYME INTRAVENOUS RECON SOLN 35 MG	2	MO
FORTESTA	3	PA; MO
FORTICAL	1	MO
KUVAN ORAL TABLET,SOLUBLE	2	MO; LA
LUMIZYME	2	MO; LA
MIACALCIN INJECTION	3	MO
MYALEPT	2	PA; MO; LA
MYOZYME	2	MO
NAGLAZYME	2	MO; LA
oxandrolone oral tablet 10 mg	1	PA; MO
oxandrolone oral tablet 2.5 mg	2	PA; MO
pamidronate intravenous solution	1	MO
paricalcitol	1	MO
SAMSCA ORAL TABLET 15 MG	2	PA; MO; QL (30 per 30 days)
SAMSCA ORAL TABLET 30 MG	2	PA; MO; QL (60 per 30 days)
SENSIPAR	2	MO
SOMAVERT	2	MO; LA
STIMATE	2	MO
SYNAREL	2	MO
TESTIM	3	PA; MO
testosterone cypionate	1	MO
testosterone enanthate	1	MO
ZAVESCA	2	MO; LA
ZEMPLAR INTRAVENOUS	2	MO
zoledronic acid intravenous solution	1	MO
THYROID HORMONES		
levothyroxine oral	1	MO
LEVOXYL	1	MO
liothyronine intravenous	1	
liothyronine oral	1	MO
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
atropine injection syringe	1	
dicyclomine	1	MO
diphenoxylate-atropine	1	MO
glycopyrrolate	1	MO

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Drug Name	Drug Tier	Requirements /Limits
loperamide oral capsule	1	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
ALOXI	2	MO; QL (10 per 30 days)
AMITIZA	2	MO
APRISO	3	MO
ASACOL HD	2	MO
balsalazide	1	MO
budesonide oral	1	MO
CANASA	2	MO
CHENODAL	2	PA; MO; LA
CIMZIA	2	PA; MO
CIMZIA POWDER FOR RECONST	2	PA; MO
CIMZIA STARTER KIT	2	PA; MO
COLOCORT	1	MO
COMPRO	1	MO
CONSTULOSE	1	MO
CORTIFOAM	2	MO
CREON	2	MO
cromolyn oral	1	MO
CYSTADANE	2	MO
DELZICOL	2	MO
DIPENTUM	3	MO
dronabinol	1	PA; MO
EMEND INTRAVENOUS	2	MO
EMEND ORAL	2	PA; MO
ENULOSE	1	MO
GAVILYTE-C	1	MO
GAVILYTE-G	1	MO
GAVILYTE-N	1	MO
GENERLAC	1	MO
granisetron intravenous solution 1 mg/ml (1 ml)	1	MO
granisetron oral	1	PA; MO
granisetron (pf) intravenous solution 100 mcg/ml	1	
hydrocortisone rectal	1	MO
lactulose oral solution 10 gram/15 ml	1	MO
LIALDA	2	MO
LINZESS	2	MO
LOTRONEX	2	MO
meclizine oral tablet	1	MO
mesalamine with cleansing wipe	1	MO
metoclopramide hcl injection solution	1	MO
metoclopramide hcl oral	1	MO
MOVIPREP	3	MO
ondansetron	1	PA; MO
ondansetron hcl oral solution	1	PA; MO
ondansetron hcl oral tablet 24 mg	1	PA

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Drug Name	Drug Tier	Requirements /Limits
ondansetron hcl oral tablet 4 mg, 8 mg	1	PA; MO
ondansetron hcl (pf) injection solution	1	MO
peg 3350-electrolytes oral recon soln 236-22.74-6.74 gram	1	MO
PENTASA	2	MO
polyethylene glycol 3350 oral powder	1	MO
prochlorperazine	1	MO
prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)	1	MO
prochlorperazine maleate oral	1	MO
PROCTO-PAK	1	MO
PROCTOZONE-HC	1	MO
RECTIV	2	MO
RELISTOR	2	MO
REMICADE	2	PA; MO
SANCUSO	2	MO
SUCLEAR	2	MO
SUCRAID	2	MO
sulfasalazine oral tablet	1	MO
SULFAZINE EC	1	MO
SUPREP	2	MO
TRANSDERM-SCOP	2	MO
TRILYTE WITH FLAVOR PACKETS	1	MO
UCERIS	2	MO
ursodiol	1	MO
VIOKACE	2	MO
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-34,000 - 55,000 UNIT, 15,000-51,000 - 82,000 UNIT, 20,000-68,000 - 109,000 UNIT, 25,000-85,000-136,000 UNIT, 3,000-10,000-16,000 UNIT	2	MO
ULCER THERAPY		
amoxicil-clarithromy-lansopraz	1	MO; QL (112 per 30 days)
CARAFATE ORAL SUSPENSION	1	MO
cimetidine	1	MO
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 30 MG	3	MO; QL (30 per 30 days)
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 60 MG	3	MO
esomeprazole sodium	1	

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Drug Name	Drug Tier	Requirements /Limits
famotidine oral suspension	1	MO
famotidine oral tablet 20 mg, 40 mg	1	MO
famotidine (pf)	1	MO
famotidine (pf)-nacl (iso-os)	1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	1	MO; QL (30 per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	1	MO
misoprostol	1	MO
NEXIUM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG	2	MO; QL (30 per 30 days)
NEXIUM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40 MG	2	MO
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG	2	MO; QL (30 per 30 days)
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	2	MO
nizatidine	1	MO
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg	1	MO; QL (30 per 30 days)
omeprazole oral capsule,delayed release(dr/ec) 40 mg	1	MO
omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram	1	MO; QL (30 per 30 days)
omeprazole-sodium bicarbonate oral capsule 40-1.1 mg-gram	1	MO
pantoprazole intravenous	1	MO
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	MO; QL (30 per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	MO
PYLERA	2	MO
rabeprazole	1	MO
ranitidine hcl injection solution 25 mg/ml	1	MO
ranitidine hcl oral capsule	1	MO
ranitidine hcl oral syrup	1	MO
ranitidine hcl oral tablet 150 mg, 300 mg	1	MO

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Drug Name	Drug Tier	Requirements /Limits
sucralfate oral tablet	1	MO
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE	2	MO
ARANESP (IN POLYSORBATE)	2	PA; MO
ARCALYST	2	PA; MO
AVONEX INTRAMUSCULAR KIT	2	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	2	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE	2	PA; MO; QL (4 per 28 days)
AVONEX ADMINISTRATION PACK	2	PA; MO; QL (4 per 28 days)
BETASERON SUBCUTANEOUS KIT	2	PA; MO; QL (15 per 28 days)
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
EXTAVIA SUBCUTANEOUS KIT	2	PA; MO; QL (15 per 28 days)
ILARIS (PF)	2	PA; MO; LA
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	2	MO
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	2	MO
LEUKINE	2	MO
MOZOBIL	2	MO
NEULASTA	2	PA; MO; QL (2 per 30 days)
NEUMEGA	2	MO
NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML	2	PA; MO
NEUPOGEN INJECTION SYRINGE	2	PA; MO
NORDITROPIN FLEXPRO	2	PA; MO
NORDITROPIN NORDIFLEX	2	PA; MO
PEGASYS	2	MO; QL (4 per 28 days)
PEGASYS CONVENIENCE PACK	2	MO; QL (4 per 28 days)
PEGASYS PROCLICK	2	MO; QL (4 per 28 days)
PEGINTRON	2	MO; QL (4 per 28 days)

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Drug Name	Drug Tier	Requirements /Limits
PEGINTRON REDIPEN	2	MO; QL (4 per 28 days)
PROCRIT	2	PA; MO
PROLEUKIN	2	MO
REBIF (WITH ALBUMIN)	2	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	2	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	2	PA; MO; QL (12 per 28 days)
REBIF TITRATION PACK	2	PA; MO; QL (12 per 28 days)
SYLATRON	2	MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	2	MO
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION	2	MO
bcg vaccine, live (pf)	2	
BOOSTRIX TDAP	2	MO
BOTOX INJECTION RECON SOLN 100 UNIT	2	PA; MO
CERVARIX VACCINE (PF)	2	MO
COMVAX (PF)	2	MO
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SUSPENSION	2	PA; MO
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	2	PA
fomepizole	1	MO
GAMASTAN S/D	2	MO
GARDASIL (PF) INTRAMUSCULAR SUSPENSION	2	MO
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	2	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	2	
IMOVAX RABIES VACCINE (PF)	2	MO
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	2	
IPOL INJECTION SUSPENSION	2	MO

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Drug Name	Drug Tier	Requirements /Limits
IXIARO (PF)	2	MO
M-M-R II (PF)	2	MO
MENACTRA (PF)	2	MO
MENOMUNE - A/C/Y/W-135 (PF)	2	MO
MENVEO A-C-Y-W-135-DIP (PF)	2	MO
PEDVAX HIB (PF)	2	MO
PRIVIGEN	2	PA; MO
PROQUAD (PF)	2	
RABAVERT (PF)	2	MO
RAGWITEK	2	MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	2	PA; MO
ROTARIX	2	
ROTATEQ VACCINE	2	
tetanus toxoid,adsorbed (pf)	1	MO
tetanus-diphtheria toxoids-td	2	MO
THYMOGLOBULIN	2	PA
TWINRIX (PF) INTRAMUSCULAR SUSPENSION	2	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	2	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	2	MO
VARIVAX (PF)	2	MO
YF-VAX (PF)	2	MO
ZOSTAVAX (PF)	2	MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
allopurinol	1	MO
ALOPRIM	1	
colchicine-probenecid	1	MO
COLCRYS	2	MO
probenecid	1	MO
ULORIC	2	ST; MO
OSTEOPOROSIS THERAPY		
alendronate oral solution	1	MO; QL (1286 per 30 days)
alendronate oral tablet 10 mg, 5 mg	1	MO; QL (30 per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	MO; QL (4 per 28 days)
FORTEO	2	PA; MO; QL (2.4 per 28 days)
FOSAMAX PLUS D	3	MO; QL (4 per 28 days)
ibandronate intravenous	2	PA; MO
ibandronate oral	1	MO; QL (1 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
PROLIA	2	PA; MO
raloxifene	1	MO
risedronate	1	MO; QL (1 per 30 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA	2	PA; MO
BENLYSTA INTRAVENOUS RECON SOLN 120 MG	2	MO
CUPRIMINE	2	MO
DEPEN TITRATABS	2	MO
ENBREL SUBCUTANEOUS KIT	2	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51)	2	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (0.98 ML)	2	PA; MO; QL (4 per 28 days)
ENBREL SURECLICK	2	PA; MO; QL (4 per 28 days)
HUMIRA SUBCUTANEOUS KIT 20 MG/0.4 ML	2	PA; MO; QL (2 per 28 days)
HUMIRA SUBCUTANEOUS KIT 40 MG/0.8 ML	2	PA; MO; QL (3.2 per 28 days)
HUMIRA CROHN'S DIS START PCK	2	PA; MO; QL (4.8 per 180 days)
HUMIRA PEN	2	PA; MO; QL (3.2 per 28 days)
HUMIRA PSORIASIS STARTER PACK	2	PA; MO; QL (3.2 per 180 days)
leflunomide	1	MO; QL (30 per 30 days)
ORENCIA	2	PA; MO
ORENCIA (WITH MALTOSE)	2	PA; MO
OTEZLA	2	PA; MO
OTEZLA STARTER	2	PA; MO
RIDAURA	3	MO
SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	2	MO; QL (1 per 30 days)
SIMPONI	2	PA; MO
SIMPONI ARIA	2	PA; MO
XELJANZ	2	PA; MO
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
CAMILA	1	MO
CRINONE VAGINAL GEL 4 %	3	MO
CRINONE VAGINAL GEL 8 %	3	PA; MO

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Drug Name	Drug Tier	Requirements /Limits
DEPO-PROVERA INTRAMUSCULAR SOLUTION	2	MO
DEPO-SUBQ PROVERA 104	3	MO
ERRIN	1	MO
ESTRACE VAGINAL	2	MO
estradiol oral	1	MO
estradiol transdermal	1	MO; QL (4 per 28 days)
estradiol valerate	1	MO
estradiol-norethindrone acet	1	MO
ESTRING	3	MO
estropipate	1	MO
JOLIVETTE	1	MO
LYZA	1	
medroxyprogesterone intramuscular suspension	1	MO
medroxyprogesterone oral	1	MO
MENEST	3	MO
MIMVEY	1	MO
MIMVEY LO	1	MO
NORA-BE	1	MO
norethindrone (contraceptive)	1	MO
norethindrone acetate	1	MO
PREMARIN ORAL	2	MO
PREMARIN VAGINAL	2	MO
progesterone micronized	1	MO
VAGIFEM	2	MO
MISCELLANEOUS OB/GYN		
CLEOCIN VAGINAL SUPPOSITORY	2	MO
clindamycin phosphate vaginal	1	MO
metronidazole vaginal	1	MO
MICONAZOLE-3 VAGINAL SUPPOSITORY	1	MO
NUVARING	3	MO
ORTHO EVRA	3	MO
terconazole	1	MO
tranexamic acid oral	1	MO
VANDAZOLE	1	MO
XULANE	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
AMETHIA	1	MO
AMETHYST	1	MO
APRI	1	MO
ARANELLE (28)	1	MO
AVIANE	1	MO
BALZIVA (28)	1	MO
BRIELLYN	1	MO
CRYSELLE (28)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
CYCLAFEM 1/35 (28)	1	MO
CYCLAFEM 7/7/7 (28)	1	MO
drospirenone-ethinyl estradiol	1	
ELLA	2	MO
EMOQUETTE	1	MO
ENPRESSE	1	MO
GIANVI (28)	1	MO
GILDAGIA	1	MO
INTROVALE	1	MO
JUNEL 1.5/30 (21)	1	MO
JUNEL 1/20 (21)	1	MO
JUNEL FE 1.5/30 (28)	1	MO
JUNEL FE 1/20 (28)	1	MO
KARIVA (28)	1	MO
KELNOR 1/35 (28)	1	MO
LARIN 1/20 (21)	1	
LARIN FE	1	MO
LEENA 28	1	MO
LESSINA	1	MO
LEVONEST (28)	1	MO
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	1	MO
LEVORA-28	1	MO
LOMEDIA 24 FE	1	MO
LORYNA (28)	1	MO

Drug Name	Drug Tier	Requirements /Limits
LOW-OGESTREL (28)	1	MO
LUTERA (28)	1	MO
MARLISSA	1	MO
MICROGESTIN 1.5/30 (21)	1	MO
MICROGESTIN 1/20 (21)	1	MO
MICROGESTIN FE 1.5/30 (28)	1	MO
MICROGESTIN FE 1/20 (28)	1	MO
MONONESSA (28)	1	MO
NECON 0.5/35 (28)	1	MO
NECON 1/35 (28)	1	MO
NECON 1/50 (28)	1	MO
NECON 10/11 (28)	1	MO
NECON 7/7/7 (28)	1	MO
NORTREL 0.5/35 (28)	1	MO
NORTREL 1/35 (21)	1	MO
NORTREL 1/35 (28)	1	MO
NORTREL 7/7/7 (28)	1	MO
OCELLA	1	MO
OGESTREL (28)	1	MO
ORSYTHIA	1	MO
PIMTREA (28)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
PIRMELLA ORAL TABLET 1-35 MG-MCG	1	MO
PORTIA	1	MO
PREVIFEM	1	MO
QUASENSE	1	MO
RECLIPSEN (28)	1	MO
SPRINTEC (28)	1	MO
SRONYX	1	MO
TRI-LEGEST FE	1	MO
TRI-PREVIFEM (28)	1	MO
TRI-SPRINTEC (28)	1	MO
TRINESSA (28)	1	MO
TRIVORA (28)	1	MO
VELIVET TRIPHASIC REGIMEN (28)	1	MO
VESTURA (28)	1	MO
VYFEMLA (28)	1	MO
ZENCHENT (28)	1	MO
ZENCHENT FE	1	MO
ZOVIA 1/35E (28)	1	MO
ZOVIA 1/50E (28)	1	MO
OXYTOCICS		
methylergonovine oral	1	MO
OPHTHALMOLOGY		
ANTIBIOTICS		
bacitracin ophthalmic	1	MO
bacitracin-polymyxin b ophthalmic	1	MO
BESIVANCE	2	MO
CILOXAN OPHTHALMIC OINTMENT	2	MO
ciprofloxacin ophthalmic	1	MO
erythromycin ophthalmic	1	MO
gatifloxacin	1	MO
GENTAK OPHTHALMIC OINTMENT	1	MO
gentamicin ophthalmic drops	1	MO
gentamicin ophthalmic ointment	1	
levofloxacin ophthalmic	1	MO
NATACYN	2	MO
neomycin-bacitracin-polymyxin	1	MO
neomycin-polymyxin-gramicidin	1	MO
ofloxacin ophthalmic	1	MO
polymyxin b sulf-trimethoprim	1	MO
tobramycin	1	MO

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Drug Name	Drug Tier	Requirements /Limits
TOBREX OPHTHALMIC OINTMENT	2	MO
ANTIVIRALS		
trifluridine	1	MO
ZIRGAN	3	MO
BETA-BLOCKERS		
betaxolol ophthalmic	1	MO
carteolol	1	MO
levobunolol ophthalmic drops 0.5 %	1	MO
metipranolol	1	MO
timolol maleate ophthalmic	1	MO
CHOLINESTERASE INHIBITOR MIOTICS		
PHOSPHOLINE IODIDE	3	MO
DIRECT ACTING MIOTICS		
pilocarpine hcl ophthalmic	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
azelastine ophthalmic	1	MO
BEPREVE	2	MO
cromolyn ophthalmic	1	MO
CYSTARAN	2	MO
epinastine	1	MO
LACRISERT	2	MO
LASTACAFT	2	MO
PATADAY	2	MO
PATANOL	2	MO
RESTASIS	2	MO; QL (60 per 30 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
bromfenac	1	MO
diclofenac sodium ophthalmic	1	MO
flurbiprofen sodium	1	MO
ILEVRO	2	MO
ketorolac ophthalmic	1	MO
NEVANAC	2	MO
PROLENSA	2	MO
ORAL DRUGS FOR GLAUCOMA		
acetazolamide oral	1	MO
acetazolamide sodium	1	
methazolamide oral	1	MO
OTHER GLAUCOMA DRUGS		
COMBIGAN	2	MO
dorzolamide	1	MO
dorzolamide-timolol	1	MO
latanoprost	1	MO
LUMIGAN	2	MO
SIMBRINZA	3	MO
TRAVATAN Z	2	MO
travoprost (benzalkonium)	1	MO

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Drug Name	Drug Tier	Requirements /Limits
ZIOPTAN (PF)	3	ST; MO
STEROID-ANTIBIOTIC COMBINATIONS		
neomycin-bacitracin-poly-hc	1	MO
neomycin-polymyxin-dexameth	1	MO
neomycin-polymyxin-hc ophthalmic	1	MO
tobramycin-dexamethasone	1	MO
ZYLET	2	MO
STEROIDS		
ALREX	2	MO
dexamethasone sodium phosphate ophthalmic	1	MO
FML S.O.P.	2	MO
LOTEMAX	2	MO
prednisolone acetate	1	MO
prednisolone sodium phosphate ophthalmic	1	MO
STEROID-SULFONAMIDE COMBINATIONS		
BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	3	MO
sulfacetamide-prednisolone	1	MO
SULFONAMIDES		
BLEPH-10	2	MO
sulfacetamide sodium ophthalmic	1	MO
SYMPATHOMIMETICS		
ALPHAGAN P OPHTHALMIC DROPS 0.1 %	2	MO
apraclonidine	1	MO
brimonidine	1	MO
IOPIDINE OPHTHALMIC DROPPERETTE	3	MO
VASOCONSTRICTOR DECONGESTANTS		
naphazoline	1	MO
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGENIC AGENTS		
ADRENALIN INJECTION SOLUTION 1 MG/ML (1:1,000) (1ML)	1	
cetirizine oral solution 1 mg/ml	1	MO
desloratadine	1	MO; QL (30 per 30 days)
diphenhydramine hcl injection solution	1	MO
diphenhydramine hcl oral elixir	1	PA; MO
EPIPEN	2	QL (4 per 30 days)
EPIPEN 2-PAK	2	MO; QL (4 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
EPIPEN JR	2	QL (4 per 30 days)
EPIPEN JR 2-PAK	2	MO; QL (4 per 30 days)
hydroxyzine hcl oral tablet	1	PA; MO
levocetirizine oral solution	1	MO
levocetirizine oral tablet	1	MO; QL (30 per 30 days)
promethazine injection solution	1	MO
PULMONARY AGENTS		
acetylcysteine solution	1	PA; MO
ADCIRCA	2	PA; MO; QL (60 per 30 days)
ADEMPAS	2	PA; MO; LA
ADVAIR DISKUS	2	MO; QL (60 per 30 days)
ADVAIR HFA	2	MO; QL (12 per 30 days)
AEROSPAN	2	MO; QL (17.8 per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml	1	PA; MO
albuterol sulfate oral	1	MO
aminophylline intravenous solution 250 mg/10 ml	1	MO
ANORO ELLIPTA	2	MO; QL (60 per 30 days)
ARCAPTA NEOHALER	3	MO; QL (30 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (30 DOSES)	2	MO; QL (30 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (120 DOSES)	2	MO; QL (240 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (60 DOSES)	2	MO; QL (60 per 30 days)
ATROVENT HFA	2	MO; QL (25.8 per 30 days)
BREO ELLIPTA	2	MO; QL (60 per 30 days)
budesonide inhalation	1	PA; MO
budesonide nasal	1	MO; QL (17.2 per 30 days)
CINRYZE	2	PA; MO
COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
cromolyn inhalation	1	PA; MO
DALIRESP	2	PA; MO
DULERA	2	MO; QL (13 per 30 days)
DYMISTA	2	MO; QL (23 per 30 days)
ELIXOPHYLLIN	3	MO
FIRAZYR	2	PA; MO
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	2	MO; QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	MO; QL (240 per 30 days)
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACTUATION	2	MO; QL (12 per 30 days)
FLOVENT HFA INHALATION AEROSOL 220 MCG/ACTUATION	2	MO; QL (24 per 30 days)
FLOVENT HFA INHALATION AEROSOL 44 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
flunisolide	1	MO; QL (50 per 30 days)
fluticasone nasal	1	MO; QL (16 per 30 days)
FORADIL AEROLIZER	2	MO; QL (60 per 30 days)
ipratropium bromide inhalation	1	PA; MO
ipratropium-albuterol	1	PA; MO
KALBITOR	2	MO
KALYDECO	2	MO
LETAIRIS	2	PA; MO; LA
levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml	1	PA; MO
metaproterenol	1	MO
montelukast	1	MO
NASONEX	2	MO; QL (34 per 30 days)
OPSUMIT	2	PA; MO; LA
PERFOROMIST	2	PA; MO
PROAIR HFA	2	MO; QL (17 per 30 days)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 1 MG/2 ML	2	PA; MO
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	2	MO; QL (2 per 30 days)

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Drug Name	Drug Tier	Requirements /Limits
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	2	MO; QL (1 per 30 days)
PULMOZYME	2	PA; MO
QVAR	2	MO; QL (17.4 per 30 days)
REVATIO INTRAVENOUS	2	PA; MO
SEREVENT DISKUS	2	MO; QL (60 per 30 days)
sildenafil	1	PA; MO; QL (90 per 30 days)
SPIRIVA WITH HANDIHALER	2	MO; QL (90 per 30 days)
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION	2	MO; QL (10.2 per 30 days)
SYMBICORT INHALATION HFA AEROSOL INHALER 80-4.5 MCG/ACTUATION	2	MO; QL (6.9 per 30 days)
terbutaline oral	1	MO
terbutaline subcutaneous	1	MO
THEO-24	3	MO
theophylline oral solution	1	MO
theophylline oral tablet extended release	1	MO
theophylline oral tablet extended release 12 hr	1	MO
TRACLEER	2	PA; MO; LA
triamcinolone acetonide nasal	1	MO; QL (16.5 per 30 days)
TYVASO	2	PA; MO
XOLAIR	2	PA; MO; LA; QL (6 per 28 days)
zafirlukast	1	MO
ZYFLO	3	MO
ZYFLO CR	3	MO
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
ENABLEX	2	MO
flavoxate	1	MO
MYRBETRIQ	2	MO
oxybutynin chloride oral	1	MO
tolterodine	1	MO
TOVIAZ	2	MO
trospium	1	MO
VESICARE	2	MO
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
alfuzosin	1	MO
AVODART	2	MO

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Drug Name	Drug Tier	Requirements /Limits
finasteride oral tablet 5 mg	1	MO
JALYN	2	MO
RAPAFLO	2	ST; MO
tamsulosin	1	MO
CHOLINERGIC STIMULANTS		
bethanechol chloride	1	MO
MISCELLANEOUS UROLOGICALS		
CIALIS ORAL TABLET 2.5 MG, 5 MG	2	PA; MO; QL (30 per 30 days)
CYSTAGON	2	MO; LA
ELMIRON	2	MO
potassium citrate oral tablet extended release 10 meq, 5 meq	1	MO
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
calcium acetate oral capsule	1	MO
ELIPHOS	1	MO
K-TAB	3	MO
KLOR-CON ORAL TABLET EXTENDED RELEASE	1	MO
KLOR-CON 10	1	MO
KLOR-CON M15	1	MO
KLOR-CON M20	1	MO

Drug Name	Drug Tier	Requirements /Limits
lactated ringers intravenous	1	MO
magnesium sulfate injection syringe	1	
NORMOSOL-R IN 5 % DEXTROSE	2	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 30 meq/l, 40 meq/l	1	
potassium chlorid-d5-0.45%nacl intravenous parenteral solution 20 meq/l	1	MO
potassium chloride intravenous parenteral solution	1	MO
potassium chloride intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	1	
potassium chloride oral capsule, extended release	1	MO
potassium chloride oral tablet,er particles/crystals	1	MO
potassium chloride in 0.9%nacl	1	

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Drug Name	Drug Tier	Requirements /Limits
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l	1	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	1	MO
potassium chloride-0.45 % nacl	1	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	1	MO
potassium chloride-d5-0.3%nacl	1	
potassium chloride-d5-0.9%nacl	1	
ringers intravenous	1	
sodium chloride intravenous parenteral solution 2.5 meq/ml	1	MO
sodium chloride 0.45 % intravenous parenteral solution	1	MO
sodium chloride 3 %	1	MO
sodium chloride 5 %	1	
sodium lactate intravenous	1	
MISCELLANEOUS NUTRITION PRODUCTS		
AMINOSYN II 10 %	2	PA
AMINOSYN II 15 %	2	PA
AMINOSYN II 7 %	2	PA
AMINOSYN II 8.5 %	2	PA
AMINOSYN II 8.5 %-ELECTROLYTES	2	PA
AMINOSYN-PF 10 %	2	PA
AMINOSYN-PF 7 % (SULFITE-FREE)	2	PA
CLINIMIX 5%/D15W SULFITE FREE	2	PA
CLINIMIX 5%/D25W SULFITE-FREE	2	PA
CLINIMIX 2.75%/D5W SULFIT FREE	2	PA
CLINIMIX 4.25%-D20W SULF-FREE	2	PA
CLINIMIX 4.25%-D25W SULF-FREE	2	PA
CLINIMIX 4.25%/D10W SULF FREE	2	PA
CLINIMIX 5%-D20W(SULFITE-FREE)	2	PA
HEPATAMINE 8%	2	PA
HEPATASOL 8 %	2	PA

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Drug Name	Drug Tier	Requirements /Limits
INTRALIPID INTRAVENOUS EMULSION 20 %	1	PA; MO
INTRALIPID INTRAVENOUS EMULSION 30 %	2	PA
IONOSOL-B IN D5W	2	
IONOSOL-MB IN D5W	2	
ISOLYTE-P IN 5 % DEXTROSE	2	
ISOLYTE-S	2	
LIPOSYN III INTRAVENOUS EMULSION 10 %, 20 %	1	PA
NEPHRAMINE 5.4 %	2	PA
NORMOSOL-R PH 7.4	2	
PLASMA-LYTE 148	2	
PLASMA-LYTE A	2	
PLASMA-LYTE-56 IN 5 % DEXTROSE	2	
PREMASOL 10 %	1	PA
PREMASOL 6 %	2	PA
TRAVASOL 10 %	2	PA
TROPHAMINE 10 %	2	PA
TROPHAMINE 6%	2	PA
VITAMINS / HEMATINICS		
PRENATAL VITAMIN	1	
sodium fluoride oral tablet	1	

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With Express Scripts Medicare, you will have access to over 68,000 network pharmacies nationally. You may fill your prescriptions at a retail, home infusion, long-term care or Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) pharmacy, or through our convenient home delivery service.

You must use network pharmacies to fill your prescriptions to get the most of your benefit. However, there are emergency circumstances under which you may be reimbursed for a covered prescription that is not filled at a network pharmacy. Limitations, copayments and restrictions may apply.

This formulary was updated on 08/06/2014. For more recent information or other questions, please contact Express Scripts Medicare Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week. You can also visit us on the Web at **www.Express-Scripts.com**.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

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